UNIVERSITY ALEXANDRU IOAN CUZA,

Department of Sociology and Social Work

Frequent Attenders in Primary Health Care within Medical Services in Israel

Long Abstract

PhD Thesis in SOCIOLOGY

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Table of Contents:

List of Figure

List of Table:

ABSTRACT

The goals of this study were: to characterize the population of frequent attenders in the 22-70 age range who visit community-based primary care clinics; to learn about the feelings that these patients arouse among the medical staff (doctors and nurses); and to provide a solution for managing the phenomenon of frequent attenders.

This study employed the convergent parallel mixed methods technique. In the qualitative part semi-structured interviews were conducted with frequent attenders and in the quantitative part a closed questionnaire was administered to the medical staff (doctors and nurses).

The findings of the current study indicate that the reasons for frequent visits by frequent attenders are motivated by their personal, emotional and mental condition and this finding derives both from the words of the patients themselves and from the outlook of the medical staff – doctors and nurses. Another important motivation that arose as a reason for frequent visits was the sense of trust that exists between the patient and the medical staff (doctors and nurses). Moreover, the sense of belonging and of health-related security that the community-based primary care clinic gives frequent attenders was also one of the reasons for frequent visits to the clinic.

Ultimately, the research developed a holistic and integrative model for intervention in the phenomenon of frequent attenders by managing the phenomenon through the nursing staff at the community clinic. The model portrays the phenomenon as a three-stage process leading from prevention to modification of the phenomenon, which is a burden on the healthcare system in Israel and around the world.

In order to facilitate management of this phenomenon of frequent attenders it is necessary to operate on several levels, for instance: conversation with a nurse, conversations with a doctor and nurse, conversations with a nurse and social worker, support group, workshops and others. A unique intervention plan must be constructed for each population group.

Keywords: Frequent attenders, primary health care, nurse, family doctors, preventive model

INTRODUCTION

I. Research Aims and Focuses

This study centres on patients who are frequent attenders of primary and secondary medical clinics in Israel and it will focus primarily on frequent attenders of clinics belonging to the Clalit Health Services HMO in the Tel Aviv – Jaffa District. For this purpose, Israel's health system shall first be described, with an emphasis on Clalit Health Services.

Historically, Israel's healthcare system is at base a public healthcare system, from the early 19th century to the present. Until the twentieth century, healthcare services were normally provided by charities, usually churches. The first Jewish hospitals were established in the late 19th century, for example: Bikur Holim (1857), Misgav Ladach (1871), Ezrat Nashim (1895), and the Hadassah hospital established by the Hadassah women's organization and forming the foundation of many current day health services, including a chain of clinics that formed the basis of Israel's mother and well-baby clinics. At present, some foreign hospitals remain that have existed since the 19th century, for example: the Italian, German and Scottish hospitals in Haifa, Tel Aviv and Tiberias. The local community and hospital healthcare infrastructure (family healthcare clinics and centres) gradually developed beginning from the British Mandate period. When the State of Israel was established in 1948, this infrastructure was expanded in response to the increase and growth of Israel's population (State of Israel, 2007; Bin-Nun, Berlovich & Shani, 2010). From the early 20th century, the healthcare system was based on healthcare organizations that combined service provision and health insurance and provided services to hundreds of thousands of new immigrants before and after establishment of the state. Clalit Health Services was established in 1911 by the Workers Society of Israel (the Histadrut) in response to the need for medical services for immigrants from the second wave of immigration (Second Aliya), and it developed a network of community clinics throughout the country. In the 1930s additional organizations followed suit (Bin-Nun, Berlovich & Shani, 2010; Boldor, 2013).

The healthcare system is comprised of four groups of institutions and organizations:

- The Ministry of Health
- Healthcare organizations (HMOs)
- Public institutions, such as: Hadassah Hospital, Shaarey Tzedek Hospital, Magen David Adom, the Israel Cancer Association.
- Private institutions, such as: private hospitals, dental services (State of Israel, 2007).

Seven HMOs operated in Israel until the early 1960s: Clalit, Leumit, Maccabi, Amamit, Merkazit, Otzar Harofim and Shiloach. In the 1960s, Maccabi annexed Otzar Harofim and Shiloach, and in the 1970s Amamit and Merkazit merged to form one organization, now called Meuchedet. In 1974 the organizations were further united to form four HMOs: Clalit Health Services, Maccabi Health Services, Leumit, and Meuchedet. Until 1995, when the National Health Insurance Law was enacted, Israeli HMOs were unique for their integration of medical insurance with an extensive array of healthcare services provided both in hospitals and in the community (Bin-Nun, Berlovich & Shani, 2010).

At present, Clalit Health Services provides medical services to more than half the population of Israel and it is the largest HMO in Israel's healthcare system and one of the largest in the world. It currently owns eight general hospitals and five other hospitals and some 1300 primary care clinics that include specialists, as well as many pharmacies, institutes and laboratories. Services are provided partly through internal services of the HMO itself and partly through purchased services, particularly at government and public hospitals (Bin-Nun, Berlovich & Shani, 2010).

Clalit has five divisions, and these are responsible for setting and shaping policy as well as supervising and providing the necessary equipment. Clalit is divided into districts that provide services in all parts of the country, as follows: Northern and Western Galilee District, Haifa District, Sharon – Shomron District, Tel Aviv – Jaffa District, Dan – Petach Tikva District, Jerusalem District, Central District , Southern District and the Eilat region (Ofer, 2010).

Clalit has a basic infrastructure that provides a response to global health challenges and also involved in treating populations with socioeconomic hardships, including an extensive primary care infrastructure, a teamwork setup on the clinic level (with a combination of a family doctor (general practitioner), community nurse, and medical office services), collaborations with local authorities as well as welfare and education authorities, a long-term tradition of promoting high medical standards, and an advanced computerized infrastructure that provides support to local teams, who cope with significant challenges in caring for socioeconomic minorities (Averbuch & Avni, 2014).

A health survey conducted in 2009 found that 45 million family doctor appointments take place each year, as well as another 4.6 million telephone consultations with physicians Residents of Israel see a doctor around 6 times a year on average. Females were found to have more doctor appointments than males, aside from the very young (0-4) and the elderly (75 and older).

Women were observed to have double the number of doctor appointments than men on average during the age of fertility (25-44), while among those aged 75 and older the average number of doctor appointments was (17.1) of the entire population, almost six times that of 15-24 year olds (3.0), not including soldiers).

The results of the 2009 health survey indicate a drop in doctor appointments compared to 2000. The average number of doctor appointments per person in 2000 was 7.1 (versus 6.2 in 2009). The drop may be explained by growing use of telephone consultations with physicians. When telephone consultations are included in the total number of doctor appointments, the mean number of appointments per person in 2009 rises to 6.8 (Central Bureau of Statistics, 2012).

The quality of the doctor-patient relationship is important for both sides. The more the relationship is based on mutual respect, knowledge, trust and shared values, and the better the views on the disease and on life and the time devoted to treatment - the better the quality and quantity of illness-related information given by the doctor to the patient, improving the accuracy of the diagnosis and the patient's knowledge about the disease. When this relationship is not based on trust, the doctor's ability to reach a full assessment is affected and the patient might have doubts about the diagnosis and the treatment offered, as well as implementation of the medical proposal (Pogoda, 2004).

The family doctor is the primary care physician who provides the family with overall care according to the biopsychosocial model. Trust in the treating physician and continuity of care are among the foundations of family medicine. In the absence of such trust, the medical care provided is ineffective (Lancaster & Boissoneau, 1990).

