TALKING POINT

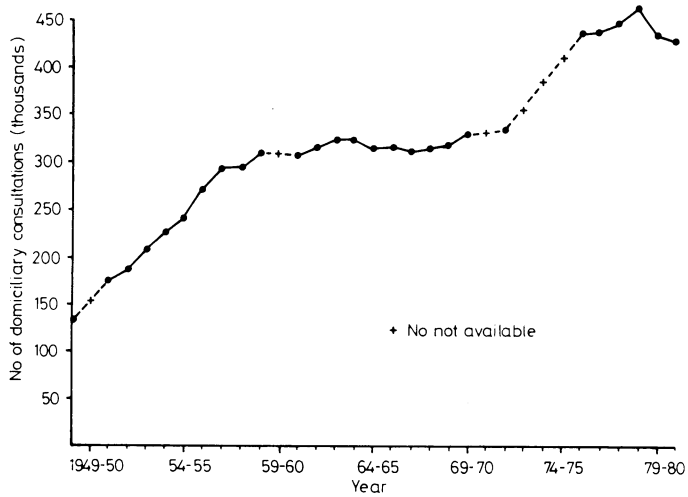
National trends in domiciliary consultations

ROBIN DOWIE

The 1982 report of the Review Body on Doctors' and Dentists' Remuneration[1] observed that fees paid to consultants by the National Health Service, of which 85% are for domiciliary consultations, amount to just over £1000 a year for each consultant. The review body asked for details about the distribution of these fees among specialties. This paper provides such national information and looks at some demand and supply aspects of these consultations. Data were supplied by the Department of Health and Social Security and the South East Thames Regional Health Authority.

National trends

The figure shows that the annual number of domiciliary consultations performed by all consultants in England and Wales has increased more than threefold since 1948-9. (The figures for some years are unavailable.) It seems unlikely that the increase can be attributed simply to the growth in consultant manpower given the differing patterns in expansion. In the 1950s the average annual increase in consultations was more than two and a half times the increase in consultant appointments of around 5%. In the 1960s the numbers remained static while manpower continued to expand at much the same rate. In the 'seventies the rates rose again (by nearly 5% annually on average), while consultant manpower increased by 3-4% in each year. But in 1973-4 the maximum number of domiciliary consultations for which a consultant may be paid was increased from 200 to 300 and this change probably contributed to the growth rate. Since 1978-9 consultation figures have shown the first substantial fall since the NHS began in 1948.



Annual number of domiciliary consultations (year ending 30 September), England and Wales, 1948-9 to 1980-1.

Table I shows short term trends in selected specialties (only specialties in which the consultants did 1% or more of the total number of domiciliary consultations in 1980-1 are included).* The recent downturn in the national figures has been reflected in most specialties, the notable exceptions being mental illness, geriatric medicine, and rheumatology and rehabilitation. In certain specialties, such as general surgery, the rates have been falling since the mid-1970s.

Table I also shows that mental illness had the largest domiciliary consultation workload in each year from 1975-6. Geriatric medicine overtook general medicine as the specialty with the second largest load in the late 'seventies. (The figures for geriatric medicine exclude home visits.†)

The differing clinical roles of the specialties are reflected in the vast interspecialty variations in average visits by consultants, excluding honorary appointments (table II). For example, in 1980-1 geriatric medicine, with 408 individual consultants (at 30 September), averaged nearly 212 consultations by each consultant, while the 1639 consultant anaesthetists performed overall less than one visit each. The average figures for the 108 consultants in genitourinary medicine and the 110 consultant orthodontists were even smaller. (The 1979-80 and 1980-1 averages in table II are slightly inflated because they include the numbers of consultations done by consultants who retired during those years.)

General practitioners' demands for domiciliary consultations

Under the terms and conditions of service for hospital medical and dental staff (England and Wales), "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."[2]

Thus the demand for domiciliary consultations is generated by general practitioners, while the supply of these services depends on the availability and disposition of hospital consultants. (Included in the model consultant contract is an obligation to carry out domiciliary visits, but not all consultants in post actually have this provision in their contracts.[1])

Under what circumstances do general practitioners request domiciliary consultations? Forty five family doctors in a district in south east England were asked this question as part of a wider study into how referral decisions are made.[3] (The interviews were semi-structured.) Consultations were done in three sets of circumstances. In the first group the general practitioners took the initiative and asked the consultants to undertake visits. In the second group the

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*Copies of tables I and II expanded to cover nearly all specialties are available on request from RD.
†The geriatric medicine specialty has a second category of home visiting. On such visits patients at home or elsewhere are assessed for possible admission to hospital and the visits are made with the general practitioners' consent. They may be done by a consultant or his deputy or by a nurse or social worker. No fee is paid.

