

## Caring and respect can reduce malpractice risk

As an attorney with 2 decades of experience representing plaintiffs in suits against mental health facilities and professionals, I can say that Dr. Douglas Mossman is right on target about the drawbacks of defensive medicine (“Defensive medicine: Can it increase your malpractice risk?” Malpractice Rx, CURRENT PSYCHIATRY, December 2009, p. 86-88). This is particularly true in psychiatry, where an alliance and trusting relationship between doctor and patient are crucial. It’s hard for a patient to perceive a clinician’s empathy and concern if the clinician’s actions amount to treating the patient as a potential litigant or adversary.

The psychiatrists I admire and respect focus on caring and empathy, understanding the patient’s needs, and respectful treatment, and these professionals tend not to get sued. On the rare occasions that these psychiatrists initiate involuntary interventions—because these interventions often do disrupt therapeutic relationships, as Dr. Mossman says—they are straightforward and honest with the patient about their reasons (caring and concern, not fear of litigation) and apologize for the distress they are causing. Patients can tell that a doctor sincerely cares about and respects them, and they forgive a lot when they perceive that attitude. Patients hate being coerced and threatened with the psychiatrist’s power to involuntarily commit hanging over every interaction if the patient is not “compliant.”

I have seen psychiatrists negotiate with their patients brilliantly and



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respectfully, and, as Dr. Mossman suggests, patients generally don’t sue these doctors. The doctors who get sued often are those who are afraid to apologize or admit error, are controlling and disrespectful, really aren’t listening, and care more about following institutional rules than about their patients. I have never represented a patient in a lawsuit who would not have been satisfied with a sincere apology, even after pretty terrible events. These patients sought legal help only after being rebuffed or ignored when they sought to complain or protest their treatment.

Obviously, there are exceptions to all generalizations, but my observation is the product of 20 years of this work.

Susan Stefan, JD  
Center for Public Representation  
Newton, MA

## Consider cost and efficacy

After reading “A case of sudden psychosis” (Cases That Test Your Skills, CURRENT PSYCHIATRY, November 2009, p. 62-72), I wondered why the

authors administered ziprasidone IM and olanzapine IM when haloperidol and lorazepam IM would have been effective for a lower cost. I have seen clinicians use ziprasidone and lorazepam instead of haloperidol and lorazepam for acute agitation, but there is little evidence that it is better.

In a naturalistic study, Preval et al<sup>1</sup> reported that ziprasidone is as effective as haloperidol plus lorazepam, and observed that ziprasidone patients wake up sooner and therefore can be triaged more quickly, but this statement may be premature.

I think there are few, if any, reasons to use ziprasidone or olanzapine IM instead of haloperidol, 5 mg, and lorazepam IM, 2 mg every 6 hours as needed, in an emergency setting. I am curious if anyone has a different opinion based on scientific evidence.

Corey Yilmaz, MD  
Southwest Behavioral Health Services  
Tolleson, AZ

### Reference

1. Preval H, Klotz SG, Southard R, et al. Rapid-acting IM ziprasidone in a psychiatric emergency service: a naturalistic study. Gen Hosp Psychiatry. 2005;27(2):140-144.

### The authors respond

At 2 of our local hospital pharmacies, the cost of haloperidol combined with lorazepam is approximately \$9 less than ziprasidone per administration: \$1.51 vs \$10.29 and \$3.08 vs \$12.23, respectively. Certainly, imagining this cost difference on a larger scale highlights the importance of cost efficiency, but herein enters the fear of sacrificing optimal patient care for the sake of budgeting.

With respect to efficacy, ziprasidone IM has been found to be superior to haloperidol IM in the acute setting.<sup>1</sup> In a recent

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study of severe agitation in adolescent patients, ziprasidone monotherapy was as effective as haloperidol plus lorazepam.<sup>2</sup> Regarding side effects, ziprasidone has demonstrated greater safety in terms of extrapyramidal symptoms and akathisia when objectively measured with the Extrapyramidal Symptom Rating Scale and Barnes Akathisia Scale.<sup>3</sup> Change in QTc generally was comparable between the 2 medications; however, a more substantial change with haloperidol was seen at 24 hours, given its longer half-life.

