Domiciliary consultations: some facts and questions

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Abstract

The domiciliary consultation scheme introduced at the start of the NHS enables joint consultation between a consultant and general practitioner in a patient's home when the patient cannot attend hospital on medical grounds. Consultants claim a fee from the NHS, general practitioners do not. Data from the Department of Health and Social Security on domiciliary consultations in England and Wales during 1981-6 were analysed. The number of domiciliary consultations fell during 1981-6 from 429 759 in 1981 to 387 394 in 1986, a fall of 10%, whereas the numbers of consultants and general practitioners increased by 1404 (12%) and 2400 (10%), respectively. The yearly rate of domiciliary consultation per consultant fell by 19% from 36 in 1981 to 29 in 1986 and that per general practitioner by 18% from 18 to 15. In 1986 geriatric medicine had the highest rate of domiciliary consultation per consultant (187) followed by psychiatry (89), general medicine (52), dermatology (49), rheumatology (42), general surgery (36), gastroenterology (35), thoracic medicine (34), and orthopaedics (30). In 1986 all specialties apart from clinical pharmacology and therapeutics and clinical genetics showed a decrease in the yearly rate of domiciliary consultation when compared with the rate for 1981.

Domiciliary consultation seems to have become a domiciliary visit by the consultant alone. At an estimated cost of about £20m for 1988 the scheme needs critical evaluation.

Introduction

One of the better customs of the collaboration between general practitioners and consultants before the formation of the NHS that was incorporated into the service in 1948 was the domiciliary consultation. This is a joint bedside meeting between a consultant and general practitioner, called when considered necessary by the general practitioner when a patient cannot attend hospital on medical grounds. Consultants now receive a special fee from the NHS, general practitioners do not. Apart from being beneficial to patients, domiciliary consultations are considered to be helpful in promoting mutual education and better relationships between doctors.

Forty years later, however, few reports exist about the domiciliary consultation scheme nationally, although there have been local and regional reports.¹⁻³ We studied data on the scheme for 1981-6.

Method and results

The data for England and Wales from 1981 to 1986 were given to us by the Department of Health and Social Security. The information included the total number of domiciliary consultations claimed by hospital consultants and the numbers of consultants

and principal general practitioners in the NHS. The number of domiciliary consultations were available for each specialty, and we calculated the mean number of domiciliary consultations per consultant.

Table I shows the numbers of domiciliary consultations, consultants, and general practitioners for each year. The difference between the numbers of domiciliary consultations for 1981 and 1986 was 42 365, or a decrease of 10%. The difference in the numbers of consultants for 1981 and 1986 was 1404 and that in the numbers of general practitioners 2400, or an increase of 12% and 10%, respectively.

Table II shows the yearly rates of domiciliary consultation per consultant and per principal general practitioner. The difference between the rates per consultant for 1981 and 1986 was 7.0, a decrease of 19%, and that per principal general practitioner 3.3, a decrease of 18%.

Table III shows the yearly rates of domiciliary consultation per consultant in each specialty. The ten specialties with the highest rates of domiciliary consultation were (in descending order): geriatric medicine, mental illness, general medicine, dermatology, rheumatology, general surgery, gastroenterology, thoracic medicine, trauma and orthopaedics, and neurology. All specialties showed a decrease in the rate of domiciliary consultation when comparing the rates for 1981 with those for 1986 apart from clinical pharmacology and therapeutics and clinical genetics, which both showed considerable increases. Most specialties showed a gradual decrease in rates from year to year but some such as forensic psychiatry and medical oncology showed noticeable fluctuations in the rates during 1981-6. Some specialties such as obstetrics and gynaecology, ear, nose, and throat surgery, nephrology, and endocrinology showed a considerable decrease in the rate of domiciliary consultation to a value much less than the mean overall (32.4).

