

ORIGINAL ARTICLE

Views of healthcare consumer representatives on defensive practice: 'We are your biggest advocate and supporter... not the enemy'

Nola M. Ries PhD, LL.M, MPA, JD, BA (Hons), Professor¹  |

Briony Johnston BComm/BLaws (Hons), PhD candidate, Research Assistant¹ |

Jesse Jansen PhD, MA²

¹Faculty of Law, Law Health Justice Research Centre, University of Technology Sydney, Sydney, New South Wales, Australia

²Faculty of Health, Medicine and Life Sciences, School for Public Health and Primary Care, Maastricht University, Maastricht, The Netherlands

Correspondence

Prof. Nola M. Ries, PhD, LL.M, MPA, JD, BA (Hons), Faculty of Law, Law Health Justice Research Centre, University of Technology Sydney, PO Box 123, Broadway, Sydney, NSW, Australia.
Email: nola.ries@uts.edu.au

Funding information

Avant Foundation

Abstract

Background: The patient–clinician interaction is a site at which defensive practice could occur, when clinicians provide tests, procedures and treatments mainly to reduce perceived legal risks, rather than to advance patient care. Defensive practice is a driver of low-value care and exposes patients to the risks of unnecessary interventions. To date, patient perspectives on defensive practice and its impacts on them are largely missing from the literature. This exploratory study conducted in Australia aimed to examine the views and experiences of healthcare consumer representatives in this under-examined area.

Methods: Semi-structured interviews were conducted with healthcare consumer representatives involved in healthcare consumer advocacy organisations in Australia. Data were transcribed and analysed thematically.

Results: Nine healthcare consumer representatives participated. Most had over 20 years of involvement and advocacy in healthcare, including personal experiences as a patient or carer and/or formal service roles on committees or complaint bodies for healthcare organisations. Participants uniformly viewed defensive practice as having a negative impact on the clinician–patient relationship. Themes identified the importance of fostering patient–clinician partnership, effective communication and informed decision-making. The themes support a shift from the concept of defensive practice to preventive practice in partnership, which focuses on the shared interests of patients and clinicians in achieving safe and high-value care.

Conclusion: This Australian study offers healthcare consumers' perspectives on the impacts of defensive practice on patients. The findings highlight the features of clinician–patient partnership that will help to improve communication and decision-making, and prevent the defensive provision of low-value care.

Patient or Public Contribution: Healthcare consumer representatives were involved as participants in this study.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2021 The Authors. *Health Expectations* published by John Wiley & Sons Ltd.

KEYWORDS

defensive practice, healthcare consumer, interview, low-value care, partnership, patient, qualitative

1 | INTRODUCTION

The patient–clinician interaction is a site at which defensive practice can occur, when clinicians provide tests, procedures and referrals to reduce perceived medico-legal risks, such as complaints and litigation.¹ Clinicians see this practice as legally protective,² yet it drives low-value care of no or little benefit.³ Defensive practice falls afoul of ethical obligations by prioritizing professionals' self-interests over patients' interests, exposing patients to avoidable harms and misallocating scarce healthcare resources.^{4,5} Patients and clinicians are recognized as important partners in addressing low-value care,⁶ and involving patients in initiatives to promote healthcare safety and reduce avoidable harms has been described as a 'moral imperative'.^{7(p.77)} However, clinicians' anxieties about legal risks can undermine this by fuelling 'hostile attitudes, such as viewing patients chiefly as potential complainants, not as partners in a therapeutic relationship'.^{1(p.7)}

Empirical research has focused on healthcare professionals who widely report defensive behaviours across higher-income countries in North America, Europe, the Middle East and Asia Pacific.^{1,8} Discussion of ways to reduce defensive practice often focuses on legal reforms,⁹ yet legislative and policy changes targeted at the legal risk environment for clinicians have had, at best, modest impacts on defensive practice.¹⁰ The growing deimplementation literature urges that '[p]atients are directly involved in and impacted by low-value care and may play a pivotal role in solutions to reduce its use'.¹¹ Likewise, patients' experiences and expectations are part of the puzzle in understanding defensive practice and optimizing the clinician–patient interaction to reduce medico-legal risks and low-value care.

However, patient perspectives on defensive practice and its impacts on them are largely missing from the literature. A recent Italian study used 1-hour interviews with five physicians and 20-minute interviews with 15 patients to explore dynamics within the doctor–patient relationship.¹² The results described four relationship archetypes and the implications for defensive practice. A British study of defensive practice in obstetric care appeared to include patient perspectives; the article stated the views of three consumer representatives were sought in addition to midwives and medical specialists, however, the published data only reported the professionals' comments.¹³

Given the dearth of patient-focused research on defensive practice, we undertook an exploratory qualitative study to investigate the perspectives of healthcare consumer representatives in Australia. Medical professionals were also interviewed as part of a broader project on defensive practice and low-value care. Results from doctors' interviews are reported separately.

2 | METHODS

Our methodological description is guided by the Consolidated Criteria for Reporting Qualitative Studies (COREQ).¹⁴

2.1 | Study design

This study uses a qualitative descriptive design, a suitable method when researchers aim to present 'straightforward descriptions of experiences and perceptions, particularly in areas where little is known about the topic under investigation'.^{15(p.444)} The study was approved by the University of Technology Sydney Human Research Ethics Committee (Ref No. ETH18-2985).

