Psychiatrist

Report on Opinion - Case 97HDC7814

Subject Matter of Investigation

In August 1998, on my own initiative, I commenced an investigation into a psychiatrist. It had come to my attention, as part of another investigation, that a registered nurse had applied for and received a practising certificate from the Nursing Council while she was receiving treatment from the psychiatrist. The nurse later went on to harm her patients. The purpose of my investigation was to ascertain whether the psychiatrist had complied with all necessary obligations to his patient in terms of notification to the Nursing Council, thereby not only protecting the nurse but also ultimately protecting the interests of any potential patient of the nurse. Investigations under the Health and Disability Commissioner Act include looking at omissions to act.

Background

In August 1997 the Commissioner received a complaint from a law firm on behalf of the estates of an elderly couple about a Nursing Bureau. The Nursing Bureau employed a registered nurse, who on behalf of the Bureau provided nursing care to two elderly, terminally ill patients, (a couple). The elderly couple died in August 1996 while in the care of the nurse, who was later tried in respect of their deaths. In June 1997 the nurse was found not guilty of murdering the couple by reason of insanity.

In March 1998 I commenced an investigation of the Nursing Bureau to ascertain whether it had taken all reasonable steps to ensure that the nurse was an appropriate person to provide care to elderly, terminally ill patients. My investigation concluded with the forming of an opinion that the Nursing Bureau had not breached the Code of Rights as proper procedures had been in place with respect to the nurse's selection process.

In the course of the investigation it came to my attention that the Nurse was receiving psychiatric treatment at the time she applied for and was granted a practising certificate by the Nursing Council. I was concerned that had the Nursing Council known of the nurse's psychiatric history, it may not have allowed her to continue practising as a nurse, thereby putting her patients at risk.

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Investigation

Information was obtained from the following people:

The Provider / Psychiatrist
Two Directors of the Nursing Bureau
A Lawyer from the Law Firm

Correspondence and various employment policies and procedures utilised by the Nursing Bureau were sighted. The nurse's clinical records were not examined.

Outcome of Investigation

The psychiatrist responded to the Commissioner's investigation by setting out his qualifications, a clinical precis of the nurse's treatment and the matters he considered with regard to the nurse's employment as a nurse while under psychiatric treatment.

History of Patient

The nurse was referred to a Community Mental Health Centre in May 1994 from a Hospital where she had been treated under the Mental Health Act for psychotic depression. She was discharged as an informal patient to her parents' home and the Mental Health Centre continued her outpatient follow up.

The nurse engaged in a long process of treatment with the psychiatrist over the following two years, featured by variable compliance with medication and distrust of medical intervention. The psychiatrist's biggest challenge over this time was to develop and maintain a therapeutic alliance with the nurse who was philosophically opposed to psychiatric treatments. Although the psychiatrist states that the right combination of medication and psychotherapy was eventually arrived at, the nurse terminated these when she was feeling well.

The psychiatrist first reviewed the nurse in June 1994. At that time she remained depressed and anxious with mild psychotic phenomena. Her antidepressant treatment was continued and an antipsychotic introduced. She was referred to the Day Treatment Service for a few weeks at the Centre because of concerns about her mental state and her strong dislike of hospitalisation. Over the ensuing year she slowly improved on an accommodation of drugs.

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Outcome of Investigation, *continued*

In 1995 the nurse began private psychotherapy and found the combination of medication and psychotherapy particularly useful. The psychiatrist advised that by the beginning of 1996 her mood was virtually normal and she had stopped her antipsychotic medication, although she continued on other drugs.

In March 1996 the psychiatrist went on four months' leave and the nurse's care was taken over by a locum psychiatrist. In April 1996 the consultant for the Crisis Team saw the nurse because she was displaying signs of hypomania due to non-compliance and she was advised to restart her medications. This was reviewed by another doctor later in April who found the nurse still elevated and continued her medications. After several non-appearances the nurse was contacted by phone. She had run out of medication and a further prescription was arranged so that she could continue on mood stabilising medication.

After his return from leave, the psychiatrist again saw the nurse in July 1996. The psychiatrist advised that at this time the nurse was mildly hypomanic with considerable grandiosity and religiosity. He noted that it was difficult to clearly establish whether this was delusional or part of her system of ordinary religious beliefs. The nurse refused to accept that she had a psychiatric disorder or any need for further treatment. The nurse was urged to recommence on mood stabilising medication to keep control over her mood and prevent relapse, but unfortunately she declined this because she thought that there was nothing wrong with her. The psychiatrist did not consider she was certifiable under the Mental Health (Compulsory Assessment and Treatment) Act because he did not consider her to be a serious risk to her own health or safety or that of others, nor was she seriously diminished in her capacity to care for herself.

