Inside Madness: The murder of a psychiatrist

Dr Michael Diamond is going to discuss the difficulties encountered by organisations and registration bodies when dealing with paranoid individuals. Michael graduated from the University of Cape Town and is a fellow of the Royal Australian and New Zealand College of Psychiatrists. He is a consultant psychiatrist in private practice, with a special interest in psychotherapy for personality disordered people. His interests include the analysis of human behaviour in forensic and high-risk settings. He provides advice to law enforcement, industry and other security and intelligence agencies. He was previously a medical consultant to the New South Wales Medical Board. His responsibilities included the development and management of the program for impaired practitioners and students.

Paranoid people - their interaction with institutions

My intention is to provide additional comment about the difficulties faced when attempting to deal with paranoid individuals when they become of concern to official bodies of various types.

I must first compliment Melissa on her presentation. I thoroughly enjoyed her book. I was interested in the broad nature of the issues she raised, but my paper is more focussed on looking at the psychiatric issues. I had direct involvement in a small way, as medical consultant, at the time the NSW Medical Board first became aware of concerns about Dr Gassy. I provided advice to the Board Secretariat and to the relevant committee handling notifications about potentially impaired medical practitioners.

The changed Medical Practice Act

Contextual information is relevant. The Medical Practice Act was changed in 1992 to include, amongst other things, a section dealing with impaired practitioners. The timing of Dr Tobin's notification of Dr Gassy in 1994 is significant. It was a period when the new Impaired Registrants Program of the NSW Medical Board led the way amongst Australian medical registration bodies. It has continued to be a very well-devised program. At about the time Dr Gassy was notified to the Board, however, the process of interpreting and using the new Act was not yet firmly established.

The new section specifically allowed the Board to deal - in a manner different from, and separate from, the disciplinary stream - with doctors who were unwell and impaired. While the primary focus remained public protection, doctors suffering illnesses were able to pursue appropriate treatment whilst remaining accountable to the Board. This they did by demonstrating their continued well-being by complying with conditions on their registration. Importantly, this process included a voluntary component: it required the doctor and the Impairment Panel to reach agreement about the nature of the recommended conditions.

No compulsion at Impairment Panels

That is the point Dr Arnold raised in his comment to Melissa. There was no direct compulsion on the doctor, but the process possessed an inbuilt test of judgment and insight. What it meant was that the doctors, by agreeing that they did have an illness and by agreeing to be compliant with the agreed conditions on their registration, in fact demonstrated some understanding - some insight - into the fact that they were unwell. That voluntary aspect was important, but it was also relevant that, if they point-blank refused to engage in the process, there was another tier of action by the Board. The problem could, if deemed necessary, be moved into the disciplinary arena. The relevance of that, in respect of Dr Gassy, will soon become apparent.

The failings of the former undertakings

A further consideration was that the new legislation replaced previous ineffectual mechanisms of dealing with unwell doctors. They had formerly been dealt with relatively informally by way of counselling interviews, at which they undertook to take certain actions to remedy their illnesses. These undertakings were, however, unenforceable and failed to provide any nexus of accountability to the Board. The process was simply based on the idea that professional people would behave professionally and sensibly.

These undertakings were, not surprisingly, often ineffective. They failed to produce any assurance that the doctor was in recovery and well enough to practise. In fact, what happened was that doctors would not engage in the process and would remain unwell. This failing is captured by the survey Melissa referred to: where nothing would be addressed. Not infrequently, this resulted in those doctors again coming before the Board because of ongoing problems, and then their being dealt with as disciplinary matters.

The disciplinary route

The disciplinary stream involves investigation by the Health Care Complaints Commission. The HCCC's role is to investigate complaints and to put the case forward before a Professional Standards Committee (PSC). This is the lower level of conduct hearings, dealing with matters which are not of such severity that

the practitioner could be deregistered. It is a far less formal body than the Medical Tribunal (chaired by a District Court judge). Arguments are advanced before the PSC as to whether or not the doctor's conduct warrants criticism. It often ends up with conditions on the doctor's registration, but unlike an IRP Inquiry, which might reach the same conclusions, it does have the power to impose those conditions. This adversarial process does not often support a *milieu* in which an impaired doctor might recover. It leads to polarisation and a lack of co-operation.

