RAIS RESEARCH ASSOCIATION for INTERDISCIPLINARY STUDIES
AUGUST 2020

DOI: 10.5281/zenodo.4006005

Liability in Medical Negligence Cases: A Comparative Study of Indian and American Laws & Policies

Anupama Goel

Professor of Law, National Law University, Delhi, India anupama.goel@nludelhi.ac.in

ABSTRACT: America and India share a lot in common. Both countries have rich and diverse democracies with a liberal constitutional framework. Any service-oriented profession inherently poses a risk of some kind to its consumer. But it is the medical profession alone which potentially risks the body and life of its consumer (patient). At the same time, the service provider, i.e. the doctor, or the paramedic, is but a human being, who if severely pressured to dire consequences in case of an error, may not be able to deliver. The American and Indian jurisdictions have different sets of laws to regulate medical negligence. While American laws aim at a quick and effective reparation of injury suffered by patient and his family, the Indian laws are more amorphous in character and can potentially result in a multi-faceted attack on the erring doctor. Courts, particularly the Indian Supreme Court, have often tilted the balance in favour of the patient and his family. This may have serious consequences on the morale of the medical profession, as well as the quality of healthcare, which is ultimately provided to the citizen. The paper seeks to survey the entire law, policy and practice on medical negligence in America and India, by studying the judicial pronouncements by the courts of record in both the jurisdictions. The objective is to propose a viable alternative for balancing the rights and interests of both the patient and doctor, which is not only justice-oriented, but also meets the social requirements.

KEYWORDS: Medical Negligence, Doctors, Damage, Compensation, Tort, Liability, Constitution, Court, Laws, Justice

Introduction

Medical professionals are an integral part of a civilized society. Dedicated medical professionals have always been the source of relief and comfort to people in times of illness and pain. This professional relationship between a patient and a doctor has always based upon the bond of trust. Proper communication, sense of empathy, up to date skill and knowledge and innate desire to apply that knowledge for the benefit of patients under all circumstances are always expected. With the growing complexity of clinical care, increasingly complex organization of society, this simple equation has become a 'dream cliché' that is worth recapturing. For the benefit of society, it is imperative that the trust in medical professionals is maintained and enhanced. It is also imperative that medical professionals maintain the highest standards of behavior and ethical standards of medical practice.

Society's expectations from the medical profession have increased many folds but with the new technological advances and increasing complexities of medical science, it has become more uncertain and unpredictable. Any adverse outcome of the medical treatment cannot be an evidence of poor medical service, as there can be several other contributory factors, which can be analysed only after proper investigation. Only after a thorough analysis of each case, it is established that a particular case pertains merely to a medical error or is of medical negligence or of medical malpractice.

Medical negligence becomes medical malpractice when after the doctor's negligent treatment, the patient condition worsens or causes some injury or unreasonable and unexpected complications occur, or necessitates additional medical treatment in a given situation. In other words, two additional elements i.e. legal causation and damage are required in cases of medical negligence to give rise to a case of medical malpractice. But in case, if the doctor's negligence was not a foreseeable probability of the patient's harm or injury (causation), or if the doctor's medical negligence actually had no detrimental effect on the patient's condition (injury or damage), there will not be a case of medical malpractice.

Medical Negligence Cases in India and America

According to the Indo-Asian News Service, Geneva in September 2019, the World Health Organization has reported that more than 138 million patients are injured annually by the errors committed by the doctors. Mistakes or negligence during diagnosis or in prescriptions and treatments, and the inappropriate use and administration of medicines are the main reasons due to which most of the patients suffer. In the USA, due to medical negligence, more than 2.5 million people die annually, which is the third-highest cause of mortality after heart diseases and cancer. A study by the Johns Hopkins University of USA has also approved of this fact that medical error is the third-largest killer in the USA. In India, the number of deaths is nearly 5 million per year due to a lack of acre and practical knowledge among the doctors and nurses to handle the patients. In a study by Harvard University in 2013, it has been estimated that India records 52 lakh injuries each year (out of the 430 lakh globally) due to medical errors and adverse events, which can be reduced to half with proper care and training of medical staff.

History of Medical Ethics and Medical Malpractices in America

In the USA, the history behind medical malpractice claims began in the 1800s (DeVille KA 1990), but claims cases in the courts were filed only in the 1960s (Sloan FA 1991). Later, due to the following factors, the number of medical claims cases in courts increased enormously: *(i)* newer complex treatments with higher risks of iatrogenic harm *(ii)* modified legal liability rules with less barriers *(iii)* changes in satisfaction with the health care system etc.(Robinson 1986). With the rise in medical malpractice litigation, organized medical lobby emerged which ultimately resorted to defensive medicine and mandated various insurance covers to reduce the burden of the malpractice liability costs.

