Doctor dependency is a recognised concept, although it has not been clearly defined. As a working definition, doctor dependency is likely when a patient persistently consults more frequently than is appropriate for their clinical situation; or where the pattern of requesting help suggests reliance on the doctor or the medical consultation, to an extent which is unhelpful.

Balint recognised that ‘the doctor is a drug’; that ‘no guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself’; and that there may be ‘hazards’ and ‘undesirable side-effects’ of this type of medication. Recognition of doctor dependency is important. It can be useful to look at the doctor-patient relations as ‘transactions’ involving both patient and doctor factors.

Causes of doctor dependency

Background and comorbidity:
- Frequent consultants are a heterogeneous group.
- Few conform to the ‘heartsink’ stereotype.
- They have high rates of physical disease, complex problems, chronic illness, psychiatric illness, social difficulties and medically unexplained symptoms. In one study, 12 out of 28 ‘heartsink’ patients had, or developed, serious medical problems.

Patient and doctor factors:
- Dependency may be part of the patient’s style of relating to others. This may relate to the patient’s previous experience of relationships, especially in childhood.
- Doctors may like power or need to be needed. As with patients, the doctor’s past experiences and psychodynamic factors play a part.
- Dislike of change or confrontation - allowing dependency may seem easier than trying to help the patient be more assertive.
- The doctor and patient may be emotionally attached or involved with one another.
- Loneliness may increase the consultation frequency.

Dynamics of the doctor-patient relationship:
- The dynamics of interpersonal relationships were explored by Berne in his book ‘Games People Play’. He classified relationships into 3 types:
  - Parent - taking control and making decisions
  - Child - submissive and letting others make decisions
  - Adult - being autonomous
- Where doctor/patient assume parent/child roles respectively, doctor dependency may be more likely.

Social and cultural factors:
- Family patterns - illness behaviour is influenced by family background, and most GPs recognise that some families are frequent consultants.
- Cultural influences:
  - These affect the presentation of illness and the role of the doctor and patient.
  - They may play a part in doctor dependency, especially if cultural issues promote misunderstandings. For example, in some cultures, psychological illness or other problems such as epilepsy or rape, are considered shameful and will tend to be hidden. This may lead to somatisation or hidden agendas, both of which contribute to doctor dependency.

Medical and diagnostic factors:
- Undiagnosed, undertreated problems can make patients appear as doctor dependent when they are, in fact, appropriately seeking help.
For example - hypothyroidism and depression can present with subtle, insidious symptoms; anxiety or depression may present with somatisation.

Some patients find it difficult to request help with psychological problems - this may be for cultural reasons.

Medicalisation of self-limiting or psychosocial problems (eg issuing unnecessary prescriptions) may encourage patients to re-attend or to view their problem as requiring a doctor. Research suggests that many patients don't want a prescription anyway.\[^{9,10}\]

### Recognising the problem[^1]

'Symptoms' for concern are:

- Frequent consultations for minor problems.
- Regular consultations with little content or same content.
- The patient won’t see another doctor/nurse, or has no faith in external advice, eg a specialist.
- Strong feelings on the doctor’s part (negative or positive), on seeing that the patient is on their appointment list.
- Refusal to terminate treatment or the consultation.
- Gifts or excessive, positive feedback.
- Persistent symptoms without any identifiable pathology or aetiology, despite extensive examination and investigations.

### Management[^1]

Possible strategies include:

- Gaining insight - through regular review and discussion with others outside the relationship.\[^{11}\]
- Teamwork and management plans:\[^{2,5}\]
  - Helps provide insight (as above)
  - The team plans management strategy; team members support one another in implementing it.
  - The ‘7H+T’ model of Bellon incorporates these concepts of insight and team support:\[^{12}\]
    - 7H+T refers to a training package for GPs, in which they identify one of 7 hypotheses (7H) as being the main reason for the patient’s frequent attendance. The ‘T’ refers to team discussion and management plans.
    - In one study, this package was effective in reducing consultation rates for frequent attenders.
- Allowing more time for complex consultations:
  - In one study, this improved patient enablement and GPs’ morale.\[^{13}\]
- Promoting patients’ self-care and coping skills:
  - Education, for example, reducing antibiotic prescribing, educating patients about minor illness, using deferred prescriptions, offering information leaflets or discussion instead of a prescription.
  - Improving life skills, eg through counselling or cognitive behavioural therapy.
- Information management:
  - Summarising the patient’s notes is often suggested, and may be helpful in understanding the patient. However, one study found that this in itself did not affect the frequency of attendance.\[^{14}\]

