Frequent attenders: Who needs treatment?

MOST doctors and nurses can bring to mind patients who attend frequently and with monotonous regularity. As with any distribution of behaviour, some patients in primary care attend more than others; 4.5% of patients account for one-fifth of the general practitioner's workload.[1] However, despite research over the last 25 years, it has not been established whether frequent attendance is simply behaviour at one end of a normal distribution of consulting frequency or something more significant. Put another way, there may be two hypotheses about frequent attenders. They may be viewed either as individuals behaving appropriately in response to a real need, who happen to be at the top end of the consulting spectrum, or as deviant individuals who create an unnecessary and unwelcome workload, with whom 'something must be done'. In reality, most frequent attenders will fall into a position between these two extremes, and they comprise a heterogeneous group of patients with a wide variety of differing needs. At a time of debate about general practitioners' workload and responsibilities, this issue becomes topical because of the presence of individuals who do persistently consult more than others, and because some of these frequent attenders seem to cause a real problem for some doctors, and may be described as being 'heartsink'.[2] Therefore, an appraisal of frequent attenders is both timely and appropriate.

There are difficulties in defining a 'frequent attender'. The first difficulty arises in the definition of a consultation, and the second in quantifying frequency. There is no standard definition of a consultation, although perhaps it would be prudent to adopt one for use in future research; for example, the one used in the *Fourth national study* of morbidity statistics from general practice.[3] Two studies have used the same definition for frequency, the upper quartile after stratifying for age, but each used different study time periods.[4,5] Other studies have used different arbitrary numerical definitions for frequent attenders, such as 11 or more consultations a year.[6] Although most studies have used 12-month observation periods, little is known about the patterns of frequent attendance over longer periods than this.[7]

It is established that consultation rates are higher, and frequent attendance more likely, with increasing age and female sex,[8] marital disharmony or separation,[4] and lower socio-economic status or unemployment.[1] Past and present physical health,[1,4-6] perceived health,[9] psychological health,[4,5] and somatization[10] are associated with frequent attendance. Furthermore, consulting rates are influenced by aspects of personality,[11] family factors[12] and life-events.[9] The consequences of frequent attendance for the patient are a higher chance of receiving a prescription or being referred.[5,9,13] The consequences to practices are that frequent attenders consume a disproportionate amount of resources, and use more health and social services.[1] Moreover, those who are perceived as being 'heartsink' may influence the health and well-being of the health care team.[2] However, many of the studies of frequent attenders must be interpreted with caution because of variable definitions of these individuals, small sample and control group sizes, and settings in different countries, where reasons for attendance may be confounded by inherent differences in health care systems.

In an area generally dominated by quantitative approaches, two studies of consulting behaviour are notable for their use of qualitative methodology. These provide information about the process of frequent attendance. Kokko developed descriptive categories of individuals such as 'information seekers', 'support seekers' and the 'hard to convince', all of whom consulted more than other categories.[14] Dowrick found that frequent consulting was associated with change within both the family and the health care team.[15] Qualitative approaches may be more appropriate to explore the behavioural aspects of frequent attendance both because of the difficult and sometimes sensitive nature of the subject, and the complexity and diversity of consulting.[16]

However, fundamental questions remain unanswered. Why do people with the same medical and social characteristics attend with different frequencies? What are the patterns of frequent attendance over several years and over lifetimes, and within families? Do 'trigger' and 'stopper' factors exist for frequent attendance? What are the health and emotional needs of frequent attenders, and do they attend only for the same reasons as other people? Is frequent attendance harmful in terms of inappropriate investigation, treatment or referral? It is unknown what contribution general practitioners make to frequent attendance, although 30% of consultations were reported to be doctor-initiated by one study.[17] The relationship between primary and secondary care frequent attenders, high service users and the health economics of the phenomenon are unknown, as are the effect of patient satisfaction, and length and quality of consultations on the delivery of health care to frequent attenders. There are also questions to be answered concerning the desirability and possibilities of intervention, and how outcomes could be measured.

Almost 10 years ago, in a response to previous descriptions of 'faulty behaviour' and 'undesirable patterns of behaviour',[18] Schrire suggested that the recognition of the frequent attender as a patient whose attendance is itself a sign of ill health needing treatment may be important.[19] Whilst this may be the case for some, we believe that what is important is the fundamental understanding of frequent attendance in the context of the doctor–patient relationship, as it may represent a dysfunction in this relationship.

Some strategies to reduce attendance are straightforward, and represent good practice. Firstly, frequent attenders must be recognized. Consultation frequency and intervals between consultations could be checked as a normal part of reading clinical or computerized notes prior to or during consultations. Secondly, many general practitioners may benefit from turning the microscope on themselves as part of ongoing personal and professional development and education. What is the doctor's consultation style, and what effect does this have on the doctor-patient relationship and consulting frequency? How do individual doctors within a practice vary with regard to 'doctor-initiated consultations' and in modifying patients' help-seeking behaviour? Practices may find that teamwork and referral within the primary care team may not only reduce attendances, but also improve clinical care. In time, useful non-pharmacological interventions may be developed to modify the behaviour of both patients and doctors. The introduction of commissioning and fundholding, together with the need to optimize care from finite resources creates an environment that may permit the introduction of both simple and radical strategies to address the issues. Looking further into the future, political change may lead to the end of free health care at the point of delivery; and this may have a profound effect on attendance patterns in primary care.

The unanswered questions constitute an important challenge to primary care. Substantial resources may be saved by rationalizing primary care treatment of these patients, and avoiding unnecessary referral, investigation and treatment. Perhaps most impor-

tantly for a profession burdened by the stress of increasing workload, the mythology and unanswered questions of the 'frequent attender' could be replaced by an evidence-based and efficient approach to the few patients who contribute such a large part of general practitioners' daily work.

