DEFENSIVE MEDICINE AND HEALTH JUSTICE

Ana Belén Cruz Valiño

University of A Coruña (Spain). Postdoctoral research. PhD and Bachelor of Laws from University of A Coruña. Bachelor of Political Sciences and Sociology. Master´s in Bioethics. Lawyer. [1]

Abstract:

The aim of this work is to unify the analysis of defensive medicine with the clinical relationship based on rights. Defensive medicine which began in the 60s and 70s of the 20th century, resurfaces in the face of clinical uncertainty and connects, surprisingly with the authors of the 70s who anticipated its dangers for the quality of care, and the allocation of the resources. It compromises the sustainability of the system and harms the individual patient and the group of patients due to overuse and its logical corollary -the underuse of clinically useful therapies-. Criminal law is considered as a driver of these practices among others. By contrast, Health Theory of Justice promotes human rights. Thus, it is necessary to account for the presuppositions of the relational perspective, in particular the meaning of health as a right, capacity and safe functioning; in order to facilitate its comparison and evaluation with defensive practice.

Keywords: Defensive medicine; Health justice; Human capacities; Human rights; Overuse.

Introduction

Defensive medicine which began in the 60´s and 70´s of the 20th century, resurfaces in the face of clinical uncertainty and connects, surprisingly with the authors of the 70´s who anticipated its dangers for the quality of care, and the allocation of the resources. It compromises the sustainability of the health care system and harms both, individual and group of patients. In fact, it can be said that there is no single definition, although some elements have been exposed to define this medical practice as subject, objective, motivation, and purpose (Cruz-Valiño, 2021), despite it is a phenomenon in con-

1 This work is one of the results of the research project witch received an aid from the consolidation and structuring programme for competitive research units: groups with potential of Growth. Ref. ED431B 2017/43. Funding body: Council of Galicia – Office of Culture, Education and University Administration.

tinuous transformation. For this reason, there would be no single definition (Cruz-Valiño, 2019). By the way, Sneyder Sulmasy & Weinberg (2014) offered a simple one:

> "*defensive medicine consists of ordering or avoiding tests or procedures mainly for negligence liability*".

Taking into account this general framework, one can summarize the effects that these medical practices produce in the health care system, as a problem of public health. Thus, defensive medicine shifts the best interest of the patient to a secondary place, raising the interest of the professional to the foreground, with devastating effects for the health care at divers' organizational level:

1) microethics; it compromises the good clinical judgment of the professional, which empties morally and moves away from the internal good of the profession;

2) mesoethics, the quality-of-care decreases; and at the same time, it increases the cost and compromises accessibility, and finally;

3) macroethics, it destroys the trust that society deposits in the medical profession by failing to fulfill the purposes that give it legitimacy social, sacrificing other workings of the system.

In this sense, the key to the vault consists in prescribing many tests, not specific tests, while the response of the Law is insufficient, and even exacerbates the problem, overestimating the chances of success of claims, which influences the clinical decision-making process. On the other hand, it promotes this medical practice with the opportunity cost: 1) overuse, and 2) underuse (clinically useful therapies).

Iatrogenesis as a public health problem

Defensive medicine is fear of iatrogenesis, and excuses itself behind this fear to preserve the safety of the patient. The root that nourishes it is that of fear, as Broggi (2017) explains, sinks its roots

"*in the terrain of the unaccepted part of ignorance, in poorly tolerated uncertainty, in weakness, vulnerability*". Defensive medicine is built on "*it is better to do more than not, just in case*", deviating from prudent practice as an inadequate response to facing error, which increases the risk of iatrogenesis (González López-Valcárcel y Campillo-Artero, 2017: 369).

