Psych Admissions for Kids Doubled in 1996-2007

BY MITCHEL L. ZOLER

FROM THE ANNUAL MEETING OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PYSCHIATRY

NEW YORK – During the period 1996-2007, hospitalization rates for psychiatric disorders among American children aged 5-13 years rose dramatically, nearly doubling during that period.

Concurrently, psychiatric hospitalizations for U.S. adolescents (aged 14-19 years) also rose substantially, by 42%. During the same period, psychiatric hospitalizations rose modestly (by 8%) for adults aged 20-64 years, whereas psychiatric hospitalizations for Americans aged 65 or older fell dramatically, Joseph C. Blader, Ph.D., said while presenting a poster at the meeting.

The reasons behind these changes and their implications remain unclear, said Dr. Blader of the State University of New York at Stony Brook, but the shifts in hospitalization rates – especially the larger such shifts among children and adolescents – raise concerns that demand further analysis.

"It's not a good thing" that substantially more children and adolescents require hospitalization for psychiatric diagnoses, Dr. Blader said in an interview. The shifts "represent a significant development in mental health treatment in the United States," he said in the poster.

The data Dr. Blader analyzed came from the Centers for Disease Control and Prevention's National Hospital Discharge Survey and also showed that in 1996-2007, payment for the psychiatric hospitalizations underwent a significant shift away from private insurance coverage and toward an increased share of the hospitalizations paid for by government agencies, most typically Medicaid.

According to Dr. Blader, the questions now are, Does the rise in hospitalizations result from "problems in the level of services provided by community care," and has "more cost shifting" of patients into Medicaid from private insurance led to or resulted from the rise in hospitalizations?

"Beneficiaries of publicly funded inpatient care may have become disproportionately vulnerable to psychiatric emergencies," or perhaps the effect "indicates better outpatient care among the privately insured," he said in his poster. "In many states, privately insured patients with extended psychiatric hospitalizations become eligible for Medicaid coverage."

He noted that during the period studied, the psychiatric field made a diagnostic shift: More children who engage in injurious behavior are being labeled with bipolar disorder. He also speculated that the increasingly complex polypharmacy treatment of psychiatric patients, including children, might be a factor boosting hospitalizations.

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DR. BLADER

In 1996-2007, the rate of hospitalization for a primary diagnosis of a psychiatric disorder in children aged 5-13 years rose from 15.6 per 10,000 U.S. residents to 28.3. In adolescents aged 14-19 years, the rate rose from 68.4 per 10,000 to 96.9, while in those aged 20-64 years, the rate increased from 92.1 per 10,000 to 99.1. All of the changes were statistically significant. Dr. Blader's poster did not report rates for patients aged 65 or older, but in his analysis, this number fell "dramatically" from 1996 to 2007, he said.

During the period studied, private insurance coverage of these psychiatric hospitalizations among children fell from 36% of cases to 23%, while government-based sources of payment rose from 63% of cases to 71%. Among adolescents, private payment fell from 52% of cases to 22% while government coverage rose from 44% to 62%. Among adults, private coverage fell from 36% to 23%, while government coverage was flat, at 58% in 1996 and 59% in 2007. ■

VITALS

Major Finding: In 1996-2007, hospitalizations for primary psychiatric diagnoses in children aged 5-13 years jumped from 15.6 per 10,000 population to 28.3. In the same period, hospitalization rates rose by 42% in adolescents aged 14-19 and 8% for adults aged 20-64.

Data Source: Representative, nationwide database maintained by the Centers for Disease Control and Prevention.

Disclosures: Dr. Blader had no disclosures.

LAW & MEDICINE

Contributory Negligence

Question: Patient underwent uneventful varicocelectomy and was warned not to get out of bed. However, instead of using the bedpan as instructed, he walked to the bathroom, fell off the toilet seat, and injured his groin. The doctor did not examine him until several days later and found a large scrotal hematoma. The patient eventually developed testicular atrophy. Expert testimony apportioned 40% of the damage to the fall, and 60% to the doctor's delay in diagnosis and evacuating the hematoma. In a lawsuit for medical malpractice, which of the following choices is best?

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A. This is a case of contributory negligence.

