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Editor-in-Chief

Even experienced practitioners are not immune from making a mistake in the hustle and bustle of daily work

Errors of omission and commission in psychiatric practice

There are many rewards for full-time academic psychiatrists such as myself, including didactic teaching, clinical supervision, and 1:1 mentorship of freshly minted medical school graduates, transforming them into accomplished clinical psychiatrists. The technical and personal growth of psychiatric residents over 4 years of post-MD training can be amazing and very gratifying to witness.

But the road to clinical competence often is littered with mistakes. It is the duty of the clinical supervisor to convert every error into a learning opportunity to hone the skills of a future psychiatrist. Over time, fewer mistakes occur, not only because of maturity and seasoning, but also because psychiatric residents learn how to thoughtfully deliberate about their clinical decision-making to select the best treatment option for their patients.

Yet, even with exemplary training, the rigors and constraints of clinical practice inevitably lead to some unforced errors, mostly minor but sometimes consequential. Even experienced practitioners are not immune from making a mistake in the hustle and bustle of daily work (exacerbated by the time-consuming pressures of electronic

health record documentation). No one is infallible, but everyone must avoid making the same mistake twice, even if mounting demands lead to “shortcuts” that may not necessarily put the patient at risk but could lead to suboptimal outcomes. But once in a while, a serious complication may ensue.

Here are some common errors of omission or commission that even competent practitioners may make in a busy clinical practice.

Rushing to a diagnosis. To arrive at a primary psychiatric diagnosis, all potential secondary causes must be ruled out. This includes systematic screening for possible drug-induced psychopathology related not only to drugs of abuse, but also to prescription medications, some of which can have serious iatrogenic effects, including depression, anxiety, mania, psychosis, or cognitive dulling. The other important cause to rule out is the possibility of a general medical condition triggering psychiatric symptoms, which requires targeted questioning about medical history, a review of organ systems, and ordering key laboratory tests.

Skipping a baseline cognitive assessment. Cognitive impairment, especially memory and executive function, is now well recognized as an important

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component of major psychiatric disorders, including schizophrenia, bipolar disorder, major depressive disorder, anxiety, and attention-deficit/hyperactivity disorder. A standardized cognitive battery can provide a valuable profile of brain functions. Knowing the patient's cognitive strengths and weaknesses before initiating pharmacotherapy is essential to assess the positive or negative impact of the medications. It also can help with patients' vocational rehabilitation, matching them with jobs compatible with their cognitive strengths.

Inaccurate differential diagnosis.

Is it borderline personality or bipolar disorder? Is it schizophrenia or psychotic bipolar disorder? Is it unipolar or bipolar depression? Is it a conversion reaction or a genuine medical condition? The answers to such questions are critical, because inaccurate diagnosis can lead to a lack of improvement and prolonged suffering for patients or adverse effects that could be avoided.

Using a high dose of a medication immediately

for a first-episode psychiatric disorder. One of the least patient-friendly medical decisions is to start a first-episode patient on a high dose of a medication on day 1. Gradual titration can circumvent intolerable adverse effects and help establish the lowest effective dose. Patient acceptance and adherence are far more likely if the patient's brain is not "abruptly medicated."

Using combination therapy right away.

There are a few psychiatric conditions for which combination therapy is FDA-approved and regarded as "rational polypharmacy." However, it always makes sense to start with 1 (primary) medication and assess its efficacy, tolerability, and safety before adding an adjunctive agent. Some patients

may improve substantially with monotherapy, which is always preferable. Using drug combinations as the initial intervention can be problematic, especially if they are not evidence-based and off-label.

Selecting an obesogenic drug as first-line.

Many psychotropics, such as antipsychotics, antidepressants, or mood stabilizers, often come as a class of several agents. Clinicians can select any member of the same class (such as selective serotonin reuptake inhibitors [SSRIs] or atypical antipsychotics) because they are all FDA-approved for efficacy. However, the major difference among what often are called "me too" drugs is the adverse effects profile. For many psychotropic medications, significant weight gain is one of the worst medical adverse effects, because it often leads to metabolic dysregulation (hyperglycemia, dyslipidemia, and hypertension) and increases the risk of cardiovascular disease. Many psychiatric patients become obese and have great difficulty losing weight, especially if they are sedentary and have poor eating habits.

Using benzodiazepines as a first-line treatment for anxiety.

Although certainly efficacious, and rapidly so, benzodiazepines must be avoided as a first-line treatment for anxiety. The addiction potential is significant, and patients with anxiety will subsequently not respond adequately to standard anxiolytic pharmacotherapy, such as an SSRI, because the anxiolytic effect of these other medications is gradual and not as rapid or potent. Some primary care providers (PCPs) resort to using strong benzodiazepines (such as alprazolam) as first-line, and then refer the patient to a psychiatrist, who finds it quite challenging to steer the patient to an evidence-based option

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These unforced errors have the potential to delay response, increase the disease burden, or complicate the illness course

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that is less harmful for long-term management. The residents and I have encountered such situations often, sometimes leading to complex interactions with patients who demand renewal of a high dose of a benzodiazepine that had been prescribed to them by a different clinician.

Low utilization of some efficacious agents. It is surprising how some useful pharmacotherapeutic strategies are not employed as often as they should be. This includes lithium for a manic episode; a long-acting injectable antipsychotic in the early phase of schizophrenia; clozapine for patients who failed to respond to a couple of antipsychotics or have chronic suicidal tendencies; lurasidone or quetiapine for bipolar depression (the only FDA-approved medications for this condition); or monoamine oxidase inhibitors for treatment-resistant depression. These drugs can be useful, although some require ongoing blood-level measurements and monitoring for efficacy and adverse effects.

Not recognizing tardive dyskinesia (TD) earlier. TD is one of the most serious neurologic complications of dopamine-receptor working agents (antipsychotics). FDA-approved treatments finally arrived in 2017, but the recognition of the abnormal oro-buccolingual or facial choreiform movements remain low (and the use of the Abnormal Involuntary Movement Scale to screen for TD has faded since second-generation antipsychotics were introduced). It is essential to identify this adverse effect early and treat it promptly to avoid its worsening and potential irreversibility.

Other errors of omission or commission include:

- Not collaborating actively with the patient's PCP to integrate the medical care to improve the patient's overall health, not just mental health. Collaborative care improves clinical outcomes for most patients.

- Not using available pharmacogenetics testing to provide the patient with "personalized medicine," such as establishing if they are poor or rapid metabolizers of certain cytochrome hepatic enzymes or checking whether they are less likely to respond to antidepressant medications.

- "Lowering expectations" for patients with severe psychiatric disorders, giving them the message (verbally or nonverbally) that their condition is "hopeless" and that recovery is beyond their reach. Giving hope and trying hard to find better treatment options are the foundation of good medical practice, especially for the sickest patients.

Psychiatrists always aim to do the right thing for their patients, even when the pressures of clinical practice are intense and palpable. But sometimes, an inadvertent slip may occur in the form of an error of omission or commission. These unforced errors are rarely dangerous, but they have the potential to delay response, increase the disease burden, or complicate the illness course. Compassion may be in generous supply, but it's not enough: We must strive to make our patient-centered, evidence-based clinical practice an error-free zone.



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