HOW SHOULD MEDICAL MALPRACTICE CLAIMS BE HANDLED? AN ECONOMIST'S VIEW

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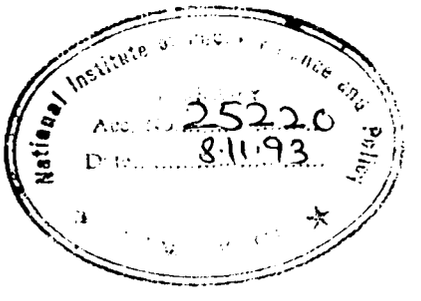
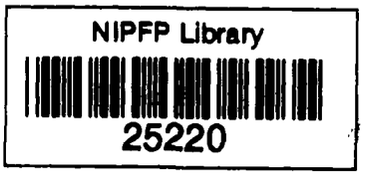
NO.9 NOVEMBER 1993





EXECUTIVE SUMMARY

The recent decision to bring medical malpractice claims under the jurisdiction of Consumer Fora is based on three untenable assumptions. First, medical services are similar to all other services and hence defective product liability applicable to the normal goods and services is applicable to medical services as well. Second, the 'torts' method of compensating for personal injuries, implicit in the adjudication by Consumer Fora, will be effective in redressing compensation claims and also builds adequate deterrence against negligence. Third, redressal can be afforded fast and with the least cost. The decision seems to have been taken without considering its adverse long run consequences on health service costs, practice of medicine and development of insurance markets. The paper argues that a tax funded 'no fault' insurance, covering all medical accidents caused by negligence or otherwise, and adjudication by the Medical Councils should take the primary and initial responsibility in settling compensation claims. The role of the Fora should be limited to acting as a deterrent to negligence by imposing liability under torts in rare cases of *prima facie* evidence of negligence. A mandatory internal audit of all adverse clinical events occurring in hospitals followed up by a periodic (once in three to five years) social audit by the Councils should be introduced as a preventive measure to identify avoidable accidents in order to help reduce clinical risks. Such an audit, besides bestowing other benefits, will also help the Councils to develop norms of practice and safety standards empirically from the practices followed in hospitals under varying circumstances, and not from individual experiences or anecdotal evidence.

How Should Medical Malpractice Claims Be Handled? An Economist's View

V. B. Tulasidhar

The recent decision to bring medical malpractice claims within the purview of Consumer Fora will have far reaching consequences on the health services costs, development of insurance markets and the way medicine is likely to be practiced in future. Yet, the decision seems to have been taken without properly examining its long term implications from all angles. Even the debate generated by the decision has failed to examine the implications dispassionately. Instead of leading to any worth while modifications in the policy, the debate has only resulted in polarisation of views between the medical profession and the rest; with physicians bitterly opposing the decision. Physicians have apprehensions about the wisdom in giving exclusive jurisdiction to Consumer Fora to adjudicate on matters in which the Fora have no expertise. They possibly do not oppose Consumer Fora adjudicating *prima facie* cases of medical negligence provided safeguards do exist to protect them from litigation in all other cases of medical accidents arising from inherent risks in medical interventions and procedures and uncertainties in medical practice. In other words, some capable agency should impartially identify or set norms to determine the cases of gross negligence from all medical accidents. This is not provided for in the present policy.

The medical accident cases fall under three distinct categories: (i) those involving negligence supported by *prima facie* evidence; (ii) personal injuries and deaths arising due to risks inherent in medical interventions and procedures including those caused by the failure of equipment; and (iii) losses arising from the imperfections in medical science and its diagnostic procedures. Out of these, physicians can and should certainly be held responsible in the first category of cases[1] . It is neither fair nor feasible under the consumer protection legislation

1. The available evidence shows that a considerable proportion of medical injuries are caused by normal risk of medical treatment. Mills (1977), found evidence of patient disability caused by medical treatment in 970 of 20,864 (4.65%) medical records they had scrutinised. Out of these injuries, about 17% (or 0.8% of total cases) were possibly due to negligence on the part of the providers (physicians, health care workers and hospitals). Similar rate of injury due to provider error (0.64% of all cases) was found by another study (Couch, N.P., et., al., 1981).

to hold physicians responsible in the latter two categories of cases. But, physicians fear that they will be tried under all categories of cases. Their fears cannot be brushed aside, because, people tend to take legal action even in 'no fault' cases in the hope that they will be able to establish the negligence and claim large sums as compensation when the cost of litigation is low, as is with the Fora[2] .