Patients, who frequently visit the clinic usually unjustified by a new symptom or aggravation of a previous problem, are called frequent attenders. This negative appellation is used to describe the sense of hopelessness, misunderstanding and even distress felt by practitioners (Reis, 2009). The literature portrays no consensus as to the definition of frequent attenders, who are said to account for a wide range of 3-25% of all doctor appointments. The most common definition is that of more than 10 appointments a year. The time frame is varied as well, ranging from 2-48 months. Most of the researchers use a span of 12 months to define frequent attenders (Smits, Brouwer, ter Riet, & van Weert, 2009). Frequent attenders are very heterogeneous and are characterized by high rates of chronic illness, psychological-mental disorders, social deprivation, faulty health beliefs, more need for information or for calming, and a lower quality of life than patients who are not frequent attenders. Hypochondria is also

associated with frequent visits to the clinic, and hypochondriacs have a 20-45% higher rate of physical complaints (Hirsikangas, Kanste, Korpelainen & Kyngäs, 2016). According to Rennemark, Holst, and Fagerstrom Halling (2009), illness is the main reason for frequent visits to the primary clinic, while psychological and social problems, as well as demographic data, are no longer relevant (were rejected).

From the perspective of the healthcare system, the extensive use of healthcare services means a rise in the need for resources. When there is a good relationship with practitioners (doctors and nurses) and the care is based on cooperation with patients and is adapted to their life style, patients are more compliant with treatment (Kääriäinen, Paukama & Kyngäsm, 2013). In the case of frequent attenders, it is evident that the medical staff do not understand their condition and that they experience a sense of rejection or distrust which increases their suffering (Wiklund-Gustin, 2011). In primary care, frequent attenders with unexplainable symptoms are more inclined to seek emotional support from their general practitioner, but they do not necessarily seek more explanations or additional physical interventions (Salmon, Ring, Dowrick & Humphris, 2005). Consistently frequent attenders merely seek to be healthier, more beneficial, and to satisfy others, and they come to healthcare settings only when they experience unbearable suffering (Wiklund-Gustin, 2011).

This phenomenon of frequent attenders overburdens community healthcare services: doctors, nurses, clinical specialists and others. They constitute a significant volume of up to 50% of the clinic's activity, although comprising only 10% of all patients. Green, , Israeli, Vinker, (2008) claims that better understanding of this population can help plan and solve patient problems, find the best way of providing a response to their needs without overburdening the therapeutic system, and raise the satisfaction of both patients and carers while also reducing treatment costs. In my work as a nurse at a community-based primary care clinic I meet patients who visit the clinic frequently, once and even twice a day, whether to see the general practitioner or the nurse. These recurring visits create a sense of resistance and of unwillingness to provide a response among by the caregiving staff – doctors, nurses and even medical secretaries. These feelings of frustration and resistance experienced by the caregiving staff led me to investigate this topic. The study will focus on nursing and its contribution to reducing the prevalence of frequent attenders. The literature gives less emphasis to the role of the nurse in treatment interventions with frequent attenders. Since in Israel community nurses are dominant figures in case management, and they follow patients and their family throughout the life in health and sickness and have an essential role in ensuring the continuity and quality of care (Stat of Health

Serivces, 2016), it is important to investigate the effect of nurses on the phenomenon of frequent attenders.

II. Research Goals

1. To map frequent patients aged 22-70 in the primary clinic and their categorization.

2. To explore what motivates patients to be frequent attenders and to come to the clinic more often.

3. To examine the perspective, views, and relationships of doctors and nurses regarding frequent attenders.

4. To suggest the optimal way for managing the phenomenon of frequent attenders in the primary clinic.

III. Research Questions

1. What is the profile of. Frequent attenders patients who visit the clinic frequently from the sociodemographic aspect? (characteristics(
2. What are the reasons that frequent attenders frequently visit the primary clinic?
3. What feelings and emotions frequent attenders evoke in the medical staff (doctors and nurses)?
4. How do patients, medical staff and nursing staff perceive their relationship between patients, doctors and nurses, and what are their views on this relationship?
5. What is the optimal way of managing the phenomena of frequent attenders?

1. THEORETICAL PERSPECTIVES

1.1 The Sociological theories

1.1.1 The Sick Role

Throughout life, each of us occupies quite a few roles. Work roles, which we occupy in order to subsist, and at the same time other roles as well: parents, spouses, friends, neighbors, drivers, caregivers, patients… and more. This study deals with patients who attend the clinic on a frequent basis to see a physician or nurse. The purpose of the study is to try and characterize this patient population by understanding their sick role.

The lexicographic definition of "role" is: "position, work, job" – "The worker joined the company in the role of advisor". Obligation, field of responsibility. "The parents' role is to educate their children" (Milog, 2016). From a sociological perspective, the term is used to indicate one's reference to his or her own expectations and those of others (perceived role), the congruence between the individual's expectations and performance of his or her role, and how people learn to perform their social role (role behavior) (Itzhaky, 2003). Expectations are normally considered one of the independent variables with an essential contribution to the individual's role behavior. Role behavior is a pattern with several components, whose interrelations create the specific role definition (Itzhaky, 1985).

People assume roles and play roles naturally. Namely, the ability to describe yourself as someone else and to play the role of that person is not an acquired skill, rather it is genetically programmed. Moreover, human behavior is extremely complex; any activity or thought in the world can be best understood in the context of that which it faces. Any role, although related to other roles, is unique in its features, functions, and style. The role is not a constant entity, rather a reality that can change with the changing circumstances of the person occupying the specific role (Robert, 2000). In other words, the role can be perceived as a behavioral quality of one or more people within an environment (Kipper, 1992) and/or the final consolidation of all one's acts in a certain situation means that the role has achieved a dimension of self-expression (Dayton, 1994).

Talcott Parsons (1951) was the first to coin the term sick role, extracting the patient from the doctor-patient equation. According to Talcott Parsons, the term sick role exempts one of responsibility for a restriction per se, as well as from the daily social commitments of the sick individual, and creates new expectations of the sick individual. These expectations involve a

balance of rights and obligations. The sick individual is released of his or her routine work and family commitments, while also obliged to act in order to leave the sick situation as rapidly as possible. Also, he or she must have the motivation and willingness to recover and to seek help, including consulting with a doctor or other practitioners, in order to leave the state of illness (Segall, 1976). The sick role is "also a social role, characterized by special exemptions, rights and obligations, and shaped by the society, social culture and groups with which the sick person is affiliated" (Weiss & Lonnquist 2014).

1.1.2 The Health Belief Model

The Health Belief Model helps explain the behaviour of the population. In this model, one's responses to disease symptoms change according to the circumstances and according to perceived susceptibility, for example: motivation to act is affected by the perceived threat of the disease and by one's perceived ability to cope with it. The model includes various concepts that serve as "cues to action", namely certain conditions, information or recommendations might act as a final stimulus that affects performance of a behaviour, for example an encounter with a doctor (Leavitt, 1979). A person's health behaviour changes when one feels a threat to one's health and is motivated to effect a change. The threat might lead to a change in behaviour, because the person assumes that this change is "worthwhile". In this way, behaviour is a product of balancing benefits against barriers (Rosenstock, 1975).