2.2 | Participants

Healthcare consumer representatives were recruited by invitation notices shared through national and state-based healthcare consumer advocacy organisations, such as the Consumers Health Forum of Australia. These organisations support the aims of Choosing Wisely Australia, a national initiative that encourages healthcare organisations and consumer groups to question and reduce unnecessary tests, treatments and procedures. The invitation defined defensive practice and its connection to low-value care, and sought insights from consumer representatives, especially those with interests or experience in matters related to improving healthcare quality and safety. This convenience sampling approach enabled us to reach informants with relevant knowledge and experience in relation to the study aim. Interested individuals contacted the research team.

2.3 | Data collection

The lead author (N. R.) conducted semi-structured interviews with nine healthcare consumer participants in October–November 2019. Eight interviews were conducted by tele- or web-conference and one person chose to be interviewed in person at a university campus. Interviewees gave verbal consent to participate, including consent to audio-recording and transcription. The interviews averaged around 60 minutes.

The interviews explored participants' views and experiences on the following topics: patient awareness of defensive practice; impact of defensive practice on the clinician–patient relationship; patient attitudes and expectations; and patient involvement in solutions to defensive practice. At the start of the interview, defensive practice

was defined as including doctors ordering tests and procedures, making referrals and prescribing medication mainly to reduce perceived legal risks, such as complaints or lawsuits.

2.4 | Data analysis

Thematic analysis was used to describe and interpret the data.¹⁶ Two authors (N. R. and B. J.) independently read each transcript to identify the main themes across participants' responses to the four interview topics. This analysis was then compared and discussed and an iterative writing process was used to prepare a descriptive account of the themes, remaining intentionally close to the participants' own words, consistent with our qualitative method.¹⁷ Exemplar quotations were selected to illustrate the main points. The third author (J. J.) reviewed and commented on this analysis. All authors participated in the interpretation of the results to reflect on their broader implications, which informs our discussion of themes in connection with literature on defensive practice, medical overuse and patient-centred care.

3 | RESULTS

Interviews were conducted with nine participants, aged from 29 to 70 years. Most ($n = 6$) were aged 45–59 years and reported over 20 years of involvement and advocacy in healthcare. This included personal experiences as a patient or carer for a person with chronic illness and formal service roles on committees or complaint bodies for healthcare organisations. Eight participants were female, one was male, and all reported university degrees. Participants were from six of Australia's eight states and territories. This was an experienced group of informants and, given the specific focus of the study on a medico-legal topic, our targeted recruitment strategy through consumer advocacy organisations, and the in-depth interviews, adequate informational power for our study aim was attained with this sample size.¹⁸

3.1 | Patient awareness of defensive medical practice

Participants were of the view that, in general, many patients would not think their doctors provide low-value care as a form of legal self-protection. One participant stated most patients 'think doctors do no harm and that they're experts, and they [patients] want to put their care in the hands of the experts'. (P6) Similarly, another participant felt a 'majority [of patients] would be surprised' that doctors engage in defensive practice, thinking instead that if a test or procedure is ordered, 'the doctor would do it for health checking, safety reasons, rather than for protection against complaints'. (P3)

Most interviewees had not heard of the specific term 'defensive practice'; however, several reflected on their own healthcare

experiences and situations they felt were examples of defensive behaviour. These included referrals to specialists perceived as unnecessary, so-called 'routine' tests or observations, and consent documents that interviewees felt were written in legalistic language. Several interviewees described situations where they advocated for themselves to decline proposed tests, treatments or procedures they considered unnecessary (P3, P4, P7, P9):

I've rarely had that [wait and see] approach from a medical practitioner or my GP, let's just see how it goes. They have been, in the manner of defensive medical practice, keen to do something. Before we meet next, we have to have some test or some quantitative number to look at... I myself have been the one normally who has sided with [the approach of] no, let's sit back and see how it goes. (P9)

Sometimes the best thing is to say [to the doctor], no thank you, we don't want that test. Or if that's not going to change what you're going to be doing, then don't do it. (P4)

3.2 | Impact of defensive practice on the clinician–patient relationship

Participants uniformly viewed defensive practice as having a negative impact on the clinician-patient relationship: 'It's not going to deliver the best health outcome if a doctor feels that they have to practice defensively as opposed to practising in the patient's best interests...' (P2) Practising defensively implies 'an antagonistic relationship instead of a partnership relationship. ... I'm concerned that once you have a litigation sort of frame, it's not really the right frame for a therapeutic human relationship'. (P8) Good care is 'not about care to a patient, it's care *with* a patient. It's a very different thing'. (P4)

Participants called for a partnership involving a sharing of expertise, where the patient is recognized as 'the expert in themselves ... helping them [doctors] do their job ... It's supposed to be relationship-based care with two-way respect'. (P6) Several participants (P4, P6, P8, P9) pointed out that patients have the biggest stake in their own health and wellbeing; clinicians should recognize and build on this as an asset:

"View your patient [as] the biggest advocate ... because who's got the biggest incentive to ... avoid low quality care and have high value care? Who of anybody in the system, who has the most to gain and the absolute most to lose? It's your patient and [their] family. So, we are your biggest advocate and supporter ... not the enemy, not the hostile [person] that has to be managed ... and defensively engaged with. If you communicate well and bring us along the journey ... to

make good, informed decisions ... then we will be the biggest supporter for" high value care. (P4)

