Psikiyatride Güncel Yaklaşımlar-Current Approaches in Psychiatry 2020; 12(2):195-207
doi: 10.18863/pgy.562489

Malpractice in Psychiatry
Psikiyatride Malpraktis

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Abstract
Medical malpractice is defined as medical practice errors caused by a lack of standard treatment and care due to neglect, carelessness, lack of knowledge and skills. Despite psychiatry is seen as a low-risk area for medical malpractice, it constitutes 3% of all medical malpractice lawsuits. The purpose of this review is to describe the content of malpractice lawsuits in psychiatry and to determine the measures to be taken for malpractice in psychiatry by reviewing the studies in the literature dealing with malpractice lawsuits in the field of psychiatry. As a result, the content of malpractice lawsuits in the field of psychiatry consists of suicide lawsuits, involuntary admission to psychiatric hospitals, failure to diagnose, psychopharmacologic agents prescribing errors, inadequate treatment, and boundary violation in professional practice. It was determined that suicide lawsuits took first place in these legal cases. Most of the studies focused on the measures to be taken for malpractice in psychiatry. It has been seen that these measures are related to psychiatric professionals, patients, patient relatives and management in hospital settings and need to be handled in cooperation. As a result, in order to avoid malpractice in mental health settings, the rights of patients and psychiatric professionals must be protected, involuntary or compulsory treatments and hospitalizations should be clearly identified, easy access to advocates of patients and health workers and a supervisory board should be established. In this respect, it is thought that an establishment of national legislation about mental health will guide this issue.
Keywords: Malpractice, psychiatry, practice error

Öz
Tıbbi malpraktis ihmal, bilgi ve beceri eksikliği, dikkatsizlik nedenleriyle standart tedavi ve bakımın yapılmaması sonucunda ortaya çıkan tıbbi uygulama hataları olarak tanımlanmaktadır. Psikiyatri alanı, malpraktis açısından düşük riskli bir alan olarak görülmesine rağmen, tüm tıbbi malpraktis davalarının %3'ünü oluşturmaktadır. Bu derlemenin amacı literatürde psikiyatri alanındaki malpraktis vakalarının ele alındığı çalışmalar incelenerek psikiyatri alanındaki malpraktis davaları içeriğinin ve psikiyatride malpraktis için alınacak önlemlerin belirlenmesidir. İnceleme sonucunda psikiyatri alanındaki malpraktis davalarının içeriğini; intihar vakalarının, zorla yatışların, tanı koyamamanın, yanlış psikofarmakoloji uygulamalarının, yetersiz tedavi ve mesleki sınır ihlalleri konularının oluşturduğu görülmüştür. Bu davalarda ilk sırada intihar vakalarının olduğu saptanmıştır. Çalışmaların çoğunda psikiyatride malpraktis için alınacak önlemlere odaklanılmıştır. Bu önlemlerin hastane ortamlarında psikiyatri profesyonelleri, hasta, hasta yakınları ve yönetim ile ilgili olduğu ve işbirliği içinde ele alınması gerektiği görülmüştür. Sonuç olarak, malpraktisi önlemede hasta ve psikiyatri profesyonellerinin haklarının korunması, istemsiz ya da zorunlu tedavi ve yatışlardaki uygulamaların net olarak belirlenmesi, hasta ve sağlık çalışanlarının savunucularına kolay ulaşabilmeleri, denetim kurulunun oluşturulmasının gerektiği ve bu konuda ruh sağlığı yasasının yol gösterici olacağı düşünülmektedir.
Anahtar sözcükler: Malpraktis, psikiyatri, hatalı uygulama

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Received: 09.05.2019 | Accepted: 01.07.2019 | Published online: 21.10.2019

TURKISH Language Association defines the concept of malpractice in the glossary of nursing as "unwanted practices and cases that directly affect the patient's life and health as a result of the imprudence and carelessness of the health team members in the diagnosis, treatment and care services" and "medical error" Malpractice is also defined as "negligent practice" in Guideline of Medical Terms. In the literature, medical malpractice is defined as medical practice errors caused by lack of standard treatment and care due to neglect, carelessness, lack of knowledge and skills. Various reasons related to the health care professionals and the health system such as lack of both quality and number of health professionals, financial inadequacy, increased patient burden, unfavourable working conditions, insufficient collaboration of consultations and administrative problems are contributed for the emergence of malpractice (Turkmen 2009, Ersoy 2014).