The proposed changes in the consumer legislation, which favor plaintiffs, are often justified on the ground that the existing torts legislation in India is too cumbersome and weak in dealing with the medical malpractice cases. No law of torts was enacted in India. At present the English law of torts is followed, almost entirely, by virtue of the operation of Article 372 of the Constitution[3] .
The position of medical malpractice claims under the torts legislation was laid down by the case law which is also mostly British. Under the existing legislation, the onus of proving negligence and that the negligence has caused the injury in question is on the plaintiff[4] . Further, the case law also stipulates application of the following tests to determine negligence:

> " A doctor who acts in accordance with a practice accepted as proper by a responsible body of medical men, is not negligent merely because there is a body of opinion that takes a contrary view " (Ranchhoddas and Dhirajlal, 1987, p. 414).
>
> " A man need not possess the highest expert skills ... it is sufficient if he exercises the ordinary skills of an ordinary competent man exercising that particular art .... In the case of medical men negligence means failure to act in accordance with the standards of reasonably competent medical

2. The US experienced a rapid increase in the malpractice claim frequency, severity and claim costs per capita after the pro-plaintiff changes in common law (similar to what is implied in consumer fora handling the malpractice cases) were made in early 70's (Danzon, 1983). During the post pro-plaintiff change period of 1970-76, the claims filed all over the US were 4 times the total number of medical malpractice cases during the preceding 35 years (American Medical Association 1984). This graphically illustrates the potential damage the envisaged changes in consumer legislation can do.

3. See Ranchhoddas and Dhirajlal (1987), p.2.

4. Anto Nio Dias vs Ferdreick Augustus as reported in Ranchhoddas and Dhirajlal (1987) p.414.

men at that time. There may be one or more perfectly proper standards and if he confirms with one of these proper standards then he is not negligent" (Ranchhoddas and Dhirajlal, 1987, p 415).

The above tests cover the entire field of liability of a physician, namely diagnostics, treatment and warning patients about the inherent risks of treatment. The existing torts legislation is in favuor of doctors, as the tests seem to be quite lenient and the process of litigation long and time consuming. But the suggested changes in the consumer legislation swing the pendulum to the other extreme.

The proposed adjudication process, for the reasons stated below, cannot be implemented successfully with the least social cost unless the physicians' fears are allayed and the profession co-operates. Their apprehensions can be cleared only by providing certain safeguards to protect them from unnecessary litigation which in turn need the following preconditions to be met. They are: (i) the adjudication process should explicitly recognise the peculiar characteristics of medical risks and medical services; (ii) self governing bodies of physicians such as the Medical Councils and Associations are involved in setting norms of practice so as to separate out cases of gross negligence and other related matters; and (iii) an appropriate compensation system which reduces the tendency to file malpractice claims and yet maintains a good deterrence against negligence is put in place. These issues are discussed below. It will also be shown that in the absence of such safeguards, physicians will increasingly get embroiled in needless litigation. Consequently, they will be forced to resort to defensive medicine and malpractice insurance both of which will considerably enhance the cost of medical care. Since no safeguards exist in the proposed adjudication arrangement to protect the legitimate interests of the physicians, their fears are to a large extent justified.

Medicine is Different

The decision to bring medical services under the jurisdiction of Consumer Fora is based on the premise that medical service is *like* any other service and therefore, defective product liability principle applied to other normal commodities and services can be applied to medical services with equal validity. This assumption is untenable. Medical services have certain peculiarities - uncertainty and consumer ignorance - which are not found in other commodities and services. Economic analysis recognises these peculiarities and treats medical service sector on a separate footing.

The conventional services predominantly deal with man made systems and gadgets where the knowledge about the system or gadget is almost complete. Health services do not have this advantage. They deal with more complex systems, the knowledge about which is incomplete and constantly changing. This imparts the characteristic uncertainty to health services. Further, patients quite often do not know that they are ill. A famous experiment called 'Peakham experiment' done in the United Kingdom showed that 64 per cent of the persons examined had identifiable disorders about which they were not aware of[5] . The ignorance is probably more wide-spread in our country. Even when patients feel that they are ill, they may not know what the ailment is. Neither can they judge the quality of treatment they receive. Shopping around in search of quality is neither possible nor feasible in most cases. Even if a patient decides to take a second or for that matter a third opinion, he cannot reasonably ascertain the accuracy of different opinions received. Again, he may have to depend on another qualified practitioner to decide for him.

