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Helping vs. Preventing Harm: Reversing Mission Creep in Psychiatry

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Abstract

This essay discusses a shift in the priorities in the psychiatric community over the past several decades from one that focuses upon the relief of suffering toward one that emphasizes harm reduction and danger prevention. The essay reviews the various forces that have driven this evolution including legal decisions that have limited grounds for admission to dangerousness, models of care that emphasize "zero suicide," a rise in liability for outpatient suicide and the resulting practice of defensive medicine. The essay also notes the role that the overselling of psychiatry's ability to prevent negative outcomes has played in shaping these developments. The essay then argues that while preventing self-harm and violence are certainly important goals, the overall refocuses of psychiatric practice to prioritize these aims has had a deleterious effect upon patient care and should be reversed. The essay advocates for a different approach to mental health care and will enable to psychiatric profession to return to its helping origins.

Keywords: Harm prevention, Defensive medicine, Positive psychiatry, Helping, Healing

Commentary

Medicine is frequently described as a "helping profession" [1]. Helping others is among the leading reasons students report pursuing careers as physicians [2,3]. Laypeople also perceive doctors to be "thinkers who help others" [4]. Historically, psychiatrists and other mental health providers have been described in similar terms [5]. As important, these objectives are more than aspirational. While intellectual candor requires acknowledging the checkered past of American psychiatry—a history tarnished by misguided interventions (e.g., frontal lobotomies, insulin comas, etc.), highly flawed diagnostic categories (e.g., drapetomania, hysteria, etc.), barbaric conditions at large state institutions like Willowbrook and Milledgeville, and the pathologization of same-sex attraction—the record of the past fifty years provides strong evidence that psychiatric treatment proves helpful, and even life changing, for large numbers of people [6,7]. In two generations, systemic legal reforms, novel classes of medication and efforts at destigmatization have radically altered the fates of many individuals suffering from mental illnesses—whether high-functioning outpatients being treated for depression and anxiety, or individuals afflicted with severe psychiatric conditions such as schizophrenia. Needless to say, significant challenges persist. Anyone who has ever witnessed the tragedy of those with psychiatric disorders living on the public streets of our urban centers understands this reality. Yet despite critiques by various anti-psychiatry forces, the evidence shows that psychiatry has the potential to benefit significant numbers of people [8].

At the same time, the culture of psychiatry—in training programs, in hospitals, and in outpatient settings—has increasingly embraced a second role: harm prevention. While helping individuals with mental illness certainly remains a goal of psychiatry, keeping patients from injuring or killing themselves and others has increasingly become a priority, and arguably a primary focus, of the psychiatric profession. These developments have occurred gradually, often preventing practitioners from fully registering this evolution—much like "the proverbial frog who boils alive without jumping to his freedom because he does not realize the water temperature in the pot is slowly being elevated". This essay explores the causes for this shift in priorities and calls for a recentering of the

psychiatric profession away from danger mitigation toward an orientation that concentrates upon helping, healing, and the relief of suffering.

Psychiatry and Harm Prevention

Multiple factors explain the dramatic shift of the psychiatric profession's focus toward harm prevention. Starting in the 1960s, as a result of court decisions that have limited the grounds for involuntary psychiatric admission and forcible treatment of patients to situations involving dangerousness, the psychiatric profession has increased its emphasis on risk assessment [9]. Shortly thereafter, plaintiff's attorneys succeeded in persuading courts to hold outpatient psychiatrists liable for "negligent failure to prevent suicidal behavior"—a claim first recognized in the seminal California case of *Bellah v. Greenson* (1978) [10]. Over a relatively short period of twenty years, suicide became one of the leading causes of malpractice payouts in adult psychiatry [11]. High profile acts of violence by mentally unwell perpetrators, although not representative of the vast majority of individuals with psychiatric diagnoses, have also shifted public attitudes and expectations regarding the role of behavioral health providers [12].