Also the mis management of information when an adverse event occurs, and the absence of an explanation generates conflicts. Knowing how the negative result occurred is key to the patient's emotional healing process. Unnecessary stigmatization drives this remedy which turns out to be worse than the disease, while avoiding it does not mean indulging in mistakes or negligence, and to a lesser extent enjoying impunity (Catino, 2008). Iatrogenesis

is a public health problem that requires a global approach, not just medical or health. It calls for the active participation of the social sectors, including the legal operator, and assumes that health interventions have advantages and disadvantages and strategies from patient safety that respond to overuse, and even the trivialization of medicine (Lipitz et al, 2017; Segura, 2014; 2018). In a conceptual effort, the Spanish Society for Healthcare Quality (SECA) and the Collegiate Medical Organization (OMC) define defensive medicine "*as a deviation from good medical practice for fear of litigation*", and is emerging as a paradoxical cause of the iatrogenesis intended to prevent: iatrogenic effects cause grievances and promote defensive clinical attitudes that generate further harm.

They take up the meaning of the term "*iatrogenesis*" that the Royal Academy of the Spanish Language (RAE) defines as "*alteration, especially negative, of the patient's state produced by the doctor*", and how Eugen Bleuer (1924) uses it to refer to the symptoms that the therapist induces in a suggestible patient. The etymological root of the Greek *iatros* (doctor) and *genus* (generated) gives an account of the damage caused by the doctor. It introduces some conceptual confusion and adds "*noise to what requires a calm and proactive approach*", not in vain, a pertinent or indicated intervention, properly sought, in a correct dose, can cause an adverse reaction, the result of the pharmacological action primary, or secondary effect (Abraira et al, 2017).

The argument that in medicine "*doing less is more*" is reinforced as a result of the Covid-19 pandemic. Cognitive biases lead to overacting with unproven or off-label therapies and produce more damage, while the rational use of scarce resources is imposed in the face of an emerging disease (Soong et al, 2021).

What is the rol of criminal law?

Criminal law is considered a driver of defensive medicine among others. The progress of science and specialization, and a more intensive medical activity, together with the awareness of patients´ rights, increases the number of cases that go to the criminal order to demand accountability. Thus, the judicialization of medical activity encourages defensive medicine as a self-protective behavior of the professional against the fear of a complaint. The so-called "risk society" or the question of "modernity" updates the problem of professional responsibility, to whose dynamics the order can only respond after a deeper social change. It requires a joint effort; an objective risk assessment and assuming a conception of the reasonable level of professional risk, that society accepts the degree of uncertainty inherent in medicine, and that the Legal Profession assumes its obligation to respect the principle of minimum intervention of criminal law (De Ville, 1998; Gherardi & Gherardi, 2007).

On the basis of human rights, criminal justice is neither the most reaso-

nable nor the most useful solution, except in cases where there is serious and proven medical liability, which fuels the emotional reaction. At the same time, from a consequentialist perspective, the dissuasive value offered by criminal penalties sanctions in preventing incidents is questioned. With this statement, Angelo Fiori synthesizes a kind of "hidden criminal law of danger" (*diritto penale occulto del pericolo*) and according to Fiori and Marchetti (2009:2), in a flexible interpretation of causality and guilt in response to a social pathology that, can be alleviated by reducing incidents (exiological therapy); and with the economic repair of iatrogenic damage (symptomatic therapy). They suggest reconsidering medical liability and seek alternatives, that is, in the civil and administrative order to protect the victims, and a system of solidarity reparation for iatrogenic damage because of medical error.

Maurizio Catino (2011) considers "*necessary to rethink the use of criminal law, promoting a different civic epistemology in the case of accidents caused by involuntary errors",* using Jasanoff's legal arguments (2005) and Andrea Perin (2018) proposes to redefine medical criminal guilt (recklessness) from a comparative perspective.

Health Justice Theory

To unify the defensive medicine analysis with the Health Justice Theory it is appropriate to conceptualize and contextualize the clinical relationship based on rights. In the same way, one can perceive the antinomy between the rights invoked by the clinical relationship based on rights and the collision of rights that are violated through defensive medicine, such as, for example, autonomy.

For this purpose, it is necessary to account for the presuppositions of the relational perspective (meaning of health as a right, capacity and safe functioning); its regulative ideal, which contrasts with that pursued by defensive medicine,its distinctive characters in order to facilitate its comparison with defensive medicine.

