Article Summary

The jaded cliché of 'defensive medical practice': from magically convincing to empirically (un)convincing?

Dr Paula Case

The central claim of 'defensive medicine', that proposed reforms or threats of new or broader avenues of legal liability will cause doctors to practice defensively, exposing patients to the unnecessary risk of harm, and consuming scarce resources which could be better used elsewhere, has become a cliché and has lost much of its rhetorical force in UK jurisprudence. Despite a substantial body of research appearing to validate the existence of harmful defensive medicine, arguments based on the risk of defensive practice triggered by litigation more broadly have declined in potency, particularly since the Supreme Court's judgment in *Robinson v Chief Constable for West Yorkshire*. The first half of this paper charts and deconstructs the declining influence of the defensive practice argument in court judgments. In the second half, the author reflects on the forensic value of existing research into defensive medicine and whether it might usefully contribute to the assessment of defensive practice argumentation in medical negligence cases. In doing so, the paper draws from studies of defensive practice in medicine conducted in the UK to date, and observations from interviews with medical practitioners representing lived experience of defensive practice.

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Introduction

> *'… it is self-evident that there is a public interest in avoiding excessive litigation and in keeping to a minimum what one can call, in shorthand, defensive medicine.'*[1]

Defensive practice in medicine has been an enduring staple of medical law discourse/scholarship across the globe.[2] As Lord Justice Irwin intimated in *ABC v St George's Healthcare NHS Trust* it has become 'shorthand' for a bundle of arguments pertaining to the negative impact of liability.[3] These include suggestions that proposed reforms or incremental extensions of liability will cause doctors to practise defensively, exposing patients to the unnecessary risk of harm, and consuming scarce resources in the National Health Service (NHS) which could be better used elsewhere, all of which has, and should, rouse deep concern.

In the UK context, the importance of stemming harmful[4] and costly defensive practices in a resource deprived National Health Service (NHS) has perhaps never been greater.[5] However in negligence jurisprudence, legal arguments referencing defensive practice have become clichéd. The term 'cliché' is used here as metaphor, to illuminate the process of an argument, once powerful, and having a taken for granted meaning, losing its potency from overuse. The work of Anton Zijderveld is helpful in applying the cliché metaphor. He used 'cliché' to refer to a metalinguistic[6] social phenomenon, found in concepts, ideas or rituals which:

> 'seem to carry truth – an old and an obvious truth – not because of their semantic content but because of their repetitive use. They are usually not

1 Irwin LJ in *ABC v St George's Health Care NHS Trust* [2017] EWCA Civ 336 at [31].

2 S Vento et al, 'Defensive Medicine: It is time to finally slow down an epidemic' (2018) 6 (11) World Journal of Critical Cases 406.

3 *Supra* n 1 above.

4 The profession continues to take these concerns seriously: see Royal College of General Practitioners Working Group on Overdiagnosis: available at https://www.rcgp.org.uk/policy/rcgp-policy-areas/overdiagnosis.aspx.

5 'These brutal cuts to the NHS will haunt the Conservatives,' *The Guardian*, 25 October 2019; 'NHS "run ragged" by scandalous underfunding, warns BMA,' *GP*, 25 June 2018; *Reducing Emergency Admissions.* Public Accounts Committee, June 2018 which blamed underfunding of preventive services in the NHS for rising emergency admissions.

6 G Olson, 'The generational cliché: Then you saw it, now they don't' (1985–1986) Journal of Advanced Composition 105.

> heuristically convincing (that would require a reflective pondering of their meaning), but they are magically convincing.'[7]

Clichés in this sense become a shortcut to reasoning, indeed Zijderveld regards their most remarkable quality as their 'capacity to bypass reflection'[8] – their original meaning becoming superseded by a political functionality.[9] In the case of defensive practice, the cliché's function became resisting extensions of liability in certain 'pockets' of negligence.[10] Now, however, the jurisprudential cliché of defensive practice has been dismantled and replaced by opposing propositions which also bypass reflection, namely judicial instinct that increased liability only enhances standards. With neither the 'defensive practice argument' nor the 'standard enhancing argument' being explicitly supported by further evidence in court, a stalemate has been reached. According to Zijderveld, the power of the cliché can be deliberately 'bound' or limited, and scrutiny used to restore the essential balance between meaning and function.[11] In the final sections of this article, the author explores whether existing research into defensive medical practice could usefully restore the balance between meaning and function to court decisions on this issue.

This paper will first examine the dynamics of defensive practice in medicine, using the meaning employed in court judgments as a way into the discussion (Part I). In Part II the rise and fall of defensive practice argumentation more generally is traced through common law negligence cases, including in the context of high profile medical negligence judgments, such as *Gregg v Scott*,[12] *Montgomery v Lanarkshire Health Board*[13] and *Darnley v Croydon Health Services NHS Trust*.[14] A panoramic sweep of negligence jurisprudence suggests that judicial attitudes have recently shifted. Judicial discourse has switched from treating the proposition that extending liability will increase defensive practice as 'magically convincing' and endorsing it as a legitimate policy consideration in shaping liability with little oversight, to the rebuttal of defensive practice arguments on the basis that the proposition 'lacks empirical evidence' or that imposing additional liabilities tends, in fact, to be 'standard enhancing'. In Part III, the author examines whether the sum of UK studies of defensive practice in medicine substantiates claims that there is no empirical evidence of defensive medicine in particular, and that therefore argumentation based on defensive practice in medicine has no place in negligence jurisprudence.

Although this paper is not the first to comment on existing studies of defensive practice,[15] it is the first to either systematically chart the demise of defensive practice argumentation or to interrogate connections between these shifts in the case law and the findings of defensive practice studies. The analysis that follows attempts to triangulate negligence jurisprudence, a substantial body of defensive practice research spanning over

7 A Zijderveld, *On Clichés: The Supersedure of Meaning by Function in Modernity* (Routledge & Kegan Paul, 1979) 66.
8 *Ibid* at 6 and 65.
9 *Ibid* chapter 3.
10 See below.
11 Zijderveld, *supra* n 7 at 89.
12 [2005] 2 AC 176.
13 [2015] UKSC 11.
14 [2018] UKSC 50.
15 See M Kapp, 'Defensive medicine: no wonder policymakers are confused' (2016) 28 International Journal of Risk & Safety in Medicine 213 and G van Dijck, 'Should physicians be afraid of tort claims? Reviewing the empirical evidence' (2015) 6 JETL 282.

four decades and 10 in-depth interviews with medical practitioners (including 3 x General Practitioners (GPs), 1 x rheumatologist, 1 x anaesthetist, 1 x obstetrician, 1 x geneticist, 1 x specialist in infectious medicine and 2 x FY1s). Interviewees were asked if they were aware of instances of defensive medicine in their own practice, or that of their colleagues, before being asked their views on the causes behind defensive practice. Content analysis software, NVivo 12.0 was used for initial exploratory coding, followed by fuller systematic re-coding of the interview transcripts.[16] Prominent narratives emerged from coding; namely, the enmeshed nature of defensive practice in medicine and the impossibility of unravelling its multiple causes and other dimensions of defensiveness which are hidden by quantitative studies, but which go to the heart of the doctor–patient relationship. These narratives were extremely valuable, both in exposing problems with the use of 'shorthand' references to defensive practice in medicine, and in highlighting intractable problems of causation which can limit the usefulness of research in evidencing defensive practice claims.[17]

I. The narrow judicial account of defensive practice in medicine: questionable assumptions

As this paper starts by positioning defensive medicine in the jurisprudence, judicial definitions are used as a way into the analysis. Such definitions are rare, but in 1985 Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital* referred to defensive practice as 'the practice of doctors advising and undertaking the treatment which they think is legally safe even though they may believe that it is it not the best for their patient'.[18] This definition is almost identical in scope to Lord Justice Lawton's earlier reference in *Whitehouse v Jordan* to defensive medicine as:

> 'adopting procedures which are not for the benefit of the patient, but safeguards against the possibility of the patient making a claim for negligence.'[19]

Both definitions rely explicitly or implicitly on four common assumptions, which together make up a fairly narrow account of defensive practice in medicine. These assumptions, explored further below, are that:

(i) defensive medicine is a corruption of the doctor's duties;
(ii) defensive medical practices are bad for patients;
(iii) defensive practice in medicine manifests as an unnecessary 'intervention'; and
(iv) that negligence litigation can be isolated as a unique trigger for defensive medicine.

16 See H Schebesta, 'Content Analysis Software in Legal Research: A Proof of Concept Using ATLAS.ti' (2018) 23(1) Tilburg Law Review 23 – 'content analysis software has the capacity to enhance the systematicity of research, while continuing to rely on the interpretative capacities of the researcher', at 24.

17 Whilst the researcher subscribes to the principles of 'grounded theory' (See eg A Strauss and J Corbin, *Basics of qualitative research: grounded theory procedures* (Sage, 1990)), in conducting interviews, she also recognises the paradoxes that emerge from grounded theory. A baseline of knowledge is necessary before a researcher can engage in interviewing and, having engaged with the literature, it is impossible to be free from preconceptions about what might emerge. Nevertheless, the researcher attempted to minimise the risk of bias, looking for themes which emerged from the interview data rather than trying to fit the data into existing theories.

18 [1985] UKHL 1.

19 [1980] 1 All ER 661 at 659.

(i) A corruption of the doctor's duties

The normative content of defensive medicine discourse tends to blame doctors for their preference of self-interest (in Lord Scarman's words, being 'legally safe') ahead of the patient's interests. This prioritisation of the doctor's interests involves a distortion of the doctor's purpose, a corruption of their duty of beneficence.[20] Such framing may generate concerns that go to the integrity of the profession[21] or to the confidence that patients can have in their doctors.[22] Arguably this 'corruptive' framing is objectionable as it obscures the real issue of whether the medico-legal defensiveness is good for patients, and also because it speaks to a time when doctors were unhelpfully and unrealistically regarded as paragons of virtue who could reliably be expected to shelve all self-interest.[23]

(ii) Defensive practice is 'unnecessary' and potentially harmful medicine

In addition to corruptive framings, defensive practice in medicine is assumed to necessarily lead to bad outcomes for patients. Lord Scarman's reference to 'unnecessary' treatment implies 'harms', whether in exposing the patient to unnecessary risks and side effects or losses to the net health of the population, as resources have been misallocated.[24] As will be outlined later, however, it is far from clear that defensiveness per se is necessarily bad for patients, and it is incredibly difficult to reliably ascertain when defensiveness in medical practice becomes harmful to patient's interests.[25]

(iii) Defensiveness is expressed through 'intervention'

Any assumption that defensive practice in medicine is necessarily expressed through *intervention* is problematic, as intervention implies the application of treatment or prescription of a drug and underplays the insidious, protean forms of defensive practice in medicine. In contrast, most researchers regard defensive practice in medicine as encompassing both defensive *acts*, including referral, diagnosis and treatment and defensive *omissions* to treat. The vocabulary of defensive practice research is now shaped by Bourne et al's study[26] which popularised the terms 'hedging' for interventions and 'avoidance' for

20 A modern expression of which is included in General Medical Council (GMC) guidance – the first duty of a good doctor is stated as being to 'make the care of your patient your first concern.' (*Good Medical Practice* (GMC, 2013)).

