DEFENSIVE MEDICINE

— THE NEED FOR RE-IMAGINATION OF OUR MEDICAL LITIGATION PARADIGM

PROFILE

TEXT BY

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Defensive medicine has been in the news with Chief Justice Sundaresh Menon proposing a review of the medical litigation paradigm to a less adversarial process in order to reduce the practice of defensive medicine, during his speech at the opening of the legal year on 11 January 2016.[1] In this paper, we attempt to understand the "whats" and "whys" of defensive medicine and the need for a less adversarial system of medical dispute resolution.

WHAT IS DEFENSIVE MEDICINE?

Defensive medicine is a deviation from sound medical practice that is induced primarily by a fear of medical malpractice (medical litigation in the courts and threat of legal action by licensing boards). The deviation in practice aims at reducing adverse outcomes, deterring patients from filing malpractice claims or complaints and persuading the legal system that the standard of care was met. Defensive medicine is primarily focused to help avoid and protect the physician from liability rather than to substantially further the patient's diagnosis or treatment.[2]

The practices in defensive medicine are classified as **assurance practices** and **avoidance practices**. **Assurance practices** involve the use of more investigations, more medications and more referrals than would be normally indicated. Assurance practices intend to reassure patients and their relatives concerning the quality of care and also offer psychological reassurance for the physicians.

Avoidance practices involve restriction of practice, including eliminating procedures prone to complications and avoiding patients who have complex medical problems or are perceived as litigious. Avoidance behaviours reflect physicians' efforts to distance themselves from situations of high legal risk. Obstetricians are known to limit their practice only to gynaecology and tend to retire early. Orthopaedic surgeons tend to avoid spinal work.[3]

The prevalence of defensive medicine is high in the US with reports as high as 90%.[2,3,4] There are no local studies measuring the prevalence of defensive medicine. Speaking to practising clinicians, both specialists and generalists, many are convinced that defensive medicine has been fully incorporated into daily medical practice. The extent may vary according to legal risk in that specialty.

Defensive practice correlated strongly with respondents' lack of confidence in their liability insurance cover, perceived high financial burden of insurance premiums and experiences of being dropped by insurers in the past.[2]

THE NEED TO REVIEW MEDICAL LITIGATION PROCESSES

Moving away from the adversarial model of medical dispute resolution would definitely reduce the sting of litigation from the medical profession and pave the move away from defensive medicine.

Physicians feel vulnerable to malpractice suits because claims often do not involve medical error or negligence and physicians have been sued despite practising within the standard of care. The strongest reason for review and reform is the inefficiency of the current adversarial malpractice system — neither is it beneficial to the plaintiff nor in terms of improving the patient's safety. There is minimal correlation between negligent acts that harm patients and adverse outcomes that prompt lawsuits.[5] There is no evidence that the deterrence of lawsuits does anything beneficial in reducing the prevalence of medical errors. Leaders in the field of patient safety and quality improvement view the blaming and shaming of individual physicians as a largely counterproductive strategy for improving patient safety.[6,7]

Legal commentators critical of the US tort system have gone on to claim that it is harder to design a more inefficient system of just compensation in medical malpractice. If one were to deliberately try to design a bad system for compensating the victims of medical errors, it is difficult to show how the present system could be exceeded.[8, 9]

Reducing the adversarial nature of the litigation process by encouraging mediation creates a safe space for open disclosure, expression of empathy and apology and reconciliation of the doctor-patient relationship. A judge-led inquisitorial process lends to a more efficient finding of the facts. "Hot-tubbing" of experts and neutral medical assessors in complex cases allows for effective use of medical expert advice.

DEFENSIVE MEDICINE TO PATIENT-CENTRED MEDICINE

Defensive medicine often leads to altered clinical judgement, defensive communication and finally, the deviation from good clinical practice. It distorts the doctor-patient relationship where the physician is committed to serve the patient's best interest. In addition to reforms in the litigation process, doctors should upgrade their knowledge on medico-legal matters so that they can act from a position of knowledge rather than have a fear of medical litigation.

We should return to our humanistic mission of building strong therapeutic relationships with our patients and their families based on mutual respect and trust. In patient encounters, doctors should elicit patient's expectations, seek to understand their illness perspective and engage them in shared decision-making.

When our patients suffer an adverse event, doctors and hospitals must have in place policies, practices and expertise that will enable engagement in open and truthful communication, empathise always, apologise when appropriate and develop systems for early and just compensation.

Doctors should work collaboratively with hospitals and other stakeholders to reduce medical errors, improve patient safety and be committed to optimise use of healthcare resources.

Moving from defensive medicine to the delivery of safe, effective, efficient and affordable patient-centred medical care is the best way to reduce medical malpractice and its unwanted effects. ◆

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