1. Presuppositions

In this way, the clinical relationship based on rights responds to the following questions: 1) What does it protect? namely, health, understood here as capacity and safe functioning protected through care; 2) Who does it protect? that is, to which person or subject it is addressed, which will lead to its universal character; 3) How to recognize and guarantee health? from a normative point of view, as an obligation of justice.

José-Antonio Seoane (2019) formulates a theory of health justice that, as a political conception, is supported by philosophical foundations: 1) Theories of recognition, 2) the capabilities approach, and 3) safe functionings, which completes 4) with the theory care policy: its result is a model of social health care limited in aspirations, although accessible, and responsible for

health needs, economically viable and sustainable in line with the inherent purposes.

2. Recognition theories: what person?

Recognition theories constitute the first pillar in a theory of justice in health, in two dimensions:

1) subjective or individual recognition; requires self-identification and acceptance of abilities and attributes, through self-confidence, self-respect and self-esteem, and

2) intersubjective recognition; ratifies the above and implies being recognized by others, necessary to complete one's identity and to recognize oneself.

To broaden the progressively realized goals and to turm them into core obligations reflect the evolution of a society and its legal system towards a fair health care; and converselly; the legally unnaceptable regression or reduction of rithgs to health care illustrates the oposite process. In other words, our relationships in a context of recognition, community and dialogue build, in part, our personality and identity.

Three levels or forms of reciprocal recognition are identified: affections, legal recognition and social esteem. Its denial or contempt raises questions of justice; its recognition, prior to the assignment, improves justice in the distribution (Seoane, 2019) and update other contributions as Nacy Freaser (2008) or Axel Honneth (1997) who considers "reciprocal recognition" essential in the construction of personal identity.

3. The capabilities approach: what does it protect?

Health is valuable insofar as it enables us to pursue vital objectives and interact within the social framework; it is an opportunity or possibility of life, a basic human capacity; providing the means for people to have a realistic choice by choosing between options; and as a basic faculty of free vital configuration, it establishes a *continuum* between capacity, freedom and equality.

Understood as combined capacities, -internal and external to the individual-, they allow each person to define their good from the margin of freedom, that is, being an agent of their life. However, exercising them requires a context: basic conditions of equality that can become funtionings. Human capacities have been grouped into ten categories, including health and its care (Nussbaum, 2012).

Health inequity, or unfair and avoidable differences, is understood from the social determinants of health or conditions in which people are born, grow, live, work and age, as well as the set of social and political structures that shape his life, the economic political system and social policies. They ares considered the cause "of the causes" allows personal health to be the result of the interaction between: 1) endowment and biological needs, 2) individual

behavior, 3) physical environment and 4) social conditions (Seoane, 2016).

The social, plural and suprasanitary dimension of health care considers individual and collective factors: fair health care becomes a public duty and not limited to health care, requiring actions related to other rights.

4. The safe funtioning approach: how to recognize health?

The funtioning indicate what the person "*does or is*". This approach complements that of capabilities (what the person can or is capable of doing and being), and provides a guarantee towards genuine opportunity (or safe funtioning).

It avoids exposure to extreme risks or the sacrifice of other capacities or functions and offers reasonable options to choose and act, counteracting the social disadvantages derived from the lack of internal, external resources or the social framework: a limited number of genuine opportunities for safe funtionings.

Add three categories to the list of basic human capacities, the ethics of caring for language and justice, highlighting the community dimension: 11) Doing good to others, being able to care and express gratitude. 12) Respect and comply with the Law, to be able to live within its limits, without feeling obliged or forced to break the law, to swindle, deceive or defraud people or institutions. 13) Understand the law, the obligations and the rights and powers that it grants, through an accessible legal system (Wolff & De-Shalit, 2007).

In summary, the central objective of this text is to highlight the fundamental difference between the clinical relationship based on rights and defensive medicine practice, putting in danger the health as a human right.

