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On 6 April 2019, the CPME Board adopted the 'CPME Position Paper on Defensive Medicine' (CPME 2019/030 FINAL).

# CPME Position Paper on Defensive Medicine

*The Standing Committee of European Doctors (CPME) represents national medical associations across Europe. We are committed to contributing the medical profession's point of view to EU and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues.*[1]

## DEFINITION/ BACKGROUND[2]

Defensive medicine has seen an increase in both prevalence and impact over the past years.

*The concept of 'defensive medicine' is subject to varying definitions which broadly describe the practice of ordering medical tests, procedures, or consultations which are not medically indicated or refusing the treatment of certain patients in order to protect the responsible physician from malpractice challenges.*

Defensive medicine consists of two general behaviours. As Studdert et al. set out, "[o]ne is assurance behaviour (sometimes called "positive" defensive medicine), which involves supplying additional services of marginal or no medical value with the aim of reducing adverse outcomes, deterring

[1] CPME is registered in the Transparency Register with the ID number 9276943405-41. More information about CPME's activities can be found on www.cpme.eu.

[2] In 2016, CPME carried out a survey mapping the situation of defensive medicine across Europe (CPME 2016/008 FINAL). Responses to the CPME survey showed that a majority of National Medical Associations support further CPME action concerning defensive medicine, in particular to raise awareness about this problem.
The impact of defensive medicine is discussed in relation to several policy areas. There are CPME policies relating to the liability of doctors which also address the concept of defensive medicine, in particular the CPME policy on the liability of service providers adopted in 1991 (FR only) and the CPME Proposal for a directive on health care liability adopted in 2000. Although discussions on doctors' liability were raised both in the context of the Services Directive 2006/123/EC, the Cross-Border Healthcare Directive 2011/24/EU and the Professional Qualifications Directive 2005/36/EC, there is currently no EU legislation on this issue.
Awareness of an increasingly defensive medical practice culture and its negative implications has paved the way for a much-needed political focus, like the 'Choosing Wisely®' campaign in the UK launched by the Academy of Medical Royal Colleges. International projects analyse opportunities to eliminate waste and lower value care (Netherlands, Alliance of University Hospitals and Training centres - NFU programme), the European Collaboration for Healthcare Optimization (ECHO).

patients from filing malpractice claims, or persuading the legal system that the standard of care is met. The other is avoidance behaviour (sometimes called "negative" defensive medicine), which refers to physicians' efforts to distance themselves from sources of legal risk."[3]

**THE PREVALENCE OF DEFENSIVE MEDICINE IN EUROPE**

A review of international scientific literature confirms that defensive medicine is widespread and occurs in all diagnostic-therapeutic areas, although some medical specialties are affected more often than others. Various studies have looked at the situation at national level, both within the EU and internationally[4] [5] [6] [7] [8] [9] [10] [11] [12] [13].

**IMPACT OF DEFENSIVE MEDICINE**

The adverse effects of defensive medicine affect healthcare systems worldwide.

It is complicated to calculate or quantify the economic impact of defensive medicine due to the many conflicting and overlapping factors[14] [15] [16] [17]. Nevertheless it is expected that the cost of defensive medicine is significant.

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[3] Studdert DM, Mello MM, Sage WM, Des Roches CM, Peugh J, Zapert K, et al. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. JAMA. 2005;293:2609–17.

[4] J Health Serv Res Policy. 2017 Jan, Prevalence and costs of defensive medicine: a national survey of Italian physicians. Panella M, Rinaldi, Leigheb F, Knesse S, Donnarumma C, Kul S,Vanhaecht K, Di Stanislao F.

[5] Health Econ Policy Law. 2017 Jul;12(3):363-386. The determinants of defensive medicine practices in Belgium. Vandersteegen T, Marneffe W, Cleemput I, Vandijck D, Vereeck L.

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

[7] Studdert DM, Mello MM, Sage WM, Des Roches CM, Peugh J, Zapert K, et al. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. JAMA. 2005;293:2609–17.

[8] Hiyama T, Yoshihara M, Tanaka S, Urabe Y, Ikegami Y, Fukuhara T, et al. Defensive medicine practices among gastroenterologists in Japan. World J Gastroenterol. 2006;12:7671–5.

