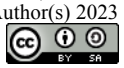
Sociology and Social Work Review
Volume 7 (Issue 2)/2023 | pp. 6-25


DOI: 10.58179/SSWR7201
https://globalresearchpublishing.com/sswr/


Healing Voices: A Deep Dive into Doctor Perceptions on relation between Malpractice and Medical Legislation and Healthcare system in Romania. The results of a qualitative sociological research

Radu-Mihai Dumitrescu [a]
Adrian Nicolae-Dan [b*]
Corina Ilinca [c]
[a b c] *University of Bucharest, Bucharest, Romania*

Abstract

This article presents findings from a comprehensive survey titled "Dimensions of Malpractice in Romania" addressing the negative aspects of the current legislation on professional liability. The data reveals a notable gap in doctors' knowledge of the legislative framework specific to the medical profession, emphasizing a high demand for formal, institutional training. The prevalence of "I don't know" responses suggests a conceptual gap, possibly stemming from ultra-specialized training that lacks trans-disciplinary education, particularly in legal matters.

Medical malpractice emerges as a significant challenge for both the healthcare system and society at large. This survey delves into the complex social context of medical practice, exploring individual experiences and social influences. The large participant pool (8,121 participants, with 4,729 responses) enhances the research's scalability, allowing for the identification of prevalent themes and subsequent correlations through advanced statistical methods.

The study, conducted through a questionnaire administered within a month to over 8,000 participants, highlights the cost-effectiveness and efficiency of survey research compared to interview-based approaches. Despite its advantages, the qualitative nature of the study presents limitations, such as the potential subjectivity in data interpretation. Limitations include the potential lack of generalizability, leading to the organization of data based on frequency rather than broad applicability. The findings may be more relevant for specific contexts, requiring further evaluations and independent assessments.

This qualitative sociological research prioritizes an in-depth understanding of phenomena over quantitative aspects. The identified themes and sub-themes reflect negative conditions and vulnerabilities in medical practice, serving as a basis for potential amendments to legal texts. A legislative framework adapted to local social conditions is proposed to benefit both the healthcare system and broader society. The article concludes with a call for

[*]Corresponding author: Adrian Nicolae-Dan. *E-mail: dan_adrian3@yahoo.com*

continued research, emphasizing the importance of refining the legislative framework to enhance the overall healthcare landscape in Romania.

***Keywords**: Malpractice; Doctor perceptions; Medical legislation; Healthcare system.*

The present paper is part of a large survey, based on a questionnaire, carried out in Romania, commissioned by the Romanian College of Doctors, entitled "*Dimensions of Malpractice in Romania - Analysis and diagnosis of the prevalence of professional burnout among doctors and migration trends*".

Data collection for this study conducted nationwide between January 16 and February 20, 2023. The questionnaire asked open-ended questions along with structured and filtering questions based on respondents' personal malpractice history via an online form, sent by email.

The present study presents the main findings[1] resulting from the qualitative analysis of the answers to the question: "What are the main negative aspects that exist in the current legislation regarding professional liability?" The qualitative approach remains a pillar of the investigations carried out in the areas of interest of all social and human sciences; qualitative research is described as an effective model that allows the researcher to develop a high level of observational detail and an involvement similar to real experiences (Creswell, 2009). The use of data sets and their analysis in an interpretative way manage to make the world and situations in people's lives much more visible; it is possible to uncover more subtle aspects, some even hidden or difficult to accept for society or various social groups. It is a type of social science research that collects and works with non-numerical data, seeks to interpret meaning from this data, and ultimately helps us understand social life by studying precisely the target populations (Punch, 2014). Doctors' perceptions regarding intimate aspects of their professional activity are probably difficult to reveal and, in this way, we believe that the qualitative approach was beneficial. In this way we investigate local knowledge and understanding of a concrete situation, people's experiences, meanings, relationships and social processes with contextual factors that marginalize a group of people (Leedy & Ormrod, 2010). Although the result may be less structured in the description, opportunities for formulating and building new theories are opened.

A total of 4729 responses were recorded from a total of 8121 participants in the general study. The frequency of certain themes was calculated considering the number of responses, regardless of the amount of information provided.

Based on the data collected, we can assume, with a high degree of predictability, that we are in a situation where, a professional group, believes that it does not know the concrete data of the legislative framework specific to the medical profession, it has a high need to be trained in this sense in a formal, institutional framework and wants an adaptation to the concrete situation of medical practice. The multitude of "I don't know" responses can also be viewed from a conceptual perspective in an ultra-specialized profession: long-term professional training focused on the acquisition of specific notions

[1] This article is a summary of the book "*Doctors on the Alert: Seeking Treatment for Change! Doctors' perceptions regarding medical legislation and the health system in Romania. The results of a qualitative sociological research"* / „Medici în alertă: căutăm tratament pentru schimbare! Percepțiile medicilor privind legislația medicală și sistemul sanitar din România. Rezultatele unei cercetări sociologice calitative", [authors: Radu-Mihai Dumitrescu, Adrian-Nicolae Dan, Corina Ilinca], published by Tritonic, December 2023.

leaves a gap in trans-disciplinary training that includes that of legal nature. In this way, the answer may suggest that doctors fail to establish what are the causal or contextual links between legal norms and direct practice, perhaps seeing them as belonging to another profession or within another specialized training. It is possible that there is a gap between the perspective that society has regarding the legal regulations that act in medicine and the integration of laws in the medical education process and even the awareness of the need for training regarding laws, within the professional group of doctors. In the course of time, a trend of evolution of the doctor-patient relationship could be observed, which produces a distance from the traditional paternalistic relationship. The conceptualization of the last decades pursues medical negligence in relation to an acceptable standard of care which must be that from which "no reasonable physician in a similar position" would not deviate in his practice (Kaba & Sooriakumaran, 2007), and the courts reserve the right to make this judgment. The literature abounds with works that attest to a continuous increase over time in the number of malpractice complaints in many healthcare systems; the American system, after overcoming a number of "crises of malpractice" knows a certain decrease in the prevalence of the phenomenon and a settlement of its components (the operation of insurances, the granting of compensation in courts). For example, it was observed : "A drop from a high of 17 claims per 100 physicians in 2000 to fewer than seven claims per 100 physicians today" and "On average, from 2007-2016, 70 percent of cases closed without payment" (Gottlieb & Doroshow, 2023). Romania is, most likely, in the first stages of a process of regulating the phenomenon at the level of society, a painful path for both doctors and patients. Knowing the laws and mastering some legal notions seems to be an imperative requirement for the professional medical body in Romania.

