



The detrimental impact of social isolation on the patient presenting to the Emergency Department

Debkumar Chowdhury

Emergency Medicine Department, University Hospital Ayr, Ayr, Scotland, UK

Correspondence to: Debkumar Chowdhury. Specialty Doctor in Emergency Medicine, University Hospital Ayr, Ayr, UK.

Email: dc7740@my.bristol.ac.uk.

Abstract: There has been an increase in the number of attendances of patients to the Emergency department in the United Kingdom. This is compounded with rising costs of healthcare with limited resources. Social isolation and loneliness has significant impact on our patient's wellbeing and is becoming a health crisis. Social isolation has a direct impact on physical health including the hastening the development of vascular disease. The predominant group identified as being socially isolated tend to be the elderly population. Patients with underlying mental health problems have also been identified as being at high risk of social isolation. Interventions done at the community level may reduce the number of hospital presentations due to social isolation and reduce the rate of development of disease with improvement in general wellbeing. Improving social cohesion may reduce the impact of social isolation and loneliness experienced by a large proportion of our patients. Local government authority are placed to liaise with primary healthcare, mental health care and eventually secondary health care to tackle this underlying issue.

Keywords: Social isolation; loneliness; health

Received: 14 June 2018; Accepted: 06 August 2018; Published: 16 August 2018.

doi: 10.21037/jeccm.2018.08.05

View this article at: <http://dx.doi.org/10.21037/jeccm.2018.08.05>

Introduction

There has been a significant rise in the number of attendances of patients to the emergency department. For example, in NHS England in 2016, there was record 23.57 million attendances to A + E which represents an increase of 5.2% compared to figures in 2015 (1). There is a similar trend for NHS Scotland.

The current pressures on resources across the National Health Service (NHS) are compounded with rising cost of healthcare in all domains.

Primary health care teams are faced with some of the greatest pressures since the formation of the NHS. General practitioners are expected to or are managing patient with complex health problems, sometimes within one consultation. Social isolation has an important impact on the wellbeing of patients.

Through the article we aim to explore the impact of social isolation on the wellbeing of patients and what can potentially be done to attain a more favourable outcome.

The resources

Within the Emergency Department the focus of treatment is on the immediate presenting complaint. As we know a disease process has both physical and psychological components, we as emergency physicians tend to perform better in addressing the physical components and are often not as skilled in the treatment of the psychological aspect.

Understanding the psychological component requires a structured approach with utilization of significant resources mainly in the form of the time which is the most challenging aspect.

Social isolation and loneliness

A significant proportion of the regular attendees do suffer an element of social isolation and loneliness. Social isolation is becoming a major problem which may be contributory to a variety of health conditions largely affecting the individual's mental health. Recently an article written

by Teuton (2) highlights the prevalence and the current situation in Scotland, both loneliness and social isolation. Both social isolation and loneliness are separate entities (2) and the two terms are not interchangeable where socially connected individuals many not necessarily feel lonely and vice versa.

In the domain of social support, in the study (3) it is reported than 14% had fewer than three people they could turn to in situations of personal crisis. In terms of loneliness, there are various surveys that categorize loneliness in various classifications. In the adult population, recent studies have shown that 11% of adults feel lonely often whilst 38% feel lonely sometimes (4). The elderly and adults in their midlife are at increased risk of the above. The combination of lack of social support and loneliness may perhaps be contributory to its impact on health care.

Socially advantaged adults are at an increased risk (Scottish government unpublished analysis) of social isolation, subsequently lower levels of social support with limited involvement with the community in which they live. Although there are no defined characteristics that predispose an individual to social isolation, there is a greater prevalence of social isolation amongst those that are economically disadvantaged (5) and are in debt.

With rising costs of living and further squeezes on household income this problem is likely to worsen making individuals more disengaged with social services. This will have a knock-on effect on health care services.

Impact of loneliness on health in general

There are several studies that have studied whether loneliness has an impact on both physical and mental health. Gerst-Emerson (6) studied the impact of loneliness in the elderly population in the US. The authors found that chronic loneliness was associated with an increased number of doctor visits and not necessarily an increase in the number of hospitalisation. Molloy (7) found that among the elderly Irish population there was increased number of emergency hospitalisation in individuals with reported loneliness.

Figures from NHS England in 2016 has shown that there has been increase in the number of emergency department presentations in patients over 80 years of age (8). As previously mentioned the elderly patient populations are most likely to report loneliness as a cause for accident and emergency presentation.

Impact of social isolation on physical health

There is well documented evidence that social isolation has detrimental effects on physical health. It has been noted in epidemiological studies that social isolation has been a predictor of increased morbidity and mortality associated with cardiovascular disease (9). It has also been noted that in the presence of cardiovascular risk factors, social isolation can lead to accelerated atherosclerosis and double the risk of major cardiovascular events (9,10).

