

# Ethics in health care: the practice of defensive medicine

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## Abstract

Defensive medicine is the practice of diagnostic or therapeutic measures that are conducted primarily as a safeguard against possible malpractice liability, rather than to ensure the health of the patient. Defensive medicine, a significant problem, is discussed in this article. First, an overview of the nature of defensive medicine is provided, with a focus on how it damages the doctor-patient relationship. It has been determined that doctors who utilise defensive medicine ultimately exact more harm than good on the practice of medicine. Finally, it is suggested that through ensuring that the doctor-patient relationship is impenetrable, fear of medical litigation will dissipate. The best antidote to malpractice allegations is ethical clinical practice. Core decisions remain bound in dialogue between the doctor and his or her patient. Continuing the tradition of the therapeutic alliance, informed consent and confidentiality in medical practice will diminish threats of medical liability.

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## Introduction

Raw, thoughtless and dangerous advertising (Table 1) is enthusiastically supported by many plaintiffs' attorneys.

**Table 1:** An example of reckless advertising

<p>In hospital? Injured or sick? On treatment? You may have a case! Just sms us at 082 Get docs* for a free consultation. No cost. No obligation. *: Standard call rates do not apply</p>
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Such advertisements support a common consumer-orientated mechanical model of malpractice which implies that if there is injury or illness, then there must have been medical negligence. Is it any wonder that doctors are increasingly embracing what is termed "defensive medicine"? Defensive medicine, a significant problem, is discussed in this article. First, an overview of the nature of defensive medicine is provided, with a focus on how it damages the doctor-patient relationship. It has been determined that doctors who utilise defensive medicine ultimately exact more harm than good on the practice of medicine. Finally, it is suggested that through ensuring that the doctor-patient relationship is impenetrable, fear of medical litigation will dissipate.

## Discussion

In 1994, the USA Congress Office of Technology Assessment provided a useful definition of defensive medicine:<sup>1</sup> "Defensive medicine occurs when doctors

order tests, procedures or visits, or avoid high-risk patients or procedures primarily (but not necessarily or solely) to reduce their exposure to malpractice liability. When physicians do extra tests or procedures primarily to reduce malpractice liability, they are practising positive defensive medicine. When they avoid certain patients or procedures, they are practising negative defensive medicine". In other words, defensive medicine may be defined as the practice of diagnostic or therapeutic measures conducted primarily as a safeguard against possible malpractice liability, rather than to ensure the health of the patient.

Provoked by the threat of liability, defensive medicine is a worldwide phenomenon that represents a deviation from ethical medical practice.<sup>2</sup> A survey of 300 physicians, 100 nurses and 100 hospital administrators in the USA found that more than 76% of the physicians responded that malpractice litigation had negatively affected their ability to provide quality care to patients.

Because of their fear of the excesses of the litigation system:<sup>3</sup>

- Seventy-nine per cent said they had ordered more tests than they would normally have done based only on their professional judgment of what was medically needed. Ninety-one per cent had noticed other physicians ordering more tests.
- Seventy-four per cent had referred patients to specialists more often than they believed was medically necessary.

- Fifty-one per cent had recommended invasive procedures, such as biopsies, to confirm diagnoses more often than they believed were medically necessary.
- Forty-one per cent said they had prescribed more medications, such as antibiotics, than they would have based only on their professional judgment.
- Seventy-three per cent had noticed other doctors prescribing medications similarly.

Some of the ethical problems arising from the practice of defensive medicine include the erosion of the doctor-patient relationship, which leads to profound social and economic repercussions. Doctors order more medically unjustified tests and other examinations in an attempt to cover all possible areas from which a claim of patient negligence might arise. The idea behind this is that if taken to court, the doctor has on hand records of all diagnostic tests performed, and can make the claim that he or she practised due prudence, care and professional concern. However, the burdens of overutilisation of scarce healthcare resources, increased hospital stays resulting in the inability of other patients to access health care, and the consequent higher costs of patient care are negative repercussions.<sup>4</sup>