21 For example, Jonathan Montgomery's re-writing of the *Bolitho* judgment: defensive practice 'would lack professional integrity as it would depart from the ethical orientation to patient welfare'. S Smith et al, *Ethical Judgments* (Hart Publishing, 2017) 123.

22 *Good Medical Practice* (GMC, 2013) para 57: 'the investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options.'

23 P de Prez, Self-Regulation and Paragons of Virtue: The case of Fitness to Practise' (2002) 10(1) Med L Rev 28.

24 Academy of Medical Royal Colleges, *Protecting Resource, Promoting Value* (2014) at 6.

25 For example, referring to positive (beneficial) and negative (harmful) kinds of defensive practice see N Summerton, 'Positive and negative factors of defensive medicine: a questionnaire study of general practitioners' (1995) BMJ 310 (discussed further below). Similarly, not all commentators regard blame culture as necessarily unhealthy: see eg J Murphy, *The Discursive Construction of Blame: The Language of Public Inquiries* (Palgrave Macmillan, 2019) 1.

26 T Bourne et al, 'The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross sectional survey' BMJ Open 2015.

defensive non-intervention, a stepping away from certain procedures or patients because they represent a higher risk of complaint.[27] The 10 interviewees in the present study readily reported awareness of defensive conduct (by themselves and by others) as including; ordering CT scans, X-rays or ultrasound scans for ever lower thresholds of symptoms, ordering 'full bloods', keeping patients in hospital unnecessarily, defensive prescribing (eg of antibiotics[28]), but also practices which might not be termed 'interventions' but which certainly consumed resource, for example, adding superfluous notes to a patient's records, spending longer over explanations to patients, additional referrals, excessive use of chaperones and additional follow ups with patients. Consistently with other studies, all 10 interviewees were less likely to identify with examples of avoidance, '*if you work in the NHS it's hard to avoid a patient! (laughs)*',[29] but all volunteered examples, nevertheless. A few identified with avoidance as a factor in surgery (a kind of 'audit' defensiveness, exhibited by surgeons wanting to protect their mortality statistics[30]) and others cited examples of avoiding 'medico legally hazardous jobs', such as 'out of hours' GP work, avoiding intimate examinations or avoiding particular patients who had a reputation for being litigious. Occasionally, the implications were particularly serious: surgery cancellations due to 'avoidance' of the high-risk patient would usually only mean that the patient had to wait a little while longer as the procedure would be re-listed and often with another surgeon, but in cases of emergency, avoidance by a surgeon reluctant to take on a perceived 'high-risk' patient could cause delay and the patient's condition worsened as a result:

> *'I sometimes pick up the pieces the next day of this patient who is that little bit more septic or that little bit more confused because they've become iller overnight. And that sucks, that sucks for the patient. And we all feel bad.'*[31]

Interviewees confirmed findings of earlier research, in that it is the former type of defensive medicine (interventionist) which is far more prevalent.[32] Avoidance, although considered rare, could result in patients being '*passed from pillar to post*' with no-one really taking responsibility for their care[33] and should therefore not be ignored.

(iv) The trigger for defensive practice is negligence litigation

The fourth assumption, namely that defensive medicine is a response to the threat of negligence liability, involves a highly selective, reductionist account of defensive practice.[34] *Sidaway* belongs to an era when professional regulators stood accused of complacency and

27 O Ortashi, 'The practice of defensive medicine amongst hospital doctors in the UK' (2013) 14 BMC Medical Ethics 42 and M Sekhar, 'Defensive Medicine: A Bane to Healthcare' (2013) Ann Med Health Sci Res 295.

28 On this, see the fascinating piece by A Broom et al 'Myth, Manners and Medical Ritual, Defensive Medicine and the Fetish of Antibiotics' (2017) 27(13) Qualitative Healthcare Research 1994.

29 Interviewee #3.

30 Supported by the concerns raised by S Westaby et al, 'Publishing SSMD: the risks outweigh the benefits' (2015) 97(4) Royal College of Surgeons – Bulletin 155.

31 Interviewee #6.

32 For example, Bourne, *supra* n 26 at 9.

33 Interviewee #6.

34 (emphasis added). And also, 'when … diagnostic and treatment measures are employed explicitly for the purposes either of averting a possible lawsuit or of providing appropriate documentation that a wide range of tests and treatment have been used in a patient's care.': L Tancredi and J Barondess, 'The problem of defensive medicine' (1978) Vol 200 Science 876.

inaction, and the negligence claim probably did constitute the main avenue of complaint for substandard medical care.[35] Research into defensive practice in medicine has, however, re-contextualised such defensiveness as a multifactorial phenomenon with broader parameters. Summerton, for example, defined defensive practice in medicine as 'ordering treatment, tests and procedures "for the purpose of protecting the doctor from criticism" rather than diagnosing or treating the patient',[36] identifying the trigger as the threat of 'criticism', rather than medico-legal repercussions exclusively. Similarly, Chamberlain characterises defensive medicine as a means of 'protection against possible accusations of negligence or under performance'.[37] This re-contextualised version of defensive practice in medicine adopted by researchers disrupts potential alignment with defensive practice argumentation in the courts, where the assumption is that negligence liability can be isolated as a trigger for harmful defensive practices. As we will see, this divergence may impact on the ability of lawyers to claim that there is convincing empirical evidence of defensive practice in medicine for the purposes of influencing the shape of negligence liability.

II. Doctrinal engagement and the demise of defensive practice argumentation in negligence: from magically convincing to empirically unconvincing?

Judicial definitions of defensive practice in medicine provide only a 'snapshot' or 'shorthand' for this nuanced and complex phenomenon as researchers tend to understand it. The narrow jurisprudential account blames doctors for harmful defensive practices, focuses on 'interventions', assumes that we can easily identify when defensiveness becomes undesirable, and that we can isolate negligence litigation as a cause of harmful defensive practice. It does not seamlessly correspond with the re-contextualised discourse of defensive practice in research which encompasses both 'hedging' and 'avoidance, rarely interrogates the line between harmful and beneficial defensiveness and which recognises multiple causes of defensive behaviour. Meanwhile, the language of defensive practice was also being re-contextualised in court judgments, albeit in a different direction. The following section examines court judgments to chart the re-contextualisation and demise of explicit defensive practice arguments in negligence doctrine.

Re-contextualisation of defensive practice arguments in negligence

With its jurisprudential roots in the 1980s cases of *Whitehouse v Jordan* and *Sidaway* referred to above (both concerned with the standard of care in medical negligence), the

35 For example, M Stacey's research into the workings of the GMC between 1976 and 1984: *Regulating British Medicine* (Wiley, 1992).

36 Summerton, *supra* n 25. Summerton's research borrowed its definition of defensive medicine from McQuade's work: 'Trends in negative defensive medicine within general practice' (2000) 50 Br J Gen Pract 565, borrowing from J McQuade, 'The medical malpractice crisis – reflections on the alleged causes and proposed cures: discussion paper' (1991) 84 J R Soc Med 408.

37 M Chamberlain, *Medical Regulation, Fitness to Practice and Revalidation: A Critical Introduction* (Policy Press, 2015) at 166 and also Ortashi's work, *supra* n 27, on defensive practice in hospitals 'a doctor's deviation from standard practice to reduce or prevent complaints or criticism'.

language of defensive practice came to be used in arguments of more general application to professions beyond medicine and also public bodies, usually tied to the concept of duty of care. A search of Westlaw UK for 'defensive medicine', 'defensive practice', 'defensive policing' and 'detrimentally defensive state of mind'[38] reveals that there are at least 49 reported cases where defensive practice arguments are expressly[39] referenced.[40] Within these judgments, the defensive practice argument is most readily associated with a series of cases concerning police liability, starting with Lord Keith's judgment in *Hill v Chief Constable of West Yorkshire*.[41] However, it is in the earlier case of *Rowling v Takaro Properties* that we see Lord Keith experimenting with arguments of what he then termed 'overkill':

> 'It is to be hoped that, as a general rule, imposition of liability in negligence will lead to a higher standard of care in the performance of the relevant type of act; but sometimes not only may this not be so, but the imposition of liability may even lead to harmful consequences. In other words, the cure may be worse than the disease.'[42]

The medical analogy herein hints at a transposing of the defensive medicine argument from *Whitehouse* and *Sidaway* into a more general policy concern. Less than a year after *Rowling*, Lord Keith developed this argument against imposing a duty of care into what became known as 'the *Hill* principle', namely that: 'the imposition of liability on the police for failures to protect members of the public from third party criminals 'may lead to the exercise of a function being carried on in a detrimentally defensive frame of mind.'[43] That Lord Keith's reasoning here represented a transposition of defensive medicine concerns into a policy argument of more general application is again signalled by Lord Justice Staughton in *M v Newham LBC* where he said of the *Hill* principle:

> 'Certainly that danger is very important in medical negligence cases: high standards of duty and vast awards of damages result in unnecessary tests and other procedures at great expense, as experience in the United States has shown.'[44]

The cliché of defensive practice, now 'unbound' from medicine, featured in a number of prominent late twentieth century judgments endorsing suggestions that public bodies ought to be protected from certain claim types because of the social cost of defensive

38 See, 'detrimentally defensive frame of mind' being the words used by Lord Keith in *Hill v Chief Constable of South Yorkshire* [1988] 2 WLR 1049.

39 Whilst recognising that as Lord Neuberger observed, policy sometimes masquerades as principle and can become somewhat subterranean in its impact (see *Singapore Conference on Protecting Business and Economic Interests: Contemporary Issues in Tort Law* by Lord Neuberger, 2016) this analysis of judicial narrative focuses largely on judgments where defensive practice has been explicitly named.

40 As of 7 November 2019 discounting any cases which do not engage with defensiveness on a doctrinal level. The composite search identified 49 cases, some of which include multiple judgments (eg Court of Appeal and Supreme Court). Cases concerning police liability made up almost half of the total (23).

41 [1988] 2 WLR 1049.

42 *Ibid*.

43 *Ibid*.