There is strong relationship between social isolation and the hypothalamic pituitary axis (HPA) with increased blood levels of catecholamines (11). The HPA is responsible for the production of glucocorticoids, chronically raised levels of glucocorticoids lead to glucocorticoid resistance. This glucocorticoid resistance (12) is implicated in the development of atherosclerosis and diabetes amongst other associate conditions, thereby hastening the development of coronary heart disease.

In the UK media over the past couple of years there has been greater discussion to address the issue of loneliness to reduce the impact on physical health. It reported studies carried out at University of York (13) showed a 30 percent increased risk of cardiovascular events however the data will need to be studied in detail to assess if this has a causal relationship.

Possible Interventions

As we have seen though the article that there is a significant impact of social isolation on a person's wellbeing, the problem is multifactorial. This can be addressed at various stages from the community to the hospital setting as this could possibly lead to wellbeing and fewer emergency presentations to the hospital.

In the community, social clubs are a potential solution whereby individuals from all age groups meet on a regular basis with programmed activities, this would invariably promote social cohesion. Liaising with social services, primary health care can work together to improve the patient's mental health.

With the help of mental health, the primary health care team can regularly review the patients that they consider as being high risk of hospital admission due to chronic health problems and chronic isolation. Although there are various community support groups available to the general public, greater awareness of the availability of these community-based groups can help.

In the emergency department setting, patients presenting on a regular basis over a period of time can be studied with regards to the primary presenting complaint with an emphasis on the social circumstances. Measures including a joint meeting of multidisciplinary team can address the immediate medical concerns as well measures relating to social isolation.

Conclusions

Social isolation and loneliness are both becoming major health crises and requires a concerted effort from health care providers to address this issue. Local government authorities (LGA) are placed to address this from a community perspective and potentially relieve the burden on emergency care workers. As mentioned in our article that chronic isolation leads hasten the development of disease states, timely interventions can potentially tackle this problem. Improved social cohesion is another potential solution that contributes to the wellbeing of our patients. We hope with the application of the aforementioned measures this can benefit our patients and improve their wellbeing.

Acknowledgements

None.

Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

References

1. A&E Attendances and Emergency Admissions. Available online: <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/>
2. Teuton J. Social isolation and loneliness in Scotland: a review of prevalence and trends. Edinburgh: NHS Health Scotland; 2018.
3. Duncan D, Bell R. Local Action on Health Inequalities: Reducing Social Isolation Across the Lifecourse – Practice Resource. London: Public Health England; 2015.
4. Griffin J. The Lonely Society. London: The Mental Health Foundations; 2010.
5. Kearns A, Whitely E, Tannahill C, et al. Loneliness, social relations and health and well-being in deprived communities. *Psychol Health Med* 2015;20:332-44
6. Gerst-Emerson K, Jayawardhana J. Loneliness as a Public Health Issue: The Impact of Loneliness on Health Care Utilization Among Older Adults. *Am J Public Health* 2015;105:1013-9.
7. Molloy GJ, McGee HM, O'Neill D, et al. Loneliness and emergency and planned hospitalizations in a community sample of older adults. *J Am Geriatr Soc* 2010;58:1538-41.
8. Rosengren A, Hawken S, Ounpuu S, et al. Association of psychosocial risk factors with risk of acute myocardial infarction in 11 119 cases and 13 648 controls from 52 countries (the INTERHEART study): case-control study. *Lancet* 2004;364:953-62.
9. White CN, VanderDrift LE, Heffernan KS. Social isolation, cognitive decline, and cardiovascular disease risk. *Curr Opin Psychol* 2015;5:18-23.
10. Menendez-Villalva C, Gamarra-Mondelo MT, Alonso-Fachado A, et al. Social network, presence of cardiovascular events and mortality in hypertensive patients. *J Hum Hypertens* 2015;29:417-23.
11. Hawkey LC, Cole SW, Capitanio JP, et al. Effects of social isolation on glucocorticoid regulation in social mammals. *Horm Behav* 2012;62:314-23.
12. Cacioppo JT, Cacioppo S, Capitanio JP, et al. The neuroendocrinology of social isolation. *Annu Rev Psychol* 2015;66:733-67.
13. Loneliness is public health problem which raises risk of stroke and heart disease. Available online: <https://www.telegraph.co.uk/science/2016/04/19/loneliness-is-public-health-problem-which-raises-risk-of-stroke/>

doi: 10.21037/jeccm.2018.08.05

Cite this article as: Chowdhury D. The detrimental impact of social isolation on the patient presenting to the Emergency Department. *J Emerg Crit Care Med* 2018;2:67.