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# Exploring The Mental Healthcare Maze

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## **EXPLORING THE MENTAL HEALTHCARE MAZE – INTRODUCTION**

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If a fortune teller looked into a crystal ball when I was seventeen and foresaw decades of mental illness without diagnosis or treatment, I would have been shocked. If the visionary foretold that I would enter a health maze, investigate substandard care, research practice guidelines and explore restorative care, I would have said he was nuts. A future that dark and difficult didn't seem like my destiny.

As a child, I was hypersensitive and anxious. Migraines started when I was twelve. My mother, sister and son get them too. Obviously we inherited a neurological condition that affects our brains. To look on the bright side, these painful episodes 'reset' our brains about once a month. I learned to accept the resetting and take an extract of the feverfew plant to ease the pain.

At seventeen, I was skinny, introverted, hypersensitive and anxious, younger than my peers. After my best friend moved away and my girlfriend dumped me, I felt lost and alone. Studying and thinking about going away to college, I did little but worry and mope around, in a black funk. No one said much and I didn't think to ask for help. I didn't recognize these bad moods as an episode of depression.

During four years at university, my courses fascinated me but the workload was heavy. The depressions came and went; my memory didn't work right and my marks were not good. Even while studying biological and medical sciences and psychology, I did not recognize the symptoms of mental illness. I did normal college stuff, made new friends and fell in love with the empathetic woman who is still my wife. I was moody: variable, volatile, vulnerable (to episodes of depression and angry irritable outbursts), reactive, intense, hypersensitive, periodically creative and surgingly energized. In retrospect, this is no surprise because I had a mood disorder as well as anxiety.

With memory problems limiting my studies, I changed career plans. I took night courses in commerce and worked days in an accounting firm. Office work did not involve the life sciences but number problems and business logic appealed to me so I became a chartered accountant. At the age of twenty-six, I qualified for a CA designation after passing rigorous final examinations. Then, I went into a major depression. It made no sense to get so blue right after qualifying for a professional designation. *What was depleting me? What was wrong with my brain?*

I consulted eight health professionals over twenty years. None diagnosed my bipolar II mood disorder or treated me restoratively. I got worse. While I was sick and getting sicker, my healthcare consisted of the following:

1. the silent treatment (by an older psychiatrist);
2. being laughed at (by a family doctor); and
3. being told that I was ignorant, negative and egocentric (by a psychologist who talked for hours about her problems).

Professional caregivers gave me quick labels and tried easy treatments. They watched me get worse. There was a dark side to care involving silence, laughter, fault-finding, rejection and abandonment. I didn't know that my symptoms were consistent with a bipolar II mood disorder. I didn't know how this condition was diagnosed or treated. I didn't know the chances for recovery. Therapy, insightful at times, did not resolve the episodes of depression or correct my biochemical disorder. I call this initial exploration of the mental healthcare maze my 'in-the-dark' phase.

A National Depressive and Manic-Depressive Association (NDMDA) study indicates that many people who have bipolar mood disorders see several doctors before they are accurately diagnosed. Without a correct diagnosis of the root causes of a mental illness, problems can go on for years.

It took twenty-eight years before I got an accurate diagnosis. Fortunately, I was not hospitalized, did not have ECT treatments and did not take antipsychotic medications. For decades, I endured the brain pains of an undiagnosed and untreated mood disorder. It is not surprising that an untreated illness will get worse. My family worried. In 1994, my wife insisted that I see a doctor. After reading that low brain fuels can cause symptoms of depression and anxiety, I politely asked my doctor about that possibility. When the doctor just laughed, I knew it was time to find another doctor.

The second doctor did some tests and ruled out five of the fifty medical conditions which can cause or contribute to symptoms of depression. He concluded that I was depressed. He prescribed antidepressant medication, a selective serotonin re-uptake inhibitor (SSRI). The drug numbed the pain of my depression, dumbed my brain and stimulated my energy. It also caused negative effects such as akathisia (a state of restless aggressiveness) and constant sweating. The SSRI turned off my sexuality and chilled my marriage (lukewarm after years of mood disorder symptoms, episodes and outbursts). This medication was not an effective treatment for my condition.

When I asked if he was going to wait until I was dead before treating me properly, the doctor was blunt; he told me to see another physician.

A friendly therapist encouraged me to see a psychiatrist. After a morning-long meeting and psychological testing (but no medical testing and minimal patient or family medical or mental history-taking), the psychiatrist diagnosed dysthymia. He prescribed an MAOI antidepressant. Initially, I was pleased to get a diagnosis (not knowing that ‘dysthymia’ means chronic depression). I followed his instructions but the MAOI was not the answer. For a short time after taking each pill, I felt a bit better; then I slowly slid back into depression. Until the next pill. Up and down, all day long.

That psychiatrist did not see regular patients because of his medical-legal specialty. He was too busy writing reports. He referred me to the expert psychiatrist, Dr. T.T. ShorCu but I was not diagnosed properly or treated effectively.

I kept on exploring the mental healthcare maze. After consulting with physicians, psychiatrists, psychologists and therapists, I knew something was wrong but I didn’t know what it was called or how to get well. When I was suicidally depressed, I decided to read medical books to learn how mood disorders are diagnosed and treated. Another depressive suggested orthomolecular medicine. It did not take long before the restorative approach worked. I have been stable since 1996. Not perfect, but much better.

In 1996, I started an Independent Depression Project and interviewed 150 depressed people. Some were clients of my consulting practice; others called when they heard about the book. They were keen to share their experiences. Many of their stories were worse than mine. It surprised me to learn that so many depressed people do not get restorative care. I wondered what would happen if a recovered patient investigated a bad outcome and blew the whistle on substandard psychiatry.

After working as a forensic and investigative accountant (i.e., a fraud investigator), I knew that a case can take a long time. Even if there is evidence, little happens until responsible people make the time to consider the problem and take action. “Surely, the authorities will do something if substandard psychiatry is risking lives,” I said to myself. Once again, I was heading off in the wrong direction.

## **CHARTING THE HEALTHCARE SYSTEM**

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I never used to wonder how the healthcare system works or whether its checks and balances actually operate to protect patients. I never realized that the laws, offices, organizations and people are coordinated. I assumed that a doctor would help a sick patient. While suffering with a bipolar mood disorder, migraines and anxiety for thirty-three years, I learned that quality mental healthcare is hard to find.

I charted the system for this book, outlining the healthcare laws. In Ontario, Canada, the Regulated Health Professions Act, 1991 (RHP Act) covers the provincial minister of health, a regulatory advisory council, a review board and twenty-one health professions, including physicians. The Act authorises health professional associations to investigate complaints of incompetence, incapacity or misconduct. The Act stipulates that The Medicine Act applies to physicians. The Criminal Code also has sections which apply to health professionals.

### **Relevant sections of the RHP Act include the following:**

#### **Incompetence – Section 52:**

“A panel [of the health professional’s association] shall find a member to be incompetent if the member’s professional care of a patient displays a lack of knowledge, skill or judgment or disregard for the welfare of the patient ...”

#### **Investigation of complaints – Section 25:**

“A complaint filed with the Registrar [of the health professionals’ association] shall be investigated by a panel ... [of] the Complaints Committee ...”

#### **Complaint in bad faith – Section 26(4):**

“if the panel considers a complaint to be frivolous ... it shall give ... notice that it intends to take no action ... the complainant and the member [can] ... make written submissions within 30 days ...”

#### **Timely disposal – Section 28:**

“a panel [of the health professional’s peers] shall dispose of a complaint within 120 days after the filing of the complaint.”

If the physicians’ association does not investigate a complaint properly or come to a reasonable decision, the patient can ask a review board to consider the matter.

**Review by Board** – Section 29:

1. “... the [review] board shall review a decision of a panel of the Complaints Committee if the board receives a request [from the complainant]”.

**Conduct of review** – Section 33:

1. “In a review, the board shall consider either or both of,  
(a) the adequacy of the investigation conducted; or  
(b) the reasonableness of the decision.”

These quotes indicate that a victim of medical incompetence can ask the physicians’ association to investigate a bad outcome and then consider whether there is enough evidence to discipline an incompetent doctor.

A health professional’s peers may not believe that a complaint by a recovered patient is credible. Depending on the outcome of their investigation, the complaint committee may take action. If the panel deems a complaint to be ‘frivolous’, the committee can do nothing. “Frivolous” is not defined in the RHP Act.

The Medicine Act is short and to the point. Section 3 defines “the practice of medicine [as] the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction.” This law does not allow a physician to make a sick patient worse, misdiagnose or fail to treat. Since incompetence involving a physician is covered by the RHP Act, the Medicine Act does not deal with it.

The Criminal Code has sections which apply to health professionals. For instance, S216 deals with “legal duty to use reasonable knowledge, skill and care in administering medical treatment that may endanger life.”

The RHP Act, the Medicine Act and the Criminal Code can protect trusting patients from incompetence, incapacity and criminal misconduct by a physician.

The diagram, “Health System in Ontario, Canada,” outlines the laws, the offices in the system and the people in the offices. It shows that a psychiatrist is highly qualified after years of education, study of professional references and clinical experience.

The education of a doctor starts with a university degree in biological and medical sciences and continues with four years of medical school. A successful medical student graduates as a physician. After years of specialty education, a physician can take qualification exams and practise as a psychiatrist.

A psychiatrist reads, studies, learns and understands books about life sciences, medical sciences, psychiatry and psychology. Further study covers professional journals which report medical research, clinical trials of

psychiatric medications and current practices. The practice guidelines of national psychiatry associations (e.g., American and Canadian) outline and summarize the consensus of experts. The guidelines specify the standard of care procedures which a psychiatrist uses to diagnose a patient accurately and treat the patient effectively.

Psychiatrists gain clinical experience during medical school. They work as resident doctors training in teaching hospitals. As graduate physicians, they work as staff doctors in hospitals. As staff psychiatrists, they work in hospitals, consult with other physicians and see patients in private offices. A psychiatrist sees hundreds, if not thousands of patients during the course of his medical education and clinical experience. After this much preparation, the trusting patient assumes that a psychiatrist will be ethical and use normal procedures to diagnose the root cause of the patient's symptoms and help the patient recover. The trusting patient would not expect a psychiatrist to misdiagnose or mistreat.

At this time, in Ontario, there is no assessment process to rate the ethics of health professionals. There is no public record of the performance of medical specialists. Although the RHP Act, the Medicine Act and the Criminal Code encourage competent healthcare, these laws are not rigorously enforced. Even though the health system has laws, offices and people responsible for monitoring and controlling healthcare, unethical doctors can practise without timely investigation or discipline of incompetence. In May 2001, *The Toronto Star* printed a series of articles that reported that 99% of patient complaints are routinely dismissed by the physicians' association without proper investigation and without disciplining incompetent doctors. More than 300 victims of incompetence involving one specialist physician recently started legal action to resolve their concerns.

At specified years, the RHP Act empowers a regulatory advisory council to review the effectiveness of the Act and recommend improvements. In 2001, the Minister of Health of Ontario received three reports. The results of their reports have not been released to the public after the council and consultants investigated cases of incompetence and considered weaknesses in healthcare quality controls.

The consultants and the council may recommend improvements to the RHP Act. Changes may improve the quality of care and better protect trusting patients. These reports may be released later in 2001. Meanwhile, vulnerable patients can read about their illnesses and ask for competent healthcare. It is all right for the patient to ask if his doctor is following standard of care procedures for diagnosis and treatment.