In this same era, thought leaders in psychiatry created, often unwittingly, the false perception in the public consciousness that psychiatry has the ability to "cure" these ills—from overselling the efficacy of medications like selective serotonin reuptake inhibitors (SSRIs) to advancing suicide eradication as a public health objective [13]. The United States Surgeon General's 2012 National Strategy for Suicide Prevention set "zero suicide as an 'aspirational goal' for healthcare systems," while the National Action Alliance for Suicide Prevention argues that "suicide should be a 'never event'" [14]. In 2009, John Campo spoke for many in the field with his declaration that the "time to adopt a 'zero-tolerance' mindset" for suicide "is now" [15]. This emphasis occurred against a backdrop of evidence suggesting that suicide rates can *never* be reduced below certain levels by any ethically acceptable measures, and despite persuasive arguments that too aggressive a drive toward suicide reduction might actually produce the opposite result [10,16]. Whether or not these efforts were wise or foolish, they have unquestionably reshaped both psychiatric practice and the training of future psychiatrists.

These developments in the aggregate are not without their concrete negative consequences. So-called "defensive psychiatry" has been on the rise since the 1980s [17]. Reuveni *et al*. define this practice to include "any action undertaken by a psychiatrist mainly to avoid malpractice liability, rather than for the sole benefit of the patient's mental health and well-being" [18]. They characterize "defensive psychiatry" as consisting of two distinct elements: "Assurance behavior" or "positive defensive" psychiatry, "which involves ordering diagnostic tests and/or treatments, referrals to other physicians and additional services of marginal medical value merely to prevent or limit liability," and "avoidance behavior" or "negative defensive" psychiatry, which "refers to the physician's reluctance to be involved in the treatment of high-risk patients or procedures" [18]. Positive defense might include hospitalizing patients involuntarily in situations where doing so may be legal, but not clinically necessary, resulting in damage to therapeutic relationships and rendering patients with psychiatric illnesses less likely to seek care again in the future. Negative defense might entail refusing to accept patients with histories of suicide or violence into one's outpatient practice—a collective action problem that often results in the patients most in need of ongoing treatment having the least access to care [19]. In extreme cases, "bad actors" may take advantage of this fear of liability by malingering suicidality or homicidality to garner psychiatric admission or forestall criminal responsibly, taking away scarce resources from patients with legitimate psychiatric conditions [20].

Yet the shift toward harm prevention has reshaped psychiatric practice in far more subtle, yet equally unsettling, ways as well. These changes are most pronounced in the emergency and inpatient settings—two subfields to which psychiatry residents generally have considerable exposure early in their training. While clinical evaluation for risk of suicide is certainly an important aspect of any acute psychiatric evaluation, the proliferation of lengthy screening tools, which often require extensive documentation, lends an outsized emphasize to this aspect of the exam. In addition, although the data supporting the efficacy of these tools is limited, at best, they create the false impression among house officers that suicide risk can be predicted algorithmically on the level of the individual patient [21]. Focusing upon dangerousness in this manner may lead clinicians to overlook other critical symptoms. The emphasis may also convey to the patient that the provider is less interested in his psychiatric wellbeing and more concerned about matters such as mitigating liability and upholding public safety. For too many trainees, the treatment of acute psychiatric patients becomes a prolonged exercise in risk management, rather than an endeavor of mutual engagement and learning.

More troubling, when a negative outcome does occur—either when a patient ends his own life or commits an act of violence—a "culture of blame" often holds the treating providers responsible for these results [22,23]. Investigations tinged with a punitive flavor, attitudes of supervisors and colleagues, and even internalization of fault—far more than any formal legal or administrative consequences—are largely responsible for this effect. While oncologists consider death from cancer as a tragic, but sometimes unavoidable, consequence of a disease that too often remains resistant to medicine's best interventions, psychiatry does not view suicide stemming from mental illness in a similar manner. The unexpectedness and the relative rarity of completed suicides in comparison to cancer deaths may, of course, play a role in

shaping these attitudes. Obviously, keeping such deaths rare is desirable. But they need not be unexpected. One of the reasons such losses are shocking to psychiatrists is because they work in a culture where they are trained to view them as shocking, rather than the natural outcome of severe medical conditions.

