Registrar – Crown Health Enterprise

Report on Opinion - Case 97HDC7185

Complaint

The Commissioner received a complaint with respect to treatment the consumer received in the emergency department of a Crown Health Enterprise in late September 1996. The complaint is that:

- *The registrar did not properly introduce herself to the consumer or advise the consumer of her status.*
- *The registrar divulged personal health information about the consumer to the consumer's flatmate without asking permission.*
- *The registrar did not investigate the possibility of an adverse drug reaction as being the cause of the consumer's seizures.*
- *The registrar was influenced by the consumer's "psychiatric patient" status in the quality of treatment provided.*
- *Did not contact the psychiatric liaison team if she considered that the consumer's seizures were part of the consumer's psychiatric disorder.*

Investigation

The Commissioner received the complaint from the consumer on 8 July 1997. An investigation was commenced and information was obtained from:

The Consumer
The Provider / Registrar
The Manager, Medical and Surgical Services, Crown Health Enterprise
The Manager, Clinical Practice Group - Community, Crown Health Enterprise

The consumer's medical records and documentation relating to the consumer's initial complaint to the Crown Health Enterprise ("CHE") were viewed. The Commissioner received advice from an emergency medicine specialist.

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Outcome of Investigation

The consumer has a psychiatric disorder, which has been stabilised with medication since 1994. The consumer stated she started some new asthma medication in about September 1996 and approximately ten days later began to experience seizures. She discussed these seizures with her psychiatrist, who referred her for an electroencephalogram (EEG) noting the following on the requisition form:

> "*2 complex partial seizures at 2-3am in past two weeks. Begun on asthma medication 4 wks ago. Past history of seizures on Thioridazine. Previous EEG shows mild abnormality. Wakes from sleep, body feels very limp but arms and leg jerking rhythmically and trunk flexing. Awake but not able to stop movements.*"

On a date in late September 1996 at approximately 3.00am, after having suffered several seizures, the consumer telephoned an ambulance and was transferred to the emergency department of the CHE. The consumer states that she was reluctant to telephone an ambulance due to previous experiences of discrimination in the public health system in the region but that her flatmates thought it was the best thing to do. The consumer advised that during her transfer to hospital she had one seizure and on arrival at the hospital, the seizures continued regularly, with occasional five to ten minute breaks.

The consumer was initially seen and assessed by the doctor on duty in the emergency department, who undertook a history and physical examination, and recorded the following:

> "*Tonight having seizures. Investigated* [once] *for seizures. On Tegretol and Prozac. Past medical history: psychiatric history, cutting. Drugs: Tegretol, Prozac. On examination: alert, orientated, CNS – tone, power, reflexes sensation normal. Plantar response right down and left up on admission and then right and left down post 'seizure'. Cranial nerves II-XII no abnormalities demonstrated. Unable to visualise fundi. Peripheral nervous system as above. Plan: observe. Discussed with medics.*"

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Outcome of Investigation *continued*

The doctor then told the consumer that he would like to get a second opinion. The consumer stated she had to wait two and a half hours to see the registrar (the doctor who was asked to provide another opinion) and that during this time continued to have regular seizures. When the registrar arrived the consumer stated that the registrar did not introduce herself or advise of her status. The registrar asked the consumer's flatmate, who had waited with her, to leave.

The consumer stated in her initial complaint letter to the CHE that the Registrar did not examine her but simply sat down and told her that she and the other doctor did not believe the seizures were real. However, in a later statement the consumer advised that the registrar did a brief examination by looking at her eyes and checking her reflexes.

The consumer stated that the registrar said to her that she had full control of her seizures and could stop and start them at will. The consumer further stated that the registrar advised her that people with borderline personality disorders come in with this sort of seizure regularly and they were called pseudo seizures. The registrar then said the consumer should see her therapist to discuss her stress levels. The consumer further stated:

> "*I asked* [the registrar] *if she was saying the seizures were brought on by stress and she replied that she would be blunt with me and basically indicated I was attention seeking. I absolutely refute this. I had no control over the 100 or so seizures I had that night and found them to be very frightening. At this stage, I knew there was no point in discussing this further as she had obviously made up her mind without examining me thoroughly or knowing anything of my history or current situation.*"

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Outcome of Investigation ***continued***