**Extracts – Canadian Legislation**

**Regulated Health Professions, Act, 1991**

*S 52 ... incompetent if the care of a patient displays a lack of knowledge, skill or judgment or disregard for the welfare of the patient ... "*

*S 25 "A complaint filed with the Registrar ... shall be investigated by a panel ... "*

*S 25 (2) "after investigating and considering ... all records and documents ... relevant"*

*S 28 "A panel shall dispose of a complaint within 120 days ... "*

*S 33 (1) "In a review, the Board shall consider either or both of  
(a) the adequacy of the investigation ...  
(b) the reasonableness of the decision."*

**Medicine Act, 1991**

*S3 "The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction."*

**Criminal Code**

*S 216 "legal duty to use reasonable knowledge, skill and care in administering medical treatment that may endanger life"*

**Offices in the System**

Provincial minister of health

Regulatory advisory council

Review board

Health profession associations  
(21 in Ontario)  
Members

National associations  
eg., psychiatry

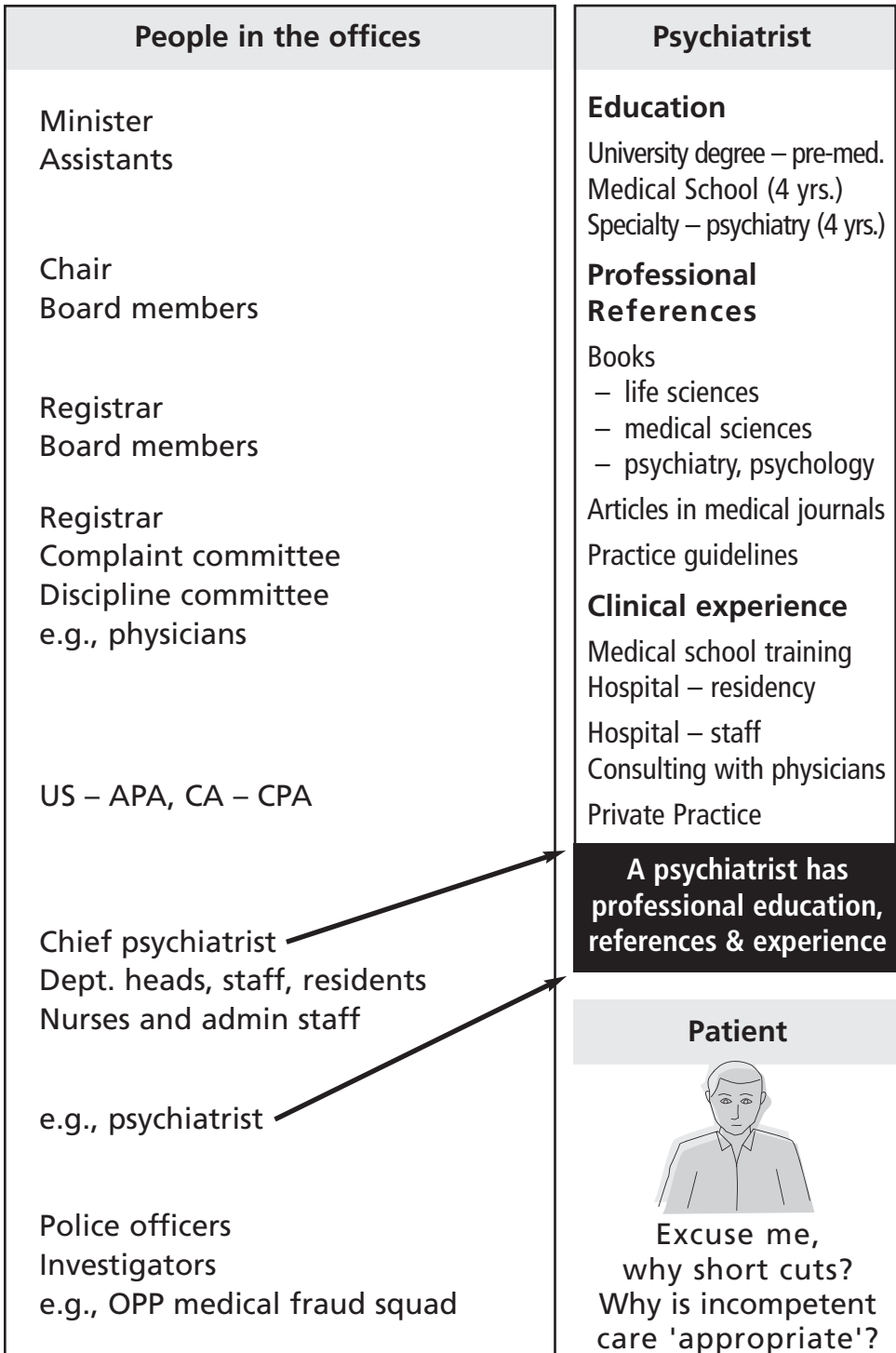
Hospital  
Inpatient care  
Outpatient clinics

Health professionals

Law enforcement



# HEALTH SYSTEM IN ONTARIO, CANADA



## **MAPPING THE MAZE OF DEPRESSION DIAGNOSES AND TREATMENT**

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**D**epression, anxiety, mental episodes and brain disorders can be difficult to diagnose and treat. There are many possible diagnoses and a range of treatments. Conventional health professionals use the Diagnostic and Statistical Manual (DSM) to label the patient. Then they may recommend medications or talk therapies – or a combination of the two. The standard of care procedures work well in many cases. Some patients find it difficult to get proper care. They may end up running around like mice trapped in a research maze. The diagram “The Maze of Depression Diagnoses and Treatments,” shows how this can happen. Even when health professionals intend to be helpful, patients may not be diagnosed accurately or treated effectively. The patient, family and caregivers can cooperate to monitor the quality of care and resolve problems.

The family doctor is often the first health professional consulted when a patient becomes depressed or anxious. A competent physician will test for underlying medical conditions. Depending on the results of the tests, a doctor may offer counselling or antidepressant medications. If the patient does not recover, the physician may decide to refer the patient to specialists for in-depth diagnosis and treatments.

In the case of mental illness, the specialist is a psychiatrist. The practice guidelines of psychiatry recommend a series of steps to accurately diagnose the root cause of the patient’s symptoms and treat the patient effectively until the patient recovers. The trusting patient assumes that a psychiatrist will follow his practice guidelines and use standard of care procedures.

Other specialists may also be consulted. Neurologists or endocrinologists consider the patient’s symptoms and the severity of the patient’s problems. These specialists use the standard of care procedures of their respective specialties to diagnose patients and offer appropriate treatments. Some conditions are difficult to diagnose and treat. By consulting with specialists, patients can get in-depth care.

Medical professionals may learn that the patient is troubled by personal issues, family of origin difficulties or abusive relationships. A range of psychological and social problems can lead to symptoms of depression and anxiety. If there seem to be social or psychological issues, the patient may be referred to a psychologist, social worker, therapist or counsellor. Talk therapies can identify negative patterns of thinking, feeling and acting.

Competent therapists can help the patient resolve certain types of issues and shift toward positive and productive patterns.

In many cases, multiple factors strain the patient until there are symptoms of distress or illness. Patients who suffer with depression, mental episodes and brain disorders can have combinations of causes. They may have inherited biochemical vulnerabilities, underlying medical conditions or live in abusive homes. It may not be easy for a mental health professional to identify the root cause(s) of the patient's discomfort or help the patient get an accurate diagnosis and find effective treatments. Mental patients can go back and forth, exploring the mental healthcare maze, trying therapy and taking medications, while underlying medical conditions are left undiagnosed and untreated. Meanwhile, they are expected to cope with the multiple involuntary symptoms of depression and anxiety, tolerate the negative effects of powerful psychiatric medications and continue living in difficult environments.

Fortunately, the mental healthcare maze has restorative options. European health professionals, naturopaths, homeopaths and herbalists are trained to use plant extracts called phytopharmaceuticals in cases of mild to moderate depression and anxiety. These treatments have been developed over centuries of use. There are scientific methods to standardize, research and test the effectiveness of herbal medications for psychiatric conditions.

Orthomolecular health professionals are medical doctors who combine the life science of biochemistry with the practice of medicine. After root cause diagnostic testing, they tailor regimens of supplements. Vital amines (vitamins), trace minerals, amino acids, energy, enzyme co-factors and essential fatty acids can help individual patients, depending on their biochemical needs. Nutritional supplements can restore patients and maintain their mental health without negative effects.

Other methods may be effective treatments for depression and anxiety, depending on the root causes of the patient's problems. Optimum doses of exercise, full spectrum light, rest, nature walks, pass times, meditation and yoga have helped people recover and keep well. Even if there an underlying medical condition, supportive methods can be a useful part of the patient's overall program to maintain wellness.

Electroconvulsive shock therapy (ECT) helped some patients recover from suicidal depressions after other treatments failed. Many patients report problems with memory loss and other difficulties. Current ECT treatments are less problematic than earlier methods which used higher voltages and bilateral shocks.

New treatments are being researched and developed for depression. Transcranial magnetic stimulation (TMS), vagal nerve stimulation and EEG neurofeedback are three promising possibilities.

People who suffer with depression, mental episodes or brain disorders can find competent mental healthcare, get accurate diagnoses and benefit from effective treatments. If there is little or no progress exploring the mental healthcare maze, patients can do the “Mental Healthcare Reality Check” (see page 59). Patients getting poor care can ask for second opinions and negotiate for better care.

# MENTAL HEALTHCARE REALITY CHECK

## Substandard Care

### Diagnosis

- label
- no histories, no tests

### Treatments

- short cuts
- unproven alternatives
- masking, cover-up

### Medication

- negative effects
- side or adverse effects

### Communication – education

- withhold and deny
- silence or put-down
- reject, abandon
- false and misleading

### Results

- misdiagnosis
- mistreatment
- minimalist
- negligent
- deterioration

## Quality Care

### Diagnosis

- mental status exam
- histories, tests

### Treatments

- standard of care procedures
- practice guidelines
- restorative, healing

### Medication

- positive response
- improvement, side benefits

### Communication – education

- share information and support
- communicate and encourage
- consider, cooperate
- true and helpful

### Results

- accurate diagnosis
- effective treatment
- conservative
- competent
- recovery

# THE MAZE OF DEPRESSION DIAGNOSES AND TREATMENTS

## There are many possible diagnoses:

1. symptom, syndrome, sign of medical illness, a mental illness (e.g., a mood disorder, involuntary, kindled or learned illogic, anxiety or helplessness)
2. physical, medical, neurological, psychological, biological, metabolic, inherited condition, environmental, individual overload, unresolved transition, loss or grief *(continued page 61)*

## There are many possible treatments:

### Conventional – medicate symptoms and talk i.e. counsel

General practitioner or family doctor	Psychiatrist	Psychologist, therapist social worker, counsellor
<p>test for, treat related medical conditions e.g., hypothyroid</p> <p><b>counselling</b></p> <p><b>antidepressants</b> <b>**watch for 'side' effects</b></p> <p>refer to specialists for in-depth diagnosis-treatment</p>	<p>test for underlying medical conditions</p> <p><b>talk therapy</b></p> <p><b>antidepressants</b> <b>**watch for 'side' effects</b></p> <p>choices include:</p> <ul style="list-style-type: none"> <li>• SSRI, TCI, MAOI</li> <li>• antiseizure / sleeping</li> <li>• antianxiety (alone or combinations)</li> <li>• lithium (mega dose of a trace mineral that affects brain function)</li> </ul> <ul style="list-style-type: none"> <li>• severe cases may mean                             <ul style="list-style-type: none"> <li>• antipsychotic drugs</li> <li>• ECT</li> <li>• hospitalization</li> </ul> </li> </ul>	<p>refer to physician for medical testing</p> <p><b>talk therapy</b></p> <p>Focus of therapy</p> <ul style="list-style-type: none"> <li>• self, others and the world</li> <li>• shift from negative to positive</li> <li>• unrealistic expectations</li> <li>• contexts of therapy include:                             <ul style="list-style-type: none"> <li>• overloads, depletions</li> <li>• self esteem, assertiveness</li> <li>• grief – unresolved</li> <li>• relationships, abuse</li> <li>• metaphors, issues</li> <li>• learned helplessness</li> <li>• cognitive restructuring</li> <li>• transitions</li> </ul> </li> <li>• may recommend seeing physician for diagnosis of medical illness(es) and / or prescribing antidepressants</li> </ul>

\*\* Note – synthetic antidepressant medications are known to cause negative side effects in some people.

