

To: patients, families, caregivers and health professionals,
From: Robert Sealey, BSc, CA, founder IDP – Independent Depression Project

Subject: One Patient’s Investigation of Unsafe Mental Healthcare

Synopsis: Between age 23 and 45, the patient consulted eight professionals - physicians, psychologists and psychiatrists. Polite and appropriate, he asked for help but the first doctors did not diagnose or treat. The others appeared professional but they misdiagnosed, mistreated, lied or laughed. The patient got worse. After eight months of misdiagnosis and mistreatments by one psychiatrist, the patient finally smelled a rat. Desperate to recover, the patient dusted off his degree (in biological and medical sciences) and applied his experience as a fraud investigator. He obtained his medical file, noted substandard care, reported incompetence, became an author and an advocate for safer mental healthcare.

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One Patient's Investigation of Unsafe Mental Healthcare

About the Author

Robert Sealey obtained a BSc degree from the University of Toronto in 1972. Then he took night courses in business and qualified as a chartered accountant in 1976. Self-employed as an accountant in North York, Ontario, Sealey offers accounting, tax and consulting services to local clients, including people who suffer from depression or other brain episodes or care for affected family members. As a recovered patient, Sealey became an author and published the SEAR series of layman's guides which includes Finding Care for Depression, articles, book reviews and a website www.searpubl.ca

My Investigation Started in 1995

In 1995, I consulted a psychiatrist who specialized in mood disorders. The diplomas on his office wall looked impressive. Every few weeks, he smiled reassuringly and said, "You will get well." I trusted the psychiatrist but got worse. Month after month, he prescribed pills and increased the doses. As a patient, I did not know what to expect. I did not know that he shortcut 13 procedures. He did not test or diagnose, discuss risks or caution about adverse effects of prescription medications. He did not monitor or note drug-induced neurological disorders. He did not mention that the practice guidelines of his profession recommend basic medical procedures for diagnosis and treatment. Was the doctor experienced? Yes. That psychiatrist was a specialist, in charge of the mood disorder clinic at a large Toronto teaching hospital (where they see patients and train physicians). For eight months, the brain doctor smiled as he misdiagnosed, mistreated and watched me deteriorate. As the trusting victim of an expert psychiatrist, I nearly ended up dead.

After recovering, I began to investigate. In 1997, I obtained a copy of my medical file (allowed by Section 36 of the Mental Health Act). The clinical record showed that after each visit, the psychiatrist wrote an average of nine words. I soon learned that the doctor wrote an article for the *American Journal of Psychiatry* in which he defined two words as meaning problems with diagnosis and problems with treatment: *he wrote those same two words in my medical file after every consultation - for eight months! According to his own notes, he knew there were problems with the quality of my care.*

The Evidence Pointed to Unsafe Shortcuts

The evidence, *which the doctor wrote in the medical file*, pointed to willful incompetence, unexpected for a psychiatrist working at a large teaching hospital. Did the expert forget, withhold or just ignore the recommended procedures?

The clinical record, written by the psychiatrist, proved that he shortcut the care. The four underlined phrases below summarize his quick and easy approach.

1. He did not diagnose. He offered no safe, effective or restorative treatments.
2. He did not discuss or document any treatment plan. He just prescribed meds.
3. He did not order blood tests when prescribing lithium, but noted problems.
4. After eight months, he abandoned me as a patient.

** 15 years later, I am still waiting to learn which psychiatrist took over my care.

By reading the practice guidelines of psychiatry, I learned that a series of routine medical procedures are recommended for the diagnosis and treatment of a mental illness. By comparing those steps to my medical file, I noted thirteen shortcuts. For eight months, the psychiatrist did not discuss, perform or document these standard-of-care procedures.