The consumer stated that after the consultation was finished, the registrar spoke to her flatmate without first seeking her permission and said to her:

> "*…very "bluntly" that I was a psychiatric patient with a borderline personality disorder and that the seizures were pseudo seizures and that there was no danger to me. She told* [the flatmate] *that I could control them by stopping and starting them when I wanted and I only had seizures when a doctor or someone in authority walked into the room. She said I was doing it for attention and that for people with borderline personality disorders this type of seizure was common and that "we all" make the same movements. She said it is not physical and that* [the flatmate] *was not to worry or pay any attention to me or fuss over me as I would just do it more. She said it was obvious that I was very experienced at getting attention in this way as I had "slashes" all over my stomach and wrists.*

The consumer stated the conversation between the registrar and the consumer's flatmate took place in a public corridor and that although she wanted to be present at this discussion, the registrar stopped talking when she approached and asked if she would go with a nurse to organise a taxi to transport her home. The nurse responded to the registrar's prompt and led the consumer down the corridor. The consumer says that whilst walking down the corridor she had two seizures which resulted in her falling over and having the seizures on the hard floor.

The registrar responded to the consumer's complaint to the CHE and apologised to the consumer for causing any distress as a result of the discussion she had with her in the emergency department on 26 September 1996. The registrar stated that the casualty officer had asked her to see the consumer as she had been in the emergency department for some time and had experienced several seizures, which he thought were non-epileptic in nature. The emergency department doctor told the registrar the history that the consumer had given him of the onset, frequency and nature of the seizures, her current medication as well as her past medical and psychiatric history. The registrar noted that on examination, the emergency department doctor had found the consumer's cardiovascular, respiratory, abdominal and neurological systems to be entirely normal.

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Outcome of Investigation *continued*

The registrar said that both the emergency department doctor and the duty nurse reported that when they observed the consumer when she was alone and unaware of their presence, she appeared normal and calm. She had no seizures during these times. They said that when the emergency department doctor, the nurse or either of the consumer's two flatmates entered the room, the consumer would have a seizure shortly afterwards. The emergency department doctor and the duty nurse reported that at no time did the consumer have any altered level of consciousness, appear drowsy, confused, or exhibit altered speech.

The registrar advised that when she entered the room to see the consumer, she introduced herself, which is her usual procedure, to both the consumer and her flatmate. She also advised that she was wearing her white coat displaying both her name badge and identity card, which state her name and position. She then asked the consumer's flatmate to leave as she wished to see the consumer in private.

The registrar advised that she observed about four seizures during the 30 minutes that she was with the consumer. She notes that these seizures appeared to be generalised clonic convulsions, however, a number of clinical features, along with the supporting history and examination, suggested a clinical diagnosis of psychogenic non-epileptic seizures. The registrar based this diagnosis on the following clinical features:-

- Intermittent arrhythmic and out-of-phase activity;
- an absence of stereotypy the presence of which would otherwise be expected during generalised clonic convulsions of an epileptic origin;
- at no time was there loss of consciousness and there was no post-ictal confusion or lethargy;
- the consumer had a normal ictal breathing pattern and there was no laboured breathing or dribbling following the generalised convulsions;
- each attack was different in its intensity and severity, not usually seen in epilepsy, and the consumer displayed intermittent wild movements of her head, arms and body;
- the consumer's conversation was normal in between seizures and at one point she broke off mid-sentence to continue exactly at that point after the seizure;

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Outcome of Investigation ***continued***

- the consumer's posture and motor tone remained normal throughout the interview and when it was over she jumped to her feet, gathered her belongings and walked normally;
- the occurrence of seizures was stimulated by the presence of other people in the room.

The registrar stated that the consumer *"presented as clear-thinking and intelligent, which is why I was direct with her"*. In response to the consumer's complaint that personal information was divulged to the consumer's flatmate, the registrar confirmed that she spoke to the flatmate in the corridor but states that this was at about 6.30am and that there was no one else around. She stated that before divulging any information, she ascertained that the flatmate was already aware of the consumer's behavioural difficulties and psychiatric background.

The consumer maintained that her flatmate told her that the registrar "ascertained" what she knew by firstly divulging personal information and that she did not ask the flatmate what she knew.

