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Physicians and low-risk frequent users in emergency services: ethical implications

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Abstract

There is an increasing demand for Emergency Department (ED) services from frequent users with problems of low clinical complexity. The overuse of ED poses several ethical-professional dilemmas for physicians and other medical staff. The study analyzes the ethical implications that emerge from the relationship between physicians and low-risk frequent users in a university hospital. This is a qualitative research developed through semi-structured interviews with physicians and low-risk frequent users and ethnographic observation in the field. It was observed that medical staff tend to stigmatize the demand of frequent patients. They, on the other hand, are satisfied with the physicians but discontent with primary health care and specialized outpatient care. It is concluded that the overuse generates ethicalprofessional conflicts, especially due to the stigmatization of these users by physicians. Nevertheless, frequent users are satisfied with the service, which motivates them to continue using it often.

Keywords: Medical ethics. Physician-patient relations. Hospital emergency services. Triage.

Resumo

Médicos e hiperutilizadores de baixo risco em emergências: implicações éticas

É crescente a demanda de usuários com problemas de baixa complexidade clínica que procuram serviços hospitalares de urgência e emergência frequentemente. Essa hiperutilização dos serviços impõe dilemas éticos aos médicos e demais profissionais. O presente estudo analisa as implicações éticas do encontro entre médicos e usuários hiperutilizadores em uma unidade universitária. Trata-se de pesquisa qualitativa desenvolvida por meio de entrevistas semiestruturadas com médicos e pacientes hiperutilizadores de baixo risco clínico e observação de campo etnográfica. Observou-se que os profissionais tendem a estigmatizar a demanda desses usuários. Já os usuários demonstram satisfação com os médicos, mas descontentamento com a atenção básica e especializada ambulatorial. Conclui-se que a hiperutilização gera conflitos ético-profissionais decorrentes sobretudo da estigmatização dos pacientes pelos médicos. Apesar disso, os hiperutilizadores se sentem satisfeitos com o atendimento, o que os motiva a continuar frequentando os serviços com frequência.

Palavras-chave: Ética médica. Relações médico-paciente. Serviço hospitalar de emergência. Triagem.

Resumen

Médicos e hiperfrecuentadores de bajo riesgo en urgencias: implicaciones éticas

Existe una demanda creciente de usuarios con problemas de baja complejidad clínica que frecuentemente buscan servicios hospitalarios de urgencia y emergencia. El uso excesivo de SUH impone varios dilemas éticos a los servicios, médicos y otros profesionales. El estudio examina las implicaciones éticas que surgen del encuentro entre médicos y pacientes hiperfrecuentadores de bajo riesgo clínico en un SUH universitario. Es una investigación cualitativa desarrollada a través de entrevistas semiestructuradas con médicos y pacientes hiperfrecuentadores de bajo riesgo clínico y observación de campo del tipo etnográfico. Se observó que los médicos tienden a estigmatizar la demanda del hiperfrecuentador. Los pacientes, por otro lado, muestran satisfacción con los médicos y refuerzan el descontento con la atención básica de salud y los servicios ambulatorios especializados. Se concluye que el uso excesivo del SUH genera conflictos en el ejercicio ético-profesional, principalmente como resultado de la estigmatización de estos pacientes por parte de los médicos. A pesar de esto, los hiperfrecuentadores están satisfechos con el servicio, lo que los motiva a convertirse en grandes usuarios.

Palabras clave: Ética médica. Relaciones médico-paciente. Servicio de urgencia en hospital. Triaje.

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Research

Accident and emergency hospital services, known as Emergency Departments (ED), aim to assist individuals with acute clinical conditions who seek care through referral or spontaneously. To regulate access and qualify clinical management, the Brazilian National Emergency Care Policy recommends risk rating and necessary and appropriate intervention for different health problems [1]. However, there is a growing demand from users who seek ED inappropriately with low-complexity complaints and problems, and who could obtain care from other areas of the health system [2].

EDs have thus become the main gateway to the health system, either due to difficulties in accessing primary healthcare or to the convenience of 24-hour medical services [3]. The result is inappropriate access, which directly interferes with the use of resources and the quality of services, besides contributing to overcrowding [4], posing ethical dilemmas for physicians and other healthcare professionals.

