Domiciliary consultations

As the domiciliary consultation service is specifically for patients who are unfit to attend hospital it is hardly surprising that Drs John Fry and Gerald Sandler found the highest rates of consultation in geriatric medicine (30 July, p 337). Some geriatric units have, however, abandoned domiciliary visits altogether, regarding them as a barrier to admission,[1] while others have a policy of assessing all referrals to the geriatric service.[2]

Local audit of services to patients is useful within limitations: it concentrates on outcome, which is attractive to NHS managers, but may not measure the benefits of geriatric assessment, details of which may be useful in planning discharge or alternative forms of care. In our unit 825 visits were carried out by four geriatricians in 1987, and a quarter of the patients visited were subsequently admitted. The basic visit fee was incurred in each case.

We prospectively evaluated 190 consecutive visits, half of which were to patients aged over 80. Day hospital attendance was arranged in 80 cases, 68 required admission, and 8 attended outpatient clinics. Information provided by general practitioners was accurate in 139 referrals, although in only 40 was a drug history provided. Potentially hazardous drugs were found in 49 patients. Of major interest was that the practitioner suggested an outcome in 103 referrals and the consultant agreed in three quarters of these (77). When there was disagreement nine admissions were prevented but three had to be expedited despite a request for day hospital attendance.

With greater communication of information on functional state, drugs, home environment, and stated outcome we may be able to reduce the number of visits, but we suspect that an appreciable number will still be required owing to the non-specific presentation of illness in old age and doubt about appropriate action.

Perhaps our colleagues in other specialties could provide similar information on outcome, whether subsequent admission was prevented, and whether any costs over basic costs were incurred, particularly as some investigations are repeated in hospital. With the increasing use of highly specialised hospital based investigations it may be pertinent to ask whether any patient other than the elderly, disabled, or mentally ill actually falls within the criteria laid down for domiciliary consultation.

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1 Hodkinson M, Jeffries PM. Making hospital geriatrics work. *Br Med J* 1972;iv:536-9.
2 Arcand M, Williamson J. An evaluation of home visiting of patients by physicians in geriatric medicine. *Br Med J* 1981; **283**:718-20.

While welcoming the surge of interest in the extramural activities of consultants (and other hospital doctors) evidenced by recent contributors to the journal (Drs John Fry and Gerald Sandler, 30 July, p 337; Dr Graham Mulley, 20 February, p 516) let us address the issue of remuneration clearly. It is difficult to escape the feeling that some commentators suspect that herein lies a pot (albeit small) of gold that might be rescued from wickedly overpaid consultants and made available for other (more deserving) forms of patient care.

It is clear that home visiting is an essential part of the strategy that has enabled services for the elderly mentally ill to reach out to and remain available to many patients without recourse to admission were it available or dismissal to a waiting list when it is not.[1] Joint visits with general practitioners are rarely undertaken for there are many and better ways of liaising with them. Beds, day hospital places, outpatient attendances can be and are being severely restricted by cash limits. Extramural work is not thus far restricted, though much of it goes on uncounted.[2]

In our service only a fraction of doctors' contacts with patients at home are deemed "domiciliary consultations" demanding a fee: roughly six out of 60 or more each week. Some of the home visits are undertaken by doctors in training but most by the two consultants. While extramural work is important, there is also much to do at the hospital. It is not possible to do all that is required within the "normal" working day and most new contacts are made outside the normal working week.

It seems appropriate that such activity carries extra remuneration, but there is evidence that health authorities anxious to cut back on every possible expense want consultants to undertake all home visits as part of their routine work. Thus I recently had to advise that a job description that included two sessions for "home assessments," none for ward liaison work, and two sessions (none for travelling time) to manage 86 inpatient beds on three sites and 80 day hospital places on two further sites was unreasonable. The time may come when health authorities have enough funds to employ sufficient staff to allow home consultations to be performed as part of the routine day's work and most of us will be grateful for the time free to spend with our families. For the present I suggest that the £20m that Drs Fry and Sandler have identified is money well spent in getting more out of existing staff and other resources than anyone could reasonably expect.