The key concepts of this model are:

A. **Perceived susceptibility** to personal harm – to what degree do we see ourselves as susceptible, meaning our perception of the risk of contracting a disease. Personal risk and susceptibility are one of the strongest motivations for performing health behaviours. The higher the perceived risk the higher the chance that a person will perform health promoting activities to reduce the risk (De Wit et al., 2005). It is only reasonable that when people feel they are at risk of becoming ill they will act to prevent this from occurring. Regretfully, the opposite is true as well: When people believe that they are not at risk or that they have a low risk of harm they tend to behave unhealthily (Rose, 1995; Mase & Louis, 2003). Perceived susceptibility leads to unhealthy behaviour and low perceived susceptibility leads to unhealthy behaviour (Lewis & Mallow, 1997).
B. **Perceived severity/gravity** of the disease – The severity of the health risk means to what degree one perceives the disease and its implications as serious. Perceived severity

is often based on acquired medical information or knowledge. Perceived severity derives from one's view (belief) as to the difficulty the disease will create in one's course of life or how the disease will affect one's existing course of life (McCormick-Brown, 1999).

C. **Perceived benefits –** The perceived benefits of preventive behaviour, meaning the perceived advantages and utility of the recommended health behaviour for preventing the disease or reducing its impact. Namely, this is how one perceives the benefit or utility of adopting a new behaviour, reducing the risk that the disease will emerge. People tend to adopt a health behaviour when they believe that the behaviour will significantly reduce their risk of contracting a disease (Frank & Swedmark, 2004).

D. **Perceived barriers** – Barriers to performing a health behaviour, meaning the costs of or barriers to performing the behaviour, which include concrete costs (for example time, expenses, availability, skills) as well as the psychological cost associated with performance of the behaviour (for example pain, sense of anxiety, pessimism, threat, embarrassment). Since change is not easy to implement, this perception presents obstructions that prevent one from effecting change. Perceived barriers are the significant element that determines whether one will effect a change (Janz & Becker, 1984). In order for people to change their behaviour and adopt new behaviour, they must believe in the advantages that the new behaviour holds for them over the old one. If they believe in the advantages this will make it possible for the old behaviour to disappear and for the new behaviour to become rooted and replace the old behaviour (Umeh & Rogan-Gibson, 2001) (fried, 1992).

E. **Cues to action** – Cues to action motivate people to effect change. These are strategies that can produce a possibility of action, based on appropriate beliefs. Behaviour is also affected by cues to action. Motivation to act derives from events, people or stimuli that cause people to act (Ali, 2002).

F. **Self-efficacy –** Self-efficacy was added to the model un 1988 (Rosenstock, Stretcher & Becker, 1988). Self-efficacy is the belief in your ability to perform an action. This is the individual's belief in one's ability to perform the behaviour and to arrive at the desirable result (Glanz, Rimer & Lewis, 2002). When a young child says: "I can do it, I'm old enough…" that is the essence of self-efficacy (Cohen & Friedman, 2002). People normally do something new only if they feel or think that they are capable of doing it or if they think that a certain behaviour is beneficial (perceived benefits). If they think that they can't perform the behaviour (perceived barriers) then the chance is

that they will not do so (Hayden, 2014). One's belief in one's ability to handle a certain task well increases the person's inclination to make an effort. In this way, high self-efficacy leads to high investment of efforts aimed at achieving goals. Alternately, low self-efficacy reduces motivation and leads to thoughts of failure.

1.2 Conceptual framework

1.2.1 Background for the current study

This study examines the phenomenon of patients who visit primary care clinics at a higher than average frequency to see a doctor or nurse. These patients are called frequent attenders. Frequent attenders overburden the community healthcare services comprised of doctors, nurses, clinical specialists and others. They account for a significant volume of up to 50% of the clinic's activity, although constituting only 10% of the clinic's patients.

In Israel, community-based nurses are dominant figures in patient care. They accompany patients and their families throughout life in health and in sickness, and have an essential role in ensuring the continuity and quality of care. This study will refer to the nursing dimension and its effect on reducing the prevalence of frequent attenders. The purpose of the current study is to explore the characteristics of frequent patients aged 22-70 and their motivation for visiting the clinic on a frequent basis, and also to explore the attitudes and feelings of the treating staff towards frequent attenders. In addition, to investigate whether the relationship between the treating staff, i.e., doctors and nurses, has an effect on the visits of frequent attenders to the clinic. Finally, to clarify the desired manner of intervention, as perceived by the treating staff – doctors and nurses – in order to reduce the number of visits by these patients (frequent attenders). Therefore, the research questions examined were: What is characteristic of frequent attenders in primary care clinics? What motivates frequent attenders? How are frequent attenders perceived by doctors and nurses? What are the views and attitudes of doctors and nurses on frequent attenders and their constant presence at the primary care clinic? How can the phenomenon of frequent attenders in the primary clinic be optimally managed?

The research hypotheses examined the impact of patients with high perceived vulnerability, manifested by loneliness, mental health problems, chronic disease, hypochondria, anxiety and more, on more frequent visits to the clinic. Patients often visit the clinic due to the secondary gain they receive as a result of the attention provided by the health care team or of being sick. The more frequently patients visit the clinic, the more doctors and nurses will perceive them

as bothersome, creating a workload, costly and difficult to please. Positive relationships between patients and nurses or doctors will grant patients a sense of security and they will tend to come to the clinic more frequently for consultations.

1.2.2 The study is based on the following theories:

The first three theories are sociological by nature. This theory and model attempt to explain and predict health behaviors:

The Sick Role, according to Parsons (1951)

Sense of coherence (SOC) , According To Antonovsky (1987)

The Health Belief Model (1950s, by social psychologists Hochbaum, Rosenstock and Kegels).

The four additional models are:

Andersen's behavioural model (1968)

The Chronic Care Model (CCM) (1998)

a conceptual model that will serve as a basis for demonstrating the factors that lead to utilization of healthcare services.

In addition, the following multi-factor models will serve as the basis for understanding the attitude of caregivers to patients and their relationship:

Peplau's model (1952(

Engel's model (1977)

1.2.3 The concepts list

The concepts listed below derive from these theories and follow the research questions and aims. The visual model presented below describes the conceptual framework that underlies the study.