The issue of medical malpractice represents a challenge for the health system as well as for the whole society, and the current research represents the first survey of this kind, both by its complexity and by the large number of doctors who expressed their opinion.

Overall, it was possible to explore the social context in which medical practice takes place, the one in which the participants live, and to understand the social influences on individual experiences. By applying the questionnaire to such a large number of doctors, far exceeding the sampling criteria, an effective research tool with scalable results was obtained; the reporting of the identified themes was done in the order of the frequency observed in the population and the subsequent use of the data, through advanced statistical methods, can establish significant correlations with other determinants and even build some sociological models of local malpractice. The short time the research instrument (questionnaire) was administered provides superior data consistency.

In general, survey research can be less expensive than interview research because it does not require the physical presence of the researcher. In the present case it was possible to collect data from about 8000 participants in a time frame of about one month.

Through the qualitative approach, we encountered a series of limitations that will have to be corrected during further research. The possibility to generalize the information obtained is limited and, therefore, we limited ourselves to organizing the data according to the frequency of some themes. The results may be more relevant for specific contexts (specialty groups, geographic regions of practice, age categories) and therefore the frequency tables were kept for the categories proposed by the research team. Further evaluations, even independent ones, can be made from this information. Data interpretation in qualitative research is highly dependent on the subjectivity of the researcher; there is a

risk that individual perceptions and interpretations may influence the results. To limit this vulnerability there was a phasing of the data processing within the research team; initial coding on themes and sub-themes was done by team members who did not have direct professional contact with the health system. The axial coding stage was a later one and was structured by the member of the research team with direct experience within the health system; in this way it was possible to contextualize the presented situations. The final structuring of the information was done within the research team which decided to keep an important portion of the original texts to clearly highlight the division into themes and sub-themes. All three members of the research team have relevant qualifications and experience in sociological research.

Qualitative sociological research focuses more on in-depth understanding of phenomena, and this can lead to an under-representation of quantitative or statistical aspects. Traditionally, in the medical field, quantitative data can provide valuable information about the effectiveness of treatments or the prevalence of certain health conditions. The present research does not pursue such aspects but some that concern a medical socio-professional group. The relationship between researcher and participant can often influence the results of qualitative research. Participants may be influenced by the researcher's perception or willingness to respond in a certain way, which could affect the validity of the data. In our case there was a methodological distance between those who answered the questions and the research team.

The themes and sub-themes that resulted from the codification of the answers obtained by applying the questionnaire led to the identification of negative conditions for medical practice or to the observation of vulnerabilities felt by the members of the professional body; the final utility would consist in taking them into account when amending specific legal texts. Ensuring a legislative framework adapted to local social conditions could bring benefits in the health system but also in the general social one. These negative conditions have been discussed within each section; in the following we will list most of them and we will detail the main particular aspect identified (criminal incrimination). According to the qualitative research model, there was a coding and later a selection on predominant themes identified in the comments sent by the doctors through the administered form. Afterwards, there was an axial coding through which the establishment of logical connections between the identified themes was pursued. In order to achieve the objectives of the present work, I have chosen a limited number of fragments from the comments made by doctors.

- Deficiencies in the knowledge of legal provisions regarding malpractice among members of the professional body, educational programs specific to legal aspects poorly represented at the national level (both during basic training and after entering the profession);
- The penal incrimination and investigation of doctors within this field of law can lead to a public culpability of the entire professional body and global damage to the public images of the profession;

> *"It is not normal for the doctor to be interrogated as a criminal along with common law criminals and shoplifters. A doctor should not end up in such situations. Yes, you die in medicine, but doctors are not criminals. They have nothing to look for at the prosecutor's office and prosecutor's office. Point. It is beneath their professional dignity."*

- The penal investigation, repeatedly presented in the media, leads through a phenomenon of labeling to the association of medical mistakes with other forms of delinquency, associating the medical professional body with other social groups with a deviant character, by building a negative social image;

> *"Treating medical staff as potential criminals. Allowing the exposure of medical personnel in what we call a media circus before the certification of guilt by professional jurisdictional bodies and then by justice."*

Regarding the criminal incrimination, some important clarifications are necessary. This theme can be seen as the main negative condition reported by Romanian doctors, recording the highest frequency of the collected valid comments. A number of 444 comments regarding this aspect were sorted and represented 9.38% of the total comments. If we return to the main research report and observe the frequency of cases in front of various types of institutions, some particular aspects of the way malpractice cases are investigated in Romania are revealed. 616 doctors reported one to more than four procedures instrumented by Police, "Suspicious Deaths" Office or Homicide Office. In total, they reach a minimum number of 997 procedures. 232 doctors reported instrumented procedures through the Prosecutor's Office. In total, they reach a minimum number of 371 procedures. It is likely that some of these procedures overlap and have been implemented by both institutions in accordance with judicial practice; these procedures represent what is publicly understood by the notion of „criminal file" *(„dosar penal").* In other words, it can be approximated that the number of such files reported by the population of responding doctors is around one thousand.

In this way, the main particular aspect for Romania is outlined, represented by the instrumentation in relation to the criminal law. If we look at the way in which the investigation procedures of malpractice cases are carried out in the American system, the legislative structure is in the sphere of civil law. The American system is recognized as having appreciable volumes of malpractice litigation and serial legislative reforms were necessary due to the emergence, in waves, of malpractice crises. The laws that define and intervene in cases of malpractice, as well as the legal reforms, have names that contain the particle „tort". Medical malpractice cases in the United States are a specific subset of tort law that deals with professional negligence. „Tort" is the Norman word for „wrong", and tort law is a body of law that creates and provides rewards for civil wrongs that are distinct from contractual duties or criminal offenses (White, 2003).