Psychiatry is considered a low-risk area of expertise for medical malpractice. However, the number of malpractice lawsuits against psychiatrists, medical negligence claim reports and alleged misapplications have been rapidly increased within years (İlnem and İlnem 1999). In a study conducted in United States which examined 17 medical disciplines (Kent 2011), showed that 7.5% of physicians faced malpractice lawsuits each year. The field of psychiatry covers 3% of these lawsuits (Kent 2011). The main contents of malpractice lawsuits include misdiagnosis, wrong or inadequate treatment, drug errors, involuntary hospitalization, occupational border-violations in the patient-physician relationship, and misevaluation and management of the suicidal patient, and so on (Herbert and Modlin 1990, Reich and Schartzberg 2014, Martin-Fumado et al 2015, Reuveni and Pelov 2017).

Despite the increasing number of malpractice lawsuits in the field of psychiatry, the current up to date researches conducted in Turkey as well as in the world is found to be quite limited. Therefore, the purpose of this review is to describe the content of malpractice lawsuits in psychiatry and to determine the measures to be taken for malpractice in psychiatry by reviewing the studies in the literature dealing with malpractice lawsuits in the field of psychiatry. Contributing to the literature, creating awareness and being a pathfinder to the further studies are the other purposes of this study. For this purpose in this study, Scopus, Elsevier/Clinical Key/Science Direct, PubMed and Google Scholar electronic bibliographic databases were searched between March 10 - June 6 2019 by using the following keywords "malpractice, malpractice and psychiatry, medical malpractice, medical malpractice and psychiatry". As a result of this search, 29 studies which deal with malpractice in psychiatry in a conceptual framework were examined which are accessible on line. This research revealed that the content of malpractice lawsuits in the field of psychiatry consisted of suicide lawsuits, involuntary admission to psychiatric hospitals, failure to diagnose, psychopharmacologic agents prescribing errors, inadequate treatment, and boundary violation in professional practice.

Suicide ideation/attempt and malpractice

Generally, disease symptoms or inability to cope effectively with these symptoms can cause difficulty in making decisions. It is the responsibility of psychiatry professionals to make the best choice for the benefit of the individual, to make decisions to ensure the safety of the patient, even against the wishes of the individual, in accordance with the laws and ethical rules. An example of this is that a patient at risk of suicide attempt is admitted to hospital without his consent (Hal et al. 2013). Some interventions in psychi-

atric treatment have compelling features for healthcare workers. Treatment of a patient with suicidal ideation or high risk of suicide attempt is one of them. Healthcare professionals are held responsible for suicide attempts in both hospitalized, outpatient and discharged patients.

Because of this responsibility, legal problems arise when no measures are taken against a real suicide risk and when the suicide attempt results in death. Alexander et al. (2000), stated that 67% of psychiatrists had lost at least one patient due to suicide. In parallel with these rates, the leading causes of malpractice that are claimed to be related to psychiatry are suicide attempts and deaths due to suicide by 17%. Interventions to prevent suicidal ideation and attempt should be an integral part of psychiatry practice. Unstructured clinical assessments may be insufficient to recognize suicidal ideation and attempt. Therefore, there is a need for structured clinical assessment; suicide risk assessment scales to determine and reduce suicide risk level and to define protective factors; and models that manage the clinical suicide risk estimation and assessment process. Examples of these models and scales in the literature are; Collaborative Assessment and Management of Suicidality (CAMS), Suicide Status Form (SSF), Columbia-Suicide Severity Rating Scale (C-SSRS), Beck Scale for Suicidal Ideation (SSI), Oxford Mental Illness and Suicide Tool (OxMIS) and Nurses' Global Assessment of Suicide Risk (NGASR) (Cutclıffe and Barker 2004, Oquendo and Bernanke 2017, Fazel et al. 2019). It is evident that with structured clinical assessment reinforced by instruments, malpractice rates and malpractice lawsuit rates resulting from these practices will decrease. In addition to clinical assessments, the multifaceted approach, clinical care with better quality, and document registration also contribute to reducing malpractice (Alexander 2000). These practices reduce both suicide attempts and malpractice to protect both the patient and the healthcare workers.

