

UC Irvine

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health

Title

Frequent Users of the Emergency Department: Risky Business

Permalink

<https://escholarship.org/uc/item/8q24s4gw>

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 10(3)

ISSN

1936-900X

Authors

Grover, Casey A
Close, Reb JH

Publication Date

2009

Copyright Information

Copyright 2009 by the author(s). All rights reserved unless otherwise indicated. Contact the author(s) for any necessary permissions. Learn more at <https://escholarship.org/terms>

Peer reviewed

Frequent Users of the Emergency Department: Risky Business

Casey A. Grover*
Reb JH Close, MD†

* University of California, Los Angeles School of Medicine, Los Angeles, CA
† Community Hospital of the Monterey Peninsula, Department of Emergency Medicine, Monterey, CA

Supervising Section Editor: Mark I. Langdorf, MD, MHPE

Submission history: Submitted September 25, 2008; Revision Received November 23, 2009; Accepted November 28, 2009

Reprints available through open access at www.westjem.org

[WestJEM. 2009;10:193-194.]

Frequent users of the emergency department (ED), recently defined as having four or more visits per year, are a diverse group of patients that provide a challenge to emergency physicians (EPs).¹⁻³ These so-called “frequent flyers” have been shown to have more psychiatric, psychosocial, and substance abuse issues than the general population and tend to be complex to manage.¹⁻¹⁰

One issue yet to be addressed is that ED frequent users may be doing themselves a disservice by choosing emergency care rather than seeking consistent care from a single physician. The ED, designed and staffed for emergent illness, usually lacks the resources and personnel for the long-term management of chronic or recurrent conditions. Furthermore, ED physicians tend to lack the training and information necessary for the management of such conditions. Instead they focus on ruling out acute disease.^{4,6,9,11}

Repeated ED care can be detrimental to patients seeking care for a chronic condition, such as chronic pain,^{7,11,12} migraines,¹³ and opiate addiction,^{8,11,14} whose symptoms or complications can be quickly managed by the ED. For the busy EP, chronic pain patients in need of medication may appear to be a simple patient encounter. However, a quick fix with a pain shot or narcotic script is likely hurtful to these patients in the long run. Pain literature has demonstrated that opioid therapy can lead to conditions of hyperalgesia, altered perceptions of pain, and abnormal functioning of pain receptors and signaling pathways. Chronic pain is best managed by a single provider who is in a position to reassess a treatment plan, for example, because he is aware of increased needs or usage.¹² While the ED can treat acute pain symptoms, chronic pain patients often feel worse after short-term medications wear off. This can result in worsening pain with repeat ED visits for pain control.^{11,12,15} Patients may prefer the convenience and ready availability of the ED, but the seemingly simple ED narcotic treatment is not an ideal plan of care for these patients.

Another group of frequent ED patients for whom

emergency care is less than ideal include those whose psychological stress or psychiatric illness produces somatic pain or symptoms. For example, it has been estimated that 30% of patients with chest pain and no evidence of coronary artery disease suffer from panic disorder.⁹ Perpetually in a rush, EPs are unable to engage in a long conversation about psychosocial stressors or anxiety and may overlook the underlying cause of the patient’s disease. Additionally, the fear of missing serious illness leads EPs to avoid attributing somatic symptoms to psychiatric or psychosocial causes. As a result, many of these psychosocial issues are not explored, and patients are often discharged with the cause of their symptoms unaddressed. Consequently, the symptoms will likely recur leading the patient to return to the ED yet again.

Finally, the extensive workup that ED patients receive in trying to rule out acute causes of symptoms is a source of potential harm to those frequently seeking emergency care. EPs have become increasingly dependent on radiological diagnostics to rule out acute disease and avoid missing occult illness.^{16,17} Recent evidence has shown that 0.4% of all cancers in the U.S. between 1991 and 1996 were possibly attributable to radiation from computed tomography (CT) studies. Extrapolation of this data puts estimates of the prevalence of cancer from CT scans in the near future at almost 2%.¹⁸ Consider a patient with chronic abdominal pain related to underlying anxiety disorder. Each time he or she presents to the ED, the treating physician is concerned about acute abdominal pathology and may not be aware of the patient’s anxiety or history of recurrent abdominal pain. For what appears to be an acute abdominal process the physician may utilize radiologic studies, such as radiograph or CT scans, to aid in diagnosis. Should the underlying condition continue, the patient may receive numerous radiological studies, and incur the risks associated with radiation exposure.

