**Title:** DEFENSIVE MEDICINE -SWORD OF DAMOCLES

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**Abstract:**

Defensive medicine is the deliberate departure by doctors from Standard Operating Medical Procedures with a view to safeguarding themselves against possible medical malpractice litigation. It is on a rise in both developed and developing nations across the globe. There has been an increase in defensive medicine and it ranges across all the fields of medicine. Different aspects of this practice as evident and many new are unfolding by the day. It is silently encroaching upon the health care systems and could produce detrimental outcomes. This article probes the determinants of defensive medicine, the possible implications and the recommendations for addressing it.

**DEFENSIVE MEDICINE AND SWORD OF DAMOCLES**

**Introduction**

The debate on merits and demerits of ‘Defensive Medicine’ (DM) continues to raise controversy. The protagonists and the antagonists; both compete with one another advancing their own perspectives. Currently, the protagonists appear to be having the upper hand. Is t

This paper attempts to critically analyze both the perceptions, summing up with the personal take of the authors on the subject. he noble profession losing its well entrenched credibility, patient confidence and professional integrity by indulging in a practice that is scoffed by some as unethical, avaricious, cowardly and ironically termed as ‘defensive medicine? Is the practice actually cowardly, imprudent, and unethical; or it is a rational and desirable conduct under coercive circumstances and legal threat?

**Definition**

Briefly, Defensive Medicine [DM] is a deliberate departure by Physicians from Standard Operating Medical Procedures with a view to safeguarding themselves against possible medical malpractice litigation. DM involves physicians prescribing non-essential tests, procedures, referrals or other unnecessary or evasive steps to protect themselves from legal liability under torts - medical malpractice to be precise. (1–3) DM can be positive or negative - a commission or an omission. It can range from “positive” actions like prescribing non-essential tests, uncalled for referrals to specialists, performing unwarranted procedures and even hospitalization. On the negative side, doctors tend to avoid high-risk patients, complex procedures etc.(1) The standards of appropriate or excessive medicine are not well defined in many clinical situations. A compartmentalized definition of DM is not possible.

**Burden**

There is a thin line and even overlap in what constitutes Appropriate, Cautious or excessive (Defensive) medicine. Exposing patients to unnecessary health risks and excessive expenditure for the sole purpose of avoiding malpractice litigation is bad medicine. But what fits the definition of excessive is important. There is no foolproof measure that can actually describe this term. Practice of defensive medicine is widely prevalent at almost all levels of healthcare and an issue concerning physicians globally(4). Every field in medicine is vulnerable to the practice of defensive medicine. There have been a decrease in the rates of vaginal delivery and a rise in the practice of caesarean deliveries in some settings.(5)(6) Irrational use of antibiotics, is another face of this practice, observed in almost all fields and contributing to antibiotic resistance.(7) Past experiences of being sued and penalized are associated with a more defensive behavior on the parts of physicians and surgeons.(8) Some physicians are anxious to the extent that they would rather limit their practice only to basic sustenance earnings than going in for risky and complicated procedures. (6,9) They tend to avoid critical patients, patients with prior complications and suspect litigants, fearing malpractice allegations against them.

## Determinants of DM

## Physicians are expected to maintain a minimum standard of care that a reasonably prudent medical provider would or would not take under the same or similar circumstances. In case of failure to maintain these minimum standards, the defaulter exposes oneself to the charge of negligence. The failure to correctly diagnose, provide improper treatment, failure to warn the patient of known risks, post treatment medical care and even inadvertent negligence during medical procedures has been judged as a medical malpractice. This fear of litigation is the primary reason that prompts physicians to err on the side of caution and indulge in DM. Alleged medical negligence or malpractice, if proved, entitles the aggrieved party to secure hefty financial compensations from the perpetrators/s or visits them with other penal implications. The cause of action arises from the law of Torts that facilitates claims to huge financial compensations for damages of any kind. Law of Torts has already taken roots in developed countries and other countries are following suit fast. Resultantly, even at the cost of practicality and obvious common sense, they succumb to DM. It is the fear of law, viz; securing oneself from malpractice litigation that prevails and molds the mindset of physicians.(10)(4) Of course, monetary considerations and vested interest involving greed and avarice may also sometimes contribute to this phenomenon.

