Conversation Piece – The Forensic Psychiatrist

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DR PHILIP WELSBY: Dr Chiswick, as you are a forensic psychiatrist currently working in Edinburgh might I ask what does a forensic psychiatrist do?

DR DEREK CHISWICK: Forensic psychiatry is a relatively new specialty and at present there are about 70 consultants working in Britain. Forty years ago a handful of forensic psychiatrists spent their time giving evidence in the various ‘hanging’ trials (Haig, Christie, True, and Ruth Ellis) which decided whether a murderer was to live or die. Today the picture has changed. Forensic psychiatrists are fully involved in both assessment and treatment (the latter very important) of a wide range of mentally abnormal offenders. Some of these include the most seriously disturbed, disruptive and dangerous people presenting to the psychiatric services. You will find forensic psychiatrists in various clinical settings including the maximum security or special hospitals (of which there are five in Britain), in the new regional secure units which have developed in England (though not in Scotland), in ordinary psychiatric hospitals and clinics, and also as visiting psychiatrists to prisons.

PDW: If a junior doctor conceived a notion to become a forensic psychiatrist how should he or she proceed?

DC: Junior doctors must first undergo their general professional training in psychiatry and obtain the membership of the Royal College of Psychiatrists and then need to obtain one of the 25 or so forensic psychiatry senior registrar training posts. About a quarter of these posts are currently held by women trainees and we would be delighted to welcome more young women into the specialty. Like all other senior registrar posts there is scrutiny by a joint higher training committee and in general they provide excellent experience. I would advise a potential forensic psychiatrist to look at the various schemes on offer and talk with those currently in post. As there is only a small number of trainees they have organised their own ‘club’ which meets regularly; the ‘grapevine’ is very effective.

PDW: How did you enter forensic psychiatry?

DC: I was always interested in psychiatry as a medical student although I then had no intention of entering the specialty. After qualifying I had a brief flirtation with surgery but decided to look at psychiatry again and soon was hooked. I started at a peripheral hospital and came to Edinburgh, which has a well known reputation for psychiatry (it is often known as the McNaughten). One of my first patients in Edinburgh was a stalwart middle class lady who had been arrested for shoplifting in a supermarket and had subsequently made a near-successful attempt at suicide. She clearly had a severe depressive illness but what had made her break the law in a way totally alien to her normal habits? My interest in the relationship between psychiatry and the law was thereby aroused. I completed a small research project into the use of the emergency measures in the then Mental Health Act and was well on my way.

PDW: What psychiatric disorders do criminals have?

DC: There is a major debate concerning the relationship between criminality and mental disorder; the biggest problem is that there are no satisfactory definitions of either term. Two points arise. Firstly there is no specific mental disorder associated with criminality; contrary to popular belief not all criminals are psychopaths—and the latter term is itself disputed as a clinical entity. We, like general psychiatrists, deal with major functional psychoses (schizophrenia and manic depressive illness), severe personality disorders, organic brain disease, and problems of substance abuse. Secondly we do not claim to treat criminality—which is an impossible thing to do. We see only a minute proportion of the two to three million offenders who pass through the criminal courts in Britain every year. We see only those patients in whom the court thinks there is evidence of mental disorder such that he or she requires psychiatric assessment.

Having said this, there are no one-to-one relationships between one particular psychiatric illness and a particular type of crime: just as people who are not mentally ill may commit any crime so may someone with schizophrenia or mania. Thankfully they are more likely to commit a minor rather than a major crime and interestingly the likelihood of their offending at all is probably no more or less than that of the general public.

PDW: How do you differentiate between evil and mental illness when the results may be the same?

DC: The traditional ‘hoary chestnut’ question! Mental illness is diagnosed, like any other medical condition, by taking a history and examining the patient. Diagnosis is clearly a task for a psychiatrist. Evil, on the other hand, is not a quality I am qualified to judge; I think you should ask a minister of religion! The courts have evolved their own tests like the McNaughton rules. We are obliged to observe these when providing evidence but they have no clinical basis, and most psychiatrists regard them as absurd and antiquated. The old conundrum ‘is he bad or mad?’ is not a conundrum as ‘bad’ and ‘mad’ are not comparable; it is like asking if someone is either or clever or tall. The presence of mental illness requires psychiatric evaluation, the presence of evil a moral philosopher.

PDW: And whilst there are a few amateur psychiatrists there is no shortage of amateur moral philosophers! Do you not have difficulty when dealing with patients whose crimes are an offence against God and man—including Derek Chiswick?

DC: I think one has to learn to be non-judgemental in forensic psychiatry. A lot of people have committed very serious crimes but it is not our job to moralise. Our job is to assess the presence of mental disorder, to make a diagnosis and provide treatment. This must be done wherever we find the patient—including prisons. One of the most appalling features of our prisons is the way certain criminals (particularly, but not exclusively, sex offenders) are subjected to abuse and violence at the hands of other prisoners. I find these self-appointed moralists in the prisons utterly repugnant. As far as I am concerned prisoners are people who have committed crimes and my job is to assess their mental health.