The registrar stated that as she was the consumer's flatmate, and therefore directly involved in her care on the way home and at home, she acted in good faith in trying to explain to her that the consumer did not have true epilepsy, requiring admission to hospital, but had non-epileptic seizures. The registrar stated that she informed the consumer's flatmate of this in order to allay any concern. However, the consumer's flatmate did not fully comprehend her explanation.

The registrar stated that in her judgement the consumer was safe to go home but did need to see her psychiatrist. She noted that the consumer was very concerned that the recent introduction of asthma inhalers to her usual medication was the cause of her seizures. She stated that convulsions are not a recorded side effect of asthma inhalers, being neither reported or listed in any adverse drug reaction compendium. The registrar stated that she discussed this with the consumer and reassured her that her new asthma medication was not likely to be the cause of her seizures.

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Outcome of Investigation *continued*

The registrar stated that:

> "*...A psychiatric history is not a prejudice to a patient's care or quality of treatment but is an important part of any medical history from any patient. At the very beginning of our meeting, the consumer had volunteered the information that she had been diagnosed as having borderline personality disorder by* [her psychiatrist], *with a history of depression, mood swings and was currently under his care. Having a psychological disorder can support a clinical diagnosis of non-epileptic seizures along with the other objective features observed... Knowing that the consumer has a psychological disorder did not in any way prejudice my treatment of her. Like all the patients I treat, she received the best treatment I was able to provide.*"

The registrar disputed the fact that she told the consumer or her flatmate that non-epileptic seizures are encountered specifically in people with borderline personality disorders. She stated that non-epileptic seizures are commonly encountered in clinical practice and are seen in people with a huge variety of disorders. She stated further that she did not write the consumer off as "attention seeking". She said that she discussed with the consumer that the seizures were not necessarily wilful, that they appeared very real to her and could be subconsciously directed. She stated that:

> *"I reassured her that these events were not due to abnormal electrical activity of her brain and that she did not need anti-epileptic drugs or other medical treatment which could in fact be harmful, rather than beneficial. I was not in any way trying to minimise her experience. As such, it was important to emphasise that psychological input would be more valuable in helping sort the underlying issues out".*

The registrar stated that during her discussions with the consumer she presented as clear thinking and intelligent, which was why she was direct with her. She stated that at the end of the examination she reiterated it was very important that she see her psychiatrist promptly, to which the consumer agreed.

The Commissioner's advisor provided background on seizures and on the proper evaluation of patients who have had a seizure.

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Outcome of Investigation *continued*

The Commissioner's advisor stated:

"Seizures

Seizures account for an estimated 1% to 2% of [emergency department] *visits and result from any of a variety of pathologic processes that provoke excessive and disorderly neuronal discharge in the cerebral cortex. A number of conditions can be confused with seizure disorders, among them fainting (syncope), decerebrate posturing (comatose patients), drug reactions, tetanus, poisonings and psychogenic events. A detailed history and physical examination can usually differentiate among these.*

Psychogenic seizures, also referred to as pseudoseizures, are functional events with a clinical presentation mimicking neurogenic seizures, yet with no corresponding alteration in EEG activity. These events are often conversion reactions and not under the patient's conscious control. It is estimated that 20% of patients followed in epilepsy clinics are misdiagnosed and actually have psychogenic seizures. Psychogenic seizures often last longer than neurogenic events, frequently for more than 5 minutes. There usually is not a postictal period; patients can often recall events during the seizure, have not been incontinent, and do not incur physical injury. (Ictus – refers to the period during which a seizure occurs. Post-ictus is the period immediately following the seizure.) Psychogenic seizures are classically manifested by forward-thrusting pelvic movements and head turning from side to side. Several manoeuvres and tests are useful in diagnosing psychogenic seizures. These patients often avoid or resist noxious stimuli (while in the ictus), they may display gaze aversion and look away from an examiner regardless of positions. On laboratory testing, they do not have a metabolic acidosis and there is not a postictal increase in serum prolactin levels.

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Outcome of Investigation *continued*

Seizures may be the result of acute or progressive neurological insults or systemic stressors, which are often reversible or treatable. The two most commonly identified aetiological precedents to seizures are neurological injury from birth (8%) and cerebrovascular disease (11%). Other identified aetiologies [sic] of secondary seizures include trauma (5.5%), tumour (4%), cerebro-degenerative disease (3.5%), and infection (2.5%). Metabolic and toxin-related aetiologies [sic] are also possible, with hypoglycaemia being the most common, followed by low sodium, low calcium and low magnesium. Alcohol is the toxin most commonly associated with seizures, followed by tricyclic antidepressants, cocaine, amphetamines, antihistamines and isoniazid. Also, a number of physiological and psychological stressors can activate seizure disorders. These include fatigue, sleep deprivation, hyperventilation, photic stimulation, emotional stress and menstruation.