44 [1994] 2 WLR 554 at 582.

practices that increased litigation would bring.[45] Wider dispersal of the defensive practice argument was not accompanied by attempts at further definition, indeed it had no precise meaning, and as is often the case with clichés, it became 'autonomous', attracting a new meaning and 'momentum of its own'.[46] Appeals to the need to avoid incentivising harmful defensive practices were most commonly associated with 'policy'[47] reasons for not imposing a 'duty of care' in negligence cases, particularly when considering 'novel' cases and assessing under *Caparo* principles whether it was 'fair, just and reasonable' to impose such a duty.[48] However, infiltration of these policy concerns was not confined to the 'duty' question, and could manifest when considering whether the defendant should be regarded as in 'breach' of that duty,[49] when addressing the appropriate test of causation[50] and when deciding whether to impose vicarious liability.[51]

Whilst re-contextualised defensive practice argumentation tended to congregate around duties of care, the axiomatic status of the duty of care owed by health care professionals to their 'patients'[52] generally ruled out a finding of 'no duty'.[53] In the medical sphere, defensive practice arguments remained more readily associated with 'breach' in negligence cases. Lord Diplock in *Sidaway*, for example, had appeared to support an application of the *Bolam* test[54] to determine breach of duty in matters of a doctors' non-disclosure of risks to patients. According to this test, a doctor is not negligent if his conduct is accepted as proper by 'a responsible body of medical opinion',[55] a standard which relies heavily on peer support from the profession and the application of which came to be regarded as a defence of 'accepted medical practice'.[56] Reference to the *Bolam* standard in the context of questions of disclosure in *Sidaway* was proposed on the grounds that a stricter test could cause doctors to avoid modern treatments and would encourage 'defensive medicine with a vengeance'.[57] Use of the *Bolam* test in relation to disclosure was also expressly justified by the need to minimise defensive medicine in *Gold v Haringey Health Authority.*[58]

45 For example, *Hill* above at n.41 (police); *Elguzouli-Daf v Metropolitan Police Commissioner* [1995] QB 335 (prosecutors); *Stovin v Wise* [1996] 2 AC 923, particularly Lord Hoffmann; *Smith v Ministry of Defence* [2013] UKSC 41.

46 Zijderveld, *supra* n 7 at 16–17.

47 See *Sidaway*, *supra* n 17, *Barrett v Enfield LBC* [1999] 3 WLR 79 and *ABC v St George's Health Care NHS Trust* [2017] EWCA Civ 336 where the defensive practice argument is treated as a 'policy' consideration.

48 That is, when applying the tripartite test from *Caparo v Dickman* [1990] 2 AC 605. (Is harm to the claimant a reasonably foreseeable result of a failure to exercise reasonable care? Is there a sufficient relationship of proximity between the claimant and defendant? And is it fair, just and reasonable to impose a duty of care?). For examples, see *ABC v St George's Healthcare NHS Trust* [2017] EWCA Civ 336; *A v Essex County Council* [2003] EWCA Civ 1848 at [46].

49 For example, *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 at [92], *May v Lancashire Teaching Hospital NHS Trust* [2009] EWHC 3175 and *Parkes v Mann* [2011] EWHC 1724 at [79].

50 *Gregg v Scott* [2005] UKHL 2 at [55] and [56].

51 *NA v Nottinghamshire CC* [2015] EWCA Civ 1139. But see text accompanying notes 72 and 73.

52 *Robinson v Chief Constable for West Yorkshire* [2018] UKSC 4 referring to the doctor's duty to patients as 'well established' (at [26]); and applicable to NHS Trusts more broadly *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50 (at [23]).

53 However, questions are sometimes raised about the extent of that duty and whether a duty can be owed to third parties/'non-patients': eg *ABC v St George's Health Care NHS Trust* [2017] EWCA Civ 336.

54 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

55 *Ibid*.

56 H Teff, 'Standard of Care in Medical Negligence – Moving on from *Bolam?*' (1998) 18 OJLS 473 at 474.

57 [1985] UKHL 1 at [17]. The use of *Bolam* to minimise defensive medicine is also referenced in *ICL Tec Ltd v Johnston Oils Ltd* [2012] CSOH 62.

58 [1988] QB 481, per Lloyd LJ.

Demise of defensive practice argumentation: no longer magically convincing?

The fusion of defensive practice concerns with the use of *Bolam* was unfortunate. Excessive judicial deference to the medical profession through over-application of the *Bolam* test was staunchly criticised.[59] The effects of this protective device offered a 'preferential position' to medical professionals, viewed by some as showing that medicine was 'above the law' and had been 'left to its own devices' by the courts.[60] The territorial creep of *Bolam* into issues of disclosure in *Sidaway* was later 'marginalised'[61] before finally being overruled in *Montgomery v Lanarkshire Health Board* in 2015.[62] Now the courts, not the profession, were the arbiters of when non-disclosure was negligent, and the *Montgomery* judgment gave short shrift to arguments based on the risk of defensive practice.[63] The strong association between judicial defensive practice narratives and old policies of excessive/undue judicial deference to doctors may provide further clues as to defensive practice's demise.

In fact, a survey of negligence judgments over the last five years[64] reveals a vivid pattern of endorsement of defensive practice arguments at High Court or Court of Appeal level,[65] followed by 'ousting' of the same argument if the case was appealed to the Supreme Court. Particularly significant in this regard was Lord Reed's judgment in *Robinson v Chief Constable West Yorkshire*, a pivotal moment in determining the role of policy in shaping negligence liability. The Court of Appeal had denied the police owed a duty of care[66] to a bystander injured in a scuffle which occurred during the arrest of a suspected drug dealer. The basis of the ruling was an application of the defensive practice and policy reasons articulated in *Hill v Chief Constable for West Yorkshire* in respect of omissions,[67] but extended here to encompass positive acts by the police when in the course of their policing functions. The majority of the Supreme Court however, inverted the Court of Appeal's position to find that public authorities generally owed duties of care in the same way as ordinary citizens, labelling this 'a return to orthodoxy',[68] and thereby suppressing the 'defensive policing' lines of argument. Lord Reed, giving the lead judgment, found that recourse to policy considerations to justify a rejection of liability on the grounds of

59 Frequently termed 'Bolamisation' – eg O Quick, *Regulating Patient Safety: the end of Professional Dominance* (CUP, 2017) 94.

60 M Davies, *The Law of Professional Immunities* (OUP, 2014) at 4.26.

61 J Montgomery, 'Patient no more? Health Care Law' (2017) 70(1) Current Legal Problems 73.

62 [2015] UKSC 11.

63 *Ibid* at [83] and [93] respectively, and discussed further below.

64 *Supra* n 38.

65 For example, in *A v Essex County Council* [2003] EWCA Civ 1848 'if such claims are allowed, disclosure of relevant confidential material is inevitable; there is the risk of defensive practice; and of a deleterious effect upon the adopted child; and picking apart who was to blame for the problems encountered is an almost impossible task.' At [46]. An exception appears to be Irwin LJ in *ABC* where the argument *for* a duty of care being owed to a third party was in principle supported by the idea that recognising a duty to the patient but not an identifiable relative at risk of genetic disorder was likely to produce defensive practice: [2017] EWCA Civ 336 (at [31]), approved later in the same litigation at [2020] EWHC 455, [178]).

66 [2014] EWCA Civ 15 at [44].

67 [1989] AC 53 (as a reason for not recognisng a duty of care to protect members of the public from third party criminals).

68 [2018] (Rev 1) UKSC 4 at [31] and [40].

assessing whether it was 'fair, just and reasonable' to impose a duty of care under *Caparo* principles was reserved for truly 'novel' cases.[69]

Defensive practice arguments were revisited in the *CN v Poole BC* litigation, where the issue at stake was constructed as whether local authorities owed a duty of care to children who were known by the authority to be at risk of harm from third parties. In the Court of Appeal Lord Justice Irwin had cited the risk of practising defensively as one of the main reasons against finding such a duty: 'liability in negligence will complicate decision-making in a difficult and sensitive field, and potentially divert the social worker or police officer into defensive decision-making'.[70] This was once again reversed in the Supreme Court; Irwin LJ had failed to observe the shift away from 'policy reasoning' in subsequent cases and the substitution of defensive practice reasoning for limiting the liability of public authorities with consideration of whether a duty of care would conflict with the legislative scheme under which the public authority was working.[71] In a similar manoeuvre, the Court of Appeal in *NA v Nottinghamshire CC* had refused to impose vicarious liability on local authorities for the acts of foster carers. 'Particularly influential' in Lord Justice Burnett's thinking was 'the fear that it would also lead to defensive practice in relation to the placement of children,'[72] an argument later rejected by the Supreme Court as 'difficult to accept.'[73]

In a fourth iteration of this sequence, the Court of Appeal in *Darnley v Croydon Health Services NHS Trust* found that NHS trusts owed no duty to provide accurate information about waiting times via their receptionist staff, as the '[i]mposition of such a duty would be likely to lead to defensive practices on the part of NHS trusts to forbid their receptionists to provide any information about likely waiting times'.[74] The 'social cost' of withdrawing information from those awaiting treatment outweighed 'considerations of justice as between claimant and defendant in this sort of case'.[75] Once again, the Supreme Court disagreed. The legal issue was reframed – the proposed duty of care was not 'novel' but the application of an established duty to new facts, and in any case, 'the undesirable consequences of imposing the duty in question' had been 'considerably over-stated'.[76] Although not following the same pattern of 'reversal', three additional Supreme Court judgments in *Montgomery v Lanarkshire Health Board, Michael v Chief Constable of South Wales* and *Commissioner of Police of the Metropolis v DSD*[77] (discussed below) can be added to this list as further recent examples of the defensive practice argument being discarded.[78]

69 *Ibid* at [40]. Whilst the scope for policy reasoning to pre-empt a duty of care appears much reduced by *Robinson*, it has not been excluded altogether (see para [42]), as evidenced by the 'novel' case of *James-Bowen v Commissioner of Police for the Metropolis* [2018] UKSC 40 – no duty of care owed by Police Commissioner to protect her police officers from economic or reputational damage in proceedings relating to the officer's alleged misconduct.

70 [2017] EWCA Civ 2185.

71 *Poole BC v GN* [2019] UKSC 25 at [75].

72 [2015] EWCA Civ 1139 at [62].

73 [2017] UKSC 60 at [68].

74 [2017] EWCA Civ 151, *per* Sales LJ at [88].

75 *Ibid*.

76 [2018] UKSC 50 at [22].

77 [2015] UKSC 11, [2015] UKSC 2 and [2018] UKSC 11 respectively.

78 With the exception of *Darnley* and *Montgomery*, it might be said that these judgments are mainly concerned with the liabilities of public authorities for the wrongs committed by third parties and have limited import for medical negligence litigation. But the historic ill-advised, over-use of the broad re-contextualised version of defensive practice clearly has the potential to taint any hint of defensive practice argumentation.