5. The political theory of care

Autonomy needs to be reconsidered as the ability to choose the life project and make decisions in the health field, which is reflected in informed consent. However, it requires a certain society and the support of people and institutions that guarantee its exercise and compensate for limitations. It requires transformative actions that, from equal opportunities, become life possibilities, which are historical, within the framework of a reflective interdependence, of independent practical reasoners (MacIntyre, 1999).

A conscious independence of vulnerability, fragility and dependence, a vault key built on the recognition of dependence, which takes charge of the human condition, and harmonizes autonomy and independence; that is, the free exercise of powers to manage vulnerability and dependency with support. Human beings are dependent to develop their basic capabilities, and the way they are cared for they have an obligation to care.

Caring is not a good defined by the market, nor can it be understood as an attitude of gratitude or generosity. It becomes a political responsibility, and as a universal necessity, philosophically elevated to capacity, it becomes

a question of justice demandable by anyone. Understood as a right (entitlement) it allows to speak of rights of care; 1) right to receive care, 2) right to care, 3) right to decide how to care and be cared for (Seoane, 2019).

As it can be seen, that author completes this theory of justice 4) with the theory care policy: its result is a model of social health care limited in aspirations, although accessible, and responsible for health needs, economically viable and sustainable in line with the inherent purposes.

Conclusions

Throughout this work, it has been sought, in the first place, to demonstrate how defensive medicine is a problem of public health. It compromises the sustainability of the health care system and harms (both individual and group of patients). It shifts the best interest of the patient to a secondary place, raising the interest of the professional.

Defensive medicine which began in the 60s and 70s of the 20th century, resurfaces in the face of clinical uncertainty and connects, surprisingly with the authors of the 70s who anticipated its dangers for the quality of care, and the allocation of the resources. In this sense, as it can be seen, defensive medicine is built on it is better to do more than not, just in case, deviating from prudent practice as an inadequate response to facing error, which increases the risk of iatrogenesis.

Criminal law is pointed out as a driver of defensive medicine among others. In this sense, criminal justice is neither the most reasonable nor the most useful solution. After criticizing and challenging the positive basis of criminal law, the question that remains is how to substantiate them. One solution is to reconsider medical liability and seek alternatives (in civil and administrative order to protect victims, and a system of solidarity reparation for iatrogenic damage) even to redefine medical criminal culpability (recklessness) from a comparative perspective. The scope of the discussion developed by criminal authors cannot be adequately summarized in this work. However, the first assumption presented here is that legal positivism is insufficient to defend human rights.

By contrast, Health Theory of Justice promotes human rights. Thus, to unify the analysis of defensive medicine with the clinical relationship based on rights, it is necessary to account for the presuppositions of the relational perspective, in particular the meaning of health as a right, capacity and safe functioning; in order to facilitate its comparison and evaluation with defensive practice the option is a case for a rights-based theory for health care justice.

Based on a biopsychosocial concept of health and a relational concept of human being, authors have made a case for a rights-based theory for health care justice, underpinned by a political conception of health care and three philosophical supports: 1) the theories of recognition, 2) the capabilities approach, 3) the secure functioning approach. It is completed 4) with the

theory care policy: The result is a finite model of health care: limited in aspitions, economically more plausible, responsive to our need of Good health, with affordable, accessible, and sustainable health care goals.

References

ABRAIRA, Víctor, et al. **Documento del grupo de trabajo SESPAS-OMC sobre iatrogenia**. FEM: Revista de la Fundación Educación Médica, 2017, vol. 20, no 6, p. 255-264.

BROGGI, Marc Antoni. "Medicina defensiva o miedo a la responsabilidad". In **Iatrogenia y medicina defensiva** (p. 44-53). Barcelona: Fundació Víctor Grífols i Lucas, 42, 2017.

CATINO, Maurizio. **A review of literature: individual blame vs. organizational function logics in accident analysis**. Journal of contingencies and crisis management, 2008, vol. 16, no 1, p. 53-62.

CATINO, Maurizio. **Why do Doctors practice defensive medicine? The side -effects of medical litigation.** Safety science monitor, 2011, vol. 15, no 1, p. 1-12.

