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Defensive practice in mental health

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Abstract

Aim This study aimed to assess the extent of defensive clinical practice by psychiatrists and psychiatric nurses in a New Zealand Mental Health Service.

Method An anonymous questionnaire survey, addressing perceptions of a variety of defensive practices, was sent to all psychiatrists and psychiatric nurses working in acute clinical settings in the publically funded mental health service in Dunedin, New Zealand.

Results Defensive practice is perceived as widespread in psychiatric settings. In particular, practices such as questioning patients about their safety, admissions to hospital, and delayed discharge from hospital were often perceived as occurring for defensive purposes. Psychiatric nurses were more likely than psychiatrists to perceive such practices as defensive.

Conclusion Defensive practice is common in mental health. This is despite New Zealand's no-fault compensation scheme, and so presumably results from concerns other than the risk of financial liability. There may be particular pressures in mental health to practice defensively.

Defensive practice occurs whenever a practitioner gives a higher priority to self-protection from blame than to the best interests of the patient. Two forms, positive and negative, are conventionally considered.[1]

Positive defensive practice (assurance behaviour) is where additional effort, of marginal clinical utility, is made to avoid complaint or legal liability. Examples include the ordering of extra tests or the keeping of excessively detailed notes. Such practice may be wasteful of resources and have little or no beneficial impact on individual patients.

In contrast, negative defensive practice (avoidance behaviour) consists of avoiding certain procedures, patients or clinical scenarios because of the perception of the hazard of liability.[1,2] Negative defensive practice appears by definition to be adverse in its clinical impact. Both positive and negative defensive medical practice appear commonplace.[2–5]

Defensive practice is commonly attributed to concern at malpractice litigation, in particular financial liability.[4,6] This is particularly so in the USA where the overall costs of defensive practice amount to several billions of dollars annually.[7,8] Concern at potential litigation may be a common reason for professional dissatisfaction amongst psychiatrists.[9] However, concerns other than the financial may contribute to defensive practice in mental health. For example patient suicide appears to have a substantial emotional impact on psychiatrists and psychiatric nurses, and to result in a more defensive approach to risk.[10–12]

In a survey of defensive practice among psychiatrists in England most reported practicing defensively in the past month, 21% admitting to over-cautious admission to hospital, and 29% to using higher levels of observation than were judged clinically necessary. Defensive practice appeared to be a consequence of concern at complaint and litigation.[13]

Mental health practice may raise particular pressures to practice defensively. Questions of diagnostic validity and reliability are such that the evidence base for mental health practice is less easily interpreted, so that clinical decisions are based more on the impression and opinion of individual clinicians than is the case in other areas of medicine.

Where practice is informed by evidence, variations in patient's individual circumstances, preference, and psychopathology are probably greater in psychiatry than other specialties. Mental health interventions are also counterintuitive. For example, intrusive precautions, such as the use of constant observation on an inpatient unit, has been argued to increase the risk of suicide.[14]

Some patients who make repeated suicide attempts may appear to be in need of admission and close monitoring, or (it may equally be argued) to be in need of a limit setting approach, one that may seem to be a negligent denial of care.[15]

Defensive practice may also occur because psychiatric practice deals with matters that are emotionally charged such as suicide, aggression, and sexual abuse. Clinicians in mental health are under pressure to respond not just to the needs and preferences of individual patients, but also to those of their families, and to wider societal concerns.

Controversies in mental health, and occasional tragedies, are often the subject of close media attention and reporting which may be inflammatory. Negative public perception of the mental health service may influence practitioners' decision making and so contribute to defensive practice.

New Zealand (NZ) might be expected to be an environment that does not encourage defensive practice. Established no-fault legislation means that medical practitioners are rarely sued. The cost of malpractice insurance in NZ is minimal. Payouts after medical error are via the established national Accident Compensation Corporation that separates the process of complaint from compensation. However NZ doctors remain concerned about the complaints process.[16]

NZ studies of medical practitioners report high rates of defensive practice and concern regarding complaints.[17,18] In NZ, mental health clinicians may feel vulnerable in relation to ambiguity regarding clinical accountability, and they have reported feeling forced to practice in a defensive manner by the impression that they are increasingly being held to account for inadequacies within the mental health sector as a whole.[19]

The NZ Parliament has legislated for a Health and Disability Commissioner (HDC)—an independent agency designed to facilitate the rapid resolution of complaints about the quality of healthcare and disability services. Complaints are considered an opportunity to improve health services and they rarely end in the censure of a practitioner.[20]

Method

An anonymous questionnaire was sent to all 83 registered nurses and 31 psychiatrists (consultants and those in training grades) practicing in acute inpatient and community settings within the local Dunedin mental health service. The questionnaire covered several forms of practice: hospital admission, use of the Mental Health Act, prescription of psychotropic drugs, inpatient seclusion, referrals within the clinical team, delayed discharge from hospital, questions to patients regarding their safety, close follow-up in the community, and close observation on inpatient wards. The survey was resent to initial non-responders.

