

## NEW PERSPECTIVES

## Coming Home to Visit

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**S**now disrupts life in North Carolina the way that a bath inconveniences and provokes a house cat. It brings a mix of the ridiculous, the catastrophic, and the miraculous—and that's why snow is so much more enjoyable in the South. Because of its relative novelty, we have not developed the routines that allow us to handle snow efficiently or without histrionics. In February 2014, central North Carolina was surprised by five inches of snow with a simultaneous freeze-over of the roads. More than 1,000 people—visitors, doctors, staff, and ambulatory patients—spent an unexpected night at the hospital. The roads were littered with abandoned cars pointing bizarrely in all directions—all because the coefficient of rolling friction had been suspended for an afternoon. For two days, ambulatory and elective services were canceled.

On the second day of the catastrophe, my afternoon clinic was canceled. I did, however, have three home visits scheduled for the morning. The roads were still frozen, but the day promised warmer temperatures that would unfreeze them. I have a four-wheel drive pickup truck. Although there was institutional dispensation to take the day off, I saw no reason for the visits not to proceed. I first drove to a local apartment complex and picked up the resident assigned to work with me. There, people were finally digging out their cars only to discover that unplowed parking lots, lack of clearance, and the ongoing lack of friction on paved surfaces were continuing to make driving very difficult.

We soon headed 20 miles into a rural North Carolina county. Once we left the interstate, the road was really lousy, and for the first time in our four-year relationship, I felt that my

pickup truck was not, after all, the manly indulgence for which it was intended. Our first visit was at the house of a 93-year-old woman who had recently been hospitalized with both pneumonia and a urinary tract infection. She had had respiratory failure and was barely spared endotracheal mechanical ventilation by a bipap apparatus. This patient was neither one of my continuity patients nor one of the resident's. She was another resident physician's patient, and we were seeing her as a part of a broader initiative in our clinic to reduce hospital readmissions.

The patient was surprised to see us. Patients are surprised to learn that anyone still does home visits. A home visit combined with a snowstorm in North Carolina was even more disorienting. (Just consider the independent probabilities!) That is, two unnatural phenomena were occurring simultaneously. The patient lived alone in a "double-wide" modular home, but she was surrounded by relatives spanning five generations.

Whenever I do home visits, I avoid discussion of medical issues for at least several minutes after entering the house. After all, it's my patient's home—not an exam room, an operating room, or an infusion center. I start with the social history and try to talk about something that has personal meaning. The easiest way to figure this out, especially in patients you have not seen before, is to look at the walls and surfaces and ask about what they have mounted on them. Decorations and keepsakes are a good place to start a conversation on the safe assumption that people usually showcase the things in their lives that remind them of joy, love, and achievement. Often, these are family pictures, but other items on display have included trophy fish

(bass in North Carolina), trophy animals shot in Africa, and in one case a bronze sculpture that a resident estimated was worth as much as all of her medical school loans.

On this day, I was drawn to a fading black-and-white picture on the wall. It was the picture of an African-American man in the fields wearing a semi-sleeveless white work shirt, and on his head was a classy fedora relegated to sun protection. He was vigorous and had a bright, proud smile. He was probably in his early to mid 40s when the picture was taken. His arms told the story of his life. They were long and muscular. These were the honest arms of a laborer.

I asked the patient if this was her husband. She said it was. When was it taken?

The mid 1950s. I knew that the patient was a widow. I asked when her husband had died. A few years after the picture, she replied. What did he die of? A stroke. Life was hard for farmers in the central piedmont of North Carolina, I concluded. The plausible sequence of events was clear: poverty, untreated hypertension, no health care, cardiovascular disease, premature death. I then asked about her children. She had had six. I asked her how many were still alive. Just one, she responded. I thought that my inquiry about the social circumstances of her life was possibly counter-therapeutic. To avoid potentially inflicting more emotional harm, I signaled to the resident that it was time to start the medical portion of the visit. Life was hard for poor families in North Carolina in the last century, I reminded myself again.

We started with the neurologic exam. I asked the patient to bring us her medications. She rose easily from a couch, walked across her cluttered room, and handed me a box of pills.   
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tered living room, down a hall, and returned with about eight bottles, which she laid out on a table. We asked her how she felt. Fine, she said. She was no longer using the oxygen she came home with, and my pulse oximeter confirmed that she no longer needed it. Her vitals and exam were otherwise normal. She was attending to all of her activities of daily living. She had family checking in on her. Meanwhile, the resident was astonished. As it happens, she had cared for the patient during her recent hospitalization, and this was not the dependent and enfeebled person she remembered. In the hospital, she had even questioned the utility of such aggressive supportive care in a 93-year-old woman. As it turned out, her illness and hospitalization had only temporarily suppressed a vitality that her caregivers did not imagine existed. Our visit was over, we thought.

As we walked out of the house and prepared to leave, a sedan pulled sloppily into the snowy driveway. A tall, professional-looking man

emerged. He started by apologizing for what was a very unsatisfactory rental car. He identified himself as the patient's son, which meant her last surviving child. He was a colonel in the military and had come from Texas to check on his mother after the snowstorm. We introduced ourselves as physicians caring for his mother, and we offered to return to the house to discuss recent medical events.

Nothing had prepared us for the nature of their reunion as we all entered the house together. This woman, in her nineties, positively levitated off of her couch. Her glee was intense and incandescent. She was sparkling, effervescing. She literally seemed seventy years younger at that moment. An exchange of affectionate taunts and false insults ensued between mother and son. She was flirting with her child. She was proud. We were witnessing something miraculous, but we were intruders. We efficiently explained recent medical events and left. The snow was melting rapidly, and the drive to the next visit was uneventful.

I tell learners and colleagues that home visits are done for the convenience of the patient. This may seem obvious and mundane to the point of irrelevance—except when you consider how many ways our fragmented and self-absorbed health care system inconveniences patients and their families. Until this visit, I also asserted that home visits teach us to respect our patients in a way that is not possible within medical space. After this visit, I realized that home visits can do something more profound. Not only can they reinforce our respect for patients, but they can also teach us to admire them—their autonomy, their resilience, their joy, their pride. The act of admiring patients catalyzes altruism, displacing our attention from ourselves and our practice environments to the patient and her environment. They are a respite and sanctuary from the kind of utilitarian care that limits our view of the patient to the immediate and finite. In the end, the humanity we share is infinite.

*SGIM*