B. This is a case of assumption of risk.

C. Damages are to be reduced by 40%.

D. A and B are correct.

E. A and C are correct.

Answer: E. To win a malpractice lawsuit, the plaintiff must prove, with a preponderance of evidence, the four elements of negligence: duty, breach, causation, and damages. However, the law allows for affirmative defenses that can defeat, in whole or in part, a malpractice action even if the evidence satisfies all four elements. One of these affirmative defenses is contributory negligence, which requires the claimant to be partly at fault. At common law, any degree of negligence on the part of the plaintiff constituted a complete defense. This was felt to be overly harsh to the victim who may have been only slightly careless, so the law gradually changed to where the amount of damages is proportionately reduced by the percentage of plaintiff's negligence.

This is called contributory or more accurately, comparative negligence, and many states have enacted statutes covering this defense, e.g., Florida's §768.819 (4) (a), Fla. Stat. (1993). In the above hypothetical case, the 40% negligent plaintiff will be able to recover only 60% damages. In some states, if the plaintiff is more than 50% negligent, that is, fault greater than the defendant's, then no recovery is allowed. In a few jurisdictions (five at last count), strict contributory rather than comparative negligence still remains the law.

Assumption of risk is a complete bar to recovery and requires both full knowledge of risk and manifest consent on the part of the claimant. The facts in this case are insufficient to sustain this defense. Assumption of risk is commonly invoked as a defense in sports injuries, but rarely in medical malpractice.

In order for the defense to successfully plead contributory negligence, there must be a showing that the plaintiff had acted without reasonable regard for his or her own safety. In a Florida case of thrombophlebitis that developed following a fracture, the patient omitted her physical therapy, failed to elevate her legs, continued smoking, and remained inactive in bed for several days, all against medical advice. The jury found the claimant 45% comparatively negligent, which was upheld on appeal.

However, the defense of contributory negligence is not always successful. In *Weil v. Seltzer*, the patient was treated for many years with steroids that his doctor represented to be antihistamines. He developed steroid complications, and died suddenly at age 54 years from a saddle block pulmonary embolus that contained bone marrow fragments, thought to have originated from steroid-induced osteoporotic bones. The court dismissed the defense of contributory negligence, as there was insufficient evidence to show that the patient knew he was taking steroids and could not have reasonably informed his other treating physicians of this fact.

In a case of missed diagnosis of popliteal artery laceration, a court refused to instruct the jury regarding contributory negligence where the patient did not receive specific instructions regarding an earlier return to the emergency room and it was questionable whether an earlier return would have made a difference. And in *Gray v. Brock*, the Missouri Court of Appeals reversed a lower court's judgment of 82% con-

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tributory negligence after finding no evidence that the plaintiff had actual knowledge that his diabetes was out of control or that it contributed to his death.

Contributory negligence, which speaks to plaintiff fault, should be differentiated from "loss of a chance," where defendant's act or omission deprived plaintiff of an opportunity of avoiding or reducing resultant injury. The former is a defense argument, and the latter, a plaintiff argument. Contributory negligence translates into a proportionate reduction in damages. On the other hand, some jurisdictions require the underlying risk in "loss of a chance" cases to be over 50% to begin with, and/or may require the lost chance to itself increase the risk by greater than 50% before allowing any recovery.

Claimant's negligence must be a cause of, not merely incidental to, the sustained injury. For example, a negligent rider on a traxcavator who was injured after being struck from behind by the careless driver of a dumper truck was found to be contributorily negligent. However, the court pointed out that contributory negligence would not have been a defense had he been injured instead by an incidental stray shot from a negligent sportsman.

In a recent Tennessee case, a patient sustained a cardiac arrest because of negligent monitoring during a CT scan. His antecedent negligence stemmed from the fact that he had alcohol in his blood upon arrival at the hospital following a car accident. The state Supreme Court found the hospital 100% liable and disallowed the jury's assessment of 30% comparative fault, holding that "principles of comparative fault did not apply such as to allow fault to be assessed to patient, and thus jury should not have been allowed to consider patient's antecedent negligence in assessing fault." ■

DR. TAN *is professor of medicine and former adjunct professor of law at the University of Hawaii, Honolulu. This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is adapted from the author's book, "Medical Malpractice: Understanding the Law, Managing the Risk." For more information, readers may contact the author at siang@hawaii.edu.*