# The Malaysian Medical Association's Position Paper on Domiciliary-Based Primary Medical Care

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## Abstract

Home visits, house calls, domiciliary-based primary medical care, and concierge care are variations of the same service, which is now experiencing a resurgence in the private healthcare sector. However, this service presents several uncertainties regarding medicolegal considerations, clinical guidelines, and limitations of the provider. This paper seeks to address key concerns related to domiciliary care while also providing practice-based guidelines derived from both local and international sources. As guidelines continue to evolve, this paper will require periodic revisions.

## Introduction

House calls refer to primary care services provided at a patient's home. For this paper, the discussion is limited to that context. House calls, home visits and concierge care are gaining popularity due to various factors. In the early 19th century, home visits accounted for nearly 40% of a physician's service offerings. However, this practice declined in the 1980s (Kao et al., 2009) and is now making a comeback, rebranded as concierge care. Given the growing aging population and increased demand for home-based medical services (Department of Statistics Malaysia, 2021), this paper aims to provide clarity on the subject.

## Problem Statement

### *Medicolegal Considerations*

- Both Act 586 (Private Healthcare Facilities and Services Act 1998) and Act 50 (Medical Act 1971) provide little to no guidance on a doctor's responsibilities regarding house calls.
- Medical indemnity insurance policies often limit coverage to a physician's designated practice territory, offering only minimal protection for Good Samaritan acts performed outside this area.
- Does this mean doctors should avoid house calls or restrict services to specific territories? Absolutely not.

## *Challenges of Home Visits*

1. *Interactions Beyond the Patient*
   Home visits involve not only the patient but also family members, caregivers, and well-wishers. These individuals may have unrealistic expectations regarding the scope of care a primary provider can offer, leading to potential conflicts.

2. *Limitations in Emergency Care*
   Even with advanced life support or emergency care training, most doctors lack the necessary equipment and auxiliary staff to handle life-threatening situations during home visits. It is crucial to remember that house calls are not emergency medical services but rather routine primary care visits.

3. *Operational and Financial Costs*
   Leaving the clinic for a home visit results in additional expenses, such as hiring a locum doctor or temporarily suspending clinic operations. This can negatively impact the clinic's financial sustainability.

# Position Statement

Providing healthcare services outside the clinic offers numerous challenges. However, rather than avoiding house calls altogether, healthcare providers should be well-informed and prepared to ensure the highest quality of care, regardless of location. The following recommendations are based on clinical practice guidelines.

## *Key Considerations for Home Visits*

1. *Triaging Patients Effectively*
   Telemedicine can assist in pre-assessing patients and determining whether a home visit is necessary (Lai et al., 2005).

2. *Prioritizing Safety*
   The safety of both the patient and the healthcare provider must be paramount. If a request appears suspicious, threatening, or deceptive, it should be declined.

   Providers should never attend home visits alone and must have a contingency plan in case the situation becomes unsafe (West Pennine LMC, 2015).

3. *Preparation and Medical Equipment*
   Before the visit, all relevant patient information should be collected to allow the doctor to plan logistics, including medications, consumables, and diagnostic kits (Morden Hall Medical Centre, 2015).

4. *Detailed Medical Documentation*
   Comprehensive records should be maintained, covering initial patient contact, events during the visit, and travel details (National Guideline Centre & Royal College of Physicians, 2018).

5. *Understanding Limitations*

Most primary care clinics are equipped with emergency trolleys and staff to handle medical emergencies. In contrast, home visits lack these resources. If a provider is not confident in managing a patient at home, they should refer them to a healthcare facility (National Guideline Centre & Royal College of Physicians, 2018).

6. *Transparent Fee Structure*

The cost of a home visit must reflect:

- Consultation and treatment fees.
- Travel time and expenses.
- Potential loss of income from clinic closures.

Providers are advised to follow the fee guidelines established under the Private Healthcare Facilities and Services Act 1998.

7. *Managing Expectations*

Providers should be mindful of their own mental well-being. The nature of home visits often requires compromises in medical service quality, which can impact morale. Clear and realistic expectations should be set before offering this service (West Pennine LMC, 2015).

8. *Ensuring Continuity of Care*

Clinics should remain operational even when a doctor is conducting home visits. Ideally, two doctors should be on duty to maintain clinic operations and ensure patient care remains uninterrupted.

9. *Cultural Sensitivity*

Malaysia's diverse cultural and religious landscape requires providers to approach home visits with respect and non-judgment. The focus should remain on delivering medical care (Department of Human Service, 2022).

## *Alternative Approach: Dedicated Mobile Teams*

Establishing a dedicated mobile medical team could be an efficient alternative to physicians conducting house calls themselves. However, the high operational costs pose challenges for most private primary care providers.

# SMART Recommendations

To ensure successful implementation, the home visit strategy must meet SMART criteria:

- Specific: Establish a structured workflow with clear eligibility criteria for home visits.
- Measurable: Monitor patient satisfaction, recall rates, and doctor productivity.
- Attainable: Ensure financial sustainability through tiered consultation fees.
- Relevant: Focus on elderly care, chronic disease management, and post-hospitalization follow-ups.
- Time-bound: Implement a 6-month pilot program with periodic assessments.

# Implementation Strategy

### *Pre-Visit Triage & Assessment*

- Conduct telemedicine screenings to determine the necessity of a home visit.
- Gather patient history and assess medical needs.

### *Safety & Risk Management*

- High-risk visits should include accompaniment for the physician.
- Implement personal protective equipment (PPE) protocols and emergency contact plans.

### *Financial Structure & Insurance Integration*

- Introduce tiered pricing based on distance and complexity.
- Evaluate insurance coverage for home-based medical services.

### *Staffing & Training*

- Train GPs and nurses in mobile diagnostics and homes visit protocols.
- Ensure clinic staff can manage appointments in the absence of home-visiting doctors.

### *Follow-Up & Continuity of Care*

- Schedule follow-up appointments at the clinic or via telehealth.
- Digitally integrate records for seamless documentation.

# Monitoring & Evaluation Strategy

### *Key Performance Indicators (KPIs)*

- Patient Satisfaction Rate: Target >90% approval.
- Reduction in Emergency Visits: Compare pre- and post-home visit data.
- Operational Efficiency: Measure time spent per visit vs. clinic consultations.
- Financial Viability: Ensure revenue covers operational costs.
- Compliance & Risk Management: Track medico-legal incidents.

### *Review Period*

- Quarterly evaluations to refine strategies.
- Annual policy reviews to maintain regulatory compliance.

# Conclusion

These recommendations are adapted from international clinical practice guidelines and tailored for local implementation. However, they should be considered as general guidelines, as individual patient needs will vary.

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