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THE DOCTRINE OF MEDICAL MALPRACTICE SUIT WITH REFERENCE TO POLITICS, LAW AND SOCIETY: AN INTERNATIONAL PERSPECTIVE

Dr. Rajib Kumar Majumdar[1], Abhishek Majumdar[2]

[1]Professor, Surgery and Neurosurgeon RAMA Medical College Ghaziabad, UP, India
[2]Legal Researcher, TERI School of Advanced Sciences, New Delhi, India.

ABSTRACT
Over the past three decades, the field of medical malpractice has become a field of increasing interest to a wide variety of academicians including, but not limited to legal and economic scholars. One of the key factors contributing to the surge in interest is the gradual growth in litigations. This crisis can be traced back to the early 1960s US, where it started to gain momentum and was already at the forefront by the dawn of the decade of 1980s. The conjectural aspect of the crisis has paved the way for the generation of an extensive literature, which is a result of collation of massive data from various diversified fields of study. The medical malpractice suit theory as a doctrine owes its evolution to a set of contributions, not only from the medical field but diverse areas of study such as law, commerce, economics, etc.
Keywords: Doctrine, medical malpractice, suit, law, politics, society.

INTRODUCTION
It is often considered that when it comes to literature on medical malpractice, the most significant contribution made by fields such as law and economics is through empirical studies which are focused on two key areas. The first of these detailed studies focuses on the nature and extent of the 'crisis' concerning the medical malpractice liability and the insurance market. The second part is concerned with focusing on reforms aimed towards medical malpractice. Some of these studies happen to be theoretical and often provide for an argument towards a particular type of reform being best suited to right the deficiencies which exist in the system. The others are an attempt to assess the impact which were brought about by amendments to the U.S. legislative at the state level, to the medical malpractice system.
The theoretical explanation for medical malpractice law is a part of a much larger legal and economics literature, examining the existence and economic competence of tort law. The law governing medical malpractice, and tort law generally, hold medical professionals to a court-approved 'legal standard of care' which, if violated establishes the negligence of the provider. Negligence will, in turn, fix the accountability of the medical professional, or other health care provider, for any resultant injuries suffered by the patient. The Law of Tort in a wider sense and the medical malpractice law, specifically, serves two principal purposes. First is to compensate the injured parties for the loss suffered as a result of negligence. Second, the risk of liability for negligence induces prospective injurers to take precautions against potential harm.

THE MEDICAL MALPRACTICE LITERATURE AND FOCUS ON DETERRENCE
The existing literature on medical malpractice tends to focus effects which the law has created in terms of 'deterrence' rather than the compensation of negligent accidents although, certainly, exceptions exist. The more vast literature on law and economics literature does address the issue of compensation as it is related to involuntary insurance against adverse outcomes. That is, higher average compensation levels will, all else being equal, induce

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potential injurers such as physicians to increase the price of their services to all patients. The literature provides that in case of optimal insurance, full compensation levels lead to higher levels of implicit insurance than is optimal. As far as the concept of deterrence is concerned, the literature attempts to establish whether or not negligence, or any other form of liability rules, will lead to *optimal* or efficient deterrence. Optimal deterrence occurs when "the liability rule gives each party (that is, both health care provider and patient) an incentive to take actions, or precautions, which minimize the total the price of bodily insult due to any actual or purported malpractice should include the expected expenditure as a result of the accidental happening hindering any such future happening and the expenditure involving the management of a malpractice system.". When information is expensive to obtain and, hence, deficient, tort law does not necessarily result in optimal deterrence.

Although, the theoretical literature on medical malpractice ponders upon the general background of tort law, the medical malpractice literature moves beyond this general theoretical framework (although not always), by using formal, mathematical models of deterrence.

RULE OF STRICT LIABILITY AS AN ALTERNATIVE TO NEGLIGENCE LIABILITY RULE

Presently, the field of medical malpractice makes use of some form of the negligence liability rule, where the courts establish a legal standard of precaution against which a practitioner's actual precaution is assessed in order to determine negligence and liability. Substitutes to a negligence liability rule, such as a strict liability rule or a no-fault rule, could be used to determine liability.

