Domiciliary consultation — who benefits?

PETER C. LITTLEJOHNS, BSc, MRCGP
Registrar in Community Medicine, Merton and Sutton District Health Authority

SUMMARY. A survey was conducted of the domiciliary consultation service provided in one health district in order to identify the pattern of referral by specialty, the reasons for the consultation and its outcome and to determine whether the service is realizing its original objectives.

The district domiciliary consultation service was used in the majority of cases as an initial means of assessment for elderly patients with chronic disease. The majority of patients were kept out of hospital but responsibility for their care was usually transferred to the consultant. The domiciliary consultation service was rarely used as a means for joint consultation between family doctor and hospital specialist. To facilitate the care of patients in the community, it is suggested that domiciliary visiting should be incorporated into a consultant's NHS contract and the present regulations abandoned.

Introduction

THE domiciliary consultation service was formed at the advent of the National Health Service in 1948, to continue the tradition of joint consultations between a hospital-based specialist and the family doctor in the patient's home. The criteria for a domiciliary consultation are laid down in the terms and conditions of service for hospital and dental staff which state that 'A domiciliary consultation shall be understood to mean a visit to the patient's home, at the request of the general practitioner, and normally in his company, to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital. Visits not falling within this definition include: a visit at the instance of a hospital or specialist to review the urgency of a proposed admission or to continue or supervise treatment initiated or prescribed at a hospital or clinic'.[1]

While domiciliary visiting by general practitioners decreased by 41% over the 10 years 1969–79,[2] consultant domiciliary visiting increased by 40% in the same time period (a 300% increase since 1948).[3] A number of surveys have shown considerable variation in consulting patterns between health authorities, specialties, and even consultants within individual specialties.[4,5] Explanations for this variability have ranged from the financial, through differing clinical practices and resources, to true differences in disease patterns and have led to speculation concerning the efficacy of the domiciliary consultation service as a mode of referral.

This article is based on a survey of the domiciliary consultation service provided in one health district. It identifies the pattern of referral by specialty, the reasons for the consultation and its outcome, and it questions whether the service is realizing its original objectives as specified in the terms of service.

The survey

Merton and Sutton, a health district in the South-West Thames Region, has a catchment population of 240 000. Its main hospital has university status. It is a Resource Allocation Working Party losing district with above-average resources. Its Jarman index — an index of general practitioner workload based on socioeconomic factors — is 40%. All domiciliary consultation forms (842) submitted to the health authority over one year (April 1984 to March 1985) were analysed by specialty and 338 consecutive forms over a six-month period were analysed in detail for characteristics of patients (age and sex), diagnosis at consultation, presence of general practitioner, outcome of consultation and general practitioner usage of the service.

Pattern of referral

Seventy-five per cent of general practitioners in the Merton and Surrey district used the domiciliary consultation service over the year, with a frequency of requests that ranged from one to 24 per doctor. Of the 338 patients referred, 28% were male and 72% female. The age of the patients ranged from 21 years to 98 years with a mean of 72 years; 28% were over the age of 85 years.

The specialties most frequently requested for domiciliary consultation in the Merton and Surrey district were geriatrics and psychiatry, corresponding to the pattern in the UK as a whole (Figure 1). What was surprising, however, was the large number of referrals for specialty investigation — requests for haematology and radiology services were 5.0 and 2.5 times the national average respectively.

Dowie[4] suggested that the rate of domiciliary consultations might decrease with increased availability to general practitioners of special investigations, for example, 'open-access' to laboratory and radiology facilities as well as acquisition of equipment such as electrocardiographs. The high use in this district of domiciliary investigatory services may confirm a trend for general practitioners to investigate their patients before referring them to hospital, and is possibly a contributory factor to the low overall rate of domiciliary referrals in this district (3.3 per 1000 population compared with the national average of 8.8 per 1000).[6,7]

Reasons for requesting a visit

The reasons for a general practitioner requesting a domiciliary visit are numerous and have been reviewed by Dowie.[4] There appear to be three sets of circumstances surrounding a domiciliary consultation:

— a general practitioner takes the initiative and requests a visit;
— a general practitioner wishes his patient to be seen urgently as an outpatient or admitted, and accepts a domiciliary consultation as a second choice;
— a patient needs psychiatric or geriatric help and a domiciliary consultation is thought more appropriate as the patient can be assessed in a home environment.

Within these circumstances there are, broadly speaking, three medical reasons for referral:

— the doctor wants confirmation that a terminally ill patient is actually beyond curative and palliative intervention that could only be administered in hospital and to reassure the family with a second opinion;
— attendance at an outpatient department would be an uncomfortable or distressing experience for the patient and the doctor wants advice on management;

© *Journal of the Royal College of General Practitioners*, 1986, **36**, 313-315.

