survivor, the assessment found insufficient evidence for PTSD. The evaluation revealed that publication of her name would likely constitute a major stressor potentially causing deterioration in her mental health condition, suggesting psychiatric treatment and monitoring before any publication whilst recommending against revealing details about the sexual assault.
Results: The case exemplifies the challenging position of forensic psychiatrists who must balance competing ethical obligations between individual patient welfare and duties to the court. The forensic assessment demonstrates a nuanced approach, distinguishing between different types of potential disclosure. Whilst recommending against publication of details regarding PDS's sexual trauma, which appears peripheral to the core professional misconduct and would serve no legitimate public purpose, the assessment acknowledges the court's legitimate interest in transparency about plagiarism and non-disclosure issues directly relevant to professional fitness. The psychiatrist's recommendations represent a harm-reduction approach that would provide required mental health support whilst maintaining judicial transparency.
Conclusion: Ethical resolution in cases involving mental health and professional accountability may require graduated approaches rather than absolute positions. Courts can balance open justice principles with harm minimisation through careful distinction between relevant professional misconduct requiring transparency and peripheral personal information warranting protection. Forensic psychiatric assessments provide valuable frameworks for achieving proportionate outcomes that acknowledge both public interest in professional standards and individual rights to protection from disproportionate harm.

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Functional Neurological Disorder Complicated by Persecutory Delusions in a General Hospital: A Case Study

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Aims: Functional neurological disorder (FND) frequently co-occurs with psychiatric conditions, most commonly anxiety, depression, and trauma-related disorders. The coexistence of FND and psychotic illness remains less well characterised, particularly in general hospital settings. The emergence of fixed persecutory beliefs in individuals with FND presents significant diagnostic, ethical, and management challenges, especially when such beliefs interfere with essential medical care. This case illustrates the complexity of assessing risk, decision-making capacity, and the role of compulsory psychiatric treatment when physical health deterioration arises from treatment refusal rather than suicidality
Methods: We describe a middle-aged man admitted to a general hospital with acute onset functional neurological symptoms, including rapidly evolving limb weakness, sensory disturbance, and functional paralysis, following significant occupational stress. During admission, he developed persistent persecutory delusions characterised by profound mistrust of healthcare professionals, beliefs of deliberate harm and surveillance, and accusations of abuse. These beliefs led to sustained refusal of nutrition, investigations, and treatment, resulting in significant weight loss, electrolyte disturbances, and functional decline. Extensive medical and neurological investigations supported a functional diagnosis, with no evidence of delirium or organic pathology to account for the psychiatric presentation. Multidisciplinary management was complicated by impaired engagement and contested use of mental health legislation.
Results: This case highlights diagnostic uncertainty at the interface between FND and psychotic disorder, emphasising the importance of distinguishing illness-related beliefs from fixed delusions associated with behavioural consequences. Risk arose predominantly from malnutrition, immobility, and impaired decision-making rather than deliberate self-harm. While compulsory psychiatric treatment mitigated immediate physical health risks and resulted in partial behavioural stabilisation, it also appeared to intensify feelings of injustice and mistrust. Prolonged hospitalisation and adversarial dynamics may have reinforced persecutory beliefs, underscoring the need for early integrated neuropsychiatric formulation, consistent communication, and relational safety.
Conclusion: This case demonstrates that FND may coexist with psychotic illness, with significant implications for risk assessment, capacity evaluation, and treatment planning. Clinicians should remain alert to risks arising from treatment refusal and physical deterioration in the absence of suicidality. Early multidisciplinary collaboration and proportionate use of mental health legislation are essential to minimise iatrogenic harm and support recovery in medically complex patients.

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High-Stakes Decision-Making Before ECT: The Power of the Pause

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Aims: Background

Electroconvulsive Therapy (ECT) is among the most effective treatments for severe and life-threatening psychiatric illness, yet its use in medically complex patients demands refined clinical judgment.

With rising multimorbidity and increasing prevalence of implanted medical devices, clinicians are more frequently required to balance urgency against evolving physical risk.

This presentation introduces the concept of the *therapeutic pause;* not as delay, but as an active, patient-centered safety strategy, demonstrating how structured reflection and multidisciplinary collaboration can transform high-risk uncertainty into safe, timely intervention.

The aim is to highlight how deliberate pauses at critical decision points can improve both clinical outcomes and patient safety.
Methods: Case Reports

Two urgent liaison psychiatry referrals for ECT are presented.

Case 1 involved a 72-year-old man with schizophrenia and mild learning disability, admitted with catatonia, severe self-neglect, and nutritional failure requiring nasogastric feeding. He had a proximal deep vein thrombosis (DVT) diagnosed three weeks earlier and hyperkalaemia, raising concern about embolic risk and physiological stress during ECT.