CRUZ-VALIÑO, Ana Belén. **Medicina defensiva: significado vs medición**. Anales del Sistema Sanitario de Navarra; 2019, vol. 42(1), p. 109-111.

CRUZ-VALIÑO, Ana Belén. **Medicina defensiva: aproximación conceptual**. Ed. Comares, 2021.

DE VILLE, Kenneth. **Act first and look up the law afterward?: medical malpractice and the ethics of defensive medicine.** Theoretical Medicine and Bioethics; 19(6), 569-589. 1998.

FIORI, Angelo & MARCHETTI, Daniela. **Medicina Legale de la responsabilità medica**. Milano: Giuffrè. 2009.

FRASER, Nancy. **La justicia social en la era de la política de identidad: redistribución, reconocimiento y participación**. Revista de trabajo, 2008, vol. 4, no 6.

GHERARDI, Carlos R.; GHERARDI, Natalia. **La judicialización del acto médico y la generación de nuevos conflictos.** Medicina (Buenos Aires), 2007, vol. 67, no 5, p. 502-510.

GONZÁLEZ LÓPEZ-VALCÁRCEL, Beatriz; CAMPILLO-ARTERO, Carlos. **La prevención y el control de la iatrogenia requieren varios frentes y alianzas. SESPAS llama a la colaboración**. 2017.

HONNETH, Axel. **La lucha por el reconocimiento**. Barcelona: Crítica. 1997.

JASANOFF, Sheila. **Restoring reason: Causal narratives and political culture**, Organizational encounters with risk. Cambridge University Press. 2005, p. 209-232.

LIPITZ-SNYDERMAN, Allison; KORENSTEIN, Deborah. **Reducing overuse—is patient safety the answer?.** Jama, 2017, vol. 317, no 8, p. 810-811.

MACINTYRE, Alasdair C. **Dependent rational animals: Why human beings need the virtues.** Open Court Publishing, 1999.

NUSSBAUM, Martha Craven; MOSQUERA, Albino Santos. **Crear capacidades**. Madrid: Paidós, 2012

PERIN, Andrea. **La redefinición de la culpa (imprudencia) penal médica ante el fenómeno de la medicina defensiva. Bases desde una perspectiva comparada**. Política criminal, 2018, vol. 13, no 26, p. 858-903.

REAL ACADEMIA DE LA LENGUA ESPAÑOLA (RAE). Royal Academy of the Spanish Language. Concept "iatrogenesis".

SEGURA, Andreu. **Prevención, iatrogenia y salud pública.** Gaceta Sanitaria, 2014, vol. 28, no 3, p. 181-182

SEGURA, Andreu. **El sistema sanitario, la atención primaria y la salud pública**. Atención Primaria, 2018, vol. 50, no 7, p. 388-389.

SEOANE, José-Antonio. **El derecho a una capacidad de salud segura**. Ius et scientia; 2016, 2(2), p. 42-53.

SEOANE, José-Antonio. **"Health Justice & Rights".** A cura di S. Salardi e M. Saporiti. In **Le tecnologie "morali" emergenti e i diritti fondamentali in Europa**. p. 30-42. Politeia. Anno XXXV, núm. 133, 2019.

SNEYDER Sulmasy, L. & WEINBERG, Steven E. **Better care is the best defense: high-value clinical practice vs defensive medicine.** Cleveland Clinic journal of medicine; 2014, 81(8), p. 464.

SESPAS y OMC. Sociedad Española de Salud Pública y Atención Sanitaria y Organización Médica Colegial. **Informe sobre la iatrogenia** 2017. Acessivel in: < http://sespas.es/2017/09/06/presentacion-del-informe-sespas-omc-sobre-iatrogenia >.

SOONG, Christine; BORN, Karen B.; LEVINSON, Wendy. **Less is more, now more than ever**. BMJ Quality & Safety, 2021, vol. 30, no 1, p. 56-58.

WOLFF, Jonathan & DE-SHALIT, Avner. **Disadvantage**. Oxford: Oxford University Press: Oxford Scholarship Online, 2010.