In comparison to a negligence rule, a strict liability rule does not draw comparison of a defendant's level of precaution to a legal standard. Rather, as long as the accident or injury was caused by the medical treatment, the defendant is found liable for the costs of such incident. Arguably, the key advantage of strict liability rule is that it decreases the costs of the legal system because only causation needs to be established rather than, both causation and negligence as is the case of negligence rules, which happens to be problematic as adverse medical outcomes routinely happen because of prior medical conditions. Under the medical malpractice law, unlike other torts, 'causation' is often determined to exist when an adverse outcome happens and the defendant is found to have acted negligently. Hence, a discovery of negligence is often required to be preceded with causation which obviates the cost advantages of strict liability. Similar problems are incurred if one was to make use of the 'no-fault liability' because no-fault rules generally require proof of causation as well.

Thus, medical malpractice law ends up providing the health care workers a leeway to avoid negligence injuries, caused by their medical treatment. Ideally, medical malpractice results in optimal deterrence. However, since real world conditions are not realistically, ideal, some thought as noted above, has been given to alternatives to the negligence standard set up by medical malpractice, such as strict liability and no-fault rules.

EFFICIENCY OF THE LAW

An alternative outlook provides that "the law, especially common law, can be best understood as a method of achieving societal efficiency (that is, maximizing the wealth of society)". Under Posner's efficiency theory of the law, "legal rules do not necessarily result in perfectly optimal, or first-best, outcomes. Rather, the law is seen as a system for achieving the best possible, or second-best, outcomes given the constraints faced in the real world (for example, costly and, hence, incomplete").

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In view of the efficiency theory of law, one can view the medical malpractice law as 'efficient, albeit imperfect, system' which is still evolving. Researchers have made attempts to examine medical malpractice from this viewpoint. Some of the researchers continue by proposing reforms that they suggest, will improve the malpractice system implying, at the very least, that malpractice law has not yet reached its optimum position. Thus, a key flaw in the theoretical literature on medical malpractice law remains an insistence that 'medical malpractice law is inefficient'. This, persistence view can be, for the most part, traced to the widespread perception in the literature that the medical malpractice system is in 'crisis'. As it stands out, it is the events of the last few decades which act as the driving force in support of the discussion on existence of a supposed 'crisis' in the medical malpractice system.

MEDICAL MALPRACTICE SYSTEM: BEFORE 1950 AND AFTER 1950

It is pertinent at this juncture to mention a very interesting fact that during the 1950's the market of malpractice insurance was so dull and uneventful that insurance policy sellers used to club a medical negligence insurance liability cover as an additional benefit while buying an indemnity policy for home and vehicle insurance.

Beginning in the 1960s, however, malpractice insurance premiums rose dramatically, over 500 percent in the 1960s and by the mid-1970s a full blown 'crisis' was thought to have developed. It was not just the case that a hefty premium was being charged if one wanted to avail insurance, but as it happened insurance with the purpose of indemnifying a wrong occurred by way of medical negligence was all together unavailable in the states of California and New York. The story with surge in the premium rates continued throughout the 1980s. Some estimates showcase a staggering 45% rise in the premium between 1982 to 1984. As mentioned above the rate of malpractice suit in the 1950's was so low that medical indemnity coverage was less than one percent of the total policies sold. The empirical medical malpractice literature gives insight into why malpractice premiums rose at such dramatic rates during this time period. Essentially, as with all insurance premiums, the root cause of increased premiums can be traced to increased average benefits paid by insurers. Three variables affect the average benefits paid by medical malpractice insurers. The frequency of malpractice claims measures how often, usually on a per capita or per physician basis, malpractice claims are being filed. Mathematical calculations involving the probability factors influence the outcome of a medical negligence case rather than the actual reasons cited behind the institution of a case, and the same factor determines whether a case will be won or lost and not due to actual or purported incidence of insult.