Getting Back to Basics

Today, many psychiatrists, especially junior ones, have become so accustomed to this harm prevention culture that they have "grown to resemble the fish who no longer recognize that they live in water". They cannot imagine their profession any other way. Yet psychiatrists need look no further than other medical fields for better alternatives. In oncology, when a patient expires, an investigation only occurs if suspicions of error arise. Routine cancer deaths for recently discharged patients do not mandate reporting—beyond a standard death certificate—to state authorities. In such cases, root cause analyses and morbidity and mortality conferences are not routine. In contrast, these matters have become the norm in hospital psychiatry after a patient's suicide, even in the absence of any indication of physician error. No amount of collegial or supervisor support can overcome the message of blame that these measures deliver.

Yet steps can be taken to change this culture. Some of these efforts will have to occur at the level of advocacy and policy, such as altering reporting regulations and arguing for statutory limitations on liability for outpatient suicides [10]. Yet others remain in the power of individual hospitals, training programs and supervising attendings. At the most basic level, trainees and established clinicians should be encouraged to think of themselves foremost as caregivers, secondarily as mental health advisors, and only in a tertiary role as assessors of dangerousness. Too many clinical encounters conclude with the care team focused on the question: *Is this person dangerous?* Instead, every psychiatric encounter should conclude with the care team engaging with two questions: 1) *What help did this patient seek or need?* and 2) *How has this patient been helped by this clinical interaction?* That approach seems intuitive, but is used all too rarely in a psychiatric culture that penalizes negative outcomes far more than rewarding positive ones.

The culture of harm prevention has encroached insidiously into even the most minor aspects of care. For instance, many psychiatric notes include statements like "no history of previous suicide attempts or suicidality" in the opening line of a history of present illness (HPI)—even for patients who present with entirely unrelated concerns. In comparison, rare is the note that documents "no history of psychosis" or "no history of anxiety" in the HPI of a patient presenting for complaints unrelated to these conditions. Giving such prominence to the risk of danger in its absence shifts the caregiver's focus in the wrong direction. Assuming patients presenting to an emergency room for a psychiatric condition pose a danger to themselves or others by default, entirely independent of their presenting complaint, has similarly become standard practice—although the same is not true in a general medical setting. In the absence of all evidence, save the label "psychiatric patient," these individuals are often stripped of their belongings in the name of safety and even denied the right to depart without seeing a psychiatric provider. One must ask why a patient who presents to an emergency room seeking a refill of an anxiolytic or antidepressant medication is any more at risk of acute self-harm in the triage bay than one who presents seeking a refill of an antihypertensive. Again, the therapeutic damage caused by this temporary loss of basic human rights gives way to a desire to prevent a purely hypothetical harm. That is not to say, of course, had *some* patients should not have their belongings temporary removed or their rights to leave without evaluation curtailed *based upon evidence*—only that the assumption of potential dangerousness and the prioritization of risk mitigation in *all* cases in which the patient presents for a mental health need may thwart psychiatry's mission to help.

A Path Forward

The great tragedy of this cultural shift in psychiatry is that the transformation has not occurred through malice or indifference. Rather, clinicians and policymakers with the best of intentions have contributed to these changes in the name of patient and societal wellbeing. Challenges to this culture risk being interpreted as a lack of concern for the patient who does pose a danger to himself or others—which could not be further from the case. Nor should questioning this culture be mistaken for a critique of necessary involuntary psychiatric interventions. The prevention of suicide and violence are certainly valid goals, and in some specific cases, they should be the primary focus of psychiatric assessments and interventions. But they are not the be-all and the end-all. Rather, they are one aspect of the much larger role of caregiving. At present, a golden opportunity exists to return psychiatry to refocus on its roots as a helping profession. Such changes cannot occur overnight; they require a comprehensive reimagining of psychiatry's purposes and potential. Professional organizations, residency training programs and individual thought leaders in the field all have the opportunity to play an important role in this process. Academic psychiatrists, in particular, have the platform and power to place a crucial part in this transformation—but they can only do so with increased awareness of a cultural shift that have too often gone unrecognized.

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