A small number of individuals with low clinical risk are classified as "frequent users" for seeking these services often, four or more times on average in a period of up to 12 months, according to the literature [5]. These users generally have chronic health conditions and mental disorders [6-9] and, despite being a small proportion of total ED patients, demand care that strongly impacts associated costs in the long term [6,10-17].

In this respect, overuse can also lead to overcrowding and longer waiting times, factors that affect the quality of services [14] by generating ethical-professional conflicts in the relationship between physicians and patients. Physicians and healthcare staff may, for example, view such patients as overly insistent, consuming resources, time and care that should be used on people facing more serious conditions [18,19].

In some cases, this leads to prejudice in health care, which goes against the Brazilian Code of Medical Ethics (CME), grounded in the practice of medicine with no discrimination of any kind and the responsibility to prioritize patients' well-being [20]. A systematic review [21] identified terms such as "health system abusers" and "nightmares" used by health staff to refer to these users. Negligent care was also observed, which is serious, for although frequent users do not usually present serious and urgent signs and symptoms, at some point they may develop a serious health condition that, if not adequately evaluated and treated, may lead to complications [22]. In this case, the physician in charge would also be violating the CME by causing harm to the patient through inappropriate and improper action or omission, which can be characterized as malpractice, imprudence or negligence [20].

This study used three documents as reference sources: CME, approved by the Brazilian Federal Council of Medicine (CFM) Resolution 2217/2018 [20], which provides rules for the exercise of the medical profession; CFM Resolution 2077/2014 [23], which regulates the operation of accident and emergency hospital services, as well as the number of medical staff and the working system; and the Brazilian Ministry of Health Ordinance 1600/2011, which reformulates the National Emergency Care Policy [2].

The research aimed to analyze the ethical implications of the relationship between physicians and low-risk frequent users treated in the emergency department of a university hospital. It also sought to: identify how physicians working in ED acknowledge the ethical principles that should guide their relationship with low-risk frequent users; analyze how those physicians apply such principles in their daily work; and analyze the perception of low-risk frequent users regarding the ethical dimension of care provided in ED.

Method

This article presents the results of a qualitative research that used mixed data collection techniques (semi-structured interviews and ethnographic field observation), focusing on the relationship between physicians and low-risk frequent users in the adult emergency department of Hospital São Paulo (PS-HSP), of the Federal University of São Paulo.

Through the HSP information system, we collected data of patients with four or more visits to PS-HSP in 2018. Then, four of those patients were selected to be interviewed according to the following inclusion criteria: adults, rated by nurses

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as "blue" or "green" (low complexity), and who agreed to take part in the survey and sign the informed consent form (ICF).

Regarding healthcare staff, five physicians were selected (residents, assistants and professors), who were directly responsible for the care of the interviewed frequent users and agreed to take part in the survey and sign the ICF. Interns from the 5th and 6th years of medical school were excluded as they were still undergoing academic training.

The users were approached inside PS-HSP, in waiting areas where the provision of services would not be affected and patients' integrity and privacy were respected. The physicians were interviewed at appropriate times of their own choice within their routine in PS-HSP.

The semi-structured questionnaire aimed to provide an overall profile of the participants and an understanding of the organization of PS-HSP, besides raising the main experiences, negative or positive, in the relationship between physicians and low-risk frequent users. In addition to the interviews, the researchers carried out ethnographic observations of the consultations, with no verbal or physical interference.

In the qualitative data analysis, we privileged the points of view of users and physicians to observe ethical aspects of the care and relationships in the daily routine of ED. The empirical material was explored through the analysis of interview transcripts and field diaries in search of recurring narratives, but without neglecting the individuality of each patient or professional. To this end, the concept of visibility plan was used to examine and organize the research material into categories.

The study was approved by the Research Ethics Committee of Unifesp/HSP, in accordance with National Health Council (CNS) Resolution 466/2012 [24] and regulations of the National Research Ethics Committee (Conep). The researchers received a research grant from the Regional Council of Medicine of the State of São Paulo.

Results

PS-HSP Physicians

As shown in Table 1, we interviewed five physicians, four women and one man, aged between 25 and 53, all of them holding medical degrees from public universities. The three youngest professionals participated in the medical residency program at HSP/Unifesp.