Some specialties in which the diseases concerned do not usually confine patients to bed at home had high rates of domiciliary consultation. Thus dermatologists

TABLE I—Numbers of domiciliary consultations, consultants, and principal general practitioners in England and Wales, 1981-6

	1981	1982	1983	1984	1985	1986
Domiciliary consultations	429 759	428 014	436 681	385 698	379 909	387 394
Consultants	11 953	12 160	12 445	12 760	13 049	13 357
Principal general practitioners	23 600	24 200	24 700	25 100	25 600	26 000

TABLE II—Yearly rates of domiciliary consultation per consultant and principal general practitioner in England and Wales, 1981-6

	1981	1982	1983	1984	1985	1986
Per consultant	36.0	35.0	35.1	30.2	29.1	29.0
Per principal general practitioner	18.2	17.7	17.7	15.4	14.8	14.9

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TABLE III—Yearly rates of domiciliary consultation per consultant by specialty, 1981-6

Specialty	1981	1982	1983	1984	1985	1986	Difference between years 1981 and 1986 (% change)
<i>Medical</i>							
General medicine	71.7	69.0	67.4	56.7	54.7	52.0	19.7 (-28)
Paediatrics	22.4	22.0	22.3	18.1	15.8	15.8	6.6 (-30)
Infectious diseases	26.1	25.6	23.7	24.9	22.4	17.7	8.4 (-32)
Thoracic medicine	47.2	52.5	51.0	46.8	41.7	34.1	13.1 (-28)
Dermatology	60.9	59.3	62.0	51.1	50.0	48.6	12.3 (-20)
Neurology	33.5	33.3	32.0	28.0	31.3	27.4	6.1 (-18)
Cardiology	18.8	19.6	13.8	12.8	10.1	12.8	6.0 (-32)
Rheumatology	52.9	50.0	53.4	48.1	40.1	42.1	10.8 (-20)
Clinical pharmacology and therapeutics	8.7	7.8	38.5	24.2	23.4	20.1	11.4 (+131)
Geriatric medicine	211.5	211.7	218.9	196.2	185.0	187.3	24.2 (-11)
Endocrinology	32.1	22.5	13.8	11.2	11.6	10.7	21.4 (-67)
Gastroenterology	50.3	49.1	52.0	39.6	38.9	34.9	15.4 (-31)
Clinical genetics	0.2	0.4	30.9	19.1	19.8	18.9	18.7 (+9350)
Nephrology	13.1	12.3	15.9	9.5	7.4	6.6	6.5 (-50)
Medical oncology	47.2	14.1	5.6	0.1	0.7	2.7	44.5 (-94)
Radiotherapy	14.3	15.0	14.9	13.4	12.7	12.8	1.5 (-11)
<i>Surgical</i>							
General surgery	51.8	49.6	47.8	37.6	37.4	35.7	16.1 (-31)
Trauma and orthopaedics	43.7	41.5	39.8	33.0	33.2	30.4	13.3 (-30)
Accident and emergency	11.1	10.9	11.9	7.6	3.4	3.6	7.5 (-68)
Ophthalmic	22.9	21.1	21.2	18.0	17.0	15.3	7.6 (-33)
Ear, nose, and throat	16.6	14.7	14.7	12.1	11.1	8.6	8.0 (-48)
Obstetrics and gynaecology	17.4	15.8	13.5	10.8	10.4	8.7	8.7 (-50)
Urology	15.7	16.7	16.6	12.6	11.1	11.1	4.6 (-29)
<i>Psychiatric</i>							
Mental illness	91.9	92.5	95.8	86.7	84.4	89.4	2.5 (-3)
Forensic psychiatry	3.5	2.4	1.9	3.7	12.9	0.4	3.1 (-89)
<i>Diagnostic</i>							
Haematology	23.6	23.3	22.8	18.4	18.9	19.9	3.7 (-16)
Medical microbiology	16.4	8.6	10.1	5.7	7.3	4.1	12.3 (-75)
Radiology	14.5	14.0	14.3	12.7	12.7	13.6	0.9 (-6)

averaged one such consultation a week during 1981-6 and clinical pharmacologists one every two weeks since 1983. During 1981-6 radiotherapists averaged 13 domiciliary consultations a year and ophthalmologists and haematologists 20, and since 1984 the yearly average of clinical geneticists has been more than 19.