Participants also commented that defensive practice focuses on legal risk management rather than patient safety and clinical best practices: 'It's not patient safety at the top [of clinicians' priorities], it's risk at the top so it's not a good thing... Overwhelmingly I can't see that defensive medicine's going to have a positive effect, I think it's going to have a negative effect'. (P8) Another participant stated: 'They [doctors] talk about clinical evidence and the best practice and the needs of the individual. I think all of that goes out the window really when [they're] worried' about legal risks. (P1)

Another interviewee described the difference between a conversation driven by defensiveness and a conversation to engage the patient as an informed participant in their own care:

That means you [the doctor] work with the level of health literacy with that patient and you have a conversation that does require the doctor to explain why they're doing something and the thoughts and rationale. Not because they're defensive and trying to cover their butt, but because ideally that conversation is driven by informing, helping ... the patient to get a better outcome, that you have a patient that understands what is happening to them or what the recommended treatment is and why, and you're together working out a plan. (P4)

Participants expressed concern about the burdens of unnecessary or low-value care, including out-of-pocket costs, time demands on patients and their family members or carers, and ongoing worry. In the words of one participant, the harms include: 'a waste of time, a waste of money ... anxiety that is still not alleviated by having the tests done, because they are still in that situation where the doctors can't give them an answer as to why they are experiencing the symptoms that they are'. (P2)

3.3 | Patient attitudes and expectations

Participants were asked for their views on the role of patient demand and intolerance of uncertainty as triggers for defensive practice. Interviewees commented on patient expectations that a medical visit will result in 'some kind of intervention' (P3), such as a prescription, pathology testing, scans or a specialist referral, which may drive low-value care. Participants described societal forces that shape patients' attitudes and expectations, including the internet:

Consumers are way more informed and misinformed than what they were many years ago. ... Through social media they are bombarded with stuff. There's always stories about someone who ended up being really ill or died ... because they weren't diagnosed. I

think consumers nowadays are bombarded with it, so there is a problem with people thinking that the least little thing means something terrible. (P2)

This factor is intensified by a cultural expectation of 'instant gratification ... wanting an instant answer' (P6), which can also influence health professionals' attitudes: doctors 'think most people turn up, it's easier to give them a script, they probably want a script'. (P7) Several participants (P2, P3, P5, P9) elaborated on additional health system drivers of low-value care, including financial incentives for healthcare providers and a perceived proliferation and fragmentation of healthcare services. For example, one participant commented on practitioner over-supply as a driver of unnecessary interventions: 'surgeons sitting around doing nothing who want to cut your knee open...'. (P9) Another participant recounted experiences where allied health professionals recommended interventions that medical professionals did not endorse and commented: 'There needs to be consistency across the messaging and the explanations from all of the [providers] that a consumer is dealing with for their health condition'. (P2)

Participants commented that doctors have a responsibility to inform and educate patients and to address unrealistic or inappropriate expectations. Doctors who defensively give patients low-value care were seen as reinforcing skewed expectations that a medical visit will culminate in an order for pathology testing, a specialist referral or a prescription. One participant made an analogy: 'It's a little bit like a parent having spoilt a child ... then just going, "Well this child, I can't manage their expectations"'. (P8) This participant urged doctors 'to build that trust [with patients] and have those conversations about why they're not going to do things - it's not fun and it's not easy - but again I would contend it's part of the much needed process of [encouraging] higher health literacy in our population'. (P8)

It was also suggested that these conversations need to address diagnostic uncertainty, a situation that can provoke defensive practice. One participant noted that being upfront about the harms of low-value care could clarify the reasons in favour of tolerating uncertainty for a period of time:

sometimes waiting and seeing ... [and having] uncertainty might be the best course of action so that we don't put you through unnecessary testing ... because it could just make things even more grey. ... We could actually cause you more harm [including] psychological harm and not actually change how we would be treating the symptoms that you have. (P4)

Openness about uncertainty can provide peace of mind for patients: 'We can sleep at night and know we're fully informed and all on the same page, accepting the risks because of that open, honest, transparent conversation that wasn't defensive'. (P4) It is also 'an investment in health literacy that will actually pay off. You're going to have an informed patient'. (P4) Building a relationship through

effective communication also reduces doctors' legal risks; one interviewee commented 'the more relationship-based care that they [doctors] offer, that not only are there better outcomes for the patient, but the less chance of being sued'. (P6)

3.4 | Consumer involvement in solutions to defensive practice

As experienced healthcare consumers, participants described practical strategies to ensure clinical encounters are effective, efficient and support the development of a therapeutic partnership that avoids defensive provision of low-value care. Suggested strategies included preparing a plan for the conversation with the doctor, including a diary or summary of symptoms/concerns and any care received from other practitioners. This approach 'means you have a much better dialogue and you actually talk about the most important thing'. (P4) Several participants (P1, P4, P6) said they check online health record systems (e.g., in Australia, the 'My Health Record' system) to ensure information is up to date and accurate. For complex health concerns, booking a longer appointment or two appointments to allow time to reflect on information, were other strategies that participants valued.