Increased litigation also raises the cost of medical indemnity insurance, which results in higher medical costs for private patients. The public health sector is not immune, “especially in catastrophic claims amounting to millions of rands, affects the State’s ability to finance health care in the medium to long term, has a negative effect on service delivery and ultimately hits the taxpayer”.<sup>5</sup> Like other widespread phenomena, medical malpractice litigation does not occur in a vacuum. Medical litigation cases have increased in South Africa, with or without due cause. Concurrently, there appears to be a rise in the practice of defensive medicine. The Medical Protection Society conducted a survey of 700 South African general practitioners. The survey results indicated that 76% of respondents were aware of a significant increase in medical negligence claims and complaints, and that “58% of them are practising defensive medicine to protect themselves against possible medical negligence claims and complaints”.<sup>6</sup>

A 2010 USA health affairs study identified some interesting findings on defensive medical practice and liability.<sup>7</sup> The researchers started with a database of 1.9-million Medicare claims for 2008, as well as responses to a survey that same year that asked some 3 400 doctors about their malpractice concerns. Of the Medicare patients in the database, 29 000 had visited an office-based doctor that year for one of three complaints: chest pain, lower back pain or headaches. However, none of them were diagnosed with a serious illness relating to that complaint.<sup>7</sup>

Based on the survey results, the researchers designated doctors as having a low, medium or high level of concern

about malpractice, and then linked those doctors using the claims data to the tests that they had ordered for patients.<sup>8</sup> The researchers found that patients with headaches who saw a doctor with a high level of malpractice concern were more likely to receive advanced imaging, such as a computed tomography scan, than patients who saw a doctor who was less anxious about malpractice. Eleven per cent of the patients with headaches who were seen by a doctor with a high level of concern received additional testing versus 6% of patients who were seen by a doctor with a low level of concern. Nearly a third of the patients with lower back who were treated by litigation-wary doctors were referred for additional imaging tests versus 18% of those who saw doctors who were less concerned about litigation. The less worried the doctors were about malpractice, the more likely they were to order a stress test for chest pains.<sup>8</sup>

Importantly, the results indicated that doctors who “felt” they might be sued, even though there was a very low probability of it because of financial liability limits, would order more tests than normal for their patients. Mello, the study’s principal researcher, said that “even with caps or other reform measures, it doesn’t make physicians feel safer”. He added: “We are finding that the focus should be on how physicians are feeling. That has real implications for future policies”.<sup>7</sup>

Types of defensive medical practice may be categorised in two broad groups. “Negative” defensive medicine or “avoidance behaviour” in practice tends to supplement ordinary care (increase patient testing and treatments), replace care (result in the referral of patients to other doctors or institutions), or reduce care (refusal to treat particular patients). “Positive” defensive medicine is sometimes termed “assurance behaviour”, and involves “providing the patient with additional services which have little or no medical value (such as continuing chemotherapy in a patient with cancer who is dying), with the intent of reversing adverse outcomes, deterring patients from filing malpractice claims or persuading the legal system that the standard of care was met”.<sup>9</sup>

The conundrum is that for practising South African doctors, a genuine fear of being sued exists. The ethical obligations that doctors have to their patients in respect of the cost and quality of care are diminished as a result.

Perhaps the most far-reaching negative result of the fear of malpractice liability is an alteration in the doctor’s stance towards the patient. This is because the focus of clinical practice may shift from the patient’s well-being to one of legal self-protection for the doctor. In this situation, a doctor could view a patient as a possible risky legal case, as opposed to a suffering patient in need of care.<sup>10</sup> The practice of defensive medicine has become entrenched owing to the fact that patients are more aware of their rights

with respect to the doctor-patient relationship. However, doctors should remain as ethical as possible in their interactions with patients by explaining all care options, and by knowing when to appropriately refer. When in doubt, a second opinion from a colleague must be obtained.

## Conclusion

The relationship may become so altered in the most destructive of doctor-patient encounters that both of the parties assume an adversarial role in an attempt to protect themselves from the other's perceived or actual harm. This is the antithesis of the ethos of medicine. The best antidote to malpractice allegations is ethical clinical practice. Core decisions remain bound in dialogue between the doctor and the patient. Continuing the tradition of the therapeutic alliance, informed consent and confidentiality in medical practice will diminish threats of medical liability.

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