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# THE MAZE OF DEPRESSION DIAGNOSES AND TREATMENTS

## There are many possible diagnoses:

3. neurotransmitters: genetic imbalance, depletion, interference with synthesis; metabolism; cellular energy; biological systems responding to ongoing distress
4. diet may lack nutrients, missing enzyme cofactors may imbalance or interfere with normal brain function, promote yeast; environment may be a factor (e.g., toxic metals / enzymes)

## There are many possible treatments:

Restorative		
European practitioners use phytopharmaceuticals	Orthomolecular medical professionals physicians / psychiatrists / other	Other approaches
test for, treat related physical illness e.g., hypothyroid	test for, treat related physical illness e.g., hypothyroid	<ul style="list-style-type: none"> <li>• exercise</li> <li>• light</li> <li>• rest, relaxation</li> <li>• art, beauty</li> <li>• nature walks</li> <li>• distractions, hobbies, pastimes</li> <li>• meditation</li> </ul>
<p><b>talk therapy</b></p> <p><b>antidepressants</b></p> <p><b>**watch for 'side' effects</b></p> <ul style="list-style-type: none"> <li>• may treat using natural medications i.e., phytopharmaceuticals</li> <li>• less toxic than synthetics, possibly milder acting</li> </ul>	<p><b>talk therapy, counselling</b></p> <p><b>antidepressants (nontoxic)</b></p> <p><b>**watch for 'side' effects</b></p>	
	<b>Extensive biological testing looking for root cause(s)</b>	
	<ul style="list-style-type: none"> <li>• may treat with natural supplements to restore normal brain function:                             <ul style="list-style-type: none"> <li>• vitamins e.g., B-6</li> <li>• trace minerals, e.g., Zn, Mn</li> <li>• amino acids e.g., l-tyrosine</li> <li>• precursors, cofactors</li> </ul> </li> <li>• may consider:                             <ul style="list-style-type: none"> <li>• metabolism</li> <li>• interference from:                                     <ul style="list-style-type: none"> <li>• yeast imbalance</li> <li>• toxic metals</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• may consider cellular energy enzyme cofactors e.g., Coenzyme Q10</li> <li>• may consider stress hormone precursors e.g., DHEA</li> <li>• may consider diet:                             <ul style="list-style-type: none"> <li>• add nutrients</li> <li>• avoid allergies</li> <li>• food allergies</li> <li>• balance</li> </ul> </li> </ul>
		<p><b>Other professionals</b></p> <ul style="list-style-type: none"> <li>• naturopath</li> <li>• homeopath</li> <li>• herbalist</li> <li>• acupuncturist</li> <li>• chiropractor</li> <li>• may consider noninvasive nonsynthetic                             <ul style="list-style-type: none"> <li>• CES, EEG</li> </ul> </li> </ul>

**INVESTIGATING A CASE OF CARE GONE BAD**

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**W**hen care goes bad, a sick patient can get worse or even be harmed. Every year there are medical errors and damage involving toxic medications, complications and drug interactions. A patient may not be accurately diagnosed or effectively treated. Bad care may be linked to inexperience, incompetence, malpractice or even negligence involving health professionals. In the case of depression, mental episodes and brain disorders, there is a risk of suicide. If a painful condition gets worse, a patient who feels helpless can give up hope and decide that death is the only way out. For instance, painful symptoms can worsen due to the negative effects of excessive doses of the wrong medications. If a despairing patient is impulsive, there can be a tragic loss of life.

It is hard to believe that an expert psychiatrist would misdiagnose or mistreat any patient, knowing that a bad outcome could damage the patient. It is difficult for a patient to prove that his medical care was bad. A patient's credibility is reduced by his mental disorder. People may suspect a whistleblower of paranoia. Meanwhile, a negligent health professional can continue using short cuts.

While working on consulting projects and fraud investigations, I learned to study systems and monitor controls. I was trained to compare the facts of a situation with standard procedures. If a bad outcome is the result of incompetence or negligence, it makes sense to review what went wrong, starting with the written evidence in the medical file. A patient may assume that files prepared by a psychiatrist are not available to the patient. In Ontario, Canada, a mental patient can see the file. A polite request to the hospital and a small fee soon produced a copy of my file.

During my illness, I kept a diary. I was upset and ashamed to have a mental illness. Even though my family cared, they were not familiar with the mental health system and they did not want to discuss many of my concerns. For a long time, I had no one to talk to about my difficulties. As my life deteriorated, I coped with episodes, symptoms and negative effects of medications. A journal became my faithful companion. I made regular notes. Without complaint, the diary recorded my symptoms and problems, fears and frustrations and the effects of medications.

I compared the doctor's file with my journal. A patient expects his psychiatrist to apply years of study, education, training, knowledge and experience in order to practise competently, according to the current standard of care. It baffled me that the file was so skimpy. The doctor's notes were



either incomplete or not consistent with my experiences. Furthermore, the psychiatrist did not complete the documentation as recommended in medical books and practice guidelines.

In view of my problems with his care, I wondered how my psychiatrist could possibly be an expert. When I read *Risk Management of Suicidal Patients*, I learned that negligent care may involve (1) improper procedures being done to a patient, or (2) standard of care procedures being omitted. The worst failures in care can result in a patient's death. Court cases (after the suicide of a patient) focus on aspects of failed care. It was not hard for me to compare my medical file with negligence checklists. After listing thirteen failures, I began to understand why my care went bad.

Thinking that my case was not typical, I learned about other cases by interviewing and studying reports of patients with depression, mental episodes and brain disorders. I read medical references, the practice guidelines of psychiatry, articles in professional journals and books by survivors and health professionals. When I was sick, bibliotherapy renewed my hope. I learned how other patients cope with substandard care. If their mood disorders, migraines and anxiety were not diagnosed accurately or treated effectively, other patients reported problems similar to mine.

A 2001 issue of a physicians' association newsletter reported a case of medical incompetence involving a physician. The association's discipline committee decided that it was

“unanimous in its decision that [the doctor] was guilty of professional misconduct in the care of his patients for failure to maintain appropriate standards of practice, and of incompetence in that he displayed a lack of knowledge, skill or judgment of the patient ... the following reasons [were] the basis for this decision:

1. ... failed to take a complete history and carry out a physical examination ...
2. ... did not consider a differential diagnosis nor did he order appropriate laboratory and clinical investigations to establish a specific diagnosis ...
3. ... did not meet any recognized standard (of care) ... did not monitor his patients adequately ...
4. ... the standard of practice of the profession is determined by ...
  - (a) what is taught to medical students and residents
  - (b) what is actually done in practice
  - (c) what is known to be effective and safe in publications (peer reviewed)
  - (d) what is accepted by competent and ethical physicians
5. ... [failed] to monitor the liver or kidney function [of patients taking certain medications] ...”

The committee concluded, based on “clear, convincing and cogent evidence that ... guilty of professional misconduct ... failed to maintain the standard of practice ... was incompetent ...”

It is odd that no patients complained even though the physicians’ association decided that the doctor’s care was incompetent.

My case included the five problems listed above and eight others. My medical file did not have enough documentation to suggest that the psychiatrist cared, diagnosed accurately or treated properly. At each visit, the doctor followed the same pattern. He made very brief notes:

*Mood was depressed.*

*Assess – refractory depression*

*Plan – [drug dose] ... See in 2 weeks.*

By noting about twenty words after each visit, the psychiatrist made efficient use of his time, but his documentation was not consistent with the standard of care.

## **Significance of the missing standard of care procedures**

### **1. failed to diagnose**

Without an accurate diagnosis, I was not treated for bipolar II mood disorder, anxiety or migraines. The doctor’s assessment of “refractory depression” sounds like a diagnosis, but according to published sources, those words mean “[problems] with diagnostic-treatment variables.” By failing to diagnose, the psychiatrist could not recommend appropriate medications; give professional advice about restorative care; or use standard treatments. It is obvious that he could not treat health problems that he did not identify. As I deteriorated, he knew something was wrong because he continued to write “refractory depression” for eight months.

### **2. failed to take proper histories; never got files from previous doctors**

This meant that the doctor did not know there were mood disorder symptoms for twenty-eight years as well as migraines and anxiety. My defective brain is not the doctor’s fault, but without proper histories, the psychiatrist could not consider the symptoms, diagnose or treat any illnesses.

Not taking histories means that the doctor was not aware of my family history of migraines, mood disorders, diabetes, diverticulitis, kidney dysfunction and prostate cancer. Without histories, he could not consider whether inherited health problems might be causing symptoms, affecting my ability to process medications or prolonging the symptoms.

Not getting files from a previous family doctor meant that the psychiatrist had no knowledge that a previously prescribed SSRI medication caused

negative effects. He prescribed another SSRI without considering or noting negative effects. Not having the file from a consulting psychiatrist meant that the psychiatrist did not consider the basis for any diagnosis. Without histories or prior files from other health professionals, the psychiatrist was working blind.

### **3. failed to do diagnostic tests**

This meant that the doctor had no objective test results for an accurate diagnosis. Even though his professional practice guidelines, medical books and his own articles (written for professional journals) recommend diagnostic testing, the psychiatrist did not test me for medical, mental or psychological problems.

### **4. failed to do mental status exams**

There are no detailed mental status exams in the medical file. The practice guidelines of psychiatry recommend a mental status examination as the first step with any new patient and every returning patient. The psychiatrist failed to do this procedure which is relevant to diagnosing the patient and assessing the effectiveness of ongoing treatments.

### **5. failed to monitor lithium levels, failed to test kidney function**

With family history of polycystic kidney disorder not known to the psychiatrist, he watched as I deteriorated while taking lithium. He knew, according to articles in his professional journals, that some patients do not respond well to lithium, particularly patients who have kidney problems.

The doctor knew about this risk, and he saw deterioration. He failed to test lithium levels and kidney functions. He did not warn my family or me that lithium might cause problems.

### **6. failed to educate about condition, risks, options or prognosis**

As my life deteriorated, the skimpy medical file proves that I was never educated or informed of: 1. the diagnosis, 2. trigger factors, 3. the purpose of patient and family, medical and mental histories, 4. the need for testing, 5. the increasing risk of suicide, 6. options for combining medication with therapy, 7. orthomolecular medicine or 8. the prognosis. I was left to read, research, study, learn, call the drug company and get a list of SSRI effects from a dentist. The file proves that there was no effective treatment plan.

### **7. failed to document risk of suicide**

After years of mood disorder problems, I was thinking about ending my life. I am not proud to admit this. My suicidal thoughts darkened while taking medications which made me worse. I discussed dark thoughts with the doctor but he failed to note these discussions in the file.

## **8. failed to recommend therapy**

Psychiatrists know that many patients respond to a combination of medication and therapy. Medical books suggest this for quality care. Psychiatry texts and the practice guidelines of psychiatry recommend the same approach. The psychiatrist advised against therapy when my life was deteriorating. When I needed support, encouragement and help to cope with losses of personal functioning, business problems, family concerns and financial difficulties, he just smiled.

## **9. failed to note symptoms**

Neither my symptoms nor my deterioration were noted in the medical file. Three months after seeing him, his nurse noted that I was worse. Eight months after seeing him, a consulting psychiatrist noted that I was a lot worse. For eight months, the psychiatrist did not seem to notice or note that I deteriorated. The file has the evidence.

## **10. failed to warn about negative effects of medications**

Psychiatric medications have negative, adverse, side and toxic effects on some people, particularly people who are hypersensitive to medications, are misdiagnosed or have kidney problems. The psychiatrist did not warn me, monitor negative effects, take blood levels or test kidney functions. He did not obtain informed consent before prescribing medications.

## **11. failed to get informed consent before treatments, failed to explain to family**

My family could not understand what was going wrong. After all, the psychiatrist was a mood disorder expert. For months, neither my family or I knew there were problems with the treatments or a risk of suicide or that tests could have been done to make a diagnosis, develop a treatment plan and prescribe nontoxic medications or restorative supplements. The psychiatrist did not help me recover. He failed to get informed consent before treatments and he failed to explain to the family. When my wife attended one visit and said, "Bob is fading away," the psychiatrist did not note her visit in the file.

## **12. failed to note problems tolerating prescription medications**

As the doctor increased the doses of prescription medications (one to more than twice the maximum recommended dose), problems with negative effects increased and symptoms continued. One drug caused daily migraines and precipitated a painful episode of hypomania. The doctor did not note that there were a number of problems tolerating prescription medications.

### **13. failed to make arrangements for care when psychiatrist left the hospital**

While I was experiencing an episode of hypomania (likely caused by an SSRI medication), the psychiatrist stopped working at the hospital. A consulting psychiatrist noted in the file that I was to be seen by the regular psychiatrist. The expert psychiatrist left the hospital without calling, helping me cope, explaining the risks or making arrangements for continued care.

