

Frequent attenders' consulting patterns with general practitioners

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SUMMARY

Background. Despite the growing literature on frequent attendance, little is known about the consulting patterns of frequent attenders with different doctors. To develop appropriate intervention strategies and to improve the clinical care of frequent attenders, a full understanding of these consulting patterns is essential.

Aims. This paper has three aims: to determine whether frequent attenders consult more with some doctors than others; to determine how many different doctors frequent attenders consult with; and to determine whether frequent attenders exhibit greater continuity of care than non-frequent attenders.

Method. Analysis of a validated dataset of 592 028 consultations made by 61 055 patients from four practices over 41 months. Comparisons between the consulting patterns of the frequent attenders, defined as the most frequently consulting 3% of the population by practice, with non-frequent attenders and the overall practice populations.

Results. There was considerable variation in the numbers and proportions of consultations with frequent attenders between individual doctors. Most of the frequent attenders consulted with most or all of the doctors within practices over the timeframe. Frequent attenders exhibited more continuity of care than non-frequent attenders.

Conclusion. The reasons why some doctors have more consultations with frequent attenders is unclear. Some doctors may actively encourage frequent attendance. While many frequent attenders have clear allegiances to one doctor, many also consult widely with a large number of doctors. The consequences of such behaviour are unknown. These findings have important implications in the development of appropriate interventions for reducing problematic frequent attendance.

Keywords: frequent attenders; consulting patterns; general practitioners.

Introduction

THE growing literature on frequent attendance to general practice has focused primarily on the frequent attenders' morbidity, sociodemographic status, and 'patient-initiated' reasons for consulting.¹⁻⁶ However, the way in which frequent attenders consult with different doctors has been relatively ignored. This may

be an important area to focus on, especially in the light of evidence from qualitative work that has found that general practitioners (GPs) have significant control over frequent attenders' consultation patterns and help-seeking behaviour and demonstrated the reasons why some frequent attenders choose to consult with certain doctors.⁷

Examination of 'consultation timelines' of frequent attenders has shown that the ways in which frequent attenders consult with different doctors is complex with, for example, some frequent attenders predominantly consulting with only one doctor, some consulting with one doctor and then switching to another, and some having an almost random pattern.⁸⁻⁹ Two other trends were apparent in this study: that most of the frequent attenders consulted with most of the doctors within the practices over the 41 months and that some doctors had more consultations with frequent attenders than others. Data from one insurance scheme in Quebec showed that 3639 patients received ambulatory care from more than 20 doctors over one year, suggesting that within that setting, frequent and multiple use of doctors was common.¹⁰ However, it is not known how generalisable these findings may be to other settings.

There is only one study that has examined continuity of care in relation to patients who consult more frequently than others. This found that patients with more consultations exhibited more continuity of care than those with fewer consultations.¹¹ There is some evidence to suggest that greater continuity of care is linked to improved quality and delivery of care,¹²⁻¹⁴ one of the government's key health policy aims.¹⁵ There is continued debate, however, over how continuity of care should be measured,¹⁶ especially in view of the ongoing debate concerning 'longitudinal' (the provision of care by one practitioner over a defined time) and 'personal' continuity of care, i.e. the nature and quality of contacts and therapeutic relationships with members of a primary health care team and consistency in the management of diseases and conditions.¹⁷⁻¹⁸

If the issue of inappropriate frequent attendance is to be addressed,¹ then the ways in which these patients consult with different doctors, and in which their clinical care is provided, needs to be understood. Doctors' behaviour may both cause and perpetuate frequent attendance and one hypothesis is that intervention for frequent attendance may be best directed at GPs and other practice staff rather than the patients themselves.¹ Other authors have suggested that, for example, interventions should focus on the effective management of depression and related disorders.⁵

We sought systematic methods of quantifying the consulting patterns by frequent attenders with different doctors. The aim of this paper is to describe the patterns of attendance of frequent attenders with different doctors to address the following three questions:

1. Within practices do frequent attenders consult more with some doctors than others?
2. Within practices how many different doctors do frequent attenders consult with?
3. Are frequent attenders more likely than non-frequent attenders to see the same doctor at successive consultations and, if so, does this vary between doctors?

