‘I always seem to be there’ — a qualitative study of frequent attenders

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SUMMARY

Background. *Much is still unknown about the consultation behaviour of frequent attenders, including why they consult as often as they do and why they consult in the patterns that they do.*

Aim. *To determine why frequent attenders to general practice consult in the patterns that they do.*

Method. *A qualitative study based on semi-structured interviews. Twenty-eight frequent attenders were purposively sampled from three practices; 13 exhibited a ‘burst and gap’ pattern of attendance and 15 exhibited a ‘regular’ pattern of attendance.*

Results. *A two-part model is proposed. The first part encompasses each individual decision to consult and is based around eight questions that may be asked as part of the decision-making process (these concern the perception of the general practitioner’s [GP’s] role, past experience of symptoms and consulting, comparison with others’ consulting, relationship with the GP, balancing fears, lay consulting, individual reasons, and whether it was a symptom that they would not normally consult for). The second part determines the pattern of consulting and has four major themes: predominantly medical reasons for attending, experience of what happens during the consultation, access- ibility of the GP, and periods of not consulting. Two further themes are proposed: ‘multiplicity’, whereby the reasons for consulting lead to further consulting for related and unrelated problems, and ‘passivity’, whereby consulting seems to be out of control.*

Conclusions. *The reasons underpinning each individual decision to consult were complex. The control that GPs were perceived to have over the pattern of consulting, for example concerning prescribing, review visits, and in addressing further help-seeking behaviour, may provide more possibilities for developing intervention strategies than targeting frequent attenders themselves. An understanding of the processes behind the consulting behaviour of frequent attenders may lead to more functional consultations and better clinical care as a result.*

Keywords: frequent attenders; consulting behaviour; help-seeking behaviour.

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Introduction

DESPITE an increasing body of work on frequent attendance,[1-5] much is still unknown about the consultation behaviour of frequent attenders and the related behaviour of their general practitioners (GPs) and primary health care teams. This includes the fundamental question as to why frequent attenders consult as often and in the patterns that they do. The body of evidence concerning why, when, and how people consult their GPs provides various models of consulting.[6-11] However, these models are inadequate to explain the degree and pattern of consulting demonstrated by some frequent attenders; and, with the exception of the Network Episode Model,[11] they focus on a single end point (usually a consultation) as a discrete entity, rather than regarding each one as a part of a larger pattern of consulting. Thus they ignore a reality of general practice that is relevant for many patients, not just those who consult frequently.

Previous work on frequent attenders has focused on the disproportionate amount of the clinical workload that they consume,[1,3] outcomes of what happens when they consult,[2,12] and their health status.[4] More recent work has identified different groups of frequent attenders by the temporal pattern of their consulting.[13] This classified the majority (45%) of frequent attenders into a mixed group, without a clearly identifiable pattern, and identified other more distinct groups: those who attended with great regularity over several years (‘regulars’ [37%]), and those who had a pattern typified both by bursts of consultations and by periods where they did not consult (‘burst/gaps’ [18%]).

The qualitative study reported here illustrates and clarifies quantitatively derived findings;[1,13] it aims to determine why frequent attenders consult in the patterns that they do and thereby develop a model to capture the main features of this. The only previous qualitative study of frequent attendance was limited to one frequently attending extended family,[14] and while this provided a thorough account of one family’s behaviour the findings cannot be generalised.

Method

Sampling

Responders were recruited from three general practices from which we had previously collected data and with whom the authors were unconnected.[15] Patients fulfilling the criteria (see Box 1 for definitions and exclusions) were sampled. This included two types of frequent attenders: ‘regular’ and ‘burst/gap’ frequent attenders, because it was hypothesised that these groups would include patients with more diverse and clear-cut elements to their consulting behaviour that a more heterogeneous group would not. It also permitted comparison between these groups, whose members exhibited quite distinct patterns to their consulting. Recruitment was undertaken on a practice by practice basis, and potential responders purposively sampled to ensure that the final sample contained sufficient subjects from both groups and a diverse age and sex mix. The sampling was informed by analysis of emergent themes from the data to elicit a maximum variety of patient perspectives, and data collection continued until no new themes arose from the data. The responders were aware that the principal author (RDN) was a GP, although not associated with

Sampling of 'regular' and 'burst/gap' frequent attenders
Potential responders were identified by analysis of 'consultation timelines' of the top 150 adult attenders in each practice; each individual was classified into one of three groups:

- *'Regular' frequent attenders.* At least one consultation in every 90-day period, and no periods of 10 consultations over 90 days (a 'burst');
- *'Burst/gap' frequent attenders.* At least one burst, and at least one period of no consultations over 90 days (a 'gap'); and
- *'Others'.* Not falling into one of the categories above.