Dr Gassy

The case of Dr Gassy, was, on its face, straightforward. The Board received a notification from the senior person responsible for his employment and clinical performance. The cause for notification was clear. Dr Gassy was a psychiatrist. He had been on sick leave for a number of months because of mental health difficulties and now intended to resume practise. This raised concerns about his fitness to practise and public safety issues.

The Board received the notification and, proceeding normally, requesting that Dr Gassy be examined, since it was a psychiatric illness, by a Board-nominated psychiatrist, for an independent assessment. The expert identified a previously undiagnosed and untreated psychiatric illness. As a result of that assessment, the matter was referred to an inquiry by an Impaired Registrants Panel (IRP).

The Impaired Registrants Panel hearing

At the inquiry, Dr Gassy was accompanied by a representative of his medical defence organisation. By all accounts, if one follows what occurred there, he received good advice and acted on it. The IRP comprised a general practitioner and a psychiatrist. The outcome was entirely unremarkable; the psychiatric disorder, as described by the Board-nominated psychiatrist, was confirmed and the suggested conditions on his registration were agreed to by Dr Gassy.

He was considered unfit to practise at that time and was to seek treatment by a psychiatrist of his choice - not someone suggested by the Board, but someone entirely of his own choosing. Review by the IRP was to follow after a further consultation with the same Board-nominated psychiatrist who had already seen him, who would advise the Board of any change or improvement in his condition.

A timely process

Up to this point, the process had been relatively timely. It had taken place over about a seven-week period, which is really not long for these kinds of operations, as it involves setting up appointments, turn-around time for correspondence, and time to receive reports and to convene meetings. The outcome of the IRP was in keeping with normal practice: it allowed Dr Gassy to access appropriate treatment with the intention that he return to work as soon as his illness was adequately treated.

The role of the treating psychiatrist

The treating psychiatrist is usually kept at arm's length from the Board's processes for two important reasons. The first is that a doctor, like any other person, is entitled to confidential and expert treatment. Secondly, the treatment objectives and the role of advocacy often clash. The treating doctor might have to decide whether or not to report important issues emerging in the course of treatment. That, of course, can contaminate the treatment and influence what the treating doctor is or is not told by the patient. Keeping the treating doctor at arm's length is therefore a very important part of the program. For these reasons, the Board has not encouraged treating practitioners to become involved in advocacy for their patients. The advice of a Board-nominated expert is preferred, so that progress or otherwise can be assessed dispassionately, according to a review protocol.

The beginnings of conflict

From this point onwards, events took a decidedly aberrant course which has lasted right up until the present, with Dr Gassy remaining in disagreement with all who have had to assess his mental state and his conduct. After the IRP Inquiry of 2nd September 1994, Dr Gassy, in accordance with his conditional registration, consulted a treating psychiatrist on three or perhaps four occasions.

In this case, however, the medical defence organisation involved at the time took it upon themselves to obtain a report from the treating psychiatrist and tendered that report to the Board. The report refuted the opinion of the Board-nominated psychiatrist. I don't have any difficulty understanding that different psychiatrists are told different things in their interviews. Furthermore, nobody had had any great length of time of engagement with Dr Gassy. The interviews occupied, in the case of the Board-nominated psychiatrist, two consultations, and in the case of the treating psychiatrist, three or four consultations, so we are talking about very brief contact indeed.

The treating psychiatrist, in the course of treatment, also attempted to assist his patient to disentangle himself from the conflicted circumstances of his former workplace. There were very definite problems in that environment which clearly would have had an impact on his mental health. The treating psychiatrist attempted to place him in a new work environment in a different Area Health Service - very helpful and supportive treatment. But, once the treating psychiatrist had provided his report, Dr Gassy stopped seeing him. This was in breach of the conditions on his registration.

The review interview

A Review Interview scheduled for 24th November 1994 did not take place. The time-line to this point is that the notification had been lodged in June or July, the IRP hearing took place in early September with a review scheduled for November, in the hope that, by that stage, he would have been treated, would have shown some progress, would have been involved in the recovery process and could have been encouraged back into the workplace. That was the intended course.

Prior to this scheduled November meeting, Dr Gassy had seen the Board-nominated psychiatrist, who found no change in his condition. Dr Gassy then informed the Board that he rejected the whole process and refused to attend. He dismissed his legal adviser from the medical defence organisation and briefed, and dismissed, a number of other legal advisers in short succession. At the same time, his treating psychiatrist, as a result of these developments, changed his view and said that he now had second thoughts about Dr Gassy's psychiatric well-being and judgment.