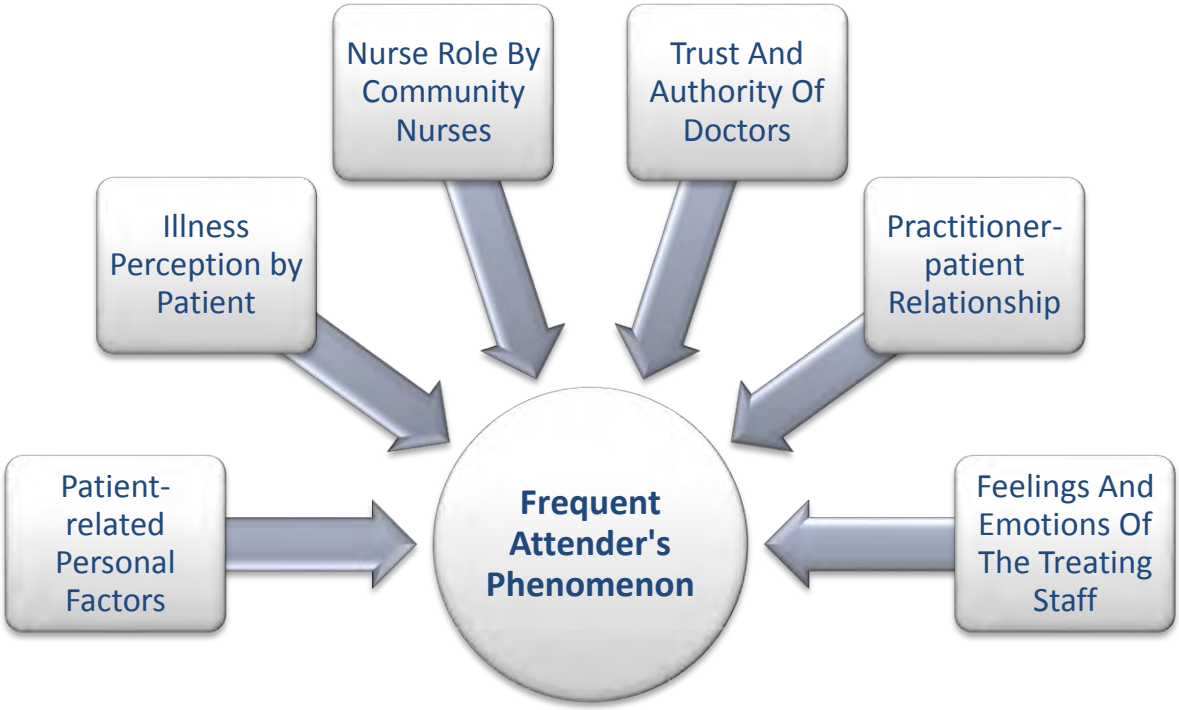


Figure 1 The visual model of the conceptual framework.

Frequent attenders: The phenomenon of frequent attenders overburdens the community healthcare services: doctors, nurses, clinical specialists and others. Frequent attenders account for a significant volume of up to 50% of the clinic's activity, although constituting only 10% of all the clinic's patients. The literature does not contain a uniform definition of frequent attenders, defined as covering a large range of 3-25% visits a year. The most common definition is of visits more than 10% times a year. The range of visits varies as well, determined in the literature as 2-48 months. Researchers usually use 12 months to define the time period (Smits, Brouwer, ter Riet, & van Weert, 2009). In the current study, the definition of frequent attenders referred to patients with more than 12 visits a years to the treating physician, as according to Israel's Central Bureau of Statistics the average number of visits per year is 6.8, with 5.5 for

men and 6.9 for women including telephone consultations (Green et al., 2008; Central Bureau of Statistics, 2012)

Trust and authority: means confidence on the honesty, strength, ability, surety of a person or thing .Confidence; obligation or responsibilities forced on someone or something in whom confidence or authority is placed; a fiduciary relationship; being left in responsibility of another. believe, rely; confidence; certainty; faith; no fear of consequences; commit; hope; a person on whom or thing on which one relies" (Milog, 2016) Companionship, friendship, love, concurrence, relaxation, and comfort are some emotions associated with trust (Straker, 2008). Trust is a dynamic concept that may be divided into three stages: building trust, in which trust is created; stabilizing trust, in which trust exists; and disintegration, when trust ends (Kautonen & Karjaluoto, 2008).

Community nurse: A registered nurse who provides treatment, counselling and nursing services to clients at community-based healthcare facilities, performs home visits to provide nursing services and care, and counsels family members as necessary. The nurse accompanies patients and their family members throughout their life in health and in sickness and has an essential role in ensuring the continuity and quality of care. The nurse serves as a foundation of organizational quality processes and health promotion processes (State of Israel, 2016b).

Practitioner-patient relationship: The doctor-patient relationship is comprised of two parts: one consists of the emotional relationship between the practitioner and the patient and the other is the cognitive part, which includes the patient's rights. In the present medical culture, the practitioner perceives the patient as an active partner in the medical procedure. They both share responsibility for decision making regarding the necessary medical treatment and its provision. Inclusion of patients in medical decision making is based on an honest, open and direct practitioner-patient relationship – with the underlying premise that the patient has the right to decide about his or her body and the role of the practitioner is to consult and help reach proper medical decisions (Gal, 2008; Reches, 2014).

Illness perception: is the patient's cognitive and subjective evaluation of the severity of his or her disease and its impact on his or her life. Cognitive representations of the illness are defined as beliefs originating from the patient's common sense regarding the illness. According to this model, patients actively process information about their illness and construct their own cognitive representations of it. Together, these representations form the illness perception that

shapes their coping and thus affects the psychological impact of the illness, manifested for example in tension and mental stress (Fortune et al., 2002).

Personal patient-related factors: Personal factors include the demographic characteristics of age, sex, social aspects, education, occupation, ethnicity, sector, social-familial ties, marital status, political, social-cultural ties, social network, and mental factors in terms of one's health beliefs, attitudes, and knowledge about the healthcare system and the accessibility of healthcare services (Babitsch, Gohl & von Lengerke, 2012; Andersen & Davidson, 2001; Andersen, 1995). Also included are the patient's readiness to suffer pain or to cause his or her loved one's pain in order to lengthen the patient's life. Added to this is the patient's perception of a certain event as an illness or as something worth taking seriously and what is not (Frank, 2013). All these are significant factors in the patient's decision whether to come to the clinic.

Feelings and Emotions of the treating staff: Patients who are frequent attenders tend at times to arouse negative feelings among doctors and nurses, such as: anger, guilt, hatred, and sometimes depression. Furthermore, these patients demand a great deal of time, perform more tests, are referred more frequently to doctors for a second opinion. Moreover, they overburden the doctors and nurses and do not necessarily receive adequate care (Karlsson et al, 1997; Scaife, 2000). As a result, doctors react with "Oh no, not he again!" at visits by frequent attenders. In addition, these patients are called "difficult patients" (Gili et al, 2011). The many visits to the clinic create a sense of frustration and these patients are sometimes even called hated patients (Hauswaldt, 2013). These feelings express the frustration that the doctor feels towards these patients, because despite all the treatment and efforts they are not cured (Groves, 1978).

2. RESEARCH METHODOLOGY

The current study aims to explore the population of frequent attenders at community-based primary clinics in the Tel Aviv – Jaffa District of Clalit Health Services and their relationship with the doctors and nurses.

Generally speaking, there exist three research approaches: The quantitative approach, the qualitative approach and the mixed methods paradigm (Newman & Benz, 1998).

In quantitative research, it is possible to notice a linear sequence that begins with the selection of a research topic and ends with the confirmation or refutation of the research hypothesis. In qualitative research, in contrast, it is possible to note a cyclic sequence that also begins with selection of a research topic but sometimes the study itself leads to redefinition of the topic and repetition of several stages (Shkedi, 2015) Since each of the approaches has biases and weaknesses, in the current study data collection from the patients through interviews contributes to comprehension of the problem and to understanding which solutions the patients prefer, while the quantitative research method will provide information about the solutions, the perceptions and attitudes of doctors and nurses, and which solutions they perceive as potentials for handling this problem of frequent attenders. Moreover, triangulation was used by conducting a focus group, in order to ensure the reliability of the findings and of the conclusions reached through the different research approaches.