Exclusion criteria
GPs excluded patients who:

- had died or left the practice since the original consultation data were collected;
- had a terminal illness or had severe mental illness or impairment;
- had a severe alcohol or drug problem;
- had severe sensory impairment;
- had poor use of English;
- were antisocial, violent, or aggressive; and
- felt they should not be interviewed (with reason).

Box 1. Sampling strategy and exclusion criteria.

their practice. Throughout the data collection and analysis, RDN adopted the role of researcher rather than clinician.

Development of the interview schedule

Semi-structured interviews[16] were conducted by RDN with a sample of frequent attenders. The interview schedule was developed to address the aim and, in doing so, was informed by the literature on frequent attendance and patients' perceptions of consulting, the analysis of quantitative data regarding patterns of frequent attendance,[1,13] and the clinical experience of the three authors. The broad topic areas covered are shown in Box 2. Each interview was further informed by knowledge of the responder's pattern of consulting over the previous three years;[15] explanations of these patterns were sought.

Data analysis and inter-rater reliability

The interviews were audiotaped and transcribed; the resulting data were analysed using Framework, a well established tool for qualitative data analysis.[17] This was facilitated by the use of NUD*IST software.[18] The emergent themes that arose from the data and the coding structure were discussed at regular meetings between the authors; the analysis was refined by reading and re-reading the transcripts. The data were carefully analysed to identify similarities and differences between the two groups of frequent attenders. This was done by analysis of textual data from which each major theme arose and by specific analysis of data from responders from both groups. Furthermore, comparison of data between practices, between males and females, and between younger and older responders, was undertaken. The major themes were fitted into a conceptual model.

Twenty selected pieces of text from the transcripts were independently coded by a second unrelated researcher using a shortened list of codes that reflected the main codes in the analysis; these were compared with RDN's original coding and a kappa statistic calculated. One complete transcript was independently coded by the second unrelated researcher and coded a second time by RDN, six months after the initial coding. Differences in the coding were discussed and the importance of these ascertained.

Health status questionnaire

An SF-36 health status questionnaire[19] was administered to objectively describe the health status of the responders. This questionnaire takes between five and 10 minutes to fill in, and has been validated on a United Kingdom general practice population.[20] The results were compared with normative data.[21]

The broad topic areas covered in interviews were:

- recent consultations: process of decision to consult, and what happened when they did consult;
- consulting in general and perception of pattern of consulting;
- perception of GP and practice in general;
- perception of other patients' consulting/frequent attendance;
- health and health beliefs in general (including use of other health services); and
- others (e.g. past health and consulting, health and consulting of family).

Box 2. The interview schedules.

Results

The sample

Seventy patients from three practices were invited for interview. Thirty (43%) consented, of whom 28 were interviewed (two were excluded because no new themes were emerging from the data by the time they had returned their consent forms). Fourteen declined to consent and 26 did not respond to two mailings. The group of 42 individuals who were not interviewed (15 with a burst/gap pattern and 27 with a regular pattern) contained a higher proportion of women and regular attenders, were younger, and consulted more. Of the 28 responders, 24 were married, two were widowed, and two were divorced. Seven were in employment, 18 were retired (including 10 on the grounds of ill health), and three were housewives. The sex, age, and number of consultations of the responders and the non-responders are shown in Table 1.

SF-36 scores

Twenty-six out of the 28 responders completed an SF-36 questionnaire. Although the data are not reproduced in full here, the key findings were that for all the measured domains, more than three quarters of the scores were lower than the normative data (representing 'poorer' health), with over half being more than one standard deviation lower, and almost one-third being two standard deviations lower. These differences were most marked for the domains 'role physical', 'bodily pain', 'general health', and 'vitality', and less marked for the domains 'social functioning', 'role emotional', and 'mental health'.

Inter-rater reliability

There was close agreement between the two raters for the 20 pieces of text (kappa = 0.80). There were only minor differences between raters in the coding of the complete transcript, and between RDN's 'before and after' coding; these were thought unlikely to have an important effect on the subsequent analysis and interpretation of data.