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1 Arie T, Jolley D. Making services work: organisation and style of psychogeriatric services. In: Levy R, Post F, eds. *The psychiatry of late life*. Oxford: Blackwell Scientific 1982: 222-51.
2 Jolley D, Benbow S, Baldwin R. Measuring performance or balancing the budget. *Br Med J* 1987;**295**:1350.

Drs John Fry and Gerald Sandler highlighted some of the facts on domiciliary consultations (30 July, p 337). Dr Graham P Mulley also tackled the subject in his leading article (20 February, p 515). Both articles failed to mention the domiciliary consultations made by psychiatrists.

I would divide psychiatric domiciliary consultations into two types.

(1) Emergency domiciliary consultation, in which the consultant is requested to assess a patient urgently in his or her home, in another place of safety such as a police station, or sometimes even in a public place such as a public house or a hotel. This can be done at any time of the day as the patient requires assessment with a view to admitting him or her under the Mental Health Act. This consultation is usually done conjointly—that is, the psychiatrist, the general practitioner, and an approved social worker assess the patient at the same time. Most general practitioners do not know that they are entitled to specific fees, whether or not the patient is admitted to hospital. The main precipitant for such domiciliary consultations is that the patient is extremely ill and refuses help or to attend an outpatient department. Sometimes social or legal problems created by the patient precipitate such consultations.

(2) Non-urgent domiciliary consultation. Even non-urgent consultation is usually characterised by comparative urgency—that is, it will not wait for more than a few days at the most. Psychogeriatricians are most commonly asked to make such a domiciliary consultation among the specialty; it is usually to assess a demented or confused elderly patient as a patient who is demented could become more disorientated at the outpatient department—which could be catastrophic—and the psychiatrist would not have a clear picture of the patient's mental condition. In addition to this carers often feel embarrassed taking their elderly patient to the outpatient department because of behavioural problems.

It is not uncommon for the psychogeriatrician to be accompanied by a community psychiatric nurse and sometimes by an occupational therapist or a social worker, so the team approach still prevails even during the domiciliary visit. Futhermore, psychogeriatricians accept referrals from community psychiatric nurses, social workers, and officers in charge of residential homes, which means they do not claim fees.

Dr Mulley stressed the advantages of a domiciliary visit—that is, getting a detailed history from different people. The psychiatrist usually asks about the social background of the patient, psychiatric and medical history, and the family history of mental illness. It is not uncommon for the patient's general practitioner either not to have this information in his or her records or not to have time to read between the lines. The above information is usually reported to the general practitioner to help with future diagnosis and management.

As Dr Mulley recognised, the domiciliary consultation is time consuming, and a domiciliary visit in a rural area can sometimes take up to two and a half hours, including driving from hospital to a patient's home and back.

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The code for promoting drugs

Professor Michael Langman in his editorial on the code of practice for the pharmaceutical industry rightly exhorts doctors to remember their personal responsibility for effective and efficient prescribing (20-27 August, p 499). With that no one could possibly disagree. He, however, casts a cynical eye over the code itself, and in his comments on postmarketing surveillance makes no mention of the guidance issued on this subject earlier this year under the auspices of the Association of the British Pharmaceutical Industry, the Committee on Safety of Medicines (of which he is a member), the BMA, and the Royal College of General Practitioners.[1]

Before I became medical director of the Association of the British Pharmaceutical Industry my attitude towards the code was similar to Professor Langman's; like so many others, I could not see how a set of rules administered by a trade association looking after the interests of its members could have any clout, particularly when its ultimate sanction would be to drum an offending company out of the club. As soon as I began to work with the association I assessed the effectiveness of the code to be quite different. Companies strive not to be found in breach of it, heads may roll within companies if they are found guilty, and a great deal of money may be lost if advertising has to be changed or stopped. Above all, the publicity that accrues against a company within the industry itself acts as a deterrent, and I am certain that the code does far more than Professor Langman implies. Nevertheless, it can be effective only if breaches suspected by doctors are brought to the attention of the code of practice committee, and doctors should write to the secretary of the committee at the association if they consider that the code has been breached.

Finally, Professor Langman states that postmarketing surveillance seems particularly unhelpful for various reasons. This comment is ill timed because the guidelines, which were drawn up by all those interested in what postmarketing