RICHARD NEAL
Research fellow, Centre for Research in Primary Care, University of Leeds

ANTHONY DOWELL
Director, Centre for Research in Primary Care, University of Leeds

PHILIP HEYWOOD
General Practitioner, Leeds

STEPHEN MORLEY
Senior Lecturer in Clinical Psychology, Division of Psychiatry and Behavioural Science in Relation to Medicine, University of Leeds

References

1. Browne GB, Humphrey B, Pallister R, Browne JA, Shetzer L. Prevalence and characteristics of frequent attenders in a prepaid Canadian family practice. *J Fam Pract* 1982; **14:** 63-71.
2. O'Dowd TC. Five years of heartsink patients in general practice. *Br Med J* 1988; **297:** 528-532.
3. Royal College of General Practitioners, Office of Population Censuses and Surveys, and Department of Health. *Morbidity statistics from general practice. Fourth national study 1991-1992.* London: HMSO, 1995.
4. Westhead JN. Frequent attenders in general practice: medical, psychological,and social characteristics. *J R Coll Gen Pract* 1985; **35:** 337-340.
5. Svab I, Zaletel-Kragelj L. Frequent attenders in general practice: a study from Slovenia. *Scand J of Primary Health Care* 1993; **11:** 38-43.
6. Karlsson H, Lehtinen V, Joukama M. Frequent attenders of Finnish public primary health care: sociodemographic characteristics and physical morbidity. *Fam Pract* 1994; **11:** 424-430.
7. Ward AM, Underwood P, Fatovich B, Wood A. Stability of attendance in general practice. *Fam Pract* 1994; **11:** 431-437.
8. Office of Population Censuses and Surveys. *General household survey.* London: HMSO, 1991.
9. Robinson JO, Granfield AJ. The frequent consulter in primary medical care. *J Psychosom Res* 1986; **30:** 589-600.
10. Margo KL, Margo GM. The problem of somatization in family practice. *Am Fam Phys* 1994; **49:** 1873-1879.
11. Hood JE, Farmer RDT. A comparative study of frequent and infrequent attenders at a general practice. *Int J Nurs Stud* 1974; **11:** 147-153.
12. Huygen FJA. *The medical life history of families.* Netherlands: Dekker en Van de Vegt, 1978.
13. Heywood PL, Cameron-Blackie G, Cameron I. *Final report of the Street Lane Project: the Leeds Integrated Purchasing Project.* Leeds: Leeds Healthcare, 1995.
14. Kokko SJ. Long term patterns of general practice consulting behaviour: a qualitative nine year analysis of general practice histories of a working aged rural Finnish population. *Soc Sci Med* 1990; **30:** 509-515.
15. Dowrick C. Why do the O'Sheas consult so often? An exploration of complex family illness behaviour. *Soc Sci Med* 1992; **34:** 491-497.
16. Britten N, Fisher B. Qualitative research and general practice. *Br J Gen Pract* 1993; **43:** 270-271.
17. Martin E, Russell D, Goodwin S, Chapman R, North M, Sheridan P. Why patients consult and what happens when they do. *BMJ* 1991; **303:** 289-292.
18. McCormack JS. Familiar faces—the constant attender. *Proc R Soc Med* 1972; **65:** 507-508.
19. Schrire S. Frequent attenders—a review. *Fam Pract* 1986; **3:** 272-275.

Address for correspondence
Richard Neal MRCGP, Research Fellow, Centre for Research in Primary Care, University of Leeds, 30-32 Hyde Terrace, Leeds LS2 9LN.

Summative assessment — threat or opportunity?

THE examination for membership of the Royal College of General Practitioners is recognized as a suitable assessment of the completion of vocational training for general practice, but although the number of general practitioner registrars sitting this examination has increased, a substantial minority either choose not to sit the examination or fail to meet the standard required. These doctors can receive their certificate of satisfactory completion of vocational training because the MRCGP is not compulsory and is set to measure an optimum standard.

In 1993, the Joint Committee on Postgraduate Training for General Practice agreed that all doctors completing vocational training for general practice should have reached a nationally agreed standard.[1] In November 1995, it was agreed that the date of implementation would be 4 September 1996. Over the last 3 years, the regional advisers in general practice have worked to produce a four-part assessment package that covers the six areas identified by the joint committee: assessment of clinical knowledge and problem solving skills; assessment of communication and consulting skills; a written submission of practical work; and a trainer's overall report.[2-4] The results of a consensus conference to determine the content of the trainer's report are published in this issue of the *Journal*.[5] The RCGP has restructured its examination into a modular format. The new structure will facilitate the use of the MRCGP in the JCPTGP's summative assessment framework.

General practice now has a complete package that has been specifically designed to assess minimum competence at the end of vocational training. Each of the four parts making up the package has been subjected to peer review through publication,[2-4] and each has used a combination of experts in the field and representatives of training practices to determine the standards. For each of the components, every region has arranged specific training for assessors, and there is a national system to ensure that the package is applied equitably across the UK. This compares favourably with the work in place to implement the certificate of completion of specialist training.[6]

As with all innovations, summative assessment poses opportunities and risks. Perhaps the most important opportunity will be a guarantee for patients that their general practitioner has reached a minimum standard of competence. General practice might be seen as the jewel in the crown of the National Health Service, but an incompetent general practitioner could make both the jewel and the crown inaccessible or inappropriate for patients.

General practitioner registrars may appear to have the most to lose with the implementation of summative assessment; indeed, this may have been the reason behind their resistance.[7] Yet