United States law applies the concept of *mens rea*, or criminal intent, in criminal cases. *Mens rea* is a Latin phrase meaning „guilty mind". It refers to the defendant's state of mind when he committed an alleged crime. Generally, there is no crime if there is no criminal intent. Suppose a doctor tries in good faith to cure a patient's illness. While he was performing his duties, the doctor made a mistake that made the patient's condition worse. This is an ordinary act of negligence without criminal intent. The doctor may be liable for medical malpractice, but likely will not be charged with a crime. However, some cases go beyond ordinary negligence. Indiana law (IC 35-41-2-2) specifies three levels of culpability (or responsibility) in criminal acts. These three levels can be used to describe criminal negligence. A person can commit an act:

Intentionally – with the „conscious aim" of doing so; Knowingly, that is, while „he was aware of the high probability" of doing so; Reckless – if the act is committed „in clear, conscious and unjustified disregard of the harm likely to result and involves a substantial departure from acceptable standards of conduct".

A retrospective look at the malpractice lawsuits in the United States of America gives us a series of figures: 49.2% of doctors 55 years and older were sued; 39.4% of male doctors were sued; 22.8% of female doctors were sent to court; approximately 15,000 to 18,000 lawsuits are filed each year for negligence or medical malpractice (Dimetman, 2022). Although the volume of these processes is very high, the criminal investigation is extremely limited. Describing the prosecution of healthcare providers in the United States as a trend is an overstatement when you compare the flurry of criminal cases to the blizzard of civil litigation providers face when accused of malpractice. However, medical record prosecution is on the rise. Between the first such criminal case in 1809, Commonwealth of Massachusetts v. Thompson, and 1981, appeals courts heard about 15 similar cases. Over the next twenty years, about two dozen cases found their way into the lower courts (Monico, Kulkarni, Calise, Calabro Citation, & Calabro, 2006). The same author concludes: criminal sanctions against medical personnel should be an extraordinarily rare event in medicine. Although cases are rare, the number of medical professionals facing criminal prosecution is increasing. Clearly, the time to solve this problem is now.

There are several theories used to explain the increase in criminal prosecutions. Some mention a growing acceptance of the idea that medical negligence is like a white-collar crime, having a hybrid nature (civil and criminal) (Bucy, 1989). Others cite the failure of state regulatory agencies to „police" the medical profession (Adler, 1991). Proponents of criminal prosecution rely on utilitarian and retributive theories of justice to rationalize their position. Utilitarians believe that criminal sanctions are appropriate when they punish careless behavior because prosecution encourages all individuals to behave more cautiously; utilitarian theory applied to health care supports the idea that the threat of criminal sanctions would force doctors to monitor their own practices (Dressler, 2015). Retributive justice, a theory centered on the idea that punishment is justified on the grounds that the offender has created an imbalance in the social order, also supports criminal sanctions for medical acts; involuntary risk-taking by a doctor can be seen as a „failure in social interaction" that should be punished by criminal sanctions (Fletcher, 2000). Opponents of criminalizing medical malpractice argue that a just criminal system should punish only those who have voluntarily committed a wrong. Based on this theory, it would be unfair to punish a physician for involuntarily taking risks or when the physician is unaware that his action creates a risk. Furthermore, a negligent physician who fails to identify his dangerous conduct would also fail to understand the potential threat of sanctions for such conduct (Dressler, 2015). Therefore, it would be unfair for such a defendant to lose his freedom and be stigmatized. Medical associations and doctors' specialty groups add that criminal prosecution for clinical errors would set a dangerous precedent. They argue that such a precedent will discourage doctors from taking on difficult cases or experimenting in new areas. Others argue that such a criminal procedure will encourage the practice of defensive medicine and may contribute to further increasing the cost of health care (Adler, 1991). The path that Romania will follow in the future legal regulations regarding medical malpractice is difficult to predict; only the need for a formal social control over medical activity does not seem sufficient to justify the

criminalization of medical error and negligence. If we look at the absolute figures of medical malpractice complaints in our country, related to the number of doctors and the volumes of activities, and add the way in which the news regarding problematic medical cases and the real functioning of the compensation system are circulated on media channels, the need for a legislative reform it seems as strict as possible.

- The way in which malpractice investigation procedures are initiated and carried out, as well as their presentation on communication channels, can shape the perception of doctors regarding the lack or limited application of the presumption of innocence. The idea of promoting a culture of guilt at the social level can be outlined, a possibility accentuated by a minimization of the context of professional practice and the specific pathological elements of each individual patient;

  "The doctor is criminalized without the presumption of innocence and without taking into account the ailments with which the patient presented (the patient did not come to the consultation healthy, and the doctor does not have supernatural powers)."
  "We are looking for the culprits and not the solutions to solve and prevent problems. We do not have the culture to learn from our own mistakes and from the mistakes of others. We do not promote education by analyzing medical errors in order to prevent them."
  "Doctors are "judged" in the press, in the media and are attacked as an image and professional guild with the aim of diverting the attention of patients from the real problems of underfunding and corruption at the top (from where the funding of the public and private health system comes from) . Exposure on social media should be prohibited by law, until the guilt of a doctor or nurse is proven beyond any doubt."

- The imprecise definition in the text of laws of some essential aspects in the management and treatment of cases (adverse reactions of medication or medical procedures, complications of diseases, the natural evolution of serious diseases) as well as the practical applicability of these judicial procedures, can lead to unwanted pressures. on doctors and even on changing the importance of professional practice (defensive medicine);

  "The fact that there could be, at a given moment, a prosecutor who implements a case of alleged malpractice, even if the evidence attests to the presence, rather, of a spectrum of adverse reactions causing damages. Neither the legislator/nor the courts do NOT understand/do NOT want to understand the difference between adverse reaction to the administration of a treatment (surgical or medicinal) and malpractice. Informed consent is, most of the time, devoid of substance and does not cover the actual medical act."

