



Development of consultation-liaison psychiatry as dynamic key for decreasing legal cases

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Abstract

The incidence of medical slipups in primary care is not rare and the likelihood of faults producing grave harm is great. 'Misdiagnosis' means the improper diagnosis of a morbid condition. On the other hand, while patient's safety is vital in patient care, there is a shortage of studies on medical errors in primary care settings. Anyhow, the most common errors usually are those related to delayed or missed diagnoses, followed by management inaccuracies. Whereas about one percent of hospital admissions result in an adverse event due to negligence, faults are probably much more common, because these studies detect only errors that led to computable adverse events occurring soon after the slips. Differences in healthcare provider teaching and practice, blurred lines of power of doctors, nurses, and other care providers, poor communiqué, incoherent recording systems, overestimation of insufficient data, failure to recognize the frequency and significance of medical errors, sleep deficiency and night shifts, unfamiliar settings, doctor's depression, fatigue, and burnout, diverse patients, and, lastly, time pressures have been accounted as important bases of medical fault. So, careful medical checkup, based on acceptable clinical abilities and knowledge, is required for analysis of medical problems, especially in view of therapeutic golden-time. Moreover, supplementary and all-inclusive instructive courses, for upgrading the skills and knowledge of medical students in the field of 'somatic symptom disorder' and consultation-liaison psychiatry conceivably is valuable for diminishing misdiagnosis or negligence. Current medical teaching and tryout can not discount the vital role of liaison-psychiatry in present-day clinical practice, since the mutual connection between mind and body is more complex than what was thought before in primary care setting.

Keywords: consultation, psychiatry, dynamic, decreasing, medical

Introduction

Medical malpractice law is that segment of tort law that addresses harm caused by health care professionals^[1]. It relies on the basic principles of tort law supplemented by special rules that address issues such as statutes of limitation, standard of care, and damage caps to mention a few^[2]. The expectations of malpractice law, as written' are modest. Medical malpractice law does not expect physicians to cure all their patients. Nor does it expect that any doctor need perform at an above-average level. Rather, medical malpractice law expects only that doctors will not intentionally (i.e. purposefully) or negligently (i.e., unreasonably) harm their patients^[3]. Most patients injured by substandard medical care either do not realize the cause, choose not to be vengeful, or just let it go. Most medical malpractice does not result in a tort claim^[4]. The quality of the doctor-patient relationship plays a major role in this decision. Bad outcomes combined with bad feelings increase the likelihood of litigation seeking compensation^[5]. Good doctor patient relationship is one of the best ways to prevent an adverse outcome being transformed into a lawsuit^[6]. As reflected in the claims made against the liability insurer for American Psychiatric Association (APA) members' the categories of errors claimed to have caused harm were dominated by: 1) incorrect treatment (36%), 2) attempted or completed suicide (17%), 3) medication error or drug reaction (14%), 4) incorrect diagnosis (8%), 5) unnecessary commitment (4%), 6) improper supervision (4%), 7) breach of confidentiality (3%), and 8) undue familiarity (3%)^[7]. Making a diagnosis is only the

beginning of any assessment, whether clinical or forensic^[8]. In clinical practice, more information must be gathered to understand the patient's psychological state and to devise and implement an appropriate treatment plan^[9]. Evaluation of the relevant functional impairment or changes resulting from the mental disorder should be specific and explicit and, where appropriate, should include a dimensional model of description^[10]. While sub-threshold diagnoses illustrate the significant differences between the application of standard categorical diagnosis and that of dimensional diagnosis in litigation, dimensional diagnosis permits consideration of sub-syndromal conditions and their associated impairments along a continuum of symptom severity rather than on all-or-none categorical terms^[11]. On the other hand, and in the realm of psychiatry, the law's reliance on "official" DSM diagnosis, however, makes the use of a dimensional model problematic^[12]. Principally, there is a lack of studies regarding medical faults in primary care settings. Many features of primary care such as early presentation of indistinguishable disease^[13], different patient population and physiognomies, and the diversity of caregivers and sites of care render the study of medical slips to be complex^[14]. This is further complicated by the different error reporting techniques, descriptions and categorizations of varieties of medical slips used by researchers^[15]. It has been estimated that around 10-15 percent of doctor's diagnoses are wrong^[16]. The current data indicates that medical mistakes kill yearly around 180 000