Mixed methods research includes quantitative research and qualitative research within one study. In this way it seeks to neutralize the weaknesses of each research paradigm, utilize the benefits of each, and provide a more intensive, wide and rich research picture (Creswell, 2014). In other words, the data collection and their method of analysis must be consistent (Tashakkori & Teddlie, 2003). Therefore, in-depth analysis of the interviewees' answers, together with quantitative analysis, formed the basis for performing convergent validation and concurrent validation of the research findings. Namely, data triangulation from all types of research, both qualitative and quantitative, as facilitated by mixed methods research makes it possible to explore the findings of each type of research separately in comparison to the others, and rejects interpretations based on only one source of data that can lead to conclusions with low reliability and weak validity (Hathaway, 1995). In order to carry out the convergent validity, triangulation was used (Creswell, 2014). To understand this phenomenon of patients who attend the clinic on a frequent basis (frequent attenders), characterize them, understand the feelings, attitudes

and perceptions of the medical staff (doctors and nurses) and find the appropriate solution to this problem of frequent attenders, the mixed methods approach was chosen.

2.1 Research goals

1. To map frequent patients aged 22-70 in the primary clinic and their categorization.

2. To explore what motivates patients to be frequent attenders and to come to the clinic more often.

3. To examine the perspective, views, and relationships of doctors and nurses regarding frequent attenders.

4. To suggest the optimal way for managing the phenomenon of frequent attenders in the primary clinic.

2.2 Research Questions

1. What is the profile of. Frequent attenders patients who visit the clinic frequently from the sociodemographic aspect? (characteristics(
2. What are the reasons that frequent attenders frequently visit the primary clinic?
3. What feelings and emotions frequent attenders evoke in the medical staff (doctors and nurses)?
4. How do patients, medical staff and nursing staff perceive their relationship between patients, doctors and nurses, and what are their views on this relationship?
5. What is the optimal way of managing the phenomena of frequent attenders?

2.3 Research hypotheses

1. Patients who are frequent attenders will evoke in the staff (doctors and nurses) more negative emotions (impatience, anger, frustration, rejection, and avoidance) and less positive emotions (calmness, relaxation, and affection).
2. The treating staff attributes the reasons for the frequent visits more to the patient's emotional and personal state and less to the quality of the relationship with the treating staff.
3. The caregiving staff will perceive referral to a psychologist or psychiatrist as the most efficient solution for managing the phenomenon (more than solutions centering on initiated contact with the treating staff or a support group).

2.4 Dependent variable

Frequent visits to the clinic, practitioner-patient relationship, the nurse's role.

2.5 Independent variable

Geographical proximity to the clinic, support systems, health condition, gender, sociodemographic status, ill perception, perceived health condition, feelings and emotions of the doctors and nurses.

2.6 The rationale for selecting the research strategy

Mixed methods research includes quantitative research and qualitative research within one study. In this way it seeks to neutralize the weaknesses of each research paradigm, utilize the benefits of each, and provide a more intensive, wide and rich research picture (Creswell, 2014). This combination contributes to highly reliable and efficient research, which merges the human aspect with the scientific aspect by using various research methods in different stages of the study (Tashakkori & Teddie, 2003). This leads to a richer picture as a result of combining diverse sources – numerical, behavioural and verbal. If so, a well-researched mixed methods study may provide a more complex, valid and generalizable picture than disparate research designs (Asaf, 2011).

According to Creswell (2014), there are three main models in sociological research:

The first model is convergent parallel mixed methods, The second model is explanatory sequential mixed methods. The third model is exploratory sequential mixed methods.

2.6.1 The chosen research design is: Convergent parallel mixed methods

The main premise in this approach is that the two research approaches, qualitative and quantitative, provide different information collected in different ways, and together they are expected to produce assumedly identical results (Creswell, 2014). In the current study, the research population is comprised of patients who are frequent attenders, whom we examined through a semi-structured interview in a qualitative approach. The second population is the medical staff, doctors and nurses, whom we examined through a questionnaire that explores attitudes, feelings and perceptions towards those patients who are frequent attenders, in the quantitative approach. Namely, this study compares different perspectives of patients in the qualitative study of doctors and nurses in the quantitative study. In this research model, data collection for both types of research is carried out concurrently and the researcher combines

the information in the overall interpretation of all the results and makes it possible to explain conflicting or unclear results (Creswell, 2014).

In the current study, questionnaires were administered to doctors and nurses, and at the same time interviews were conducted with patients found to be frequent attenders, based on "high frequency attender" reports from the Clicks software (a work program that manages patients' files in the primary clinic) received from the data extraction committee in the community.

The data from the two approaches, qualitative and quantitative, were quantified as conclusions. Hence, the current study used the convergent parallel mixed methods research strategy that is the most suitable of the three mixed methods approaches for the current research method.

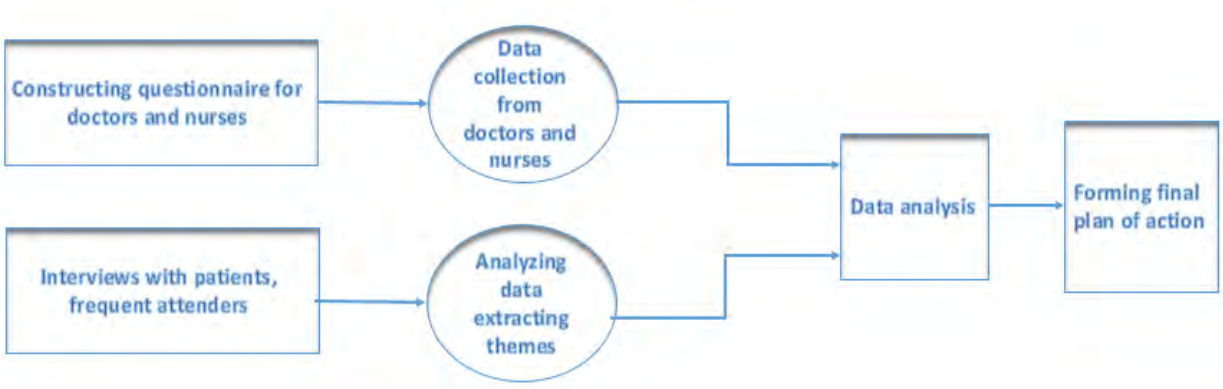


Figure 2 describes the research stages according to Creswell (2014, p. 221)

3. RESEARCH DESIGN AND POPULATION

Table 1 the research design and population

Stage	Goal	Participants	Research tools	Method of analysis
Qualitative	1. To identify and detect the reasons that patients become frequent attenders. 2. To examine their views concerning the relationship with the nurse	18 frequent attenders 9 men and 9 women from the Tel Aviv – Jaffa District of Clalit Health Services	Semi-structured in-depth interviews following an interview guide	Content analysis
Quantitative	1. To identify the feelings and behaviours that arise among doctors and nurses towards frequent attenders. 2. To examine whether gender affects attitudes towards frequent attenders	78 doctors and 106 nurses A total of 184 participates who work at primary and secondary clinics	Questionnaire on views and opinions, to be designed for this study	Analysis by means of SPSS, to include descriptive and deductive statistics

4. FINDINGS

Table 2 A summary, analysis and interpretation of the findings.