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Method

A dataset containing a date record of all consultations made between 1 October 1991 and 28 February 1995 for every patient on the lists of four practices (representing 592 028 consultations by 61 055 patients) was analysed. The collection and validation of these data has been previously reported.¹⁹ The practices are all situated in Yorkshire. Practices A and B are four-partner urban practices, Practice C is a six-partner practice in a small market town, and Practice D (which operated a personal list system) a ten-partner practice working from two suburban sites. The age and sex breakdown of each of the practices is similar to that in the Fourth National Morbidity Study²⁰ and the General Household Survey.²¹ The dataset related to face-to-face doctor contacts, whether home visits or surgery attendances, and included planned clinics (chronic disease management, child health surveillance, health promotion) if they were with a doctor.

Since there is no standard definition of frequent attendance, we used the same definition that we have used in other published work from this dataset.⁶⁻⁷ Hence, frequent attenders were defined as the most frequently consulting 3% of patients, per practice. This definition equated to frequent attenders having an average of at least one consultation a month and permitted meaningful comparison between the four practices. The numbers of frequent attenders thus defined are shown in Table 1. Since the dataset contained no morbidity data, the definition of the groups was limited to the measure of patients' frequency of attendance alone. The dataset included a code for who each consultation was with. This included named principals in general practice and doctors other than principals (locums, registrars, deputies, and previous principals). For analysis, these were aggregated into a single category.

Within practices do frequent attenders consult more with some doctors than others?

First, to determine the overall distribution of consultations between doctors and to see whether this differed for the frequent attenders, the total number of consultations with each doctor made by frequent attenders was plotted alongside the total number of consultations made by the overall practice populations. Secondly, and to determine whether individual doctors were seeing more or fewer frequent attenders than would be expected from their proportion of the workload, the total number of consultations for each doctor of frequent and non-frequent attenders (the remaining 97%) was cross-tabulated and a chi-squared statistic calculated.

Within practices how many different doctors do frequent attenders consult with?

The number of different doctors consulted by each frequent attender was calculated and plotted alongside that of the total practice populations.

Do frequent attenders exhibit greater continuity of care than non-frequent attenders?

There are no standard ways of quantifying continuity of care applicable to this dataset.^{13,14} Continuity of care was therefore measured on a 'consultation-to-consultation' basis to determine whether a consultation was with the same doctor as the previous one. This was determined for each individual who consulted at least twice; those with only one consultation were excluded because they had no previous consultation to compare with. For each individual three categories of consultations were calculated:

1. 'Same doctor', if the consultation was with the same named doctor as the previous one;
2. 'Different doctor', if the consultation was with a different, but named, doctor to the previous one;
3. 'Others', if the consultation was with an 'other' doctor.

Consultations in the third category were excluded because it was impossible to determine their continuity of care. The data were then analysed in two ways. First, to test the null hypothesis that frequent attenders did not have more continuity of care than 'non-frequent attenders', chi-squared tests were performed on each 2x2 cell of a cross tabulation of the numbers of same doctor and different doctor consultations. Secondly, the percentage for each individual of same doctor consultations out of the total number of their consultations was calculated and, from this, the weighted mean of these percentages. Weighted means were calculated since they take into account the number of consultations with each individual.²²

Results

Completeness of data

The percentages of consultations that were therefore available for analysis were: 38.6%, 78.4%, 82.8%, and 80.6% for practices A, B, C, and D respectively. The data for Practice A were therefore excluded from further analysis.

Within practices do frequent attenders consult more with some doctors than others?

As is demonstrated in Figure 1, frequent attenders consulted more with some doctors than others within each of the practices (the codes applied to doctors are the same as those used in our other published work in this area).^{7,8} However, the doctors who had more consultations with frequent attenders were the ones who also had more consultations overall. Within practices the distribution of the proportion of frequent attenders' consultations between doctors was similar to the proportion of the overall number of consultations: those doctors who worked part-time or who had more outside commitments saw fewer patients overall and saw fewer frequent attenders. However, there were some doctors who saw a greater proportion of frequent attenders than expected from the distribution of the overall workload (e.g. Dr 306) and others who saw a smaller proportion (e.g. Dr 304).