individuals in hospitals. If these implications are exact, the present health care system can be accounted, as well, as a community health threat [17], and the existing scheme of medical negligence or misconduct does a poor job as regards the wellbeing of patients [18]. All of the following examples, which have been chosen in this regard, have been diagnosed initially and unreasonably, by at least one neurologist or internist as conversion disorder and referred to psychiatric facilities. So, most of them have been turned finally into a forensic issue. Names, dates and locations have been omitted totally to keep the confidentiality of the cases.

Clinical Examples

i. A thirty-seven years old male technician had been referred to a consultant psychiatrist, due to depression, anxiety, sleep problems, breathlessness and slight weight loss, in the last few months. Although annoying environmental and occupational stresses were manifest in his past and present history, investigation regarding a sudden pleural effusion in him resulted to no reasonable cause or diagnosis. Because the patient did not appear, at all, to be anxious about that and based on the aforementioned stressors and/or symptoms, Fluoxetine (20-40 mg daily) had been prescribed for him with a probable diagnosis of mixed anxiety-depressive disorder. After a few weeks and despite acceptable amelioration of psychological symptoms and the subjective sense of wellbeing, however, losing weight had not been stopped, and since its degree or rapidity was more the SSRI's recognized adverse effect (as a weight reducer), thus he was referred once more to a pulmonary center for a new consultation and examination. After new clinical examination, chest radiography, computed tomography scan of the chest and plural biopsy, the patient was diagnosed as a case of Mesothelioma, and accordingly had been referred to a general hospital.

ii. A thirty-six years old obsessive male worker with complains of depression, anxiety, lack of energy, loss of appetite, sleep problems, and trivial physical weakness and negligible weight loss during the last few months, had been referred for a psychiatric consultation. There was obvious history of bothersome professional distresses and multiple family clashes in the past few months, in advance of beginning of the aforementioned sickness. The routine laboratory and physical examination by an internist, although suitable, was indecisive. So, he was prescribed Clomipramine (50-75 mg/day) for a plausible diagnosis of mixed anxiety-depressive disorder. But despite reasonable improvement of symptoms mild weakness and lack of energy did not respond similarly. Hence, after a few weeks he had been referred for an extra psychiatric consultation, and this time after a new physical examination, due to existence of an asymmetrical but true weakness and aching in the upper and lower limbs, absence of rational ideations of depression and to some extent chronological antecedence of somatic symptoms as against psychiatric symptoms, he was referred to a rheumatologic service for a new inspection. After clinical evaluation, chest radiography, computed tomography scan of the chest, and total body imaging (Bone scanning), the primary diagnosis of Metastatic Bone Tumor had been identified for him. In view of that, the aforesaid weakness of the limbs could be due to systemic symptoms of malaise, anorexia, cachexia, weight loss and bone

pain, due to metastatic extra-pulmonary manifestations of small cell (oat cell) carcinoma of the lung, which was his primary suspicious cause of malignancy.