PDW: How should a simple physician such as myself decide whether to call the police, a psychiatrist, or a forensic psychiatrist?

DC: I presume you mean in respect of disturbed patients
CONVERSATION PIECE

who present to 'general medical' services. This is a question for a liaison psychiatrist - currently a burgeoning psychiatric subspecialty. We teach our psychiatric trainees and medical students that when a patient on an acute medical or surgical ward becomes disturbed the most likely causes are: (1) a toxic confusional state; (2) a toxic confusional state and (3) a toxic confusional state. Rehydration, appropriate antibiotics, or the proper treatment of delirium tremens can have an amazing effect on a patient's psyche. I do not think that you are likely in the normal course of events to need the services of a forensic psychiatrist. When a patient's behaviour is disturbed and disruptive in your ward and you have ruled out psychiatric illness (and it might require a psychiatrist to do this) then how you deal with the situation is for you to decide.

PDW: Is a personality disorder a psychiatric illness?
DC: Opinions vary on this. In general we regard illness as something that supervenes during a patient's life; it has a clearly definable onset. In contrast, disorders of personality are lifelong and consistent over time. Unfortunately the term personality disorder implies therapeutic despondency and is often wrongly applied to any patient who does not get better.

PDW: Do you enjoy your job?
DC: Although it sounds trite to say, I do enjoy my work and there are many satisfactions. Patients often present in the most dire and tragic circumstances and seeing patients through from start to finish, making a good clinical assessment, and guiding them through appropriate treatment is very satisfying. Quite often the patient must be helped through the ramifications of the criminal justice system and this too requires skill and a knowledge of the system. When it goes wrong it can be disastrous but thankfully the outcome is usually appropriate. Other satisfactions come from training new entrants to the specialty. It gives me quiet satisfaction that I have been responsible for the training of a number of senior registrars who have become established consultants.

PDW: How often have patients been violent to you?
DC: I have only been hit once by a patient - when I was a house officer dealing with a patient postoperative from an aortic valve replacement (toxic confusional state!). We do learn skills in defusing situations and learning the verbal and non-verbal cues which both we and the patients make that can inflame a situation.

PDW: Such as?
DC: It is important not to respond to challenging behaviour by being confrontational. Much depends on circumstances but it is generally best to interview the patient in conditions of privacy (but tell other staff where you are). Patient and doctor should be seated. Give the patient your attention (no leafing through casenotes or looking bored) but don't engage in eyeball-to-eyeball contests. Listen; show that you are interested and reply in a calm, steady voice in a lower tone than in normal conversation. Some patients are belligerent as a way of life, but others are aggressive through fear. It is not an easy task to deal with such patients - and the problem is becoming more common.1

PDW: A topic of current interest in Edinburgh is the problem of intravenous drug abusers (IVDA)s. In the past, society, if I may speak for society, used to regard IVDA as a social or police problem whilst waiting for the IVDAs to mature out of this habit, as most did. Now that IVDAs have acquired HIV infection they are firmly in mainstream medicine. Why is it that psychiatrists have not, with a few exceptions, involved themselves in the management of IVDA?

DC: HIV has given a new dimension to the problem of IVDA. Psychiatrists have always been involved in the problem of substance abuse though, sadly, therapeutic advances in both alcohol and drug addiction are slow. Whilst psychiatrists may succeed in treating illness we traditionally have had little effect on modifying people's behaviour. There is no agreed policy for treating IVDAs.

PDW: When is someone certifiable? Quite a few of my IVDA patients make decisions that are inconceivably stupid and likely to cause harm to themselves and possibly others: in other words mad decisions. Any advice to help me?
DC: The law is phrased in broad terms. A patient suffering from mental disorder can be detained in hospital to protect his safety or that of others so long as it is appropriate for him to receive treatment in hospital and so long as such treatment can only be given if he or she is detained. Our law makers differentiate between 20th Century social problems and mental disorder: the Mental Health Act specifically excludes alcohol and drug dependence from mental disorder (promiscuity and immoral conduct are also excluded). Your IVDAs cannot be detained because of drug abuse unless they have a mental illness such as Korsakoff state when detention might be indicated. You are in the same situation as any doctor whose patient fails to take the advice on offer.

PDW: Do your think that methadone, needles and syringes, and condoms ought to be available inside prisons?
DC: My views may differ from those of other psychiatrists. Firstly we need to know whether provision of this equipment would be of significant value in limiting disease spread. If the answer is 'yes' I think they should be made available. However, psychiatrists should not become involved in deciding which prisoners should have these provided.

PDW: Psychiatrists have available the option to retire five years earlier than standard doctors. Are psychiatrists abnormal in some way to justify premature retirement?
DC: I think the preferential retirement terms (which also apply to psychiatric nurses) are an anachronism and an embarrassment. Presumably it was thought that psychiatrists had a more stressful life than other doctors: psychiatrists have a higher suicide rate than the rest of the medical profession, which itself has a high suicide rate.

References

Conversation piece. The forensic psychiatrist. Interview by Philip Welsby.

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