Recent work on managing frequent users on a more individual basis through consistent outpatient services has been shown to both reduce ED use and improve symptoms of

the chronic conditions that bring the patient to the ED^{12,19,20}. Efforts such as these are much needed for the ED frequent user, as they can help improve quality of care while reducing potential risks incurred by seeking emergency care for chronic conditions. In the meantime, a prudent EP should keep in mind the potential risks to the ED frequent user when treating this group of patients.

Address for Correspondence: Casey A. Grover c/o Reb JH Close, MD, Department of Emergency Medicine, Community Hospital of the Monterey Peninsula, PO Box HH, Monterey, CA 93942. Email: caseygrover@gmail.com.

Conflicts of Interest: By the WestJEM article submission agreement, all authors are required to disclose all affiliations, funding sources, and financial or management relationships that could be perceived as potential sources of bias. The authors disclosed none.

REFERENCES

- Hunt KA, Weber EJ, Showstack JA, et al. Characteristics of frequent users of emergency departments. *Ann Emerg Med.* 2006; 48:1-8.
- Byrne M, Murphy AW, Plunkett PK, et al. Frequent attenders to an emergency department: a study of primary health care use, medical profile, and psychosocial characteristics. *Ann Emerg Med.* 2003; 41:309-18.
- Ledoux Y, Minner P. Occasional and frequent repeaters in a psychiatric emergency room. *Soc Psychiatry Psychiatr Epidemiol.* 2006; 41:115-21.
- D'Onofrio G. Treatment for alcohol and other drug problems: closing the gap. *Ann Emerg Med.* 2003; 41:814-817.
- Rockett IRH, Putnam SL, Jia H, et al. Assessing substance abuse treatment need: a statewide hospital emergency department study. *Ann Emerg Med.* 2003; 41:802-813.
- Chan BTB, Ovens HJ. Frequent users of emergency departments. Do they also use family physicians' services? *Can Fam Physician.* 2002; 48:1654-60.
- Hansen GR. Management of chronic pain in the acute care setting. *Emerg Med Clin North Am.* 2005; 23:307-38.
- Hansen GR. The drug-seeking patient in the emergency room. *Emerg Med Clin North Am.* 2005; 23:349-65.
- Coley KC, Saul MI, Seybert AL. Economic burden of not recognizing panic disorder in the emergency department. *J Emerg Med.* 2009; 36:3-7.
- Bernstein E, Bernstein J, Levenson S. Project ASSERT: an ED-based intervention to increase access to primary care, preventive services, and substance abuse treatment system. *Ann Emerg Med.* 1997; 30:181-189.
- Wilsey BL, Fishman SM, Crandall M, et al. A qualitative study of the barriers to chronic pain management in the ED. *Am J Emerg Med.* 2008; 26:255-63.
- Svenson JE, Meyer TD. Effectiveness of nonnarcotic protocol for the treatment of acute exacerbations of chronic nonmalignant pain. *Am J Emerg Med.* 2007; 25:445-9.
- Chan BT, Ovens HJ. Chronic migraineurs: an important subgroup of patients who visit emergency departments frequently. *Ann Emerg Med.* 2004; 43:238-42.
- Do you give poor care to patients in pain? *ED Manag.* 2003; June:65-67.
- Finlayson RE, Maruta T, Morse RM, et al. Substance dependence and chronic pain: profile of 50 patients treated in an alcohol and drug dependence unit. *Pain.* 1986; 26:167-174.
- Schwartz DT. Counter-Point: Are We Really Ordering Too Many CT Scans? *West J Emerg Med.* 2008; 9:120-122.
- Henderson SO. Point: Diagnostic Radiation: Why Aren't We Stopping (Or At Least Slowing Down)? *West J Emerg Med.* 2008; 9:118-119.
- Brenner DJ, Hall EJ. Computed tomography - An increasing source of radiation exposure. *New Engl J Med.* 2007; 357:2277-2284.
- Derlet RW, Nishio DA. Refusing care to patients who present to an emergency department. *Ann Emerg Med.* 1990; 19:262-7.
- MacLeod DB, Swanson R. A new approach to chronic pain in the ED. *Am J Emerg Med.* 1996; 14:323-326.