TABLE I—*Total number of domiciliary consultations by specialty, England and Wales, 1975-6, 1978-9, 1979-80, and 1980-1**

Specialty	Number of domiciliary consultations†					
	Excluding those done by retiring consultants			Including those done by retiring consultants		
	1975–6	1978–9	Average annual percentage change 1975–6 to 1978–9	1979–80	1980–1	Percentage change 1979–80 to 1980–1
Mental illness	78 308	85 963	+3·3	88 399	91 433	+3·4
Geriatric medicine	64 060	81 879	+9·3	84 226	86 285	+2·4
General medicine	73 101	69 399	−1·7	67 021	63 058	−5·9
General surgery	54 188	49 177	−3·1	46 419	44 301	−4·6
Traumatic and orthopaedic surgery	30 231	29 187	−1·2	28 194	27 866	−1·2
Dermatology	11 121	11 662	+1·6	12 216	12 114	−0·8
Radiology	12 252	12 676	+1·2	12 041	12 105	+0·5
Obstetrics and gynaecology	17 810	14 643	−5·9	12 804	11 272	−12·0
Rheumatology and rehabilitation	7 613	9 223	+7·0	9 839	10 964	+11·4
Paediatrics	9 089	10 886	+6·6	10 497	9 665	−7·9
Ophthalmology	10 305	9 231	−3·5	8 947	8 984	+0·4
Chest diseases	12 674	12 398	−0·7	10 258	8 731	−14·9
Haematology	5 555	7 489	+11·6	7 667	6 552	−14·5
Ear, nose, and throat	8 246	6 902	−5·4	6 721	6 106	−9·2
Neurology	4 437	5 197	+5·7	4 886	4 728	−3·2
All specialties	417 911	444 573	+2·1	436 058	429 759	−1·4

*Year ending 30 September.
†Numbers for 1975–6 and 1978–9 exclude domiciliary consultations done by consultants who retired during those years. This group of domiciliary consultations forms 4–5% of the annual totals.
Source: DHSS.

TABLE II—*Average number of domiciliary consultations per consultant* by specialty, England and Wales, 1975-6, 1978-9, 1979-80, and 1980-1†*

Specialty	Average number of domiciliary consultations per consultant‡					
	Excluding those done by retiring consultants			Including those done by retiring consultants		
	1975–6	1978–9	Average annual percentage change 1975–6 to 1978–9	1979–80	1980–1	Percentage change 1979–80 to 1980–1
Mental illness	80·8	90·4	+4·0	90·6	92·0	+1·5
Geriatric medicine	194·7	219·5	+4·2	216·5	211·5	−2·3
General medicine	82·8	82·9	0	78·4	71·7	−8·5
General surgery	62·9	57·2	−3·0	54·2	51·8	−4·4
Traumatic and orthopaedic surgery	52·0	47·8	−2·7	45·1	43·7	−3·1
Dermatology	60·4	62·4	+1·1	63·3	60·9	−3·8
Radiology	16·4	16·1	−0·6	14·9	14·5	−2·7
Obstetrics and gynaecology	28·6	23·2	−6·3	20·3	17·4	−14·3
Rheumatology and rehabilitation	40·7	46·6	+4·8	48·5	53·0	+9·3
Paediatrics	25·2	26·3	+1·5	24·5	22·4	−8·6
Ophthalmology	28·2	23·9	−5·1	23·2	22·9	−1·3
Chest diseases	45·3	54·6	+6·8	50·5	47·2	−6·5
Haematology	23·0	28·6	+8·1	27·7	23·7	−14·4
Ear, nose, and throat	22·9	19·2	−5·4	18·5	16·6	−10·3
Neurology	33·4	37·4	+4·0	34·7	33·5	−3·5
All specialties	38·1	38·8	+0·6	37·3	36·0	−3·5

*All paid hospital medical and dental consultants in post at 30 September.
†Year ending 30 September.
‡Numbers for 1975–6 and 1978–9 exclude domiciliary consultations done by consultants who retired during those years. This group of domiciliary consultations forms 4% to 5% of the annual totals.
Source: DHSS.

general practitioners contacted the consultants or their secretaries to ask whether patients could be seen urgently as an outpatient or admitted; they were offered a domiciliary consultation, which they accepted. Patients needing psychiatric, geriatric, and psychogeriatric help gave rise to the third group because for many of these patients their domestic arrangements needed to be assessed.