Table 1. Characteristics of the interviewed physicians of the Emergency Department of Hospital São Paulo

Participant	Age (years)	Gender	Position	Year of graduation and university
M1	40	Woman	Head of otolaryngology emergency services	2000, Universidade Estadual Paulista
M2	26	Man	Ophthalmology resident (R2)	2017, Universidade Federal de São Paulo
M3	25	Woman	General surgery resident (R1)	2018, Universidade Federal de São Paulo
M4	26	Woman	Clinical practice resident (R1)	2017, Universidade Federal da Paraíba
M5	53	Woman	Attending clinical practice physician at the HSP emergency department	1992, Universidade Federal do Pará

Based on the interviews and observation, the following visibility categories emerged: "stigmatization and devaluation of user demand"; "the patient is to blame"; "the crisis is to blame"; and "the Primary Healthcare Center (PHC) is to blame."

Stigmatization and devaluation of user demand

Feelings ranging from anger to pity are shared by most of the interviewed physicians, expressed in relation to low-risk patients, whether frequent

users or not. The investigation indicates that what bothers the interviewed physicians the most are simple complaints, of little or no seriousness and complexity, which take up time that could be devoted to critically ill patients and emergencies:

"I've never seen a colleague of mine refuse to examine or mistreat a frequent user, but what I do know is that some doctors are annoyed by the time wasted with such patients, while there are other more serious cases. I don't think this affects the actual service, it's more of an internal thing" (M2).

"Many doctors don't like or don't want to treat these patients. In a very busy shift, we feel rather angry at the patients" (M4).

"Why come here in the early hours with such simple problems? I don't rush to the ED just because I have a stomachache or a simple malaise" (M3).

One of the physicians reported that in recent years, with the introduction of the electronic health record system, the perception about patients has changed and, consequently, so has the attitude of health staff. Previously, the presence of frequent users usually went unnoticed, given the turnover of residents on duty. However, with the electronic record, the physician is able to identify the patient's frequency at PS-HSP and the most common complaints before the consultation:

"Because we know through the computer who the frequent users are, we may give less attention to a patient, which is bad, because if one day there is a more serious complaint, it may go unnoticed" (M1).

"It's common to see these patients more than once a month, so you usually examine them with an idea of what you'll find" (M2).

Identifying a patient as a low-risk frequent user also affects the time dedicated to care, which in most cases ends up being shorter:

"Depending on the patient, some consultations last up to one minute. If there's a worrying condition, it's different, but if there isn't, we don't even waste much time (...). I can't waste time on one [patient] *who doesn't have a complex condition. I think of complaints that make me invest in the patient. If it's not urgent, we promptly refer them to the PHC"* (M3).

"As they always arrive with similar or less relevant complaints, the consultation also tends to be faster" (M4).

Clinical management instruments, such as risk ratings, aimed at streamlining patient flow and optimizing care time, do not seem to interfere in the way some physicians treat users, including low-risk patients and frequent users:

"There is little difference between care given to low-risk and high-risk patients, including frequent users. The triage serves mainly to estimate patient waiting time outside. In here, I try to treat them equally, they are all patients" (M1).

The field research did not identify the use of any nicknames or adjectives intended to characterize or discredit frequent users.

The patient is to blame

The physicians lack a clear perception of the patients' difficulties to grasp how the health system works. There is a consensus among the interviewed professionals that patients are unable to identify the different levels of health care, which increases the demand for emergency services. However, all claimed to have only become aware of this subject after starting medical school. One of the interviewees argues that guiding patients should be the responsibility of the PHC:

"I think the PHC should be responsible for explaining to the population the levels of care to avoid overloading emergency services. The PHC has closer ties with patients" (M5).

Some physicians, while recognizing that patients do not adequately grasp the roles of each level of health care, view some of the low-risk frequent users as "crafty," since they try to circumvent the official access flows and visit the ED aiming to take tests or secure treatment at a higher level of health care:

"When we realize that a patient has really been waiting a long time for an appointment, we refer them to the Unifesp outpatient clinic, even though it is not the most correct procedure from a structural point of view" (M2).

"There are many patients who come here wanting to do tests, and we tell them this is not the right

place. Others come looking for a referral to an outpatient clinic, but we can't do that anymore. We rarely make exceptions" (M3).

One of the reasons given for inappropriate visits to ED is the frequent users' need for attention. Many of them are older adults who seem to lack opportunities to be heard and supported in society or even in the PHC:

"Patients come here often because they need attention, to be heard. We sit down with them and really listen. It is part of the medical profession to listen and help as much as possible. Some patients we already know by name. We never refuse to see them or send them away without examining them" (M2).