The thirteen failures are obvious from the file. I could accept the doctor forgetting one or two steps and cutting corners to save time, but the picture painted by thirteen failures is consistent with a bad outcome. The psychiatrist ignored his professional practice guidelines, published articles and medical books, his education, training and clinical experience. I do not know why there were thirteen failures in my case.

As I got worse, I could not work effectively and I could not maintain the mortgage on my home. I could not operate my business without hiring staff and borrowing money that I could not repay. I experienced financial, personal, family, client and staff losses. I nearly lost my family, my business, my home and my life.

A peer psychiatrist could scan the file and see proof of short cuts. Any doctor could confirm that the psychiatrist failed to follow the thirteen steps outlined above.

For months, the psychiatrist knew there were problems with diagnosis and problems with treatments. He cut corners and I got worse. The file proves that there were thirteen failures. Hoping to help other patients, I decided to blow the whistle on substandard psychiatry.

## *C h a p t e r 10*

### **BLOWING THE WHISTLE ON SUBSTANDARD PSYCHIATRY**

Questions remain unanswered after the physicians' association (PA) dismissed my complaint – twice. Who monitors the quality of medical care? Can a patient trust a psychiatrist to use standard procedures and follow practice guidelines? Why doesn't the PA investigate a credible complaint?

The National Depression and Manic Depression Association (NDMDA) reports that a typical patient with a bipolar mood disorder consults more than five doctors and it may take over five years before he gets an accurate diagnosis and effective treatments. NDMDA 1992 and 2000 surveys found that even a psychiatrist can misdiagnose a bipolar patient. Misdiagnosed and mistreated, a sick patient gets worse.

On April 27, 2001, Dr. Kay Jamison, a psychologist from Johns Hopkins University, spoke at the University of Toronto. She told 250 supporters of the Arthur Sommer Rotenberg chair in suicide research that she was “appalled at the callousness and incompetence of [some] doctors” who treat patients with depression and manic depression. Her book, *Night Falls Fast*, reports that every year, misdiagnosed and mistreated patients take their own lives.

I believe that ethical psychiatrists do help patients; but substandard care can cause damage. This report does not name any of the individuals involved in my case: the expert psychiatrist, the chief psychiatrist, the hospital, the physicians’ association, the committees, the review boards or the lawyers. They know who they are and they know the truth. For six years, they refused to investigate this case properly. Maybe they prefer the pleasure of a secret shared to the work of investigating and reprimanding. Maybe they have too many other priorities. The health system diagram in this book may suggest the names of people who are known as a matter of public record. They were not involved in my case. They are still not involved.

### **In 1995, my psychiatrist omitted thirteen standard of care procedures**

For twenty-eight years, I suffered symptoms of a bipolar II mood disorder, migraines and anxiety. From time to time, I consulted with health professionals including family doctors, psychologists and psychiatrists. Sadly, I was misdiagnosed and mistreated. Without getting a proper diagnosis or effective treatments, I got worse. Early in 1995, I was referred to a mood disorder expert. I was encouraged when I visited the large hospital and saw the psychiatrist’s office and his medical diplomas. He was credible when he prescribed antidepressants and other medications but my symptoms worsened and I deteriorated.

As I got sicker, the psychiatrist smiled and reassured me saying, “You will get well” or “Let’s increase your dose.” When I was ill, I trusted him. I did not know about the standard of care procedures. Two years later, I found proof that the expert cut corners. The medical file that the psychiatrist prepared had no personal, family, mental or medical histories. There were no mental status exams or diagnostic tests. There were only short cuts. No wonder I deteriorated for months.

I trusted my psychiatrist. He was an experienced specialist. He ran a mood disorder clinic. I believed he was competent. After eight months, another psychiatrist told me that the medication was making me worse by causing hypomania and migraines. I felt betrayed. My regular psychiatrist did not tell me about the risks of medications, monitor my condition, document my problems, examine my mental status or get my informed consent. I was too sick to realize that the expert psychiatrist cut corners.

## Thirteen Standard of Care Procedures Were Omitted

1. Failed to diagnose accurately or treat effectively as per practice guidelines; wrote ‘refractory depression’ in the patient’s file for months knowing this meant [problems] “with diagnosis and treatment”
2. Failed to discuss, obtain or record patient, family, medical or mental histories (yet falsely claimed these were taken); failed to get patient’s file from a former doctor at the same hospital
3. Failed to do diagnostic tests (medical, biological, psychological or social); without testing, could not and did not make an accurate (differential) diagnosis
4. Failed to do mental status exams, or if any were done, none were documented in the patient’s file
5. Failed to monitor lithium blood levels; failed to test kidney functions, did not warn patient about the negative effects of lithium; failed to note negative effects while patient was taking lithium
6. Failed to educate patient about his condition; failed to develop a treatment plan, failed to discuss treatment options or prognosis with patient or family
7. Failed to document risk of suicide; failed to note worsening suicidal thoughts as patient’s condition deteriorated over eight months
8. Failed to listen or recommend therapy or counselling when patient tried to discuss problems and needed help with his deteriorating condition
9. Failed to note patient’s symptoms; watched patient get worse; failed to note in patient’s file that his wife, an RN, came in to report that the patient was worse
10. Failed to warn patient about known side effects, negative effects and adverse effects of prescription medications; failed to note negative effects of medications (MAOI, SSRI, lithium, and benzodiazepine) in the patient’s file (instead the doctor smiled and said “Let’s increase your dose.”)
11. Failed to get informed consent before drug treatments; failed to explain diagnosis, treatment plan, risks, options, condition and deterioration to family
12. Failed to note patient’s problems tolerating prescription medications; did not act after patient deteriorated to the point that patient nearly lost his business, his family, his home and his life; doctor just smiled and said, “You will get well.”
13. Failed to make arrangements for patient’s care after physician left the hospital (doctor later claimed patient had another doctor); failed to follow up or help patient after another psychiatrist noted an SSRI medication caused hypomania

## **In 1997, I complained to the physicians' association (PA)**

Believing that the physician's association would investigate substandard care, at first I reported my concerns without naming the doctor. The PA was not interested. I wrote a series of polite letters to the psychiatrist, asking for explanations. I wanted to meet the doctor and discuss the damaging effects of his short cuts: prolonged pain and suffering, worsening family and money problems.

The psychiatrist did not respond until May 1997. He waited out the one-year time limit for civil litigation, then reported me to the police, claiming that my letters constituted a threat. The police officer listened to me carefully. He advised me to complain to the association. So I did. Formally. Expecting nothing, but wanting to understand what went wrong with my care. Hoping for closure.

The PA sent my complaint to the psychiatrist and the psychiatrist's written reply to me. Without investigating the matter or evaluating the damage done by the thirteen short cuts, their in-house lawyer suggested dropping the matter. By that time, the psychiatrist had not seen my file for two years because he left the hospital and he had no access to the file. Nevertheless, he wrote to the PA that he took histories and treated me properly. The medical file proves that he didn't.

With my consent, the PA obtained the medical file from the hospital. The file was skimpy. Thirteen standard procedures were omitted. Even after seeing documentary evidence of substandard care, prepared by the psychiatrist and noted in the medical file, the PA refused to investigate. The complaint committee dismissed the matter, somehow deciding that the "care was appropriate." The doctors on the committee were not psychiatrists and they did not ask a peer psychiatrist to review the file. They did not explain why standard procedures were omitted. They did not disclose other complaints.

## **I followed through but the physicians' association dismissed the matter**

From 1997 to 1999, I read medical books and learned about the standard of care procedures. As the law allows, I submitted extracts to the physicians' association to support the complaint. According to expert opinions in the practice guidelines of psychiatry, reference books and journal articles, the standard of care for depression includes the following procedures:

1. mental status exams;
2. patient, family, medical and mental histories;
3. psychological, biological and medical testing;
4. investigate symptoms, medicate after informed consent;



5. accurate (differential) diagnosis of the root cause(s) of the patient's symptoms; and
6. effective treatments which help the patient recover and keep well.

The medical file proved that the psychiatrist did not discuss, do or note any of these procedures in my case. I know they were omitted because I paid \$25 for a copy of the hospital file. I was shocked to learn that while I was trusting the psychiatrist, taking the pills he prescribed and hoping to recover, the expert noted in the file: "refractory depression," drug doses and little else.

The psychiatrist did not diagnose accurately or treat properly. He knew that "refractory depression" means [problems] "with diagnosis and treatment variables." He wrote this in an article for a medical journal. Nevertheless, he repeatedly wrote "refractory depression" in my medical file, for eight months. He wrote an article about another patient who was also misdiagnosed and mistreated. That patient ended up dead, by suicide. His own articles prove that the psychiatrist knew about misdiagnosis and mistreatment and he knew about the risks of substandard care. He never even noted my deteriorating condition.

A year later in 1996, I asked my family for medical history information. While I was sick, my father was suffering kidney failure and had a kidney removed due to a progressive condition called oncocytoma. I learned there was a family history of polycystic kidney disease, a possible explanation for my body's intolerance of lithium. The psychiatrist never asked for family histories, monitored lithium levels or tested kidney functions. While I was taking lithium, I was melancholy, apathetic and had tremors – possibly toxic effects of too high a dose.

Even though the medical file proves that the psychiatrist omitted standard of care procedures, the PA dismissed the case without a proper investigation. They wrote that the [missing] "care was appropriate," but I could appeal to a review board. I thought there was a misunderstanding.

### **In 1999, the review board heard the story and saw the evidence**

The review board held a public hearing in November 1999. It was difficult to tell the story to strangers. There were three board members, the PA's representative, the doctor's lawyer and several members of the public. I offered the medical file as proof and questioned the short cuts. I brought evidence: five copies of a 75-page document brief (one for each member of the board, the PA and the lawyer). There were copies of the medical file, a chronological summary and extracts from articles and reference books. In 2001, the board wrote that its three copies were gone.

The PA's representative at the hearing was a part-time military chap. He politely admitted that the complaint committee ignored 87% of my submissions. He said there was no psychiatrist on the committee (that dismissed the case without investigating properly). The physicians' association wrote that they ignored most of the evidence, including a list of the missing procedures.

I showed the board how the psychiatrist, a recognized mood disorder expert, wrote "refractory depression" in the medical file for eight months but little else other than medication doses. The board saw the expert's article which proved that the psychiatrist understood 'refractory depression' to mean [problems] "with diagnosis and treatment variables."

The psychiatrist did not come to the hearing. His lawyer claimed that the care was appropriate and histories were taken. The doctor's lawyer did not explain why there were no history notes in the medical file, prepared over eight months, or why so many standard procedures were not done. The board wondered why the doctor did not come to the hearing to answer their questions or use the medical file to justify his methods. The doctor's lawyer said that she advised him not to attend.

After 90 days, the board decided that the evidence was credible. They asked the PA to investigate one of the thirteen missing procedures – patient and family, medical and mental histories.

### **In 2000, the association dismissed the complaint again, without investigating**

In 2000, the PA contacted the large hospital and received a second copy of the medical file. They wrote to the psychiatrist again. He wrote back that the history notes were dictated but not typed. It seems odd that a file prepared by a health professional, over eight months, has no medical, mental, family or other histories and there is no history or file data from two previous doctors.

The PA dismissed the complaint again, without investigating. The skimpy hospital file proved that the doctor omitted thirteen standard procedures. The association counselled the psychiatrist to type histories in future. They did not ask a peer psychiatrist to interview the patient or speak to the doctor. They did not compare the file with the practice guidelines for psychiatry.

In Ontario, the physicians' association is legally responsible for investigating a patient's complaint. In minutes, a peer psychiatrist could scan the skimpy medical file and verify that thirteen standard of care procedures were omitted.

## **In 2001, the review board heard the story again**

The second dismissal letter indicated that I could request another review board hearing. In May 2001, I appeared at the review board again, one day after *The Toronto Star* reported that the physicians' association dismisses 99% of patients' complaints without investigating properly.

I was stuck in a catch-22 runaround. During the second hearing, I referred the board to the Regulated Health Professions Act, 1991 which allows the PA to investigate if a patient complains about incompetence. There were no medical professionals on the review board that heard my case in 1999; there were no medical professionals on the 2001 board either. I explained to the lawyer (chairman) and two board members that the psychiatrist did not follow the standard of care procedures. Using practice guidelines and reference books (about negligent psychiatry), I pointed out thirteen failures in the care. Neither the doctor nor his lawyer came to the second hearing but the lawyer wrote and claimed that histories were taken and the care was appropriate. The lawyer knew that the file has no proper history notes. The PA did not send a representative to the second hearing.