INSURANCE AWARDS AS A MARKER OF WINNING OR LOSING A CASE

Thus, in a given period of time whether a doctor loses or wins a case depends more upon the fact that how many cases of medical negligence has been won by him or lost by him in the past and not upon the fact that he is an efficient or a negligent doctor. So legally speaking in a given frame the intensity and frequency of occurrence of a malpractice in a given area depends most upon the total indemnity costs an insurance company has to dole out as a result of cases lost or won and not due to actual proven cases of malpractice. It is the basic fiduciary issue that in areas of excessive malpractice awards the insurance companies jack up their policy costs. This in turn causes a cascading financial ripple which many practitioners are unable to bear and abandon their practice. A good part of the empirical malpractice literature has focused on estimating these three variables. The literature demonstrates that, not surprisingly, during the same decades that malpractice insurance premiums rose dramatically so did malpractice frequency, probability and severity. For example, although claim frequency remained stable from the 1950s through the early 1960s, by 1968 claim frequency

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had risen 76 percent from its earlier level. One of the major areas of concern in the literature has been the large increases in the average size of paid malpractice claims (malpractice severity) over the past three decades. As compared to rate of growth of 10% (annually) in case of average awards, the median awards were recorded to grow at a lower rate of 4-5% (annually) comparatively. Lower growth rates for median, as compared to average, awards indicate that much of the increase in average awards is due to a small number of cases with extremely large awards while most cases had much more modest increases. Thus, above discussion makes it ample clear that various fields of personal injury litigation areas see a sea change in their practice with an increasing occurrence of malpractice cases.

LEGAL AND SOCIAL ATTITUDE AFFECTING MONETARY AWARDS

It was observed that malpractice frequency and severity rose at much higher rates. From 1971 to 1990 average annual growth rates in Canadian frequency and severity were 6.1 percent and 9.6 percent respectively. Although Canadian growth rates are similar to US growth rates, US malpractice frequency during these years was consistently 8-10 times as large as Canadian malpractice frequency. Although, the usual size of the awards in malpractice suits remained similarly scaled during this period. As discussed above as 1950's saw a stable and low incidence of negligence Law suits US and Canada saw an increase in medical practice and an exponential medical facility development. Subsequently, with an increased change in Legal attitude and society becoming more money minded the number of cases saw a steady increase in number. From 1971 to 1990 average annual growth rates in Canadian frequency and severity were 6.1 percent and 9.6 percent respectively. Although Canadian growth rates are similar to US growth rates, US malpractice frequency during these years was consistently 8-10 times as large as Canadian malpractice frequency. A similar average was seen amongst the two countries in terms of malpractice suit awards with a few years in between, indicating a higher ratio for Canada.

Likewise, a similar trend was found in the United Kingdom where both severity and frequency rose at about 17 percent on average annually from the mid-1970s to the mid to late 1980s. Unfortunately, the United Kingdom data only allowed comparison to the US and Canadian data for growth rates, but not for levels, of malpractice frequency and severity. Researchers had similar findings in their comparison of the US to Canada, Australia, and the United Kingdom. In fact, it was found that growth rates in malpractice severity were substantially higher, on an average annual basis, in the UK and Canada than in the US. Similar growth rates were found in malpractice frequency (averaging about 10 percent annually) in all three countries. However, US *levels* of malpractice frequency were 5 to 6 times that of Canadian malpractice frequency even though, levels of average severity in the two countries were quite similar. It was also found that UK levels of malpractice frequency were one fifth to two thirds of the US levels, dependent upon the region of the country. It can be seen from the above example that 1950 was a watershed period. Empirical studies show that cases were few and were based upon rational assumptions during the 1950's and hence the period was a stable period. The medical delivery system was working smoothly and with very few cases physicians were able to denote more time to patients rather than to nuances to protect themselves from some alien assumption and unfounded allegations. Thus, during this period there was no revelation in a sudden increase in the frequency, severity, or probability of medical malpractice. Secondly there is empirical evidence to show that Judicial activism, increased and rampant application of consumer Laws to medicine and an exponential increase in malpractice litigations as a result ensued from 1970's onwards thereby precipitating a malpractice crisis. By way of demonstrations consisting of documented historical accounts it was propounded that medical negligence cases were not an occurring in rarity before the

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1950s, as was previously assumed by many. It was further propounded that growth rates in malpractice frequency and severity over most of the US history from 1820 on were comparable to more recent growth rates. Hence, these data suggest that if a medical malpractice crisis *does* exist, it has been an ongoing crisis for more than 150 years.