The *Robinson* judgment and the six other Supreme Court judgments identified above (*Armes, Montgomery, Michael, DSD, Darnley* and *Poole)* galvanised the status of defensive practice argumentation as being that of a worn out cliché which had lost its rhetorical force and had little place in negligence doctrine.[79] Just as 'deference' had become a 'dirty word'[80] in medico-legal scholarship, appeals to the need to limit liability to curtail defensive practices have become tainted by association with their uncritical overuse in the context of police liability. Rebuttal is now the norm; arguments about defensiveness are clearly no longer magically convincing.

Judicial rebuttals of the defensive practice argument: the need to be empirically convincing?

Within these corroborative rebuttals of the defensive practice argument in the Supreme Court (and earlier judgments), there are broadly two forms of rebuttal which are dissected below. These are: (i) that there is no convincing evidence of the likelihood of harmful defensive practice; and (ii) that imposing additional liabilities tends to in fact be standard enhancing rather than detrimental.

Rebuttal #1: 'unproven'

Appellate courts have repeatedly rejected defensive practice arguments connected with duty of care on the grounds of a lack of evidence that a particular ruling risked increasing defensiveness in practice. In the early 2000s, this first strain of rebuttal was key in dismantling advocates' immunity from negligence litigation in *Hall v Simons*, Lord Steyn claiming that the notion that fears about unfounded claims might negatively impact conduct had 'a most flimsy foundation, unsupported by empirical evidence'.[81] Shortly before *Robinson*, Lord Kerr in *Michael v Chief Constable for Police of South Wales* had treated the lack of empirical evidence as partial grounds for rejecting 'defensive policing' reasoning:[82] 'A large part of that difficulty stems from the lack of empirical evidence to support any of the feared outcomes such as have been adumbrated in [previous cases]'.[83] However, not all judges agree that claims of defensive consequences require empirical validation. Lord Hughes (dissenting) in *Robinson v Chief Constable for South Yorkshire* regarded the risk of harmful defensive practice as an 'inevitable' result of increased avenues of litigation which could 'scarcely be doubted'.[84]

Rejection of defensive practice concerns on the grounds that there is 'no evidence', at first sight may seem disingenuous, as it implies that an affirmative court decision on a policy issue is contingent upon some empirical evidence ('empirical' being used here to

79 Jonathan Morgan agrees that in negligence litigation 'the pendulum has swung away from "defensiveness"': J Morgan, 'Abolishing personal injuries law? A response to Lord Sumption' (2018) 34(3) JPN 122.

80 N Priaulx et al, *Ethical Judgments*, *supra* n 21 at 122.

81 *Arthur JS Hall & Co v Simons* [2002] AC 615, Lord Steyn at 682D. See also *South Essex NHS Trust v Savage* (test for liability) (Eg *South Essex NHS Trust v Savage* [2007] EWCA Civ 1375 at [33]: 'First, there is no evidence … we are unable to accept that there is a risk of what is sometimes called defensive medicine being practised.' The House of Lords concurred [2008] UKHL 74 at [100]).

82 [2015] UKHL 2.

83 [2015] UKSC 2 at [184].

84 [2018] UKSC 4 at 112, agreeing with Lord Brown in *Van Colle v Chief Constable of the Hertfordshire Police; Smith v Chief Constable of Sussex Police* [2009] AC 225.

mean some form of knowledge based on experience or observation rather than theoretical deduction). Yet, controversial judgments in medical law are often made in 'an empirical vacuum.'[85] Hartshorne et al remarked on the speculative nature of what was known as the *Hill* policy argument:

> 'not based upon research into the likely effects of the imposition of a duty of care; they were not even based upon factual evidence adduced at the hearing. Ultimately they were based upon the submissions of counsel and the thoughts of the judges, all based on speculation.'[86]

Having rejected defensive practice arguments partly on the grounds of the lack of empirical evidence either way, there is some irony in Lord Kerr's later statement in *Michael* in the specific context of assessments of justice, fairness and reasonableness for duty of care purposes:

> 'These calculations are not conducted according to fixed principle. They will frequently, if not indeed usually, be made without empirical evidence. For the most part, they will be instinctual reactions to any given set of circumstances.'[87]

Lord Kerr's unapologetic realism is admirable for its candour. It clearly, however, raises questions about transparency, accountability and certainty if 'instinctual reaction' rather than evidence is the acknowledged basis of judicial decision making.[88]

Rebuttal #2: instinctual reaction – liability is 'standard enhancing'

The second strand of judicial rebuttal of defensive practice argumentation is clearly based on Lord Kerr's 'instinctual reaction'. Whilst a number of recent judicial accounts reject claims of defensive practice on the basis that empirical evidence is absent, others neutralise the defensive practice argument by preferring what may become a competing cliché which asserts that extensions of liability will produce *enhanced* standards of performance (despite the identical absence of supporting evidence). An early example is seen in *Phelps v Hillingdon* where Lord Slynn, responding to the question of whether educational psychologists could owe a duty of care to pupils, stated:

> 'Nor should it inspire some peculiarly defensive attitude in the performance of their professional responsibilities. On the contrary it may have the healthy effect of securing that high standards are sought and secured.'[89]

More recently, Lady Hale's minority judgment in *Michael* was similarly persuaded by the positives of potential liability of the police in negligence when they had failed to protect

85 K Williams, 'Litigation against English NHS ambulance services: the rule in *Kent v Griffiths*' (2007) 15 Med L Rev 153.
86 J Hartshorne et al '*Caparo* under Fire: a study into the effects on the fire service of liability' (2000) 63(4) Modern Law Review 502 at 505.
87 [2015] UKSC 2 at [160].
88 See Stevenson on whether judges should be making such policy decisions at all: R. Stevenson, *Tort and Rights* (OUP, 2007) 308.
89 [2001] 2 AC 619.

individuals from imminent injury: 'It might conceivably … lead to some much-needed improvements in their response to threats of serious domestic abuse'.[90] Further, in *Commissioner of Police of the Metropolis v DSD*, Lord Kerr, the same judge who in *Michael* had rejected defensive practice on the basis of a lack of empirical support, was confident in asserting that policy reasoning should not constrain the shape of liability for police failures to protect members of the public:

> '*On the contrary, it should lead to more effective investigation of crime, the enhancement of standards and the saving of resources.* There is no reason to suppose that the existence of a right … would do other than act as an incentive to avoid those errors and to deter, indeed eliminate the making of such grievous mistakes.'[91]

The landmark judgment from the Supreme Court in *Montgomery v Lanarkshire* went further. Lord Kerr and Lord Reed's joint speech demonstrated both a 'short shrift' approach to the defensive practice argument, but also a suggestion that jettisoning the ubiquitous *Bolam* standard for disclosing risk could improve practice and simultaneously reduce litigation for the future.[92] Raising the standard of care would ultimately perhaps be 'less likely to encourage recriminations and litigation' than the previous approach where patients relied on doctors to decide whether an inherent risk of the procedure was material.[93] In short, the greater flow of information to the patient envisaged would 'responsibilise' the patient for their own health care decisions and reduce tendencies to blame the doctor when things went wrong. Whilst there was some recognition that changes in the standard of care threshold introduced some unpredictability, it was simply the profession's responsibility to adapt: 'The approach which we have described has long been operated in other jurisdictions, where healthcare practice presumably adjusted to its requirements'.[94] Needless to say, no evidence was presented regarding the experience of adaptation in those other jurisdictions.

When the defensive practice flag was raised to ward off accepting proof of causation on the basis of a 'lost chance' of a better outcome after negligent medical treatment in *Gregg v Scott*, a slightly different approach was evident, suggesting that expanding liability would simply not affect clinician behaviour. Lord Nicholls found the defensive practice argument 'unimpressive', every doctor was already aware that they may be sued if negligent, and there was 'no reason to believe that adopting the approach set out above will affect the practices followed by doctors'.[95] Again, all of the above was said with no identified evidence on the

90 *Michael v Chief Constable for South Yorkshire* [2015] UKSC 2 at [198].

91 *Commissioner of Police of the Metropolis v DSD* [2018] UKSC 11 at [71] (emphasis added). Although this was outside the context of negligence claims, it concerned a parallel cause of action under Article 3 of the European Convention of Human Rights for a failure to investigate allegations of crimes which would meet the Article 3 threshold of 'inhuman and degrading treatment' to their victims.

92 [2015] UKHL 11, [92] to [93].

93 *Ibid*. Initial commentary broadly agreed: R Heywood, 'R.I.P. *Sidaway*: A Standard Worth Waiting For? (2015) 23(3) Med L Rev 455: 'medical lawyers may well be justified in questioning whether the aspect of *Montgomery* that confines *Sidaway* to the history books actually tells us anything that we did not already know' (at 457) 'It is unlikely that Montgomery will initiate a huge upsurge in terms of the volume of litigation' (at 461); A-M Farrell and M Brazier, 'Not so new directions in the law of consent? Examining *Montgomery v Lanarkshire Health Board*' (2016) 47 Journal of Medical Ethics 85: 'The Supreme Court has endorsed a view that most lawyers and doctors thought already prevailed, and it reflects the General Medical Council's guidance on the issue of consent in any case' at 85. Cf 'Inevitably there will be an increase in consent claims', Bevan Brittan, available at https://www.bevanbrittan.com/insights/articles/2015/changeinthelawonconsenttotreatment.

94 [2015] UKHL 11 at [93].

95 *Gregg v Scott* [2005] UKHL 2 at [55]–[56].

matter. There is incidentally some irony in the fact that clinical judgement in negligence litigation must be 'capable of withstanding logical analysis',[96] that a clear evidence base must underpin decision making, whereas legal judgement on issues of defensive practice is invariably a product of conjecture without the benefit of evidence either way.

Rebuttal #3: Incompatibility of the 'unproven' and 'standard enhancing' rebuttals

It is worth commenting at this point that these two broad rebuttals of the defensive practice argument appear mutually inconsistent – either the defensive practice argument fails because it is lacking empirical substantiation, or it fails because of an unsubstantiated judicial assumption that recalibrations in the duty of care threshold enhance standards to an extent which outweighs the harms of resulting defensiveness. One rebuttal suggests a need for empirical evidence to substantiate these kinds of arguments, whereas the other is satisfied with judicial hunch.