While describing their own development as empowered and proactive healthcare consumers, participants noted some patients may not have the knowledge, confidence or skills needed to support that kind of relationship:

It comes back to how much knowledge the consumer has to lend to the discussion ... [to] have a better conversation with your GP, better relationship in assessing this [low value care]. But I tend to think a lot of consumers don't. They just take what they're offered, from the experts so to speak. (P9)

Participants also noted that medical appointments can be stressful, especially when patients are unwell or in pain, and this hinders effective communication and patient recall (P3, P5, P7, P8). They agreed written resources help to improve the quality of the discussion, including a list of question prompts to discuss with the care provider, patient-oriented brochures and websites, and the clinician providing a brief written summary for the patient: 'the doctor makes dot points about what the problem is, and if there's no intervention, the last dot point will be, what to do if there is no change or it gets worse'. (P3)

To support patient education and health literacy, several participants (P4, P7, P8) advocated for new or expanded practitioner roles, such as nurse-led clinics and health educator roles:

I firmly believe there are new roles in our health system that will start to emerge that will help provide better patient outcomes and better patient experiences that don't currently exist ... an investment in

new and expanded roles... would be significantly cheaper than your heavily educated, long-term trained doctor or even nurse that should start to evolve in the health system to have these conversations. (P4)

The opposing view was that this is core to doctors' role: 'if doctors really are engaging, practising and improving their communication ... that's probably a better strategy [than] involving another clinician' or new role. (P3)

Several participants (P1, P4, P7, P8, P9) recommended peer supporter or advocate roles, especially to help people with complex conditions navigate healthcare systems:

I don't think there's any substitute for the peer and somebody who's had that disease who can talk people through what the options really are ... sharing the power, sharing the expertise ... [like] somebody having a diagnosis of cancer and being with somebody who's been cancer free for 10 years with the same cancer but [who] knows exactly what it feels like when you are facing all those tests and treatment... (P8)

Participants discussed the importance of processes to raise concerns or make complaints. These were perceived as opportunities for learning and improvement: 'It's disappointing that complaints are seen in such a negative way [by practitioners] because complaints of course are the bedrock of quality and safety improvements'. (P8) However, processes need to be fair, transparent and open, and ensure both patients and doctors are supported, such as via access to a peer support person. From a patient perspective, participants described desirable outcomes from complaint processes, including: practitioners taking responsibility for identified problems and not trying to deflect blame; apologies; and follow-up information about steps taken to ensure similar problems do not occur in the future:

Unless it's a major, major problem, I think a lot of the time you just want an apology ... and you don't want it to happen to somebody else. (P7)

I have no way of knowing whether anything that we asked for [in complaint resolution meetings] has ever happened. ... They said they would do it, but I have no way of knowing. ... I think if there could be more ... open communication and discussion and ... feedback to the patient about ... what's changed. (P1)

Several participants (P2, P6, P8) also commented on broader strategies to support health literacy in communities and ensure consumers have access to high quality, reliable information. Suggestions included more transparent reporting of safety, quality and performance data from healthcare organisations and stronger regulation of sources of health misinformation.

4 | DISCUSSION

Current literature on reducing medical overuse calls for patient-centred approaches, recognizing the clinician–patient interaction is where decisions to engage in or avoid low-value care are made.^{6,11} Legal defensiveness is a factor in this interaction and clinicians' anxieties about medico-legal risks can stymie efforts to reduce unnecessary tests and procedures. For example, some clinicians perceive that following professionally developed guidelines to reduce low-value care will increase patient complaints or other legal risks.^{19,20} However, defensive practice can invite such problems by exposing patients to the harms of low-value interventions.⁴ Defensive practice pursues false reassurance and induces a 'more is better' mindset that drives overdiagnosis and overtreatment.²¹ It diverts the clinical consultation to tests and treatments and shirks conversations about options that may include tolerating a period of uncertainty to wait and see how symptoms evolve. The cumulative effect is to diminish patient trust.^{22(p.168)}

The healthcare consumer perspectives from this study reinforce these critiques. Participants concurred that the adversarial concept of defensive practice works against a therapeutic relationship. The findings add to the dialogue on patient-centred approaches in the deimplementation of low-value care. In particular, the themes support a shift from the concept of *defensive* practice to *preventive* practice (see Figure 1), which seeks to *prevent* patient dissatisfaction, complaints and litigation by fostering partnership, communication and informed decision-making. Preventive practice focuses on the shared interests of patients and healthcare professionals to coproduce safe and high-value care.^{12,23}

4.1 | Partnership

Our participants emphasized the importance of a therapeutic partnership between clinicians and patients. The findings resonate with the concept of the 'expert' or 'involved' patient, which recognizes patients' expertise in their own life circumstances, body, symptoms, values, goals and risk tolerances.^{24,25} Education and support to build patients' health literacy and confidence can enable 'active engagement and empowerment of patients in the planning and provision of their care', especially when living with a chronic condition.^{26(p.2617)} However, health professionals' views on the 'involved' patient vary; one clinician may consider such a patient as confident, informed and resourceful, while another may see warning signs of a potential

litigant: 'the demanding patient, the unreasonable patient, the time-consuming patient, or the patient who knows it all'.^{27(p.723)}

But from a legal and ethical perspective, patient involvement in informed decision-making is vital. The extent of the involvement needs to be tailored to the preferences and abilities of the individual patient.^{28,29} As our participants noted, patients' stake in their own health should be recognized as an asset to develop to improve engagement and outcomes. Batalden et al.²³ highlight how this asset-focused approach supports an effective patient–clinician partnership and Sutton et al.^{7(p.77)} observe: 'Patients can become experts in their own conditions, are highly motivated to ensure a good outcome, and are the only people who are present at all stages during the provision of care...'