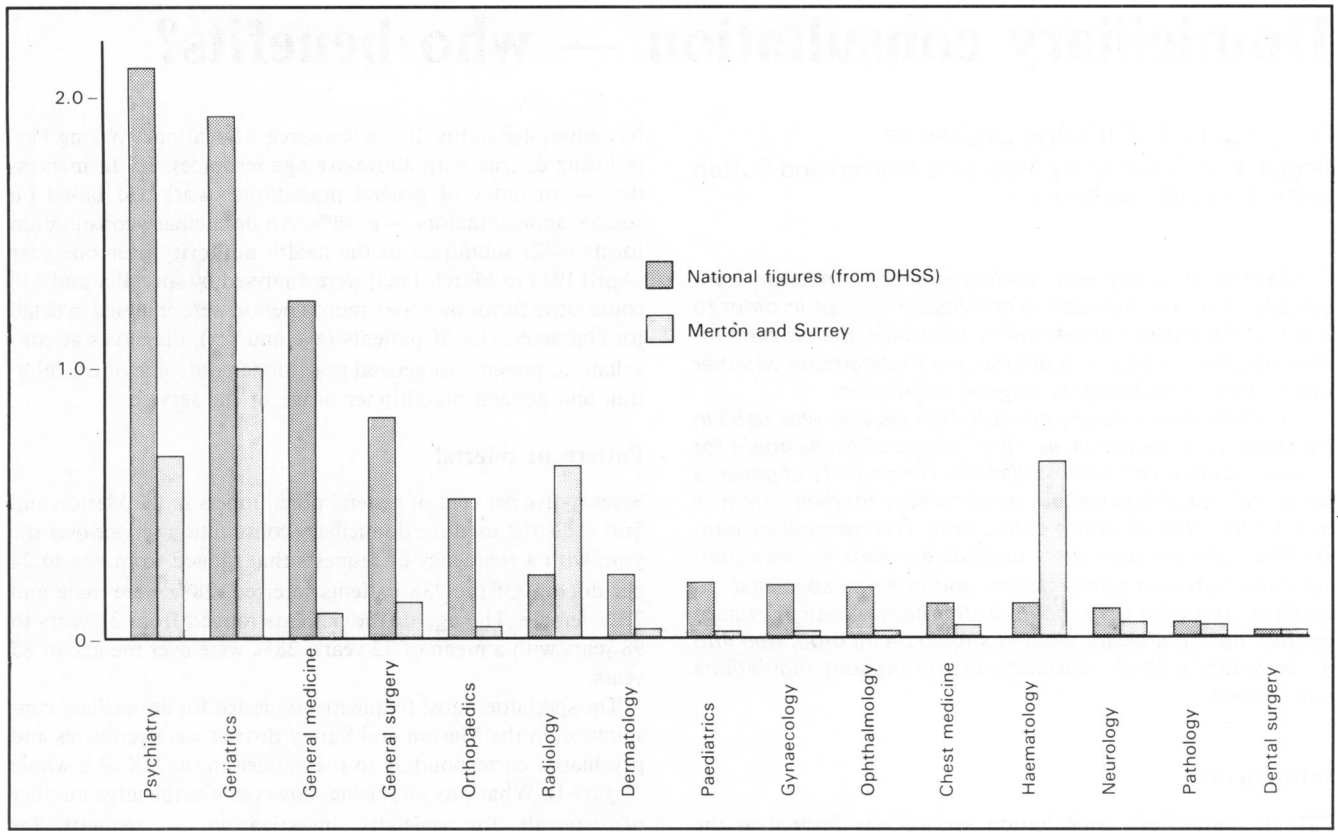

Figure 1. *Number of domiciliary consultations per 1000 population per year for the UK (mean number 8.8) and Merton and Surrey (mean number 3.5), by specialty.*

— faced with an acutely ill patient whom the doctor does not feel needs direct inpatient admission, the doctor would like assistance with diagnosis and/or management.

It is the last reason that has been shown to be the most frequent in surveys based on interviews with general practitioners. While this study confirms these findings for surgical referrals, it does not for medical and psychiatric referrals; only 28% and 27% of cases referred to these categories respectively were for acute problems, the remainder were for chronic conditions (Table 1).

A joint consultation no longer appears to be a reason for requesting a domiciliary visit. Only 4.4% of the consultations with the consultant took place in the presence of the general practitioner (7% excluding radiology and haematology). Half of these were for psychiatric cases which, for the purposes of sectioning under the Mental Health Act, require the presence of the general practitioner. This confirms the Trent study figures of 3.7% of their total sample having joint consultations (8.6% of the respondents).[8] Dowie also commented that there is 'fragmentary evidence ... that joint consultations are exceptional'.[4,9,10] Why this change in practice should have come about since the setting up of the service needs active discussion, as a valuable interface between hospital and family practice is being lost.

Table 1. Diagnosis of acute or chronic at time of domiciliary consultation by category of specialty (total number of cases with single diagnoses = 320[a]).