Finally, as Dr. Yilmaz mentions, less sedation with ziprasidone vs haloperidol is a marked advantage in the emergency room, which is where our patient initially received these medications. In the case of our previously healthy patient presenting with new-onset psychiatric symptoms, return to a lucid state was important to elucidate an accurate diagnosis and implement appropriate treatment promptly.

**Cathy Southammakosane, MD**

Pediatrics/psychiatry/child psychiatry resident  
Cincinnati Children's Hospital Medical Center

**Anthony Cavalieri, MD**

General psychiatry resident

**Christopher White, MD, JD, FCLM**

Assistant professor of psychiatry and family medicine  
University of Cincinnati  
Cincinnati, OH

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**Opioid use could cause mania**

In "A mysterious case of mania" (Cases That Test Your Skills, *CURRENT PSY-*

*CHIATRY*, October 2009, p. 48-59), we concur with the authors' diagnosis of a substance-induced mood disorder (secondary mania) in Mrs. P, who presented with an abrupt onset of a mania with no known history of a similar episode. The authors list substances that could have provoked this patient's mania: antidepressants, phenylephrine in an over-the-counter medication, and sudden withdrawal of methadone. We propose another possible contributing factor: the direct mood-elevating effect of opioids. We previously reported this clinically important potential adverse effect in a study of patients with bipolar disorder.<sup>1</sup>

A clue to preexisting bipolar disorder in Mrs. P is that she had been taking sertraline and desipramine prescribed for "unknown reasons." Mrs. P reportedly accidentally overdosed on maintenance opioid pain medications (methadone, hydrocodone, and tramadol) 2 weeks before the onset of her manic episode. This overdose probably caused a sudden increase in opioid blood levels, which could have caused the manic episode. Psychiatrists should be alert for this possible reaction in patients with bipolar disorder who take opioids prescribed by other physicians.

**Charles B. Schaffer, MD**

Clinical professor of psychiatry

**Thomas E. Nordahl, MD, PhD**

Professor of psychiatry

University of California Davis School of Medicine  
Sacramento, CA

**Reference**

1. Schaffer C, Nordahl T, Schaffer L, et al. Mood-elevating effects of opioid analgesics in patients with bipolar disorder. *J Neuropsychiatry Clin Neurosci.* 2007;19(4):449-452.

**The authors respond**

*The question of whether opioid pain medications could induce mania is not without some controversy. A literature search*

*revealed only 2 case reports on tramadol-induced mania.<sup>1,2</sup> Our case presentation discussed a manic syndrome that was most likely caused by multiple substances. With Mrs. P's complex polypharmacy, we were unable to pinpoint the exact cause of her symptoms. If we hypothesize that she had mania induced by tramadol, we still have to include other factors that were present on the day of admission, such as antidepressants, phenylephrine in an over-the-counter medicine, and sudden withdrawal of methadone.*

*Gold et al<sup>1</sup> present data that support the hypothesis that opioids have antidepressant, antimanic, and antipanic effects. Interestingly, case reports suggest that opioids may have an antidepressant effect in patients with affective disorders.<sup>1,2</sup> A few case reports have noted hypomanic or manic symptoms associated with opioid use.<sup>3-5</sup> Specific opioids suggested to have this property include the  $\mu$ -opioid agonists tramadol and codeine and the partial agonist buprenorphine.*

*To our knowledge, there are no case reports commenting on possible manic effects from the use of oxycodone, hydrocodone, methadone, or morphine. Sleep loss also may trigger mania and plays an important role in the condition.*

**Magdalena Romanowicz, MD**

Psychiatry resident

**Timothy W. Lineberry, MD**

Assistant professor

Mayo Clinic

Rochester, MN

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