"There is an old man who comes often to the ED and I already know him, I know he has no family and that the only opportunity he has for socializing is at the hospital, which is his excuse for coming. Caring for low-risk frequent users is not good because we feel it is a waste of time, but the main feeling is pity, as in the case of this man I told you about" (M3).

The crisis is to blame

The economic crisis is also singled out as one of the causes of high demand. Most interviewees mention that a significant number of homeless people seek the ED for shelter and sleep, as there are no restrictions to staying in the waiting area: *"Homeless people often come to the ED, night after night, with some complaint or to take medicine as an excuse to sleep in the hospital while waiting for the appointment"* (M1).

Despite being a complex issue that exceeds the social sphere, alcohol and drug abuse should be mentioned, as it also influences the frequency with which some patients visit the ED:

"Another patient comes several times complaining of a sore throat, but always asks to be examined with lidocaine, probably because he is an alcoholic. It is important that patients' medical records show that they are alcoholics, or drank hand sanitizer in the ED, or have any other addiction, to avoid giving them morphine and other medications" (M1).

The Primary Healthcare Center is to blame

The role played by the PHC featured prominently in all interviews. For the professionals, when patients seek primary healthcare, they face problems with access and the low quality of care provided, especially when they need to be referred to specialized outpatient care. As patients are seen each day by a different physician at the ED, they no longer have longitudinal follow-up, which makes it difficult to control their illnesses:

"All patients are instructed and referred to the PHC, but many go there and cannot get minimum care, such as having ear wax removed, so they return and overload the ED" (M1).

"We have to deal with the volume, but ideally they [people] should have medical appointments close to their homes. Besides, clinical doctors rarely deal with ophthalmological complaints, and as the PHC does not have that specialty, patients always tend to come here, even with non-urgent complaints" (M2).

Frequent users

We interviwed four patients, three women and one man, aged 70 to 75, retired and living in the catchment area of PS-HSP (Table 2). Only one participant had complete secondary education and none had a private health insurance plan. The frequency of use in 2018 shows that the selected patients were in fact frequent users, especially P1 and P3, who used the emergency service on average every 6 and 14 days, respectively.

Table 2. Characteristics of interviewed low-risk users of the Emergency Department of Hospital São Paulo

Respondent	Age (years)	Gender	Schooling Level	Employment status	Residence	Visits to ED in 2018
P1	75	Woman	Complete secondary	Retired	Vila Mariana (South Zone)	58

continues...

Table 2. Continuation

Respondent	Age (years)	Gender	Schooling Level	Employment status	Residence	Visits to ED in 2018
P2	71	Woman	Incomplete primary	Retired	Tucuruvi (North Zone)	8
P3	75	Man	Illiterate	Retired	Capão Redondo (South Zone)	25
P4	70	Woman	Incomplete primary	Retired	Grajaú (South Zone)	9

We grouped the findings into three categories of visibility that emerged from observation and interviews with patients: satisfaction and ties with the ED physicians and medical care; overvaluation of physicians vs. devaluation of multidisciplinary team; and lack of consistency of PHC and specialized outpatient services.

Satisfaction and ties with the ED physicians and medical care

The low-risk frequent users feel well cared for in the ED. They report that they often return to the ED because they feel supported by the physicians, with whom they develop ties: "*I am always treated by Dr. Z, who works here in the emergency department. I like her a lot, the consultation is wonderful and I always come when she's on duty* (...). *In fact, Dr. Z is retiring soon and I don't want to come anymore when she leaves*" (P1).

The patients feel respected and report that physicians talk to them, examine them and are not negligent:

"*The doctors are very obliging. Others from the SUS* [Brazilian Unified Health System] *don't do anything, they barely look at us and don't say what's wrong with us. Here they examine us, do tests, give complete consultations. I really like it here, I won't change it for anything. I think they're rather fed up with me but I always come back*" (P2).

Overvaluation of physicians vs. devaluation of multiprofissional staff

One notes that the users tend to overvalue the physicians, dissociating them from the problems, frictions and deficiencies of the service. They attribute the main problems found to the other ED staff and do not clearly understand the role of those professionals in emergency care. When asked about negative experiences, the patients reveal disagreements with nurses, some of them caused by frequent use of the service:

"*One day the risk rating nurse asked me what I was doing there again at HSP because of my constant presence at the ED. But I come whenever I want and whenever I need to, I don't come for fun or because I like to. My doctor recommended rushing to the ED whenever I felt any pain or had a problem, because I've already had a heart attack*" (P1).