In 2011, the National Conference of State Legislatures (NCSL) came up with medical malpractice reforms and addressed three major objectives: Restricting the costs associated with medical malpractice, deterring medical errors and ensuring fair compensation to the harmed patients. To avoid unnecessary litigation, these reforms also introduced mandatory pre-filing certificates and review of medical merits of the case; recommended caps on the payment of noneconomic damages such as pain and sufferings etc. and initiated flexible payments overtime instead of large sum awards (Mello 2014). Later, alternative dispute redressal mechanisms were also introduced such as mediation and resolution based programs, which are much better than adversarial litigation. Due to transparency and open communication between patients and doctors about medical errors, ethical obligations expected of medical staff can be easily enforced. Since 2010, the Patient Protection and Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act (HCERA) have regulated the ways how health care in the United States is organized, financed and delivered. A primary goal of the ACA is to increase access to affordable health care for the medically uninsured and underinsured in the USA.

History of Medical Ethics and Medical Malpractices in India

In ancient India, notable works on medical science are found in many literary works such as *Charak Samhita*, *Sushruta Samhita* and *Vagbhata Sushruta Samhita.* Wrong treatment or '*mithya*' (false, wrong, improper, error, illusive or incorrect) has been used in *Charak Samhita. Sushruta Samhita* (*Sushruta Samhita*, (1-2) used it as '*mithyopachara*' in the sense of improper conduct. Physicians (*vaidyas*), who were found to act improperly used to be liable for punishment and the quantum of punishment/penalty varied according to the status of the victim. According to *Yajnavalkya Smriti*, a physician who acted improperly should pay the first fine if it is the case of animal, the second highest in the case of men and highest in the case of king's men. Comprehensive measures of protection from the irresponsible physicians in the cases of medical negligence depending upon the severity of the lapse after taking into account all other

accompanying circumstances have also been laid down in *Manusmriti* (*Manusmriti* IX.284) and accordingly, the penalties are provided by the king. But *Manusmriti* did not discriminate on the basis of *varna* or category of victim. *Sushruta Samhita* also acknowledged that "If the death of patient under treatment is due to carelessness, the physician shall be punished with severe punishment, growth of disease due to negligence or indifference of a physician should be regarded as assault or violence."

The *Kautilya's Arthasastra* provided a code of ethics for physicians. In case, a physician while treating a patient found that the disease is dangerous to the life of the patient, it is required that he should inform to the authorities. If that patient dies, the physician used to pay a lowest fine, but if death occurs due to any mistake on the part of the treating physician, medium rate fine has been prescribed by the king. But If death is due to the *vaidya's* negligence, the highest punishment is used to be inflicted. It is provided that physician's duty to take care varied with the social status of the patient, but degree of monetary penalty is not dependent on the degree of guilt. To impose penalty has been an absolute discretion of the judge for ensuring good administration of the King/State, not only to safeguard interests of the patient. Therefore, specific mention can be found in *Dharmashastras* (*Manav Dharmashashtra*, 9 284) and *Arthashastra* regarding the right of the patient to indemnify.

After the Indian Medical Council Act, 1956, all cases pertaining to medical errors, negligence and malpractices against the registered medical practitioners are handled by the Medical Council of India. Medical professionals must demonstrate adherence to ethical medical practices as provided in the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. Detailed duties and responsibilities of doctors, medical ethics, dignity and honour of profession, professional conduct, medical knowledge and skills, proper manner of rendering of service etc. has been provided in these Regulations.

Legal Remedies for Medical Negligence Cases in the USA

Since 2010, the Patient Protection and Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act (HCERA) have regulated the health services in the USA. These legislations prescribe the ways to organize, finance and deliver healthcare in the USA. Increased access to affordable health care for the medically uninsured and underinsured is the primary goal of ACA.

In the USA, the injured patient must show that the physician acted negligently in rendering care, which has resulted in injury. To make out a successful claim of medical malpractice, it is required that the patient must prove the following four elements/ the legal requirements: (a) presence of a legal duty to take care on the treating doctor; (b) breach of that duty to take care due to some lapse/failure to adhere to the standards of the medical profession by that doctor; (c) causal connection between the breach of duty and damage/injury suffered by the patient; and (d) Injury/damage to which legal system can provide redress

In the USA, medical malpractice law has traditionally been under the authority of the individual states and not under the federal government. Civil suits relating to the medical malpractice are filed in a state trial court, unless the case involves federal funding or concerns a military medical facility etc. in which case, it would be filed in a federal district court. In case the parties involved are from different states, or there is a violation of a fundamental right given under the Constitution of the USA, then also the claim will be filed in a federal court. Sometimes, both parties may agree to settle the case prior to the court verdict. They may arrive at a 'settlement,' when the defendant agrees to pay the plaintiff a mutually agreed amount. If they are unable to settle, the case will proceed to trial, which is always held by the jury. Appeal from the trials lies to the higher court.