Patient's self-harm and harm to others and malpractice

Not only suicide lawsuits, but also the patient's self-harm and harm to others can lead to malpractice lawsuits. Jašović-Gašić et al. (2009) presented four cases of psychiatric patients whom had to self-harm and physical aggression against others. These cases; 1) self-injury in a patient with acute organic mental disorder after jumping through a hospital window, 2) suicide by drowning of a patient with acute mental disorder after escaping from intensive care unit, 3) suicide in a depressive patient after escaping from a low-security psychiatry unit, 4) physical violence against body and life of other persons in a patient with chronic mental disorder. Evaluations of these cases concluded that the risks of violent behaviour are predictable and that psychiatry professionals and hospital management should ensure patient protection. In these and similar situations, if the psychiatry professionals don't follow all the necessary measures, by ensuring appropriate diagnostic and treatment procedures and don't ensure adequate setting for treatment in order to prevent harmful consequences, then psychiatry professionals are found to be criminally negligent.

Psychopharmacology and malpractice

One of the issues of malpractice in psychiatry is psychopharmacological medication errors. Lawsuits can be filed against pharmaceutical manufacturers, physician who prescribes, hospitals, nurses and pharmacists (İlnem and İlnem 1999). Causes of psycho-

pharmacological malpractice include poor clinical assessment of the patient's past medical history, lack of clinical assessment prior to the treatment plan, administering the patient the wrong medication, administering or applying the patient the wrong dosage of medication, use of medication for wrong duration, wrong route, lack of observation during medication and lack of recognition of side effects and toxicity sign and symptoms, not warning the patient about drug-drug, drug-nutrient interactions, not requesting necessary consultation and not able to record the treatment (İlnem and İlnem 1999, Haw and Stubbs 2003). In addition, failure to inform the patient and his / her family about the late side effects of the psychopharmacological drug and the risks of prolonged treatment may lead to malpractice lawsuits. In the literature, there are some lawsuits which are related with late dyskinesia caused by antipsychotics, delirium and sudden death caused by benzodiazepines, suicide attempts due to inadequate use of antidepressants, complications due to non-follow-up of lithium carbonate, car accidents resulting from not giving information about the the risk of driving the vehicle during psychotropic medication use (İlnem and İlnem 1999). Those are lawsuits filed for damaging third parties and won by plaintiffs.

Meagher and Snowden (2003) found in a study that evidence-based guidelines were not used when regulating drug therapy. Of the 217 patients when were receiving antipsychotic drugs, 169 were found to be using only oral agents, 71 were long-acting intramuscular agents and 34 were using oral and intramuscular agents together. In a similar study (Yorston and Pinney 2000), it was found that polypharmacy was common among patients and 258 patients were being prescribed antipsychotic agents, 30 of whom received higher doses than offered in evidence-based guidelines. In a study by Paton and Banham (2003), an analysis of prescription errors detected by pharmacists working in a 400-bed psychiatric hospital was examined. Two counsellor psychiatrists and a pharmacist, screened and classified drug prescribing errors. Of the 311 errors detected, 56% were found clinically insignificant and 9% were found to have the potential to harm the patient but were not life-threatening. Prescription errors were found to be more common with 88% than decision-making errors. Non-psychotropic drug error rate was found to be twice as high as psychotropic drug errors. This was explained by the familiarity of psychiatrists with prescribing psychotropic drugs.

