DEFENDING DEFENSIVE MEDICINE

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In the classical triad of "noble professions"– priests, lawyers and doctors – all results are not guaranteed. Unrealistic expectations result in malpractice suits, especially against doctors.

Civil suits against doctors

Litigation against UK doctors accelerated in the 1950s, resulting in the landmark case of Bolam.[1] As with all offensive weapons, "defensive medicine" shields were developed to meet the growing menace. How big should a shield be? Too small and one will die like the 300 Spartans under volleys of cowardly Persian arrows. I recommend the Roman Testudo (tortoise) formation of adjacent shields impenetrable to arrows from all sides.

Lord Denning, Master of the Rolls and prominent jurist, stated that a medical man should not be found negligent unless he has done something of which his colleagues would say: "He really did make a mistake there. He ought not to have done it."[2]

In 1954, Lord Denning directed the jury with instructions which are still applicable today:

"…there is always some risk, no matter what care is used. Every surgical operation involves risks. It would be wrong, and, indeed, bad law, to say that simply because a misadventure or mishap occurred, the hospital and the doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining a patient, or a surgeon operating at a table, instead of getting on with his work, would be forever looking over his shoulder to see if someone was coming up with a dagger, for an action for negligence against a doctor is for him like unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body."[3]

While I subscribe to the wisdom in this passage, it is difficult for doctors not to be wary of the occasional dagger. Julius Caesar was assassinated when he let his guard down.

Definition

Defensive medicine describes the situation where a doctor performs a procedure with the main objective of protecting himself from legal liability and relegates the patient's interests to a secondary place in decision-making.

Two emblematic clinical situations which are used to illustrate defensive medicine are chest pain and head injury. Endless discussions have yet to produce any definitive guidelines.

Assessment of intention is illogical

It is obvious that it is impossible to read the mind of the doctor at the very instant of decision-making. We can only make an educated ex post facto guess after the case is closed. A doctor manages a patient without a prophetic knowledge of what is going to happen in the end. It is unfair to use hindsight to retrospectively determine decisions which were made long ago, and after full knowledge of all the results of a procedure, or a conflation of procedures.

After all the dust has settled, retrospective introspection still cannot be extrapolated backwards to prove the doctor's motive. Even when all the cards are open, it is still difficult to find the "Goldilocks management": not too much, not too little but just right. It is therefore illogical to criticise judgement calls in circumstances of uncertainty and where the ultimate benefit is totally unknown during the procedure. It is sufficient that a procedure falls within a "broad band of reasonable responses". There is rarely consensus on an ideal "gold standard".

A defensive intention may fortuitously result in much concrete benefit later on. Luck plays a large part in medical decisions and their attending results. It is the difficulty in controlling the patient's medical destiny which makes defensive medicine so controversial.

Beware counsels of perfection

Defensive medicine does not cure anyone and is not a sensible way of doing things even if it occasionally yields benefits. The huge drawback of name-dropping "defensive medicine" is that there are no established guidelines.

Few policy makers have the courage to lay down well-defined "rules of engagement".

Clinical situations are now complicated by advocates of patient-centricity. [4] Doctors are told to empower patients to exercise their autonomy in decision-making about their own care. The corollary to patients being so empowered is that patients can also enter the discussion on what procedures they think are appropriate. If patients demand procedures which fall within the "broad band of reasonable responses", it would be foolish for a doctor to try to save patients from themselves.

The *Straits Times* had this advice for doctors:

> *"What must be avoided is the practice of defensive medicine. This is when doctors – to shield themselves from legal complications – avoid high-risk patients or procedures, or refer patients early to specialists, who may then order more advanced tests to rule out every other condition. Patients lose by paying for possibly unnecessary treatment, and society loses through rising health-care costs. Only a doctor-patient relationship based on trust can prevent the practice of defensive medicine from becoming a norm here."* [5]

All this is just fanciful cogitation. Doctors are urged to gamble their expensively hard-earned careers against a reasonable premium for tests. If a doctor has the misfortune to be sued, the *Straits Times* has no capacity to testify for the doctor.