DOMICILIARY CONSULTATIONS THAT GENERAL PRACTITIONERS INITIATE

There are three main circumstances in which family doctors request a domiciliary visit. Occasionally, a doctor wants a consultant to confirm that admission to hospital of a patient dying, perhaps from an inoperable carcinoma, would be inhuman since nothing further can be done in a curative or a palliative sense, and the aim is to reassure the family by this collaborative decision. Secondly, and also infrequently, there are occasions when patients can attend the outpatient clinics but because their general health is poor attendance would be an uncomfortable or distressing experience. What the doctors want from these domiciliary consultations is advice on management. Examples in the study included a lady with ulcers of the ankles arising from an arthritic hip and a man with an artificial leg and obstructive jaundice.

The third and by far the most frequent circumstance occurs when patients are acutely ill but the general practitioner does not think that direct inpatient admission is warranted. Some of the doctors interviewed were mainly seeking help in establishing a diagnosis and determining whether admission was desirable: "They're not sufficiently well to be hanging around home too long if I've missed the point in diagnosis," and, "Where I'm unsure about the diagnosis and where if one diagnosis is come to then hospital admission is vital to them." Other doctors claimed that they usually wanted guidance on managing a patient whose condition they had confidently diagnosed and whom they intended to look after themselves. To quote two doctors: "Someone that you can cope with at home but there is anxiety about them, either your own or very often relatives . . . the older person who has had a bit of a heart attack," and, "I think any sort of heart case which I think ought not be moved." Neither of these doctors had an electrocardiograph. Another doctor reported that his group practice was seeking fewer domiciliary consultations because it now had a machine. This trend has been observed elsewhere.[4]

Some general practitioner requests may be a strategy for getting a patient admitted to hospital. The available data about general medical consultations, however, do not suggest that this is a major problem —or, at least, it is not a successful tactic. A 10% sample of domiciliary consultations carried out in the south east metropolitan hospital region during 1967-8 showed that only one fifth of general medicine visits resulted in immediate admission (the proportion for all specialties was about one quarter).[5] Again, 10 years later, fewer than one quarter of the domiciliary consultations performed by three general physicians over three months resulted in admissions being arranged.[3] What we cannot tell, however, is how frequently general practitioners adopt this strategy for elderly patients who are severely physically or mentally ill.

DOMICILIARY CONSULTATIONS AS A SUBSTITUTE FOR HOSPITAL VISITS

Ad hoc decisions by individual consultants and restricted clinical resources give rise to the second group of domiciliary consultations. Here the demand for consultations is being directly influenced by supply factors. In the interviews ad hoc decisions arose when a consultant was temporarily under such great pressure in the outpatient clinics that he could not cope with extra urgent or semiurgent patients and offered instead to visit them at home. Visits were also made to assess the need of some immobilised patients for hospital based treatment because restricted resources locally meant that they were not acceptable as direct admissions. This applied particularly to patients with acute back pain. The general practitioners did not have direct access to the physiotherapy service.

GERIATRIC AND MENTAL ILLNESS* DOMICILIARY CONSULTATIONS

The interviews suggested that the family doctors' decisions to ask for help from these specialties were frequently precipitated by a crisis affecting the patient or the carer(s) or both which made the general practitioner realise that he could no longer manage suitable care for the patient. "Because you happen to care about your [geriatric] patients you keep them at home longer than you should. But suddenly a crisis arises." When reviewing psychiatric referral studies Goldberg and Huxley found that patients' failure to respond to treatment from the family doctor was the one reason for referral common to them all.[6] Thus with so many of the referred cases to these specialties being semiurgent the local consultants were unable to cope quickly or properly with all of them on an outpatient basis and a proportion were seen as domiciliary consultations. But the general practitioners also realised the advantages of having these patients, notably psychogeriatric patients, assessed in their homes—to smell the effects of any incontinence, to look in the refrigerator of those living alone. Also, the effects of the patients' condition on relatives or other carers could be observed and any postdischarge plans formulated. National data (see below) suggest that these consultation patterns of practice are widespread.