MEDICAL MALPRACTICE CRISIS AND THE SYSTEM CHANGES

It may be the case that rather than there being a predominant 'malpractice crisis', the system is reacting to a variety of changes brought about by externalities. A number of scholars support the view that the system is indeed working coherently. One of the inherent deficiencies in the scholarly works in the field put forth, is the failure to even take into account the possibility of this occurrence. The new academic line of thought which has evolved aims to address this occurrence in the affirmative. It is often justified by interested parties that there is no existential malpractice crisis but the system is reacting to the change in the social environment and the Legal developments favouring the patient hereinafter changing his character to that of a consumer. However, they fail to explain why such changes and pressures are being exerted on a scientifically expressed and efficient system. A very drastic contrast is the way in which "quacks" are treated by the very Judicial and social system. A glaring example is the present altercation between the Indian Medical Association and a supposedly Yogic practitioner presenting himself in various avatars i.e., from an alternative medicine practitioner to that of having panacea for all the illnesses. During this very difficult time of Pandemic where only mainstream medicine with its dedicated workforce trying to save lives, such rants are also being facilated. Law enforcers and society in these cases become totally silent and Political patronage to these "quacks" embolden them. However the legal aspect of the malpractice system completely veils itself in silence which somewhat gives these people a credibility without any scientific, legal or social sanctions. Increased technology and, especially, the increased physician productivity (that is, an increased ability of physicians to avoid medical injuries) that has historically been linked with increased technology, explains much of the historical increases of medical malpractice liability which actually is quite baffling with respect to the above submission. When a physician is to be burdened with liability, the various factors taken into considerations are, higher levels of skills, competence and technological innovations. This somehow is quite missing while interacting with quacks, and in the presence of a pliant Political coverage, Law just looks the other way and such people are patronised to bloom. Thus, the first Hypothesis propounded to mitigate the above problem of increased malpractice suits is based upon the Standard Tort Model. This hinges upon the thesis of deterrence mode in which in order to avoid any advertent or inadvertent injury arising out of a liability, incentives to be provided to high and medium productivity physicians. This will not only drastically decrease the litigation cost but will also increase the Trust between both the patient and the doctor, which in fact has become a very rare commodity.

EXPERT TESTIMONY AND ITS RATIONALE IN A MALPRACTICE SUIT

A trending theory is that the probable cause of few malpractice suits prior to 1960s was the absence of an expert testimony.

A number of researchers detail the emergence of this phenomenon, which made it much more difficult for plaintiffs to prove malpractice against physicians. 1960's and onwards saw an increase in availability of expert witnesses as Locality Rule as an important factor for pinning liability was being resisted by the legal system. Now this type of judicial activism should actually be based upon scientific principles but is based more upon judgemental factors favouring patients. An explanation to the above hypothesis is based upon the rationale is that

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medicine is a fluctuating science. Evidence based medicine changes from place to place. It is based upon environmental conditions and climate also. Most medical teaching is based upon a mathematical model of average occurrence. This can however have many mitigating factors and a locality rule was the best suited Model. The expert testimony could have been the supplemental evidence rather than the primary evidence. This model could have been helpful in controlling the menace of uncontrolled litigations. Locality rules supplemented by expert evidence can discipline 'unethical' practices as well as help in restricting the financial liabilities by avoiding unnecessary litigations.

MALPRACTICE LAW REFORMS MANDATED IN US

United States has been the first country to be plagued by unnecessary malpractice litigations. This caused a huge demand upon the state as well as the exchequer. Huge costs of suits burdened upon the legal system with very few outcomes, malpractice attorneys queuing up in courts to institute cases at a drop of a hat and physicians burdened with financial and professional liability was eating up the system. This malpractice crisis pressurised the US government to make many tort reforms, like contractual liability of malpractice to be equally borne by both parties, no fault liability to be borne by insurance company thus releasing the doctor from appearance and denoting principle time to the welfare of the patient.

India, however at this juncture is far from such a reform. Where instituting a civil consumer suit does not cost a penny to the litigant why would not a patient, whether harmed or not would not try to extract some money from a gullible physician. This is an actual scenario and many times investigating agencies in India have received a rap on the Knuckle by the Higher judiciary.