Main themes from the qualitative data analysis

The main themes that arose from the data have been incorporated into a model (Figures 1 and 2), the two sections of which are closely interconnected. Because of the similarity to an existing model, the structure of the first section is loosely based on that model.[9] This describes the factors influencing individual decisions to consult. The second section examines factors leading to

Table 1. The sex, age, and number of consultations of the responders and the non-responders.

				Annual consulting rate[b]	
	Male	Female	Mean age	Median	Interquartile range
All responders (n = 28)	8	20	54.1	16.2	14.2–17.9
Burst/gap[a] (n = 13)	4	9	50.6	16.7	14.0–18.3
Regular[a] (n = 15)	4	11	57.6	16.1	14.9–18.1
Non-responders[c] (n = 42)	8	34	42.2	17.6	15.2–21.4

[a]As defined in Box 1; [b]averaged over the 41 months between 1 October 1991 and 28 February 1995; [c]those who refused consent, did not respond or were not recruited.

different patterns of frequent consulting. All the data presented are direct quotes from responders; names and places have been changed.

The dataset was investigated to explore similarities and differences between the two groups of responders, younger and older responders, and males and females. None of the major themes that emerged were exclusive to one of these groups, and all of the major themes were generated from data from both; no differences were found between the practices.

Section 1: Factors influencing individual decisions to consult

Faced with a problem or symptom, each responder had to reach a decision to consult (Figure 1). To do this, each responder had a set of 'ground rules' for consulting; these were very individual, and are presented below as a series of questions. Fulfilling these ground rules enabled them to make, and to justify, a decision to consult, within the context of their own lives.

1. *Does the problem fit with my perception of the GP's role?* The responders behaved in ways that responded to what they regarded the GP to be for. Three broad roles were identified, with responders often describing more than one:

- to talk to, be there if needed, be a friend;
- to provide help and/or advice; and
- to find out what is wrong, treat symptoms, make people better, to reassure.

'I think they [the GPs] *think that you* [I] *go a bit too often, but that is what they are there for. They are there to reassure you that you are going to get well.'* [Responder 26.]

2. *What have I learned from my past experience of symptoms, and of consulting, that can inform this decision to consult?* All responders had considerable experience of symptoms and problems, some of which they had consulted with; this experience was used to inform future decisions. If the 'natural history' of the symptom was understood then the decision, and the timing of it, was made easier.

'I couldn't get in with anyone else so I went you know, I got in with him. I knew that I needed some tablets or it wouldn't go off.' [Responder 17.]

3. *How does my own consulting compare with others, and what does my GP think of me?* Most responders were aware that they consulted more than others; but also knew others who consulted more than themselves. They perceived that their GP thought they were a nuisance or a hypochondriac, because of frequent, rather than inappropriate, consulting.

'I do go more than some, I don't go as much as others. I know of others who go far more often than I do.' [Responder 13.]

'I sometimes get it into my mind that, "Oh God they are going to think I am a hypochondriac because I never seem to be away".' [Responder 18.]

4. *What is the nature of the relationship with my GP(s)?* Most responders reported long-term familiarity with their GP and well established relationships, making it easier for them to decide to consult in a given situation.

'I try to go to Dr 302. I can talk to him, sit and talk to him and I don't feel stupid you know for saying, and I can ask questions and he will always explain ... I suppose I sort of treat him as a friend really because I can, I mean when I have got to go, I hate it, but I have never felt uncomfortable and I can have a conversation with him and ask him questions you know. I feel as if he is interested in me.' [Responder 12.]

5. *Do the fears of consulting outweigh the fears of not consulting?* The responders tried to do the right thing for themselves and for their GPs. Many consultations were because they were frightened about what may be wrong; the process of consulting was to reduce this fear. The fear of not knowing what was wrong with them was often balanced against the fear of finding out what may be wrong. There was a very real fear of consulting inappropriately (either too soon or too late in the natural history of an illness) and consequently meeting the GP's disapproval or being labelled as a nuisance or a hypochondriac.

'And I actually thought I was dying, and that is the reason half the time when I was ill I wouldn't go to the doctors.' [Responder 22.]

6. *Do other people (family and friends) corroborate my decision to consult?* Most responders reported the influence of others on their decision to consult, either as unheralded advice from others or corroboration of the decision to consult; the advice was invariably to consult.

'My husband would say to me, "Go to the doctor's if you don't feel any better". I would say, "But why go, they don't know what is wrong with me and I am just wasting their time". He said, "Yes but Janet, you are not wasting their time, you aren't well".' [Responder 22.]