Lack of consistency of PHC and specialized outpatient services

Most interviewed patients visit the PHC, usually for appointments with a general practitioner. However, the waiting time for a medical appointment, especially with specialists, which is considered excessive, and the low quality of care are the alleged reasons for resorting to ED, even in cases of low complexity problems:

"*At the PHC they referred me to the neurologist, but he recommended an ineffective treatment and even so I was discharged. After that, I started attending PS-HSP, and after several visits, the hospital doctors referred me to the neurology outpatient clinic*" (P2).

"*I don't have any other type of outpatient follow-up, I just go to the PHC, although I don't like it, because I wait about 6 to 7 months for an appointment with a specialist when I need it, and also because I think that general practitioners don't monitor my health properly, they don't ask for routine tests*" (P4).

Despite feeling satisfied with the resoluteness of the PS-HSP, some patients complain that physicians do not ask for enough additional tests. There is a general idea that these tests are key proof that their pathologies are in fact being treated:

"The emergency care is good, but here they only give medicine. You don't do tests to check the real disease. You only go to the appointment, they examine you, give you medicine and send you away" (P3).

Discussion

The experiences of ED physicians and users are marked by dualities, especially with regard to care for low-risk frequent users. From the physicians' perspective, what mainly emerges is the culpability and stigmatization of frequent users, whether low-risk or not. The overall understanding is that these patients consume time and resources that should be made available to those who actually need emergency services. The feeling of discomfort of professionals in dedicating effort to the care of frequent users conflicts with CME, which recommends practicing medicine with no discrimination of any kind and provides that the target of all medical attention is the health of human beings, to the benefit of which physicians should act with the utmost zeal and to the best of their professional capacity [25].

Although physicians do not believe that dissatisfaction with such users affects the quality of their services, considering that all patients, whether their complaints are more or less serious, are treated and have their problems resolved, it is undeniable that this judgment changes the professional's attitude. While there is no immediate harm to the patient, there is a risk of damage caused by underestimating complaints and discrimination, which are practices proscribed by CME in Articles 1 and 23, respectively [20].

When analyzing the reasons for the demand of ED by frequent users, which they consider inadequate and inappropriate, healthcare professionals make a moral judgment that attributes the blame to the actual patients. These patients, according to the physicians, are employing means to access services that they can obtain in primary care. Therefore, their behavior aggravates the overcrowding of ED and hinders the provision of services to those users who need them most. Physicians also blame frequent users for ignoring the health system structure and not respecting the "rules of the game" (although the physicians themselves confess that they only grasped this structure after beginning their medical studies).

For physicians, two other factors are crucial to understanding the overuse of ED by low-risk users. First, the inappropriate use of ED is associated with the effects of the economic and social crisis and the inexistence of policies to, for example, offer services and support for homeless people. This population, as shown in the interviews, views the emergency department, available 24 hours a day, as the only safe place to spend the night and meet basic needs such as sleeping and using the restroom.

The physicians also emphasize the inability of primary healthcare to meet the demands of low-risk users. Without having their needs met at the PHC, frequent users constantly resort to EDs, viewing them as a support network for access to medical appointments, referral to specialists (which would take months following the usual flows of the primary healthcare system) and complementary tests that they consider decisive for their care.

These users also feel that at the ED they are supported, heard and assisted regarding their psycho-affective needs, which points to the need for primary healthcare to go beyond the technical care model based on medical appointments and procedures [26]. In other words, even if users understood the correct way of using the health care system, based on the regionalization and hierarchy proposed by SUS, there would still be no guarantee of timely and adequate access to PHC and specialized outpatient services [27].

There is a certain trend to overestimate and idealize primary healthcare, as if it possessed a huge store of human and material resources and was able to quickly meet all non-urgent and low-complexity demands with efficiency and quality. The reality, however, is that these services are overloaded due to the imbalance between the number of patients and healthcare staff, especially in peripheral areas or towns far from large urban centers, which concentrate leading technology and services.

