A hundred years ago, district medical officers made house calls. Now, patients tend to go to the casualty clinic. However, house calls may be crucial for appropriate treatment and follow-up.

From family doctor to medical centre

For a district medical officer in the late 19th century, a house call could last several days (1). People did not take it for granted that the doctor would invariably be able to come. A hundred years ago, general practitioners still spent a large part of their working day on the road, even though telephones and cars rapidly helped free up more time for patients (1). My grandfather, Abraham Randinius Aasland (1879–1942), who was a general practitioner in Skien in the years 1914–42, was not among the automobile pioneers. He preferred to travel by Shanks's pony and actually died while on the way to a house call on foot. My father, Arne Jacob Aasland (1913–85), who took over his practice, also spent a lot of his time on house calls. His working day was divided into two: seeing patients in his surgery in the daytime, then home for supper and a brief nap before going out by car for 3–4 house calls. At weekends, the GPs in Skien organised their own voluntary on-call schedule.

As for myself, I belong to the generation of doctors who undertook on-call duty as a sideline. As a young, fledgling doctor, it was a major challenge to visit a worried family and convey calmness and confidence. At that time there was nothing called patient safety – people were happy to have a doctor call on them at home and took it for granted that the doctor would always do what could possibly be done.

This form of out-of-hours activity has now been replaced by the new municipal system of medical centres. It is obviously a more rational solution that the patients come to the doctor instead of having the doctor call on each individual patient. Out of 191 municipal and inter-municipal out-of-hours schemes in 2014, only five were categorised as «mobile doctor». The vast majority of them were located in some form of medical centre (2). However, out-of-hours duty is still largely a sideline for doctors who are not necessarily working in the primary health services. In 2013, only 20.4 % of all out-of-hours consultations were performed by specialists in general practice (3). The rest were most likely performed by young, fledgling doctors who have a lot of theoretical competence but fewer practical skills (4). Obtaining a job as an occasional out-of-hours doctor is not difficult since many GPs are not very motivated for extra on-call duty and are more than happy to assign their duty periods to somebody else (5).

An out-of-hours arrangement based on occasional doctors is obviously not an optimal solution. A hearing memo for the new regulations on emergency medical services (6) proposes that out-of-hours doctors should be specialists or specialty registrars in general practice, or specialists or specialty registrars in internal medicine, surgery, paediatrics, neurology or anaesthesiology. If these regulations are adopted and followed up, we will have taken a major step towards improving the quality and safety of out-of-hours services.

The recommendation to establish inter-municipal cooperation in the provision of out-of-hours services featured already in the Municipal Health Services Act in 1984, and it is increasingly being followed. The number of single-municipality casualty clinics has declined from 102 in 2009 to 80 in 2014 (2). One would assume that this pooling of resources would lead to better quality in each casualty clinic, but such an effect has been difficult to prove so far. In 2014, eight out of ten casualty clinics have only a single doctor on duty in the evenings, at night and at weekends, and only one of five casualty clinics have organised a secondary on-call scheme for the doctor on duty (2). For many patients, fewer medical centres mean increasing distances to the casualty clinic. Unless this is compensated for by better service quality, the patients stand to lose. If this is the case, we have created an acute and serious health policy problem for ourselves.

In this issue of the Journal of the Norwegian Medical Association, the recently established but highly productive National Centre for Emergency Primary Health Care provides a detailed overview of distances and travel times to casualty clinics (7), and they have estimated the correlation between travel distances and utilisation (8). The centre is in the process of establishing and operating a national emergency primary health care registry (9), and has developed a method that uses postcodes to calculate the distance to the nearest casualty clinic, and thereby also the travel time and distance for each municipality. They find that the longer the distance to the casualty clinic, the less it is utilised, and that in more than half of all municipalities the travel distance will be so long as to threaten patient safety. A natural remedy would be to make the out-of-hours services more mobile in order to reach those patients who otherwise would not have turned up – meaning more doctors on secondary on-call duty. Perhaps it will also be important to improve our ability to reject patients who are not in need of urgent treatment?

My first landmark house calls as a foundation doctor in Rogaland county fortunately went well; as far as I know, no dead or injured patients were left lying under my steep but spectacular learning curve. In the name of rationalisation and patient safety we should not cease to make house calls. Hopefully, all good GPs visit their patients at home whenever this is necessary. Meeting the patients on their home ground, especially the elderly and chronically ill but also substance abusers and psychiatric patients, is often a precondition for the ability to provide appropriate treatment and not least prevent future acute episodes. House calls should be included in foundation periods as well as in basic training, as has been done in the new study programme at the University of Bergen (10, 11).

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