7. *Do I have any particular individual reasons that I need to consult for?* Specific reasons were suggested for making an individual more likely to consult in a given situation. These were deeply individual and included, for example, a belief

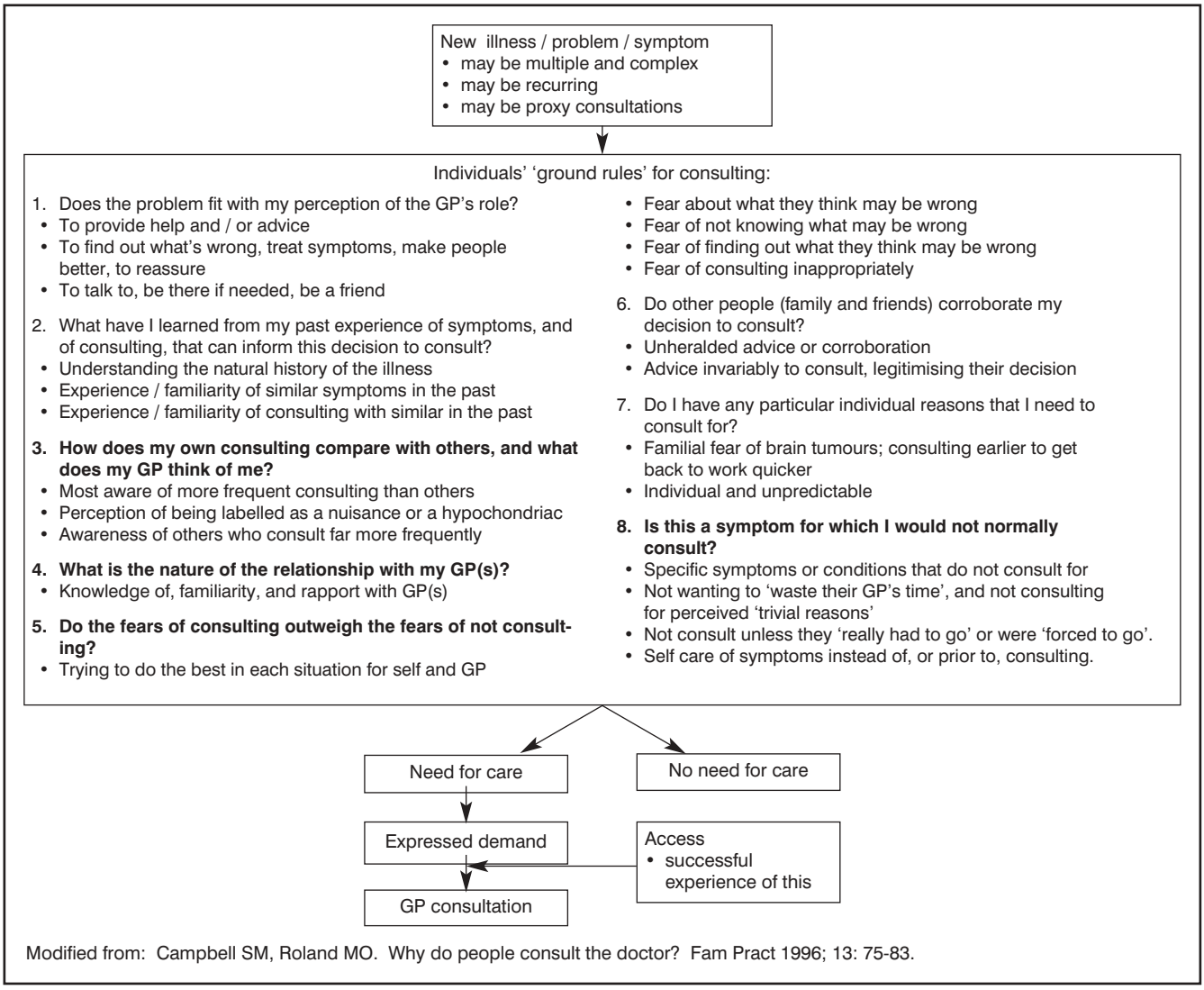

Figure 1. Factors influencing frequent attenders' individual decisions to consult.

that consulting sooner would help them get back to work quickly.

'When I was poorly, after a couple of days I used to be so anxious to get back to work I used to think my doctor could give me something to speed things up like you know ... I think this is why I have rushed back to the doctor's a lot — to get back to work in the past.' [Responder 28.]