Professional boundaries in therapeutic interventions and malpractice

Another issue of malpractice in psychiatry is the violation of professional boundaries in therapeutic interventions. In professional practice, professional boundaries are the determination of the distinction between professional and personal identity. Boundaries are necessary for the safety of both professionals and patients. Therefore, border infringements harm the security of the relationship between the health worker and the patient. Evidence of border violations are difficult to obtain. It is known that only very serious violations are reported, and the smaller ones are more likely to fail. It is possible to classify border violations as sexual and non-sexual border violations. Non-sexual border violations; excessive self-disclosure of personal life, low or no fee, deliberate extension of therapy, allowing telephone calls in sessions, establishing a social relationship with the patient, addressing the patient and physician by name, treating the patient as a friend or confidant during the treatment, frequent touches or frequent hugs (Sarkar 2004). Sexual

border violations are a much more serious problem. These are considered more than violations and are accepted as illegal in many countries. This situation does not only affect the patient's current treatment process, but also adversely affects the subsequent treatment process. In addition to this, the initiation of a new romantic relationship after the therapeutic relationship is terminated and the use of trust, knowledge and emotions obtained during the treatment process are accepted as ethical violations (American Medical Association 2002). As a result of border violations, patients experience emotional and identity confusion and feel shame, fear, anger and guilt. Border violations may cause paranoia, depression, sexual dysfunction, self-harm and even suicide attempts (Sarkar 2004).

With this in mind, the psychiatry was the first medical specialty to take a formal stand in terms of sexual border violations. The rationale for this attitude is the sensitivity of the therapeutic relationship, the ease of border infringement, and the vulnerability of patients in many ways.

The Canadian Medical Association's code of ethics includes: A physician will carefully refrain from using the doctor-patient relationship to meet his or her emotional, financial and sexual needs (Canadian Psychiatric Association 2002). The American Medical Association reports sexual contact, sexual abuse that occurs simultaneously with the doctor-patient relationship as a violation of medical ethics. Similarly, in the UK, the Code of Ethics for Good Medical Practices and the Code of Ethics of the Royal College of Psychiatrists clearly states that sexual relations between physicians and patients are completely unacceptable (Royal College of Psychiatrists 2002). The American Nurses Association (2014) states in The Scope, Standards and Codes Of Professional Ethics of Psychiatry and Mental Health Nursing that "professional boundaries are an integral part of the professional interpersonal process and behaviours involving sexual intimacy are unethical". According to the ethical rules of psychiatry in Turkey (Psychiatric Assocaition of Turkey 2002), the accordance with the principle of dropping out of the patient-physician relationship, "The psychiatrist should not allow any type of relations between him/her and the patient outside of diagnosis and treatment purposes. The psychiatrist should not have any sexual relationship with his or her patient." These ethical decisions ensure the principle of beneficence and prevent the patient from being harmed. In addition, they ensure that the therapeutic and trust based relationship is developed and maintained, treatment is applied and maintained in accordance with its purpose, and that objective decisions are taken in treatment.

Notification and consequent sanctions of border violations vary from country to country. In the UK, between 1998 and 1999, 23 border infringement complaints against psychiatrists and 60 against psychotherapists were reported (Sarkar 2004). The American Psychiatric Association has reported that during the last decade an average of ten psychiatrists have been expelled per year for sexual border infringement. In addition, many lawsuits against emotional abuse result in fines or suspension of licenses (Garrett 2002). Sanctions for improper conduct are considered in the context of rendering the profession unworthy for a professional and include temporary or permanent expulsion from the professional organization, dismissal and removal of the application license. In the United States, even entering a consensual sexual relationship is considered a crime in at least 18 states. In the UK, it is seen that the infringement of professional institutions is less frequent and also the sanctions on this issue are less frequent (Sarkar 2004). There are no sources in the literature on border infringement of other psychiatric professionals.

