MALPRACTICE COUNSEL

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Failure to Properly Assess Patient With Depression

A 35-year-old Ohio man was arrested for DUI. Because he exhibited suicidal tendencies and signs of depression, he was transported to an emergency department, where he was evaluated by three emergency physicians. He was then discharged to a facility for individuals who need to sleep off the effects of alcohol after drinking too much. He was left at the facility without any paperwork or any indications that he was experiencing depression or suicidal ideation. Within minutes of his being dropped off, he hanged himself in a bathroom.

The plaintiff alleged negligence in the three emergency physicians' assessment and treatment of the decedent's depression, suicidal ideation, and comorbid conditions; according to the plaintiff, the defendants failed to provide proper dosing and monitoring of the effectiveness of the antidepressant medication they prescribed. Additionally, the plaintiff claimed that the defendants failed to obtain and document an adequate health history.

The defendants claimed that the decedent's injuries were self-inflicted and that proper treatment was provided. The defendants contended that the decedent denied a desire to commit suicide and said he wanted to receive treatment for alcohol abuse.

Outcome

According to a published account, a defense verdict was returned.

Comment

The number of psychiatric patients who present to the emergency department for care continues to increase across the country. The reasons for this are myriad: decreasing numbers of inpatient psychiatric beds; lack of appropriate community resources; and decreasing reimbursement for psychiatric services, to name a few. When a patient presents to the emergency department with a psychiatric complaint, the first responsibility of the emergency physician is to clear the patient medically. This may involve simply completing a good history and physical exam; sometimes laboratory or imaging studies are also required. Once the patient is medically cleared, the emergency physician must then determine whether the patient is a danger to himself/herself or to others. If the answer is "yes" to either of these conditions, the patient cannot be discharged.

The presentation of an intoxicated, depressed patient is common in the emergency department. Because alcohol is a depressant, many patients will voice complaints of depression and suicidal thoughts while under the influence of alcohol. Frequently, however, once they are allowed to sober up, they no longer feel suicidal and can be managed for depression as an outpatient.

The other complicating factor in this case is the fact the patient presented in police custody. It is not uncommon for a recently arrested patient to complain of a medical or psychiatric problem for secondary gain (ie, to avoid arrest or going to jail). These patients can make it exceedingly problematic for the emergency physician to tease out what is real and what is not.

Unfortunately, this patient, in retrospect, was truly suicidal. Despite the best efforts of everyone involved, it can be very difficult to prevent patients from hurting themselves if they are determined to do so. **FLC**

Failure to Diagnose Appendicitis

A 25-year-old man with right lower quadrant pain sought care at an urgent care facility. The urgent care physician suspected appendicitis and ordered blood work, urinalysis, and imaging studies. The patient agreed to undergo the blood work and urinalysis, but declined the imaging studies. Because of good results on the blood work and urinalysis, the physician placed appendicitis lower on the differential diagnosis list. The patient was told to go to an emergency department if his symptoms persisted.

Two days later, he awoke with significant pain and sought care at a Virginia emergency department. The man was diagnosed with a ruptured appendix. An appendectomy was performed, and he required an extended hospital stay.

The man claimed that the defendant urgent care physician should have diagnosed his appendicitis on the basis of the right lower quadrant pain alone and should have referred him immediately to an emergency department.

The defendant maintained that a clinical diagnosis of appendicitis cannot be made on the basis of right lower quadrant pain alone.

Outcome

According to a published account, a defense verdict was returned.

Comment

This case illustrates two important points. First, the diagnosis of appendicitis can be made clinically, but not by right lower quadrant pain alone. The three signs and symptoms with the highest likelihood ratio for appendicitis are: right lower quadrant pain and tenderness; abdominal rigidity; and radiation of pain from the periumbilical area to the right lower quadrant. While many other signs and symptoms are associated with appendicitis (ie, nausea and vomiting, anorexia, fever, etc), none is significantly sensitive or specific to be of much help. If a patient presents with the classic signs and symptoms of appendicitis, no imaging study is required; Surgery need only be consulted. However, if the diagnosis is less clear (as in the majority of cases), then a CT scan should be ordered (but for pediatric or pregnant patients, graded compression ultrasound is the initial study of choice). We do not have enough information to determine whether it was possible to make a clinical diagnosis of appendicitis in this patient.

The second point involves the role of patient responsibility in their care. The physician did want to obtain an imaging study (we do not know what type; plain radiographs would not be helpful). While it is fine for a patient to refuse a particular test or study, they must realize that by doing so, they may be limiting the ability of their physician to make the correct diagnosis. If a patient refuses a study, the physician should consider whether there is an acceptable alternative. If not, the potential consequences of foregoing the test should be communicated, and reasons to seek additional medical care (as were given to this patient) should be provided. **FLC**

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