	Number of cases diagnosed		
	Acute	Chronic	Total
Medical	53	137[b]	190
Surgical	39	20	59
Psychiatric	19	52	71

Chi-square = 31.54; degrees of freedom = 2; $P<0.001$.

[a] 11 cases had a combination of diagnoses, seven cases had no diagnosis documented; [b] 37 of the consultations for chronic medical disorders were for anticoagulation control only.

Outcome of the consultation

It has often been postulated that a domiciliary visit is requested as a means of obtaining rapid hospitalization for a patient, especially in the areas of psychiatry and geriatrics. This survey showed an immediate hospitalization rate of only 10% overall and of 17% and 6% respectively for psychiatry and geriatrics (Table 2). Along with other studies[9] this result suggests that rapid hospitalization is not an important factor in requesting a domiciliary visit from the consultant. In the remaining consultations 59.0% resulted only in advice being given to the general practitioner. Although only 10% of patients were immediately admitted, a further 31% entered the hospital system via a day hospital, an inpatient waiting list or an outpatient appointment. It may be that this transfer of responsibility and the consequent rallying of additional services is the key determinant in requesting a domiciliary consultation.

Cost-effectiveness

Studies have tried to establish the cost-effectiveness of this service on the basis of prevention of hospitalization.[11] This district service had an outgoing of £24 000 in fees for domiciliary consultation. Whether this is an appropriate use of resources will need further evaluation. The emphasis is now on care in the community for all age groups of patients. With the shift from acute to chronic disease management in response to an ageing population, it appears that the original objectives of the

Table 2. Immediate outcome of domiciliary consultation according to specialty (total number of consultations documented = 329[a]).

Specialty	Number of consultations			
	Admitted to hospital (day hospital)	Put on waiting list	Given outpatient appointment	Advice to GP
General medicine	3	2	0	9
Geriatrics	5 (11)	49	10	18
Psychiatry[b]	10 (4)	1	24	20
General surgery[c]	8	0	0	10
Haematology[d]	1	0	0	54
Radiology	2	0	0	63
Dermatology	0	0	0	8
Neurology	1	0	0	3
Orthopaedics	1	1	0	5
Oral surgery	1	0	0	0
Ophthalmology	1	0	0	3
Obstetrics and gynaecology	0	0	0	1
Total	33 (15)	53	34	194
Percentages	*10.0 (4.6)*	*16.1*	*10.3*	*59.0*

[a] Outcome not documented for nine cases. [b] Including psychogeriatrics. [c] Including urology. [d] Including one case referred to chemical pathology.

domiciliary consultation service are no longer valid and the regulations surounding its implementation are obsolete. Geriatricians, psychiatrists and paediatricians today run a community service with limited inpatient beds. They need to assess an increasing number of patients in their own homes before deciding what mode of treatment is appropriate. This option should be available whenever a patient is referred to them rather than secondary to a request by a general practitioner. Both these circumstances are outside the present regulations and, as a result, some health authorities have included domiciliary visiting in their geriatricians' contracts. Perhaps this should be expanded to other districts and include all specialties.

References

1. Department of Health and Social Security. *National health services, medical and dental (England and Wales). Terms and conditions of service, April 1981* (revised). London: HMSO, 1981.
2. Fry J. *Present state and future needs in general practice.* Lancaster: MTP, 1983.
3. Dowie R. National trends in domiciliary consultation. *Br Med J* 1983; **283:** 819-822.
4. Dowie R. *General practitioners and consultants.* London: King's Fund, 1983.
5. Coupland AI, Todd GB. Pattern of domiciliary consultations in the Trent region. *Br Med J* 1985; **290:** 1399-1402.
6. Robinson AM. A country practice's use of domiciliary radiology. *Practitioner* 1984; **228:** 633-639.
7. Fleming HA. Domiciliary visits by consultants. *Br Med J* 1980; **280:** 406-407.
8. Andrews J, Coupland AI. Pattern of domiciliary consultations in the Trent region. *Br Med J* 1985; **290:** 1987.
9. Smith MV, Blythe JD. Domiciliary consultation. *Update plus* 1971; **1:** 135-139, 149.
10. Kimber J, Silver CP. Home visiting by a geriatric department. *J R Coll Gen Pract* 1981; **31:** 41-44.
11. Ginnebery RN, Richards JDM. Domiciliary visits by pathologist: an evaluation. *J R Coll Gen Pract* 1980; **30:** 224-227.

Acknowledgements

I would like to acknowledge the assistance of Dr M. Spencely, Dr E.S. Williams and Miss R. Macnair, during the preparation of this paper.

Address for correspondence

Dr P.C. Littlejohns, Registrar in Community Medicine, Merton and Sutton District Health Authority, 6 Homeland Drive, Sutton, Surrey SM2 5LY.