In order to prevent border violations, education and awareness studies should be carried out with health professionals. Laws and ethical principles should clearly define the issue of border infringements, and arrangements should be made to ensure that infringement notifications aright. If border infringement occurs, professional associations and euro chambers should impose sanctions and ensure the protection of both patients and health workers by law as well. Institutions should also develop strategies at the organizational level (Sarkar 2004).

Strategies to avoid malpractice in psychiatry

It is possible to avoid malpractice by developing strategies. Considering that 80% of the faulty medical practices in psychiatry are in the process of clinical practice, the measures should also cover clinical practice (Herbert and Modlin 1990). The information obtained as a result of this literature review is compiled and the measures to be be taken for malpractice are presented below (Herbert and Modlin 1990, İlnem and İlnem 1999, Turkish Medical Association 1999, Alexander et al. 2000, Psychiatric Association of Turkey 2002, Sarkar 2004, Jašović-Gašić et al. 2009, Oren and Santopietro 2013, Reuveni and Pelov 2017).

1. The health workers should have in-depth knowledge of malpractice.
2. To prevent malpractice, health workers, patients, patient relatives and hospital management should cooperate.
3. It should be ensured that the psychiatrist who plans the treatment of the patient is preferably the psychiatrist who performs the examination of the patient.
4. The clinical assessment of the patient should be structured, the time required for the complete assessment should be allocated to the patient and the necessary tools should be provided to determine and reduce suicide risk level and protective factors shouls be well defined.
5. The risk level of the patient in terms of self-harm or harm to others others should be assessed clearly and this assessment and the and the data and measures taken should be recorded.
6. In order to prevent psychopharmacological malpractice, medical history of the patient should be well evaluated and clinical assessment should be done in detail before treatment plan.
7. All healthcare professionals working in psychiatry and involved in treatment and care should perform their roles and responsibilities precisely about prescribing and administering the correct drug/correct dose, ensuring the use of medication for a required duration, applying the drug by correct route, observing the patient during the treatment, recognizing side effects and toxicity sign and symptoms, monitoring and preventing and warning the patient about drug-drug or drug-nutrient interactions, requesting the necessary consultation and recording the treatment.
8. The patient, his/her relatives should be informed about treatment plan, risks, effects and side effects, alternative treatment options should be explained and informed consent should be obtained from the patient and, if necessary, the relatives.

9. Psychiatry professionals should sign forms or documents which indicates their roles and level of responsibilities in planning and applying the treatment and care and shows the medical responsibility of the interventions.
10. Psychiatry professionals should have the clinical records to guide the preparation of the treatment plan including the patient's previous medical records, clinical assessment, diagnostic results, treatment plan, physician's opinion on the risk-benefit of the treatment, interviews with a family member.
11. Education and awareness studies should be carried out with health professionals in order to prevent border violations; employees should be informed about the relevant ethical principles and laws and institutions should develop strategies at the organizational level.
12. When necessary other psychiatrist's consultations or other specialty consultations should be requested and this request must be recorded.
13. Psychiatry professionals should transfer and record the patient's information in detail when they encounter a situation that should transfer the patient to whom they treat and care.
14. In cases where the measures taken to prevent malpractice are insufficient, some behaviours developed by the health worker to protect himself should be prevented. These behaviours are defined as defence medicine.

Defence medicine against malpractice

Defence medicine is basically carried out to reduce exposure to misconduct or to provide legal protection in the event of a malpractice lawsuit. In order to avoid malpractice lawsuits, health professionals often turn to defence medicine. However, especially in the field of psychiatry, defensive medicine may remove the decision of treatment from reliable interventions. This behaviour has two forms. The first is to demonstrate an "assurance behaviour, such as hospitalizing a patient with suicidal ideation who can be treated on an outpatient clinic for defence reasons. Second, the physician expresses her/his reluctance to participate in the treatment of high-risk patients and exhibits an "avoidance behaviour" (Reuveni and Pelov 2017). These two decisions which are taken to reduce the risk of malpractice can lead to patient harm, unnecessary economic burden, unnecessary tests and procedures. In addition, the results of the evidence-based studies do not support defence medicine (Kessler and McClellan 1996, Reuveni and Pelov 2017).