1. The psychiatrist did no mental status exams; he made no notes about mental status.
Doing this would take about one minute per consultation, and 30 seconds to note.
2. He took no patient or family medical or mental histories.
The psychiatrist could have suggested that I interview family members. Getting this information would not take his time.
3. He noted no symptoms; he took no blood tests; he ordered no psychological tests.
Noting symptoms could take one minute. In 30 seconds he could requisition blood tests and/or psychological tests.
4. He did not get my medical file or blood tests from the previous family doctor at the same hospital. A secretary could phone for the file.
5. He did not check thyroid, blood sugar, vitamin, mineral or hormone levels.
Here again, the psychiatrist only needed to order blood tests from a medical lab.
6. He did not order diagnostic tests; he did not make a differential diagnosis.
Symptoms can have different causes so a psychiatrist needs to see a patient's blood tests to identify a hormone imbalance, a nutritional deficiency, an infection, a metabolic disorder or some other underlying medical problem.
7. He did not make a diagnosis or indicate the nature of my illness.
Would an expert psychiatrist make a diagnosis before planning treatments?
It might take two or three minutes to review test results, suggest a likely diagnosis, briefly explain the condition and outline a treatment plan.
8. He did not warn about prescription medications: known risks or side attacks.
Any medication can cause side effects or worse problems for some patients. Pharmacists provide free drug information which a psychiatrist can discuss with the patient, taking one minute, then 30 seconds to note problems.
9. He did not discuss treatment risks; he did not obtain or note informed consent.
Each patient responds differently to medications, depending on the patient's illness, general health and biochemical individuality. Outlining the known risks and noting the patient's consent before treatment could take one minute.
10. He did not check liver enzymes, test kidney functions or monitor drug levels; he did not discuss or reduce the risk of drug-induced neurological disorders.
Ordering lab tests for drug levels, liver enzymes, kidney functions, thyroid and other hormones might take one minute. Drugs such as lithium are known to affect kidney, thyroid and other organs, as well as the brain. The guidelines recommend blood tests for patients taking lithium.

It could be difficult to discuss drug-induced neurological disorders with a very sick patient, but easy enough to have a one-minute chat and order lithium blood-level testing if a patient taking lithium develops a noticeable tremor, as I did.

11. He did not explain that brain conditions can be diagnosed and treated according to practice guidelines. (The Canadian and US guidelines refer to articles which my psychiatrist wrote for Canadian, American and British medical journals). In one minute, he could have said, “Sir, you are not well. Psychiatrists use practice guidelines to organize steps for diagnosis and treatment. Here is a copy. Please read them when you get home. During your next few visits, we can discuss these procedures, test your blood, consider your diagnosis and plan your care.”
12. He did not offer any prognosis. He ignored how mistreatments shredded my life. A sick patient hopes to recover and resume a normal life. A patient who is misdiagnosed and mistreated can get worse. Ignoring the adverse effects of ineffective, inappropriate or unsafe treatments abuses a patient’s trust. Giving information, help and hope for recovery could take one minute.
13. He did no patient education. He did not discuss or offer talk therapy. Sick patients do better if they learn how an illness can be diagnosed and then treated safely and effectively. Patient education is routine for patients with diabetes. Mental patients need the same support.

Some patients repeat problematic behaviors, use negative thinking patterns or continue in abusive relationships thereby maintaining episodes or risking relapse. Even if a busy psychiatrist has no time for patient education or talk therapy, it would only take one minute to recommend a book; and one minute to refer a patient to a psychologist, social worker or occupational therapist.

Over the eight months, my psychiatrist could have spent five minutes per consultation discussing and performing standard medical procedures. The first few steps could have helped the expert make a diagnosis. Then he could have planned appropriate treatments, noted my response and helped me recover. Why did he shortcut the care?

Interviewed the Chief Psychiatrist at a Toronto Teaching Hospital

Several years later, while researching and writing *90-Day Plan for Finding Quality Care*, I summarized the practice guidelines of psychiatry, in layman’s terms. The chief psychiatrist at the teaching hospital agreed to an interview. He was adamant that his thirty-five psychiatrists had to read, study, learn and follow the practice guidelines, with all their patients. He read my 10-step summary and said that this outline could help patients understand the process of diagnosis and treatment. I quietly pointed out that I consulted one of his psychiatrists but that expert did not follow the guidelines. The chief immediately refused to discuss my experience.