8. *Is this a symptom for which I would not normally consult?* All responders had their own individual framework for not consulting in the same way as they did for consulting. Four factors contributing to this were identified:

(a) specific symptoms or conditions that they did not consult for

'I suppose a lot of people might go with a headache or a splinter in their thumb or things like that. I wouldn't dream of going for anything like that.' [Responder 16.]

(b) they did not want to 'waste their GP's time', and did not consult for perceived 'trivial reasons'

'I don't go down because of silly things, or call them out for silly things.' [Responder 24.]

(c) they would not consult unless they 'really had to go' or were 'forced to go'

'As I say, I don't go over unless I am forced, and I don't like doctors at all. If anything crops up, you know, that you can't cope with I mean, then you've got to go. But I am not one for running over [to the doctor's] *all the time.'* [Responder 4.]

(d) self-care of symptoms instead of, or prior to, consulting

'Like with this cold, I haven't been to the doctor's with it. I just sort of, let it clear itself up.' [Responder 10.]

Section 2: Factors leading to short and prolonged bursts (regular) of consulting, and to periods of not consulting

Through analysis it emerged that the pattern of frequent consulting was a product of a number of factors; frequent attendance was not just a series of unconnected new symptoms. However, each individual consultation in the pattern fulfilled the ground rules on each occasion. Hence a different model has been developed to explain the pattern (Figure 2). The main themes that pro-