Table 1. The number of frequent attenders per practice, their age and sex, and the number of their consultations. Frequent attenders defined as the most frequently consulting 3% of each practice population.

Practice	n	Mean age	Female (%)	Consultations 1 October 1991–28 February 1995			
				n	Median	Maximum	Interquartile range
B	184	51.9	71.7	42	50	99	45–57
C	323	57.5	71.2	37	44	148	40–52
D	669	51.1	71.0	32	38	266	34–45

Such differences between doctors were apparent within each of the practices. There was a significant difference between the observed and expected numbers of consultations for each doctor for frequent attenders compared with non-frequent attenders for each practice (Practice B: $P < 0.001$, Practice C: $P < 0.001$, Practice D: $P < 0.001$).

Within practices how many different doctors do frequent attenders consult with?

The number of different doctors seen by the frequent attenders and by the overall practice populations are shown in Figure 2.

The median number of doctors seen by the overall practice populations were: Practice B: 3, Practice C: 3, and Practice D: 2. The median number seen by the frequent attenders were Practice B: 5, Practice C: 6, and Practice D: 4. The distribution of the number of doctors seen by the frequent attenders in Practice D may differ because of its split sites; it is effectively two practices administered as one.

Do frequent attenders exhibit greater continuity of care than non-frequent attenders?

The overall percentages of 'same doctor' consultations varied

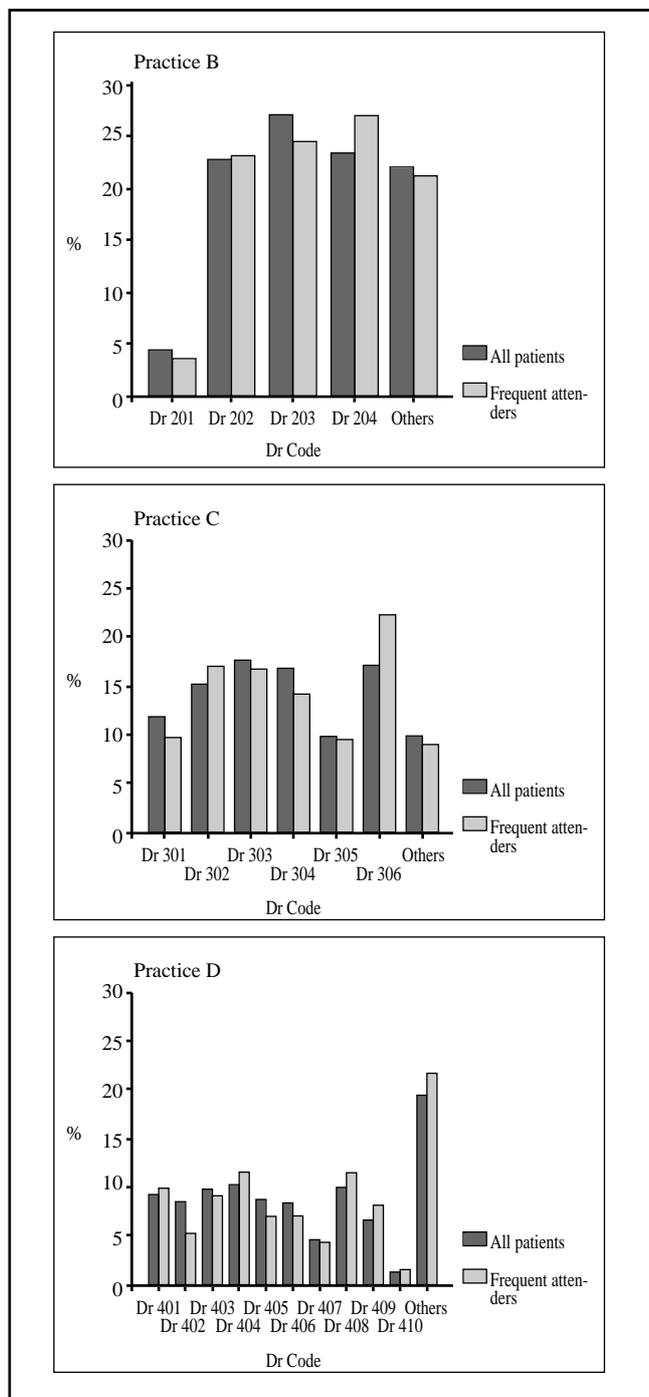


Figure 1. Percentage of consultations with each doctor: all patients and frequent attenders.