## Advances in diagnostic and therapeutic technologies make accurate detection of various diseases possible and thus reliable. Now a days, patients, especially from the higher economic strata, look for fast and effective relief even at exorbitant costs involving high tech tests and procedures. Physicians’ general desire to meet patients’ expectations, continued patient trust and to avoid conflict is a major contributory factor leading to DM. However, sometimes detrimental to effective medication, use of these technologies tends to pacify demanding patients, bolster the doctor’s self-confidence and also creates documented court evidence. (4) Further, it is an acknowledged fact that multiple cheap low yield tests churning out uncertain results are no substitute for expensive but technologically advanced tests that provide accurate diagnosis. Moreover, excessive procedures stand a better chance than skipped procedures at a court of law examining a case of medical malpractice.

## Instances of violence against doctors have been by attendants of patients is becoming increasingly common these days. Their lack of medical knowledge and high expectations from the medical fraternity endangers the lives of the resident doctors, making them adopt a highly cautious approach. Pressure from influential people of society, for ‘best treatment’ is another aspect, which burdens the physicians’ ability to function professionally. Moreover, lack of setting-specific standard treatment guidelines for most procedures, result in confusion for medical practitioners.

## Implications

## Defensive medicine is expensive and loaded with attendant health and other risks. The harm might be in the form of physical or mental trauma, fiscal loss, radiation exposure etc. (11,12)The list is not exhaustive and new causes of action continue to accrue with passage of time. Since no test is 100% accurate, unnecessary testing can lead to “false positives”. Such ambiguous and faulty findings may result in distress of various kinds and necessitate further hazardous procedures. The burden of cost due to DM is very high on the healthcare system as well. It is estimated in a few surveys that this cost may go from 3% to up to 40% of the health care costs in the western countries.(13,14,10). It is well known that perfection in medicine is elusive. The inherent inadequacies and imperfections of medical profession are there for all to see. Patients, however, continue to mistakenly believe that doctors are demigods who will always diagnose accurately and administer most effective medication. Undesired outcomes are bound to occur and will continue to occur. Such occurrences have the potential to land the physicians and even members of their family into serious legal and other troubles. They may also severely dent their professional reputations. Even reputed professionals are known to have undergone the humiliations and ignominies of medical malpractice litigation in spite of the fact that courts had finally absolved them of the charge.

## Recommendations

## The more the physicians order tests or perform diagnostic procedures with low reliability factor the more is the likelihood of such practices becoming the legal standard of care. This tendency needs to be curtailed given the technical advancements ensuring near total reliability of tests and procedures. Specialist consultation at better equipped facilities has high potential for success rather than multiple visits to different physicians or multiple visits to the same physician. Thus, high tech expensive but reliable tests and procedures with the addition of specialist consultation could be prescribed as standard norms of medical procedures. The fact that these norms could be misused by unethical vested interests should not deter or impact the achievement of larger goal of restoring physicians’ confidence. Referral of difficult cases to more specialized physicians or technologically better equipped hospitals may, in most cases, be rewarding and useful to the patients and also set a healthy benchmark for referring physicians. Promotion of insurance schemes that enhance coverage liability of patients at low premiums could go a long way in controlling DM. Patients would have higher affordability and access to high tech procedures and specialists. For doctors, the answer could be a reasonably worked out financial cap on malpractice awards and liabilities at manageable premium. Law should be enacted in such a way that the onus of establishing medical malpractice lies on medical professionals rather than on the whims and fancies of non-medical personnel, legal professionals and judges. Arbitration panels and health courts could be established to decide malpractice cases. This would inspire confidence in the doctors and also take care of probable ignorant lapses by the non-medical fraternity. There is a strong case for no-fault insurance or counter compensation for doctors who are successfully able to defend medical malpractice charges in the courts. Another remedy could be to have clinical, evidence-based, guidelines with global application and acceptability, modified as per the regional requirements. This would avoid subjectivity of interpretation and physicians would also be able to focus on practicing evidence-based medicine, confident that the standards would be the same everywhere in the legal world. Practicing medicine is considered to be a noble profession. Doctors achieve this status after a prolonged regimen of academic studies, practical training and experience. Why not create conditions of trust and confidence for them protecting them from undesirable litigation. Practicing DM is good neither for patients nor for the physicians. Thus, trust in doctors should be a rule and distrust, a rare exception. The sword of litigation hanging over their heads needs to be removed while encouraging self-discipline and ethical conduct.

this isall very general, if sage advice.

