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Patients who keep coming back often require physicians to walk the line between diagnosis and judgment.

Caring for Frequent-Visit Patients

Patients who frequently return to our offices for seemingly insufficient reasons are a constant challenge as we seek to provide care that is both effective and efficient. This article offers a framework for thinking about these patients and meeting their health care needs.

Simple linear disease models often don't work well with frequent-visit patients because their actions are driven in substantial part by their beliefs and psychological needs, and these must be considered if their health care is to be effective. Biological disease and behavioral factors may interact to influence people's perceptions about their health. For example, a level of pain that self-confident individuals would find tolerable may seem overwhelming to those who are anxious or self-occupied. Professionals

Simple linear disease models often don't work well.

who have been trained to suspect any line of thinking not supported by rigorous, replicable objective data are sometimes critical of those who take a more comprehensive approach to patient care. "Common objections to caring for the whole patient" (page 59) addresses the tension between these thinking styles.

In this article, I've identified eight common categories of frequent-visit patients and techniques for caring for them. Please keep in mind that more than one category may apply in a given instance. For example, a lonely, dependent patient may also have legitimate information needs about valid biomedical problems. Remember, too, that it may take a few visits before the big picture becomes clear in each case.

1. Patients with rational questions

Patients with diabetes, migraine headaches or other chronic conditions need basic information to become effective partners in their care, but many of them also need time to absorb the information they receive as well as frequent coaching to make lifestyle changes. It's easy for busy physicians to forget this and to become irritated when compliance and outcomes are unsatisfactory.

Management. Recognize that people assimilate information at different rates and that some may not

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Frequent-visit patients are driven in substantial part by their beliefs and psychological needs.

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In order for their health care to be effective, the physician must consider both of these.

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The author describes eight of the more common types of frequent-visit patients in this article, but points out that there are more.

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Keep in mind that more than one category may apply to a patient at any given time.

get it right the first time. If patients' recurring questions are bogging you down, involve people on your staff who have a knack for patient education. Use teaching resources offered by your hospital or other organizations. Build a small collection of printed patient education materials, but use them only as adjuncts to one-on-one and group discussions. Log onto the Web sites of medical organizations you trust for high quality patient education materials. Make sure these handouts are short (one page whenever possible), written at an appropriate reading level and focused on the most important information. When appropriate, involve relatives and friends in patients' care, especially when dietary restrictions are part of the treatment program.

During the office visit, ask patients for feedback in an unhurried, nonjudgmental way that lets them give you honest answers. For example, ask patients if they are comfortable with the information you have provided. Can you explain anything further? Does any of it conflict with what they have heard from other sources? Can they repeat to you what you've just told them? What can they do to apply it in their daily lives?

2. Misinformed patients

Patients know a lot of "things that ain't so" – bits of lore that create more problems than they solve. One common example is that heat should be applied to fresh soft-tissue injuries, when in fact this increases swelling and pain. Another is that everyday respiratory infections won't get well until treated with antibiotics or other prescription pharmacotherapy. Each of us could generate a long list of other misinformation our patients have shared with us.

Management. Listen for common misconceptions. Take advantage of teachable moments when patients are thinking about their symptoms and looking for ways to relieve them. Correct inaccuracies tactfully when they surface. Patients like to leave your office carrying some tangible token of their visit. A prescription often fills that purpose. For many, though, a brief oral explanation and a one-page information handout or a handwritten list of what you want them to do will serve just as well.

Our purpose is not to 'see through patients,' but to 'see them through.'

KEY POINTS

- There are many types of frequent-visit patients and many approaches to treating them. This article identifies eight common types.
- Frequent-visit patients generally require more than black-and-white science or rational professional advice.
- The first step in treating them should be trying to identify the underlying reasons for their frequent visits.

3. Patients who are ashamed or embarrassed

Many patients are hesitant to bring up family issues such as a spouse who is abusive or sexually troubled, a child they suspect is taking drugs, a parent who may have Alzheimer's disease, or perhaps a recent or impending death in the family. A history of childhood abuse, sexual or other, is often associated with vague aches and pains in adult life. Such patients often present with ill-defined symptoms or with deterioration of known biomedical problems.