In similar vein, the 2019 Ministry of Health (MOH) Workgroup stated:

> *"The fear is that more doctors, distrustful of the system and fearing that their patients would lodge complaints, would move towards defensive medicine. This includes giving patients too much information, ordering more tests and procedures than necessary, or even possibly refusing to treat high-risk patients.*
>
> *Such practices can confuse or make patients more fearful, and lead to higher healthcare costs and possibly increasing litigation."* [6]

This ad hoc workgroup's opinion cannot help a doctor facing a civil suit or a disciplinary proceeding.

Every workman practises defensiveness. We see this in phrases like "terms and conditions apply", "this is an artist's impression', "while stocks last", etc. The Chief Justice in *Lim Lian Arn*, for example, berated a lawyer for "defensive lawyering". [7]

A lucky break

In the past, the Singapore Medical Council (SMC) took a "no smoke without fire" approach. The "guilty until proven innocent" attitude meant that any doctor who appeared before the SMC could expect punishment.

The current practice is that a doctor has to intentionally depart from reasonable standards and the departure has to be "serious" or "egregious". The test of "serious" or "egregious" departure has gained more authority from frequent use since 2008. *Lim Lian Arn* [2019] is now the leading case.[7]

In Singaporean patois, all doctors should agree that "this is too much" or "this is disgusting". Complaints Committees (CCs) have now been instructed not to refer minor cases to a Disciplinary Tribunal (DT), but to use a suite of other powers like a letter of warning or mediation. At a training session for the CC, an influential senior doctor advised that, "*last time when in doubt, CC members referred cases to the DT. Going forward, when you are in doubt, you should not refer the case to the DT.*"

This current thinking and changed attitude is indeed a lucky break for doctors. Dodging the DT bullet – which requires proof beyond reasonable doubt – does not exonerate a doctor from a subsequent traumatic civil suit.[8]

Doctors should continue to learn counter-measures to shield themselves from poisonous arrows. Medical Protection Society bulletins are useful – Confucius was attributed with the saying "wise man learn from mistakes; wiser man learn from mistake of others".

As clinical notes become important in litigation, doctors have to learn to strike a balance between active listening, targeted copying of key words while trying to understand patient issues, and letting patients know that the doctor is listening.

The meek shall inherit the earth

Matthew 5:5: "Blessed are the meek: for they shall inherit the earth". "Meek" is "praeis" in original Koine Greek. No German or English translation of "praeis" does justice to the fullness of meaning in the Greek word. It does not mean "friendly", "soft", "humble", "passive" or "compliant".[9] A satisfactory interpretation is "restraint", like a skilled swordsman who can wield his weapon to kill but prefers to keep his sword sheathed.

Restraint is a profitable quality, now fashionably termed "anger management". It is too easy for doctors to lose their tempers. Spoils belong to victors who conquer with restraint.

Everything you say can be taken down in evidence and used in a complaint against you. We live in an age where a smartphone can capture all conversation and transliterate it into words. A wireless connection to a printer can reproduce the whole conversation in document form.

All procedures should be guided by the caveat of "restraint".

The Coase theorem

The Coase theorem is a complicated and debated concept in economics which can have a different significance for different people. My simple rendering is that the true cost ("basic cost") of a service will be disturbed, distorted and displaced by "externalities" such as administrative cost, time, effort, resources, legal cost, taxation, licensing, insurance and so on. There are frictional "transaction costs" and "compliance costs" which impact demand-supply graphs.

The first paper by Ronald Coase appeared in 1960. By the time I studied economics for my Bachelor of Arts degree from 1984-1986, legal scholars had appropriated the Coase theorem to support their "construct" (theoretical idea) that more laws and regulations drive up the cost of goods and services. Conversely, deregulation will send costs down closer to the true cost. Coase was awarded the Nobel Prize in 1991.

In medical practice, the more judgements against doctors and the more regulations to comply with, the higher the cost of medical care. After Dr Lim Lian Arn was fined $100,000, the cost of hydrocortisone and lignocaine injections jumped over 30%. QED for this construct of the Coase theorem.

Lord Denning again:

> *"Malpractice suits (in the USA) have become a curse of the medical profession. The legal profession get contingency fees. So they take up cases on speculation. The jury gives enormous damages. Insurance premiums are high. The doctors charge large fees to cover them. It is all very worrying."*[3]

Over-regulation and the cost of compliance drive up medical costs more than the nebulous concept of defensive medicine. Whether regulations are good or bad is not in frame here.