In the USA, most of the doctors and the medical professionals have medical malpractice insurance to protect themselves in case of negligence/unintentional injury to their patients. Mandatory insurance cover is a requirement for employment within a specific medical group or

hospital system. It is found that medical malpractice suits often lead to 'defensive medicine' i.e. the medical professionals start behaving in unproductive or harmful ways, just to avoid malpractice litigation (Kass and Ross 2016).

Legal Remedies for Medical Negligence Cases in India

In India, there are several remedies provided to the patients in case they are the victims of medical negligence or malpractice. Under Part –III of the Constitution of India, fundamental rights have been provided which pertains to the protection of any patient in case of infringement of any right pertaining to life, bodily safety or personal liberty. (Article 21 of Indian Constitution) These rights are enforced with the help of extraordinary remedies provided under the Indian Constitution (Article 32 of Indian Constitution). Any person can directly approach the High Court or the Supreme Court for the enforcement of Part-III rights by filing an appropriate writ or Public Interest Litigation (PIL) when the grievances affecting the public at large are not properly redressed. PILs are ordinarily resorted to when public health programmes are not implemented properly.

Under the Indian Medical Council Act, 1956, Indian Medical Council (IMC hereinafter) regulates and disciplines medical professionals throughout India. The medical councils, both at national and state levels are constituted to regulate the medical profession by monitoring their skills, knowledge, conduct, and competence by imparting continuous and updated education with the help of workshops, seminars and conferences, etc. Councils do not have powers to award any monetary compensation to the aggrieved parties, but have enough powers to punish the medical practitioners, in case found negligent or at fault. IMC is empowered to remove the name of any person enrolled on a state medical register on the grounds of professional misconduct (section 24 of the Act). It along with Regulations prescribes standards of professional conduct, etiquette and code of ethics for medical practitioners and institutions thereof.

To redress grievances relating to medical malpractice, the provision to file a civil suit in a trial court is also there under tort law, appeal from which would lie to the appellate court. After the judgment, if either party is not satisfied, it may approach the High Court, and lastly, the apex court may decide that case finally in accordance with the constitutional principles and basic concepts relating to tort and contract law. Civil law remedies mainly provide for monetary compensation depending upon the extent of damage or injury suffered by the patient because of the alleged medical negligence or malpractice therein.

Apart from civil suit, the patient or his/her family could also file a complaint in the consumer courts for deficiency in service under the Consumer Protection Act, 1986 which was interpreted as included in the definition of 'service' despite the fact that it was not specifically mentioned under the Act (*V.P.Shantha Case*). In 2019, this legislation has been repealed and new Consumer Protection Act has come into force after receiving the assent from the President of India on August 9, 2019. In this Central legislation also, the provision relating to 'medical service' has not been specifically included under section 2 (42) of the Act. Moreover, there is neither any mention under section 2 (11) defining deficiency of service with regard to deficiency or negligence or malpractice in medical services nor there is any other specific provision with regard to that. There is utter confusion whether medical services are covered under the present Act or not which only time will clarify.

To impose criminal liability under section 304-A of Indian Penal Code, Supreme Court in the case of *Kurban Hussein Mohammedali Rangawalla* v. *State of Maharashtra* quoted the statement of law by Sir Lawrence Jenkins from *Emperor* v. *Omkar Rampratap:*

> "To impose criminal liability under Section 304A, Indian Penal Code, it is necessary that the death should have been the direct result of a rash and negligent act of the accused, and that act must be the proximate and efficient cause without the intervention of another's negligence. It must be the *causa causans*; it is not enough that it may have been the *causa sine qua non*."

Therefore, in the cases of criminal negligence, it is generally found that there is gross and culpable neglect or failure to exercise reasonable care and precaution to guard against injury either to the public generally or to an individual in particular. It is an imperative duty of the medical professional or his team to perform carefully and diligently, as they are supposed to be possessing special skill and expertise.

Till 2005, medical practitioners could be held liable under both civil and criminal negligence. (*Dr. Suresh Gupta v. Government of NCT of Delhi*). But after *Jacob Mathew v. State of Punjab*, the three Judges' Bench of Supreme Court on August 5, 2005, doubted the correctness of the view taken in the above-stated case. The Court cautioned that the doctors should not be held criminally responsible unless there is prime facie evidence before the Court in the form of a credible opinion from another competent doctor, preferably a Government doctor in the same field of medicine who is convinced with the charges levied against the erring doctor regarding the rash and negligent act. The Court held that to prosecute a medical professional for negligence under criminal law it must be shown that he had done something or had failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the resultant injury was most likely imminent. The Court emphasized that the statutory rules or executive instructions incorporating certain guidelines need to be framed and issued by the Government of India and/or the State Governments in consultation with the Medical Council of India. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been leveled against him). Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigation officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld. Therefore, the application of criminal prosecution against a medical practitioner is made on limited grounds, which must also rest on the credible opinion from another competent doctor.

