An incorrect diagnosis of psychosis?

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This article examines a recent claim in which a patient alleged his general practitioner had incorrectly diagnosed him as suffering from psychosis. The GP had prescribed Melleril, which was complicated by the development of pancytopaenia.

Case history

On 12 July 2000, the 53 year old patient saw his general practitioner. Mr S gave a history of 1.5 weeks of bright per rectal bleeding. Dr B advised the patient that she would need to examine him. On examination, Dr B noted a small haemorrhoid but no other abnormality. She suggested that he should undergo a colonoscopy. The patient then became very concerned that he might have cancer. The GP replied that the bleeding was probably caused by the haemorrhoid, but she couldn't be certain until she had the results of the colonoscopy. On 18 July 2000, Mr S saw another GP in the practice. The patient reported that the bleeding was occurring in larger volumes and he was very concerned about it. The GP thought the patient was depressed and prescribed Cipramil. Two days later, Mr S saw Dr B again. He was concerned about the bleeding and the fact that the Cipramil had not had any effect. Dr B asked him about his sleep patterns. He replied that he was not sleeping well and was waking early. On further questioning, he reported that his appetite was poor. He became quite teary during the consultation but denied any thoughts of suicide. Dr B told Mr S that she was going to prescribe some Melleril, which would help relax and calm him. She also gave him her mobile phone number in case he had any problems. Dr B asked him to return for review in 2 days time. On 22 July Dr B reviewed the patient and confirmed that he should continue taking the Melleril. Mr S saw the gastroenterologist on 2 August 2000 at which time a sigmoidoscopy was performed. This was normal. A colonoscopy was scheduled for October 2000. In early September 2000, Mr S began to experience night sweats and developed a sore throat. He was still taking the Melleril at that time. He was admitted to the local hospital on 17 September with sepsis and pancytopaenia. He was subsequently transferred to a tertiary hospital on 24 September 2000. He suffered a number of complications, including a bowel perforation secondary to the high dose steroids prescribed to treat the pancytopaenia. He was ultimately discharged from hospital on 22 November 2000. His discharge summary noted:

'Admitted for investigation of pancytopaenia? secondary to drug? Melleril

Diagnoses

- Pancytopaenia
- Sepsis – pneumonia, delirium, bowel perforation
- AMI
- ARF

Operation(s)

- Hartmann's procedure, resection terminal ileum and appendicectomy'.

Medicolegal issues

Mr S commenced legal proceedings against Dr B in June 2003. The Statement of Claim alleged Dr B was negligent in:

(a) prescribing Melleril when it was not appropriate to the plaintiff's condition as at 20 July 2000

(b) prescribing Melleril at a time which did not allow for the Cipramil to take effect

(c) failing to trial an anxiolytic, such as a benzodiazepine, before prescribing Melleril

(d) not referring the plaintiff for psychological counselling before prescribing Melleril

(e) failing to institute blood tests or otherwise to monitor the effects of Melleril upon the plaintiff.

In summary, the plaintiff (patient) alleged that the defendant (Dr B) had misdiagnosed him on 20 July 2000 as having a psychotic condition and, as a result, she wrongly prescribed Melleril, a drug known to carry a small risk of agranulocytosis. The Statement of Claim included expert reports by a GP and a psychiatrist, which were critical of Dr B's management.

The matter proceeded to trial in February 2006 and a decision was handed down on 20 July 2006. The plaintiff's GP expert stated that in 2000 a GP would have to consider

very carefully the introduction of Melleril into the management of a patient exhibiting major depression and associated anxiety. He reported that in prescribing any medication, a doctor had to balance the efficaciousness of the drug with its possible side effects. He concluded: 'In my opinion, the management of depression in general practice requires a comprehensive history recording not only the patient's symptomatology but also antecedent and family history as well as exploration of emotional losses and other trigger factors in the causation of depression. Only when this had been done would a prudent GP exercising ordinary skill and care, in my opinion, prescribe medication. There were many medications available in 2000 to treat depression depending on symptomatology and the diagnosis...' In his evidence at the hearing, the plaintiff's GP expert stated that it was not appropriate to treat anxiety or depression with an antipsychotic drug. He concluded that Cipramil was an appropriate drug to prescribe but that it can take approximately 7 days to take effect. In the event that the patient was still exhibiting anxiety or depression, then the GP expert's drug of choice would have been a benzodiazepine rather than a phenothiazine. The GP expert stated that: 'You don't use an antipsychotic for anxiolytic purposes until you have prescribed benzodiazepines or something else. That's the accepted wisdom in general practice...'