The Board's dilemma

The Board was then left with having this doctor remaining registered with conditions on his registration, but not being compliant with the conditions. Dr Gassy was not availing himself of review and reassessment as required by those conditions. His mental state, as evidenced by his actions, did not support a view that he was recovering. He believed that he was not unwell and was actively lobbying support that he be permitted to resume practice, albeit under some degree of supervision. The matter had to be resolved one way or another. At the same time, Dr Gassy had informed the Board that he had dismissed his current lawyer, one in a series at the time, and that he would be representing himself.

On 22nd December 1994, the matter was referred to the HCCC as a formal complaint. In due course, a PSC hearing was scheduled for 8th March 1995. This was adjourned because Dr Gassy had a clash of dates: he needed to appear at a Coroner's hearing on another matter. The hearing was re-scheduled for 10th April 1995. In the interim, Dr Gassy briefed yet another lawyer who promptly informed the Board that she would be overseas on that date because of family illness and requested a further adjournment. The Board refused and determined that the PSC would be convened in April.

The Professional Standards Committee hearing

Dr Gassy attended the April PSC hearing accompanied by yet another legal adviser. In the interim, he had lobbied widely and publicly by circulating correspondence throughout the psychiatric community. He had lobbied the President of the College of Psychiatrists, the AMA, psychiatric colleagues and former supervisors, as well as those doctors whom he claimed had treated him for stress and 'burnout' in the past. All of this being done in this public manner circulated and publicised the Board's concern about his mental health, reflecting especially on his judgment.

The PSC's findings were essentially similar to those of the IRP, although they differed in one substantial way: during the course of that hearing, which lasted over five hours, Dr Gassy, although demonstrating persecutory ideas, was thought not to exhibit a delusional state. His capacity to practise was accepted, provided that he did so under supervision, as stipulated. The outcome of this hearing was even more in his favour than the outcome of the IRP. He was now being permitted to return to practise conditional on his being supervised in his workplace.

Dr Gassy chooses not to practise

On 7th July 1995, Dr Gassy communicated with the Board saying that he had elected not to practise further because of the outcome of the PSC. In a period of a week short of a year, this doctor with an alleged mental illness and impairment had become increasingly deeply embroiled in a conflict with the Medical Board and then with the Health Care Complaints Commission to the point that he decided to forgo medical practice rather than address the question of whether or not he suffered from any mental illness and whether or not that illness caused concerns about his judgment and ability to practise safely.

I make that point very clearly because it goes to the heart of the issue of judgment. How could someone actually end up deciding that he was no longer going to practise when in fact the Board in its deliberations had supported the idea that he return to practice?

The question of his registration remained unresolved: he retained conditional registration, but refused to comply with the conditions. In addition, he had not been assessed independently for almost a year - since August 1994. Clearly his judgment and conduct, as evidenced by his decision-making and by the allegations he made in his lobbying, caused further concern about his mental state. This led, inevitably, to his appearance before the Medical Tribunal, to determine the question of his continued registration.

The Medical Tribunal

He appeared before the Medical Tribunal on 10th June 1997, three years after the initial notification by Dr Tobin. The determination of His Honour, Judge H H Bell, and the medical and lay members of the Tribunal was published on 1st August 1997. The decision was that his name be removed from the register of medical practitioners and that an application for review of that order not be made until a period of six months had passed.

This is a most unusual determination by the Medical Tribunal. Six months, in my experience, is a very brief period of de-registration - or more accurately a limit before which he can not apply for restoration. Implicit was an incentive for Dr Gassy to demonstrate that he had addressed the issues of his mental health by presenting himself for suitable assessment and, if necessary, treatment, so that when he did apply for restoration, the Tribunal could be satisfied that he was once again fit to practise. The Tribunal's finding was not an indictment of him; indeed, the determination dealt with his position sympathetically. He was given, I think, the benefit of the doubt in almost every situation put before the Tribunal other than the final point that, at that stage, he was not well enough to practise.

Other Cases - addicted doctors

In the course of my experience with impaired practitioners appearing at the Medical Board, it is unusual to find an escalation of conflict of this magnitude with this degree of resoluteness and indignation in relation to an allegation of impairment. Those cases where one does see conduct of this nature are almost invariably covered by a small number of diagnostic entities. The commonest are substance-abusing or drug-addicted practitioners who insist that they do not have a problem. Their indignation and refusal to comply with the process is best understood in terms of denial, which is symptomatic of the illness. Invariably, when the addiction process has become obvious and overt, the indignation subsides and recovery can begin. Anyone who has worked at the Board with impaired doctors with addiction has seen that process many times. There is nothing surprising about that behaviour.

