perspective of a GP, thinking in strict profiles of frequent attenders denies the complexity of consulting behaviour. Our research group prefers to analyse frequent attendance as a clinical risk phenomenon: consulting exceptionally more than your peers may be a sign for GPs that a mismatch exists between the needs of these patients and the actual care delivered by the GP; a sign that there are undiscovered and unmet (medical) problems. In this perspective it makes sense to only select the top attenders stratified by age and sex (method 2 in this article).

Taking a certain number of consultations as a criterion will result in a selection of relatively many older women and diminishes the number of exceptional consulters among the young.² Selecting 25% of your practice is too much to be of any practical usefulness in this concept. Therefore, we think that defining frequent attenders as a (10%) proportional part of all enlisted patients is the best method to select the exceptional attenders in all age and sex categories. Also, this method makes it possible to compare between countries and different practices.^{2,3}

Most 1-year frequent attenders have good reasons to consult more often because of intercurrent disease or other (medical, social, or psychological) problems. Therefore, most frequent attendance is temporary. Only a minority persist in frequent attendance.⁴ Moreover, persistent frequent attenders have more (multi-) morbidity, compared with 1-year frequent attenders, and their consulting behaviour is, by definition, not determined only by intercurrent illnesses.⁴

Therefore, we stated in a paper in this Journal that for GPs persistent frequent attending is of more importance and clinical usefulness than short-term frequent attending.⁵

Unfortunately, the authors did not raise this issue in their paper.

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Frequent attendance from different points of view

Frequent attenders' (FAs) phenomenon is one of the major discouraging problems that GPs have to face in their everyday life. As Luciano *et al* write,¹ this proportion of patients generates a great cost for public health systems and considerable workload and frustration for GPs.

However, the institutions seem not to be concerned about the problem, and GPs are left alone to deal with it. Many studies have tried to trace a stereotype of the FAs, showing a high incidence of psychiatric illness and social problems. Luciano *et al*'s article indicates these factors as systematically related to this status and the main reasons for consulting as: being on sick leave, being born outside of the country, and reporting mental health problems.

In Italy, we tried to find out other characteristics of the FAs that could help GPs solve the problem.^{2,3}

These characteristics were examined: number of GP consultations, age, sex, social problems, trust in the doctors, and

influence of the mass media. Patients with major diseases that appropriately required a high rate of consultations were excluded.

These characteristics were prominent: lack of trust in the other doctors, influence of the mass media, and conflictual relationships with their disease.

The FA's problem is not only a social and psychiatric matter. Often the misuse and abuse of healthcare system is deliberate. The attitude and the structural bureaucracy of the healthcare system towards the patient very often facilitates the occurrence of FAs' phenomenon.

I think that these differences in results are important and indicate a need for more research of the topic. We need a clear definition of 'frequent attendance' that would separate clinical from administrative, psychological, environmental, and misuse aspects. I agree with the authors that a health care system's policy change is required. Also, a number of GPs think that a ticket paid by every patient for consultations, home visits, and other procedures might increase the patient sense of moderation and reduce their attendance without a clinical reason, the way it is for specialistic consultations.

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