iii. A thirty-eight years old male patient had been referred to a psychiatric hospital due to suspiciousness, aggressiveness, movement problems and disturbed sleep. When he was eighteen years old, he had been identified as a case of bipolar disorder due to comparable profile of symptoms, except than movement problems, which had been presented during the last two years. Throughout the last decades a number of medications, like conventional antipsychotics and mood stabilizers had been prescribed for him. Last year he had been hospitalized in another psychiatric hospital due to his increasing movement difficulties, which had been allocated at that time to 'antipsychotic induced movement disorder' by a consultant neurologist, and so had been tried to be managed dopaminergic drugs like Levodopa – Carbidopa (Sinemet) (750-1000 milligram per day), Amantadine (200 milligrams per day), and also Trihexyphenidil (6 milligrams per day). But lack of efficiency and consequent worsening of the problem was evident. Upon the new admission and after a new clinical checkup a mild to moderate instable rigidity and tremor, in the upper and lower limbs, was palpable, which had caused clumsiness and unsteady gait, correspondingly. Also, some problems regarding swallowing solid foods and fluent talking had been displayed, in addition to a fixed stare, smiling expression and drooling. So, another neurologic consultation had been requested by the psychiatrist. The earlier 'antipsychotic induced movement disorder' had been confirmed again by the second consultant neurologist, who, also, proposed 'Tardive Parkinsonism' as a probable differential diagnosis. Due to lack of efficacy of the aforesaid managements, in spite of discontinuation of prescribed antipsychotic (Quetiapine 75 milligram per day), Electroconvulsive therapy (ECT) was started, which terminated after 5 sessions, due to mild fever and absence of remarkable result. Nevertheless, due to refractoriness of movement problems against the suggested managements, their unstable progress and perseverance in spite of cessation of neuroleptics, and a long gap (around eighteen years) between the prescription of antipsychotics and emergence of movement symptoms, an additional neurologic consultation had been requested for the patient. This time, a suspicious level of serum ceruloplasmin level (23 mg/dl), low serum level of copper (76 microgram/dl), and increased urinary copper excretion (153 microgram Cu in 24 h) had been found. MRI scan, as well, had revealed decreased signal intensity (hypo-density) in the Striatum and Superior Colliculi, and increased signal intensity in the Midbrain Tegmentum (except for Red Nucleus) and in the Lateral Substantia Nigra (Reticular Zone). So, diagnosis of Wilson's disease (Hepato-Lenticular Degeneration) had been proposed for the patient and he had been transferred to a neurologic facility for a more complete survey and treatment.

Discussion

In Forensic medicine medical malpractice Generally has been defined as 'the failure to exercise the degree of skill in diagnosis or treatment that reasonably can be expected from one licensed and holding oneself out as a physician under the circumstances of a particular case' that directly causes harm to a patient [19]. Forensic medicine, forensic pathology, and legal medicine are

terms used interchangeably throughout the world ^[20]. Sub-threshold conditions in medicine and psychiatry are common and often cause significant impairments. For example, in medicine, a patient may have some, but not all, of the clinical symptoms necessary for a clinician to make a diagnosis of migraine headache but is, nonetheless, debilitated by the pain ^[21]. The threshold for treatment intervention generally is severity of symptoms or impairment in function, not whether every diagnostic criterion has been met. If treatment does differ, the clinician has the option over time to change treatment recommendations in response to the evolution or remission of the patient's disorder ^[22]. Thus, diagnosis may direct evaluators toward closer examination of the range of symptoms associated with that diagnosis and with the functional impairments and specific capacities that are legally relevant. Similarly, the use of diagnosis can limit unsupported conclusions regarding an individual's past mental status or degree of functional impairment ^[23]. Many of the problems regarding misdiagnosis in psychiatry are in the realm of neuropsychiatry. Forensic neuropsychiatric competency may be optimally accomplished by undertaking formal training in both forensic psychiatry and neuropsychiatry. However, many psychiatrists may not have those options ^[11]. Training in the area of neuropsychological testing is an area of psychiatric education in great need of attention that is likely to become even more important as progress in the neurosciences continues to influence the nature of psychiatric practice ^[12]. Then again, the vast majority of medical errors result from faulty systems and poorly designed processes versus poor practices or incompetent practitioners ^[24]. Practitioner risk factors include fatigue ^[25], depression and burnout ^[13]. Factors related to the clinical setting include diverse patients, unfamiliar settings, time pressures, and increased patient to nurse staffing ratio increases ^[26, 27]. Current medical training and rehearsal can not overlook the vital role of liaison psychiatry and place of psychiatry in contemporary clinical practice, since the reciprocal connection between mind and body is more complex than what was thought before in primary care setting ^[27, 28].

Conclusion

Consideration of past and present history of medical or mental problems and then meticulous clinical analysis of different stages of the present complaint, together with active attention to drug history are maneuvers that may reduce efficiently malpractice, misdiagnosis, negligence and forensic issues. So, a rigorous work is indispensable for enhancement of patient safety in primary care setting. Upgrading the instructive curriculums in medical schools, like better course in psychological medicine and neuropsychiatry, or guideline modifications, and continuous post-graduation education and system modifications are among the manageable pedagogic objectives.

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