- The imprecise framing of responsibility in the event of the occurrence of infections and other unwanted events during medical activities, seems to be perceived as a decrease in institutional responsibility and an unfair increase in medical liability;

- The initiation of investigative procedures for a possible malpractice case appears to lack any form of control; the absence of a form of preliminary professional expertise is perceived negatively by the professional body;

> *"Anyone can accuse a doctor and criminal prosecution can be started without the prior consent of the College of Physicians".*
> *"The non-existence of an "expert evaluator" of the medical act provided for which the doctor is accused, from among the practitioners in the medical specialty in which the accused doctor also practices, whose expertise would be useful in the "amicable resolution" or the trial of the case in the civil court."*

- The non-existence of a group of evaluators and professional experts seems to be a vulnerability observed by doctors, along with an ambiguity regarding how to form this body of experts and the role that a series of other institutions should have (including the Romanian College of Physicians);
- Communication between the parties involved and between various institutions of the medical specialty aspects do not seem to be under any form of control or regulation. Petitioners or their representatives (including those belonging to the legal professions), practice medical documents without a form of transposition of the information into a common language, without prior contextual framing; the body of professional experts could facilitate these aspects;

> *"The involvement of the police/judiciary in assessing the quality of the medical act, the lack of expert commissions that, based on clear diagnostic and treatment protocols, assess malpractice claims; the malpractice insurance provisions are totally ambiguous and interpretable."*

- There is an overlap and an ambiguity of the various institutions and commissions that analyze potential cases of malpractice;
- Medico-legal expertise, in the way it is currently carried out, is questioned from many perspectives: the way of organization, the way in which experts are included and by the fact that they fail to include the real and complete framework of a medical situation;
- Liability and criminal investigation of malpractice cases are seen as negative determinants of medical practices, requiring a precise delimitation of the legal framework as well as objective criteria for which the doctor can be held criminally liable;
- Specific aspects of the legal order by being perceived as unclear in the current body of laws and objective framing in the field of law applicable in certain situations cannot be achieved. A differentiation of guilt is required according to severity (major - ordinary mistake), a delimitation between mistakes by omission and commission, as well as criminal liability in relation to the intention to commit a crime and not only according to the result or extent of the damage;
- The duration of malpractice investigation procedures is seen as unreasonably long, with a negative impact on both doctors and patients harmed during a medical treatment. In addition, the unpredictability of the proceedings, with multiple appeals, which can succeed over a number of years, is claimed;

- The lack of a distinct law for the resolution of malpractice cases appears to be a general idea within the professional group. There seems to be an urgent need for a special law to manage the situation of medical malpractice and to include clear aspects regarding the way in which the compensation awarded by the courts is calculated, their amount as well as the way in which legal proceedings are initiated. Preliminary research should establish in a professional framework the admissibility of the claims;
- There is an ambiguity regarding the inclusion of doctors in the body of civil servants;
- The way of collaboration between institutions that investigate cases of malpractice and medical institutions seems not to be clearly regulated and to be carried out according to a series of distinct, known procedures that provide predictability;
- Media coverage is perceived as biased, with the primary goal of obtaining ratings and without being guided by ethical principles. Returning to a news item after completion of investigations is not done in case of a favorable verdict in the case of the doctor.
- It does not seem to be known or to exist a distinct legal text that offers protection to the doctor in the case of defamation by means of media communication; an imbalance is claimed between a universal right to information of the population and the individual rights of a doctor;
- The public communication of cases of malpractice, through the media, is considered to go beyond the formal framework of the spectrum of information, building a campaign to denigrate doctors. The responsibility of media representatives does not seem to be able to be attracted and the role of public communication in the sphere of citizens' health education, the promotion and maintenance of behaviors that promote health seems to be only a formal one;

> *"At the moment, the media coverage of malpractice cases had a domino effect for patients; the consultations have become a kind of test of general medical culture for doctors, distrust in the medical body has grown unimaginably, which has increased the number of followers of conspiracy theories sometimes supported freely by colleagues looking for notoriety, political capital, etc."*

- The doctor's responsibility is perceived as disproportionate compared to that of medical institutions and, implicitly, of the state, which is a guarantor of health insurance at the public level, therefore, at the level of a social framework. It seems that an explicit involvement of the state and medical institutions is desired in terms of liability in a case of malpractice, being directly responsible for the way in which the operational framework of medical practice is built.

> *"In the event of a death, the doctor is accused of attempted murder, even if that death is medically justified as unforeseeable, sudden or the practice conditions are insufficient due to the fault of third parties: insufficient funds, old buildings, lack of equipment, lack of medical staff , the fatigue accumulated after 24 hours on duty followed by the continuation of the activity in the 8-hour shift, so in total 36 hours of sleeplessness and continuous work, unclear legislation with many changes in short periods of time that lead to difficulties in keeping up, difficulties in interpretation in daily practice, the legal department within medical institutions with too few employees, on unmotivating salaries, the lack of training of doctors from the point of view of legislation, etc."*

- The direct conditions of medical practice existing at the workplace of a doctor seem not to be taken into account when investigating a case of potential malpractice;

> *"Insufficient separation of the causes of medical errors/failures: those related to the doctor, from the causes falling under the responsibility of others. For example: insufficient staff in general, insufficient number of specialists, the impossibility of organizing guards and shifts, the hospital infrastructure lacking conditions for isolation and respect for circuits, lack of access to some important medicines, limited access to specialty consultations outside the hospital."*

- The working conditions seem to have a formal framework of existence, but their application within the health system seems to be limited and disproportionate longitudinally;
- Staffing and work load rationing are not taken into account in the investigation of a malpractice case and the liability arising from this is not assigned. The sole liability of the physician in the case of such deficiencies appears to be arbitrary or even abusive in the opinion of some physicians;

- The existence of a distinct and effective mediation system is questioned. There is ambiguity regarding the institutions that should mediate between the potentially harmed patients and the doctors who provided the challenged services. No data was found to attest that the current way of organizing the legal mediation process (through dedicated professionals) would intervene in cases of malpractice; hence the need for a separate regulation on mediation in malpractice cases.

