Difficult Patients in the Emergency Department

Personality Disorders and Beyond

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KEYWORDS

• Difficult patient • High utilizers • Super utilizers • Frequent flyers
• Countertransference • Personality traits/disorders • Borderline

KEY POINTS

- Reasons for difficult physician-patient interactions can be due to patients or the physician, or system factors (wait times, lack of community outreach services, formulary restrictions, and so forth).
- Some difficulty in patient interactions can be due to physicians' counter-transferential feelings.
- The most difficult patients tend to have undiagnosed personality disorders, may be drug seeking, or present repeatedly to the emergency department with recurrent complaints, nonadherence to prescribed treatments, or contingent suicidality.

If the patient says that they want to kill you or your staff, they are psychotic. If the patient makes you and the rest of the staff want to kill them, odds are that you are dealing with a borderline

—Anonymous

INTRODUCTION

Part 1: Who are Difficult Patients?

Factors associated with behavioral and psychiatric problems in a medical setting may seem convoluted. Not only will complex medical problems up the ante of an individual's initial presentation to the emergency department (ED) but the addition of a possible psychiatric problem can also muddle up a clear diagnosis and render an ED visit difficult for all health care team members involved as well as for the patients. A full 20% of interactions in the ED can be seen as difficult, though only 0.2% of the US population will have a high frequency of ED service utilization.[1,2] Individuals presenting

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with repeated complaints are typically the most frustrating to health care teams. In the literature, these individuals are referred to as difficult, frequent flyers, superusers, and high and superhigh utilizers.

So who are those difficult patients who seem to consume a disproportionate amount of health care resources? The groups can be roughly divided into presenting with a clear medical complaint versus not: patients with sickle cell disease, for instance, go through periods of heavy ED service utilization but may be managed effectively with thoughtful pain control, thus, reducing ED visits.[3] Similarly, patients with clear medical conditions might be seen often in an ED but are not necessarily considered difficult.

Recent evidence seems to indicate that the difficult population has a higher mental illness burden, higher levels of depression severity, fatigue, sleep difficulties, pain, high alcohol consumption, and anxiety.[4] They have a lower self-perceived quality of health and often have a history of childhood maltreatment.[5,6] Other substance use, obesity, cardiovascular disease, more comorbidity (number and severity), and pain were also noted to increase patients' risk of becoming high utilizers of health care resources.[4] However, others have suggested that the population is not homogeneous and that some more nuanced definitions are needed: according to Pasic and colleagues,[7] using 3 different ways to assess high utilization (2 SD greater than the mean number of visits to an urban psychiatric emergency service, 6 visits in a year, and 4 visits in a quarter), the first high-utilizer group was more likely to be homeless, to have developmental delays, to be enrolled in a mental health plan, to have a history of voluntary and involuntary hospitalizations, to be uncooperative, to have personality disorders, to have unreliable social support, and to have a lifetime history of incarceration and detoxification. However, the second group had more visits, was more likely to have a history of incarceration and psychiatric hospitalization, more likely to be enrolled in mental health plan, and less likely to be homeless. This last group had the highest number of visits by standard deviation (2 greater than the mean; visits were not clustered in a given quarter, suggesting a pattern of use rather than increased use in response to a crisis).

Difficult patients through time-evolving picture and management

Over the course of the past 3 decades, much has changed in the health care system; another layer of complexity was added with the wave of deinstitutionalization that hit the United States in the 70s and 80s. Emphasis moved from humane, professional, and courteous patient management to effectiveness and cost cutting. It is helpful to take a look back to understand how our system arrived at its current state: the aim of the deinstitutionalization movement was better integration of individuals with mental illness into society with expected decrease in care expenditures. Developing countries have seen similar, though less pronounced and less systematic, movements.[8,9]

An unintended consequence of deinstitutionalization is the increase in high utilizers of emergency and urgent care services; though it is not the only reason for the existence of this category of patients, it is certainly a factor. These patients often seem to have intractable social, financial, and medical or mental problems and unfortunately seem to have high rates of nonadherence to treatment recommendations. This group was recognized early, though has had different labels through the years[10]; but no concerted, useful measures have been found for effective management. In addition to the medical complaints that never seem to end, and never seem to get better, it has been suggested that frequent, high utilizers of the ED establish a different relationship dynamic with members of the health care team and almost treat the ED environment, with all its harshness, as a support system and a home: thus, frequent flyers may cause frustration in providers at all levels, seem to have trouble relinquishing control,