Characteristics of frequent attenders in the current study										
		Medium-low socioeconomics Primary and secondary education		**High socioeconomic level Technical and academic education**		**Marital status**		**Men**	**Women**	**Shared by everyone**
Theme	**Category**	**Behaviour**	**Personality**	**Behaviour**	**Personality**	**Single**	**Married**			
Psychological reasons for visits	**Illness perception**	Low coherence with increasing sense of distress Reference to the illness Concern of hearing test results	Miserableness Uncertainty Helplessness	Low coherence with sense of distress Reference to the illness Doubting the treatment	Worry Sense of fatal risk Concern Fear	Personal responsibility and care for one's health Threat to one's life	Guilt feelings Burden on marital life in the family	Sense of fatal risk A nuisance that interferes with daily routine Trauma	Damage to one's way of life Bad feeling Miserableness Loss of strengths	Deficient sense of coherence Multiple visits to the family doctor Visits to specialists
	Mental state	Needs support Desire to share one's problems with a professional	Anxious Sensitive Worried Needs attention	Seeks problem solution	Demander Needs attention Worried Stressed	Loneliness	Needs counselling	Sense of pain Inefficient treatment	Desire for emotional support Worried about deficient physical functioning	Health anxiety
	Existence of illness	Low self image Disturbing and unpleasant element	Sense of frustration Inability to fulfil prior social role	Depression Harm to family and social life	Sense of suffocation Harm to one's mood	Worry	Concern and fear	Frustration Disappointment Declining self image	Frustration Sense of rejection Inability to fulfil the feminine role	Harm to one's way of life and inability to fulfil a social role
	Receiving support	Social isolation	Tension Depression	Supportive spousal relations Sense of confidence The spouse	Depression Anxiety	Loneliness Use of the extended family	Guilt feelings Lack of acceptance Frustration	In a good marital relationship there is confidence in one's spouse Frustration and low self image in bad marital relations	Loneliness No help received	Need for acceptance by society

Characteristics of frequent attenders in the current study										
		Medium-low socioeconomic level Primary and secondary education		**High socioeconomic level Technical and academic education**		**Marital status**		**Men**	**Women**	**Shared by everyone**
Theme	**Category**	**Behaviour**	**Personality**	**Behaviour**	**Personality**	**Single**	**Married**			
Meaning of the clinic for me	**Service orientation**	Health security Attentiveness Source of assistance Source of improving health problems and receiving a response for health questions	"Life saver" Human support	Concern Belonging Source of assistance Social activity Counselling and guidance Organizing and managing appointments Clarifying health problems	Belonging **Counselling and guidance**	Sense of safety Assistance with recovery and recuperation	Imparting confidence Social support	Providing a source of support and security	Providing a source of support and security	The clinic is a source for information on the health condition and solution of medical issues
	Availability	Multiple visits to the clinic Personal conversations with the family doctor Meetings with the nurse	Receiving an explanation Confidence	Multiple visits to the clinic Telephone conversations with the doctor Convenience	Convenience Confidence	Unwillingness to leave the clinic due to its proximity	Significance of the clinic's proximity	Multiple visits and more telephone conversations with the doctor	Very high frequency of visits more than among men More appeals to the nurse	Cheap, accessible and easily available service

Characteristics of frequent attenders in the current study										
		Medium-low socioeconomic level Primary and secondary education		**High socioeconomic level Technical and academic education**		**Marital status**		**Men**	**Women**	**Shared by everyone**
Theme	**Category**	**Behaviour**	**Personality**	**Behaviour**	**Personality**	**Single**	**Married**			
Sense of trust	**Towards the medical staff**	Derives from the doctor's professionalism Personal closeness Authoritative figure Returning to receive an explanation and confirmation of a specialist's recommendation Feeling of a parent	Blind faith in the doctor	Derives from the doctor's professionalism Openness and honesty Willingness to provide a response at any time Appeal to a specialist and understanding that this is his specialty	Appreciation of the doctor's knowledge and professionalism	Attributing to the doctor honesty, caring, and readiness to contribute of his time beyond that necessary in order to provide the patient with a response	Attributing to the doctor professionalism Personal acquaintance	Close relationship Personal acquaintance Knowledge of the patient's medical history Admiration	Sense of blind faith, Admiration Caring	Many years of acquaintance as a basis for trust
	Towards the nurses	A mediator between the doctor and the patient Appreciation for her professional knowledge Source for learning new skills Appreciation for the patient's prior experience with the nurse	Loyalty to the nurse with prior acquaintance	Appreciation for the nurse's expertise Prior acquaintance Personal attention Mediator between the doctor and the patient Professional experience	Trusts the professional knowledge	Attribute significance Prior acquaintance and professional ability	Attribute significance to professionalism and prior acquaintance	Comes to the clinic due to her professionalism Prior experience	Comes to the clinic from a desire for attention, attentiveness, and prior personal experience	Reference to prior acquaintance and to her professional knowledge

Characteristics of frequent attenders in the current study										
		Medium-low socioeconomic level Primary and secondary education		**High socioeconomic level Technical and academic education**		**Marital status**		**Men**	**Women**	**Shared by everyone**
Theme	**Category**	**Behaviour**	**Personality**	**Behaviour**	**Personality**	**Single**	**Married**			
Image of the good doctor	**Concerning the doctor's personality**	Acceptance and non-rejection of the patient Patience Prepares what the patient needs in advance Accurate diagnosis Kindness Attentiveness Politeness Doctor with a soul	Seeing the doctor as a parent figure	Acceptance and non-rejection of the patient Patience Prepares what the patient needs in advance Accurate diagnosis Kindness Attentiveness Politeness Doctor with a soul	Guides and directs Counsels	Parental attitude Real and honest concern for the patient	Caring Deep sensitivity Asks questions	Thorough analysis of the problem Personal attention Observes the problems from a long-term perspective Shows real interest in the problem Patience	Sensitivity Personal attention Understanding that patients are diverse Accurate and professional diagnosis	Diagnostic skill Sincere attention to problems raised by the patient
	Attitude to the patient	Open communication Empathy Reciprocity and containment ability	Direction and guidance on how to act in different situations	Attitude, accessibility and desire to receive polite service Understanding and direction	Sincere attitude	Communication Human relations Explanations and speaking to one sincerely	Sincere attitude Politeness Unconditional acceptance	Non-judgmental acceptance Human attitude Humane approach Tolerance Open communication and containment ability	Attentiveness Patience and readiness to repeat explanations with no anger Indications of true interest and attention as a person rather than as a deficient body part	Personal attention Seeing the patient as a whole Ongoing and continuous communication

Characteristics of frequent attenders in the current study										
		Medium-low socioeconomic level Primary and secondary education		**High socioeconomic level Technical and academic education**		**Marital status**		**Men**	**Women**	**Shared by everyone**
Theme	**Category**	**Behaviour**	**Personality**	**Behaviour**	**Personality**	**Single**	**Married**			
Image of the good nurse	**Concerning the nurse's personality**	Professionalism Support Assistance and direction Sensitivity and patience Being "a semi-psychologist" Supportive, helpful and mediating figure	Teaching and directing	Receiving knowledge Explanation of information provided by the doctor Professionalism Caring and humane attitude Seeing the patient's good	Involvement in the process	Professional knowledge Sensitivity Helpful Supportive	Medical knowledge Helped the patient reach independence Initiative	Expertise in her field Professional experience Medical knowledge Prior acquaintance	Sensitivity Direction Initiating Professionalism Personal attitude	Seeing the nurse as care manager Mediating between the doctor and the patient
	Approach to the patient	Personal attitude Sympathetic and understanding Sincere care for the patient Equitable attitude Attention to details	Sensitivity to the patient's needs	Apathy Attentiveness Caring Encourages the patient to maintain his health Punctiliousness	Helps the patient understand his problems	Attention Attentiveness Assistance Seeing the patient as a whole	Personal example Empathy Attention Understanding	Understanding matters Empathy Assistance	Love Personal example	Non-judgmentally accepting the patient as he is Attentiveness
Preferred solutions	**By the patients**	Doctor, nurse Support group Workshops		Doctor, nurse Support group		Small support group Conversation with a nurse	Doctor Nurse Small support group	Conversation with 1. Doctor 2. Nurse 3. Support group	Conversation with 1. Doctor 2. Nurse 3. Support group 4. SW	Conversation with member of the medical or nursing staff was given the highest preference