Discussion

The stated aim of the domiciliary consultation service, as set out in the DHSS booklet on terms of service,⁴ is to enable a specialist to be called to a patient's home at the request of a general practitioner, *usually with the general practitioner present* (our italics), to advise on the diagnosis and treatment of patients who cannot, on good medical grounds, attend hospital.

These commendable aims are not being met as the rates of domiciliary consultation have been progressively declining over the years and its performance changing. The rates were higher in 1963-4 at 40 per consultant⁵ and in 1978-9 at 37.⁶ More importantly, the domiciliary consultation seems to have become a domiciliary visit by the consultant alone. Smith and Blythe found that in the South East Thames region in 1967-8 the general practitioner was present in only 28% of domiciliary consultations¹ and Littlejohns in Merton and Sutton in 1984-5 that he or she was present in only 4.4%.²

The mutually beneficial contact between consultants and general practitioners is being lost. There may be several reasons for this. Firstly, difficulties may arise in arranging a mutually convenient time for the visit.

Secondly, general practitioners, having had the benefit of a vocational training scheme, might think that they can deal adequately with their patient's diagnostic and management problems and therefore have less need of specialist advice.

Thirdly, domiciliary consultations may not be being used for their primary aim of obtaining guidance from a specialist on the management of a patient but to facilitate a patient's admission to hospital. Although this may not apply to all disciplines—admission resulted from 28% of domiciliary consultations in Smith and Blythe's survey but from only 10% in Littlejohns's^{1,2}—it probably does apply to geriatric medicine, in which the rate of domiciliary consultation exceeded all other specialties (table III) and admission to hospital resulted in two thirds of cases in the Trent region.³ Similarly, a general practitioner's interest in domiciliary consultations may be limited to bypassing the outpatient waiting list, a view supported by the fact that dermatologists averaged about one domiciliary consultation a week (table III). Otherwise this high rate of domiciliary consultation by dermatologists is difficult to explain.

Fourthly, general practitioners might not have reaped the educational benefits expected from joint domiciliary consultations with specialists and are reluctant to repeat the exercise.

Finally, the lack of a financial inducement for the general practitioner, unlike for the specialist, may discourage the use of the system.

The two disciplines in which domiciliary consultations increased during 1981-6 were clinical pharmacology and genetics. In clinical pharmacology this may reflect an increasing interest and growing concern by general practitioners about the potential adverse effects of prescribed drugs and possible medicolegal implications. Similarly, geneticists' increased rate of domiciliary consultation may also be due to increasing awareness by general practitioners and their patients of the problems associated with genetic abnormalities and the possible indications for a termination of pregnancy. General practitioners may call such consultations because of the sensitive personal issues and urgency entailed.

Mullery reviewed home visits by consultants from a geriatrician's point of view.⁷ He noted that 80% of such visits were to patients over 60 years of age and 28% to those over 85. The reasons were mainly for psychiatric and non-specific physical symptoms, and the visits were valuable in assessing the home environment and arrangements for carers and in allowing discussion and explanation. For elderly patients such visits avoided an emergency admission in over one third of cases.

The cost of domiciliary consultations to the NHS is considerable. The consultant's remuneration is from £33.50 to £100.50, depending on what is done; the mean is about £50. For 1988 the scheme will cost an estimated £20m. As little is known about the benefits and effectiveness of this old traditional scheme it needs to be carefully and critically evaluated.

1 Smith MV, Blythe D. Domiciliary consultations. *Update Plus* 1971;1:135-9, 149.

2 Littlejohns PC. Domiciliary consultations—who benefits? *J R Coll Gen Pract* 1986;36:313-5.

3 Coupland AI, Todd GB. Pattern of domiciliary consultations in the Trent region. *Br Med J* 1985;290:1399-1402.

4 Department of Health and Social Security. *National Health Service hospital medical and dental staff (England and Wales) terms and conditions of service*. Revised. London: HMSO, 1981.

5 Royal College of General Practitioners. *Present state and future needs in general practice*. 6th ed. Lancaster: MTP Press, 1983.

6 Royal College of General Practitioners. *Present state and future needs in general practice: report from general practice XIII*. 2nd ed. London: RCGP, 1979.

7 Mullery GP. Home visiting by consultants. *Br Med J* 1988;296:515-6.

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