Recognising their ignorance, patients rely completely on physicians and repose their trust in them, so much so that the choices regarding their use of health care services is left completely to doctors. How much and what kind of care is needed is determined in most cases by the physicians acting as agents of their patients and then supply it as producers. Thus, producers directly taking or influencing consumption decisions of the consumers is a distinct characteristic of Medical Service which separates it from all other goods and service. In view of this trust relationship, the physicians are given high social status and commercialisation of medical profession is not encouraged, even in the advanced capitalist countries - the US being the exception[6] .

Any policy that vitiates the trust relationship between physicians and patients and/or encourages commercialisation of medical practice will not have favourable long term impact on the development of health services and medical practice in the country. Doctors should be treated with respect and at the same time keeping in place an effective deterrence against negligence and blatant

5. Israel, S. and Teeling Smith, G., "The submerged iceberg of sickness in society", *Social and Economic Administration*, Vol. 1, January 1967, pp. 43-56.

6. Evans, R.G., "Life and death, money and power: the politics of health care financing", in Theodore J. Litman and L.S.Robins, eds. *Health Politics and Policy*, 2nd. edn., Albany NY: Delmer, 1991, pp. 287-309.

deviation from the accepted norms of medical practice. In other words, a delicate balance between the legitimate concerns of physicians and the interests of patients needs to be maintained. Giving unrestricted powers to Consumer Fora will turn the balance completely in favour of patients without adequately taking into account the physicians' concerns. It will destroy the time tested trust principle completely.

Imperfections

Contrary to popular belief, medicine is still an imperfect science. This has three consequences all of which can have adverse influence on patients. First, almost all medical interventions and procedures have inherent risks. While they benefit a large number of patients, a small fraction of them may indeed get harmed, which can amount to a serious injury or even be fatal. Physicians can only minimise such risks wherever possible but cannot completely eliminate them. *A priori*, they cannot pin point who is likely to get harmed, they can only take precautions while treating high risk groups. The risks may also arise on account of failure of medical equipment even when they are properly maintained. Occasionally, physicians may expose patients to a smaller risk to minimise the ill effects of some other larger risk and in the process cause personal injuries. All such losses arise not on account of physicians negligence but due to the inherent risks in medical interventions. When proved, Consumer Fora cannot compensate the victims for such medical risks and yet the doctors will have to go through the expensive and daunting legal process before they are finally exonerated. The solution to this problem is linked to the method of compensating the victims of medical accidents.

The second consequence of imperfection is the uncertainty physicians often face about the nature of the disease. Most of the medical diagnostic techniques are imperfect in that they cannot accurately identify all true cases of disease and exclude all healthy cases at the same time[7] . Some people with no

7. The validity of a diagnostic test has two components: ability to correctly identify all those with disease (called *sensitivity*); and ability to correctly exclude all those without disease (called *specificity*). Since *sensitivity* and *specificity* are inversely related, there cannot be a test which will correctly identify all positive cases and exclude all those with out disease. Besides this, ability of a test to predict disease correctly varies directly with the prevalence of the disease in the population. See, Mausner, J.S., and Kramer, S. *Epidemiology - An Introductory Text*, Philadelphia: W B Saunders 1985, Ch. 9. for more details

disease show positive test results while similar tests do not identify a fraction of those with disease. To this uncertainty one has to add uncertainties arising from diagnostic facilities such as inaccurate measurements, defective apparatus and indifferent quality of chemical reagents used in tests. Therefore, inaccuracy in tests can be quite high in certain cases leading to wrong diagnosis and the consequent personal injuries. Cases of this nature are difficult to handle particularly by agencies outside the medical profession such as Consumer Fora. Merely, co-opting a few physicians into the forum, which in any case they have to do, cannot solve such problems. Norms to judge such cases will have to be evolved from macro setting and not from individual experiences. This is where the role of Medical Councils and Associations is indispensable.