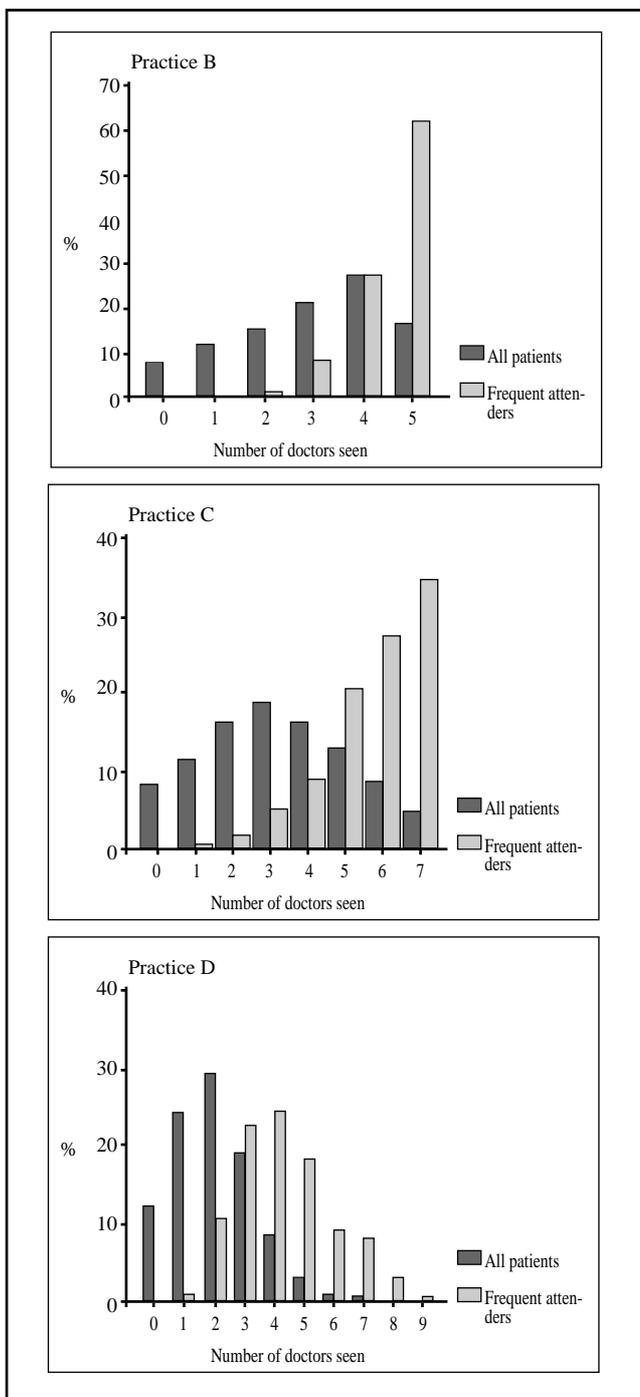


Figure 2. Number of doctors seen: all patients and frequent attenders.

from 50% in Practice C to 52% in Practice B and 71% in Practice C. Frequent attenders had significantly more 'same doctor' consultations compared with non-frequent attenders than would be expected by chance (Practice B: $P < 0.001$, Practice C: $P < 0.001$, Practice D: $P < 0.001$). The frequent attenders, compared with the overall practice lists had a higher weighted mean percentage of 'same doctor' consultations per individual (Practice B: 48.2% versus 43.6%, Practice C: 52.3% versus 45.5%, Practice D: 62.9% versus 61.2%).