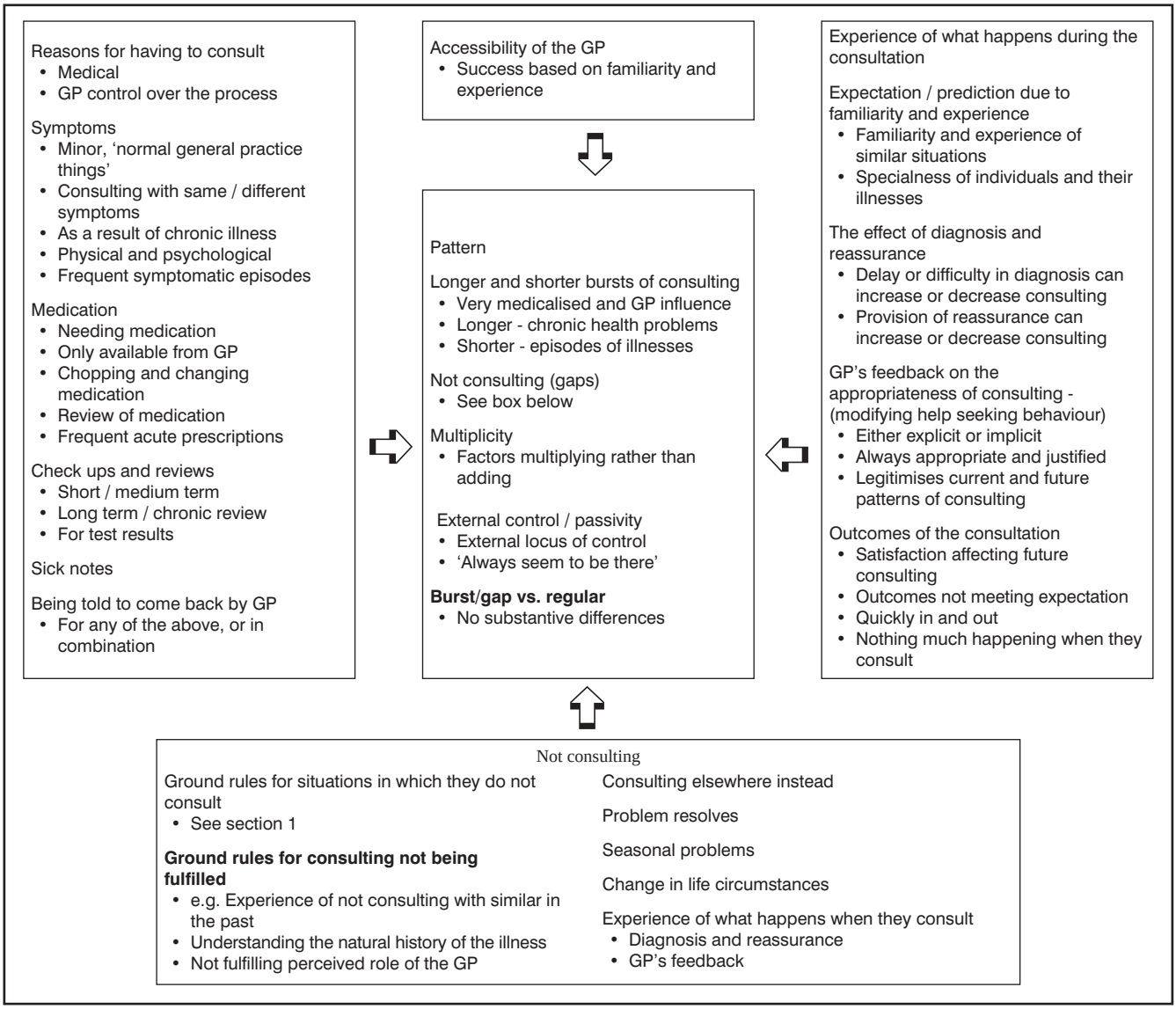

Figure 2. Factors leading to short and prolonged bursts (regular) of consulting, and to periods of not consulting.

duce the pattern are described below.

1. Reasons for having to consult. The main reasons for frequent consulting were 'medical', in terms of the responders' perceptions of their problems, and their perceptions of their doctors' interpretations of these. Some responders consulted with symptoms caused by chronic disease; others consulted as a result of different illnesses or problems. Much frequent consulting was linked to a need for medication, and this was perceived as being controlled by GPs. Consulting for medication was 'necessary' if it was only available on prescription, for frequent symptomatic episodes, because medications were being changed, or for review of long-term medication. Many responders reported 'having to go' for check-ups or being 'told to come back'.

'Well I had to keep going back ... he used to say, "Come back in a fortnight", or "If they [tablets] *are not doing you any good you must come back and see me". And this went on for about three years.'* [Responder 28.]

Most of the short bursts described by the burst/gap frequent attenders (for example, several consultations over a few weeks) were for episodes of illnesses; most included a significant amount of the GP's influence over the need to reconsult.

'Oh it were regular. I would say, with the 'flu and things like that, bad backs, monthly, sometimes twice, three times a month. Bad backs, bad shoulders, I have had injections in my shoulders, I have had pains in my knees, pains in my back, sometimes I have not been able to walk, I have had to come downstairs on my bum. What else were I going with? Thumping headaches, really thumping headaches, I was forever getting 'flu and it went to my chest, and I was forever having asthma. I was really ill and I was frightened.' [Responder 26.]

Longer bursts and regular patterns were impossible to separate in the qualitative data; they related to periods of consulting over a period of several months or more. The most common reason for these patterns exhibited by the regular frequent attenders was mental health problems.

'I had spent a year when I was poorly ... Active depression,

so I had to go quite often then. To begin with it was once every couple of days to get my tablets because he only gave me enough for a couple of days, and then they put it up to a week and then two weeks and things so, to be trusted with the amount of tablets you have got, that is why ... That seems really good to me because they were obviously bothered about you, you know, because of the state I was in they were bothered about what you could do, you went, they sort of like, they did their best to care. That went on for, going to the doctor's for, it was about, I was in about a year, it was about eleven months.' [Responder 20.]

2. Experience of what happens during the consultation. The GP's behaviour during the consultation, and the outcome of the consultation, were both powerful influences in determining future patterns of consulting. The effect of making a diagnosis, or of delays in diagnosing, had an impact on subsequent consulting, with some patients consulting frequently in search of a diagnosis and then less so when diagnosed, and others consulting frequently once diagnosed (Responder R14, after a heart attack — data presented under 'multiplicity' below).

'I had been to the doctor's for nearly two years [prior to diagnosis of MS]. *I had been going on and off with different symptoms and none of them knew what was wrong.'* [Subsequently consulted very little.] [Responder 22.]

Similarly, while some responders explicitly consulted for continued reassurance, the fact that they continued to consult suggested that they were not effectively reassured.

'I was really fed up of feeling tired to be honest, and I just felt as though if I don't go now, and get it sorted, it is either going to get worse if it is something or, probably reassuring that I was going to be all right, you know. But you see I had to go and find out ... so you have got to go for reassurance probably.' [Responder 14.]

Responders often received feedback from the GP on the appropriateness of their consulting; invariably it was appropriate and justified, legitimising their ongoing consulting. Once into an established pattern of consulting, responders felt that they were quickly 'in and out' of the consultation, and that 'nothing much' seemed to happen in the consultation.