[Emergency department] *evaluation of the patient who has had a seizure*

This must always begin with a careful history that includes:

1. *A description of the event and an indication of the frequency, pattern and duration of recent or previous seizures.*
2. *A history of incontinence, loss of consciousness, and self injury during the event.*
3. *Whether there was an aura or a postictal period.*
4. *Careful interviews of observers to obtain a clear description of the seizure to avoid misdiagnosing non-seizure events.*
5. *The circumstances preceding a seizure must be elucidated. Inciting factors such as medication non-compliance, infection, pregnancy, sleep deprivation, alcohol use, or other drug or medication use should be identified.*
6. *A past history should be sought regarding head trauma, headaches, diabetes, cancer, cerebrovascular disease, electrolyte disturbance or infections.*

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Outcome of Investigation *continued*

7. *The physical examination should note vital signs, as signs of trauma and a careful neurological examination performed.*
8. *Note should be made of the patient's mental status before and after a seizure. Postictal confusion is common.*
10. *Postictally, patients are often noted to have hyper-reflexia, up going plantar responses, evidence of incontinence or a tongue laceration.*
11. *If more than one seizure is witnessed, attention should be paid to the similarity of the seizures. In cases of psychogenic seizures there are often more than one attack but they last variable periods and are noted to be different in their manifestation*
12. *Laboratory testing in postictal patients often demonstrates a metabolic acidosis or raised muscle enzymes.*

The details of the history and physical dictate the urgency and course of any further [emergency department] *evaluation. Routine evaluation of serum electrolytes, glucose, etc is of uncertain value and probably not required in patients whose mental status and physical examination after a seizure are completely normal. Even blood gases are not routinely required, however, when considering a diagnosis of psychogenic seizures may be helpful if they are entirely normal.*

CT scans of the head are indicated only if an acute intracranial event such as a subarachnoid haemorrhage or sub-dural haematoma are suspected. If the physical examination and patient's mental status are normal this is extremely unlikely and not indicated.

EEG monitoring is not a standard practice in the [emergency department] *and only indicated in a patient with altered mental status in whom non-convulsive status epilepticus is suspected.*

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Outcome of Investigation *continued*

[Emergency department] *management of the patient with a suspected psychogenic seizure*
It is imperative that the diagnosis be made accurately, as initiation of pharmacological interventions or other supportive interventions can lead to 'iatrogenic or medical harm' to the patient. It is for this reason, that in the stable patient with normal findings who presents with an atypical clinical presentation, that psychogenic seizures should be suspected. Management of psychogenic seizures is dependent on making the correct diagnosis.

Good practice – A basic rule
A basic rule with regard to reported seizure disorders is that "everything which falls down and shakes is not a seizure". The practice is not one of "rule out seizure" and in fact such a practice is to be condemned for being intellectually and diagnostically sloppy as well as for the consequences to the individual who will be erroneously labelled a "seizure patient.

Clinical features that assist in differentiating seizures from other kinds of attacks

1. *Abrupt onset and termination. Most seizures last only 1 or 2 minutes.*
2. *Presence of an aura can indicate a possible complex partial seizure. Absence of an aura is* [sic] *not helpful.*
3. *True seizures are generally stereotyped. Attacks may vary in intensity or duration but the basic features will be consistent and maintain a pattern.*
4. *Lack of recall. Except for simple partial seizures, patients usually cannot recall the details of an attack, the responses and acts of bystanders etc. Patients who 'can hear everyone talking but could not respond' have psychogenic seizures.*
5. *True seizures are not generally provoked by environmental cures or stimuli or emotional stress.*
6. *Movements or behaviour during the attack generally are purposeless or inappropriate.*

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Report on Opinion - Case 97HDC7185, continued

Outcome of Investigation *continued*

7. *Most seizures, except simple absence (petit mal) attacks or simple partial seizures will be followed by a period of postictal confusion and lethargy. Normal mental function in the postictal period leads to a higher probability of psychogenic seizures.*"