The Board's eight page decision, dated Nov. 2001, reviewed the 1997 complaint, noted the missing patient history and named the doctor. The Board did not require an investigation of the substandard care by a peer psychiatrist; the Board confirmed that the PA 'counselled' the doctor.

According to the Regulated Health Professions Act, a board can take its own time to decide. The board can dismiss a matter. *The Toronto Star* reported that this happens in 90% of cases. The board can investigate a matter itself if the PA fails to act within six months but this case was still not investigated properly four years after the complaint was made. Since the board has no medical professionals, the law allows them to consult a health professional before deciding on a case of medical incompetence. I asked them to consult an expert but the board refused to consult with a health professional in my case. I interviewed the chief psychiatrist at the hospital where the care was substandard; he told me that the psychiatrists in his department were expected to study, learn, know and follow their practice guidelines. The chief did not attend the hearing.

If the review board decides that a patient's appeal is credible, it can return the case to the physicians' association to investigate. If a case involves incompetence, the PA can discipline the physician. The outcome of a disciplinary proceeding is noted on the public record. *The Toronto Star* reports that these quality controls are rarely used. The President of the PA, quoted in *The Medical Post*, stated that less than 1% of more than 4,000

patient complaints (in a prior year) led to discipline proceedings. Without followup, there is no public notice that a physician is incompetent.

### **Should a patient's complaint be investigated properly?**

When a credible patient complains about substandard care, the law allows the PA to investigate. If a victim is willing to appear at a public hearing; discuss the evidence; answer the board's questions; and allow the case to become a matter of public record; surely the PA can investigate properly, not just dismiss the matter and leave other patients at risk.

The evidence documented in the patient's medical file can be considered carefully by the PA and the review board. Lax attitudes about substandard care leave trusting patients at risk. The law does not state that the PA can dismiss 99% of complaints. Presumably the law intends that substandard care will be investigated and action will be taken to protect vulnerable patients.

Each case is different. Busy doctors cannot perform all possible diagnostic tests or offer a range of treatments to each patient. Cost cutting may restrict care to what is practical but, ethical physicians can still answer questions and follow practice guidelines. Patients should not assume that their physicians are using standard of care procedures (as outlined in practice guidelines and medical books). If a patient deteriorates while trusting a medical specialist, there may be something wrong with the quality of the care. If a doctor is unethical or incompetent, the PA can investigate the situation on a timely basis.

### **Trust in Secrecy: trust betrayed**

The health system in Ontario was designed to protect sick people. There are quality controls, checks and balances. There are practice guidelines. The Regulated Health Professions Act, the Medicine Act and the Criminal Code have the power to identify incompetence and deal with medical perpetrators. If these laws are ignored, malpractice may not be discovered or investigated.

In 2001, the Ontario minister of health received two reports on the Regulated Health Professions Act; the first by independent consultants and the second by a regulatory council. These reports were not released to the public at the time of writing. Maybe the reports will recommend tightening up the health system and investigating more cases of incompetence involving psychiatrists.

*The Toronto Star* reported that the official motto of the physicians' association is "Trust in Secrecy." Concerns will continue as long as the PA dismisses complaints and trusts in secrecy. If substandard psychiatry is not investigated or dealt with, trusting patients can be betrayed and damaged.

In Abigail Padgett’s mystery, *The Last Blue Plate Special*, the author writes, “Medical personnel make mistakes, but rarely does [a] medical practitioner deliberately inflict harm. It just doesn’t happen. And when it does, the perpetrator ... reveals a darkness in the human soul.”

I struggled with mental health problems for years. When my trust was betrayed, I was sick, angry, confused, frustrated and upset. Finally, I took responsibility for understanding my illness, researching the diagnosis, considering treatment options and finding restorative care. After coping with episodes of a mood disorder, migraines and anxiety for twenty-eight years, obviously I waited too long. Within months of making a commitment to find my way through of the mental healthcare maze, I used the suggestions, tools and references in this book to find quality care. Now I am much better. I have been stable since 1996, and remain so, as long as I use restorative methods.

### **Reader guide to diagrams and checklists:**

Health System in Ontario – see page 54

Mental Healthcare Reality Check – see page 59

Maze of Depression Diagnoses and Treatments – see page 60

Suggestions for Patients and Caregivers – see page 76

Health Professional Assessment and Rating – see page 97

Author’s Experience of Mental Health System – see page 103

**Addendum:** In September 2001, the 180 page report of the Ontario Health Regulatory Advisory Council was released to the public. *Adjusting the Balance: A Review of the Regulated Health Professions Act* presents their findings. During its review of effectiveness, efficiency, flexibility and fairness, HPRAC considered 360 submissions from regulatory colleges, health practitioners, members of the public and others. The report makes 65 recommendations to better “protect the public from harm, promote quality care and make health professionals [more] accountable to the public”. Suggested changes would tighten the system by improving the procedures for complaints and discipline, creating an enforcement capability and allowing the public greater access to information. The report offered no timetable for legislative action. A revised Act could restrict incompetent practitioners who ignore practice guidelines, cause bad outcomes and damage vulnerable patients.

**SUGGESTIONS FOR  
MENTAL PATIENTS AND CAREGIVERS**

**P**atients and caregivers can monitor the quality of care, ask for standard of care procedures and request a second opinion. A patient or caregiver can read the practice guidelines and ask for accurate diagnosis and effective treatments. The guidelines of psychiatry are written clearly enough for laymen.

Many of the patients I interviewed could not say whether their health professionals followed the standard of care procedures. These patients were not familiar with the practice guidelines of psychiatry. Few knew about the negative effects of their antidepressants and other medications.

A health professional need not rely on short cuts. A differential (accurate) diagnosis requires a proper work-up. If a health professional uses a short intake interview to save time, he may label a patient rather than diagnose properly. A doctor may quickly prescribe antidepressants (or other powerful medications) and then increase doses without testing for any of the fifty medical conditions that are known to cause or contribute to symptoms of depression and other mental illnesses.

No amount of antidepressant medication will heal a patient whose mental symptoms are caused by a thyroid dysfunction, hypoglycemia or a brain tumour. If a mental disorder is a chronic condition, I advise patients and caregivers to ask for standard of care procedures. Patients and family can review the practice guidelines, find competent health professionals and cooperate with restorative treatments. I suggest the following:

1. Patients can read reference books to learn about their conditions. There is nothing to be afraid of. Many books about mental illness are written by experienced health professionals. They have clear information, success stories, clinical cases and current research about restorative care.
2. Patients can complete consent forms and obtain copies of their medical files. If there are problems with the care, looking through

the files can help patients understand what their health professionals consider, do, discuss and write. This can clarify diagnosis and treatments.

3. Patients can study the practice guidelines. These are available from American and Canadian psychiatric associations. Written by professionals for caregivers and laymen, they recommend standard of care procedures for accurate diagnosis and effective treatments.
4. Patients and caregivers can ask health professionals for information and references. Even if a doctor is too busy to teach Psychiatry 101, the patient can ask about basic books with helpful information. Informed patients find it easier to ask for help and cooperate with care.
5. Patients can read the practice guidelines and books about their condition, review diagnosis and treatment practices and ask their doctors to use standard procedures. Patients can request in writing that their care follow the practice guidelines for accurate diagnosis and effective treatment.
6. Patients can ask their health professionals (doctors, nurses, pharmacists and drug companies) to explain the range of effects of medications. It is upsetting if a sick patient gets worse without knowing that certain drugs can cause negative effects – in some people. The patient can make notes of his symptoms and side effects and give a copy of these notes to his doctor.
7. If there is little progress after a diagnostic work-up and treatments, patients can ask for specialist advice, medical testing or peer consultations. Patients can ask for second or third opinions.
8. Patients can ask other patients how they are diagnosed and treated. Local and national depression support groups offer opportunities for sharing personal experiences with survivors and consumers.

Sick patients trust their lives to healthcare professionals; substandard short cuts are not acceptable alternatives to competent care.

## THE PSYCHOLOGY OF WHISTLE-BLOWING

### Protection Of The Status Quo, Even Substandard Psychiatry

It takes time and effort for a patient to report substandard psychiatry (e.g., short cuts); it was harder than I expected. A “maintain-the-status-quo” psychology protects substandard psychiatry:

1. While working hard to maintain stability during recovery, it takes lots of energy to come forward. Even though the whistle-blowing patient intends to protect other patients, the patient risks social stigma. Telling tales is not socially acceptable; giving up social support is difficult for a recovering patient. This protects the substandard psychiatrist and exposes the whistle blower to destabilization and depletion.
2. To be heard as a former patient, lacking credibility, silenced and invisible after years of illness, a person has to work hard to overcome society’s automatic discounting. Former patients have to reach a higher level credibility than is required for reporting other life-threatening conditions such as a traffic hazard or a fire.
3. Reports of substandard healthcare involving short cuts and damage to patients may not be taken seriously by medical regulatory bodies – especially if the report comes from a mental patient. They may dismiss the patient’s complaint rather than have an independent health professional interview the patient, review the medical file and seriously consider the evidence of substandard psychiatry.
4. When medical regulatory bodies discount, dismiss, find fault and do nothing, a victim can revictimize himself by documenting the case in detail, providing references, reviewing short cuts and reliving details, only to be sloughed off.
5. The people responsible for investigating complaints either cannot cope with the volume or do not pay attention when a damaged patient comes forward. A matter can be reported again and again, with little or no response; each report requires the victim to recall the details and revictimize himself while the perpetrator can continue using short cuts. An unethical psychiatrist can practise negligently for years.



6. The patient risks a double social stigma: first by declaring episodes of mental illness; second by reporting the perpetrator of medical short cuts. Two levels of discounting seem to apply when the victim of substandard psychiatry comes forward. (1) A recovered mental patient is not often credible. (2) An individual is not likely to be accepted as a credible reporter of substandard care involving a health professional.
7. It appears that no one cares if a former patient reports misdiagnosis and mistreatment. There is no sense of urgency to check the facts and assess the extent of substandard psychiatry or medical malpractice. Society seems to distance itself from victims and leave other patients at risk.
8. Administrative doctors are not likely to believe a mental patient. It is easier for colleagues of the perpetrator to believe in his medical degrees rather than pay attention to the evidence. Even when there is evidence of substandard care, the physicians' association dismisses many complaints without investigating, resolving concerns or protecting patients.
9. Hospital supervisors are not likely to question the ethics of present or former employees. A supervisor who knows about the mistreatment of a patient by a psychiatrist cannot easily report that it happened in his department. Such a supervisor would have to admit to inadequate supervision.

### **Summary**

There appears to be a bias toward maintaining the status quo, protecting the perpetrator of substandard psychiatry and turning a blind eye to the use of short-cut alternatives to standard of care procedures. Even though the RPA Act allows a patient to report substandard care, by law, healthcare regulators can accept short-cuts without checking for incompetence, investigating or maintaining the quality of care.

If you or people you care about have mental health problems and if a patient gets worse as a result of substandard psychiatry, think carefully before you report the offender. Do not expect the process to be quick or easy. If you have concerns about your legal rights, you can consult a lawyer.

**RISK MANAGEMENT WITH SUICIDAL PATIENTS – REVIEW**

**\*Edited By Bruce Bongar, PhD et al, The Guilford Press, New York, 1998**

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Many mental patients live in despair. A shocking number kill themselves. Two people I knew took their lives while I was researching and writing this book. I write this review with respect for my dead friends and their families. *Risk Management with Suicidal Patients* encourages mental patients to find competent care.

Rather than watch patients deteriorate, the authors propose a sensible action plan. For healthcare to be effective, patients have to search for practitioners who follow practice guidelines carefully and consistently. Competent professionals diagnose the root cause(s) of medical and psychological conditions and treat patients effectively. Finding quality mental healthcare may not be easy. Too many mental patients are misdiagnosed and mistreated.