The psychiatrist managed to persuade the nurse to continue in follow up care. He noted that there was no evidence that she was suicidal or homicidal and therefore his first priority was to maintain the therapeutic relationship which had become very precarious. The nurse agreed to see him in three weeks time, at which point he hoped to persuade her to resume medication and transfer her care to another Centre as she had shifted area. The deaths of the elderly couple occurred about the time of the scheduled appointment.

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Outcome of Investigation, *continued*

Consideration of the Nurse's Employment as a Nurse

As part of his response to this investigation the psychiatrist advised that he had considered the issue of the nurse's employment as a nurse. The following is a complete account of this part of the response.

> *"The major issue you have identified for investigation in your letter concerns* [the nurse's] *employment as a nurse while under psychiatric treatment. There are three major factors to consider regarding referral to the Nursing Council:*
>
> *1. The degree of risk the patient poses to the public*
> *2. The likelihood the patient will resume nursing*
> *3. The effect such a referral has on the patient's well-being*
>
> *1. <u>Risk Assessment</u>*
>
> *I must say from the outset that* [the nurse] *was always considered a low risk patient when it came to harming others. Her personality was featured by great concern and compassion for others and throughout my dealings with her she had always displayed the greatest gentleness and decency, even when we disagreed about the psychiatric issues in her treatment.*
>
> *Furthermore there was no history of aggression or violence apart from self-directed aggression in the form of suicidal thoughts while depressed. The homicidal outburst was a terrible tragedy for* [the elderly couple, the nurse] *and the families involved and I was shocked to hear the news that weekend. I deeply regret that the executors of* [the elderly couple's] *estate have felt compelled to make this complaint but I realise that all the involved parties have experienced terrible suffering.*
>
> *When I saw* [the nurse in mid-July] *I had no forewarning of even the possibility of homicide and I assessed her as a low-risk patient who was mildly hypomanic and agreeable to follow-up. When I discussed this with her family after the incident, they too were stunned at the turn of events. Her mother told me that she had been doing well and seemed to be getting on with her life.*

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Outcome of Investigation, *continued*

2. Likelihood of Resuming Nursing

[The nurse] *had not indicated at any time to me that she had resumed nursing or had any intention to do so. In the two years I had been treating her, we had not discussed plans to go back nursing. She had talked about other areas of work such as part-time waitressing and baby-sitting for family members and these seemed appropriate initial steps in her rehabilitation. Until your letter, I was not sure whether she actually had applied to the Nursing Council for registration and whether she had been employed as a nurse by the agency at the time of the incident.*

3. Effect on the Patient

The decision to refer to the Nursing Council is a clinical judgment that involves balancing the best interests of the patient with the right of the community to safe nursing practice. This brings me to the third factor. My experience has been that referral to the Nursing Council subjects patients, who are often already very distressed and finding it difficult to cope, to intense anxiety and often jeopardises the clinical rapport so crucial for effective treatment. Rapport with [the nurse] *was often precarious, particularly at the last appointment I had with her, and such a referral could have jeopardised this further.*

When the risk to the community is significant, then it is necessary to deal with this matter in the least harmful way to the patient. Obtaining the patient's consent, where possible, involving family and other significant persons and counselling the patient through the process with senior nursing staff are often useful.

All in all my judgement not to refer to the Nursing Council was based on my assessment of a low risk patient who had no intention to resume nursing and for whom any such referral could have been detrimental to her well-being. My decision is vindicated by the fact that all the other psychiatrists involved in her care from the time she was committed to the [special unit] *onward had neither noted any such intention on her part nor undertaken any such action. It is easy with hindsight to reassess this as a step that would have been optimal, but at the time this did not appear so.*

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Outcome of Investigation, *continued*

Conclusion

This was a case that has had a very traumatic effect upon me and other staff involved in [the nurse's] *case. We have reflected often about the tragedy and we were all shocked at what happened. Whilst I regret not identifying or predicting such an outcome, I believe to have expected this is unrealistic. At all times I did what was the best and appropriate management of her condition."*

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

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Opinion: Breach

In my opinion the psychiatrist was in breach of Right 4(2) of the Code by not meeting his legal duty to report the nurse's state of health to the Nursing Council.