'At one point I did say to him, I said, "You must be sick of seeing my face". He said, "No," he said, "that is what I am here for," he said, "you come back as many times as you want" or "as many times that you feel necessary until you get better", so I thought well while I can do this I have not got to worry about anything.' [Responder 28.]

3. Accessibility of the GP. Once a need for a consultation was determined, whether they actually consulted or not depended upon the accessibility of the GP. This was facilitated by the experience and familiarity that frequent attenders had in successfully accessing the GP in the past.

'I phoned up yesterday ... and the receptionist knows my voice, and she says if I were willing to go in and sit for the last appointment ... somebody would see me.' [Responder 16.]

'I have never been unfortunate enough to not be able to get in that day, I have always virtually been able to see somebody, albeit not always the doctor that I want you know but, there is always somebody there that you can go and see.' [Responder 18.]

4. Periods of not consulting. Prolonged episodes without consultations were owing to symptoms resolving, seasonal variations, consulting elsewhere (for example, complementary therapists or secondary care), and changes in life circumstances. Although they may have continued to experience symptoms during these periods, their ground rules were not being fulfilled, and no consultations resulted; this further legitimised their need to consult when they did. Surprisingly, responders from both groups of frequent attenders provided data to support this theme.

'Sometimes I probably go twice in the month and then maybe I won't go for maybe four or five months. It just depends how things crop up, really I think.' [Responder 14 — 'regular' frequent attender.]

'I think more or less I start [going to the doctor's] *in November* [each year] *with this chest problem, and it usually goes on. Well it has gone on longer this time, I mean it is now the end of March. Very rare I go in summer.'* [Responder 16 — 'regular' frequent attender.]

'I haven't been [to the GP] *for the last few weeks because I am going to see this chiropractic and I do think that he is helping a bit, but I am still not right.'* [Responder 9 — 'burst/gap' frequent attender.]

'But I always seem to have been at the doctor's then [in the past], *but since I have been in this job I think myself, my opinion I have cut down going to the doctor's. I have got to be really ill to go to the doctor's.'* [Responder 26 — 'burst/gap' frequent attender.]

Linked to these four main themes that produced the pattern were two further themes, as described below.

Multiplicity

When several of the factors discussed above were present together, this seemed to have the effect of increasing the frequency of consulting. For example, an episode of illness led to consultations for medication and regular review for that medication, for investigations and follow-up appointments, for sick notes, and for a regular review of symptoms. This led to great familiarity with the GP and with the system of accessing the GP. The outcome of this was more consultations for subsequent symptoms, for which they otherwise may not have consulted.

'Since I retired, I have effectively not been as well as I was before, and that in itself has meant more visits to the doctor's. I mean things like colds, tickly chest colds I have got to be much more careful now than I was prior to having the heart attack ... with having so much medication it is a case of knowing what I can take now, and that is often why I go to the doctor's because I am not sure ... what is safe to take.' [Responder 13.]

Passivity/external control

The concept of 'passivity', a feeling that things were happening to people beyond their control, evolved as a prominent theme; this included the notion that they 'always seemed be there', and that they had little internal control over the process of consulting. Some responders strongly expressed accounts of an external locus of control, and found it hard to present an explanation for their frequent attendance.

'They [doctors] *just can't keep it under control. In between seeing the specialist at the hospital I do see them* [GPs] *quite regularly.'* [Responder 24.]

'She [the GP] *used to say, "Make an appointment", and quite often she would walk out with me and then she used to say, "Make an appointment for three week's time" or "a month's time", and they used to give me a card, and then they used to write, then they used to phone me up and say, "We're just checking that you are coming" ... they wanted me to do it. And they kept saying, "This is what we want you to do", so I did as I was told, and that's the reason I did it* [consult so often]. *I know it sounds stupid but that's why I did it.'* Responder 3.]

'I sometimes think he must think I am a nuisance because I always seem to be there.' [Responder 13.]

'We seem to be there more than other people at the moment, yes.' [Responder 17.]

Discussion

There are several key issues arising from this study that are of importance:

1. The processes by which frequent attenders make individual decisions to consult are complex, and are informed by their experience of symptoms and of consulting in the past.
2. Chronic physical and psychological illness have a major influence over attendance patterns.
3. The perceived power of the GP in the control of medication and over when and if the patient needs to return for review.
4. The way in which individual reasons to consult aggregate together leading to more consulting.
5. The significance of the themes of passivity and external control exhibited by some of the frequent attenders and their consulting.
6. The familiarity that the frequent attenders had over the whole process, including that of gaining access to the GP, made it easier for them to consult more in the future.