Mental patients struggle with interrelated difficulties including: a) multiple involuntary symptoms, b) effects of medications, (positive and negative), c) the stigma of being rejected, excluded, found fault with and distanced, d) low self esteem, e) restricted careers and limited employment opportunities, f) minimal finances and g) family problems. Having experienced many of these difficulties myself for over thirty years, it is hard for me to write about them calmly. Since I only have a bipolar II mood disorder, anxiety and migraines, I am lucky to be functional. For many years, I was not 'restored'. After lengthy episodes of depression, I understand the despair of patients who are misdiagnosed and mistreated; I can see why some take their own lives rather than continue living with the brain pains of major depression, psychosis, mania, schizophrenia and other serious brain disorders. Such sad passings are less likely if mental healthcare is competent.

Most mental health professionals know that the Diagnostic and Statistical Manual (DSM) is used for diagnosing mental illnesses. Psychiatrists in North America know that American and Canadian psychiatric associations publish practice guidelines of psychiatry. *Risk Management with Suicidal Patients* explains how care can go wrong and how a psychiatrist can be negligent. Ten mental health professionals cooperated to write the book, psychiatrists and psychologists. The editor, Bruce Bongar, PhD, introduces the book. Chapter 1 "is a reprint of a widely cited paper on general outpatient standards of care, which includes an analysis of common failure scenarios." The authors do not link their recommendations to the practice guidelines of psychiatry.

The definition of negligence is given

“as doing something which he ... should **not** have done (commission) or omitting ... something which he ... should have done (omission).”

Although it is obvious, “... the best solution to the spectre of liability following a patient’s suicide is for the clinician to have provided good clinical care that followed acceptable standards of practice” and “... appropriate risk management is the core of a preventative approach to the unfortunate possibility of liability after the suicide of a patient.” Even though few legal claims involving negligence proceed to trial (and even if there is a trial, most cases are won by physicians), it makes sense for health professionals and patients to learn, discuss and focus on standard of care procedures. They can cooperate to follow practice guideline recommendations for accurate diagnosis and appropriate care.

The standard of care is defined as “that degree of care which a reasonably prudent ... professional should exercise in the same or similar circumstances,” and therefore “deviations from the standard of care are usually referred to as negligence.” The definition itself does not outline the steps involved in competent mental health care. Fortunately the book explains effective inpatient and outpatient care. It indicates how allegations can result from failed care and it offers risk management procedures to minimize liability. I compared the negligence checklists with the practice guidelines of psychiatry and had no problem understanding the steps for proper care. It is easy to see how concerns can arise if standard of care procedures are not followed.

The book was written for mental health professionals. A sobering quote from John Maltsberger, MD on the back cover explains its goals and objectives: “One-third of the psychologists and half the psychiatrists in this country (US) will find themselves snared in malpractice actions in the course of their careers. These ... usually drag on [for] several years; practitioners pay a heavy price and at best can expect a searing emotional experience before such a case is concluded ... knowing what is in this book is the practitioner’s best prophylaxis for safe practice.”

Dr. Maltsberger could have expanded his target readership by suggesting that knowing what is in this book is the mental patient’s best way of avoiding negligence and getting proper care. Thinking about the sobering impact after a misdiagnosed and mistreated patient dies by suicide made me realize that suicide sears the lives of family and friends with far more heat than the lives of health professionals who were negligent.

Steps can be taken to reduce the risk of misdiagnosis and mistreatment of vulnerable patients. Patients and family can cooperate and ask practitioners to explain which standard of care procedures are appropriate. I included sample checklists from *Risk Management of Suicidal Patients* so readers can assess care, identify problems and resolve concerns.

For instance, health practitioners can recommend a short reading list to educate patients and significant others about patients' illness and treatments. Many books are written for laymen. Taking an adequate history is easier if the practitioner explains to the patient and family what this involves and asks them to note details of medical and mental histories. Histories can offer valuable clues about inherited tendencies, the diagnoses of relatives and treatments which worked well for them.

A busy mental health practitioner can ask the patient and family members to help by asking for treatment records. I tested two former doctors by writing for copies of my files. Their paperwork came in two weeks. One doctor works at a hospital. He asked for a modest payment. I was comfortable with the fee, knowing that hospital staff had to take time to find the file, make copies and mail them. The other doctor, a private practitioner, also responded promptly. He provided his file with a brief letter wishing me well. My former psychiatrist never asked for these past files. When I was ill, I did not know that he was not using the files that his colleagues prepared. After I learned that histories could help, it was easy for me to obtain information which the psychiatrist could have used to diagnose me accurately and treat me effectively.

When I was his patient, I remember feeling sick and upset. I worried as my condition deteriorated. I was too sick to question the quality of care. I was stupid to trust my life to short cuts. Now I know what to expect when my bipolar II mood disorder flares up. After finding restorative mental healthcare, I have been stable since 1996. I learned about the practice guidelines of psychiatry, obtained past files and noted medical and mental histories. I am ready cooperate with a competent psychiatrist if I get sick again.

There is no point waiting until a patient dies by suicide before learning about standard of care procedures. Rather than trusting the lives of vulnerable patients to negligent health professionals, patients, family and caregivers can cooperate. *Risk Management with Suicidal Patients* is a helpful antidote to negligent psychiatry. It encourages cooperation among health professionals, patients, family and friends of people who suffer with depression, mental episodes or brain disorders.

## A MENTAL HEALTH PROFESSIONAL CAN AVOID ALLEGATIONS OF NEGLIGENCE

(A Mental Patient Can Monitor The Quality Of Care)

### 13 Essential Elements of (Effective) Outpatient Care

by A.E. Slaby, MD, PhD, MPH  
Department of Psychiatry, NYU

- 1. Conduct evaluations for suicidal ideation.
- 2. Estimate risk based on factors.
- 3. Determine need for hospitalization.
- 4. Evaluate and instigate medications to treat the (right) disorder & diminish impulsivity.
- 5. Enhance social support: directly, indirectly.
- 6. Provide individual and family therapy.
- 7. Provide concurrent substance (advice).
- 8. Provide medical consultation.
- 9. Provide ECT, if needed.
- 10.(a) Educate patient & significant others about signs of deterioration and need for intensive treatment.
- 10.(b) Plan to provide what is needed.
- 11. Arrange access to therapist and other caregivers if need for intervention arises.
- 12. Help patient, family and friends understand that goals must be realistic.
- 13. Keep careful records.

Extracts from Risk Management of Suicidal Patients, edited by Bongar et al, Guilford Press, 1998

## A MENTAL HEALTH PROFESSIONAL CAN AVOID ALLEGATIONS OF NEGLIGENCE

(A Mental Patient Can Monitor The Quality Of Care)

### 8 Most Common Allegations for Malpractice after a patient's suicide

by J.D. Robertson,  
Psychiatric Malpractice, Wiley, New York

- 1. Failure to predict or diagnose suicide.
- 2. Failure to control, supervise, restrain.
- 3. Failure to take proper tests and failure to evaluate patient to establish suicidal intent.
- 4. Failure to medicate properly.
- 5. Failure to observe patient on a frequent enough basis.
- 6. Failure to take an adequate history.
- 7. Inadequate supervision or failure to remove dangerous objects.
- 8. Failure to place the patient in a secure room.

Extracts from Risk Management of Suicidal Patients, edited by Bongar et al, Guilford Press, 1998

#### Author's addition

Failure to follow the Practice Guidelines of Psychiatry  
(APA, CPA) which suggest:

- 1. Procedures for accurate diagnosis of the root cause(s) of the patient's symptoms.
- 2. Effective treatments to help the patient restore and maintain good mental health.

## **A MENTAL HEALTH PROFESSIONAL CAN AVOID ALLEGATIONS OF NEGLIGENCE**

**(A Mental Patient Can Monitor The Quality Of Care)**

### **15 Risk Management Procedures to Minimize Liability**

by A. Berman, PhD, and B. Bongar, PhD  
Extracts from Appendix 7.1

- 1. Inform patient of confidentiality limits.
- 2. Use informed consent.
- 3. Stay current with developments in the field.
- 4. Know community resources, referral sources.
- 5. Evaluate suicide risk.
- 6. Secure past treatment records.
- 7. Assure clinical competence.
- 8. Provide adequate documentation.
- 9. Consult professional colleagues.
- 10. Maintain quality of patient care.
- 11. Discuss the benefits and limits of short-term care.
- 12. Patients in crisis should never be terminated.
- 13. Clearly document decision to terminate.
- 14. The more insurance coverage the better.
- 15. Retain a lawyer.

Extracts from Risk Management of Suicidal Patients, edited by Bongar et al, Guilford Press, 1998

**PSYCHIATIC SURVIVORS:  
MEDICAL RIGHTS OR A REALITY OF WRONGS**

If psychiatric survivors speak up about their illnesses, they may not be heard. They may not get good medical care for their involuntary symptoms. They may suffer in silence. If they get upset once too often, they may be drugged into oblivion, shocked into memory loss, hospitalized unwillingly, shunned and stigmatized.

Compare the rights of people who are reasonably healthy, 'normals', with people who have a mental illness (e.g., depression). Depressives don't always get their medical rights. Depressives are expected to ignore their symptoms, see through their darkness, accept platitudes and use their anguished brains to cope. Depressives may live in a reality where medical rights are wrong, but substandard alternatives are 'right'.

- 1. Right to a standard of care which is consistent with professional practice guidelines.** When 'normals' get hurt or sick, their rights include accurate root-cause diagnosis and restorative treatments. Medical care for 'normals' is based on finding the causes of their painful symptoms and treating their illnesses.

Depressives can suffer quick and easy 'care', labelling and drugging. Minimalist medical effort may involve finding fault and doing nothing or misdiagnosing and mistreating. The brain pain of depressives may be numbed and their cognitions dumbed by powerful drugs. Synthetic medications can, and often do, make depressives worse. The ill-being of depressives may be multiplied by negative effects which they are told will go away. Meanwhile doses may be increased until side effects turn into adverse effects. Doctors, pharmacists, drug companies and regulatory bodies know that drugs for depressives can cause a range of problems, including toxic effects. The right medications, in the right doses, can help depressives if the pills are prescribed by competent health professionals who have taken careful histories and done medical and mental tests to determine the underlying illness. Therapy can help depressives cope with troubling symptoms, chronic illness and daily distress.

- 2. Right to R.A.I.S.E.** 'Normals' expect to be treated with respect, approval, interest, support and encouragement.



Depressives often get D.D.E.D.D.: disrespect, disapproval, exclusion, discounting and discouragement.

**3. Right to medical care.** 'Normals' assume they will be tolerated with patience, comfort, consideration and compassion.

Depressives may experience intolerance, impatience, abuse, discomfort, cruelty or shunning.

**4. Right to peace of mind and a place in society.** 'Normals' take this for granted.

Depressives live with involuntary symptoms, as well as the negative effects of powerful medications, often suffering in isolation. Depressives may be shunned by polite society, family and friends during, after or because of episodes, moods and outbursts. Depressives can become social lepers. Some people treat their dogs better than relatives who periodically or regularly experience episodes of mental illness.

**5. Right to be believed.** Reasonable comments by 'normals' are listened to, learned from, believed in and trusted. They usually get ethical healthcare.

Depressives may not be credible. People may not listen, learn, believe or trust them but distrust, dismiss, discount and dispute them. Depressives may not be good enough for people to listen to their words, learn from their symptoms, believe their truths or trust their requests for standard of care procedures.

**6. Right to have complaints about neglect, negligence or sub-standard care taken seriously, investigated, verified and resolved.** 'Normals' count on being taken seriously if they are abused or victimized by unethical health professionals.

Depressives are easy victims for unethical, incompetent, inexperienced or predatory psychiatrists.

Depressives may be dismissed, discounted, or ignored if they report short cuts, substandard care or incompetence by health professionals. Credible complaints by depressives may not be investigated.

**7. Right to justice.** In the 'normal' world, people who break the law are subject to investigations, charges and prosecutions. If found guilty, they face serious penalties.

Depressives may be victims of negligent short cuts if careless or unethical doctors prescribe powerful pills which are noxious at

high doses. This can harm or even 'torture' depressives. Unethical predators can abuse patients with drugs and shocks, ignore their suicidal thoughts and watch them deteriorate until they take their lives. It is difficult to prove that harm was done to depressives by substandard care.