Survey questions were in a form that invited respondents to consider their own practice and that of their clinical (medical and nursing) colleagues, for example: "In your experience of your own practice, and that of your nursing and medical colleagues, what proportion of questions to patients about their safety are the result of defensive practice and may be contrary to the interests of the patient or their family?" Available responses to questions were on a 7-point scale in the form: none/a few/some/about half/a majority/nearly all/all.

Information about age or gender, or any other details of participants was not collected, in an attempt to emphasise the anonymity of the responses.

The project received ethical approval from the Lower South Regional Ethics Committee.

Results

A total of 86 usable questionnaires were returned (59 from nurses and 27 from psychiatrists) representing a 75% response rate overall. Some data was missing; for example, several community based nurses indicated that they were unable to comment on items concerned with use of seclusion and close supervision on inpatient units.

Responses were coded numerically, from 0 (none) to 6 (all) according to the proportion of each practice that was perceived as being defensive. Averages are shown in Table 1, separately for doctors and nurses. Also shown is the proportion of all respondents who considered that the practice was defensive "about half" the time or more.

Table 1. Mean perceptions of defensive practice for doctors and nurses, and combined percentage rating half or more practice as defensive

Variables	n	Mean (doctor)	Mean (nurse)	P	Half or more practice rated as defensive
Questions to patients about safety	83	2.0	2.7	0.08	48%
Inpatient admission	86	1.7	2.4	0.01	34%
Delayed discharge from inpatient unit	79	1.4	2.4	<0.001	27%
Close community follow up	85	1.3	2.1	0.001	25%
Internal referrals	85	1.5	2.0	0.01	21%
Close inpatient supervision	75	1.3	2.1	0.002	17%
Use of mental health act	86	1.5	1.9	0.09	19%
Drug prescription	85	1.0	2.0	<0.001	18%
Seclusion	69	0.8	1.7	<0.001	10%

Defensive practice was commonplace, with many mental health practitioners reporting that some practices were defensive more often than not. Practices most often perceived as defensive were questions to patients about their safety (48%), inpatient admission (34%), and delayed discharge (25%).

Overall, nurses perceived more practice as defensive than psychiatrists (p values for comparisons are shown in Table 1.) However, there were no significant differences in perceptions of defensiveness between nurses in inpatient compared to outpatient settings.

Discussion

This study indicates that defensive practice is widely perceived to be commonplace in mental health practice. In particular, questions to patients about their safety, hospital admissions, and delayed discharge were often perceived as being due to defensive practice.

This study has limitations. Defensive practice, by definition, requires the measurement of a motivation, rather than being the direct measurement of certain practices.[21] As such, it may be difficult to reliably and validly identify instances of defensive practice. In addition, an anonymous survey may result in inflated rates by encouraging over reporting. Non-responders may not perceive defensive practice as commonly as responders.

Compared with psychiatrists, psychiatric nurses perceived more practice as defensive. This held for practice that is mainly medical (drug prescription, admission to hospital) as well as that commonly initiated by nurses (seclusion and close supervision on ward).

Several possible reasons may be entertained. Nursing staff may feel they are more regulated by detailed protocols, and that they have less license to use their own discretion. Nursing practice structures may possibly be more hierarchical, with the implication that the clinical judgement of individuals has to be adjusted in line with perceived organisational priorities.

We suspect that nurses perceive themselves as highly vulnerable in the event of adverse outcome and that this may account for a greater impression that practice is defensive.

That both psychiatrists and nurse rated questions about safety to be most commonly defensive, and possibly counterproductive, raises questions about the value of such monitoring, which has elsewhere been considered to represent excessive concern about risk.[22]

In New Zealand, national guidelines for risk assessment in mental health acknowledge that risks have to be taken, however they also assert that “risk should be reassessed at regular intervals” (p4) and provide an extensive list of factors to be considered in assessment of risk, possibly contributing to a risk-averse culture.[23]

The increasing prominence of clinical algorithms and other protocols detracts from the individual assessment and circumstances. Even when expert committees who produce such guidelines explicitly recommend flexibility and the use of individual clinical judgement, deviation from such guidelines risks being assumed to be evidence of poor practice.