Management. When evaluating a new or established patient whose condition is worsening, ask if there are any major stressors in his or her life. You may not receive a complete and candid answer the first time you inquire, especially if the patient doesn't yet know you well enough to trust you, but the patient may open up at a later visit. Once you have a clear picture of the patient's situation, your management may include empathetic listening, acceptance and validation of the patient's feelings, and suggestions about actions your patient may want to take (but seldom firm prescriptions), including referral to appropriate agencies or professionals. Do not underestimate the value of listening, acceptance and empathy in a patient's care. Just be careful not to become so emotionally involved that you lose your objectivity or become emotionally stressed yourself.

4. Patients with mental disorders

People we may initially label as "frequent fliers" may actually turn out to have depression, bipolar disease, an anxiety disorder, a

borderline disorder, a psychosis or some other psychological problem. We need to keep these conditions in mind when diagnosing and address them when present, but their diagnosis and management are outside the scope of this article.

5. Drug seekers

The focus on effective pain treatment in recent years has had many beneficial effects, but it may also have made it more difficult for some of us to say no when confronted with inappropriate requests from patients. The situation has been made more problematic by extensive media coverage popularizing clichés such as “Pain is whatever the patient says it is.”

Management. An etiology-based approach to pain management has always worked well for me. For example, I don’t hesitate to prescribe analgesics for patients with cancer-related pain, with careful guidance and follow-up. I give patients diagnosed with non-life-threatening but painful diseases (zoster, for example) strong analgesics for acute needs, along with other medications that may be more beneficial over the long term. I will prescribe opioids for patients with pain disorders not clearly related to biological disease only after a consultation and only then in unusual, well-documented instances. At the very least, a patient’s assertions about previously

prescribed habituating drugs must be documented by mail or telephone correspondence with the previous physician or pharmacy.

Beware of gaining a reputation among patients for liberally prescribing habituating medications. You’ll be okay if you prescribe with caution and use appropriate skepticism and good documentation, but if patients with nonmalignant pain are flocking to your door, your state medical or pharmacy board may come visiting too.

6. Lonely, dependent patients

These patients tend to be socially isolated and have plenty of time on their hands. They will consume large amounts of medicine and health care when offered but are often grateful for just a smile and a little attention.

Management. Some of these folks will respond to the “five-minutes-a-month” program. Schedule them for brief visits at regular intervals. Use the time to show interest in them as people, briefly discussing one of their ongoing health problems (irritable bowel syndrome, perhaps). Set reasonable time limits and keep control of the interview – endless “organ recitals” accomplish nothing and only get you off schedule. In my experience, encouraging these patients to get involved in social activities (e.g., volunteering) or urging them to adopt a new puppy

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Some patients initially labeled as “frequent fliers” may actually turn out to have depression or some other psychological problem.



Others may be embarrassed to bring up sensitive issues and may return several times before they feel comfortable enough to talk about their problems.



Frequent-visit patients may also be seeking effective pain management.



Clichés such as “Pain is whatever the patient says it is” has made it more difficult for some physicians to say no to patients inappropriate requests for drugs.

COMMON OBJECTIONS TO CARING FOR THE WHOLE PATIENT

I would be remiss if I did not address and respond to several objections that are sometimes raised to the clinical approach that is described in this article:

1. Listening to patients is a waste of time.

This may be true when someone in an emergency department is bleeding to death, but not in ambulatory primary care. Failure to “get it right” with patients who have complicated problems often leads to misdirected study and treatment, which are costly in economic and professional terms and don’t help the patient.

2. Doctors who consider thoughts and feelings as part of illness are judgmental and paternalistic.

Diagnosis and judgment are not the same thing. The former gives us information that makes effective care possible. The latter assigns a value – sometimes strongly negative – to this reality. Our purpose is not to “see through patients” but to “see them through.” The more precise our diagnosis is, the more we can for

do and the less they will make our professional lives uncomfortable.