Section 34(3) of the Nurses Act 1977 states: *'In any case where a registered medical practitioner is in attendance on a registered nurse or an enrolled nurse and considers that the nurse is unable, because of mental or physical disability, to perform his professional duties satisfactorily, and that, because he may attempt to perform those duties, it is necessary in the public interest to prevent him from doing so, the medical practitioner in attendance on that nurse shall forthwith give written notice to the Council of all the circumstances of the case'.*

Although the New Zealand Medical Association's Code of Ethics, under paragraph 10, imposes an ethical duty on practitioners to *'Keep in confidence information derived from a patient, or from a colleague regarding a patient, and divulge only with the permission of the patient except where the law requires otherwise'*, the legal obligation to notify the Nursing Council under section 34(3) of the Nurses Act is an exception to this ethical duty.

Furthermore, the normal rules limiting disclosure of personal information under the Health Information Privacy Code have no application when a provision in another enactment authorises or requires personal information to be made available (section 7(1) Privacy Act 1993).

In my opinion the psychiatrist was required under section 34(3) of the Nurses Act to advise the Nursing Council of the circumstances of the nurse's case for the following reasons and his failure to do so amounted to a breach of Right 4(2) of the Code.

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Opinion: Breach, *continued*

The psychiatrist was aware that the nurse was unpredictable, philosophically opposed to psychiatric treatment and terminated medications when she was feeling well. While I accept that he reviewed the degree of risk to the public and considered the nurse gentle, without homicidal or aggressive tendencies, the risk to public safety goes further than physical risks to the public. Section 34(3) of the Nurses Act refers to the ability of a nurse to perform professional duties satisfactorily and this also goes to the underlying professional competence of the nurse. Based on the psychiatrist's report of the nurse's attitude to treatment and non-compliance with medication, it should have been apparent to the psychiatrist that the nurse was unable to perform nursing duties satisfactorily. Indeed, the fact that other employment options were discussed indicates he was aware of this.

The psychiatrist advised the Commissioner that the nurse had not indicated at any time that she had resumed nursing or intended to do so. However, given the statutory obligations under section 34(3) and the fact that this obligation is imposed to protect the public interest, in my view positive steps must be taken to ascertain the likelihood and ease with which a patient might return to practice. For example, in addition to raising the matter with the individual concerned, it would have been appropriate to check her current status with the Nursing Council to see if she was registered or had applied for a practising certificate.

Although section 34(3) involves an exercise of judgement by the medical practitioner, this must be exercised having full regard for the wider public interest. Indeed this is the purpose of section 34(3). Although the psychiatrist expressed concern that referral to the Nursing Council subjects patients, who are often already very distressed and finding it difficult to cope, to intense anxiety, and often jeopardises the clinical rapport so crucial for effective treatment, it must not be forgotten that a failure to notify concerns to the Nursing Council may also jeopardise the interests of the patient. Any attempt to practice when unable to do so satisfactorily may also lead to an adverse outcome, not only for potential patients of the nurse but also for the nurse herself.

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Opinion: Breach, *continued*

As a registered nurse, the nurse had only to pay for an annual practising certificate to recommence practising, which in fact is what she did. A call to the Nursing Council would have informed the psychiatrist that the nurse did not currently have an annual practising certificate. Notification to the Nursing Council would have informed it, in confidence, of the psychiatrist's concerns about the nurse's ability to practise. When the nurse applied for a practising certificate, the Nursing Council could have taken steps to ensure her mental health was satisfactory and that she could competently practise as a registered nurse.

Other Comments

I understand how traumatic this has been for the psychiatrist and the staff involved. No one could have predicted this particular outcome. However, medical practitioners have an obligation to comply with all legal, professional, ethical and other relevant standards when providing services, and in my opinion there was an omission to pass on concerns to the Nursing Council when this was called for. This tragedy must serve to educate medical practitioners throughout New Zealand that if registration laws are to be effective, they must be complied with in a manner that achieves their ultimate purpose – the protection of consumers.

Actions

I recommend that the psychiatrist adopt the practice of reviewing consumers in his care to ascertain whether any are registered health professionals. In such cases he must review whether the individual is able to practice satisfactorily and, if not, advise the appropriate registration board.

A copy of this opinion will be forwarded to the Medical Council and the College of Psychiatrists. Additionally a copy with identifying information removed will be circulated extensively to Crown Health Enterprises, Medical Journals and others to ensure that all health professionals are aware of their obligations to ensure the safety of the public at large.