Protocols and defensive medicine

Protocols are created so that practitioners may be guided by their advice and make fewer errors. But the advice in protocols may be simplified in order that the recommendations are easier to remember and easier to follow. In the process of simplification, the complexity and uniqueness of clinical experience may be lost. Simplification within protocols may also ignore the fact that in medicine much is not fully understood or not fully known.

Much thought goes into protocols, and any deviation from them should be carefully considered, well discussed and clearly recorded. The discussions may show the complexity of individual experience. The factors weighed in a decision may not be equivalent – apples to oranges.

With all protocols comes conformity – 'this is the way it should be done', even though not all in a commission or governing body that produce protocols will agree with the final draft. Uniformity of opinion is a rarity, and many practising obstetricians and gynaecologists will not completely agree.

And hereby lies the problem: any deviation from a protocol is likely to be interpreted in a review process as being against the accepted expert opinion. Conformity has been established. With conformity comes the disapproval of contrary opinions and an unwillingness to engage in vigorous debate.

Let us go back to apples and oranges. In the presence of mild hypertension without any suggestion of pre-eclampsia in an otherwise healthy pregnancy, a patient with an unfavourable cervix at whatever recommended gestation may undergo a prolonged and exhausting induction of labour with a limited or negligible chance of success, resulting in an unwanted caesarean section and a new mother entering the puerperium emotionally and physically drained. The purpose? To prevent the limited possibility of sudden intrauterine death or severe maternal morbidity at term or near to it.

Even if a national or international protocol suggests caution before entering into an induction of labour, a local protocol may be tempered by a tragic incident leading to a recommended induction before full term, including for the nulliparous patient who has a negligible chance of success.

The calamitous possibility of fetal death is weighed against the hardship of induction – apples and oranges.

So much of what is done in obstetrics and gynaecology is done 'defensively', even in the example given above. In other words, to prevent later criticism. If defensive medicine becomes increasingly the norm, much is lost in the care of the patient. A cardiotocograph in labour may show rapidly recovering decelerations with all other parameters on the trace, and clinically normal. Fearing later criticism and a potentially disastrous outcome that all dread, the less experienced obstetrician will say that this 'could' represent fetal distress and opt for an operative delivery.

As greater experience is lost, and the variations that occur in normal life are not recognised and the unreliability of any number of tests is not appreciated, not only is non-conformity likely to become more severely criticized, but debate influenced by real-life experience may become a rarity. We will live in a world that says it's right because an authority says it's right, forgetting that many in authority may criticize the very guidelines to which they have signed, and some protocol recommendations may be of lower-order evidence, lacking literature support.

Having said this, all guidelines are drawn up in good faith, and cavalier attitudes do not have a place in medicine. A deviation should be debated with all concerned, justified, and properly recorded.

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