During our interview, the chief psychiatrist did not mention that while I was getting substandard care at his unit, he was busy editing *Mood Disorders Across the Life Span*. Thirty-seven mental health professionals contributed chapters to that medical textbook. They explain how to diagnose and treat mood disorders in young, middle-aged and older people. All of these experts describe standard procedures consistent with the practice guidelines of psychiatry. Six years later, the same chief psychiatrist wrote an editorial for

the *Canadian Journal of Psychiatry* in which he referred to the tradition of “nihilism” in psychiatry. How can doing nothing help sick patients recover? Did the chief supervise guideline-quality care, nihilism or both? Did he give patients a choice?

Belief #1 – When I was sick, I trusted an expert psychiatrist to follow his practice guidelines, test and diagnose properly and treat me safely and effectively. He didn't. I trusted the chief psychiatrist to monitor and improve the quality of care. He didn't.

Why offer quality care? After all, OHIP pays the same money for shortcuts as a doctor can get for a standard-of-care workup, diagnostic tests and helpful treatments.

I blamed myself for being ill and getting worse taking the pills that the psychiatrist prescribed. Was the doctor's incompetence really my fault? Did I deserve substandard care? Eventually I learned about another patient of the same doctor who also deteriorated. That patient killed himself. How do I know? The psychiatrist wrote about that patient's death for a medical journal, apparently after learning that *antidepressants are not a safe or an effective treatment for a brain tumor*. Misdiagnosis, mistreatment and death. Apparently admitted in his article.

The Regulated Health Professions (RHP) Act of Ontario

In Ontario, the Regulated Health Professions (RHP) Act allows the victim of unsafe care to report incompetence. Complaints about physicians go to the College of Physicians and Surgeons of Ontario (CPSO). The RHP Act requires the CPSO to investigate.

Reported the Incompetent Psychiatrist to the College of Physicians - 1997

In 1997, I did what the law allows. I reported the doctor. I hoped this would alert the College of Physicians to a psychiatrist providing unsafe care so they could investigate, check a few files and assess his competence. I believed that my report would result in clarification, education, resolution and steps being taken by responsible medical professionals to protect patients from the risks and damages involved with unsafe shortcuts, misdiagnosis and mistreatments. I was wrong.

Month after month, I wrote to the CPSO. For two years, I sent polite letters which enclosed copies of pages from medical books. It was not hard to compare my skimpy medical file to the recommended procedures because I kept reading medical textbooks, hoping to understand psychiatry and find competent care. Instead of using standard procedures and following practice guidelines, my psychiatrist shortcut the care. The doctor's skimpy notes did not mention mental status, histories, blood tests or diagnosis. He just prescribed pills and watched me deteriorate.

I wondered how a psychiatrist could justify shortcutting practice guidelines which recommend standard procedures for diagnosis and treatment. These include:

- (1) ordering medical tests, (2) taking patient histories, (3) doing mental status exams, (4) making a differential diagnosis, (5) planning care, (6) prescribing safe and effective treatments, (7) discussing risks, (8) noting the patient's informed consent before new medications, (9) offering patient education and (10) talk therapy.

With my permission, the CPSO obtained a copy of the clinical record from the hospital, but the CPSO did not investigate properly. Its complaint committee – which had no psychiatrists – disposed of my complaint by writing “the care was appropriate”. The

CPSO did not indicate why it was appropriate for a psychiatrist to omit standard procedures for eight months or why it was appropriate for a doctor to prescribe pills without making a diagnosis or why prescribe more pills as a sick patient got worse. The CPSO ignored those concerns. Their dismissal letter noted that I could appeal.

Belief #2 – Thinking that misdiagnosis and mistreatments by a psychiatrist who practiced incompetently might damage other patients, I trusted the CPSO to follow the law, investigate my complaint and take steps to improve patient safety. They didn't.

Hearings at the Health Profession Appeal & Review Board in Toronto – 1999, 2002

In 1999 I appeared before the Health Profession Appeal and Review Board in Toronto. I gave copies of my clinical record to three Board members and the doctor's lawyer. The skimpy file proved that the doctor shortcut the care. That Board asked the CPSO to investigate. Even so, the CPSO did not refer the matter to its discipline committee or hold a public hearing. The CPSO just disposed of the complaint, again, so in 2002 I presented the evidence of unsafe care to a second HPAR Board with three more people. That Board did nothing. The hearings made my case a matter of public record - twice. Unfortunately, the hearings did not help me or any other patient. However, with my case a matter of public record, I can write and speak about my experience without legal repercussions.