MALPRACTICE REFORMS: THE GROUND REALITY

Rather than wholesale changes in the medical malpractice system, US courts and legislatures have, instead, focussed on reforms whose apparent intent is to diminish the perceived crisis by reducing malpractice frequency, severity, and probability. A variety of changes in the existing malpractice award system includes suggestion to decrease the monetary amount to a particular limit. Another reform intends to convert the lump sum payment into sequential periodic payments to a 30 percent reduction in average awards at verdict. Hughes, using data from the late 1970s, also corrected for potential selection bias *and* corrected the potential bias introduced by the inaccurate measurement of malpractice reforms used by earlier claim disposition studies. Only limitations on lawyer fees and a collateral source offset rule significantly increased the probability of settling the claim. It was found that malpractice reforms had a much stronger impact on the decision to drop a malpractice claim. In fact, five of the eight reforms he considered, including limitations on awards and periodic payment of awards, increased the probability that the plaintiff would drop the case. Although he did not measure the impact that reforms had on average awards, an increase in the tendency to drop cases would be expected to reduce average awards, all else equal. Different researchers also estimated the effectiveness of the malpractice reforms in reducing malpractice liability. They estimated the impact of malpractice reforms on both malpractice probability (that is, the probability that a claim would be paid) and severity (that is, the size of the award for paid claims). For example, limitations on awards were found to significantly reduce severity, as found by earlier researchers. Likewise, mandatory collateral source offset rules tended to reduce severity as well. Few of the rest of the reforms considered had a significant impact on severity. The *only* malpractice reform found to have a statistically significant impact on probability was the statute of limitations, where an increase in the number of years a plaintiff was allowed to file a claim increased the probability of payment. Synthesizing the empirical

work estimating the impact of malpractice reforms, it becomes clear that not all reforms have a consistent impact on provider liability or insurance premiums. Reforms such as limitations on awards, collateral source rules, and shortened statute of limitations have had the most consistent impact on such liability. Most other reforms have only occasionally been found to have an impact on the medical malpractice liability of health care providers.

CONCLUSION, DISCUSSION AND SUGGESTIONS

Medical Science is an ever evolving science. The mainline medical practice is an evidence based scientific endeavour to mitigate the mankind of its woes. Since man is interwoven in a societal structure Medicine is a big social incidence as well as a social influencer. Since medicine is a science associated with mankind so it is liable under various legal provisions also. So a physician has to work under tremendous pressure of self through Ethical submissions, through social bonding, influences and social structure, and Legal harness. In most of the cases this responsibility is borne through a concentrated effort of self, societal, legal scientific and academic harness. In majority of the cases this is done in accordance with what ought and should be done. However in certain cases there can be some lapses. This can be advertent or inadvertent. These lapses can result in an insult or an injury thereby putting liability on a doctor. In case of a glaring mistake hinging upon malpractice compensation through legal course is justified. This not only causes a course correction in terms of restoring the Legal right of a person but also obviates one of his social commitments. But in ever changing fiduciary relationship and deteriorating social concepts Legal liability of a doctor is rather been misused by plaintiffs (patients) to get a windfall compensation. Legal laxity and tilt towards the plaintiff most often labelled as the wronged party has seen an existential malpractice crisis internationally. This has assumed such an alarming proportion that many countries including US had to bring in tort reforms .The current COVID situation where thousands of Medical frontline workers have sacrificed their lives to save the mankind should act as a wakeup call for the society which relies more on alleged “godmen” who are simply quacks doling out instant cures . These people are neither legally nor socially netted because of the political patronage they enjoy.

Many tort reforms have been done and more are being advocated for a scientifically trained highly skilled doctor who is plagued by false and vexatious cases. One tort reform should be to immediately ban the quacks from harmfully affecting health of a person and legal leashing them from vilifying medical personnel to further their gains.

Again, this may be an efficient response to changes in medical relationships, leading one to again conclude that future research is needed which considers the possibility that current increased levels of liability are simply an efficient response to changing circumstances. Thus, a need exists for a better theoretical understanding of what changes would cause an efficient increase in malpractice liability for health care providers. One possible change which might efficiently lead to increased provider liability is the increased technological ability of medicine to provide efficacious treatment that has, especially, occurred in the last three decades simultaneous with the recent increase in malpractice liability.

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