On one view then, both the defensive practice argument and the standard enhancing rebuttal are clichés from competing paradigms, *both* of which have been used in ways which arguably bypass scrutiny and reflection. There is, however, a way in which the two broad rebuttals can be read together – if, as Lords Bingham and Browne-Wilkinson in the *X (Minors) v Bedfordshire CC* litigation famously observed, tort's primary loyalty is to the principle that 'wrongs should be remedied',[97] then it is surely disproportionate to allow arguments about the risks of practising defensively to usurp that remedy completely by blocking a duty of care, unless cogent evidence has been presented to validate these concerns. The 'wrongs ought to be remedied' policy concern, itself a legal cliché, communicates a starting position. On this view, a policy preference embedded in tort that a claimant generally deserves at least for their case in negligence to be heard, places the burden on those raising defensive practice arguments, to convince the court of the need to interfere with the usual rules. When a court takes the position that an extension of the duty of care will enhance standards, supporting evidence is therefore not required, for the court is then acknowledging a duty of care, and not proposing to deviate from the 'remedying of wrongs' policy. Further, in the context of defensive practice being used as a reason to block the path to litigation altogether by pre-empting a duty of care, it may seem proportionate to demand some empirical evidence be used to support the argument. If we accept this doctrinal reconciliation, then we should presumably accept that for the defensive practice claim to have sufficient potency to modify the usual rules of liability, certainly something more than bald assertion or instinct is needed, some form of evidence should be required. That is not to say that defensive practice arguments require evidencing when raised at the 'duty' stage, but not when raised at the 'breach' stage. Rather, that there is a greater need for scrutiny when defensive practice arguments are wielded at the duty stage, given its role as 'pre-emptive control device',[98] often used by the defence to close down the case without a full airing of the issues by means of a strike-out application in preliminary proceedings.

96 *Bolitho v City & Hackney Health Authority* [1998] AC 232.
97 *X (Minors) v Bedfordshire CC* [1994] 2 AC 633, and recounted many times since.
98 K Oliphant, 'Against Certainty in Tort Law' in *Tort Law: Challenging Orthodoxy* (Hart Publishing, 2013) 4–5.

In the context of defensive medicine specifically, there is a substantial body of research claiming to validate the proposition that medical negligence litigation increases harmful defensive practices. The second half of this paper reflects on the forensic value of existing research into defensive medicine and whether it might usefully contribute to the empirical assessment of defensive practice claims in medical negligence litigation. In doing so, the paper draws from studies of defensive practice in medicine conducted in the UK to date, and 10 interviews with medical practitioners representing lived experience of defensive practice.

III. Analysis – 'Unproven'? Unpacking the 'no evidence' claim

There is a strong argument that the use of research in judicial decision making is a valuable means of increasing the legitimacy of those decisions, for it fosters 'connection' between the legal sphere and society.[99] But, how would empirical evidence be received by the courts, and is it accurate to suggest that there is no empirical evidence of defensive practice in medicine[100] and that therefore argumentation based on defensive medicine has no place in negligence jurisprudence?

The assertion that empirical evidence is needed in relation to a policy argument is certainly an odd claim. Use of empirical data in negligence litigation is rare. Research into the use of social science research in judgments has generally concluded that judges are often unreceptive to it when raised by lawyers, although that body of research focuses on family law applications,[101] and little is known about receptiveness to its use more broadly. In practice, empirical research in adversarial negligence litigation tends to be used to inform the court on questions relating to 'risk' and 'probability' when calculating an increase of risk for proving causation or where arguments based on loss of a chance of a better outcome are interrogated,[102] and not issues of policy in the realms of duty of care. The route by which empirical evidence on defensive practice might arrive in the courtroom is also not clear – where it appears, research tends to be mediated through expert evidence, but it might be introduced as part and parcel of an advocate's argument, or by a judge independently considering material to inform her about the real world.[103] Use of experts to present this evidence at least means that they are subject to duties to 'consider contradictory findings',[104] but it would likely also lead to protracted litigation and increased costs. Introduction of empirical evidence by advocates in legal argument

99 A Blackham, 'Legitimacy and empirical evidence in the UK courts' 25(3) Griffith Law Review 414, at 415.

100 While judicial rejection of defensive practice arguments on 'lack of evidence' grounds has occurred largely outside the context of medical negligence, Jones has remarked specifically about the unsubstantiated nature of defensive medicine claims: M Jones, *Medical Negligence* (5th edn, Sweet & Maxwell, 2017) and more generally on the 'dearth of empirical evidence on the effect of regulation on professional behaviour: O Quick, *supra* n 59 at 50.

101 See Z Rathus, 'The Research Says: Perceptions on the Use of Social Science Research in the Family Law System' (2018) 46(1) Federal L Rev 85.

102 Epidemiological studies, which offer a form of empirical evidence, are used in this context, albeit with caution: see eg most famously *Sienkiewicz v Grief (UK) Ltd* [2011] UKSC 10, but also the recent interesting case of *Younas v Okea hialam* [2019] EWHC 2502.

103 Lady Hale, 'Should judges be socio-legal scholars?' (2013) *Speech at the Socio Legal Studies Association Conference* at 6, available at https://www.supremecourt.uk/docs/speech-130326.pdf, accessed 28/11/2019.

104 L Robertson and K Broadhurst, 'Introducing social science evidence in Family Court decision making and adjudication: Evidence from England and Wales' (2019) 33 Int J of Law, Policy and Family 181, at 194.

raises questions about potential for misuse of research by partisan lawyers, distillation of the researchers' message for the sake of brevity[105] and whether either judges, or the lawyers on the opposing side who should cross-examine that evidence, are in a good position to assess the value of that research.[106] Space does not permit a more detailed discussion of the mechanisms for such research reaching the courtroom and the checks in place to regulate its use. Instead we turn to consider the forensic value of existing research into defensive medicine and whether it might usefully inform the substantiation or rebuttal of defensive practice argumentation in modern medical negligence cases.

The state of research into defensive medical practice

Research on defensive practice in medicine began to appear in the United States (US) by the early 1970s at the latest.[107] A survey of studies in the UK since then offers an initially satisfying consensus of between 50 per cent and 98 per cent[108] of medical practitioners reporting themselves as adopting strategies of defensive medicine in their practice. These results have been replicated across many jurisdictions, to include; the United States,[109] Australia,[110] the United Kingdom,[111] Japan,[112] Spain,[113] Italy,[114] Southeast Iran[115] and elsewhere. The same convergence is evident across many different specialisms (obstetrics and gynaecology,[116] radiotherapy,[117] general practice,[118] surgery,[119] anaesthesiology,[120] midwifery[121] and psychiatry[122]). However, important jurisdictional differences mean that

105 J Cashmore and P Parkinson, 'The Use and Abuse of Social Science Research Evidence in Children's Cases' (2014) 20(3) Psych Pub Pol & Law 239, at 240.

106 See generally Robertson and Broadhurst (2019) *supra* n 104.

107 'The Medical Malpractice Threat: A study of Defensive Medicine' (1971) *Duke L J* 939 (authored by the Duke Law Journal editorial board and others).

108 50 per cent (*Caring, Supportive, Collaborative: Views of Doctors Working in the NHS* (BMA, 2018), 78 per cent (Ortashi's hospital doctors (*supra* at n27)) and 98 per cent (Summerton's GPs (*supra* at n 25)).

109 D Kessler and M McClellan, 'Do Doctors Practice Defensive Medicine?' 11(2) The Quarterly Journal of Economics 353.

110 L Nash et al, 'GPs concerns about medico-legal issues' (2009) Aust Fam Physician 66 (questionnaire – 73 per cent ordered additional tests because of medico legal concerns).

111 Ortashi, *supra* n 27.

112 T Hiyama et al, 'Defensive medicine practices amongst gastroenterologists in Japan' (2006) 12(47) World Journal of Gastroenterology 7671.

113 R Garcia-Retamero and M Galesic, 'On defensive decision making: how doctors make decisions for their patients' (2012) 17 Health Expectations 664.

114 M Catino, 'Why do doctors practice defensive medicine? Side effects of medical litigation' (2011) 15 Safety Science Monitor.

115 M Moosazedeh et al, 'Determining the frequency of defensive medicine among general practitioners in Southeast Iran' (2014) International Journal of Health Policy and Management (78 per cent) – 423 general practitioners surveyed.

116 M Ennis et al, 'Change in obstetric practice in response to fear of litigation in the British Isles' (1991) 338 Lancet 616.

117 Summerton *supra* n 25; G McGivern and M Fischer 'Medical regulation, spectacular transparency and the blame business' (2010) 12(6) Journal of Health Organization and Management 597; and A Jain and J Ogden, 'General practitioners' experiences of patients' complaints: qualitative study' (1999) BMJ 1596.

118 Summerton, *supra* n 25.

119 M Sethi et al, 'Incidence and costs of defensive medicine among orthopaedic surgeons in the United States: a national survey study' (2012) 41(2) Am J Orthop 69.

120 J Forrest, 'Defensive medicine: anaesthetic practice in the 1980s' 39(12) Anaesthesia 1165.

121 J Robertson et al, 'An exploration of the effects of clinical negligence litigation on the practice of midwives in England: a phenomenological study' (2016) 33 Midwifery 55.

122 McGivern and Fischer, *supra* n 117.

these corroborative findings should be treated with caution. For example, US research frequently utilises 'correlation' studies, claiming to evidence the existence and/or extent of defensive practice through the tracking of proxy phenomena. Such proxy phenomena include the estimated malpractice claim risk, determined by the adoption of 'claim friendly' tort reforms in some states, which is then tracked against 'physician supply' (the movement of doctors from one state to another, thought to signify an aversion to the introduction of claim friendly laws affecting particular states), or against 'practice intensity' (eg, the number of CT scans/MRI scans/hospital admissions).[123] This 'proxy tracking' research methodology does not translate easily to the UK healthcare system which is broadly subject to the same tort regime across the jurisdiction. Transferability is also obscured by the fact that reimbursement models in the US mean that doctors are more likely to have financial incentives to run more tests.[124] It therefore becomes impossible to separate out defensive motives and economic motives for increased diagnostic testing which might otherwise be attributed to practising defensively.

When we confine our attention to UK studies claiming to evidence defensive practice in medicine, however, two pertinent facts emerge. First, most studies are authored by clinicians or medics working as university academics and not social scientists – a fact which might suggest some unavoidable bias in the conduct of that research.[125] Secondly, the study design almost invariably relies on self-reporting of defensiveness by doctors in surveys and interviews. Consequently, the claim that these studies do not provide a *reliable* 'measure' of defensive practice or its extent has some appeal.[126] This may be what Jones is hinting at when concluding that 'there is very little empirical, as opposed to anecdotal, evidence to support the theory that doctors do practise defensively'.[127] Depending on the stringency of the requirement for 'evidence' we might have at least three initial concerns regarding the reliability of data generated in this way: first, the variability of headline reporting of defensive practice in medicine across UK studies, secondly, self-selection of participants resulting in survey bias and thirdly, self-reporting as an unreliable measure of behaviour. This is aside from the broader problematic lack of disaggregation in many of these studies, discussed further below.