Belief #3 – After the CPSO dismissed my report of incompetence by a psychiatrist, I trusted the HPAR Board to follow the law and require the CPSO to investigate the matter. The Board listened; they saw the evidence of shortcuts. The Board asked the CPSO to investigate but the CPSO did nothing to protect patients from unsafe care.

Since 1997, I have wondered why the healthcare system ignores the evidence of incompetence, fails to investigate and leaves sick patients vulnerable to damage. I have read many books about psychiatry including Canadian and American practice guidelines. No medical books recommend shortcutting, ignoring or omitting standard procedures. No guidelines suggest doing nothing if a sick patient deteriorates. No reference books advise writing 'problems with diagnosis' or 'problems with care' in a patient's file.

Health Profession Appeal and Review (HPAR) Board – in Ontario

The HPAR Board has offices at 151 Bloor St. West, 9th fl., Toronto. www.hparb.on.ca
The Board archives its annual hearings in bulging binders. Anyone can ask to see those public records and read the submissions, statements and stories of patients who present evidence of substandard care, mistreatments and incompetence.

If a victim of unsafe care states, at a public hearing, that a complaint about incompetence was disposed of by the CPSO without investigating, without checking other patient files, without determining whether doctors are following practice guidelines, without considering the damage caused by misdiagnosis and mistreatments and without taking steps to protect other patients, can the HBAR Board do anything? According to the RHP Act, the Board can ask the CPSO to investigate that patient's complaint.

If the CPSO does nothing, the Board can consult an expert and investigate the complaint itself. According to the RHP Act, no penalties apply if the CPSO dismisses the matter or if the HPAR Board fails to protect the public. The Regulated Health Professions Act of Ontario has no enforcement provisions. Victims who report incompetent care may share their medical information for nothing.

HPRAC Report recommended adding ‘teeth’ to the RHP Act - 2001

Readers may find it surprising that the Regulated Health Professions Act of Ontario (RHP Act) has no enforcement provisions. When damaged patients report incompetent care, the weakness of this law, enforcement-wise, means that health colleges such as the CPSO can get away with dismissing complaints. According to *The Medical Post* and *The Toronto Star*, the registrar of the CPSO provided its complaint-disposal rate as 99%. What happens if the CPSO does not follow the law or investigate? – nothing.

As a victim of unsafe psychiatry, I told my story in 2000 when HPRAC held public hearings in Toronto. I received a copy of their 137-page report – *Adjusting the Balance – A Review of the Regulated Health Professions Act*, which HPRAC submitted to the Ontario Ministry of Health and Long-term Care in March of 2001. That report made 75 recommendations including adding ‘teeth’ to the RHP Act. Unfortunately the report was shelved when the ruling political party in Ontario prepared for an election – which it lost.

Even though the RHP Act requires an investigation when a patient reports incompetent care, with no enforcement provisions in the Act, the CPSO can dispose of complaints without investigating substandard care or taking steps to protect patients from damage inflicted by negligent health professionals. If physicians cause harm and affect patient safety, the public might hope to see enforcement provisions added to the RHP Act. At one time, the RHP Act mandated a review of that law every 10 years by the Health Professions Regulatory Advisory Council (HPRAC). I could not find any review requirement in the current version of the Act.

Adjusting the Balance at www.hprac.org – see Reports – Other Archived Reports

Found More Evidence In a 2009 Hospital Newsletter

For fifteen years, my investigation inched along. Many times, I hoped for closure. With experience as a business fraud investigator, I knew it would take persistence to uncover evidence and patience to read medical books. It only takes a few minutes to compare a clinical record with the practice guidelines but then a victim has to analyze the evidence, write letters and speak about incompetence - in public. An investigation takes longer if the CPSO and the HPAR Board ignore the Regulated Health Professions Act, refuse to investigate and do nothing to protect vulnerable patients.