Clinical decision-making has at its heart, the judgments regarding what is best for an individual patient. Such judgment can be usefully informed, but not replaced, by protocol and algorithm. In psychiatry, in particular, there are grounds for concern that

diagnoses and treatment protocols are of limited validity. As such, the application of what has been termed tacit knowledge to clinical decision-making is unavoidable and unobjectionable.[24]

Prominent advocates of evidence-based medicine also emphasise the need for individual clinicians to interpret the problems of the individual patient, using available evidence in a critical manner, generally in the context of a dialogue with the patient.[25] What is in question is the validity of protocols and ethical conventions, the extent to which they accurately represent the body of knowledge and values that should guide practice.

Judgment of the acceptability or adequacy of care can be made from two main viewpoints: the evidence for or against certain approaches, and customary practice. Both would appear to give clinicians little need to practice defensively. However, if a group of clinicians has defensive norms, practicing less defensively carries a greater risk as it violates rather than reflects those norms. It seems that it is not enough to make the right decision, or the best available decision, the decision must also look right to outsiders.

A rule of thumb for defensible medical practice has been the Bolam Principle, whether or not an individual clinician's practice corresponds to prevailing local practice.[7,26] The Bolam Principle is accepted, to varying degrees, in the UK, NZ, and US. Its effect on practice is unknown. It may plausibly provide a barrier against defensive practice, or encourage it. Either way, the Bolam principle will tend to make clinicians behave as they believe other clinicians behave. Thus, if excessively defensive practice is the norm, less defensive practice appears correspondingly maverick and hard to justify.

The defensive response to the risk of inpatient suicide (making inpatient environments bleak and excessively custodial in an effort to remove all potentially dangerous items) has been considered more likely to increase rather than decrease the risk of suicide; its justification being freeing the institution from being blamed, rather than the needs of the potentially suicidal inpatient.[27]

Is widespread defensive practice a problem? There is no evidence base that examines the effect of defensive practice on clinical outcomes. It has been argued that defensive avoidance of certain patient groups can result in a useful concentration of service provision by those with the most expertise.[28]

A case can be made that defensive practice offers the best available way of ensuring clinical adherence to good practice, protecting patients against otherwise overconfident mavericks. However such an argument presumes that the relevant clinical situation can be codified in a treatment protocol.

Defensive practice, even if not directly desirable, may be an inevitable consequence of emphasising cautious and evidence-based practice, and may make clinicians err on the side of safety rather than heroic or idiosyncratic interventions. Complaints about practice are seen in the USA as an important means of improving healthcare quality.[29]

There are two main reasons why defensive practice may be on the increase. Firstly, defensive practice may be an inevitable part of a risk-averse culture, increasingly a concern in New Zealand as elsewhere [30]. Secondly, the proliferation of treatment

protocols and guidelines may make practitioners reluctant to substitute their own judgement.

Claims that there is a climate of defensive practice may tend to be self-fulfilling. Nonetheless, attention to the matter is warranted. A start would be realism about the likely impact of clinical interventions, a realism not always encouraged in a culture that values optimism above caution.

The need for clinical discretion, using guidelines about best practice to inform rather than to replace judgement, could be asserted more strongly. Clinical protocols and guidelines could be phrased to reflect this. Some well articulated publicity may allow concerns about defensive practice to be more widely considered. Finally, greater continuity of clinical care may plausibly provide a clinical context where clinicians feel able to use such discretion.

Our results are similar to those of other NZ studies of defensive practice.[18] New Zealand's no–fault compensation scheme does not prevent defensive practice, which presumably has origins other than in concern at the financial hazards of adverse events and complaint. Mental health practice may involve particular pressures to practice defensively.