Personality disorders

A second group of doctors has significant personality disorders that cause them to be viewed in their workplace as 'disruptive practitioners'. The argument about the diagnosis of personality disorder is one with which most of you, both medical and legal, would be familiar. These are often difficult people who go about life experiencing interactions with those around them which are frequently in conflict and which invariably create negative outcomes or problems. They may not be subjected to episodes of overt mental illness, insofar as psychosis or mood disorder is concerned, but the nature of their interactions, the disruption they cause at work and their impact upon the services and systems within which they function, are such that they are the source of a great deal of negative attention at work.

The argument invariably becomes one where the definition of impairment is contested. The diagnosis is clear. They have a disordered personality. The difficulty is always about what ought to be done. In effect, this is not now addressed through the Medical Board's Impairment Program. In more recent times, doctors who present with these problems are more realistically dealt with either through the conduct stream in relation to specific alleged complaints or in terms of more recent legislation that deals with the performance of doctors in the workplace. Very often such an approach more realistically captures the problems these doctors are having. To argue about the diagnosis and whether or not it constitutes an impairment, as defined in the Act, really is a diversion. It does not produce the results one would wish for. I think that the Board has learned over the years that there are more appropriate ways of applying the legislation to deal with those particular doctors.

Impaired appreciation of reality

The final group comprises those doctors who have, at some level, impairment in their reality testing. It is useful to look at this in terms of a spectrum of disorder. There are individuals who are insecure, unduly

suspicious, quick to take offence and who interpret the behaviour of those around them as persecutory. Whilst the extent of aberration involving their reality testing is variable, the position that they find themselves in is easily recognised. Such individuals often have a point of view that is, at least in some part, grounded in fact. The position they hold is not entirely unbelievable or lacking credibility. It is the extent to which they hold these beliefs and their reactions to those around them who do not support their point of view that is the most telling aspect of the condition.

Further to this observation is the fact that in due course, because of their vociferous and vehement adherence to their belief system, they do become a source of irritation and disruption to those around them. People do come to dislike them and decisions can be made which are not to their advantage. The notion of a self-fulfilling prophecy is useful here: if they are not persecuted from the outset, then invariably, over time, they will be, because of the extreme views they put forward, the way in which they deal with their critics and the obvious impairment of judgment which precludes them from forming a reasoned or balanced view. This last feature is really the most significant.

Where the boundary lies between a paranoid demeanour and that of a delusional state is difficult to clarify. In order to elicit the extent of the belief system, one has to address this very carefully, very patiently and in great detail. In a treatment setting where one has established at least some degree of common purpose and perhaps a little trust, the emergence of resolutely held beliefs, which are not susceptible to challenge by clearly elaborated fact, can take a long time to emerge.

Poor decision-making

To demonstrate this symptom in a medico-legal assessment consultation can be very difficult. To elicit symptoms supporting a diagnosis of delusional disorder in a patient who is himself a psychiatrist, well aware of definitions and clinical examination techniques, can be impossible. Avoidance of the actual detail and a reluctance to reveal the depth of adherence to the belief system is commonly seen.

One is therefore left with having to interpret the depth of delusional belief by looking at the decision-making process exhibited by the doctor. Examination of the exercise of judgment is a crucial factor both in making the diagnosis and also in determining fitness to practise. One may see careful avoidance of revealing the clinical symptoms of delusion in juxtaposition with gross displays of poor judgment, inappropriate decision-making and, on occasions, observable aberrant conduct and inappropriateness.

It is quite an interesting phenomenon to see somebody being meticulous about not revealing the depth of their delusional belief system, whilst at the same time giving absolutely overt clinical signs and symptoms of all the inappropriateness of judgment, conduct and interaction that is part and parcel of the condition. It is clearly something to look for rather than persevering with trying to get the belief system displayed and out in the open.

Responses by various institutions

Attempts at dealing with people in accordance with the rules of procedural fairness, natural justice and due process do not always produce the desired outcome. The interface between widely accepted rational and logical thinking and that which is exhibited by the paranoid or deluded practitioner or individual may be jagged. What is considered appropriate and helpful can be misinterpreted as being overly directive, biased or intrusive. It can cause conflict where none is intended.