Robustness of self-reporting studies

(i) Headline variations

The variability of headline figures of defensive practice in medicine, even within the UK context, requires comment. The higher rate of reported defensive practice in medicine in Summerton's study in 1995 (98 per cent)[128] may be associated with his cohort of GPs, as

123 Van Dijck's probing meta-analysis of empirical research into defensive practice includes these studies and concludes that the evidence of impact on physician behaviour is weak, *supra* n 15 at 296.

124 A Jani and A Papanikitas, 'More than my job is worth – defensive medicine and the marketisation of healthcare' in T Feiler et al (eds) *Marketisation, Ethics and Healthcare* (Routledge, 2018).

125 For example, Summerton, *supra* n 25 (Registrar), Jain and Ogden, *supra* n 117 (clinicians with University teaching positions), Bourne et al, *supra* n 26: Ennis, Bourne et al, Robertson, Ruston, all being clinicians or clinical academics in Medical Schools or similar.

126 Kapp, *supra* n 15 agrees that 'caution should be exercised in attaching too much weight to survey and interview findings' (at 214). This paper focuses on those studies which rely on asking doctors about their practice.

127 M Jones, *supra* n 100, [1-027] at 21.

128 Summerton *supra* n 25.

compared with the lower reporting of defensive practice in medicine by Ortashi's 2013 study of hospital doctors (78 per cent) and Bourne et al's 'cross sectional' study (70 per cent) constituted by approximately one third GPs.[129] Given the position of GPs at the coalface of medical practice, advising on what are often vague presentations such as lumps, headaches, non-specific backpain and bloating without specialist diagnostic equipment to hand,[130] this is likely to be where some of the highest rates of defensive practice are. However, this cohort differentiation does not explain the finding of British Medical Association research in 2018 that (only) around 50 percent of the doctors surveyed agreed with the statement 'I practice defensively because I believe I am working in a blame culture'.[131] As the headline that 50 per cent of NHS doctors report practising defensively is not specifically tied into the risk of negligence litigation, but to the far broader context of 'blame culture', it might have been predicted that the hit rate would have been even higher than in previous studies. This makes the BMA's figure of 50 per cent even more surprising, given that most research has identified at least 70 per cent of respondent doctors as identifying with defensive practice.[132]

Whatever the reasons for this variability, we could agree that there is a discernible consensus that at least half the doctors participating in such research *report themselves* as using defensive practice. The cumulative impact of this body of research may be enough to satisfy a court (if necessary) that defensive practice in medicine is real and is cause for concern. However, a court should probably harbour some methodological concerns about such studies.

(ii) Sample bias and survey framing

Most well-known studies of defensive medicine report the possibility of 'selection' or 'confirmation' bias, in that those volunteering to be surveyed or interviewed are more likely to identify with the negatives of liability, hence their agreement to get involved. Summerton's work with GPs, for example, reported that 98 per cent of GPs surveyed practised defensively, but also recorded that the survey received only a 60 per cent response rate and perhaps that this 60 per cent had 'self-selected' as the initial communication to the participants included the survey questions.[133] Bourne et al reported that most doctors surveyed reported practising defensively (over 80 per cent reporting 'hedging' and over 45 per cent reporting avoidance) but also reflected that their study might have been impacted by 'ascertainment bias', presumably as those participating may have had a particular subset of experiences/beliefs compared to the target population of doctors as a whole.[134] In addition to participant self-selection, 'survey framing' can significantly impact on reported rates of defensive practice. Baicker et al's 2015 study found that when they surveyed doctors in a 'medical malpractice survey' and then replicated the same questions in a 'cost effective care' survey, this produced significantly different levels of reported defensive practice.[135] Responses to the former survey were 11.6 per cent more likely

129 The remainder being roughly one third junior doctors and one third consultants.
130 *The Quality of GP Diagnosis and Referral* (The Kings Fund, 2010) 13.
131 *Supra* n 108.
132 See studies cited at notes 109 to 122 above.
133 This possibility of response bias is mentioned in Summerton's paper, *supra* n 25 at 28.
134 Bourne, *supra* n 26.
135 K Baicker, B Wright and N Olson, 'Re-evaluating reports of defensive medicine' (2015) Journal of Health, Politics, Policy and Law 1157.

to report ordering tests that were not medically necessary than those completing the survey on 'cost-effectiveness'. Notwithstanding these confessed limitations, 98 per cent of Summerton's 60 per cent sample of GPs identifying with defensive practice is still statistically persuasive, as is the number of participants in Bourne's study (7, 926).

(iii) Self-reporting as anecdote

Self-reporting of defensive practice in medicine might be argued to capture a doctor's 'perception' of defensive practice in medicine, which may not be mirrored in decision making on the ground.[136] Even if the doctor's perception of defensiveness does translate into practice, the fact that doctors themselves identify defensive practice in medicine in their own conduct tells us little about the pervasiveness or significance of that defensiveness in their day to day medical judgements. It might therefore be argued that studies relying on self-reporting in interviews by doctors are treating anecdote as empirical evidence and, 'the plural of anecdote is not data'. However, first, most would agree that anecdotes of sufficient quality and quantity *can* be heuristically convincing. Secondly, when Jones says that 'there is very little empirical, as opposed to anecdotal, evidence to support the theory that doctors do practise defensively'[137] we can agree without dismissing the whole body of defensive practice in medicine research, by noting that most studies do not present their findings as objective evidence of defensive practice, but rather as evidence of *perceptions* of defensive practice. The cumulative anecdotes in this instance do provide convincing evidence, at least of practitioner perceptions that defensive practice in medicine is problematic. It is worth noting Fanning's argument that doctors frequently over-estimate the risk of being sued because of misunderstandings of the law[138] – doctors would therefore perhaps be unlikely to change their practices even if liability rules were adjusted in their favour.

Quantitative over qualitative research: masking microcosms of defensive practice in medicine and the role of the patient

The majority of studies appear to be survey based and seek a positive or a negative response from doctors, rather than qualitative answers.[139] Coding by the researcher of 10 interviews with doctors revealed a prominent narrative which is masked by quantitative studies – the negotiation of defensiveness in particular doctor: patient relationships.

Defensive behaviour can in part be viewed as a by-product of a more hostile patient: doctor relationship. In the face of demanding patients, the doctor can feel like the vulnerable party,[140] with some patients acting as 'predators' and defensive doctors as

136 Van Dijck, *supra* n 15 at 297.

137 Referenced above at text accompanying n 127.

138 J Fanning, 'Uneasy lies the neck that wears the stethoscope: Some observations on defensive medicine' (2008) 24(2) JPN 93 at 99.

139 Defensive practice in medicine research based on interviews is less common. For some excellent examples see A Ruston, 'Risk, anxiety and defensive action: general practitioner's referral decisions for women presenting with breast problems' (2004) 6(1) Health Risk & Society 25; McGivern and Fischer, *supra* n 117; Jain and Ogden, *supra* n 110; and J Robertson et al, 'An exploration of the effects of clinical negligence litigation on the practice of midwives in England: a phenomenological study' (2016) 33 Midwifery 55.

140 P Brown et al, 'From patient deference towards negotiated and precarious informality: An Eliasian analysis of English general practitioners' understandings of changing patient relations' (2015) 146 Social Science and Medicine 164 – interviews suggesting GPs encountered an increasing number of challenging and aggressive patients.

'adapted prey'.[141] From this vulnerable position, defensive strategies might be used to avoid (spurious) complaints. A number of interviewees suggested that they 'profiled' new patients, 'diagnosing' whether the patient in front of them had a predilection to complain and defensive behaviour was sometimes used as a negotiation strategy in difficult doctor: patient relationships. This introduced a patient-specific dynamic, independent of clinical observations, into medical decision making based on the doctors' assessment of propensity to threaten complaint or legal action. These patients presented as either (1) aggressive or (2) particularly anxious and resistant to reassurance. Both might be sent for additional (defensive) scans. The aggressive patient (or patient's family) was observed as:

> 'quite open, especially the horrible, manipulative characters: well, if you're wrong I'm gonna sue you, I'm gonna do this, I'm gonna do that … and it actually feels very uncomfortable when they say that, because if you want to find a solicitor to take a case on, you can tell 'em a pack of lies or half-truths and get them to take on the case and potentially cause a lot of trouble.'[142]

Some aggressive patients or relatives were well known in one GP's practice:

> 'on the times that I have treated that patient my documentation has been anal (laughs). And if there's been any doubt about whether treatment is needed, say something like an antibiotic, in that person's case they would get it … whereas with someone who isn't known to be like that, you would have a reasoned conversation with them and say well, I don't think you maybe need antibiotics at this stage … you can't have that conversation with them, erm, so we just treat, cos its safest in terms of your … your safety, maybe not so much for the patient.'[143]

The really anxious patient might also be referred for further tests earlier than others with the same symptoms 'not only for their peace of mind but because in the event of an adverse outcome … in your head you're thinking, would they be likely to pursue me if I was wrong?'[144] If the doctor's clinical judgement was wrong,

> 'The patient who was maybe very, very anxious would be very keen to say, "I told you so" and create erm, some trouble. And the trouble doesn't necessarily fit with the severity of the mistake that you make either … you could make the same, have the same outcome and the same mistake but [be the subject of complaint] just because of the different character of the patient.'[145]

Another GP associated patient anxiety with the likelihood of complaint and defensive testing: 'A lady got health anxiety and has been investigated to the 'nth' degree because she has complained and, you have to think, well this isn't good for her.'[146]

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141 A Antoci et al, 'The Ecology of Defensive Medicine and Malpractice Litigation' (2016) PLOS ONE, available at http://dx.doi.org/10.1371/journal.pone.0150523.
142 Interviewee #6.
143 Interviewee #8.
144 Interviewee #7.
145 Interviewee #7.
146 Interviewee #5.