The third category of personal injuries from imperfection arises from the fact that medical knowledge is constantly changing. The new knowledge may identify certain removable risks from the existing procedures or suggest entirely new and relatively safe procedures[8] . Quite often, the new knowledge takes a long time to disseminate among the existing medical practitioners. If the process of dissemination is slow and there is no concerted effort by the Medical Councils/Associations (or for that matter the government agencies) to expedite the process, more personal injuries may result than what is warranted by the new methods. In such cases can a physician be held responsible for following the knowledge he received which might have become obsolete? Solution to such cases does not lie in penalizing physicians by imposing fines. They should be made to acquire knowledge, if necessary, by suspending their license for a temporary period. This can be achieved by introducing a mandatory system of continuing medical education (CME)[9] . This is a job only Medical Councils can and should do.

8. A good number of surgical and medical procedures in use today came into vogue much before the introduction of controlled trails to assess their efficacy. Although there is no scientific evidence to prove their superiority over other methods of interventions, they are accepted as standard practices. This is bound to change in future as more of such procedures will get evaluated scientifically. Mausner, J.S., and Kramer, S. (1985), p.209.

9. I am thankful to one of the referees for suggesting this feasible alternative.

Compensation

The social impact of alternative methods of adjudicating medical malpractice cases depends, to a large extent, on the method chosen to compensate the victims of medical accidents. Compensation for personal injuries and loss can be given in two ways, viz., the Tort system and Insurance system. Under the first, the victims of any action can claim compensation from those who cause it either by fault or negligence. This method of compensation is probably the oldest form in existence. In the second system, compensation is paid to the victim of any action provided they are covered by insurance and irrespective of how the action has occurred. Proof of negligence or fault is not required. The impact of these two systems of compensation on consumer welfare, administrative costs, legal system and access to redressal process is very different [10].

Consumer Fora rely on torts which is incidentally the predominant method of compensation followed in the United States which suffers from serious problem[11] . Besides being very expensive to administer, this method of compensation is known to have a number of other ill effects. Under this system, a lump sum compensation is given to the victim at the end of the legal process provided negligence or fault is established. And no compensation is paid when the injury is caused by legitimate risks involved in medical practice or due to its imperfections. The victims cannot get compensation to spend immediately on any rehabilitation treatment that might be needed to overcome his personal injury. In countries where tort compensation is prevalent, the administrative and legal costs of the system account for as high as 60 per cent of the total compensation payments[12] . Exclusion of pure accident cases from compensation will not deter people from filing malpractice claims indiscriminately, anticipating that

10. Dunlop, Bruce, "Compensation for personal injuries", in R.G.Evans and M.J.Treblicock, eds. *Lawyers and Consumer Interest: Regulating the Market for Legal Services*, Toronto: Butterworths 1982, pp. 383-405.

11. Even in the US there is growing realisation about the perils of torts method of compensation. Following the alarming increase in malpractice claims in the early seventies most states had introduced legislative reforms to put restrictions of medical malpractice claims (Pierce, 1985). In spite of these reforms the insurance costs to physicians and hospitals continued to increase as many reform measures have been struck down by courts(US General Accounts Office, 1986). This has created considerable uncertainty.

12. Dunlop, Bruce (1982), p. 393.

negligence can be proved. This leads to clogging of courts resulting in harassment to physicians and consequently to defensive medicine. Lawyers play a significant role in this system, and they stand to gain financially. The only attractive feature of this system is its deterrent effect on negligence. Even this disappears to some extent when malpractice liability insurance markets develop. Due to these drawbacks, choosing of tort system as a universal method of compensation will have adverse consequences on the practice of medicine and consumer welfare. Thus, instead of learning from the mistakes of the US, the policy mistakes committed there in the early 70's are being repeated here. The experience of the victims of Bhopal gas tragedy is a good example of the harm tort system can do in the extreme.

On the contrary, the 'no fault' insurance system is simple, speedy, covers all risks and can be made universal. For instance, New Zealand has a universal accident compensation system covering all personal injuries. It has virtually abolished the tort system. A major advantage of this system is that all personal injuries and losses can be covered irrespective of the fact whether there is negligence or not. The compensation is paid immediately, which gives relief to the victim when it is most needed. The experience is that very few cases end up in dispute and hence the role of courts and the legal profession is limited resulting in very low administrative and legal costs[13] . Even in our country, universal insurance schemes exist for certain types of accidents: compulsory third party automobile insurance, insurance under the Workmen's Compensation Act and Railway accident insurance for which a small insurance premium is collected from all passengers are some examples. Besides, victims of most of the natural calamities are also compensated on an ad-hoc basis. Yet, there is no system at present to take care of medical accidents even though the trauma is severe in such cases as the families quite often suffer losses after expending considerable amounts of money on health care.