Moreover, the relationship between clinicians and patients rests on a foundation of informed decision-making, meaning patients need comprehensible information to make choices about their care. Authoritative court rulings and professional codes of conduct emphasize these points.³⁰ For example, the Medical Board of Australia's professional code for doctors states: 'Relationships based on respect, openness, trust and good communication will support you to work in partnership with your patients'.³¹ Deficiencies in these relationship dimensions are commonly at the root of patient dissatisfaction and complaints,^{32,33} so a focus on building relationships will do more to reduce medico-legal risks than the defensive provision of low-value tests and treatments.

4.2 | Effective communication, questioning low-value care and managing uncertainty

Effective communication within the clinician–patient relationship is key to preventive practice, as it overcomes flaws in consent processes³⁴ and facilitates patients' rights to make informed choices. Importantly, effective conversations and decision-making must take account of the risks of tests and procedures, including emotional, financial and physical burdens. Both patients and clinicians are influenced by cognitive biases that focus attention on rare but devastating reports of delayed diagnoses, which leads to unnecessary tests and treatments.^{35,36} Evidence of the harms of overuse and patient stories of these harms may help to shift these biases^{3,35} and ensure clinicians and patients have 'a clear understanding of all the downsides of overuse [in order to] contribute fully to decisions about the care they deliver or receive...'^{3(pp.3–4)}

Our study participants reflected on the factors that influence a 'more is better' mindset, recognizing that patient 'demand' does not



FIGURE 1 Shifting from defensive practice to preventive practice

simply come into being but originates within a social ecology. Providing low-value care—motivated by legal defensiveness, acquiescence to inappropriate requests or other drivers—reinforces biases toward medical overuse. Prior research indicates mismatches between the expectations and preferences of patients and the perceptions of clinicians. For example, 'clinicians often perceive patient demand where it does not exist', or that patients value a prescription or procedure more than a discussion to explain, advise and reassure.^{37(p.280)} Our participants placed value on open conversations about care options, including the option of watchful waiting, and how to manage the uncertainty of unexplained symptoms. Similarly, participants in an American study of public views on low-value care 'expected that spending less time ordering and reading tests would allow clinicians more time to talk with their patients ... [and] encourage discussion of the benefits and limitations of each approach and greater acknowledgment of clinical uncertainty'.³⁸

Clinicians may justify defensive practices as being of some therapeutic value to patients by assuaging their anxiety.^{36,39} However, our findings underscore that diagnostic investigations can make patients' situations 'even more grey' by inducing anxiety rather than providing reassurance, particularly for patients with a low probability of having a serious illness.^{40,41} Reassurance may instead be achieved through a multistep process of communication and trust-building, where the rationale, risks and potential benefits of tests or procedures are discussed, and the clinician actively listens to and acknowledges the patient's concerns.^{42,43} Our participants offered practical suggestions for high quality, time-efficient conversations and safety netting practices so patients know what to do if their symptoms persist or worsen.⁴⁴ An informed 'wait and see' approach strikes 'a middle ground between immediate acquiescence [to low value care] and flat denial of requests, consistent in spirit with the broader, patient-centred communication paradigm'.⁴⁵

Building patients' knowledge and confidence to be involved in their care, understand their options and make informed decisions, does not just have to be the task of time-pressed clinicians. Patient-targeted educational resources, decision aids and peer supporters can strengthen health literacy, provide reassurance, and support informed and shared decision-making to help avoid overuse.^{11,46} Beyond the clinical relationship context, well-designed public information campaigns can assist in improving health literacy and raising awareness of low-value care.⁴⁷ Tackling the pernicious impacts of health-related mis- and disinformation, particularly disseminated through online sources, may require further intervention through consumer protection regulation and enforcement.^{48,49}

4.3 | Safe and high-value care

A preventive practice approach prioritizes patient safety and seeks to avoid the risks of low-value tests, treatments and procedures. Our participants noted that avenues for patients to raise concerns or make complaints are valuable to support safety and quality improvements. Managing these processes effectively is important in

meeting the needs and expectations of patients and reducing negative impacts for clinicians. In particular, doctors report that poor experiences in complaint processes heighten their medico-legal anxieties, which drives their propensity to engage in future defensive practice.⁵⁰

Research on healthcare consumers' views and experiences in relation to adverse events and complaint processes identifies the importance of open communication, apologies, corrective actions and follow-up with consumers to explain patient safety outcomes.^{51,52} Our findings reinforce these points. As a component of preventive practice, timely and effective disclosures and apologies can build trust with patients and avoid the escalation of legal actions.^{53,54} A recent systematic review highlighted defensive attitudes and blame-oriented cultures as barriers to desired communication and responses to adverse events.⁵⁵ Facilitators for optimal practices included training for clinicians and organisational changes to promote cultures of openness and transparency. These recommendations are equally salient to support a shift from defensive to preventive practice.