## Mutual trust between the physician and patient is of paramount importance in the profession and the very foundations of this trust would crumble in case of any further delay in remedying the current situation. Modern medicine is driven by technology, money power, patients’ needs and various vested interests. A delicate balance in enacting laws that reconcile all these interest is the need of the hour. Consultation with the medical professionals to set its own professional and ethical standards is of paramount importance. It’s about doing what’s right in the overall context, in the interest of the profession, the professionals and the society at large. The goal of administering efficient medication for one and all reconciling various contras cannot be achieved in the existing mechanism.

## Physicians, like any other professional, too are entitled to live a life, away from avoidable harassment, undesirable litigation and other unfortunate situations like loss of professional reputation and beyond. Thus, there is no reason why they should not protect themselves by indulging in DM. It is a catch 22 situation. While the law induces them to act extra cautiously, they get castigated when they do so! The remedy lies in the cause itself. The laws on DM need to be enacted in a reasonable, rational manner and in consonance with real situation. Physicians need to be protected by creating conditions that facilitate independent decision-making, without fear of uncalled for litigation. Of course, there is no suggestion of putting premium on irresponsibility. Blatant acts of negligence, intransigence and avarice need to be curtailed and penalized but not at the expense of the entire medical fraternity.

## Conclusion

## Physicians need protection from fear and boost of confidence for independent decision-making. The pros of advanced technology, specialist consultation, capping physician’s liability to manageable limits, adequate insurance premiums and covers etc. need to be duly incorporated in the revised law. Unless the Governments are able to provide necessary protective environment, the practice of DM appears to be perfectly justified and is there to stay.

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**References**

1. U.S. Congress O of TA. Defensive Medicine and Medical Malpractice [Internet]. OTA-H-602. 1994. Available from: https://biotech.law.lsu.edu/policy/9405.pdf. Accessed on 20th Jan 2018

2. McQuade JS. The medical malpractice crisis--reflections on the alleged causes and proposed cures: discussion paper. J R Soc Med. 1991;84(7):408.

3. McKinlay JB. Politics and Law in Health Care Policy. Milbank Meml Fund, New York. 1973;101.

4. Hvidt EA, Lykkegaard J, Pedersen LB, Pedersen KM, Munck A, Andersen MK. How is defensive medicine understood and experienced in a primary care setting? A qualitative focus group study among Danish general practitioners. BMJ Open. 2017;7(12):e019851.

5. Durrance CP, Hankins S. Medical Malpractice Liability Exposure and OB/GYN Physician Delivery Decisions. Health Serv Res. 2017;

6. Küçük M. Defensive medicine among obstetricians and gynaecologists in Turkey. J Obstet Gynaecol (Lahore). 2017;1–6.

7. Broom A, Kirby E, Gibson AF, Post JJ, Broom J. Myth, Manners, and Medical Ritual: Defensive Medicine and the Fetish of Antibiotics. Qual Health Res. 2017;27(13):1994–2005.

8. He AJ. The doctor–patient relationship, defensive medicine and overprescription in Chinese public hospitals: Evidence from a cross-sectional survey in Shenzhen city. Soc Sci Med. 2014;123:64–71.

9. Silberstein E, Shir-Az O, Reuveni H, Krieger Y, Shoham Y, Silberstein T, et al. Defensive medicine among plastic and aesthetic surgeons in Israel. Aesthetic Surg J. 2016;36(10):NP299-NP304.

10. Reschovsky JD, Saiontz‐Martinez CB. Malpractice Claim Fears and the Costs of Treating Medicare Patients: A New Approach to Estimating the Costs of Defensive Medicine. Health Serv Res. 2017;

11. Osti M, Steyrer J. A national survey of defensive medicine among orthopaedic surgeons, trauma surgeons and radiologists in Austria: evaluation of prevalence and context. J Eval Clin Pract. 2015;21(2):278–84.

12. Chen J, Majercik S, Bledsoe J, Connor K, Morris B, Gardner S, et al. The prevalence and impact of defensive medicine in the radiographic workup of the trauma patient: a pilot study. Am J Surg. 2015;210(3):462–7.

13. Saint S, Vaughn VM, Chopra V, Fowler KE, Kachalia A. Perception of Resources Spent on Defensive Medicine and History of Being Sued Among Hospitalists: Results from a National Survey. J Hosp Med. 2017;E1–4.

14. Panella M, Rinaldi C, Leigheb F, Knesse S, Donnarumma C, Kul S, et al. Prevalence and costs of defensive medicine: a national survey of Italian physicians. J Health Serv Res Policy. 2017;1355819617707224.

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