How often do general practitioners receive domiciliary consultations? The figures show that in 1980-1 the average number of consultations for each unrestricted principal in England and Wales[1] was 18, or roughly one visit every three weeks. Anecdotal accounts, however, suggest that the request rates of individual doctors range widely around this mean.[3]

Consultants as suppliers of domiciliary consultations

The maximum number of domiciliary visits for which a consultant may be paid in each year is 300, but visits in excess of 300 may be paid in special circumstances. There are, however, wide variations in the average numbers performed on a specialty basis and within specialties. Individual consultants have vastly differing rates. Table III shows the distribution of the numbers of consultations performed by individual consultants in general medicine and mental illness employed by the South East Thames Regional Health Authority for the whole year ending 30 April 1981. Other data from the South East Thames Regional Health Authority show that each consultant's annual figures tend to fluctuate only moderately from year to year.

Four groups of factors seem to affect the supply side, and each consultant trades them off according to his personal preference—financial rewards; the inconvenience of doing domiciliary visits; relations with general practitioners; and job satisfaction stemming from professional prestige.

FINANCIAL REWARDS

The fee for domiciliary consultations is reviewed annually by the Review Body on Doctors' and Dentists' Remuneration, though the review body's recommendations are not always adopted by the government. For example, the recommended domiciliary consultation fee for 1981 was £22·10 and for 1982 £23·35, but slightly lower fees were adopted.[1 13] These are shown in table IV, which also lists the fees paid since 1972. (The fee was first fixed in 1948 at £4·20.[7]) Additional fees are also paid to consultants for operative procedures carried out during visits, for the administration of general anaesthetics, and when personally owned apparatus is used—for example, electrocardiograph, portable *x* ray machine, ultrasonograph, or audiometer. Milage may be claimed.

The income of consultants employed in the NHS is derived from three main sources—their NHS salary; private practice, which, since 1980, all consultants may undertake; and allowances and fees including domiciliary consultation fees. If, in 1980-1, a consultant performed the overall average number of 36 consultations (table II) his income from this type of fee before taxation would have been about £760. It is clear, however, from table III that there are wide variations between consultants in the level of income earned in this way. There is also a suggestion in the national data that consultants who hold maximum part time contracts are likely to perform more domiciliary visits than consultants with whole time contracts. This trend is evident at specialty level. In only one third of the 20 largest specialties (according to size of manpower and consultation numbers in 1979-80 and 1980-1) was the average whole time contract rate for domiciliary visits bigger than the maximum part time rate. There are probably several reasons for this.

TABLE III—*Number of domiciliary consultations undertaken by general medicine and mental illness consultants employed by the South East Thames Regional Health Authority, 1980-1*

No of consultations	No of consultants	
	General medicine	Mental illness
0–49	26	7
50–99	11	11
100–149	10	13
150–199	6	8
200–249	6	6
250 and over		7
Total	59	52

Source: South East Thames Regional Health Authority.

TABLE IV—*Domiciliary consultation fees paid to hospital consultants, 1972-82*

Year commencing 1 April	Domiciliary consultation fee (£)
1972–4	7·50
1975–7	10·90
1978	12·30
1979	15·60
1980	20·30
1981	21·50
1982	22·75

Source: Reports of the Review Body on Doctors' and Dentists' Remuneration[1 7–12] and the South East Thames Regional Health Authority.

THE INCONVENIENCE OF DOING DOMICILIARY VISITS

If a consultant does around 50 consultations a year he is averaging one a week, while 200 consultations is the equivalent of four or more visits a week. When travel time is added in the total time committed weekly to visiting is substantial if a high load is carried, especially if geographical zoning of the visits is not feasible. Not surprisingly, consultants have individual preferences about how they would rather spend their time. Some may prefer to give extra time to seeing urgent patients in hospital—with the backup of their full range of investigatory equipment—instead of travelling to domiciliary visits.[14]

RELATIONS WITH GENERAL PRACTITIONERS

Not only is the demand for domiciliary consultations generated by family doctors but family doctors choose the consultant to whom the request is made. In the study about referral decisions[3] the doctors interviewed had different preferences about the specialties (if the diagnosis was unclear), and the consultants within the specialties. The main criteria applied when choosing a consultant for each

*This discussion excludes acutely disturbed patients whom general practitioners believe should be treated under sections 25 or 29 of the Mental Health Act, 1959.

referral was the family doctors' knowledge of the consultants' special skill and their personal preferences about the consultants' interactional styles. They tended to have a "portfolio" of consultant colleagues to whom they regularly made outpatient referrals and they also directed their requests for domiciliary consultation to these hospital colleagues. In specialties that had zoned catchment areas (each consultant being responsible for a geographical zone), however, the general practitioners felt constrained in their selection of consultant even though in theory they could approach any consultant in each specialty. Geriatric medicine and mental illness are the specialties most likely to introduce geographical zoning.