4.4 | Limitations

The informants for this study were experienced healthcare consumers with patient advocacy perspectives. A limitation of our convenience sample is that they were mainly female, with university education, high English language fluency and strong health literacy. Their views may differ from less experienced patients with lower levels of education and health literacy. The sample size was small but adequate to provide informational power for our exploratory qualitative study, in line with contemporary research methods guidance.^{18,56} Our findings reflect consumer experiences in a high income, Western country.

4.5 | Opportunities for research

This study begins to fill a gap in understanding healthcare consumer perspectives on defensive practice, its impact on the clinician–patient relationship and its contribution to low-value care. Shared themes were clear from the data and offer insights from the perspectives of consumers who have experienced a journey of becoming actively engaged in their own care, as well as in advocacy roles. Given the key theme of relationships based on partnership, future research is recommended that jointly involves clinicians and patients to better understand their attitudes, behaviours and preferences in relation to defensive and preventive practices. Codesign approaches will provide opportunities for partnering with patients in research activities.⁵⁷

Purposive sampling in future research is recommended to gain perspectives from participants with diverse characteristics and experiences, such as patients from culturally and linguistically diverse backgrounds, patients with varying levels of education and health literacy, and patients receiving care in different settings (e.g., general practice, emergency departments).

Low-value care is recognized as a global problem, but limited research investigates defensive practice in middle- and low-income countries.^{58,59} Future research would be beneficial to understand clinician and patient experiences beyond those that have largely been studied in higher-income countries.

5 | CONCLUSION

Despite its reported prevalence, defensive practice is not in patients' interests and involves behaviours that can increase, rather than reduce, medico-legal risks.^{4,5} Our study adds the views of healthcare consumers who articulated the negative impacts on patients. Indeed, patient perspectives have challenged 'traditional tort reform advocacy [that] pits consumers and providers against each other as if we were enemies'.^{60(p.22)} Likewise, our participants emphasized the features of clinician–patient partnership that will help to improve communication and decision-making, as well as prevent the defensive provision of low-value tests and treatments. Efforts to support patient involvement in their care are 'often viewed as challenging, time-consuming, and potentially costly'; however, Sypes et al.'s^{11(p.11)} analysis showed 'the ensuing reductions in low-value care make tackling these challenges worthwhile'. In turn, reducing low-value care can also reduce medico-legal risks. Instead of defensive practice, preventive practice aligns the values and interests of clinicians and patients to achieve safe and quality care. Ultimately, prevention is the best form of defence.

ACKNOWLEDGEMENTS

This study reported in this paper was supported with funding from the Avant Foundation. The authors thank all participants who generously volunteered their time to be interviewed and the organisations that assisted with recruitment. The authors are grateful to Charles Hacker for research assistance during the recruitment phase of the project.

CONFLICT OF INTEREST

The authors declare that there are no conflict of interests.

ETHICS STATEMENT

This study was approved by the University of Technology Sydney Human Research Ethics Committee (Ref No. ETH18-2985).

DATA AVAILABILITY STATEMENT

Research data are not shared due to privacy/ethical reasons.

ORCID

Nola M. Ries  <https://orcid.org/0000-0002-5264-6722>

REFERENCES

- Ries NM, Jansen J. Physicians' views and experiences of defensive medicine: an international review of empirical research. *Health Policy*. 2021;125(5):634–642. doi:10.1016/j.healthpol.2021.02.005
- Kachalia A, Mello MM. Defensive medicine—legally necessary but ethically wrong? inpatient stress testing for chest pain in low-risk patients. *JAMA Intern Med*. 2013;173(12):1056–1057.
- Brownlee SM, Korenstein D. Better understanding the downsides of low value healthcare could reduce harm. *BMJ*. 2021;372:n117. doi:10.1136/bmj.n117
- Bester JC. Defensive practice is indefensible: how defensive medicine runs counter to the ethical and professional obligations of clinicians. *Med Health Care and Philos*. 2020;23(3):413–420. doi:10.1007/s11019-020-09950-7
- Healey B, Kopen D, Smith J. Physicians, defensive medicine and ethics. *Acad Health Care Manag J*. 2011;7(1):59–78.
- Morgan DJ, Leppin AL, Smith CD, Korenstein D. A practical framework for understanding and reducing medical overuse: conceptualizing overuse through the patient–clinician interaction. *J Hosp Med*. 2017;12(5):346–351. doi:10.12788/jhm.2738
- Sutton E, Eborall H, Martin G. Patient involvement in patient safety: current experiences, insights from the wider literature, promising opportunities? *Public Manag Rev*. 2015;17(1):72–89. doi:10.1080/14719037.2014.881538
- Rinaldi C, D'Alleva A, Leigh F, et al. Defensive practices among non-medical health professionals: an overview of the scientific literature. *J Healthc Qual Res*. 2019;34(2):97–108. doi:10.1016/j.jhqr.2018.12.005
- Kapp MB. Defensive medicine: no wonder policymakers are confused. *Int J Risk Saf Med*. 2016;28(4):213–219. doi:10.3233/JRS-170733
- Agarwal R, Gupta A, Gupta S. The impact of tort reform on defensive medicine, quality of care, and physician supply: a systematic review. *Health Serv Res*. 2019;54(4):851–859. doi:10.1111/1475-6773.13157
- Sypes EE, de Grood C, Whalen-Browne L, et al. Engaging patients in de-implementation interventions to reduce low-value clinical care: a systematic review and meta-analysis. *BMC Med*. 2020;18(1):116. doi:10.1186/s12916-020-01567-0
- Riotta S, Bruccoleri M. Revisiting the patient–physician relationship under the lens of value co-creation and defensive medicine. *J Serv Theory Pract*. 2021;31:868–892. doi:10.1108/JSTP-06-2020-0142
- Symon A. Litigation and changes in professional behaviour: a qualitative appraisal. *Midwifery*. 2000;16(1):15–21. doi:10.1054/midw.1999.0193
- Tong A, Sainsbury P, Craig J. Consolidated Criteria for Reporting Qualitative Research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–357. doi:10.1093/intqhc/mzm042
- Doyle L, McCabe C, Keogh B, Brady A, McCann M. An overview of the qualitative descriptive design within nursing research. *J Res Nurs*. 2020;25(5):443–455.
- Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101. doi:10.1191/1478088706qp0630a
- Kim H, Sefcik JS, Bradway C. Characteristics of qualitative descriptive studies: a systematic review. *Res Nurs Health*. 2017;40(1):23–42. doi:10.1002/nur.21768
- Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. *Qual Health Res*. 2016;26(13):1753–1760. doi:10.1177/1049732315617444
- Calder LA, Neilson HK, Whyte EM, Ji J, Bhatia RS. Medico-legal cases involving cardiologists and cardiac test underuse or overuse. *CJC Open*. 2021;3(4):434–441. doi:10.1016/j.cjco.2020.11.018
- Chan T, Judkins S. Choosing Wisely for doctors: a survey on attitudes, perceived barriers and enablers. Paper presented at: Choosing Wisely Australia National Meeting; May 30, 2018; Canberra, Australia.