Back to Bolam

In 1957, the landmark Bolam principle was formulated. No matter what the majority of doctors think, if an accused has a reasonable and logical witness to testify that the management was acceptable by a respectable minority, there is no negligence. This decision has been very helpful for doctors. In line with the Coase Theorem, Bolam has kept medical costs down. There have been attempts to qualify this test. By a "syllogism cascade" after six decades, the law has gone full circle and returned to the Bolam principle.

In the much used "Bolam-Bolitho principle", Bolitho is actually a useless addendum. Bolitho held that if the minority opinion was devoid of logic, the court could overrule it. Since the courts always had an implied power to overrule any illogical argument, Bolitho has no practical legal purpose. Yet Bolitho continues to be tethered to "Bolam-Bolitho" with an ecstasy of vacuity.[10]

Western emphasis on human rights may have influenced Montgomery.[11] The doctor must consider all special circumstances of the patient and what the patient actually wants.

The doctor has to inform patients of:

(1) The diagnosis,
(2) The prognosis with and without treatment,
(3) The nature of treatment and its attendant risks, and
(4) Alternatives to the treatment proposed.

Singapore's Modified Montgomery Test (MMT)[12] complicated matters by adding redundant "explanations" which the UK considered implied. No wonder Dr Wong Chiang Yin said that "*the MMT resulted in a significant increase in uncertainty in the medico-legal environment; doctors are unsure what is expected of them.*"[13]

The UK Montgomery test updated Bolam with the freedom of the patient to decide how he wants to undergo treatment. The doctor has to take into account any special patient objectives and the patient's personal values.

Information dumping will not absolve doctors as the law will take into account whether they actually interacted with the patient to secure genuine informed consent.

Singapore's MMT curiously emphasised that if doctors withheld information from the patient, they will then be judged by the standard of their peers. This brings us back to the classic Bolam test, albeit updated to include informed consent.

> *It would mean that a doctor… would be forever looking over his shoulder to see if someone was coming up with a dagger, for an action for negligence against a doctor is for him like unto a dagger.*
>
> *– Lord Denning*

The MOH Workgroup recommendation was to remove the Bolam-Bolitho and MMT altogether. All medical practice, including informed consent, would be covered by what a body of reputable doctors would do.

The Bolam test of 1957 has undergone a circuitous route to return to the same position 60 years later, updated by "patient choice".

Commentary

I would like to associate myself with the views of my fellow Board Member of the SMC, Dr Lim Ah Leng, whose permission I obtained to reproduce the following:

> *"Defensive medicine is a monster that will be very hard to slay. It takes not just the change in the attitudes of doctors, but more so the attitudes of patients, lawyers and the legal system. The element of trust nowadays is very fragile and only exists when things go well. In the end, all stakeholders must come to accept that to achieve a 'sustainable healthcare system', all must agree that no one is perfect."*

For an existential rice-bowl issue, it would be over-optimistic to defeat defensive medicine with a few prodigious hammer strokes.

Summary

- Medicine can be called "defensive" only long after the event. Basically, if you do not know how things will turn out, you are not entitled to call the procedure defensive.
- The long reach of fate makes it impossible to determine what defensive medicine is. It is not given to us to peer into the mysteries of the future.
- There are no established guidelines relating to defensive medicine.
- Do not trust authorities who tell you not to practise defensive medicine as these are the last people on earth who will come down to testify for you.
- Targeted copying memory joggers on your clinical case-notes are better than no notes at all.
- A soft answer turns away wrath: but grievous words stir up anger. (Proverbs 15:1).
- You have the right to remain silent. Anything you say can be taken down in evidence and used in a complaint against you.
- The Bolam test has withstood the test of time. All the MOH Workgroup did was to update Bolam to stress patient autonomy.
- Coase theorem translated: the more rules, the more expensive medical care. Litigated cases creating more rules from precedents also drive up costs.

Conclusion

Putting a patient's interest above financial gain (or equivalent) fortifies a solid defence. Personal benefits should only be secondary consequences. Act professionally with meekness and humility and above all err on the side of caution. That, I think, is the best defensive medicine.

Never let money get in the way of clinical decisions. ◆

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Legend

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