The College of Emergency Medicine

Best Practice Guideline

Care of frequent attenders at multiple Emergency Departments

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Summary of recommendations

1. Emergency Department staff should have procedures for identifying patients who feign illness or injury.

2. Emergency Department staff should consider producing clear individualised management plans for those patients who feign illness / injury and who are frequent attenders.

3. The patient's General Practitioner and liaison Psychiatry should be involved at an early stage.

4. Management plans for frequent attenders at multiple Emergency Departments should seek to limit any potential harm to patients or staff involved in their care.

5. Emergency Departments should cooperate with each other in the identification and support of frequent attenders at multiple Emergency Departments. This includes sharing relevant information, sometimes without the consent of the patient, where it is thought to be in the best interests of the patient.

Scope

Patients who frequently attend multiple Emergency Departments have previously been labelled as 'hospital hoppers'. This terminology is not endorsed by the College of Emergency medicine. This guideline has been developed to assist Emergency Physicians and healthcare managers in the management of these patients on presentation to the Emergency Department (ED). The guideline offers recommendations for the identification and management of adult frequent attender at multiple Emergency Departments (FAMED). In this document FAMED should be considered in a patient who presents to multiple EDs feigning illness or injury. This guideline does not cover the management of all 'frequent attenders' (this is covered in a separate CEM guideline) or Fabricated illness by proxy in the paediatric setting.

Reason for development

Patients who might be thought of as a FAMED often pose a dilemma for clinical staff as to what is the most appropriate course of action to take and how far their 'duty of care' extends. These patients can be exposed to extensive, harmful investigations and unsafe prescribing.

Dilemmas exist in deciding whether informing the wider healthcare community of potential problems leads to a breach of confidentiality, and whether this is justifiable.

Introduction

Patients who might be FAMED make up only a tiny proportion of attendances in the ED; 39 cases (and 21 admissions) from a regional census of 900,000 patients [1] however ED staff are often left feeling embarrassed, irritated and questioning their diagnostic skills once the deception is uncovered.

FAMED patients consume many resources in the ED and in the hospital if admitted. FAMED patients often initially attend one ED a number of times before they become labelled as someone who is feigning illness or injury. When confronted they cease to attend that particular ED and move onto another ED where they are not known. It is likely that a FAMED patient may well have been identified as a 'frequent attender' by one ED before that patient is labelled as a FAMED patient by another ED. Being able to recognise the potential for someone to develop into a FAMED patient and institute an appropriate ED management plan should prevent unnecessary investigation, treatment or admission. This should protect the patient from harm and save money in some cases.

Behaviours associated with FAMED patients

Common presentations for FAMED patients include opiate seeing behaviour (e.g. complaining of abdominal pain, joint dislocations) pseudo-seizures, pseudo-coma, hypoglycaemia (self-induced with insulin) [3] other rarer presentations have included major trauma [4].

In factitious illness the patient's symptoms are under voluntary control and consciously produced but not a direct result of a medical or psychiatric condition.

It is important that this is not confused with functional illness which is much more common. This is where a patient experiences real symptoms for which there is no obvious physical cause and are likely to have a psychological element to it. Common examples of symptoms include abdominal pain, bowel disturbance, palpitations, chest discomfort,

fatigue, paralysis, pseudoseizures. There are various defined illnesses that are predominantly functional in nature, fibromyalgia, irritable bowel syndrome and some chronic pain syndromes.

Box 1. Factors suggesting the possibility of factitious illness include:

- Dramatic or atypical presentation
- Inconsistencies between history and objective findings
- Details that are vague and inconsistent, though possibly plausible on the surface
- Irritability and evasiveness with continued questioning
- Long medical record with multiple admissions at various hospitals in different cities
- Knowledge of textbook descriptions of illness
- An unusual grasp of medical terminology
- Employment in a medically related field, familiarity with hospital procedures
- Lack of verifiable history – especially through timing of presentation e.g. weekends and evenings
- Failure to accurately identify themselves

Findings that may raise suspicions include the following:

- Multiple surgical scars as evidence of past procedures and hospitalisation
- Evidence of repeated cannulation
- Evidence of self-induced physical signs
- Inconsistent findings on neurologic examination
- Acceptance of painful medical procedures without complaint.[7],[8]

Recommendations

Once the possibility of feigning illness has been raised (often after multiple attendances) then senior doctors and nurses within the ED team should review the case notes and determine whether a management plan should be instituted. The patient's General Practitioner should be contacted at an early stage. Factitious illness is a diagnosis of exclusion after the involvement of senior clinicians.

The plan should ideally stipulate the 'usual' presentation and what actions should be followed to limit any investigations (particularly ionising radiation) and treatments (particularly controlled drugs). Previous incidents of violence, aggression, self-discharge or abusive behaviour towards staff should be recorded in the plan. A plan should include a physical description, if this would be helpful. Consideration should be given to ensuring that if the patient re-attends that they are seen by a senior clinician.

The plan should only apply to the 'usual' presentation, and the application carefully considered for each presentation, furthermore it should not compromise a patient's ability to obtain emergency care in a true emergency. It is accepted that some patients may alter their 'usual' presentation after being confronted to another form of feigning illness / injury. Ideally the plan should be discussed with the patient and the patient given a copy (as well as the GP). A patient could be offered an appointment see one of the ED team or the GP asked to discuss it with them. It is recommended that these patients are referred to liaison psychiatry if possible.

An empathic, non-threatening confrontation may help the patient accept psychiatric care; however denial and resistance is a frequent occurrence [6] when informed that the medical and nursing staff think that there is no organic basis for their illness / injury. Consideration should be given to having another colleague present in the event of any formal complaint(s) in the future. Maintain professional standards of behaviour at all times and consider the need for a security presence. [5, 7]

This guideline does not affect the statutory and professional obligations and regulations of Information Governance, Data Protection and confidentiality.

Management plans should be held securely, yet accessible 24 hours a day seven days a week within the Emergency Department. Emergency Department computer systems should have an alert in place to highlight the existence of a management plan.

If requested, it is reasonable to share the management plan with other EDs and you feel it is in the patient's best interests and aids their continuity of care. The plan should be sent to a named ED consultant securely. Similarly requests from healthcare providers (e.g. ambulance service) should be viewed in the same light (bearing in mind the ED plan is ED specific): the ED should not be held liable for the way another organisation interprets the plan. In doubtful cases, it is sensible to discuss your concerns, within departmental structures, and document this carefully.

Informal telephone requests (verifiably) from other EDs who suspect they have a FAMED patient in their department should lead to the sharing of relevant information. If an ED has reason to suspect that a patient is visiting or likely to visit other local EDs resulting in frequent potentially harmful investigations or treatments, then it is reasonable to send this information in a secure way to other EDs. Information should also be shared if the patient has put staff at risk.

EDs receiving multiple enquiries regarding the same patient who feigns illness / injury (who has a management plan) from different EDs and believe that that patient is therefore a FAMED patient and believe that the patient's behaviour puts him or herself at harm (e.g. unnecessary ionising radiation exposure, adverse side-effects of controlled drugs, potential to undergo unnecessary surgical procedures etc.) or puts staff treating that patient at harm should consider disclosing the patient's management plan to named ED consultants in other EDs whose departments may be visited by the patient. A regional cascade system may be applicable [1].

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The Best Practice sub-committee has been involved in reviewing this guideline.

Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None.

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

National survey on how EDs deal with FAMED patients.

Key words for search

Hospital hopper, factitious illness, Munchausen syndrome

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

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