21. Pathirana T, Clark J, Moynihan R. Mapping the drivers of over-diagnosis to potential solutions. *BMJ*. 2017;358:j3879. doi:10.1136/bmj.j3879
22. Garattini L, Padula A. Defensive medicine in Europe: a 'full circle'? *Eur J Health Econ*. 2020;21(2):165-170. doi:10.1007/s10198-019-01144-0
23. Batalden M, Batalden P, Margolis P, et al. Coproduction of health-care service. *BMJ Qual Saf*. 2016;25(7):509-517. doi:10.1136/bmjqs-2015-004315
24. Shaw J, Baker M. "Expert patient"—dream or nightmare? *BMJ*. 2004;328(7442):723-724. doi:10.1136/bmj.328.7442.723
25. Buljac-Samardzic M, Clark MA, van Exel NJA, van Wijngaarden JDH. Patients as team members: Factors affecting involvement in treatment decisions from the perspective of patients with a chronic condition. *Health Expect*. 2021. doi:10.1111/hex.13358
26. Phillips RL, Short A, Kenning A, et al. Achieving patient-centred care: the potential and challenge of the patient-as-professional role. *Health Expect*. 2015;18(6):2616-2628. doi:10.1111/hex.12234
27. Shaw J, Baker M. "Expert patient"—dream or nightmare? *BMJ*. 2004;328(7442):723-724. doi:10.1136/bmj.328.7442.723
28. Fisher KA, Tan ASL, Matlock DD, Saver B, Mazor KM, Pieterse AH. Keeping the patient in the center: common challenges in the practice of shared decision making. *Patient Educ Couns*. 2018;101(12):2195-2201. doi:10.1016/j.pec.2018.08.007
29. Cribb A, Entwistle VA. Shared decision making: trade-offs between narrower and broader conceptions. *Health Expect*. 2011;14(2):210-219. doi:10.1111/j.1369-7625.2011.00694.x
30. Chan SW, Tulloch E, Cooper ES, Smith A, Wojcik W, Norman JE. Montgomery and informed consent: where are we now? *BMJ*. 2017;357:j2224. doi:10.1136/bmj.j2224
31. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Accessed May 27, 2021. <https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx>
32. Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. *BMJ Qual Saf*. 2013;22(7):532-540. doi:10.1136/bmjqs-2012-001691
33. Mattarozzi K, Sfrisi F, Caniglia F, De Palma A, Martoni M. What patients' complaints and praise tell the health practitioner: implications for health care quality. A qualitative research study. *Int J Qual Health Care*. 2017;29(1):83-89. doi:10.1093/intqhc/mzw139
34. Hall DE, Prochazka AV, Fink AS. Informed consent for clinical treatment. *CMAJ*. 2012;184(5):533-540. doi:10.1503/cmaj.112120
35. Scott IA, McPhail SM. Sociocognitive approach to behaviour change for reducing low-value care. *Aust Health Review*. 2020;45(2):173-177. doi:10.1071/AH20209
36. Michiels-Corsten M, Donner-Banzhoff N. Beyond accuracy: hidden motives in diagnostic testing. *Fam Pract*. 2018;35(2):222-227. doi:10.1093/fampra/cmz089
37. Kohut MR, Keller SC, Linder JA, et al. The invincible patient: how clinicians perceive demand for antibiotics in the outpatient setting. *Fam Pract*. 2020;37(2):276-282. doi:10.1093/fampra/cmz066
38. Schlesinger M, Grob R. Treating, fast and slow: Americans' understanding of and responses to low-value care. *Milbank Q*. 2017;95(1):70-116. doi:10.1111/1468-0009.12246
39. Klingman D, Localio AR, Sugarman J, et al. Measuring defensive medicine using clinical scenario surveys. *J Health Polit Policy Law*. 1996;21(2):185-220. doi:10.1215/03616878-21-2-185
40. van Ravesteijn H, van Dijk I, Darmon D, et al. The reassuring value of diagnostic tests: a systematic review. *Patient Educ Couns*. 2012;86(1):3-8. doi:10.1016/j.pec.2011.02.003
41. Rolfe A, Burton C. Reassurance after diagnostic testing with a low pretest probability of serious disease: systematic review and meta-analysis. *JAMA Intern Med*. 2013;173(6):407-416. doi:10.1001/jamainternmed.2013.2762
42. Ferry AV, Strachan FE, Stewart SD, et al. Exploring patient experience of chest pain before and after implementation of an early rule-out pathway for myocardial infarction: a qualitative study. *Ann Emerg Med*. 2020;75(4):502-513. doi:10.1016/j.annemergmed.2019.11.012