[9] Bishop TF, Federman AD, Keyhani S. Physicians' views on defensive medicine: a national survey. Arch Intern Med. 2010;170:1081-1083.

[10] Asher E, Greenberg-Dotan S, Halevy J, Glick S, Reuveni H (2012) Defensive Medicine in Israel – A Nationwide Survey. PLoS ONE 7(8): e42613. doi:10.1371/ journal.pone.0042613).

[11] Cross-sectional survey on defensive practices and defensive behaviours among Israeli psychiatristsI Reuveni, I Pelov, H Reuveni, O Bonne, and L Canetti· BMJ Open. 2017; 7(3):

[12] Prevalence of defense medicine in Lithuania. Liutauras Labanauskas, Viktoras Justickis, Aistė Sivakovaitė . Health policy and management, 2013.

[13]Asher E, Dvir S, Seidman DS, Greenberg-Dotan S, Kedem A, et al. (2013) Defensive Medicine among Obstetricians and Gynecologists in Tertiary Hospitals. PLoS ONE 8(3): e57108. doi:10.1371/journal.pone.0057108.

[14] J Am Health Policy. 1994 Jul-Aug;4(4):7-15. How much does defensive medicine cost? Rubin RJ, Mendelson DN.

[15] Hermer LD, Brody H. Defensive medicine, cost containment, and reform. J Gen Intern Med. 2010; 25:470-473.

[16] Health Policy, 119 (2015) 367-374. Tom Vandersteegen and others. The impact of no-fault compensation on health care expenditures: An empirical study of OECD countries.

A culture of litigation impacts both the medical and legal systems with damaging consequences to the patient-physician relationship and the quality of healthcare services even though the national legal frameworks for litigation differ.

**RECOMMENDATIONS TO PREVENT AND REDUCE THE PRACTICE OF DEFENSIVE MEDICINE**

There is no universal solution for all countries of how to reduce this phenomenon due to cultural, economic and social differences in the countries which create the different expectations of the patients, different legal systems and legal procedures. However the common essential directions may be put forward.

*Recommendations for professionals*

1. To ensure that healthcare responds appropriately to each individual patient's health needs.
2. To maintain high standards and evidence-based clinical guidelines in daily practice. Clinical guidelines require regular revision to ensure they reflect the best available evidence, while allowing for clinical independence to adequately respond to individual patients' needs and choices.
3. To practice more valuable care for every patient through informed choices and good conversation. With a patient engagement and clear communication promote awareness about appropriate care, unnecessary tests, treatments and procedures.
4. To support Continuous professional development (CPD) with the objective of ensuring that professional practice is up-to-date. This will contribute to better patient outcomes, quality of care as well as increasing the public's confidence in the medical profession.
5. To maintain clear, well-documented and detailed medical records. Appropriate documentation of all treatments and procedures contributes to quality of care and patient safety.

*Recommendations for policy-makers*

6. To build a patient safety culture aimed at transparency, and preventing and learning from errors. Appropriate open disclosure policies can support both patients and doctors and should be appropriately resourced. It has furthermore been established that the disclosure of adverse events, which may include an apology to the patient affected and their family, lowers the probability of litigation against the doctor involved.
7. To engage in a debate with the public to contribute to improving media literacy on health information in particular in relation to online sources. To inform the public about the consequences of defensive medicine: reluctance to treat high risk patients, costs and dangers if professionals continue to practice defensive medicine.

[17] Reschovsky JD, Saiontz-Martinez CB. Malpractice claim fears and the costs of treating medicare patients: a new approach to estimating the costs of defensive medicine. Health Serv Res 2017.

8. The medical community and administration of health institutions need to be aware of the 'second victim' phenomenon (or the clinical-judicial syndrome) and ensure adequate psychosocial support to both patients and doctors in the disclosure process.
9. To reduce fears of liability proceedings by reforming compensation mechanisms for medical malpractice. Mediation and administrative compensation systems all hold promise.
10. Further development of the liability system is necessary to enable a reform of tort law focused on balancing the 'no blame principle' with the 'accountability principle'. The use of extra-judicial mediation and the adoption of no-fault systems have proven to be effective approaches in reducing both defensive medicine and the waste of resources it incurs.
11. Under-resourcing and under-staffing contribute to clinical error and defensive medicine. Employers and funders have a duty of care to ensure that clinical services are adequately resourced and staffed to deal with appropriate workloads.