Moreover, the prevailing healthcare model undervalues prevention. This model fails to encourage user autonomy and co-responsibility

related to self-care, ignoring the potential of care provided by multidisciplinary teams, including to groups of patients, rather than the mere offer of individual medical appointments and the prescription of medications and tests, incessantly required by users [28].

The study reveals, however, the flip side of the coin: the protagonism of frequent users, who create healthcare strategies that go beyond the regulations of the health system or government [28], for there are other forms of regulation that intersect with the official structures, among them the so-called "lay regulation." It is a system in which users, through their experiences and network of contacts (family, friends and neighbors), seek to minimize disease time in relation to management time (bureaucratic time that governs the different levels of health care) and medical time (care time). To this end, frequent users produce their own routes in search of health care, visiting services (sometimes in ways considered excessive and inadequate by healthcare managers and staff) where they feel supported and their demands are met [29].

Based on information acquired through practice, low-risk frequent users seek and find flexibility in the services they need. This would explain, at least from the users' perspective, the high demand for EDs, which are considered more accessible and consistent compared to PHCs. Besides, users visit the ED as a shortcut for referral to specialized services (outpatient clinics) linked to the university hospital, seeking to evade the obstacles imposed by the regulatory access system.

The study shows that physicians also have regulatory strategies of their own [29]. Often, depending on the needs of their patients and their network of interests (whether producing scientific research or providing easier access to specialized services), these professionals create informal flows to respond to demands. In these cases, they walk a fine line between their actions and the ethical-professional practice of medicine, and may end up violating the provisions of Article 20 of CME [20]: no political interests or interests of any other kind should interfere with medical conduct.

Overcrowding, poor security, poor infrastructure and lack of resources were the main problems of daily work mentioned by physicians. This situation reported by respondents violates the provisions of item III of the Fundamental Principles of CME, which recommends good working conditions for the practice of medicine [20]. Although such a scenario generates dissatisfaction among users, their stress and frustration is directed less to physicians and more to other staff with direct and extended contact with patients, especially nurses working in risk rating or administering medication.

Due to the short consultation time of frequent users, the small amount of procedures necessary in these cases and the typical shift turnover of emergency services, attending physicians and residents have less contact with these users compared to other healthcare staff. It should also be considered that the goal of frequent users, achieved with great difficulty, is to see the physician, which also contributes to overvaluing the physician-patient relationship, even if such a relationship happens precariously, in appointments that may last less than a minute, as evidenced in the survey.

The university hospital (HSP), in turn, has a peculiarity directly related to access to its ED. Its financial situation has been critical for quite some time, which forces it to raise government funds. In recent years, however, with the worsening of the economic crisis, this situation has reached a breaking point, the main consequence of which is the imminent closure of the ED. In 2017, in order to avoid discontinuing the service, a partnership was signed between the hospital's administrators and the municipal government of São Paulo to accredit the ED as an Emergency Care Center (24h UPA).

This partnership enabled HSP to continue operating thanks to additional funding. However, it also forced PS-HSP to provide care for low and medium complexity emergencies, in addition to the regular services it offered. This undeniably favors the misinterpretation of its main function, given its designation as a UPA. Some patients interviewed said they visit PS-HSP precisely because it is described and identified as a UPA. Moreover, the actual hospital staff feel confused regarding the level of specialization of the ED, as many still consider it an emergency service of high complexity.

Conclusions

The findings of this study reveal the tense relationship between physicians and low-risk frequent users of EDs. Overuse is a complex issue

that generates ethical-professional conflicts arising mainly from prejudice since, in the physicians' view, these patients visit the service excessively with minor complaints, using up resources that should be directed towards more serious cases.

By interpreting the phenomenon thus, physicians stigmatize their patients and fail to comply with ethical principles provided in CME. The overuse of ED by low-risk patients also aggravates overcrowding and shortage of resources and reveals the difficulty of other levels of care – such as primary and specialized care – to ensure efficient follow-up.

When discriminating against low-risk frequent users, physicians may fail in their duty to respect and treat their patients with maximum zeal. Paradoxically however, frequent users feel supported and well treated at the ED, reason why they often return, especially because they are not satisfied with the PHC, which does not offer, promptly and with quality, medical appointments and access to specialties. Therefore, frequent users are protagonists who produce their own care strategies outside the regular flows and insufficiencies of the health system, although this does not necessarily mean better care.