> *"There is no conflict mediation. There is no understanding from the patient regarding the risks of his pathology. There is no primary health education of the population. Mass media amplifies conflict situations."*
> *"An extrajudicial alternative should be found for the settlement of malpractice complaints - the no-fault system, mediation, arbitration, amicable settlement, etc., in this way, there are also a number of advantages, both for the patient and for the doctor, lower costs, the disclosure of incidents occurring in medical practice is promoted; decreases the level of psychological stress to which the doctor and the patient are subjected. In many of the claims against doctors, patients are influenced by various outsiders: doctors, lawyers, media, friends/acquaintances. The mass media encourages the status of the patient as a victim of an act of malpractice, contributing significantly to the increase in the number of complaints from patients."*

- There is the perception of an imbalance in the doctor-patient relationship and the construction of an inequity regarding the two parties involved in the therapeutic process. It is considered that patients are not at all held responsible for compliance with medical recommendations and, moreover, in a problematic situation, the direction of responsibility shifts unjustifiably strictly towards the health system and its representatives. Patient compliance, as a determining process in the subsequent

evolution, does not seem to be taken into account when analyzing a potential malpractice;

> *"Very high responsibility of the medical body and lack of knowledge of the patient's obligations".*
> *"Responsibility of the doctor only for the patient's health - consultation, treatment, patient counseling - as if the patient had no responsibility and no obligation in maintaining or recovering his state of health."*
> *"In my opinion, the main negative aspect consists in the absence of "patient obligations" regarding the treatment they need."*
> *"All patients know that they only have rights and not obligations under the conditions in which therapeutic success is sought. At the same time, there is no measure that can be taken in the case of patients whose lack of compliance has been proven."*

- The professional liability insurance system is completely devoid of functionality and has a purely formal character, it represents a dominant idea within the professional group;
- The professional liability insurance system should be able to cover the occurrence of an insured risk through compensation;
- The medical service provider's insurance should cover the damage if it falls to the medical institution that provides the institutional framework for carrying out the medical intervention; Other distinct aspects regarding the operation of professional liability insurance seem to require precise regulations: the amount of compensation, the description of the insured professional activities (during normal working hours, during on-call hours, during independent practice) and maintaining the retroactivity of the insurance contract (from the point of view of practically, a patient can act at a distance from the actual moment of the medical act and the duration of the procedures is enormous in relation to the standard duration of one year for which such an insurance contract is signed);
- The dysfunctionality of this insurance system disadvantages precisely the patient who does not receive compensation for an injury that can be as real as possible;
- The amounts established by the courts as compensation are unpredictable (especially those for moral damages) and are disproportionate to the formal amounts within the insurance contracts; the existence of compensation ceilings or grids could be useful;
- The need for a specific law regarding insurance and compensation in the event of errors or negligence arising during the exercise of the medical profession is claimed; the fundamental role would be to create the framework for this system to become functional and leave today's formal area;

> *"The malpractice policy doesn't work, it doesn't cover the damage, it doesn't settle the lawyer. In all civilized countries the lawyer for the insurance company and the hospital talks to the patient and represents the doctor. Exceptionally, the doctor is called to a trial or confrontation. In our country, regardless of the insurer, the doctor pays his own lawyer, he has to appear himself and the damages offered in case of mistakes far exceed the amount insured by the policy. The current system favors insurers who are only making huge sums of money from legislation forcing*

> *staff to insure. I recommend that you see how a doctor is treated by the insurer in the event of a dispute in any Western European country and how it is in Romania. In short, insurers make fun of doctors, and those who should represent our interests have never taken any steps beside the legislator, to put pressure on the insurer and the doctor to be treated as he is everywhere."*

- Bureaucracy is recognized in many of the doctors' statements as a negative factor in direct patient care. The existence of a coherent health legislation would eliminate the overlaps that arise through the actions of different institutions with a regulatory and control role;
- The doctor-health system liability balance is seen as profoundly inequitable and unjust. An institutional liability should arise in the case of insufficient coverage with personnel or specialized services, in the case of insufficient technological equipment, in the case of defective supply of medicines and sanitary materials or non-compliance with working conditions;
- The current legislation is regarded as outdated and not adapted to today's social realities;
- Medical practice protocols seem to not exist, to be inapplicable in practical situations or not to be uniformly applied. The existence of medical practice protocols would work as a frame of reference for analyzing malpractice situations;
- Procedures and practice protocols for specialties are required, at the national level and adapted to the practical conditions within the health system. Overcoming the current framework of treatment protocols, a predominantly restrictive one, with the role of managing funds and obtaining medical practice standards;
- The politicization of the health system is seen as a negative condition by a professional group that, through over-specialization, has a natural tendency to see itself centered on the professional dimension;
- The association of the collegial management forums, from the health institutions and those from the university management with the political factor identifies the health system with the entire social system under a certain spectrum of political actions;
- Political statements and actions are perceived as biased precisely by the fact that they exclude the real possibilities of the system to manage, without restrictive conditions, all care needs and do not reveal the realities within the system and the social ones as a whole;

> *"The false impression left/created/exposed by the authorities, that everything is Ok, everything works perfectly and that we have everything at our disposal, when in fact, the truth is completely the opposite, we have many shortcomings, many dysfunctions and all, combined with a poor education of the entire population, but also the extremely negative impact of the daily news about alleged medical mistakes, which do nothing but drive another nail into the coffin of our healthcare system."*

- There is a need for a coherent organization of the health system. The dysfunctionalities that should be corrected were identified at the level of each functional stage: from preventive medicine, family medicine, emergency management and up to the integration of the health system within the social assistance system. Overcrowding of emergency rooms and emergency services with social cases (patients without a home,

with mental disorders, chronic alcoholism, with low incomes) burdens the system and obviously reduces the accessibility and quality of care for real cases from a medical point of view;