In her evidence, Dr B justified the prescription of Melleril instead of a benzodiazepine on the basis that the plaintiff, on 20 July 2000, suffered from anxiety of delusional intensity. The defendant GP said that at the consultation on 12 July 2000, the plaintiff was extremely concerned about the possibility that he had cancer. The medical records included an entry 'anxious +++ re possibility of ca – long consult'.

The medical records for 20 July 2000 stated:

'Phone contact

Depressed. Anxious +++ will see later today

Classical depression. No appetite, teary. Suicidal thoughts but no plans. Cont Cipramil. Add Melleril'.

Dr B was asked if she had turned her mind to the possibility of prescribing a benzodiazepine for the plaintiff. In response, she stated: 'I had to make a decision as to whether I felt Mr S's symptoms were purely anxiety or whether they incorporated... a degree of distorted thinking; an irrational conviction. My judgment on that day was that he had anxiety of delusional intensity and that that would not be fully addressed by the benzodiazepine. I was very concerned about the risk of suicide. I felt that he had features of a psychotic depression, and the risk of suicide in psychotic depression is in the order of 10%. I was obviously aware that Melleril is a medication that has side effects; more side effects than benzodiazepines. However, I felt the risk of low dose Melleril short term was far outweighed by the benefits of treating his distress and his psychotic depression'.

It was the plaintiff's case that he was suffering from depression and anxiety in July 2000, but he was not delusional, schizophrenic nor suffering from bipolar disorder and therefore he was not psychotic. His case was that there was no indication for the prescription of an antipsychotic medication of any type and certainly not Melleril, a drug that carried the risk of agranulocytosis.

The judge concluded that the evidence revealed that Dr B gave prompt and thorough attention to the plaintiff. She spent a considerable amount of time with him on 20 July 2000. She was plainly concerned enough about his condition to take what was, for her, the unusual step of providing Mr S with her mobile phone number and instructions to ring her if he felt it was necessary. This in itself reflected the fact that Dr B had assessed the plaintiff on 20 July as highly anxious as a result of an overpowering conviction that he had cancer and his life was under threat.

The judge did not put significant weight on the criticism by the plaintiff's psychiatrist expert, stating: 'Dr B was not exercising the specialist medical skill of a consultant psychiatrist. As an experienced GP, she was in a position where she was required to make a judgment as to what to do for a patient who had become highly anxious and distressed... Is a GP practising in a country region without ready access to specialist opinion, necessarily both wrong and negligent if the judgment as to 'distorted thinking' is considered psychotic rather than the product of extreme anxiety?' Whether the decision would necessarily have been considered by a specialist psychiatrist to have been 'correct' was not the appropriate legal test. It was whether a GP, in the actual circumstances presenting to Dr B on 20 July 2000, could reasonably have considered that Mr S's presentation was consistent with distorted thinking of a psychotic nature. Applying that test, the judge was of the opinion that it was open to Dr B to make a decision that the prescription of Melleril was an appropriate course of treatment. Accordingly, the judge entered a verdict for the defendant GP.[1]

Discussion and risk management strategies

The judge commented that the absence of any reference in Dr B's medical records to either psychotic symptoms or of a diagnosis of psychosis raised a factual and diagnostic issue of central importance, the resolution of which was fundamental to the liability issue in the proceedings. The plaintiff's GP expert agreed that if the plaintiff was psychotic when seen by the defendant on 20 July 2000, then antipsychotic medication would have been appropriate, adding 'but it would also be important for it to have been recorded that it was believed he was psychotic and that was the reason for giving Melleril...' In this respect, a significant focus in the plaintiff's case was the absence in the defendant's medical records of any reference to psychosis.

The judge noted that: 'In examining the question of breach of duty, I have given close attention to Dr B's failure on 20 July to record any psychotic symptoms and/or make reference to statements of conviction by the plaintiff that he was going to die of cancer and her failure to record a diagnosis of a psychotic condition'. However, in this case, the judge took into account the statements recorded in the hospital notes and comments made by the gastroenterologist in his letter to Dr B. Ultimately the judge accepted that Dr B had appropriately prescribed Melleril and judgment was entered in her favour.

Of interest, in the event that there was a successful appeal against the decision, the judge assessed the plaintiff's damages as $255 561.95.[1]

Conflict of interest: none.

Reference

1. Schultz v Bailey [2006] NSWSC 727.

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