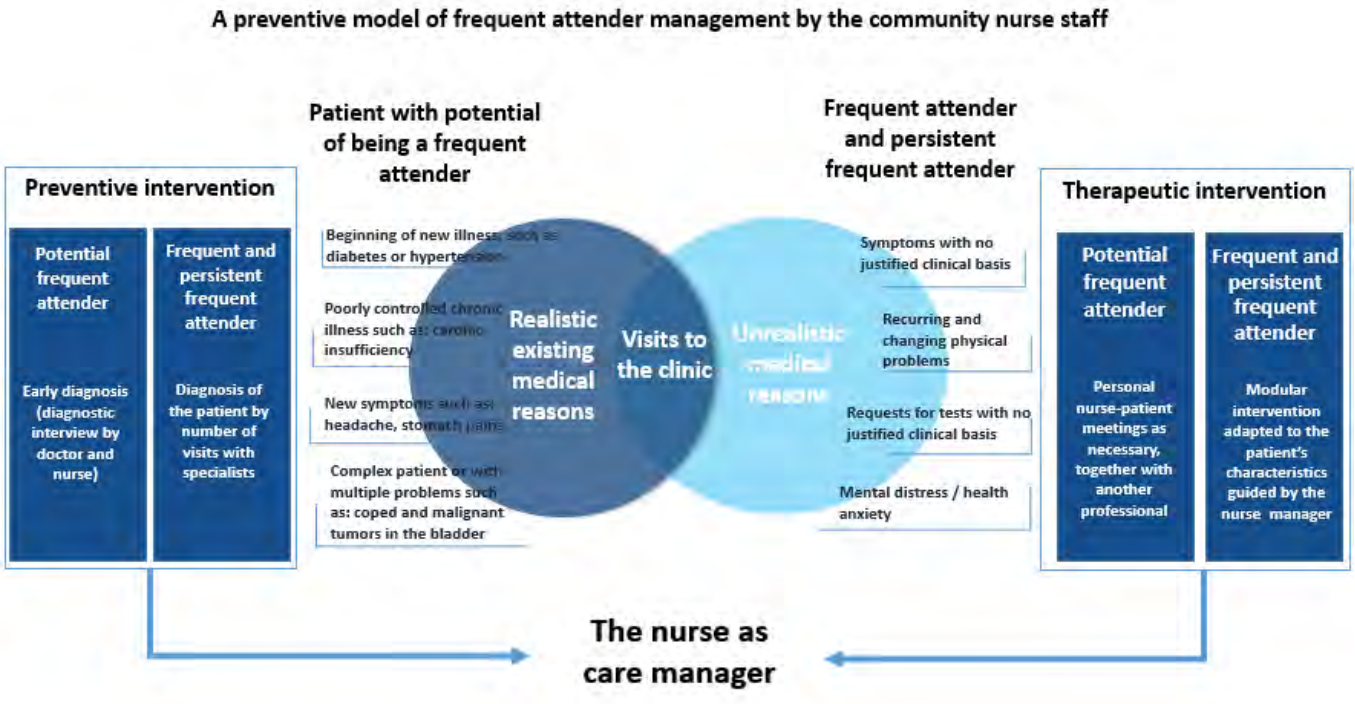
Attitudes and perception of the medical and nursing staff towards frequent attenders		
Feelings aroused by frequent attenders among doctors and nurses	**Reasons for frequent visits**	**Preferred solutions**
As a rule, these patients were found to arouse more negative feelings: anger, impatience, frustration, rejection and avoidance. Less positive feelings: calm, relaxation and affection	The patient's personality traits and mental state Relationship with the caregiving staff (doctor, nurse)	The ranking was as follows Providing knowledge < support group = initiated encounters of the medical staff with the patient < initiated encounters with the nurse = preventing secondary gain = referral to a psychologist or psychiatrist

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Main Conclusions and Recommendations

The research findings raise the phenomenon of frequent attenders and particularly that of persistent frequent attenders as a complex social issue that can be defined as a social-health issue that requires multidisciplinary involvement in order to be treated. The issue is manifested on the patient level by visits of the frequent patient to the clinic for unrealistic reasons and on the caregiver level by a sense of fatigue and unwillingness to provide treatment.

Furthermore, the research results raised the need to prevent the phenomenon as early as the initial stages, even before the patient becomes a frequent attender, and coined the term "potential frequent attender". In other words, a proactive view, namely predicting the future and preventing the phenomenon of frequent attenders even before it emerges. Hence, the study provides a new framework for grasping the phenomenon of frequent attenders from a sociological perspective. This approach is one of the most important routes in planning and referring to management of the phenomenon of frequent attenders. Embracing this way of thinking, which emerged from the current research findings, will facilitate control of primary care resources in the community,



including unnecessary visits to the doctor and nurse, as well as redundant tests. In addition, this approach will increase patients' well-being and improve their quality of life.

Figure 3 A preventive model of frequent attender management by the community nursing staff.

Figure 3 presents the conceptual organizing idea of the recommended intervention in the phenomenon of frequent attenders.

Moreover, the figure presents a different approach to intervention in the phenomenon of frequent attenders in primary care clinics in the community, compared to the existing literature.. The model demonstrates that focusing on preventing the phenomenon is in fact the most efficient way of managing it. The model is constructed of three phases, such that any primary care clinic in Israel or elsewhere with similar characteristics can utilize the relevant parts that are suitable for it in order to manage the phenomenon of frequent attenders.

In addition, the research model as it emerges from the discussion and the conclusions is an integrative model that sees the phenomenon of frequent attenders as a process comprised of varied factors and aspects that affect the patient, the medical staff (doctors and nurses) and the community-based healthcare services, as shown in Fig. 10. In this way, the model indicates that it is necessary to define the characteristics of the potential patient for becoming a frequent attender, to diagnose the reasons for visits as realistic or unrealistic, and to hold preventive and therapeutic interventions according to each characteristic of the frequent attender, with the entire process managed by a nurse at the community primary care clinic.

In other words, the first phase of the model discusses the reason that the frequent attender comes to the clinic, realistic reasons (such as new diabetes, new stomach aches) and unrealistic reasons (such as health anxiety, symptoms with no justified clinical basis). The second phase of the model is comprised of the process of identifying the potential frequent attender and it requires determining the patient's characteristics and tendency to become a frequent attender. These characteristics include: a patient with a new chronic illness or new symptoms who comes to see the family doctor and shows signs of health anxiety, such as being worried or scared by the idea of having a severe illness based on misinterpretation of physical symptoms, where the concern

perseveres despite normal medical findings (DSM 5). Moreover, a patient who asks for unnecessary referrals to specialists and extensive diagnostic tests or alternately asks to repeat diagnostic tests too often, for example, a gastroscopy once every six months although the previous test was completely normal. Hence, the family doctor must diagnose as early as the fourth or fifth visit that this patient is coming for unrealistic reasons and promptly initiate the preventive treatment process in order to prevent the patient from becoming a frequent attender.

The third phase deals with preventive and therapeutic interventions with patients who have the potential of becoming frequent attenders and treatment of persistent frequent attenders and frequent attenders, where the community nurse is responsible for managing the interventions. The recommended intervention is comprised of a multidisciplinary team according to the patient's characteristics and needs. At the end of each intervention period an evaluation of the treatment will be conducted by the care management nurse.