- The implementation of prophylaxis and prevention programs that could have a transversal impact, over time, towards chronic pathologies identified early, better controlled and towards patients who are better educated to maintain a healthy lifestyle;
- The clear definition of the medical-surgical emergency would have a considerable impact not only in the management of potentially litigious situations but also in the functioning of the health system as a whole. Easy access to the emergency room and emergency departments is seen as a vulnerability. The treatment of non-emergencies or social cases seems to be of a mandatory nature as there is no legislation that allows them to be refused;
- It is required to regulate the operation of emergency departments in relation to the real possibilities of the health units (including coverage with specialties that could later take over the cases); Specific health regulations that are considered outdated, non-functional or even non-existent: the actual classification of health facilities based on principles of competence, the functional regulation of transfers between health facilities, transparently obtaining the situation of beds available for emergencies;
- Obliging doctors to a medical practice that involves exceeding their skills seems to be a reality all the more present the more the place of practice is located on the periphery of the health system;

> *"In a case of malpractice, the attending physician is solely responsible. Unfortunately, in small hospitals, due to the lack of doctors, I am forced to exceed my competence. For example, I, as a urologist, am on call for surgery and I don't have an emergency doctor in the "Emergency Reception Department" CPU and I have to coordinate a neurosurgical or pediatric surgery case."*

- The architecture of the health system does not seem to be based on the territorial distribution of the population and the needs of medical services. It is considered necessary to think about a reorganization based on a functional territorial distribution and based on the competences of the sanitary units, with the aim of ensuring some functional circuits and eliminating some sanitary units which, by way of organization, are only consuming resources but cannot be included efficient in care flows;
- Extremely different conditions can be identified regarding the quality of medical services at the territorial level, from the perspective of coverage with specific resources; this is not only a negative aspect for medical professionals but leads to discrepancies, even social inequities between citizens, social exclusion depending on their territorial affiliation;
- The initiation of treatment in case of emergencies is considered to be standardized and based on skills and real treatment possibilities;
- The existence of medical structures under another jurisdiction, such as the SMURD (Acronym for Mobile Emergency, Resuscitation and Extrication Service) case, involves a series of vulnerabilities identified by the respondents: the partial integration of these professionals into the health functional structure, the existence of a break in the chain of care, responsibility and subordination displaced from the level the hospital to other administrative structures and the defective cooperation between professionals;

- There is a need to clearly define the notions of attending physician and the minimum package of services, with important implications on the chain of professional responsibility;

> *"The main problem is the definition of "attending doctor" - easy to identify a main culprit, even if the fault is systemic."*
> *"The lack of clear definition of the package of medical services and the lack of correlation between what is possible to offer and the promised package."*

- Overwork of doctors, physical exhaustion or even the occurrence of burn out syndrome are realities of the professional group that require objectification and appropriate institutional measures;
- The performance of work as well as the extent of professional liability in conditions of physical exhaustion are considered to be relevant for the direct process of care and for the way in which a litigious situation is judged. Professional liability is not rejected in its conceptual framework, but a fair and concrete assessment is required, stemming from the practical aspects of the medical profession;
- It is considered important to regulate professional activities during the guard period. It is a period of professional activity that brings much greater professional responsibilities by providing medical services outside the normal schedule, inherently with a much-reduced number of specialists, encountering structural problems that the doctor must face alone or in a much smaller team;

> *"Professionalism is required, but we, doctors, in practice, do not even have doctors on call every day, for interdisciplinary collaboration (for example cardiology, neurology), we do not have the necessary equipment for rapid diagnosis plus, not to mention, the possibility a diagnosis of certainty for patients with lung neoplasm (in Prahova county, there is no possibility of performing bronchoscopy)...so that the satisfaction of both the patient and the relatives is ok...not to mention how much it makes it difficult for us on us this burden of the medical act."*

- Another high aspect, of a systemic nature, concerns the way doctors are remunerated. In the situation where there would be an objective evaluation of performances and achievements, it is possible to eliminate a series of negative conditions;
- Cooperation between the various specialties involved in the care of a patient is seen as dysfunctional, as a negative condition;

> *"Team work is deficient, it is not concretely established, the inter-clinic consultation is not standardized/mandatory."*
> *"Difficult collaboration between specialties, without clear protocols, a lot of bureaucracy that steals from the time needed to be given to the medical act, discrepancies in the salary system that cause damage to officials in teams."*

- The elements related to the administrative, bureaucratic side, it seems, are not included in the actual evaluation of the doctors' activity, although they occupy a significant period of time. The direct professional activity, centered on the patient, can become a

secondary one, distancing the doctor from his essential role in the absence of an objective observation of the administrative side of the profession;

> *"There is no accountability for bureaucracy that delays investigations and treatment of patients. There are many difficult and time-consuming procedures that delay investigations and treatment of patients."*

- The specialty "Family Medicine" seems to be the most affected by the bureaucratic element and is deeply dependent on the functioning of the state's electronic systems. The bureaucratic invoice elements are not only restrictive but can even become punitive;

> *"The medical intervention in Family Medicine is very restricted. Bureaucracy takes more than half the time of a consultation. For many investigations or medicines, in order to be able to recommend them, in a compensated regime, we need medical letters from fellow specialists, also every three months, otherwise we are charged at the checks from the National Insurance House."*

- Medical services seem to be evaluated and constructed starting from gross volumes of activity, regardless of the sub-sector of medical activity considered. Reporting to the institutions, financing and other aspects are based on the number of interventions and, too little, are related to the final result of the intervention and its quality. This approach raises another vulnerability and through a lower emphasis placed precisely on the prevention of malpractice;

> *"Not enough emphasis is placed on malpractice risk, at least in my experience. Rather, clinics focus on the financial aspect (to see as many patients as possible per unit of time). Obviously, in such situations and taking into account the fact that doctors sometimes have extended consultation hours, even in multiple clinics, medical mistakes can occur more frequently. Even the malpractice insurances taken out do not fully cover compensation for moral damages, because the insurance companies know that in court, those damages will be significant compared to the material ones."*

- The need for a unified and functional IT system is raised by professionals from all specialties. A functional computer system would act transversally at the system level reducing errors and facilitating a medical act less exposed to errors and negligence;

> *"For those who work under contract with the health insurance company, the main negative aspect is the cumbersome operation of the IT system, interruptions in its operation, the doctor's obligation to complete many documents both in written format on paper and in electronic format (prescriptions, medical letters, medical leaves, dispatch tickets, medical certificates, etc.). Often, completing these documents takes longer than the consultation itself. In general, the legislation in the field seems quite confusing to me."*

"Not all of a patient's admissions and doctor presentations are centralized on one platform. There is no platform that allows us to see when and where the patient is medically evaluated."