Gauging patients for their propensity to complain was a common theme in interviews (lawyers as patients were to be treated especially cautiously![147]). Knowledge that a patient had a history of medical error prior to the current consultation might affect this assessment, but in some cases it was informed by patients blatantly threatening some form of complaint if they did not get what they wanted:

> 'I've got one at the moment, he wants me to give him diazepam and I'm not going to because it's not good for him and he's threatening to complain, but sometimes you know you're right so you can overrule them.'[148]

Another doctor admitted to picking up clues from her dialogue with patients:

> 'if they've already mentioned things like 'complications', if they've had an experience in the past where a family member has had a bad experience in health care, you can sometimes tell the patients who are going to be potentially litigious. And that will come into your decision-making process.'[149]

All of this has implications for the health of the doctor–patient relationship:

> 'most of my patients I have a good relationship with them and I enjoy the relationship I have with them, but it's got the potential to put up barriers, because you see them a bit as people who have the possibility of hurting you really.'[150]

Trust from patients was viewed by one GP who had done a lot of locum work, as part of the solution to patients applying pressure for certain tests:

> 'So you build up a bank of trust if you like, so if you do make a mistake, you've got a relationship with the patient and the relatives and its able to get explained and hopefully not escalate. I think as a locum you're at high risk of complaints escalating because you don't have that previous goodwill in the bank from patients.'[151]

Other authors have documented the use of defensive strategies as a means of managing the demands of patients and building trust and confidence in the doctor: patient relationship. As Fritz and Holten acknowledge, defensive practices are not only used as a substitute for trust, they are used by practitioners to build trust for future encounters, but can backfire in the long term. Defensive practices used in this way (such as referral for unnecessary scanning), create expectations which are then disappointed if not replicated in later appointments, and so a 'snowball effect' can occur.[152] The relationship between patient

147 Interviewee #9.
148 Interviewee #5.
149 Interviewee #6.
150 Interviewee #5.
151 Interviewee #6.
152 Z Fritz & R Holten, 'Too much medicine: not enough trust?' (2019) 45 JME 31.

propensity to seek reassurance from tests and trust in the doctor was highlighted by another interviewee. This practitioner spoke of defensive medical practice as prompted by particular patients who, for example, feigned pain on one side,[153] but were showing no signs of distress and using

> 'buzz words to get a scan or investigation … not trusting us as clinicians and so therefore it then reinforces that they can just come in and get those investigations and there's no repercussions for them, because the wonderful NHS just foots the bill.'[154]

The added value of recognising defensiveness as, in part, a response to particular patient behaviours, has implications for policy makers, raising questions about how doctors might be better supported so that they feel less vulnerable to these pressures, how patients might be better informed so that they are less inclined to apply these pressures and how trust can be strengthened in therapeutic encounters which are increasingly with locum staff. Recognising these facets of defensive medicine should not detract from the responsibility of the legal framework. The law is complicit in this process. Where culpability might be levied partially at the patient in negligence claims, that responsibility is seemingly erased due to the law's refusal to entertain findings of contributory negligence.[155] Arguably it is the law, and increased emphasis on 'outing medical error' which empowers the patient to make such threats.[156]

Non-disaggregation of intensity of defensive practice in medicine, triggers for defensive practice in medicine and beneficial effects

If lawyers utilising defensive practice argumentation in the course of medical negligence litigation were called upon to substantiate their claim with empirical evidence, not only could they potentially be confronted by the methodological concerns expressed above, but they might also find that the available research does not map onto the narrow judicial concern with harmful defensive practices triggered by negligence litigation. This is because the research agenda has tended not to disaggregate the intensity of defensiveness, the causal factors behind defensiveness or the positive impact as distinct from the negative impact of complaint pressures.

Disaggregation problems

(i) Intensity of defensive practice

The headline figures of reported defensive practice in medicine ('x per cent of doctors surveyed reported they sometimes practised defensively'), are not readily disaggregated

153 A symptom which could indicate ectopic pregnancy.

154 Interviewee #10.

155 Documented in J Herring and C Foster, 'Blaming the Patient: Contributory Negligence in Medical Malpractice Litigation' (2009) 25(2) JPN 76 and J Montgomery, 'Patient No More' and the author's future paper 'Portrait of the Patient in Medical Jurisprudence'. See also C Purshouse, 'The impatient patient and the unreceptive receptionist' (2019) 27(2) Med L Rev 318.

156 O Quick, 'Outing Medical Error: Questions of Trust and Accountability' (2006) 14(1) Med L Rev 22.

into the types of defensive conduct or its triggers. Consequently this research frequently tells us little about the gravity or frequency of defensive practice in medicine; for example, whether it affects their participants' decision making every day for every patient, once a week, or once every few months? Is its extent merely to spend a few extra minutes after appointments typing up patient notes which may be regarded as clinically unnecessary? Or is it to frequently or routinely recommend invasive procedures which are not medically indicated? There is some attempt to disaggregate types of reported defensiveness, for example, in Ortashi's study of hospital doctors (27 per cent said they 'performed unnecessary interventions' because of the fear of litigation) and Bourne's study (23 per cent reported 'suggesting invasive procedures' against their professional judgement), but in both instances, this 'twenty something' per cent is a long way from the headline figures from the same research of 78 per cent and 70 per cent of participant doctors reporting defensive practice in medicine respectively. Bourne et al's study published in 2015 is more robust in this regard, being both quantitative and qualitative.[157] Bourne's team investigated the impact of complaints on doctors' psychological health and on their medical practice in the UK. Even so, the authors' comment that their response rate was relatively low (11.4 per cent) and that this in itself may indicate their sample was unrepresentative and that the cross-sectional nature of the study (of the 7,926 respondents, approximately one third were consultants, one third in general practice and one third were junior doctors) meant that causal factors could not be elucidated. Further, some of the results of Bourne's study are perplexing, for example, the finding that very similar scores are given for reported defensive practice by doctors with a 'current or recent complaint' and those with 'no recent experience of complaints.'[158] This gives some credence to the self-selection problem as it suggests that doctors who are inclined to practise defensively are over-represented in this study – why else would the variable of experiencing a recent complaint make so little difference?

(ii) Triggers of defensiveness

Most research in this area studies the impact of 'complaint' rather than litigation in particular and this poses a major problem for existing research ever being useful in the context of supporting a claim in court that the duty of care should not be extended. As indicated, Lord Scarman's account of defensive practice which identified tort as the main trigger for detrimental defensiveness in medicine, likely needs adjusting in light of a proactive regulator (the General Medical Council (GMC))[159] and a regulatory landscape characterised by layers of organisational activity, multiple actors and complexity.[160] The regulatory mix of causes of defensive practice in medicine therefore varies. For some interviewees, it was not the negligence action which was likely to be the main source of patient harming defensiveness, but rather fear of problems with the regulator because of the greater personal impact:

157 Bourne et al, *supra* n 26.

158 'There were 88.6 per cent of doctors with a recent or current complaint and 82.6 per cent of those with a past complaint who displayed hedging behaviour; 81.7 per cent of doctors with no previous complaints reported hedging': Bourne, *supra* n 26 at 6.

159 See eg J Chamberlain, 'Malpractice and Criminality' (2015) 25(1) Med L Rev 1, reporting a 640 per cent rise in 'enquiries' managed by the GMC from 1999 to 2014.

160 See references to this in Quick's chapter, *supra* n 59.

> 'Whereas the GMC, irrespective of the outcome the process is unpleasant … and stressful … it's only a matter of time because it comes to us all at one point, but I would rather be sued than be investigated by the GMC, given the choice.'[161]
>
> 'the GMC, it cuts into who you are as a professional, you know, it could be your whole livelihood, it could be your whole life and who you are as a doctor. So as well as the financial aspect its, erm, it really takes the rug out from under your feet.'[162]

… and because of concerns that the regulator would not be fair in its assessment:

> 'they very much take a guilty until proven innocent approach, they're extraordinarily heavy handed'.[163]

There was also a perception of a ramping up of GMC action against doctors:

> 'The GMC … I get the impression, are doing a lot more fitness to practise stuff. Erm and there's lots of reasons for that as well. I think appraisal and revalidation has allowed for more scrutiny of doctors and that's not a bad thing, that's a good thing. Erm, what is acceptable professionally has changed … massively. So therefore they have to do more.'[164]

Others regarded the risk of public shaming as a key factor in motivating defensiveness, and although publicity might be generated by a negligence claim, some interviewees regarded that as a lesser concern than the publicity associated with GMC action which would result in published findings on the register of medical practitioners:[165]

> 'the GMC … huge impact. Massive impact. Erm. One, it's public so it's put on the internet isn't it? … Erm two, the processes I believe are lengthy and arduous and not easily understood. And they take quite a long time so its hanging over you for quite a long time.'[166]

For another it was the sheer multitude of avenues for complaint that was a key concern:

> 'you're in triple or quadruple jeopardy for the places where they can pursue you. There's the local complaints policy, there's the kind of Clinical Commissioning Group complaints policy, right the way up to the ombudsman, but if they decide to go off on a tangent to the GMC, they can do that. If they decide to go through civil litigation they can.'[167]

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161 Interviewee #8.
162 Interviewee #5.
163 Interviewee #7 and see G McGivern and M Fischer 'Medical regulation, spectacular transparency and the blame business, (2010) 12(6) Journal of Health Organization and Management 597.
164 Interviewee #6.
165 See also R Heywood (2019): 'GPs ought not to have been overly concerned about becoming the subject of a lawsuit; nowadays they should worry more about sanctions that could be imposed by the General Medical Council' and R Heywood and J Miola, 'The changing face of pre-operative medical disclosure' (2017) 133 LQR 296.
166 Interviewee #6.
167 *Ibid*.

Yet, for other interviewees, GMC action was perceived as a lesser threat than litigation – it was 'distant', 'it's more to do with behaviour, like taking drugs or having an affair with a patient or doing something fraudulent', 'you have to do something really pretty bad, kind of Shipman-esque for a GMC investigation'[168] and far less likely to figure in their thinking than litigation: 'I don't think most people would expect to go through that in their careers.'[169] Some were not aware of fitness to practise cases 'except tabloid reports of that paediatrician who took photos of children's bodies',[170] whereas for 'obs and gynae work', civil actions were 'guaranteed' and just 'bad luck'.[171] Any belief that the GMC would not be interested in allegations of substandard care as opposed to criminal conduct or breaching boundaries with a patient is clearly misplaced,[172] and suggests that doctors' own perceptions about complaints processes may be based on misunderstandings.

