tion should be exercised with the dosage. Patients 25 years or older may also need to “start low, go slow” when initiating a treatment for depression. Although further research is needed, these findings may help physicians choose the most appropriate type and dosage of antidepressant.

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Drafting of the manuscript: Courtet, Lopez-Castroman, Jaussent.

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Statistical analysis: Jaussent.

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Inpatient Attire: An Opportunity to Improve the Patient Experience

A recent commentary in JAMA1 suggested that patients should be encouraged to wear their own clothing so they might “maintain their self-esteem and orientation and also remind their care professionals to recognize them as people.” Other articles suggest that traditional patient gowns are associated with a loss of dignity, the reinforcement of the “patient role,” and the assumption of a low-status position in the hospital.2-3 Far more has been written on the attire of health care practitioners than that of patients.

Letters

Inpatient Attire: An Opportunity to Improve the Patient Experience

A recent commentary in JAMA1 suggested that patients should be encouraged to wear their own clothing so they might “maintain their self-esteem and orientation and also remind their care professionals to recognize them as people.” Other articles suggest that traditional patient gowns are associated with a loss of dignity, the reinforcement of the “patient role,” and the assumption of a low-status position in the hospital.2-3 Far more has been written on the attire of health care practitioners than that of patients.
Letters

Although patient attire can be graduated from an open-backed gown, at one end of the spectrum, to full home dress at the other, we suggest that the absence of lower-body attire that leaves the backside and genital areas unnecessarily exposed has an important effect on dignity. We sought to determine the proportions of our patients who were wearing clothing in this bodily region and for whom wearing it would be appropriate and to elicit patient preference on the issue.

Methods | The Research Ethics Board of McGill University Health Centre granted ethics approval of this study and waived informed consent. The presence of lower-body garments, defined as any clothing more substantial than underwear or diapers, was recorded during rounds for all patients admitted on the same calendar day to 6 clinical teaching units at 5 hospitals in Toronto, Ontario, Canada, and Montreal, Quebec, Canada. The eligibility of individual patients to wear lower-body attire was determined by the attending physicians of those services by asking themselves: “If this patient requested to wear pants or other similar garments, would you agree?” Reasons not to agree were left to the individual physician but may have included (1) that the patient had a medical problem, wound, line, or catheter precluding their wearing lower-body garments or (2) that the patient was too immobile, too incontinent, too confused, or too ill to wear such attire, given the available nursing resources.

At one center, eligible patients were asked whether they would want to wear such attire, and if not, why. We performed statistical comparisons using the $\chi^2$ test.

Results | Of 127 patients included in the evaluation, only 14 (11.0%) were wearing lower-body garments (Table). Physicians deemed 57 patients (56.4% of patients with available data) to be eligible to wear lower-body garments; however, among them only 14 (24.6%) were actually doing so. We found no significant differences between the 2 cities with respect to the proportion wearing lower-body attire; however, physicians in Montreal were more likely than those in Toronto to deem patients eligible (46 of 70 [65.7%] vs 11 of 31 [35.5%]; $P = .005$).

In the survey, 13 of 17 patients (76.5%) in a single center who were eligible but who were not wearing lower-body attire wanted to do so. The other 4 patients were indifferent and equated the hospital gown with “what patients wear.”

Discussion | We demonstrate that most of the patients admitted to our acute medical units do not wear lower-body attire. This situation occurs despite more than half of them being deemed eligible to do so, despite most of those patients surveyed being interested in doing so, and despite encouragement to wear home clothing as a means of preventing hospital-induced disability.

Despite our study being relatively small, we suspect that the results would be similar in other centers without an existing culture to encourage home attire. We suggest that to improve the patient experience, eligible patients should be encouraged to wear lower-body garments when full home attire is not feasible. Furthermore, we suggest that functional fashions for those with disabilities and special needs, such as the hospitalized patient population, should be developed to allow those who cannot wear or do not have access to their home attire something more dignified than a one-size-fits-all open-backed patient gown.