3. Looking at human behavior is becoming less relevant because we now understand the chemistry of neural function and can modify it with drugs. This is like arguing that a person who understands the thermodynamics of the internal combustion engine also knows how to drive a car. Pharmacotherapy can help some patients, but it’s no substitute for the other approaches described in this article.

4. Little hard quantitative science is available to guide physicians in managing the human side of health care. This statement is partly true, but its implications are not. We can and should tap the wealth of accumulated clinical experience and the accumulating evidence from behavioral research to do a good job for our patients. That’s what this article is all about.



For patients with pain not clearly related to biological disease, the author prescribes only after consultation and only in unusual, well-documented instances.



According to the author, the worried well and patients who don't want to get well are the two most difficult types of frequent-visit patients to care for.



Although some worried well patients may simply be seeking reassurance, many others have problems that are resistant to rational professional advice.



Patients who don't want to get well often have mixed motives that can include anxiety, dependency, loneliness, greed and misinformation.

or kitten can help. In some cases, it will become necessary to set a firm limit on unscheduled office visits or off-hours telephone calls, but try the strategies mentioned above first.

7. The worried well

These patients are anxious about their health and schedule frequent medical visits out of proportion to the presence of demonstrable disease. Some may simply be worried and merely need a few words of explanation and reassurance from their physicians. Often, though, the problem has deeper roots and is resistant to rational professional advice; this is somatization or, when particularly problematic, hypochondriasis.

Management. If you're unsure about the diagnosis, start with the basics. Ask these patients what they think the problem may be and what effect it might have on their lives. Provide whatever information you think appropriate and see what happens. If you keep hearing "Yes, but..." or ruminations about suffering, disability and perhaps even death, it's time to take the approach described in the next section.

8. Patients who don't want to get well

One day several years ago I examined a man who reported severe pain and weakness in one leg related to a workplace injury. At the end of the visit he hobbled out to the front desk to make a return appointment while I walked down a different corridor to the room where I dictated my clinical notes.

This room overlooked the parking lot. As I reached for the dictation unit, I looked up and saw the man I'd just examined stride across the parking lot to his truck without the slightest limp, give a cheery thumbs up to his waiting passenger, hop into the driver's seat and drive off.

We don't see dissimulation as obvious as this every day, but most physicians will encounter patients who have chosen, at some level of consciousness and for reasons they may or may not understand or acknowledge to themselves, not to get well. Their motives are often mixed and may include anxiety, dependency, loneliness, greed, misinformation, and advice and pressure from other people in their lives.

In theory, we should discriminate between patients who have emotional reasons for staying sick and those who are trying to exploit the system for financial gain, but in real-world practice it's not always easy to tell the difference. More often than not, clinical management must proceed without a precise answer to this question. In my experience, it is usually wise to manage these patients with strategies that are appropriate for any motive or combination of motives.

Management. The worried well and patients who don't want to get well are arguably the most difficult groups of frequent-visit patients to diagnose and manage, and the most hazardous in terms of medicolegal risk and potential for hostile behavior toward medical personnel. These time-tested steps can help:

- Take and document a careful history, including the time course and prior care of the present illness. Ask about other past illnesses and injuries, diagnostic studies, medications and other treatments, and adverse effects. Identify previous sources of care and obtain the patient's permission to request copies of records. Do not assume that what the patient tells you about prior findings and management is reliable.

- Ask about life stressors and psychosocial factors as part of your routine work-up. Back off if the patient strenuously objects to this line of questioning. Patients who do not want to get well typically lack insight into their feelings and tend to be rigidly enmeshed in their symptoms, so try to avoid

confrontations with them. Keep in mind that their reticence may indicate an area of intense personal concern.

- Perform an appropriate physical examination and indicated tests. Document your findings in terms that you could defend confidently in a courtroom. For example, "The patient demonstrated very limited back motion during the examination but had no difficulty donning his work boots while seated on a low stool after the examination was completed." Let your findings speak for themselves.

