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Psychiatrists & Psychologists: Failure to Diagnose

When is a medical condition masquerading as a behavioral health issue? Or conversely, how does one discern when mental health symptoms are obscured by a presentation of physical ailments?

The challenge is something akin to the question of which came first: the chicken or the egg?

At issue for psychiatrists and psychologists is a sometimes-perplexing evaluative (diagnostic) process as to whether a medical condition is at the root of behavioral health symptoms or vice versa. Such was the focus of a recent Wall Street Journal article by Melinda Beck published in the healthcare journal section (August 9, 2011).

In her article "Confusing Medical Ailments with Mental Illness" Beck raises public awareness of one challenge that is neither new nor revolutionary to psychiatrists and psychologists: the possibility that a latent or evolving physical (medical) condition may mask itself in the form of a mental disorder or diagnosis.

For mental health professionals, Beck's article may be regarded as a subtle reminder of the importance and benefit in understanding each patient's medical history – a useful clinical component, when applied methodically – to properly contextualize a patient's symptoms, develop an effective treatment plan and, in the process, thwart any potential allegations of "failure to diagnose" or "missed diagnosis." This medical "inventory taking" is particularly important when treating those patients who do not routinely see a primary care physician (PCP) to monitor the status of their physical health.

Beck pens an informative piece for the lay reader providing specific examples of medical conditions that often manifest themselves obscurely in behavioral health symptomatology. Her article is well-substantiated, citing recent published findings, such as Dr. Barbara Schildkrout's book Unmasking Psychological Symptoms and an article in the Journal of Clinical Psychology Practice by neuropsychologist Dr. Jerrold Pollak, et. al. It is in this latter context that Beck's article reminds us of the delicate juxtaposition of a patient's medical and mental well-being.

Some of the examples Beck cites from Schildkrout and Pollak:

- A 40s-something male suddenly exhibits fits of anger and depression. The diagnosis may be one of midlife crisis, or the latent (Pollak uses the word "sleeper") effects of head trauma sustained 20 years ago during his college years as an athlete.
- Another middle-aged male has increasingly frequent outbursts of anger. A treatment plan to address anger-management issues may be appropriate, but a CT scan of the brain identifies temporal-lobe seizure activity.
- A new mother is diagnosed with postpartum depression, but testing suggests the underlying culprit is a postpartum thyroid imbalance that is treated effectively with medication.

Beck explains, "In some cases, a psychological problem is just the first sign of a serious medical issue." She then cites a statement from Gary Kennedy, director of geriatric psychiatry at Montefiore Medical Center in Bronx, NY: "Depression predicts heart disease and heart disease predicts depression."

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Titled "warning signs" in Beck's article, below are some considerations when suspicion points its finger, suggesting that the root of a mental problem may be medical:

- Sudden change in mood or personality
- History of head trauma
- Depression occurring for the first time after the age of 55
- Recent travel or exposure to infections
- Any rash, swelling, drooping eyelid, facial tic, etc.
- Standard medication and/or therapy fails to effect a positive change

It's a reasonable assumption that amid the readership of this WSJ article will be attorneys representing patients. It's not a stretch to assume, then, that well-researched articles such as this will be filed in a plaintiff attorney's arsenal when evaluating the merits of a "failure to diagnose" or a "missed diagnosis" claim against a mental health professional.

What you can do to provide your patients the highest quality of care while protecting yourself professionally:

- Be vigilant and current in your documentation of your patients' complaints and symptoms.
- Routinely conduct intakes and periodic reviews of your patients' medical histories (with attention to prior head trauma, changes in medications prescribed by other healthcare providers and so forth).
- Develop a treatment plan that accounts for deliberation of potential medical/health conditions and the rationale to include or dismiss any medical conditions in your diagnostic evaluation (and revise when necessary and appropriate if treatment is ineffective or new patient information comes to light).
- Recommend to and follow up with your patients any tests (MRI, CT scan, blood work, as examples) that will help rule out potentially contributory medical factors, and be sure your medical record documentation is current and factual, including results of recommended tests or referrals.

Pushback from healthcare providers focuses on the element of time spent with each patient. Many argue, perhaps rightly so, that there isn't sufficient time to thoroughly evaluate and document a patient's condition and treatment. More than a few adverse outcomes of claims against mental health professionals are the direct result of inadequate documentation and the argument "I didn't have enough time." Such admissions damage the defensibility of a claim as "lack of time" is no excuse in providing quality healthcare.