Discussion

The data from this study clearly show how the proportion of the workload generated by frequent attenders is not equally shared between doctors. While this was an expected finding, the exact reasons for it are unclear. Possible explanations include certain behaviours on the part of the doctors to attract, or deter, frequent attenders, other factors relating to the doctor, and factors relating to the patients that doctors see.²³ These doctor-related factors include the personality and character of the doctor and the style of their consulting. For example, frequent attenders may be attracted to doctors who are willing to spend time with patients over a prolonged period of time to deal with problems properly; or who are good listeners; or who are more likely to prescribe according to patient's wishes; or those who have a special interest in an individual patient's condition.⁷ The differences between doctors may be influenced by the ways in which doctors tell (or invite) patients to 'come back'; or how (and how often) they 'give permission' to return if necessary.⁷ Indeed, reattendance rates are known to differ between doctors,²⁴⁻²⁶ as is the proportion of 'doctor-initiated' consultations, with GPs with higher workloads having more doctor-initiated return consultations.²⁷ Frequent attenders may be more familiar with doctors who are more established in the practice and may therefore prefer to consult with them. Lastly, differences between doctors may also be influenced by the nature of the people who consult with them. It is established that doctors differ in terms of both the demographic mix of patients, as well as the proportion of chronic illness that they see, and that they may have some control over this.²⁴ One potential confounding variable relating to patterns of consulting with doctors is that of the day of the week. Some doctors may have a greater or fewer number of consultations with frequent attenders because of the doctor's availability on certain days of the week and the frequent attenders' preferences to consult on these days. However, further analysis, not presented in full here, has demonstrated that the effect of this was only slight.⁹

The second important finding from the study was that most of the frequent attenders consulted with most of the doctors in the practice. This is probably a function of the extreme frequency of the consulting of these patients, allied to the fact that their preferred doctor may not always be available. Consulting with most of the doctors was therefore almost inevitable over a period of time. Alternatively, it may represent, at least for some, deliberate 'doctor shopping'.¹⁰ This finding does mean, however, that within a practice, over a period of time, all the doctors will see most of the frequent attenders and will therefore have a role in providing clinical care and, if appropriate, addressing their help-seeking behaviour.

The third important finding from the study was that frequent attenders, compared with non-frequent attenders, exhibited more continuity of care on a consultation-to-consultation basis and over the 41-month timeframe, which is in keeping with the findings of Veale *et al.*¹¹ There does seem to be some allegiance between frequent attenders and their doctors, although how much of this is at the instigation of the patient or the doctor, or a part-

nership between the two, is not known. One possible explanation is that this increased continuity of care is a function of more of their consultations being for chronic problems.

One of the inherent weaknesses of the data was the number of consultations that were coded as being with an 'other' doctor. There was no clear way to circumvent this limitation and the data must be interpreted with this in mind. The methods for measuring continuity of care were, in some respects, rather crude. However, despite an extensive literature on continuity of care, there are no standard measures of continuity of care. Hence the methods used were pragmatic and played to the strengths of the available data but only permitted quantitative measures relating to longitudinal measures of continuity of care. The size of the dataset and the differences demonstrated between doctors, and between frequent and non-frequent attenders, makes it unlikely that these findings were due to chance. The findings in the three practices were very similar, suggesting that implications from these findings may be generalisable to other practices and is in keeping with our previous findings.⁶

The findings from this study have several implications. First, that GPs who see more frequent attenders, for whatever reason, need to ask themselves why and question whether this is a situation that needs addressing, either for the benefit of their own morale (since at least some of these patients are likely to be perceived by the GP as 'heartsinks'²⁸) or for the clinical benefit of their patients. Many GPs may choose, possibly quite appropriately, to opt for the quiet life by maintaining the status quo of frequent consulting rather than confronting a patient's true needs, which may be painful for both parties. Secondly, that the clinical care of frequent attenders, a group with significant physical and psychological morbidity,^{2-5,29-32} may be improved by limiting doctor shopping and encouraging and facilitating a culture of greater continuity of care.¹⁷ The differences between doctors confirms our previous assertion that intervention strategies for frequent attendance may be best targeted at health professionals and the organisation of service delivery in primary care rather than frequent attenders.¹ Lastly, the findings provide further evidence that the problem of excessive demand is not based on inappropriate patient behaviour.³³

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