- Specialization in medicine is evident, as is the emergence of new categories of professionals who work alongside doctors; the latter appear to bear the full responsibility for medical care. The exact definition of the limits of competence, the way and time of the intervention and the responsibility of each professional, stemming from these interventions, is a need;
- The biggest regulatory ambiguities for related professions seem to be in the spectrum of Laboratory Medicine and in that of Medical Rehabilitation;

"Physiotherapist Law 229/2016 allows average staff, with or without higher education, called physiotherapists (FKT), to make an assessment and treatment plan instead of MFR specialist doctors (physical medicine and rehabilitation), contrary to law 95 which establishes that only the doctor is able to diagnose and prescribe treatments."

- The problem of underfunding the medical system is a general declarative condition among doctors.

"Because economic decisions matter the most in patient management, the main responsibility in malpractice should be the hospital's, the doctor being obliged to take, most of the time, a more or less inspired decision, depending on the poor endowments at his disposal."

- The mode and level of funding influences the presence of resources of all kinds within the system and thus, constructs the physician's conditions of practice. Looking from this perspective, financing cannot be excluded from the analysis of litigious situations;

"Restrictions and limitations imposed by the contact/application rules of the Insurance House", "chronic lack of funds", "modest financial resources", "underfunding".

- • In terms of financing, the way in which resources are distributed and the way in which costs are assessed is complained about. There are opinions regarding the incorrect or undervalued calculation of the costs for certain medical procedures, creating not only a distorted picture, but also a real rollover of financing gaps at the level of the system;

"Medical-surgical procedures are not calculated. For example, operations of EUR 20,000 are performed and they are accounted for 0. Patients leave a financial void in which the next patient comes...with multiple organic dysfunction...toxic-septic shock, etc."

- The tendency to tilt the balance of responsibility for the majority medical act towards the doctor is considered a deep inequity;

"Negative aspects? The patient turned into our "master"!!!!! Only one category: The lack of rights of the medical staff in front of the patient, the medical staff having only OBLIGATIONS", "The fact that the patients want to get as much money as possible from the doctors and consider them to be their "servants", not the doctor who can help them."

- The management of litigious situations in the absence of explicit laws that protect the doctor from the various forms of abuse, but also the instrumentation within a local culture based on the principle of guilt promotes a whole series of deviant behaviors, both at the level of individuals and at the level of some administrative structures;

„ Only the rights of the patients are taken into account, but the medical personnel always feel unprotected, this can be seen by the lack of respect towards the medical personnel, especially in the ambulance, by several patients, even the television stations do not take into account that through the news that attack the health system, in fact, they create a lack of trust towards the medical staff and that leads to a lack of respect and trust on the part of the patients. There is no medical staff that makes mistakes on purpose, we are human, but we are not slaves to the patients either, I say this because, several times, especially in the ambulance, we are treated very badly, as if we are employees of the patient..."

- The legislative framework that should act in case of malpractice is seen and intensely influenced by the political factor, as a result of the non-involvement of the central decision-making factors and under the influence of the politicization of the political discourse regarding the problems in the health system;
- The ambiguity and lack of clarity contained in the legal texts that act in health has various representations in the perceptions of doctors. Specifically for the issue of malpractice, we want to clarify the concept of recognized medical standards, a reference element in the analysis of litigious cases;
- Another characteristic appreciated as an important one is the predictability over time of the laws and the results of their application. This negative aspect seems closely related to the practice of changing laws frequently;
- A situation that is not only specific to medical regulations, but also appears in the public space, in connection with numerous areas of legislation: the absence, delay or inconsistencies in the technical rules for the application of a law;
- The professional group raises the appearance of a group of own vulnerabilities that could be improved by educating doctors about legal issues, offering advice and support from the legal services of health institutions;
- Establishing precise limits of competence and responsibility by professional category appears as a need within the professional group of doctors;

"According to Law no. 95/2006, in my opinion, the following aspects are not clearly defined (and which can be elaborated much more concisely): (i) it does not establish what facts represent professional error; (ii) does not clearly define what constitutes a medical or medico-pharmaceutical act, in general, or a potentially harmful medical or medico-pharmaceutical act, in particular; (iii) does not indicate exactly what should be meant by "patient harm" (ie, what type of harm is

meant to attract legal liability); (iv) does not clearly individualize the persons within the medical staff and the supplier of medical, sanitary and pharmaceutical products and services who should be held responsible, compared to the typical case of malpractice (leaving open the possibility that any and all of the persons who contributed to any medical-sanitary-pharmaceutical act to become legally liable); (v) does not precisely establish the order of liability or the degree of liability applicable to each of the staff members who took part in the performance of the medical act, relative to the typical case of malpractice."

- The existence of treatment guidelines is seen as a need that goes beyond the role of regulator of the complaint resolution procedures and is expected to have a much deeper role in the functioning of the health system, from the possibility of contributing to the elimination of the subjectivity of individual interventions of doctors to contribute to the training and professional training process;
- Hospital legal departments are seen as not involved in supporting doctors in court cases. The legal representation of doctors falls exclusively under their individual responsibility;
- The explicit definition of the patient's responsibility arising from the signing of the informed consent is required;
- The level of insurance premiums should be established according to a specific risk analysis for each specialty and level of practice;
- The compensation awarding process should be regulated to ensure the functional nature of insurance contracts;
- The risk insured by professional liability policies seems poorly defined;

Instead of conclusions ...

"Lacunarism, the lack of filters that determine the initiation of a civil or criminal process only when there are certain facts, not suspicions or hatred drives against the doctor who failed to cure a decompensated disease in a patient negligent with his health. It is necessary to introduce mandatory screening tests by age groups for the most frequent litigious pathologies and those who do not perform them should increase their medical insurance premium and not be able to initiate a lawsuit against a doctor. Also, the lack of compliance with the treatment should determine the exclusion of the possibility of triggering the "malpractice case complaint" procedure. And patients have major obligations. Bringing insurers directly into the process. Lack of compensation ceilings. Responsibility only of the staff. Lack of serious, assumed, employer involvement. The doctor is left alone, that has to go."

