

Clinically inexplicable frequent attenders in general practice

Paul Stewart and Tom O'Dowd

SUMMARY

This study was based in an isolated rural practice, and it identified 107 frequent attenders (1.95% of the practice population), who created five times the consultation workload of a similar group matched for age and sex. The general practitioners (GPs) classified 60 (56%) of these patients as attending for clinically inexplicable reasons. This subgroup had higher rates of long-term medication and hospital referral, and more free access to primary health care. The study also identified very high levels of kinship and relationship by marriage within this group (47%).
Keywords: frequent attenders; unexplained symptoms; rural practice.

Introduction

FREQUENT attenders have been a recognised feature of general practice for many years. Early research identified a number of associated characteristics, which include sex, age, socioeconomic status, family characteristics, lack of social supports, stressful life events, access to health care, and physical and psychological illness.¹

Consulting patterns among frequent attenders have also been explored, highlighting the importance of the doctor-patient relationship,² and they may reflect an interdependency between doctor and patient.³

A number of consequences associated with frequent attendance have been identified, including high prescribing and referral rates.¹ Frequent attenders also create a disproportionate workload for family doctors, and some, but not all, are a source of considerable exasperation and stress to their physicians.⁴

A small number of studies have used qualitative research methods in an attempt to explain the behaviour of frequent attenders, including exploring relationships between doctors and patients, and within families.⁵

Method

Frequent attenders were defined as patients consulting a general practitioner (GP) on more than 12 occasions during the study year. Data were collected from a rural general practice in West Donegal, which had 5342 patients and three full-time principals, with a combined total of 39 years' experience in the practice. Information that included age, sex, entitlement to free access to primary health care, consultation frequency, long-term medication, and referral and admission rates, was collected from computerised patient records. First-degree kinship relationships, and relationships by marriage, were identified by the GPs with the help of a practice secretary who had an intimate local knowledge.

The medical records of frequent attenders were compared with a randomly selected sample of practice patients who were matched for age and sex. On reviewing the patient records, frequent attenders were further divided into two groups by their own family doctor, depending on whether or not their clinical condition was considered to necessitate their level of attendance. A significant clinical condition could include psychological, psychiatric, and physical illness. The characteristics of each of these three groups were then compared.

Results

One hundred and seven frequent attenders (1.95% of the practice population) had five times the consultation rate of the sample matched for age and sex. The frequency of

P Stewart, FRCGP, general practitioner, Falcarragh, County Donegal.
T O'Dowd, MD, FRCGP, professor of general practice, Trinity College Dublin.

Address for correspondence:

Professor T O'Dowd, Department of Community Health and General Practice, Trinity College Centre, Adelaide and Meath Hospitals, Tallaght, Dublin 24, Republic of Ireland. E-mail: todowd@tcd.ie

Submitted: 9 August 2001; Editor's response: 19 November 2001; final acceptance: 24 May 2002.

©British Journal of General Practice, 2002, 52, 1000-1001.

HOW THIS FITS IN*What do we know?*

Frequent attenders create a disproportionate workload for GPs and have high prescription and referral rates.

What does this paper add?

Among frequent attenders over half had no clinically explicable reason for seeing the doctor. They had high levels of kinship and GPs often resorted to both psychiatric medications and referral to cope with them.



attendance could not be explained on purely clinical grounds in 60 (56%) of the sample (the clinically inexplicable frequent attenders). Females were over-represented among the groups in the clinically inexplicable frequent attenders, but males and females were almost equal in the group of clinically explicable attenders. The clinically inexplicable group had fewer hospital referrals than the clinically explicable group, although they both had high psychiatric referral and psychiatric medication rates.

Of the clinically inexplicable group, 16 (26%) were first-degree relatives, and 12 (20%) were related by marriage; a total of 46% who were related in a significant manner, compared with 9 (19%) in the clinically explicable group (Table 1). During both the study year and the following year, eight patients in the clinically explicable group died, compared with no patients in either the clinically inexplicable group or the matched sample dying.

Discussion

The study was carried out in a single practice in a relatively remote rural area, which raises issues of generalisability to other areas. However, the study population shared many of the features of frequent attenders described elsewhere in the literature.¹² It is known among GPs that there is an important subgroup of frequent attenders whose attendance is not explicable on clinical grounds alone. The differentiation in this paper between the clinically explicable and the clinically inexplicable frequent attenders is intuitive and

robust, and, we think, provides helpful guidance for further research. It was notable that at the two-year follow-up there were no deaths in the clinically inexplicable group, compared with a number in the clinically explicable group, which would be expected in a group of ill patients.

The high level of kinship and relationship by marriage noted among frequent attenders, and in the clinically inexplicable group in particular, appears to be a new finding. This may be explained by the isolated, circumscribed nature of this community, but could also indicate that, in part, frequent attendance is a learned behaviour, or this result may reflect a high degree of stress within particular families. This has been suggested in previous studies, in particular in work by Dowrick⁵ and Colling.⁶ It could also indicate that entire families become medically dependent, and that both their store of self-help knowledge and their confidence in managing illness become depleted. This has enormous implications for GPs.

References

1. Browne GB, Humphrey B, Pallister R, Browne SA. Prevalence and characteristics of frequent attenders in a prepaid Canadian family practice. *J Fam Pract* 1982; **14**(1): 63-71.
2. Neal RD, Heywood PL, Morley S, *et al.* Frequency of patients' consulting in general practice and workload generated by frequent attenders: comparison between practices. *Br J Gen Pract* 1998; **48**: 895-898.
3. Ellis CG. Chronic unhappiness. *Can Fam Physician* 1996; **42**: 641-651.
4. O'Dowd TC. Five years of heartsink patients in general practice. *BMJ* 1988; **297**: 528-530.
5. Dowrick C. Why do the O'Sheas consult so often? An exploration of complex illness behaviour. *Soc Sci Med* 1992; **34**: 491-497.
6. Colling A. The sick family. *J R Coll Gen Pract* 1967; **14**: 181-186.

Table 1. Characteristics of frequent attenders in a general practice categorised as clinically inexplicable or clinically explicable, together with a matched sample.^a

	Clinically inexplicable frequent attenders (n = 60)	Clinically explicable frequent attenders (n = 47)	Sample matched for age and sex (n = 107)
Consultation rate per year	15.5	14.8	3.4
Female patients (%)	47 (78)	24 (51)	71 (76)
Mean age (SD)	48.9 (23.8)	55.29 (23.7)	51.3 (24.2)
Free access to primary health care (%)	58 (97)	46 (97)	85 (79)
Mean number of long-term medications per patient (SD)	3.56 (3.0)	4.02 (2.24)	1.5 (2.0)
Mean hospital referral rate per patient (SD)	2.15 (2.3)	3.2 (2.4)	1.089 (1.86)
Patients on psychiatric medications (%)	13 (22)	3 (6)	4 (4)
Psychiatric referrals (%)	19 (32)	4 (8)	12 (11)
Patients with kinship and marriage (%)	28 (46)	9 (19)	14 (14)
Patient deaths at 1 year follow-up	0	8	0

^aWhere appropriate, figures are expressed to the nearest percentage to allow comparison. SD = standard deviation.