But the manner in which large compensation awards are calculated and given by the Indian Courts in cases of medical negligence cases irrespective of the injury or loss to the victim, but contingent upon his income and standard of living speaks volumes about the irrational, inequitable and preposterous justice delivery system. Recently, the highest amount of compensation i.e. Rs. 6.08 crores was ordered in the case of *Balram Prasad* for the death of the patient. Similarly, the Supreme Court of India in the case of *Nizam Institute of Medical Sciences v. Prashant S. Dhanaka* awarded Rs. 1 crore as compensation but still denied to pay the amount claimed for physiotherapy, nursing care, and litigation costs without citing any reasons for doing the same. In the case of *V. Kishan Rao* v. *Nikhil Super Speciality Hospital*, Rs. 2 lakhs was ordered as compensation to the husband for the death of his wife, who was given treatment for typhoid fever negligently instead of malaria fever.

In India, judges in medical negligence litigation seem to enjoy complete and absolute discretion in awarding compensation. Due to exorbitant compensation ordered against the medical professionals, they seem to be resorting to defensive medicine, as there is no mandatory protection or insurance cover required as per law.

Conclusion

Due to advances in technology, ever-increasing complexity of medical science and expanding demand for healthcare, there is an urgent need for a system of patient redress that is equitable, fair, economical, and just. Both the legal systems in USA and in India have an adversarial system of adjudication of medical negligence or medical malpractice claims, based primarily on civil or tort law. Factors such as systemic deficiencies such as heavy litigation costs, delayed and protracted litigation, as well as dependence on judicial discretion, lack of infrastructure, poor doctor-patient ratio, etc. must also be accounted for by the courts, while providing effective justice to the victims, so that minimum harm is caused to the medical professionals. Awarding

huge compensation amounts on whimsical preferences and in indefinite discretion or even on a humanitarian basis without a clear basis or guidelines often send wrong signals to the community at large and demoralizes doctors. Alternative dispute resolution may be a win-win solution for patients and medical professionals, increasing case efficiency and decreasing animosity between opposing parties, which also mitigates stress and help avoid dragging clinicians and patients through time-consuming, costly, and reputation-damaging litigation. Reforms in this field require an economically efficient system, which adequately compensates the victims of medical negligence but safeguards the interests of medical professionals too, while excluding frivolous and opportunistic medical claims.

References

Bhalchandra v. *State of Maharashtra,* AIR 1968 SC 1319.

Bhishagratna, Kunja Lal. 1907. Sushruta Samhita, (1-2) ed., Calcutta.

DeVille, KA. 1990. Medical Malpractice in Nineteenth-Century America: Origins and Legacy. New York: New York University Press.

Dr. Suresh Gupta v. Government of NCT of Delhi, (2004) 6 SCC 422.

Balram Prasad v. *Kunal Saha*, (2014) 1 SCC 384.

Emperor v. *Omkar Rampratap*, (1902) 4 BLR 679.

Gigi, P.V. 2011. *Law and Medical Negligence.* Ph.D. Thesis, Mahatma Gandhi University. Accessed August 6, 2020. http://hdl.handle.net/10603/26000

Jacob Mathew v. State of Punjab, AIR 2005 SC 3180

Joseph S. Kass, MD, JD and Rachel V. Rose, JD, MBA. 2016. "Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs." *AMA Journal of Ethics.* Accessed August 6, 2020. https://journalofethics.ama-assn.org/article/medical-malpractice-reform-historical-approaches-alternative-models-and-communication-and-resolution/2016-03.

Kurban Hussein Mohammedali Rangawalla v. *State of Maharashtra*, (1965) 2 SCR 622.

Mello, MM, Studdert DM, Kachalia A. 2014 "The Medical Liability Climate and Prospects For Reform." *JAMA* 312(20): 2146-2155.

National Conference of State Legislatures. 2011. "Health cost containment and efficiencies: medical malpractice reform." Accessed August 7, 2020. http://www.ncsl.org/portals/1/documents/health/MedicalMalReform-2011.pdf.

Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka, (2009) 6 SCC 1.

Poonam Verma v. Ashwin Patel, (1996) 4 SCC 332.

Robinson, GO. 1986. "The medical malpractice crisis of the 1970s: a retrospective." *Law Contemp Probl*. 49(2):5-35.

Sloan, FA, Bovbjerg RR, Githens PB. 1991. *Insuring Medical Malpractice*. New York: Oxford University Press.

V.Kishan Rao v. *Nikhil Super Speciality Hospital*, (2010) 5 SCC 513. https://indiankanoon.org/doc/1920027/.