### Ideas for use in practice[^1,2]

Ask yourself:

- Why do I dread/look forward to seeing this patient? Where are my feelings coming from?
- Consider the different styles of relating to others: parent/child, adult/child or adult/adult.\[^{7}\] With this patient: Who is behaving as the adult, child or parent and why?
- What else is going on in the patient's world (home, family, work, past life, culture)?

Discuss with colleagues:

- Involve other team members; or discuss the patient at a practice meeting, peer group or with a mentor.
- In very complex cases, it can help to have a meeting between all the professionals involved with the patient, both primary and secondary care staff.

More time for the consultation:

- For example, book 'catch-up slots' to allow time for complex patient needs.\[^{13}\]

Tools for moving forward:

- Explore a hidden agenda: ‘Was there something else you wanted to ask me about?’ ‘How are things at home/work?’
- Look for depression and anxiety; use a depression screening tool if in doubt.
- Flag up the situation in a nonjudgemental way: ‘Do you know I have seen you 24 times in the last 6 months?’ ‘I seem to have been seeing an awful lot of you lately and yet you don’t seem to be getting any better ...’
- Explore reasons: ‘I wonder if ...’
Share responsibility: ‘I can tell you what the alternatives are but the final decision has to be yours. You are the one who has to live with it and I cannot live your life for you.’

Set limits and agree a management plan: negotiate, agree specific goals, appointment times, what will or will not be covered outside of this plan (eg emergencies).

Encourage self-care and nonprescriptive interventions when appropriate.

Remember that listening, active acknowledgement of distress and information giving (verbal or leaflet) are interventions too.\(^9\)

Pitfalls to avoid:
- Is a physical or mental illness being missed?
- 'Everyone’s and no-one’s problem’ - a number of doctors involved but no-one responsible for decisions.
- Team members undermining one another.
- Burnout - use stress management techniques and housekeeping;\(^{15}\) accept that some patients may remain dependent, whatever the doctor does.

Prognosis

Frequent attendance at GP surgeries does not necessarily persist. In one study, 1 in 7 patients who were frequent attenders over one year, became ‘persistent’ frequent attenders.\(^{[4]}\)

However, both anecdotally and in two studies, discussions of difficult patients with colleagues did reduce consultation rates or improve the doctor-patient relationship.\(^{[2, 5, 12]}\)

Case examples

The following cases illustrate some of the different reasons for doctor-dependency:

- Undiagnosed physical illness:
  - Danzig describes the ‘patient journey’ of a man who had undiagnosed acromegaly for 10 years, despite seeing several doctors. He was a frequent attender and a ‘challenging patient’ whose GP had a ‘drawer full of his notes’. Later, after the diagnosis, the doctor-patient relationship developed into a true partnership.\(^{[16]}\)

- Undiagnosed mental illness:
  - Davis describes a patient whose many physical symptoms were dismissed, but who most likely needed help with anxiety.\(^{[17]}\)

- Roles re-enacted:
  - Norton and Smith describe how family patterns can powerfully affect the doctor-patient relationship. A frequently attending patient behaved in a way that made his doctors feel increasingly angry and unsympathetic towards him. It transpired that as a child, his parents had been very unsympathetic towards illness. Unconsciously, this patient and his doctors were re-enacting his family’s roles.\(^{[2]}\)

Further reading & references


1. GP-training.net; Patient dependency - or is it doctor dependency? Updated December 2006; This is general practice resource website written by Dr Brad Cheek, a GP Trainer in Cumbria, UK.
15. Neighbour R; The inner consultation: How to Develop an Effective and Intuitive Consulting Style. 2nd ed. Radcliffe Medical Press. 2004

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