In this qualitative analysis of doctors' perceptions of the medical legislation and the health system in Romania, a multitude of complicated issues came to the surface, generating lights and shadows on the multiple challenges facing the medical profession. Our findings, based on the information provided by doctors, highlight not only the ambiguities of the legislative framework, but also the far-reaching implications for doctors, patients and the healthcare system as a whole.

An important theme centers on physicians' lack of knowledge regarding legal malpractice provisions. The absence of comprehensive programs, both during basic training and professional development, underscores the critical need for a robust legal education component within medical training. The study reveals a worrying association

between the criminalization of doctors and the potential damage to the public image of the entire profession. Media coverage, often biased and sensational, contributes to labeling medical malpractice alongside other forms of delinquency, creating a negative social image. The perceived lack or limited application of the presumption of innocence in malpractice investigations is a significant concern. Initiating and conducting investigative procedures without prior professional expertise contributes to a potential culture of guilt, negatively affecting the professional status of physicians.

The imprecise definition of essential aspects in case management and treatment, coupled with ambiguous legal texts, leads to unwanted pressures on doctors and may contribute to the practice of defensive medicine. The study underlines the urgent need for clear and specific laws to manage medical malpractice cases.

The unreasonably long duration of malpractice investigation procedures, coupled with the lack of a distinct law for resolving such cases, poses challenges for both physicians and patients. The unpredictability of procedures and the absence of clear regulations contribute to increasing the ambiguity of the legal landscape.

The dysfunctional professional indemnity insurance system is raising concerns among doctors. The study advocates for a specific law to regulate insurance and compensation in case of errors or negligence, addressing issues such as compensation amounts, compensation criteria and retroactivity of insurance contracts.

Bureaucracy, often recognized as a negative factor in direct patient care, blocks the work of doctors in many situations. Underfunding in the healthcare system affects the availability of resources, working conditions and ultimately the quality of care provided.

Ambiguities in legal texts and the lack of clear definitions for related professions, especially in laboratory medicine and medical rehabilitation, require regulatory clarity. The study also advocates the definition of competence limits for each professional category.

The need for a coherent organization of the health system, addressing dysfunctions at every stage, from preventive medicine to emergency management, emerges as a crucial recommendation. Territorial distribution and reevaluation of medical services based on functional needs are proposed for a more efficient and equitable system.

Concerns about overwork, burnout and physical exhaustion of doctors highlight the importance of addressing working conditions and remuneration. The study emphasizes the need for explicit regulations to regulate professional activities during on-call hours and remuneration based on objective assessments.

The need for a unified and functional IT system is emphasized to reduce errors, improve the quality of medical records and streamline administrative processes. Clear definitions of competence and responsibility for each professional category are identified as essential for effective collaboration.

In conclusion, this research provides a comprehensive examination of physicians' perceptions of medical law and the health care system. The problems identified require urgent attention and systematic reforms to create a legal and healthcare framework that supports both healthcare professionals and patients. The findings underscore the need for collaborative efforts among policymakers, healthcare institutions, legal bodies, and the medical community to create a more equitable, transparent, and patient-centered healthcare system.

References:

Adler, R. S. (1991). STALKING THE ROGUE PHYSICIAN: AN ANALYSIS OF THE HEALTH CARE QUALITY IMPROVEMENT ACT. *American Business Law Journal*, *28*(4), 683–741. https://doi.org/10.1111/J.1744-1714.1990.TB01523.X

Bucy, P. (1989). Fraud by Fright: White Collar Crime by Health Care Providers. *North Carolina Law Review*, *67*(4). Retrieved from https://scholarship.law.unc.edu/nclr/vol67/iss4/7

Creswell, J. W. (2009). *Qualitative, Quantitative, and Mixed Methods Approaches The Selection of a Research Design*. *Research design* (3rd Editio). Los Angeles: SAGE Publications.

Dimetman, N. (2022). 35+ Medical Malpractice Statistics for 2022. Retrieved April 14, 2023, from https://www.justgreatlawyers.com/legal-guides/medical-malpractice-statistics?gclid=CjwKCAjw0N6hBhAUEiwAXab-TV_HOitVOudgr25Zg8cD8BirslIw7G6PysQPDMqyGdU1eYahtRmJARoCR9UQAvD_BwE

Dressler, J. (2015). *Understanding Criminal Law* (Seventh Ed). New York: Lexis Nexis.

Fletcher, G. P. (2000). Rethinking criminal law, 898. Retrieved from https://global.oup.com/academic/product/rethinking-criminal-law-9780195136951

Gottlieb, E., & Doroshow, J. (2023). *Medical Malpractice: By The Numbers*. New York. Retrieved from https://centerjd.org/content/briefing-book-medical-malpractice-numbers

Kaba, R., & Sooriakumaran, P. (2007). The evolution of the doctor-patient relationship. *International Journal of Surgery*, *5*(1). https://doi.org/10.1016/j.ijsu.2006.01.005

Leedy, P. D., & Ormrod, J. E. (2010). *Practical Research Planning and Design* (9th Editio). Thousands Oaks, California: SAGE Publications. Retrieved from www.myeducationlab.

Monico, E., Kulkarni, R., Calise, A., Calabro Citation, J., & Calabro, J. (2006). The Criminal Prosecution of Medical Negligence. *The Internet Journal of Law, Healthcare and Ethics*, *5*(1). https://doi.org/10.5580/A5237

Punch, K. F. (2014). *Introduction to Social Research: Quantitative and Qualitative Approaches*. *Introduction to social research quantitative and qualitative approaches* (3rd Editio). London: Sage Publications UK.

White, G. E. (2003). *Tort Law in America: An Intellectual History*. New York (NY): Oxford Univeristy Press.

Received 12 August 2023, accepted 11 December 2023.