43. Giroldi E, Veldhuijzen W, Leijten C, et al. "No need to worry": an exploration of general practitioners' reassuring strategies. *BMC Fam Pract*. 2014;15:133. doi:10.1186/1471-2296-15-133
44. Jones D, Dunn L, Watt I, Macleod U. Safety netting for primary care: evidence from a literature review. *Br J Gen Pract*. 2019;69(678):e70-e79. doi:10.3399/bjgp18X700193
45. Jerant A, Fenton JJ, Kravitz RL, et al. Association of clinician denial of patient requests with patient satisfaction. *JAMA Intern Med*. 2018;178(1):85-91. doi:10.1001/jamainternmed.2017.6611
46. Muscat DM, Shepherd HL, Nutbeam D, Trevena L, McCaffery KJ. Health literacy and shared decision-making: exploring the relationship to enable meaningful patient engagement in health-care. *J Gen Intern Med*. 2021;36(2):521-524. doi:10.1007/s11606-020-05912-0
47. Born KB, Coulter A, Han A, et al. Engaging patients and the public in Choosing Wisely. *BMJ Qual Saf*. 2017;26(8):687-691. doi:10.1136/bmjqs-2017-006595
48. Morley J, Cowls J, Taddeo M, Floridi L. Public health in the information age: recognizing the infosphere as a social determinant of health. *J Med Internet Res*. 2020;22(8):e19311. doi:10.2196/19311
49. Suarez-Lledo V, Alvarez-Galvez J. Prevalence of health misinformation on social media: systematic review. *J Med Internet Res*. 2021;23(1):e17187. doi:10.2196/17187
50. Bourne T, Wynants L, Peters M, 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;5(1):e006687. doi:10.1136/bmjopen-2014-006687
51. Kaldjian LC. Communication about medical errors. *Patient Educ Couns*. 2021;104(5):989-993. doi:10.1016/j.pec.2020.11.035
52. Dael J, van Reader TW, Gillespie A, Neves AL, Darzi A, Mayer EK. Learning from complaints in healthcare: a realist review of academic literature, policy evidence and front-line insights. *BMJ Qual Saf*. 2020;29(8):684-695. doi:10.1136/bmjqs-2019-009704
53. Myren BJ, Hullu JA, de Bastiaans S, Koksmas JJ, Hermens RPMG, Zusterzeel PLM. Disclosing adverse events in clinical practice: the delicate act of being open. *Health Commun*. 2020;1-11. doi:10.1080/10410236.2020.1830550
54. Allan A, McKillop D, Dooley J, Allan MM, Preece DA. Apologies following an adverse medical event: the importance of focusing on the consumer's needs. *Patient Educ Couns*. 2015;98(9):1058-1062. doi:10.1016/j.pec.2015.06.001
55. Sattar R, Johnson J, Lawton R. The views and experiences of patients and health-care professionals on the disclosure of adverse events: a systematic review and qualitative meta-ethnographic synthesis. *Health Expect*. 2020;23(3):571-583. doi:10.1111/hex.13029
56. Vasileiou K, Barnett J, Thorpe S, Young T. Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Med Res Methodol*. 2018;18(1):148. doi:10.1186/s12874-018-0594-7
57. McCarron TL, Clement F, Rasiah J, et al. Patients as partners in health research: a scoping review. *Health Expect*. 2021;24(4):1378-1390. doi:10.1111/hex.13272
58. Brownlee S, Chalkidou K, Doust J, et al. Evidence for overuse of medical services around the world. *Lancet*. 2017;390(10090):156-168. doi:10.1016/S0140-6736(16)32585-5

59. Ali AA, Hummeida ME, Elhassan YAM, Nabag WO, Ahmed MAA, Adam GK. Concept of defensive medicine and litigation among Sudanese doctors working in obstetrics and gynecology. *BMC Med Ethics*. 2016;17(1):12. doi:10.1186/s12910-016-0095-3
60. Sheridan S, Hatlie M. We're not your enemy: an appeal from a consumer to re-imagine tort reform. *Patient Saf Qual Healthc*. 2007; 4:22-26.

How to cite this article: Ries NM, Johnston B, Jansen J. Views of healthcare consumer representatives on defensive practice: 'we are your biggest advocate and supporter... not the enemy'. *Health Expect*. 2022;25:374-383. doi:10.1111/hex.13395