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Author Contributions: Dr Lee had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of data analysis.

Table. Proportion of Patients Wearing Lower-Body Garments by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>No. of Patients Undergoing Evaluation</th>
<th>No. (%) of Patients Believed Eligible to Wear Lower-Body Garments</th>
<th>Patients Believed Eligible and Wearing Lower-Body Garments, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Hospital, Montreal, Quebec, Canada</td>
<td>26</td>
<td>6 (23.1)</td>
<td>23 (88.5)</td>
</tr>
<tr>
<td>Montreal General Hospital, Montreal (2 units)</td>
<td>44</td>
<td>2 (4.5)</td>
<td>7 (23.3)</td>
</tr>
<tr>
<td>University Health Network, Toronto, Ontario, Canada</td>
<td>16</td>
<td>2 (12.5)</td>
<td>7 (43.8)</td>
</tr>
<tr>
<td>St Michael’s Hospital, Toronto</td>
<td>15</td>
<td>2 (13.3)</td>
<td>4 (26.7)</td>
</tr>
<tr>
<td>Mount Sinai Hospital, Toronto</td>
<td>26</td>
<td>2 (7.7)</td>
<td>NA</td>
</tr>
</tbody>
</table>

Abbreviation: NA, not available.

*Calculated using only sites with available data.
The Cost of Defensive Medicine on 3 Hospital Medicine Services

The overuse of tests and procedures because of fear of malpractice litigation, known as defensive medicine, is estimated to cost $46 billion annually in the United States, but these costs have been measured only indirectly. We estimated the cost of defensive medicine on 3 hospital medicine services in a health system by having physicians assess the defensiveness of their own orders. We hypothesized that physicians who were concerned about being targeted by litigation would practice more defensively and have higher overall costs.

Methods | This study was approved by the institutional review board of Baystate Medical Center. We studied hospitalists at 1 tertiary care (Baystate Medical Center) and 2 community hospitals (Baystate Franklin Medical Center and Baystate Mary Lane Hospital). All hospitalists (n = 42) were invited to complete a survey regarding demographic information and attitudes toward defensive medicine. We then showed physicians their orders placed the previous day and asked them to indicate the extent to which each represented defensive medicine—tests, procedures, or hospitalization ordered primarily because of concern about malpractice liability—using a 5-point scale from 0 (not at all defensive) to 4 (completely defensive). Itemized order costs including daily room and board costs were obtained from the hospital’s cost accounting system.

The outcomes were the percentage of orders and hospital costs due to defensive medicine. We examined the percentage of orders rated defensive (≥1) and completely defensive (4 only). The defensiveness score for each order was converted to a proportion (e.g., 1 of 4 = 0.25) and multiplied by the order’s cost to estimate the cost attributable to defensive medicine. Defensive costs were summed and divided by the total cost of all rated items.

We examined the relationship between physicians’ cost due to defensive medicine and expressed attitudes about lawsuits. Using multivariable regression, we examined the association between higher levels of defensiveness (>10% of orders considered defensive) and order volume and costs.

Results | Of the 42 physicians, 39 agreed to participate; 36 (92%) completed surveys and rated 4215 orders for 769 patients. The median number of orders was 3 per patient (interquartile range, 2-7) and 97 per physician (interquartile range, 61-141). Of the orders, 28% were defensive (Figure). Four physicians identified no defensive orders, and 21 physicians rated at least 1 as mostly defensive (range, 1%-77%). Compared with physicians with fewer defensive orders, physicians with 10% defensive orders or more placed a similar number of orders (5.4 vs 4.9; P = .68) and generated similar costs per patient ($1679 vs $1700; P = .89).

The mean cost was $1695 per patient (95% CI, $1566-$1824), of which $226 (13%) was defensive. Completely defensive orders represented 2.9% of costs, primarily through additional hospital days (Table). Physician factors—sex, training, litigation concerns—were not associated with defensive orders or costs (data not shown).

Discussion | In this study of hospital medicine services at 3 institutions in a health system, 28% of orders and 13% of