Psychiatry: a risky business?

Frank Holloway

Following a series of well-publicised tragedies the Department of Health published guidelines on the discharge and aftercare of psychiatric patients (Department of Health, 1994). These guidelines stipulate that at the time of discharge from in-patient care the treatment team will have carried out a risk assessment, with the expectation that professionals will be criticised if things go wrong. Risk assessment is now a routine, if poorly understood, element of clinical practice. The allied concept of risk management, which lacks a simple definition but is "aimed at reducing the likelihood of harming patients during treatment, minimising trauma to those who are affected, and controlling the possibility of subsequent litigation" (Vincent, 1995), is much less familiar to clinicians. The Editor has commissioned a short series of articles that address the topic of risk in psychiatry, covering suicide, dangerousness, the exposed role of Mental Health Review Tribunals in the case of Restricted patients and a variety of professional risks. The aim is not to be didactic but to raise the level of debate about the risky business that psychiatrists are engaged in.

References

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FRANK HOLLOWAY, *Series Editor*

Risk management: from patient to client

Paul Bowden

At an interview for a senior registrar a candidate from the Republic of Ireland was asked about the assessment and management of dangerousness. The candidate replied with disarming candour: 'Sure, it's the Sleep Test'. The ball was in the questioner's court. 'Tell us about the Sleep Test' the questioner directed rather testily. The candidate said that having assessed all possible factors the clinician made a decision; if he slept that night it was the correct one, and if he lay awake thinking about it, clearly he was wrong. Recognising an exceptional candidate the appointments committee offered the applicant the job.

Of course we were deceived by the blarney, although time proved that we had made an excellent choice. The sleep could have been the oblivion of denial; the wakefulness a sign of healthy dissonance. Clichés such as 'The best predictor of future violence is past violence' have gained kudos more by virtue of repetition than because they possess any internal validity. The gist of this contribution is that the route to good risk assessment and management is well-signposted, but arduous, and it is easier, but more dangerous, to travel on a wing and a prayer, than to face unpleasant realities.

At the heart of risk assessment and management is the disquieting emotion of anxiety (whether acknowledged or not), not in the patient, but in the clinician. I am not talking about the response to the bullying, threatening patient who

can only be managed properly when the behaviour is acknowledged, and neutralised, and the clinician has regained the therapeutic initiative, but of anxiety whose origins lie in facing knowledge which is not easy to live with. Alternatively, the clinician may be in a state of not knowing, consumed with paranoid anxieties about the patient's inner world which he is unable or unwilling to access.

Some patients' lives are unhappy ones and their mental experiences can be un-understandable; occasionally these are grotesque and horrific, or unbearably bleak. In such cases sense, meaning, and empathy bring a shared suffering. (Is that why we concentrate on the form rather than the content of a mental state?) Many of the tasks which the psychiatrist has to undertake are coercive, and essentially unpleasant, and since there are hardly ever no-risk options, there is a calculated risk to be taken. Living with an at worst scenario can be difficult; hence the tendency to favour the cut and dried rather than the probabilistic. From our bunker we delude ourselves that we observe concrete facts, based on hard science, oblivious of an existential and irrational vanguard.

Our impositions are usually justified by us both on the basis that we know better than the patients what is good for them, and the greater good principle. But much of the interaction between doctor and patient concerns painful things, and sometimes interventions are not understood by the patient, or they are misinterpreted, or forcefully resisted. A full appreciation of a patient's potential, and of the calculated risks that are being taken, can be difficult to sustain during cosy chats over cups of tea in out-patients. And carefully nurtured relatives rarely blow the whistle in time, even if it is themselves who are at risk. How can we both assess and manage risk, and have a nice time with our patients?

I assume that if a psychiatrist does not inform himself fully about a patient's background he chooses not to do so; it is an active rather than a neutral action. Similarly if the signs of relapse are ignored, it is because the psychiatrist chooses to do so – others can do the dirty work. Warning signals are ignored, and the mistaken belief that we are invulnerable prevails. How can all the hopes, understandings, and other accoutrements of the special relationship be squared with the first hint that not all is well? Knowledge brings with it responsibilities: detailed and readily available information on offences of violence, always to be kept in mind, raises the spectre of a patient's potential and of our relationship to it. New information may conflict with decisions already taken, or be a challenge to leadership within the clinical team, in which we have a personal investment. We must envisage all the unpleasantness that certain knowledge brings. Our hopes set an agenda of optimism.

Disagreeable consequences, with their attendant anxieties, can be avoided by ruling that the issue is beyond one's area of responsibility. This can be done on nosological grounds (calling patients clients, or changing the diagnosis from, say, schizophrenia to personality disorder), geographical (catchment area disputes), or by secretly turning a blind eye. These intellectual gymnastics reflect what the patient is doing; it is a sort of collusive denial.

Overdependent on words rather than meaning, and biased in our judgements by our roles of ally or victim we survive on good luck rather than good judgement. Perhaps we do not listen to what our patients are saying because we cannot bear to hear; we do not seek feed-back because we may be challenged and be forced to defend our position; we do not attempt to answer the 'Who?', 'How, and how seriously?', and 'When?' questions, or inform our subjects of what we are about, or think through the secondary life of our opinion because it's all so threatening. The finding that many mentally disordered offenders who commit offences of serious violence have recently disengaged from treatment raises the issue of the extent that they may have been encouraged to do so. What to do about it so as to avoid apportioning blame, and to promote understanding?

According to the *Shorter Oxford English Dictionary* the word patient has three meanings: one who suffers; being under medical treatment; a recipient to whom something is done. For its part, client has two distinct meanings: it is a person who is under the protection or patronage of another; it is someone who employs the services of another, a customer. It follows that the word client describes a relationship: of patron to dependent; of someone who has something to the person who wants the same. In the colloquial sense, patient is used to describe someone who is under medical treatment; it is a state rather than a relationship.

The transmogrification of patient to client is an example of collusive denial. The 'mad' are not ill, and their mad worlds are real ones, they are clients. It is difficult to understand how existing meanings of the word client apply to those to whom it is attached, for example someone on whom you have completed a section of the Mental Health Act. That it should refer to protection, patronage, or customer is not understandable; that it is used to describe one party in a particular relationship has more meaning. In using the word in this way it defines the nature of the relationship; patient state becomes client relationship. But in seeing patients for what they are there is a certain honesty: an acknowledgement of their suffering, and their position as being under

medical treatment. We can also adopt a neutral attitude towards them, discriminating where necessary over matters such as public safety. But clients are afforded no such impartiality; they are customers, to be patronised.

Just as we see in the false dichotomy of mental illness versus personality disorder a covert mechanism for selecting and rejecting individuals for psychiatric services, so in the journey from patient to client we see a shift from a position of having an ability to deal with things as they are, to presupposing a particular type of relationship where unpleasantness is anathema.

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