PROFESSIONAL PRESTIGE

In recent years the review body has regularly received evidence about the need for incentives to overcome the recruitment shortfalls in the shortage or less popular specialties. One suggestion made by the professions in 1978 was that domiciliary consultation fees should be increased as a way of encouraging recruitment in specialties such as geriatric medicine.[10] Other specialties with recruitment difficulties included anaesthetics, mental illness, and radiology.[11]

Discussion

The intention of this paper is to provide information about the purpose and frequency of domiciliary visiting. In any consideration of its purpose account should be taken of the advantages that the service offers to patients. Unfortunately, evaluations of outcome have rarely been published. Two pathologists, Grüneberg and Richards, reviewed 1182 consultations that they had done over an eight year period.[15] In their view almost one in 10 of the patients visited would have been admitted to hospital had they not been seen at home. A geriatric consultation/home visiting workload in east London was sampled by Kimber and Silver.[16] Inpatient admission was averted for one third of the patients. For individual geriatric departments, however, rates of admission from domiciliary consultations and home visits will depend on the availability and organisation of geriatric beds and complementary community based services.

It was pointed out earlier that general practitioners in one locality found that their urgent or semiurgent geriatric and mental illness patients were usually seen first on a domiciliary visit. A nationwide survey of 100 doctors suggests that in geriatric medicine this practice is widespread. Forty per cent of all patients referred to geriatricians were seen as domiciliary consultations, the figure for mental illness was 14%, and for general medicine 5%.[17]

This convention may explain an apparent trend in the national statistics. When analysing new psychiatric referral and follow up attendance figures for England Williams and Clare observed that the numbers of new outpatient referrals declined between 1973 and 1975. But at the same time the numbers of follow up attendances increased.[18] The researchers admitted that they were unable to include domiciliary visits in their analyses because these figures are not routinely published. This omission may have meant that the decline was a statistical artefact. When the national figures for domiciliary consultations in 1977 were compared with the figures for new outpatient attendances the ratio of new mental illness outpatients to domiciliary visits was 2·2 to one, while for geriatric medicine, the ratio was 0·6 new outpatients to one consultation.[19 20]

If national workload trends are to be reliably monitored for planning and epidemiological purposes the time has surely come for this gap in the routine statistics of all specialties to be filled. Information at health district level should also be made available to district management teams, although they cannot control the number of domiciliary consultations done by consultants. This may highlight geographical variations within health regions. At present consultants submit their claim forms for reimbursement, which have been countersigned by the requesting general practitioner, direct to the regional health authority, or the district authority if a teaching contract is held. Comprehensive statistics are passed to the DHSS, but the type of information given to health districts is at the discretion of the regional health authorities.

According to the terms and conditions of service for hospital medical and dental staff[2] a domiciliary consultation should take place normally in the company of the requesting general practitioner. Fragmentary evidence, however, suggests that joint consultations are exceptional. A small survey by general practitioners in north Kent showed that at only one fifth of domiciliary consultations was the general practitioner present (R May, unpublished report), while in east London no family doctors were present when 100 domiciliary consultations or home visits were done.[16] It is regrettable that these opportunities for mutual education are lost, and the profession should discuss this shortcoming. Admittedly, two busy doctors must find it hard to arrange their schedules to coincide, especially if patients need to be seen quickly. Moreover, there is no financial incentive for general practitioners to attend domiciliary consultations for they do not receive a fee. Yet there are family doctors who regularly attend at domiciliary visits and they praise the educative value of such meetings.[3]

The total bill for domiciliary consultation fees in England and Wales is about £10 million a year, the equivalent of about 3·5% of the total salary bill for hospital consultants.[1] Even to begin to gain some appreciation of whether the system is cost effective and equitable many more data should be collected. Meanwhile, the review body might be reassured by the downward national trends in domiciliary visiting in almost all of the larger specialties, but without evaluating the service it cannot be sure.

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