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References:

1. Simon R I. Coping strategies for the defensive psychiatrist. Medicine and Law. 1985;4:551–61.
2. Studdert DM, Mello MM, Sage WM, et al. Defensive Medicine among high – risk specialist physicians in a volatile malpractice environment. JAMA. 2005;293:2609–17.
3. Elmore JG, Taplin SH, Barlow WE, et al. Does litigation influence medical practice? The influence of community radiologists' medical malpractice perceptions and experience on screening mammography. Radiology. 2005;236:37–46.
4. Katz DA, Williams GC, Brown RL, et al. Emergency physicians' fear of malpractice in evaluating patients with possible acute cardiac ischemia. Annals of Emergency Medicine. 2005;46:525–33.
5. Summerton N. Positive and negative factors in defensive medicine: a questionnaire study of general practitioners. BMJ. 1995;310:27–9.
6. Studdert DM, Mello MM, Brennan TA. Medical Malpractice. New England Journal of Medicine. 2004;350:283–92.
7. Kessler DP, Summerton N, Graham JR. Effects of the medical liability system in Australia, the UK, and the USA. Lancet.2006;368:240–6.
8. Rubin RJ, Mendelson DN. How much does defensive medicine cost? American Journal of Health Policy. 1994;4:7–15.
9. Rey JM, Walter G, Giuffrida M. Australian psychiatrists today: proud of their profession but stressed and apprehensive about the future. Australian and New Zealand Journal of Psychiatry. 2004;38:105–10.

10. Alexander DA, Klein S, Gray NM, et al. Suicide by patients: questionnaire study of its effect on consultant psychiatrists. BMJ. 2000;320:1571–4.
11. Collins JM. Impact of patient suicide on clinicians. Journal of the American Psychiatric Nurses Association. 2003;9:159–62.
12. Ruskin R, Sakinofsky I, Bagby RM, et al. Impact of patient suicide on psychiatrists and psychiatric trainees. Academic Psychiatry. 2004;28:104–10.
13. Passmore K, Leung W-C. Defensive practice among psychiatrists: a questionnaire survey. Postgraduate Medical Journal. 2002;78:671–3.
14. Kreitman N. The clinical assessment and management of the suicidal patient. In: Roy A, ed, Suicide. London: Williams and Wilkins; 1986:181–95.
15. Gutheil TG. Medicolegal pitfalls in the treatment of borderline patients. American Journal of Psychiatry. 1985;142:9–14.
16. Bismark MM, Brennan TA, Paterson RJ, et al. Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events. Quality and Safety in Health Care. 2006;15:17–22.
17. Cunningham W, Dovey S. The effect on medical practice of disciplinary complaints: potentially negative for patient care. New Zealand Medical Journal. 2000;113:464–7.
18. Cunningham W, Dovey S. Defensive changes in medical practice and the complaints process; a qualitative study of New Zealand doctors. New Zealand Medical Journal. 2006;119(1244). http://www.nzma.org.nz/journal/119-1244/2283/
19. Chiplin J, Bos V, Harris C, Codyre D. Clinical Accountability Within The Mental Health Sector The Results Of A Review Conducted On Behalf Of The Mental Health Commission. Wellington: Mental Health Commission; 1998.
20. Paterson R. Complaints and quality: handle with care! New Zealand Medical Journal. 2004;117(1198). http://www.nzma.org.nz/journal/117-1198/970/
21. Brown J, Rayne J T. Some ethical considerations in defensive psychiatry: a case study. American Journal of Orthopsychiatry. 1989;59:534–41.
22. Buchanan-Barker P, Barker P. Observation: the original sin of mental health nursing. Journal of Psychiatric & Mental Health Nursing. 2005;12:541–9.
23. Ministry of Health (New Zealand). Guidelines for clinical risk assessment and management in mental health services. Wellington: Ministry of Health; 1998.
24. Thornton T. Tacit knowledge as the unifying factor in evidence based medicine and clinical judgement. Philosophy, Ethics, and Humanities in Medicine. 2006;1:2 doi 10.1186/1747-5341-1-2.
25. Sackett DL, Strauss SE, Richardson WS, et al. Evidence Based Medicine: how to practice and teach EBM (2nd edition). London: Churchill Livingstone; 2000.
26. Slawson PF, Flinn DE, Schwartz DA. Legal responsibility for suicide risk. Psychiatric Quarterly. 1974;48:50–64.
27. Patfield M. Creeping Custodialism. Australasian Psychiatry .2000;8:370–2.
28. Black N. Medical litigation and the quality of care. Lancet. 1990;335:35–7.
29. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. JAMA. 2002;287:2951–7.
30. Crowe M, Carlyle D. Deconstructing risk assessment and management in mental health nursing. Journal of Advanced Nursing. 2003;43:19–27.