Some interviewees spoke of being unable to separate medico-legal defensiveness from defensive practice as an inherent part of their clinical judgement, a kind of epistemic or learned defensiveness. Referring patients for scans or other tests when not clearly clinically indicated might be bound up with medico-legal concerns, but it was recognised as having the potential to identify something unexpected which would otherwise have been missed. This was therefore an expression of epistemic humility on the interviewees' part. Similarly, one GP spoke about her '"three strikes and you're out" rule' as an example of defensive medicine. This tactic/strategy had been learned from a senior partner and determined that if a patient presented with a seemingly innocuous problem three times without a definitive understanding of the problem being reached, hospital admission for further scans should be considered because of 'the concern that you might be seen to have been seeing a patient repeatedly and not taken them seriously.'[173] However, this was later explained as good practice – if three consultations had not yielded an explanation, perhaps there was something 'not right'. Again, defensiveness was wrapped up in the inherent, undiminishing,[174] uncertainty of medicine,[175] and awareness of its limitations, albeit galvanised by medico-legal concerns. Medico-legal concerns rarely had a discrete and identifiable impact on their judgement; it was merely part of a very complex process of assessing risks or 'sophisticated gambling'.[176]

These accounts of defensive behaviour confirm that defensiveness in medicine exists independently of the threat of being sued – defensive behaviours are associated with multiple avenues of complaint and are inherent in the practice of modern medicine, evidenced perhaps by the fact that even 'no fault' systems of liability still feature defensive medicine.[177] Further, there are many shades of medico-legal defensiveness, and at the

168 Interviewee #4 ('Shipmanesque' referring to Dr Harold Shipman, a GP thought to have unlawfully killed over 200 of his patients).
169 Interviewee #10.
170 Interviewee #1.
171 Interviewee #2.
172 Section 35C Medical Act 1983 specifies that deficient professional performance can impair fitness to practise and justify an investigation. See for example, *Sledzik v GMC* [2019] EWHC 189 and *Aliu v GMC* [2018] EWHC 3659.
173 Interviewee #8.
174 D Hunter, 'Uncertainty in the Era of Precision Medicine' (2016) 375 NEJM 711.
175 Fuelled by the complexity of the body and heterogeneity of patients: A Geljins et al, 'Uncertainty and Technological Change in Medicine (2001) 26(5) Journal of Health Policy and Law 913.
176 Interviewee #3.
177 K Wallis, 'New Zealand's 2005 "no-fault" compensation reforms and medical professional accountability for harm' (2013) 126 New Zealand Medical Journal 33.

edges of decision making, defensive practice concerns could nudge doctors towards options which *were not inconsistent with* their clinical judgement. But this brings us no closer to identifying whether this defensiveness is bad for patients – on one view, medico-legal fears have galvanised a precautionary approach to risk and concerted efforts to reassure which arguably benefits the patient. On the other, framing defensive behaviours as *'treating the patient's anxiety*' might be construed as a 'social defence',[178] used by interviewees to justify conduct retrospectively to others and themselves. What it does demonstrate, however, is that practitioners struggled to be sure how much of a role medico-legal concerns specifically played in their decision making, which again raises questions about the weight and significance courts would and should place on defensive practice in medicine studies which are based on self-reporting models.

(iii) Accounting for the benefits of practising defensively

In line with the optimism of the standard enhancing narratives found in *Phelps*, *Michael* and *Montgomery*, much defensive practice in medicine research envisages that practising defensively can be positive in its effects and can be read as validating suggestions that the threat of tort liability *can* generate improved standards of care.[179] Defensive practice in medicine is widely acknowledged in the literature as not inherently bad and could be consistent with 'quality improvements' such as increases in screening, note taking, eliciting of patient feedback. For example, Summerton's study of GPs used a definition of defensiveness which encompassed both beneficial and detrimental defensiveness.[180] His findings that 98 per cent of respondents to his survey reported changing practice due to the possibility of patient complaint therefore told us little about how much of this changing practice we should be concerned about.

It is notable that a number of the author's interviewees also did not regard defensiveness as necessarily undesirable, rather it was 'erring on the side of caution',[181] 'an extra level of carefulness in your documentation and management plans'[182] and 'potentially, well, it's a good thing isn't it?'[183] All of these statements would seem to be corroborative of the idea that awareness of the risk of being sued, or otherwise the subject of complaints, sharpens medical practice and is entirely consistent with the legal standard of care which emphasises precautionary intervention to address even small risks of catastrophic harm.[184] But separating out the costs and benefits of defensive medical action was acknowledged as far from easy. This was apparent when another practitioner referred to low risk interventions, used with patients experiencing pain for whom nothing else had worked, as an example of defensive medicine. These interventions might involve an injection, but there was sometimes no real evidence that it would help the patient. In some cases, these procedures were administered anyway, at least in part, to be seen to be doing something

178 See J Allsop and L Mulcahy's references to 'social defences' in, 'Maintaining Professional Identity: Doctor's Responses to Complaints' (1998) 20(6) Soc of Health & Illness 802.
179 Summerton, *supra* n 25; although, Cf Quick, *supra* n 58 – tort is likely to impede rather than improve patient safety – at 98.
180 See above.
181 Interviewee #6
182 Interviewee #7.
183 Interviewee #6.
184 *Marriott v West Midlands AHA* [1999] Lloyd's Rep Med 23.

and not neglecting or 'fobbing off' the patient. These procedures were not however purely 'defensive' as they might have a therapeutic 'placebo' effect for the patient.[185] In cases like this, defensiveness could be part and parcel of the therapeutic package for anxious patients or patients without a diagnosis or clear way forward. Defensiveness 'treated' the patient's heightened anxiety. By eliminating certain diagnoses, the patient's anxiety was addressed and that was all part of addressing the patient's broader wellbeing. In the words of one doctor:

> 'is that genuine defensive practise or is that actually us just trying to help the patient in any way that we possibly can? … That's a very difficult line to draw. Are we stopping them complaining or actually is all of medicine stopping patients complaining?'[186]

As is highlighted by these doctors' accounts, without detailed research, often we cannot know whether the defensive action in a given instance was consistent with optimal or suboptimal levels of care until we know what its outcome is for this patient and the patient population as a whole. Clearly the same defensive behaviour may prove to be positive for that particular patient (reducing anxiety by eliminating a serious but unlikely diagnosis), but negative in reducing the opportunity cost for other patients. Defensive practice research rarely distinguishes negative outcomes for that patient (eg unnecessary side effects, anxiety) and negative outcomes for the remainder of the population, such as that increasing follow up appointments to protect yourself meant that would be 'one less appointment for another person with another problem'.[187]

The above responses illuminate the disconnect between forensic accounts of defensive practice in medicine and the shape of defensive practice research. The clichéd judicial account of defensive practice in medicine in court judgments is concerned with detrimental defensiveness as *caused by* negligence litigation. Research may have affirmed the phenomenon of defensive medicine generally and its potentially harmful effects, but we remain in a state of ignorance as to the precise net outcomes of extensions in negligence liability for individual patients and the broader population. UK research has been characterised by clinicians studying other clinicians using a 'self-reporting' model. This approach has produced valuable insights, but also features a number of confounding variables which have not advanced our understanding of the extent to which increased liability in negligence specifically triggers harmful defensive medicine. As indicated above, there is a qualitative difference, however, between an argument that the risk of defensive practice justifies precluding a duty of care altogether, and saying that it is a factor which ought to be weighed in the balance when deciding whether the duty of care has been breached. In cases of the former it is arguably right that the courts should insist upon more robust evidence that extending negligence liability risks causing more harm than good, and it is not clear that the existing body of research offers that degree of certainty. The available evidence could, however, usefully inform instinctual judgements about where the standard of care should be fixed in difficult cases and provide a reminder to

185 See eg Y Fu et al, 'Identifying placebo responders …' (2016) 5 Syst Rev 183 where the placebo effect of injections for chronic pain are discussed.

186 Interviewee #6.

187 Interviewee #8.

abstain from finding negligence too readily. The result of the 'crowd effect' made up by the multitude of factors which combine to incentivise practising defensively in medicine should not absolve the courts from responsibility for their part in it.

Conclusions

The language of 'defensive practice' emerged from concerns about the impact of medical negligence liability on therapeutic endeavours. This basic premise was re-contextualised in tort jurisprudence into a broader cautionary argument against extending the liabilities of other professions and public bodies, predominantly played out in connection with questions of duty of care. These re-contextualised defensive practice arguments have lost their potency and magical influence, with judges consistently rebutting arguments of defensive practice on the grounds either of a lack of empirical evidence, or based on 'instinctual judgement' that increasing the scope of liability will be standard enhancing.

In the context of defensive medicine specifically, it seems that existing research into defensive medicine, if used to answer the call for empirical evidence, may not survive judicial scrutiny. This is because of heavy reliance on self-reporting methods of investigation and 'disaggregation problems', namely the difficulties of separating out types and forms of defensiveness and attributing or isolating the causes of defensive medical behaviour through research. The interviews conducted for this paper provide recurring indications of just why it is so difficult for research to evidence and quantify defensive practices. Examples of defensive medicine from just 10 doctors were protean and often inherently unmeasurable, so that it appeared impossible to untangle the relative impact of triggers to practise defensively, but also to say whether the benefits of defensive behaviour outweighed the costs to patients. The narratives presented here from just 10 interviews are, of course, not to be treated in themselves as 'evidence', but rather as indications that defensive practice in medicine is far more complex and nuanced than many of the narratives around defensive practice in medicine presently acknowledge. Current research has tended to mask issues which deserve further investigation, in particular, how defensiveness might cause the 'profiling' of patients for their propensity to complain, sometimes tainting the therapeutic relationship from the first meeting. These issues may be important considerations for policy making, not least because they indicate the insidious nature of medico-legal defensiveness, its weaponisation in particular types of encounter and its potential to damage doctor–patient relationships. It also suggests a need for patients to be better informed and encouraged to play their part in reducing harmful defensiveness.

Fundamentally, research has done little to disaggregate the types of defensive conduct or its causes and therefore does not unequivocally advance the claim that increasing negligence liabilities produces harmful defensive practices. This finding may be regarded as offering credence to those who point to the lack of concrete 'evidence' of defensive practice, leading some commentators to reference defensive practices as 'spectral', a 'bogeyman',[188] and a 'red herring'.[189] The author agrees that it is undoubtedly disappointing that despite 50 years of research into defensive medicine, we cannot confidently assert that

188 Implying that evidence for its existence (in New Zealand) was thin: R Paterson, 'The bogeyman of defensive medicine' (2006) September, NZ Doctor 14.

189 G Ridic, 'Medical Malpractice in Connecticut: Defensive Medicine, Real Problem or a Red Herring – Example of Assessment of Quality Outcomes Variables' (2012) 20(1) Acta Inform Med 39.

this research has generated the empirical evidence which could unequivocally validate defensive practice arguments in the courtroom. However, it is not the norm to validate policy arguments in negligence litigation with incontrovertible empirical evidence. The findings of this paper do suggest that any courts engaged in such scrutiny should be made aware of the difficulties of establishing linear relationships between negligence liability and harmful defensive practice. The dangers that must be avoided are that the courts discount altogether concerns about defensive medicine because it is no longer possible to disaggregate the role that negligence liability plays, and disregard the signs that it clearly does operate as a cumulative, contributory cause, even if not a 'but for' cause.[190]

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190 In the spirit of judges' approach to causation in negligence: *Bonnington Castings v Wardlaw Ltd* [1956] AC 613.