As it was carried out in a reference teaching hospital within the health system, considered to provide service excellence, the study has limitations that prevent its findings from being generalized. Future studies on the subject should research services with different features, expanding the discussion of results to include users and their families, students, residents, physicians and other healthcare staff, besides SUS managers, investigating the organization of the health system, the operation of EDs, the potential and limitations of primary care, the rules of access and the ethical issues involved.

This study stresses the universal nature of frequent users and the inappropriate use of health services at different levels of care. A better understanding of such inappropriate use may result in a broader view of comprehensive care in health systems, and emergency services are a crucial element in achieving that goal. Recognizing the problem of overuse leads to the development of perspectives, actions and policies capable of impacting the entire healthcare system.

References

1. Brasil. Ministério da Saúde. Portaria nº 1.600, de 7 de julho de 2011. Reformula a Política Nacional de Atenção às Urgências e institui a Rede de Atenção às Urgências no SUS. Diário Oficial da União [Internet]. Brasília, 8 jul 2011 [acesso 28 jan 2019]. Disponível: https://bit.ly/2UjN4Lv
2. Brasil. Ministério da Saúde. Sistema de Informações Ambulatoriais do SUS [Internet]. 2019 [acesso 28 jan 2019]. Disponível: https://bit.ly/3B5hv8S
3. Gnumbach K, Keane D, Bindman A. Primary care and public emergency department overcrowding. Am J Public Health [Internet]. 1993 [acesso 15 jan 2019];83(3):372-8. DOI: 10.2105/ajph.83.3.372
4. Massachusetts. Division of Health Care Finance and Policy. Non-emergent and preventable ed visits, FY05 [Internet]. Boston: Division of Health Care Finance and Policy; 2007 [acesso 15 jan 2019]. (Analysis in Brief; 11). Disponível: https://bit.ly/3BanYiM
5. Soril LJJ, Leggett LE, Lorenzetti DL, Noseworthy TW, Clement FM. Characteristics of frequent users of the emergency department in the general adult population: a systematic review of international healthcare systems. Health Policy [Internet]. 2016 [acesso 15 jan 2019];120(5):452-61. DOI: 10.1016/j.healthpol.2016.02.006
6. LaCalle E, Rabin E. Frequent users of emergency departments: the myths, the data, and the policy implications. Ann Emerg Med [Internet]. 2010 [acesso 15 jan 2019];56(1):42-8. DOI: 10.1016/j.annemergmed.2010.01.032
7. Kne T, Young R, Spillane L. Frequent ED users: patterns of use over time. Am J Emerg Med [Internet]. 1998 [acesso 16 jan 2019];16(7):648-52. DOI: 10.1016/s0735-6757(98)90166-8