- Do not keep chasing new symptoms with new tests.

- Go slow on giving the patient a diagnosis until you have enough evidence

Most physicians will encounter patients who have chosen, at some level, not to get well.

to support it. Try to avoid mentioning scary diagnostic possibilities that only increase the patient's anxiety and preoccupation with disease. However, let your clinical record show that you have considered all relevant diagnostic possibilities.

- Avoid the trap of assuming that a patient who demonstrates anxiety or manipulative behavior does not also have an organic disease that you need to find and treat. The two can coexist.

- Follow up closely. Avoid saying things like "come back in a month or so if you're not better" or "give us a call if the medication seems to bother you." In my experience, manipulative patients will often ignore such advice until the problem has festered for an unreasonably long period and then complain about your management or go elsewhere for care. At the minimum, follow up by telephone a few days after any change in the

Avoid assuming that a patient who demonstrates anxiety or manipulative behavior doesn't also have an organic disease.

treatment program. Extra attention early on tends to save time down the road.

- Encourage positive thinking and as much mental and physical activity as the patient can tolerate.

- Be reasonably optimistic, but do not promise a cure. Patients who are motivated to do so can always prove you wrong. For example,

you might say, "Most patients with an injury like yours will be fine in a month or less, but it's important for you to be an active partner in getting better."

- Aim for small improvements rather than home runs. Remind patients they are partners in their care. And don't let them make you feel guilty when progress is slow or nonexistent.

- Use consultants wisely. Begin by recognizing that other specialists may have specific knowledge that we lack, but that we are the

SUGGESTED READING

Although the following list is not comprehensive, it will familiarize you with the patterns of "frequent-visit patients." However, some of the articles below offer only limited information about effective management:

"Minor Acute Illness: A Preliminary Research Report on the 'Worried Well.'" Smith RC, Gardiner JC, Lyles JS, et al. *Journal of Family Practice*. 2002;51(1):24-29,30. Correspondence. 2002;51(5):472.

"A Framework for Understanding Visits by Frequent Attenders in Family Practice." Smucker DR, Zink T, Susman JL, Crabtree BF. *Journal of Family Practice*. 2001;50(10):847-852.

"An Assessment of the Attributes of Frequent Attenders to General Practice." Heywood PL, Blackie GC, Cameron IH, Dowell AC. *Family Practice*. 1998;15(3):198-204.

"Frequent Attender Profiles: Different Clinical Subgroups Among Frequent Attender Patients in Primary Care." Karlsson H, Joukamaa M, Lahti I, Lehtinen V, Kokki-Saarinen T. *Journal of Psychosomatic Research*. 1997;42(2):157-166.

"Healthy Patients Who Perceive Poor Health and Their Use of Primary Care Services." Connelly JE, Smith GR, Philbrick JT, Kaiser DL. *Journal of General Internal Medicine*. 1991;6(1):47-51.

"Comprehensive, Cost-Effective Care of the Multiple Problem Patient." Gillette RD, Black DJ, Romaniuk M, Smith R. *Journal of Family Practice*. 1986;23(5):431-433,436-438.

The following articles represent the subspecialty perspective. As you'll see, they are wrestling with the problems these patients present, just as are family physicians:

"Medically Unexplained Symptoms in Frequent Attenders of Secondary Health Care: Retrospective Cohort Study." Reid S, Wessely S, Crayford T, Hotopf M. *British Medical Journal*. 2001;322 (7289):767-769.

"If You Have to Prove You Are Ill, You Can't Get Well: The Object Lesson of Fibromyalgia." Hadler NM. *Spine*. 1996;21(20):2397-2400.

The final article in this list explores the stresses experienced by physicians working with critically ill patients. Although the pressures of primary care are somewhat less intense, they are similar in character and management:

"The Inner Life of Physicians and Care of the Seriously Ill." Meier DE, Back AL, Morrison RS. *Journal of the American Medical Association*. 2001;286(23):3007-3014. Correspondence. 2002;287(9):1113-1114.