Another piece of evidence came to light unexpectedly. In 1995 my psychiatrist did not tell me that prescription medications can make some patients worse or that I was at risk. In 2009, a newsletter published by the teaching hospital (where I was misdiagnosed and mistreated) reported that another expert psychiatrist working at that same hospital –

“uncovered a disturbing treatment pattern in patients with bipolar disorder . . . antidepressants taken without a mood stabilizer can make bipolar disorder worse by inducing mania . . . bipolar patients are often misdiagnosed with depression and treatment of depression calls for antidepressants . . . US researchers have documented [this] for two decades . . . now working [at that hospital] to incorporate anxiety and other risk factors into a tool that will help physicians diagnose the illness better.”

For years after my life was shredded by unsafe shortcuts and mistreatments, I wondered what my psychiatrist knew about risk. It was enlightening to learn that eight years before

I consulted the expert at the large Toronto teaching hospital, professional psychiatrists published that misdiagnosing and mistreating by mis-prescribing antidepressants can make bipolar patients worse. As an expert, my doctor knew the risk.

Belief #4 - Eventually the truth does come out.

Canadian Patient Safety Institute - report - Patient Safety in Mental Health

Also in 2009, the Canadian Patient Safety Institute, (CPSI), a Canadian government-funded organization, published *Patient Safety in Mental Health*. CPSI chose a team of mental health professionals to review the literature. Their report outlined eight risks which can affect mental patient safety, with 58 pages about:

Adverse diagnostic events	Adverse medication events
Suicide and self-harm	Patient victimization
Seclusion and restraint	Violence and aggression
Falls and other patient accidents	Absconding and missing patients

The CPSI report suggests listening to victims, evaluating bad outcomes, identifying unsafe practices and protecting patients from the damage which can result from unsafe care: misdiagnoses, mistreatments, abuses and other risks. It recommends improving the culture of mental patient safety among Canadian health providers.

CPSI established Patients for Patient Safety Canada so people can volunteer as patient safety champions. In 2009, the CPSI website posted a volunteer application form. For your interest, here's what happened when I applied – hoping to share my 15-year investigation and improve mental patient safety in Canada.

Applied to Volunteer with CPSI and Patients for Patient Safety Canada

First, I offered to volunteer with the Canadian Patient Safety Institute (CPSI). As a victim of unsafe psychiatry, an author and an investigator, I had ten years experience as a volunteer helping to educate the public. I hoped to encourage mental patient safety. Nothing happened for one year so, in 2009, I applied to volunteer with Patients for Patient Safety Canada (P for PSC). Two CPSI screeners did an interview by phone. They were not interested in my story. They did not like how I spoke. They did not see how my BSc degree with courses in biological and medical sciences, my profession as a CA, my authorship of several books (and more than 30 articles), my experience making public presentations or my interest in mental patient safety might make me a useful volunteer. Unfortunately, my application met with negativity and rejection – hardly the response a victim of unsafe medical care expects from a patient safety organization.

After CPSI rejected my application, I wrote to their volunteer recruitment manager and their CEO. They did not reply. CPSI could have checked my background, seen my medical file, verified that I reported unsafe psychiatry, presented evidence at public hearings and cooperated with HPRAC. They could have respected my story, accepted my application but assigned no volunteer duties until they decided to implement the recommendations in their excellent report – *Patient Safety in Mental Health*.

Belief #5 – Thinking that a patient safety organization would want to recruit a victim of unsafe psychiatry, I volunteered for P for PSC hoping to network, offer my story as a teaching tale and encourage safer mental healthcare. CPSI rejected my application.

Perhaps the Canadian Patient Safety Institute exists for a different reason than the public expects. Given the hard-nosed reputation of the political party which funds CPSI with millions of taxpayer dollars, CPSI may be a politically-motivated entity which does not plan to prioritize mental patient safety.