There are studies in the literature conducted about defence medicine in different aspects, but these studies mostly focus on the practices of physicians. In the study of Kessler and McClellan (1996), defence medicine was responsible for about ten percent of total health expenditure. Studdert et al. (2016) found that 93% of psychiatrists used defence medicine in a situation that could be subject to misuse. In another study, Reuveni and Pelov (2017) examined the defensive behaviours of certified psychiatrists and residents in psychiatry and found that residents exhibited more defensive behaviour in terms of hospitalization of patients at risk of suicide, and pharmacological treatment of pregnant and elderly patients. 62.1% of psychiatrists who participated in this study stated that they applied defence medicine to at least half of their patients. When psychiatrists were asked how they were affected by malpractice claims; of the 58 participants, 36 stated they felt anxious, 33 felt angry, 26 felt restless, 16 felt distrustful, 14 felt guilty, 14

reported loss of energy or fatigue, 16 had sleep problems, 11 reported impaired functioning in work, family relation or social activities.

Defence medicine is an important issue that needs to be addressed. The number of evidence-based researches, ways to cope with defence medicine, and the proposed solution are limited. The frequency of referring to "defence medicine" can be reduced by changes in the attitudes and behaviours of both psychiatric professionals and patients. In addition, the development and implementation of clinical practice guidelines targeting risky clinical situations is thought to hinder both defence medicine and malpractice (Reuveni and Pelov 2017).

Conclusion and recommendations

There are areas that may cause malpractice in psychiatry practices. Malpractice has been found to be mostly possible in the case of suicidal ideation/attempt, self-harm and harm to others, psychopharmacology, and border violations in therapeutic interventions. There are some precautions to be taken to prevent malpractice. Psychiatry professionals, patients, their relatives and administrations should cooperate in taking these precautions. When adequate precautions are not taken, psychiatry professionals may prefer defence medicine to reduce exposure to the legal obligations against misuse or to provide legal protection in the event of a malpractice lawsuit.

Malpractice may adversely affect psychiatry professionals, patients, health expenditures and management. In order to prevent malpractice, legal and ethically accepted practices should be preferred. However, in many countries around the world and especially in our country, it is seen that the legal regulations and ethical rules regarding the nature of malpractice and the sanctions in case of occurrence are not clear enough. Moreover, when the current up to date researches conducted in Turkey and as well as in the world were examined on malpractice, it is found that there is an absence of a sufficient number of current research, and the existing literature about psychiatry professionals are often found to include studies on the physicians. In Turkey, it is thought that absence of national legislation about mental health may the reason of the limited number of studies which has addressed this issue.

With the establishment national legislation of a mental health, it is thought that the protection of the rights of patients and psychiatric professionals, clear determination of involuntary or compulsory treatments and hospitalizations, easy access to advocates of patients and health workers and establishment of a supervisory board on this issue can be ensured. Therefore, it is thought that these will facilitate to establish legal regulations and ethical rules to prevent malpractice.

In this study, the content of malpractice lawsuits in the field of psychiatry is discussed in detail and in a holistic way. The measures to be taken for malpractice were determined. Obviously, studies are needed to examine the nature of the measures taken to reduce malpractice. In addition, it is suggested that future studies should include not only the psychiatrist, but other professionals and disciplines involved in psychiatric treatment and care.

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Authors Contributions: All authors attest that each author has made an important scientific contribution to the study and has assisted with the drafting or revising of the manuscript.
Peer-review: Externally peer-reviewed.
Conflict of Interest: No conflict of interest was declared by the authors.
Financial Disclosure: The authors declared that this study has received no financial support.