In summary, from a conceptual perspective, the conclusions arising from this study indicate the need to promote a cognitive and perceptual change with regard to the phenomenon of frequent attenders in primary care in Israel and elsewhere.

Moreover, the research results serve as a foundation for introducing an intervention program for the phenomenon of frequent attenders in primary care in the community. They explain the factors involved in such a program, the implications of introducing such an intervention program for primary care in the community, and the criteria that must be taken into account in order to implement it.

Finally, this is a creative and original model as there is no literature that deals with preventing the phenomenon of frequent attenders and detecting patients with the potential of becoming frequent attenders.

5.2 Practical implications and recommendations

The implications that stem from the study and that serve as a foundation for introducing management of a system of interventions in the phenomenon of frequent attenders in primary care clinics in Israel refer to the following necessary actions:

1. Support and commitment by policy makers in the Community Division of the Ministry of Health for establishing a system to manage the phenomenon of frequent attenders at primary care clinics in the community. Successful change management requires involvement and responsibility of the senior management of all HMOs in Israel.
2. Developing a multi-institutional intervention program – for this purpose it is necessary to construct a training program for nurses who will deal with the phenomenon of frequent attenders.
3. Constructing a reserve of nurses who will deal with this topic: forming a team of content expert nurses who will lead management of the phenomenon of frequent attenders in the various HMOs.
4. Defining the terms and demands that the nurse will be required to meet in order to be suitable for the role, such as: supplementing professional knowledge, acquiring experience, a certain number of years on the job etc.
5. According to the findings of the current study, the major difficulty that this phenomenon of frequent attenders creates among the medical staff (doctors and nurses) is evident. For this reason, it is necessary to coordinate expectations with the medical management of the HMOs and the head nurses concerning nurse involvement in managing the phenomenon of frequent attenders.
6. Allocating a special position for a nurse who will manage the phenomenon of frequent attenders in each HMO.
7. Forming expectations of the role in the training stage in order to construct and shape a stable professional identity of the managing nurse.
8. Creating control mechanisms for managing the phenomenon of frequent attenders at primary care clinics, with the purpose of assessing management of the phenomenon of frequent attenders.
9. Forming a program for constant recruitment of nurses for the role of manager of the phenomenon of frequent attenders.

5.3 Contribution to knowledge

5.3.1 Contribution to theoretical knowledge

There are many studies on the phenomenon of frequent attenders in primary care in the community (Matalon, Nahmani, Rabin, Mazo, & Hart, 2002; Scaife, Gill, Heywood, & Neal, 2000; Patel, Kair, Atha, Avery, Guo, James, et al., 2015; Kivell, Elo, & Kääriäinen, 2018). However, the literature does not refer to how doctors and nurses perceive the characteristics of frequent attenders. The current study presents the perceptions and attitudes of the medical and nursing staff and the reasons for frequent visits as grasped by the medical staff (doctors and nurses) as associated more with the patient's personal and emotional state than with the relationship with the medical staff (doctors and nurses). In this respect the current study is original and innovative.

Another point that the current study raised concerned the patient's point of view regarding their relationship with the medical staff and their need for the medical staff (doctors and nurses) to see them as people rather than only patients.

More importantly, the patients see the nurse as a suitable manager of the frequent attender phenomenon. This finding indicates the significance of the nurse in caring for the patients and as a link between the doctor and the patient.

Moreover, the current study developed a cognitive framework that includes criteria for introducing an outline for intervention in two types of patients: a. patients who have the potential of becoming frequent attenders; b. patients who have the potential of becoming persistent frequent attenders.

Therefore, the study closed the knowledge gap regarding patients with a risk of becoming frequent attenders and it is innovative and thus also original.

From a theoretical perspective, the results of this study add another layer to the existing knowledge, based on previous studies that discuss the phenomenon of frequent attenders. First of all – they reinforce the existing body of knowledge in the literature from Israel and from other countries with regard to the phenomenon of frequent attenders in general and add new knowledge regarding patients with a risk of becoming frequent attenders and the feelings of the medical staff (doctors and nurses). Secondly – they indicate the unique contribution of managing the phenomenon of

frequent attenders both on the level of the primary care clinic and on the level of the organization (the Community Division in the Ministry of Health).

Another unique contribution of this study is the sociodemographic characterization of the population of frequent attenders in Israel aged 22-70 at primary care clinics. Through this information it will be possible to identify those at risk of becoming frequent attenders, who might overuse and even overburden the healthcare system. The uniqueness of this study is in revealing a new phenomenon of potential frequent attenders.

Finally, the study adds knowledge to theories that discuss the phenomenon of frequent attenders (Anderson, 1995; Kivell, Elo, & Kääriäinen, 2018). First of all, the study reinforces the existing body of knowledge in the literature regarding reasons and causes for frequent visits to the clinic and characterization of frequent attenders. Secondly – the study indicates the importance of managing the phenomenon of frequent attenders on the level of the healthcare system and training nurses to manage this phenomenon of frequent attenders on the institutional level.

The study adds to the existing knowledge in nursing theories on the nurse's role in Peplau's theory (1968) and in Parsons' theory (1951) with regard to the ability to fulfill the social role of the sick person as perceived by frequent attenders.

5.3.2 Contribution to practical knowledge

Since this study offers a modular conceptual framework concerning the phenomenon of frequent attenders in primary care clinics, any primary care clinic in Israel and elsewhere coping with this phenomenon of frequent attenders can choose to implement components of the proposed intervention and utilize it according to their needs.

Moreover, since this study suggests a new view of managing the phenomenon of patients with the potential of being frequent attenders or persistent frequent attenders, it is very important to allocate many varied resources that include collaboration between offices of the Community Division in the Ministry of Health, the Finance Ministry, and directors of the HMOs. In this respect the study indicates a need for a change in the policy of allocating appropriate resources for this need. Furthermore, from a practical aspect this role will necessitate construction of a new role – that of

nurse in charge of managing the phenomenon of frequent attenders – and setting criteria for its implementation in the various HMOs.

From a practical perspective, appointing a nurse to manage the phenomenon of frequent attenders will lead to a reduced load on the family doctor and nurse and more efficient and discerning utilization of healthcare services in primary care with all its components.

The innovativeness that may be attributed to this study stems from the development of a new cognitive framework with regard to the phenomenon of frequent attenders and particularly potential frequent attenders, a term that does not appear in the literature on this phenomenon of frequent attenders in Israel.

The originality derives from the fact that it is:

A. An original study that ascribes significance to preventing the phenomenon of frequent attenders rather than only treating patients who are frequent attenders in practice.
B. Develops a designated three-phase model for managing the phenomenon of frequent attenders, where the model developed in the study can be used as a guide for anyone who wishes to diminish the phenomenon.

6. Future Research

This study recommends four possible prospective research directions. These are the recommendations:

1. Further research with regard to the research population, to include:
   A. Expanding the research population to include patients who speak other languages in addition to Hebrew (Arabic, Russian and Amharic). A sample that will include the population of frequent attenders from all HMOs in Israel.
   B. Expanding the population of the medical staff to include doctors, nurses, and secretaries from all HMOs in Israel.
2. Research that will examine the efficacy of the role of nurse manager of the phenomenon of frequent attenders.

3. Research that will examine the impact of the model on reducing the phenomenon of frequent attenders.

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