- 8. Right to workplace equity.** 'Normals' count on protected career opportunities and disability insurance if they suffer from an illness lasting for months or years.

Psychiatric survivors whose brains don't function properly during depressions, mental episodes or brain disorders cannot prove their disabilities by blood tests, fluid losses, X-rays, scans or lumps. Mental illness is an invisible disability. Repeated episodes of depression reduce people's rights to be treated fairly by employers and coworkers.

Depressives can keep silent about their symptoms, diagnosis, treatment and prognosis. Keeping quiet about their dark reality means they do not qualify for anything other than negative performance reviews. Speaking up about their illnesses may mean that depressives are disqualified from promotions, sidetracked from career opportunities or shown out the door.

Mental illness is a disabling condition but it does not stop depressives from wanting to work, advance their careers, make money, live independently and support families. Depressives may not be able to claim financial support from the insurance companies to which they pay disability premiums. Disability due to moderate physical illness is often covered by insurance, but chronic mental illness is not often covered.

- 9. Right to be fallible human beings.** 'Normals' take it for granted that their flaws, faults, frustrations and failures will be accepted as part of the human experience.

Depressives may find that no matter what they do, it is not good enough to be accepted. They may be stigmatized and dehumanized, tainted and distanced.

- 10. Right to life, liberty and the pursuit of happiness.** The North American dream is the expected right of 'normals'.

Depressives find these dreams much harder to achieve. Psychiatric survivors may exist as the living dead: people with few rights, restricted freedoms and lost opportunities. Without full medical rights, psychiatric survivors live in a topsy-turvy reality of wrongs.

**AFTER REVIEWING THE SYSTEM:  
ASSESSING THE MENTAL HEALTH PROFESSIONAL**

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**M**y exploration of the mental health maze was circular. After investigating, I ended up back where I started, sadder but wiser. I learned that there are laws to protect patients. There are complaint committees and professional associations to consider reports of incompetence, incapacity or misconduct involving physicians. There is a review board to hear matters which are not disposed of properly. There is a regulatory council to review the healthcare legislation. There is an office at the minister of health to oversee the health system as the representative of the elected government. On the plus side, it is obvious that the health system was designed to help sick people. On the minus side, little or no action is taken after a whistle blower reports substandard care. In Ontario, Canada, the procedures for investigating bad outcomes and resolving patient complaints are very slow. If complaints are dismissed, there is no incentive for patients to report cases of care gone bad and there is no way for physicians and patients to learn what happened or make sure that similar problems do not recur. If a credible patient complains about substandard care and questions the competence of a physician, the dismissal of the patient's report by the physicians' association does not maintain the quality of medical care or protect other vulnerable patients from damage due to medical incompetence, inexperience, negligence or shortcuts.

The psychiatrist chose not to tell the truth about my bad outcome. The lawyer who represented the psychiatrist was convincing. Even after seeing evidence of substandard psychiatry, the physician's association protected the doctor. The complaint committee dismissed the case without investigating properly. The review board heard the story and saw evidence of substandard care but seemed powerless to do more than refer the matter back to the physicians' association. The office of the minister of health acknowledged the case and passed the buck to the physicians' association. The regulatory council included me in a focus group discussion and thanked me for sending extracts from this book (to consider when they drafted their report on the RHP Act). There was a polite but firm bias against following up the evidence of incompetence by the psychiatrist. The medical file had clear evidence, written by the psychiatrist himself, but everyone involved gave him the benefit of the doubt; as if they could not bring themselves to believe a former mental patient.

This seems paradoxical. With evidence of incompetence, laws empowering action and responsible people authorized to investigate, it seems odd that

nothing was done to resolve the matter and protect other patients. I did not expect the psychiatrist would admit his short cuts but I did think the evidence in the medical file would be taken seriously. I did not expect the physicians' association to believe the story without investigating but I did think they would ask a health professional to compare the file with the practice guidelines. I did not expect they would trust my analysis but I did think the review board would ask an expert psychiatrist to consider the evidence of incompetence. Given the skimpy file, an investigation would have taken less than one hour. The matter could have been wrapped up within the six month time limit provided for the the RHP Act. The psychiatrist could have been disciplined and re-educated. His patients could have been protected from the damage done to me. Six years after the matter came to light, there is no progress to report.

After blowing the whistle on substandard psychiatry, I pondered the lack of response. I wondered how a mental patient could improve his chances of getting quality care. If the patient is deteriorating and doubting the competence of a psychiatrist, surely something can be done to help the patient. As I was exploring the system, reading about depression and interviewing survivors, I met other patients who had similar problems finding competent care for depression, mental episodes and brain disorders. I read medical books, studied the practice guidelines of psychiatry and looked at the legislation. It was encouraging to learn about the systems and procedures for diagnosing and treating mental illness. There is information about psychiatric, psychological and medical causes of depression, mental episodes and brain disorders. Health professionals, hospitals, organizations and support personnel can provide competent care, monitor standards and protect patients.

In theory, standard of care procedures help to maintain the quality of medical care. In practice, things are different. Although there are health professionals, thoughtful systems and careful controls, there are no teeth in the system. Unethical health professionals can cut corners and damage patients. Exploiting sick people by misdiagnosing and mistreating them is not acceptable, especially if the predator is a psychiatrist

If health systems and quality controls do not always work effectively, perhaps some problems can be related to overzealous cost cutting and staff terminations not to mention reducing the number of beds, closing hospitals and pruning mental wards. Saving money by thinning staff, combining facilities and cutting costs may strengthen the bottom line of hospitals but the health system is weakened if things go too far. With healthcare costs spiralling out of control, it is reasonable to monitor expenditures and

improve efficiencies, but it is not fair to eliminate standard procedures and reduce the quality of care until sick patients suffer.

When quality controls are weak, unethical psychiatrists can cut corners, take advantage of loopholes and escape reprimands. If too few resources are available for detection, investigation and follow-up, unscrupulous professionals are not identified or punished. Even though my test case of substandard care was reported from 1995 to 2001, the psychiatrist never explained his short cuts. There was no requirement that he improve his practise. His association counselled him to note patient histories but missed the truth – he did not take patient or family, medical or mental histories. Nothing was done to assess whether other patients had similar problems.

At this time in Ontario, Canada, there is no public record of complaints about physicians. Some American states have rules for reporting concerns if a physician is incompetent. Formal systems for reporting bad outcomes allow physicians, patients and family to monitor and maintain the quality of care. Until such systems are implemented more widely, it is up to patients, family and caregivers to monitor each case informally and discuss bad outcomes. A psychiatrist knows that a patient needs help if there are ongoing problems. Caregivers can watch for:

- multiple involuntary symptoms of depression and / or hypomania; plus co-morbid conditions (such as anxiety, migraines, hypoglycemia or other medical conditions)
- negative effects of powerful psychiatric medications (which help many people but they can, and often do, cause side, adverse and toxic effects)
- personal problems: without education and information, sick people worry about their diagnosis and prognosis; being brushed off is little comfort when patients' lives are coming apart
- rejection and exclusion by health professionals, family, friends, clients and other people who don't understand or think the sick person should pull up their socks (when socks aren't down)
- social deficits; after losing credibility; mental patients are relegated to social leper status; and
- limited financial resources; after years of illness, career derailments, business problems, difficulty paying for food and shelter and problems maintaining financial commitments during episodes.

If a sick patient does not get better, the patient can ask for tests, request an accurate diagnosis, read books to understand his illness and search for competent care. For a long time, I did not take these steps. It seems obvious

to me now that a patient can ask for quality care. Although my psychiatrist said, “You will get well,” I didn’t realize that his encouragement was not backed up by proper procedures; he didn’t bother make an accurate diagnosis and the treatments he recommended were not restorative. The drugs he prescribed were not helpful. In hindsight, it is not surprising that the wrong medications made me worse. The psychiatrist could not feel my pain. As I got worse, it was wrong for me to trust my life to substandard psychiatry.

You may question how a mental patient or family could benefit by reading the patient’s medical file. You may wonder if you have the resilience to present a bad outcome at a hearing. I did. It was unfortunate that I could not afford to hire a lawyer to represent me at the hearings but I wanted the case to be heard. After decades of health problems, many patients have limited resources and little motivation to understand files or present evidence. Even though my exploration of the mental healthcare maze was circular, I still believe that the RHP Act can protect patients. The physicians’ association and the review board can cooperate to maintain quality care. They can take timely action when standard of care procedures are not used. There are systems and procedures, checks and balances. Responsible people can do as the law allows and investigate incompetent physicians.

The patient, his family and caregivers can overcome problems with substandard psychiatry by assessing the mental health professional before and during treatments. They can notice if progress is being made and think whether to keep on trusting the practitioner. Like everything else connected with the mental health system, it is not easy for a sick patient to determine if a health professional is competent. A patient may be too sick to assess the quality of care but family and other caregivers can pay attention to what is going on. They can ask the psychiatrist for his track record helping mental patients. A patient can ask to meet some of the doctor’s other patients who have been helped. Caregivers can ask for references, testimonials and success stories.

Patients, family, friends and caregivers can use the “Health Professional Assessment and Rating Checklist” to monitor each health professional for quality of care, competence, communication and cooperation. At the start of each visit, when the health professional examines the patient, the patient can use the checklist to assess the health professional. Together patient and doctor can monitor progress. Many patients have enough common sense to use a checklist. Rather than continue if a relationship is not working, the patient can ask questions and discuss concerns. A psychiatrist who does not want feedback from a patient can refer the patient to another doctor, counsellor or support worker.

When they are not well, mental patients can be upset and upsetting. Many struggle to cope with involuntary symptoms of depressions, mental episodes and brain disorders; a good percentage of patients have negative effects when taking medications; they experience career set-backs and job discrimination. They can feel helpless and hopeless, alone and lonely, sick and tired, stigmatized and shunned. Mental patients may feel like society's rejects, the bottom class of patients in the health system. Ontario laws such as the Regulated Health Professions Act, the Medicine Act, the Criminal Code and the practice guidelines of health professionals do not discriminate against mental patients. These laws give health professionals, hospitals, professional associations, review boards and law enforcement officers the legal authority to help mental patients just the same as any other patients. The laws, checks and balances of the health system are designed to help patients recover.

My experience taught me that there are difficulties getting the proper authorities to investigate a case of substandard psychiatry. After going around in circles, I cannot advise patients, family or caregivers to report substandard care if it is only going to waste time. Rather than trust the lives of sick patients to unethical professionals who are using ineffective methods, I recommend assessing each professional for quality of care, competence, communication and cooperation. Patients, family and caregivers can use the "Health Professional Assessment Checklist and Rating Scale".

Patients are likely to get quality care if their health professionals score in the range of 3 to 5 on the R.A.I.S.E. rating scale. If a health professional scores -3 to -5 on the D.D.E.D.D. rating scale, there may be problems. The health professional may not be competent or he may not be using his education, training, references and experience. Patients, family and caregivers can watch for health professionals who seem sincere but do not care about their patients. Rather than debate matters, patients can ask for another opinion. When a patient gets worse, some hospitals have a policy of assigning a 'refractory' patient to a second psychiatrist for a consult.

Before trusting the lives of sick people to mental health professionals who may be unethical, inexperienced or incompetent, a patient can assess the health practitioner. The assessment can be updated at each meeting. The patient's goal is to find and cooperate with competent mental health professionals who score well on the R.A.I.S.E. rating scale. These practitioners are likely to follow their professional practice guidelines, use standard of care procedures, diagnose accurately and treat effectively. R.A.I.S.E. practitioners know how to help mental patients restore their mental health. D.D.E.D.D. practitioners may have medical degrees, years of clinical experience,

## HEALTH PROFESSIONAL ASSESSMENT

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A patient can see, ask, listen and learn. Does the caregiver –

### 1. **Respect** patient and family?

R

I respect depressed patients. They have involuntary symptoms and want to get well.

Mental patients have the right to quality care involving standard procedures.

### 2. **Approve?** Follow practice guidelines?

A

Mental patients deserve competent care.

If we follow practice guidelines, we can find the root causes and help each patient get well.

### 3. **Include?** Educate?

I

It is good to include the patient in the process of diagnosis and treatment. Mental patients can hear, see, talk, read and learn.

We explain that there are causes and triggers.

After we diagnose patients accurately, we can help them recover and keep well.