While interviewing people for books and articles, I learned that various risks can affect the quality of care. Too many mental patients suffer and deteriorate when they get unsafe, inadequate or incompetent care. Patients, families, and caregivers can read the CPSI report, *Patient Safety in Mental Health*, free at www.patientsafetyinstitute.ca

Learned How Mental Patients Can Find Safe Care

Patients can read medical books to learn how to navigate the healthcare maze and find quality care. If patients get worse, they can ask for guideline procedures, diagnostic tests and safe treatments. If patients suffer damage from shortcuts or substandard care, they can report incompetence. Even if nobody investigates, patients and families can:

1. monitor patients, observe progress, notice whether treatments are working;
2. compare patients' medical files with the practice guidelines of psychiatry;
3. request guideline-quality procedures if patients get substandard care;
4. ask for second opinions if the care goes bad or conditions appear unsafe;
5. report concerns and shortcuts to supervisors, hospitals and the CPSO; and
6. meet other families, network and encourage safer mental healthcare.

As you read about my investigation, please notice the highlighted beliefs. Although they seemed reasonable, four beliefs led to unrealistic expectations and disappointments. Please do not repeat my mistakes. If you or someone you love has a mental illness, you can read the practice guidelines. Then you can ask for referrals to a psychiatrist. Check his credentials. Read his publications. An ethical psychiatrist will not betray your trust.

A competent psychiatrist will take reasonable care to discuss, perform and document standard medical procedures. He will assess mental status, request medical and mental tests, take patient and family medical and mental histories, make a diagnosis, develop a treatment plan and administer treatments carefully. After each visit, he will update the clinical record by noting mental status, symptoms, medical test results, effects of medications and talk therapy, the patient's response and progress.

Competent care will include the following procedures to keep patients safe:

- a) testing, treating and monitoring underlying medical and metabolic conditions, such as thyroid, blood sugar, hormone, nutrients, vitamins and minerals;
- b) prescribing modest doses of medications, adjusting diets and supplementing (using treatments which research proved safe and effective);
- c) teaching patients to identify trigger factors and use coping strategies;
- d) explaining diagnoses, educating patients and recommending books; and
- e) offering talk therapy and suggesting other supportive programs.

Mental patients may get sicker and risk damage if they trust a psychiatrist who ignores practice guidelines and relies on shortcuts while misdiagnosing and mistreating. Patients,

families, caregivers and health professionals can read, learn and cooperate. We can help patients find safe and effective care so they can recover and live well. Yes we can!

Public Education Effort: Spoke, Wrote and Published Books, Articles & Web Site

In 1996 another depressed person mentioned the International Society of Orthomolecular Medicine in North York. What I learned there helped me recover and saved my life.

In 1997, I started IDP, an Independent Depression Project, to help other patients identify incompetence, avoid damage and find quality care. I read many books, interviewed 150 other patients, researched psychiatry, wrote books and shared my story as a cautionary tale of what can go wrong when a mental patient gets unsafe care.

In 1998, I appeared in the documentary film, *Masks of Madness: Science of Healing* featuring Margot Kidder and five other recovered patients, as well as Dr. Abram Hoffer and five health professionals who researched and developed restorative treatments for schizophrenia and other mental illnesses. Over his 60-year career, Abram Hoffer, PhD (biochemistry), MD (psychiatry) helped thousands of patients recover and live well. He wrote 35 books for patients and families and hundreds of articles for medical journals. For free archives of the *Journal of Orthomolecular Medicine*, see www.orthomed.org

While advocating for safer mental healthcare since 1997, I spoke at 20 meetings including 5 medical conferences. I wrote books, articles, book reviews and a website: www.searpubl.ca which has the SEAR series of layman's guide books including –

Finding Care for Depression, Mental Episodes & Brain Disorders

90-Day Plan for Finding Quality Care

Depression Survivor's Kit

Remembering Abram Hoffer, PhD, MD by Reviewing his Books about Psychiatry

Abbreviations Used

CPSO – College of Physicians and Surgeons of Ontario

CPSI – Canadian Patient Safety Institute

HPAR Board – Health Professions Appeal and Review Board

HPRAC – Health Profession Regulatory Advisory Council

MH Act – the Mental Health Act

OHIP – Ontario Health Insurance Plan

P for PSC – Patients for Patient Safety Canada

RHP Act – the Regulated Health Professions Act of Ontario