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It's not always easy to tell the difference between patients who have emotional reasons for staying sick and those who are exploiting the system.



Often, clinical management must proceed without a precise answer to this question.



When this occurs, the author suggests managing patients with strategies that are appropriate for any motive or combination of motives.



Because these patients are the most hazardous in terms of medicolegal risk for physicians, the author suggests going slowly when making a diagnosis.



He also recommends following up closely with these patients and taking care to document findings in objective, not pejorative, terms.



Caring for frequent-visit patients place extraordinary demands on the wisdom and character of the physicians who care for them.



There must be accommodation between what a patient wants and what is in his or her best interest in the long term.



Admittedly, some physicians are better suited to caring for frequent-visit patients and are more comfortable dealing in the shades of gray that is often required.

physicians best qualified to address the complexity and subtleties of managing patients with multiple problems. Be clear in your own mind why you are making the referral; it's usually a need for the subspecialist's specific knowledge or for authoritative support of what you already know about the patient. Communicate your needs clearly to the consultant, along with a statement as to whether you are requesting advice only or are asking the other specialist to assume ongoing

responsibility for the patient. Expect a consultation report that is equally clear and timely.

- Keep in mind the old Latin motto, "Primum non nocere" (i.e., "First, do no harm"). Be especially cautious with these patients about prescribing tests, drugs and procedures that can have adverse effects. When you are considering these, explain the benefits and risks, involve the patient

in the decision and document that you have done so.

The bottom line

Let's face it: Frequent-visit patients are difficult to manage, and nobody bats 1.000 in this league. These patients place extraordinary demands on the wisdom and — yes —

the character of those of us who care for them (see "Beyond black-and-white science" below). Some physicians are more naturally suited to

There can be major conflict between professional self-interest and doing what's right.

this type of work and have more stomach for it than others. I can't be judgmental about clinicians who are reluctant to follow the approach that is recommended here. But give it a try. You may find that the results, however imperfect, exceed what you have obtained with other approaches. **FPM**

Send comments to fpmedit@aafp.org.

BEYOND BLACK-AND-WHITE SCIENCE

The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time, and still retain the ability to function. — F. Scott Fitzgerald, The Crack-Up

Caring for the frequent-visit patient places extraordinary demands on a physician. As Fitzgerald suggests, we must function in the face of conflicting considerations that call for flexible, nuanced responses. Some examples:

- We must walk the line between diagnosis and judgment. If we give up trying to help these patients out of distaste for their attitudes or actions, we aren't serving them well. Equally unsatisfactory is being blind to a patient's manipulative or self-destructive behavior out of fear of being judgmental.
- Being too kind and indulgent with these patients reinforces their immaturity and supports unnecessary "disability." On the other hand, expecting fully adult behavior can open the door to conflict or deception. The correct course lies somewhere between these extremes and varies from patient to patient.
- Telling the truth is part of who we are as caring professionals, but some patients, especially those who don't want to get well, are not ready to accept the entire truth about their condition. If confronted with it, they may become hostile or go elsewhere (or both). Acting in the patient's best interest thus calls for sometimes telling only part of the truth, but not overtly lying.
- Proving in absolute terms that the patient probably doesn't have a crippling or potentially fatal illness is impossible. Consequently, there must be accommodation between what a patient wants and what is in his or her best interest in the long term. An MRI may be appropriate if it will really facilitate needed treatment but not if it merely gives the patient's lawyers "evidence" that the problem is serious.
- Finally, there can be major conflict between your professional self-interest and doing what's right. Any physician who works with frequent-visit patients may feel pressured at times by patients or their family members to order inappropriate tests or procedures, to shade return-to-work certifications, and to avoid spending time on patient care for which they will not be properly reimbursed. That said, none of us want to acquire reputations for being callous, being in the pocket of insurers or local employers or for failing to try the latest drugs and procedures, despite their questionable value. Unfortunately, dealing in these shades of gray comes with the territory.