### 4. **Support** patient and family?

S

We support research and medical practices. We help mental patients recover by treating underlying conditions and recommending restorative mental healthcare.

### 5. **Encourage** quality care?

E

Professional practice guidelines recommend accurate diagnosis and effective treatments to help mental patients recover.

In our clinical experience, mental patients can restore mental health and live well.



## HEALTH PROFESSIONAL ASSESSMENT

---

A patient can see, ask, listen and learn. Does the caregiver –

### 1. Disrespect? Upset?

D

A mental patient is sick. We can't do much. There is little hope of recovery.

Mental patients can't be helped. It is wrong for mental patients to hope for the impossible.

### 2. Disapprove? Deny?

D

Mental patients aren't like normal people.

We don't look for causes. We talk to mental patients. We use medications to quiet them.

### 3. Exclude? Silence?

E

Mental patients are upset and upsetting. Their brains don't work right. They can't understand. Their capabilities are limited.

We do our best to cope with mental cases.

We smile silently as patients struggle to cope in the real world.

### 4. Discount? Dismiss?

D

There is no such thing as restorative mental healthcare. Only quacks would make such claims. The scientific research, clinical protocols and recovery stories are unproven.

### 5. Discourage standard of care practices?

D

Guidelines exist but they aren't standards of care. Nice in theory, but not much use in practice. Mental patients don't often recover.

We can't do much to help most mental patients. We discourage false hope.

## HEALTH PROFESSIONAL RATING

(For use by patient, family and caregivers)

	Assessment
Respects	R <input type="checkbox"/> 1
Approves	A <input type="checkbox"/> 1
Includes	I <input type="checkbox"/> 1
Supports	S <input type="checkbox"/> 1
Encourages	E <input type="checkbox"/> 1
R.A.I.S.E. Total	<input type="checkbox"/>

### Profile of a R.A.I.S.E. Practitioner

(Scores between 3 and 5)

- focus is guideline quality of care, sincere communication, cooperation and competence
- follows professional practice guidelines for accurate diagnosis and effective treatment
- cooperates to help the patient restore mental health, maintain high functioning
- encourages recovered patient to live well

## HEALTH PROFESSIONAL RATING

(For use by patient, family and caregivers)

	Assessment
Disrespects	D <input type="checkbox"/> -1
Disapproves	D <input type="checkbox"/> -1
Excludes	E <input type="checkbox"/> -1
Discounts	D <input type="checkbox"/> -1
Discourages	D <input type="checkbox"/> -1
D.D.E.D.D. Total	<input type="checkbox"/>

### Profile of a D.D.E.D.D. Practitioner

(Scores between -3 and -5)

- seems sincere but there are problems with poor care, shortcuts, non-communication and incompetence
- fails to diagnose accurately or treat effectively, watches sick patient get worse
- if mental patient is misdiagnosed and mistreated, not concerned as the patient deteriorates
- knows worsening illness increases risk of suicide.

and promote their expertise by writing articles in professional journals but their preference for substandard short cuts can harm a vulnerable patient. Incompetence and negligence can prove deadly. Even though a mental patient may be unwell with depression, mental episodes or brain disorders, the patient can assess the quality of care, find ethical psychiatrists and cooperate with R.A.I.S.E. practitioners.

Instead of giving up, readers can use the tools and references in this book to search for competent care and avoid the traps of misdiagnosis and mistreatment. Patients, family and caregivers can use the mental health-care compass to discuss the practice guidelines and find quality care. They can use TAYO, the healthcare planner, to cooperate, get accurate diagnoses and effective treatment. You can read about these tools in Part Three.

## *C h a p t e r 16*

### **HARD LESSONS LEARNED WELL**

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**I**f you think I am bitter about the bad outcome of my mental healthcare, let me reassure you. The substandard care and my travels through the mental healthcare maze taught me about the dark side of the system. I learned valuable lessons from the expert psychiatrist, the medical file, the chief psychiatrist, the hospital clinic, the physicians' association, the review boards, the administrators of healthcare associations, the authors of reference books and other survivors. I appreciate their patience.

Maybe short cuts are helpful if a busy physician gets overloaded. Too many cuts can lead to incompetent care which can make a sick patient worse and risk the patient's life. After my care went bad, it was foolish for me to keep trusting Dr. T.T. ShortCu and his short cuts. His smiles and substandard care taught me that a psychiatrist may not always diagnose his patient accurately or treat the patient effectively. A callous doctor can write "refractory depression" in a patient's file and prescribe medications which make the sick patient worse. The trusting patient does not expect a doctor to ignore his practice guidelines or take short cuts. Even while coping with symptoms and side effects, a mental patient has to monitor his care.

The chief psychiatrist at the large hospital taught me that psychiatrists are supposed to study, learn and apply proven techniques for accurate diagnosis and effective treatment, according to their practice guidelines. The chief encouraged me to introduce the guidelines to readers of this book. He made time in his busy schedule for an interview. I asked why my

problems with substandard psychiatry happened at his hospital (where his residents, staff and expert psychiatrists are supposed to follow the standard of care). Tactfully, the chief declined to discuss the bad outcome.

The review board heard my story and saw evidence of substandard care. The board listened to the doctor's lawyer. She claimed that the doctor took histories. The board saw that there were no proper history notes in the medical file, prepared over eight months. With no physician at the hearing, it was unlikely that the board could identify substandard care or evaluate incompetence. The 1999 board understood enough to ask the physicians' association to investigate why there were no history notes in the file. The board did not consult with a health professional, as they might have done.

The physicians' association got a second copy of the file from the hospital. The histories (patient, family, medical and mental) were still missing. There were no diagnostic tests either. The physicians' association saw evidence of substandard care in the skimpy medical file, in the doctor's handwriting. They counselled the psychiatrist to follow up history-taking in future. Effectively, they let him off scot-free.

The association also taught me about short cuts. With thousands of cases every year, many complaints by credible patients are dismissed. Otherwise, the association physicians would have no time for their medical work. It would make sense for the association to use eight steps to investigate and process patient complaints which involve incompetence:

1. assign each case to a peer physician
2. interview the patient
3. study the medical evidence
4. verify the complaint
5. compare the file with the practice guidelines
6. ask the doctor to justify short cuts
7. check a sample of patient files
8. explain substandard care to patients and their families

If a pattern of substandard care is detected, medical associations should follow the provisions of the RHP Act and protect patients from incompetent, unethical, inexperienced or negligent doctors. Timely follow-up could resolve misunderstandings, maintain the quality of healthcare and save time and money.

The hearings were embarrassing but educational. Presenting my case and showing the evidence was not easy. It was humiliating to disclose my mental health problems, put the case on the public record and ask the

physicians' association to investigate Dr. T.T. ShorCu. By reporting substandard care, I did what the law allowed. Even though another patient died (after a case of misdiagnosis and mistreatment involving the same psychiatrist), my complaint was not taken seriously. It was upsetting that the system did not follow up or find out what went wrong with my care.

My experience of Ontario's mental health system (refer to diagram) taught me that there are laws, offices, people and procedures. My perception of short cuts at all levels is not consistent with the practice guidelines of psychiatry or the RHP Act. According to the RHP Act (in Ontario, Canada), if a credible patient suffers a bad outcome and suspects incompetent care by a physician, a patient can report the doctor. If a physician relies on short cuts rather than standard of care procedures, the law allows the physicians' association to investigate. The law does not encourage the association to put off the victim, ignore the evidence, dismiss the complaint or allow the physician to continue using negligent short cuts.

An investigation might discover good reasons for substandard care (unlikely). The people responsible for monitoring medicine can act to maintain the quality of care and protect patients from incompetence. Since the hearings were public, I can write about the bad outcome, the dismissals and the process, without being sued.

If it was not for the bad outcome of substandard psychiatry, I would not have gotten upset about short cuts and incompetent healthcare. I would not have read so many books. I would not have learned my correct diagnosis or found restorative care. Fortunately, I recovered. Bibliotherapy is a good strategy. You can learn from my experience that patients can read and find effective care for depressions, mental episodes and brain disorders.

Hard lessons, learned well.

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*Twists and Turns Around and Through  
The Mental Healthcare Maze*

There are hidden truths  
and obvious lies about mental illness.  
It is hard to see sense through  
the darkness of depression.

While exploring the mental healthcare maze,  
twists and turns, lies and silences,  
stigmas and defences, illusions and shadows,  
ignorance and fear, frustration and pain  
can conspire to hide the truth.

The persistent patient gets the prize:  
restorative mental healthcare.

(Extract from poem in *Wordscape Seven*, an anthology  
published by the Canadian Authors Association, 2000)

## **MY EXPERIENCE OF ONTARIO'S MENTAL HEALTH SYSTEM 1995 TO 2001**

The watchdogs were toothless. The system protected incompetence.  
Short cut alternatives to standard of care procedures  
cut costs and reduced the quality of mental healthcare.

### **Physicians' association – generalist and specialist doctors**

#### **The system receives patient complaints**

- investigators include a lawyer, a part-time military man, nurses
- website reports 4,000 patient complaints a year, few results are reported
- physicians' association can dismiss complaints, counsel or discipline doctors
- complaint committee has physicians, specialists and layman members

#### **Short cuts expedite**

- of 7 complaint outcomes, 6 dismiss and/or leave patients at risk
- less than 1% of patient complaints are referred for discipline hearings

### **Doctors – family physicians and mental health professionals psychiatrists have specialist education, training and experience**

#### **The system educates doctors and practises on mental patients**

- educated, trained, experienced, clinicians and researchers are trusted
- an expert can write articles for medical journals to gain credibility
- the practice guidelines of psychiatry recommend proven procedures
- a patient expects quality care ie. proper diagnosis and effective treatment
- a mental patient has involuntary symptoms, may be sensitive to pills

#### **Short cut alternatives = quick and easy \$\$\$\$ , save time**

- a doctor can write "refractory" and raise doses of powerful medications which are known to make sick people worse, efficient but careless
- a psychiatrist can smile and watch a sick patient get sicker, deteriorating for months. The specialist gets paid. No one seems to care if medical short cuts, incompetence or negligence damage a sick patient.

### **Practice guidelines of psychiatry – Cdn. and US**

#### **The guidelines are comprehensive**

- consensus of expert opinions, based on articles from 1971 to 1991
- explain how a patient can be properly diagnosed and effectively treated
- mental status examination is the first step in assessing the patient
- histories are the next step – patient and family, medical and mental
- can test for over 50 medication conditions known to cause depression
- advise combinations of medications and counselling to help patients
- if a patient doesn't get well, can review and re-do diagnostic workup, re-diagnose, then adjust treatments to help the patient get well

#### **Short cuts**

- psychiatric guidelines exist but doctors don't have to follow them
- practice guidelines are not considered standards of care for practitioners



## MY EXPERIENCE OF ONTARIO'S MENTAL HEALTH SYSTEM 1995 TO 2001

### Review board can hear health matters

#### The system outlined

- non-medical board hears matters in public
- sees evidence of medical incompetence
- the health professional need not attend
- the patient's credibility is questioned
- the board can appoint an investigator

#### Short cut outcomes

- can: (1) dismiss or (2) refer the matter back to the physicians' association

### Regulatory council

- notes matters to report
- covers 21 health colleges
- no power to investigate
- reviews RHP Act
- reports to the ministry
- public can submit reports

### Ministry of health

- receives patient complaints about cases of incompetence
- may refer voters to the physicians' association
- can ask OPP to investigate if there are multiple victims or fraudulent schemes

### Hospital – department of psychiatry

#### The system outlined

- employs psychiatrists to research and staff inpatient wards & outpatient clinics
- chief psychiatrist supervises the department
- department trains new doctors, residents

#### Short cuts

- some doctors may not follow guidelines
- some supervisors may not report short cuts

### Civil litigation

- patient can sue a negligent physician for malpractice
- the cost is prohibitive
- after one year, a patient cannot take civil action (in Ontario, Canada)
- experts disagree on care

### Criminal code and the police

#### The system can protect victims

- sections of the criminal code apply to health professionals
- police will listen but, if only one victim, refer victim to the physicians' association
- limited resources, have to prioritize

#### Some medical schemes are investigated

- OPP medical fraud squad can investigate schemes, e.g., if deceit is used to make money at the expense of the public health system