8. Sun BC, Burstin HR, Brennan TA. Predictors and outcomes of frequent emergency department users. Acad Emerg Med [Internet]. 2003 [acesso 16 jan 2019];10(4):320-8. DOI: 10.1111/j.1553-2712.2003.tb01344.x
9. Duope MB, Palatnick W, Day S, Chateau D, Soodeen RA, Burchill C, Derksen S. Frequent users of emergency departments: developing standard definitions and defining prominent risk factors. Ann Emerg Med [Internet]. 2012 [acesso 16 jan 2019];60(1):24-32. DOI: 10.1016/j.annemergmed.2011.11.036
10. Kumar GS, Klein R. Effectiveness of case management strategies in reducing Emergency Department visits in frequent user patient populations: a systematic review. J Emerg Med [Internet]. 2013 [acesso 16 jan 2019];44(3):717-29. DOI: 10.1016/j.jemermed.2012.08.035
11. Althaus F, Paroz S, Hugli O, Ghali WA, Daeppen JB, Peytremann-Bridevaux I, Bodenmann P. Effectiveness of interventions targeting frequent users of emergency departments: a systematic review. Ann Emerg Med [Internet]. 2011 [acesso 20 jan 2019];58(1):41-52. DOI: 10.1016/j.annemergmed.2011.03.007
12. Huang JA, Tsai WC, Chen YC, Hu WH, Yang DY. Factors associated with frequent use of emergency services in a medical center. J Formos Med Assoc [Internet]. 2003 [acesso 20 jan 2019];102(4):222-8. Disponível: https://bit.ly/36LwPtb
13. Hansagi H, Olsson M, Sjöberg S, Tomson Y, Goransson S. Frequent use of the hospital emergency department is indicative of high use of other health care services. Ann Emerg Med [Internet]. 2001 [acesso 20 jan 2019];37(6):561-7. DOI: 10.1067/mem.2001.111762
14. Cook LJ, Knight S, Junkins EP Jr, Mann NC, Dean JM, Olson LM. Repeat patients to the emergency department in a statewide database. Acad Emerg Med [Internet]. 2004 [acesso 20 jan 2019];11(3):256-63. DOI: 10.1111/j.1553-2712.2004.tb02206.x
15. Hunt KA, Weber EJ, Showstack JA, Colby DC, Callaham ML. Characteristics of frequent users of emergency departments. Ann Emerg Med [Internet]. 2006 [acesso 20 jan 2019];48(1):1-8. DOI: 10.1016/j.annemergmed.2005.12.030
16. Cunha MBMRL. Hiperutilizadores das urgências: um estudo no Centro Hospitalar da Cova da Beira [dissertação] [Internet]. Covilhã: Universidade da Beira Interior; 2011 [acesso 20 jan 2019]. Disponível: https://bit.ly/2UKC0qK
17. Ovens HJ, Chan BTB. Heavy users of emergency services: a population-based review. CMAJ [Internet]. 2001 [acesso 20 jan 2019];165(8):1049-50. Disponível: https://bit.ly/3enKOda
18. Hackenschmidt A. Should access to emergency departments be limited for "frequent fliers"? J Emerg Nurs [Internet]. 2003 [acesso 20 jan 2019];29(5):486-8. DOI: 10.1016/S0099-1767(03)00284-8
19. Dick T. Frequent flyer: loneliness is an emergency, when it's yours. Emerg Med Serv [Internet]. 2004 [acesso 24 jan 2019];33(12):68. Disponível: https://bit.ly/3koD5PG
20. Conselho Federal de Medicina. Código de Ética Médica: Resolução CFM nº 2.217, de 27 de setembro de 2018, modificada pelas Resoluções CFM nº 2.222/2018 e 2.226/2019 [Internet]. Brasília: CFM; 2019 [acesso 24 jan 2019]. Disponível: https://bit.ly/3ihnCyo
21. Malone RE. Almost "like family": emergency nurses and frequent flyers. J Emerg Nurs [Internet]. 1996 [acesso 25 jan 2019];22(3):176-83. DOI: 10.1016/S0099-1767(96)80102-4
22. Smith M. How's your frequent flyer program? EMS Mag [Internet]. 2007 [acesso 25 jan 2019];36(7):25. Disponível: https://bit.ly/2U7Mjp3
23. Conselho Federal de Medicina. Resolução CFM nº 2.077/14. Dispõe sobre a normatização do funcionamento dos Serviços Hospitalares de Urgência e Emergência, bem como do dimensionamento da equipe médica e do sistema de trabalho [Internet]. Brasília: CFM; 2014 [acesso 25 jan 2019]. Disponível: https://bit.ly/3ekhu7e
24. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial da União [Internet]. Brasília, p. 59, 13 jun 2013 [acesso 15 jul 2021]. Seção 1. Disponível: https://bit.ly/3eoUjJ0
25. Conselho Federal de Medicina. 2019. p. 15.
26. Cecílio LCO, Reis AAC. Apontamentos sobre os desafios (ainda) atuais da atenção básica à saúde. Cad Saúde Pública [Internet]. 2018 [acesso 17 jan 2020];34(8):e00056917. DOI: 10.1590/0102-311X00056917

27. Reis AAC, Soter APM, Furtado LAC, Pereira SSS. Reflexões para a construção de uma regionalização viva. Ciênc Saúde Coletiva [Internet]. 2017 [acesso 17 jan 2019];22(4):1045-54. DOI: 10.1590/1413-81232017224.26552016

28. Cecílio LCO, Lacaz FAC. O trabalho em saúde. Rio de Janeiro: Cebes; 2012.

29. Cecílio LCO, Carapinheiro G, Andreazza R, Souza ALM, Andrade MGG, Santiago SM *et al*. O agir leigo e o cuidado em saúde: a produção de mapas de cuidado. Cad Saúde Pública [Internet]. 2014 [acesso 20 jan 2020];30(7):1502-14. DOI: 10.1590/0102-311X00055913

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Authors' contribution
The authors contributed equally to conceive and design the study, analyze and interpret the data, write the paper and approve the final version.

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