Those who are familiar with this process will recognise the sense one has that the process has become derailed. There is that sinking feeling when you get embroiled in these kinds of situations, when you realise that no matter which way you go you are simply going to cause more offence and raise more suspicion and that no reasonable outcome is going to come out of the situation. Commonly one sees behaviours that actively subvert due process, and I think that the Gassy case is filled with these. What one sees are ‘symptoms’, like the invention of parallel systems, rejection of the authority of the body involved, a process of vilifying and attacking witnesses, pleading special case status, (on the grounds of having unique expertise), dismissing legal counsel when confronting advice is given and creating undue delay. Good counsel, who give good advice that is certainly based on reality, are the lawyers most likely to be sacked. The more histrionic and the more excitable lawyers seem to last a bit longer. The other issue is undue delay in actually being able to process this material. What one finds is that every step is accompanied by tremendous argument and real difficulty in getting compliance with anything. It just gets more murky, more complicated and more derailed.

Inappropriate behaviour by institutions

But let's not blame the practitioners alone. Institutions in this day and age play their role, too. Observing closely what occurs, one often sees institutions behaving differently: not doing what they normally do. You see attempts to be overly accommodating - that is quite common - providing the complainant or the doctor with extra help and information which they would not normally provide to anyone else, being extra tolerant, attempting to be pedantically fair, and abandoning usual practice, rather than taking an objective look at what is occurring. The overall effect is diversion from due process and a failure to address the core psychological problem. Everything in the world gets discussed except the core psychological issue.

What can be done?

Unfortunately, I don't have a good answer but I will do my best. These are clearly difficult situations. Whatever the mental state or views of an individual might be, their right to access all legal avenues is not in question. I think everyone can start down the path of thinking that you have a special set of rules for this particular case or type of case, and that is mistake number one. There are no special rules. It is all about applying the accepted rules properly.

What is the evidence of a disturbed mental state?

At its heart, the matter relates to what is and what is not accepted as *prima facie* evidence of a disturbed mental state. The more obvious and more bizarre aberrations of human behaviour, thought and mental processing are more readily accepted by the institutions. If people are outrageously mentally unwell, there are few arguments about how they are dealt with. The most obviously disordered and probably psychotic individuals are dealt with at the first hurdle in terms of fitness to plead and all of the issues related to that consideration.

It is the more subtle conditions which cause the difficulties. It is difficult to put forward impairment of judgment as a primary psychiatric symptom. There are people who exercise poor judgment in a completely rational, albeit unintelligent or ill-informed, manner. They do not suffer any form of mental illness. They are just not good at making good judgments.

The importance of impaired judgement

Yet there are those conditions where the most significant impairment is that of impaired judgment. It you look at the problems of dealing with people with bi-polar disorder, they might have quite subtle signs, but it is the impairment of judgment that causes such enormous problems. It is seen as such a 'soft' symptom and yet it is the core issue. The impairment of judgment of someone who occupies a key position or function is a very serious matter. Imagine a Qantas pilot on QF1 whose judgment is not as good as it should be and you are a passenger. When it occurs as a result of a psychiatric condition, it is the impairment of judgment that becomes the essential psychiatric symptom.

It is often difficult for non-psychiatrically-trained individuals to envisage that someone who is quite capable of putting together intelligent, complex and lucid argument might be suffering from a condition which causes them to exhibit impaired functioning by way of having impaired judgment: in particular, in relation to a circumscribed aspect of their functioning, as occurs with paranoid ideation or in delusional illness. They might, in fact, be functioning quite well in lots of other areas, but there is this circumscribed area where the paranoid ideation or delusional illness are expressed. It is very difficult, when there is reasonable performance in other areas, for people to see that degree of aberration in that one circumscribed area. I think that it is very hard to believe that the person has a significant mental illness.

Conclusion

The way in which significant impairment of judgment is best evidenced is by looking longitudinally at the functioning of the individual in relation to the question at hand. In brief, I believe that careful and expert assessment of that process should be given more weight than it currently has in the legal or adversarial environment. I think that it is a symptom that is perhaps under-valued and under-recognised. I also think that, if one understands the reason for that view, one can see it manifesting right through the tragic murder of Dr Margaret Tobin and the mental state of Dr Gassy.