The proposed model has similarities with other models, most notably the Health Belief Model,[7] and the Network Episode Model.[11] The first part of the model recognises that frequent attenders have a strategy for making a decision to consult in each given situation they face. The second recognises that their pattern of frequent consulting is more than just the sum of their individual decisions to consult.

The question arises as to how much this model is just about certain patterns of frequent consulting and how much it could be applied to all frequent attenders or to consulting in general. An interesting and unexpected finding from the study was the lack of differences between the themes developed from the data from the two groups of frequent attenders, with the exception of linking different chronic and shorter episodes of illness with bursts of consultations, despite purposive sampling to explore this further and ongoing analysis of emergent themes. One explanation of this is that there are no important differences between these groups and that, while they represent different patterns of frequent attendance, the reasons underpinning their patterns of frequent consulting are the same. If so, then this would suggest that the findings may be generalisable to all frequent attenders, rather than just the two groups. Further evidence to support this comes from the fact that the SF-36 scores of the sample were similar to a previously reported sample of frequent attenders,[22] and that they were considerably different from normative data. Support for several themes is found in the literature about consulting in general, including there being a range of patient perceptions regarding the role of the GP.[23] The Health Belief Model[7] corroborates the positive influence of others, the severity of symptoms, and past experience of illness. The ground rule concerning 'particular individual reasons that individuals may have' is similar to the 'wildcard factors' described by McDonald *et al*, from their study on reassurance.[24] Although the model has arisen from data from individuals with specific patterns of frequent attendance, it may have a more general application.

The framework described by which each individual had a series of 'ground rules' that determine behaviour has similarities with Helman's folk belief model,[8] which described how individuals ask questions, the answers to which determine their behaviour. His sixth question 'What should I do about it — or whom should I consult for further help?' encompasses the ground rules. The way in which individuals differently evaluate and perceive different factors has previously been described by Mechanic in his work on illness behaviour;[25] this corroborates the very individual nature of the ground rules. While it is well established that, in the general population, only a small proportion of symptoms lead to consultations,[26] the concept of frequent attenders having a framework for *not* consulting was unexpected.

Chronic ill health and the need for medication has previously been identified as a major factor in frequent attendance.[4,9] The data here link it to both specific patterns of bursts of frequent attendance and to regular frequent attendance. However, not all those with chronic ill health are frequent attenders; one explanation of this is that their ground rules for consulting must be different.

Being diagnosed and being reassured had an effect on subsequent consulting patterns, paradoxically either increasing or decreasing the frequency of consulting. The increasing body of work on the effect of medical reassurance supports this, suggesting that relatively few people have their health anxiety improved by reassurance; of the others, some have a transient benefit, while others become more anxious.[24,27,28] The feedback provided by GPs on the appropriateness of consulting was perceived as being very powerful. GPs tend to act conservatively and sometimes defensively, and may rather see an individual too frequently than risk deterring them from consulting; this may be regarded as addressing help-seeking behaviour,[29] albeit inappropriately, and may account for the extent to which express permission in telling people to come back is provided by GPs (between 30%–40% of consultations[30]). This was a powerful determinant of subsequent frequent attendance.

Lastly, the issues of multiplicity and passivity need consideration. Evidence to support the notion that people consult more after they have done so before is provided by Briscoe's work on sex differences in consulting.[31] Even when consultations for contraception, gynaecological problems, and pregnancy are taken into consideration, women of childbearing age consult more than their male counterparts. Their familiarity with access, generated by the need to consult for contraception, gynaecological problems, and pregnancy, led to a higher consultation rate for other symptoms. It has previously been suggested that consultation rates are higher for those who have no idea what has caused their symptoms.[32] In our study, this, for some responders, allied to an external locus of control,[33] led to periods when they reported little control over their consulting.

We believe that it has important implications for practice. The great control that GPs were perceived to have over the pattern of consulting by controlling medication review and repeat prescribing, controlling review visits, and (powerfully) in addressing further help-seeking behaviour, may provide possibilities for developing intervention strategies. There was a clear perception that frequent attenders believed that their own patterns of consulting were legitimate, appropriate, and fulfilled a real need. From an outside perspective they were understandable if not always rational, were sometimes explicable by undiagnosed or established

illness, and sometimes supported and controlled by the GP's behaviour. Perhaps the time has come to abandon the term 'frequent attenders' in favour of an alternative that betrays less attribution bias on the part of the doctor.

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