A proper compensation system for personal injuries from medical care should be a judicious mixture of these two types of compensation; insurance taking the lead role. But the decision to hand over cases to Consumer Fora places emphasis only on the tort system which is inherently inefficient and may encourage certain types of cost enhancing and potentially harmful practices in the

13. International evidence indicates that these costs vary between 8 to 12 per cent of the claims settled. Since universal accident insurance eliminates the need for establishing negligence, the costs come down drastically. Dunlop, Bruce (1982), pp. 394-95.

health sector. If the objective of consumer legislation is to provide compensation to personal injuries arising from medical practice without harming the practice of honest medicine based on trust, exclusive reliance on the tort system cannot achieve that objective.

Alternative

The decision to give exclusive jurisdiction to the Consumer Fora to adjudicate all medical malpractice cases will lead to a number of problems such as: exclusion of a large proportion of victims of medical accidents who cannot get compensation under tort system; no immediate relief to mitigate suffering and finance rehabilitation where needed as reliance on the tort system means that compensation is given after the litigation is resolved; very high administrative and legal costs; harassment to physicians and clogging of courts with needless litigation; and the probability of increase in health care costs as the physician may resort to defensive medicine and subscribe to expensive malpractice insurance. This is not to say that the Consumer Fora have no role to play. Their role should be limited to acting as deterrent to negligence by imposing liability under torts in rare cases involving *prima facie* evidence of negligence. A proper insurance based compensation system and Medical Councils should take the primary and initial responsibility in adjudicating most of the cases.

Ideally, a 'no fault' universal insurance should be the primary method of compensation. This should cover all victims of medical mishaps, accidental or otherwise, for there is no reason why only the victims of negligence should get compensated. Tort liability system on which the Consumer Fora depend cannot achieve this objective. As indicated above, the universal compensation system will not only bring down the probability of litigation but also is inexpensive to administer. Preferably, the 'no fault' insurance scheme should be placed under the supervision of the Indian Medical Council so that as an insurer it will develop self interest in promoting preventive measures to reduce medical accidents and negligent care. Funds for this are not difficult to find. A small cess on the output of pharmaceutical, medical equipment and hospital sectors could probably raise the necessary revenues.

To supplement the universal 'no fault' medical accident insurance, the regulatory role of the Councils should be strengthened by giving them statutory powers. They should be able to set standards of practice and safety; promote

preventive measures to minimise accidents; and detect blatant deviations from the accepted norms of practice and punish such violators. Norms of practice and safety standards cannot be set overnight even by the Medical Councils. They have to be developed empirically from the practices followed in hospitals under varying circumstances, and not from individual experiences or anecdotal evidence. Once set, such standards need to be updated periodically. In order to facilitate this, there is a need to introduce compulsory internal audit of all adverse clinical events occurring in hospitals, followed up by a periodic (say once in three to five years) social audit by the Councils. Besides providing useful information to the Councils for setting standards of practice, introduction of mandatory clinical audit will offer the following benefits: clinicians can use the audit reports to identify preventable accidents and track down the contributing factors which will help reduce clinical risks; enables evaluation of the efficacy of alternative interventions in the field settings; makes peer review of performance of hospitals possible; enhances deterrence against negligence; and promotes social accountability of hospitals and clinics.

This leaves out a category of cases which arise from a combination of factors such as imperfection in the system, inadequacies in the methods of training and diagnostic methods. Since the probability of loss arising from these cases vary with the physician's efficiency and abilities, the compensation cannot be covered exclusively under the universal insurance scheme. Losses in such cases should ideally be covered by third party liability insurance subscribed by physicians and diagnostic facilities. Risk variable system of premium can be evolved to promote efficiency and continuous updating of knowledge by older generation of physicians.

Thus, a combination of 'no fault' and third party insurance and tort method of compensation to the victim of medical accident supplemented by adjudication from Medical Councils and Consumer Fora need to be evolved to take care of medical malpractice claims. Actual mechanisms of this complex system cannot be discussed here. Medical Councils/ Associations should lead from the front by suggesting the rolé they intend to play in order to supplement, complement and guide the Consumer Fora. Simply rejecting the Consumer Fora is no solution, they are needed to enforce tort liabilities which will have healthy deterrence effect. The Medical Councils should also press for a universal medical accident insurance without which a solution to the present problem will be difficult to find.

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