The advisor stated:

> "*The registrar reviewed the workup provided by* [the former doctor]*, considered the opinions of expert nursing staff, introduced herself to the patient, interviewed the patient and performed a targeted examination. On the basis of all the inputs, she then chose to provide the patient with her diagnosis and indicated a pathway or plan of action. In all respects with regard to the medical condition of the patient, the registrar followed good practice guidelines.*"

Code of Health and Disability Services Consumers' Rights

RIGHT 1
Right to be Treated with Respect

1) *Every consumer has the right to be treated with respect.*
2) *Every consumer has the right to have his or her privacy respected…*

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

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.*
3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*
5) *Ever consumer has the right to co-operation among providers to ensure quality and continuity of services.*

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Report on Opinion - Case 97HDC7185, continued

Code of Health and Disability Services Consumers' Rights *continued*

RIGHT 10
Right to Complain
…

3) *Every provider, unless an employee of a provider, must have a complaints procedure that ensures that –*
   a) *The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period…*

CLAUSE 3
Provider Compliance

1) *A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.*
2) *The onus is on the provider to prove that it took reasonable actions.*
   For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

Opinion: No Breach the Registrar

Right 1(1)
In my opinion, the registrar did not breach Right 1(1) of the Code of Health and Disability Services Consumers' Rights. There is insufficient evidence that the registrar treated the consumer with disrespect. In reviewing the accounts of both parties, there is agreement that the registrar spent time with the consumer discussing her diagnosis and its immediate implications. The consumer disagreed with the registrar's diagnosis and wanted further examinations, however this should not be confused with the issue of whether the registrar was rude and disrespectful to the consumer. The registrar's manner may have been blunt and to the point, but I do not consider this is necessarily disrespectful.

Right 1(2)
In my opinion, the registrar did not breach Right 1(2) of the Code of Health and Disability Services Consumers' Rights. The registrar spoke to the consumer's flatmate about the consumer's condition because of safety considerations. Therefore, I consider that the registrar's actions were reasonable in the circumstances and that the registrar was considering the consumer' interests.

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Opinion: No Breach the Registrar ***continued***

Right 2

In my opinion, the registrar did not breach Right 2. I have not seen evidence that the clinical treatment, which the registrar gave the consumer, was substandard as a result of discrimination due to the consumer's psychiatric history.

Right 4

In my opinion, the registrar did not breach Right 4(2), (3), and (5) of the Code of Health and Disability Services Consumers' Rights. The registrar provided a second opinion on the cause of the consumer's seizures at the request of the consumer's emergency room examining doctor. The registrar reviewed this doctor's findings, performed an additional examination and made a clinical diagnosis on this basis. As a result, the registrar provided the consumer with a plan of action and recommended follow up with her psychiatrist. In her role as emergency doctor, the registrar gave appropriate treatment once establishing that the consumer's seizures were not life-threatening and non-organic in origin. Safety considerations for the consumer were taken into account by ensuring that the consumer had the immediate support of her flatmates as well.

In addition, I do not consider referral to the psychiatric liaison team was necessary at this time because the consumer was already under the care of a psychiatrist for whom she had an appointment with the following week.

The registrar encouraged the consumer to return to her psychiatrist who was already familiar with her concerns. The psychiatrist was the appropriate health professional for the consumer to see, rather than the psychiatric liaison team, because it had been established that this was not an emergency situation.

Opinion: Breach Crown Health Enterprise

Right 10(6)(a)

In my opinion, the Crown Health Enterprise breached Right 10(6)(a) of the Code of Consumers' Rights. The consumer wrote to the CHE in mid-October 1996. The first correspondence she received from the CHE in response to her complaint was dated over a month later. The CHE, therefore, breached Right 10(6) in failing to acknowledge her complaint in writing within five working days of receipt.

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Report on Opinion - Case 97HDC7185, continued

Actions

I recommend that the Crown Health Enterprise:

- Provide ongoing education programmes to medical staff about mental health consumer issues, with evidence forwarded to this office;
- Show that a complaints process has been implemented that complies with Right 10 of the Code;
- Provide an apology to the consumer for its breach of the Code. This apology should be sent to this office and will be forwarded to the consumer. A copy of the apology will remain on the investigation file.