Homely education: the domiciliary consultation

The NHS provides for consultants to visit patients at home at the request of the general practitioner, yet opportunities to gain experience through domiciliary visiting have diminished. This is because of the increasing demands of acute hospital medicine on consultants' time even though more long term care is being carried out in community settings. **Dr Rajesh Saksena** and **Tony Luxton** describe a consultation and highlight ethical considerations.

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Trainees in geriatric and general medicine acquire most of their experience in posts at acute hospitals and may have some duties in community hospitals. They are then very likely to take up consultant posts that include covering acute general medicine as well services for older people. As a result, the opportunities to learn about the care of older people with multiple complex needs at home or in care homes, and how to assist the general practitioner (GP) through a domiciliary consultation, may be few. One of the authors accompanied a community geriatrician as part of specialist registrar training in geriatric medicine and this article is based on that experience.

The NHS provides for a consultant to visit a patient at their usual residence to provide an opinion; this visit may attract a fee. The current NHS definition of a domiciliary consultation is[1]:

> *'A domiciliary consultation counts as a "care contact" and is a visit to the home of a patient by a consultant for which a fee is payable under paragraph 140 of the Terms and Conditions of Service for Hospital Medical and Dental Staff. The visit is at the request of a general practitioner normally in his/her company, to advise on the diagnosis or treatment of a patient who cannot attend hospital on medical grounds.'*

Visits not falling within this definition, and for which fees are not payable, include:

> a visit made at the instigation of a hospital or specialist to review the urgency of a proposed admission to hospital or to continue to supervise treatment initiated or prescribed at a hospital or clinic;
> a visit for which a separate fee is payable as part of work undertaken in the Community Health Services;
> in the case of dental staff, visits undertaken as part of a practitioner's responsibilities within the Community Dental Services.

The usual route for a GP to access a consultant opinion is through an outpatient referral. In particular circumstances, attendance at outpatients may not be suitable. Medical grounds for a domiciliary consultation include:

> the patient is too unwell to attend outpatients; for example, in a terminal phase of illness or because of a psychiatric disorder;
> patient refuses to attend hospital or leave home;
> heavily dependent patients for whom transfer to the outpatient suite might be too painful, distressing or difficult; for example, those who are bedridden, requiring a hoist for transfers and unable to occupy a wheelchair.

A consultation is at the request of the GP. Normally the consultant and GP should visit together, although this is not always possible. The consultant should be satisfied that a domiciliary consultation is necessary. Historically, consultants were paid a fee per visit, but the new 2003 contract for NHS consultants precludes fees if visits are performed during contracted hours; fees apply if visits are performed in the consultant's own time. Consultants remaining on the pre-2003 contract continue to claim a fee. Hospital-based consultants have timetabled activities and may not always be able to make time available to perform visits. It is therefore important to ensure a visit is truly necessary; for example, the logistics of visiting a patient 20 miles away might mean the whole exercise could occupy two to three hours – time where many more patients might have been seen in outpatients or a ward.

Sample case scenario *(composite)*

The GP referred a patient residing in a nursing home for advice on her complicated medical, ethical and social issues. The GP was present at the consultation. The patient was a 90-year-old frail lady with established cerebrovascular disease and had recently suffered another left hemiplegia. She had long-standing atrial fibrillation and was heavily dependant, relying on nursing staff for all her care needs. She was confined to bed and had leg contractures and pain on minimal handling. She was rousable but lapsed into sleep easily. She did not appear to respond to vocal communications intelligibly nor obey commands. She had left sided neglect and the pain required opioid analgesia.

She had developed a cheek lesion five months earlier that had progressed rapidly, particularly over the month prior to the visit. It was infiltrating the surrounding skin and had ulcerated, growing about five centimeters in diameter. The initial intention had been to refer her for an outpatient dermatology opinion but the supervening severe left hemiplegia prevented this. The combination of the cheek lesion and stroke resulted in swallowing difficulty and nasogastric tube (NGT) feeding had been instituted. Some of the family members wanted full active treatment and resuscitation included in her care plan. The issues for the GP were:

> assessment of her competency to decide future care and treatment;
> management of the rapidly growing tumour on her cheek;
> the appropriateness of subcutaneous fluid if she pulled out the NGT;
> the ethics of continuation or cessation of NGT feed;
> how to deal with the family;
> whether this was an appropriate use of the domiciliary consultation service.

The request for this domiciliary visit was considered justifiable, considering the circumstances. Attendance at outpatients would have been too disturbing for this patient and the actual facilities and staffing within the outpatient clinic would not have coped with her needs. Trained nurses at the nursing home were available to supplement the GP's history, but would not have been able to accompany the patient to clinic.

The patient was drowsy, mainly from the effects of the severe stroke and possibly some contribution from analgesia. At the time, therefore, she did not have the capacity[2] to make decisions. It was considered inhumane to suggest reducing her analgesia to see if her alertness might improve enough to assess her capacity. In someone without capacity, all decisions should be guided by the 'doctrine of best interests'[3] – trying to determine

Key points

- Domiciliary consultation is helpful in some circumstances.
- GPs and consultants should be clear when a visit is appropriate.
- The issues may be ethical and medico-legal, as well simply medical.

what she would have wanted for herself had she been well enough to express an opinion. Family or friends can provide this information, but it is important to differentiate their view of what the patient might have wanted were she well enough to express her views, from what the family members might wish for themselves.

The likely diagnosis of the cheek tumour was either squamous cell carcinoma or amelanotic melanoma and could only have been determined by biopsy. In turn, this would only have been justifiable if treatment were available for this particular patient given her overwhelming co-morbidities. We surmised that a wide excision would not be tolerated and that complications (eg, aspiration, skin breakdown and infection) could arise. Discussion moved on to the practicalities of obtaining an opinion from a plastic surgeon at the nursing home. This might have been justifiable if her general condition improved and it was felt that further intervention might be tolerated.

Artificial nutrition and hydration, mere prolongation of life?

It was agreed that the NGT feeding should continue as long as no complications arose and the patient continued to tolerate it. However if the patient pulled the NGT out, a discussion should be held with the family and staff to decide about reinsertion or maintaining artificial hydration using subcutaneous fluids.

General Medical Council guidance, reaffirmed by the Court of Appeal[4] as lawful, does allow the discontinuation of treatment that is not conferring benefit after discussion with interested parties. The European Convention on Human Rights[5] may not help because, on the one hand, the right of life (Article 2) might be construed as encouraging artificial prolongation of life; but on the other, the prohibition of degrading treatment (Article 3) might lie in the artificial prolongation of life without prospect of recovery or quality improvement in the context of a progressive debilitating and disfiguring disease in this case.

Advance directives may guide medical attendants when the patient no longer has capacity[6]. The patient's nursing home care plan and GP records contained no reference to the existence of an Advance Directive. Decisions were therefore based on her best interests and artificial feeding had already been commenced after discussion with family members. It was clear, however, that further discussions would be needed very soon because of the patient's poor general state. The aim would be to gain understanding of the patient's condition and obtain agreement about how far to continue or escalate treatment – and when to consider ceasing artificial means of prolonging life. The consultant offered to assist the GP in these discussions.

Conclusion

Circumstances do arise when consultant and GP do need to meet at the patient's residence. The purpose of the visit may be to clarify diagnosis and treatment. Government policy[7] is, however, leading to more dependent people receiving ongoing care outside hospital. Increasingly, discussions around capacity, end of life care, how far to escalate treatment and when to withdraw it will be needed, for which the GP will need access to a second opinion. Knowledge of the domiciliary consultation service will help geriatricians provide the necessary support.

Conflict of interest: none declared.

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