Medico Research Chronicles

ISSN No. 2394-3971

Review Article

REVIEW ARTICLE: CAPPING ON COMPENSATION FOR MEDICAL MALPRACTICE LAW SUITE IN INDIA

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Submitted on: October 2016
Accepted on: October 2016
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Abstract

Review Article teach US about the main people working in this field, recent major advances and discoveries in this field and significant gaps in the research. At the end the author will focus on current debates and suggest the ideas where research might go next. Medical malpractice and compensation to this effect by the court of law is a burning national issue and needs pondering. It is largely faced by health care workers among which the worst affected one includes medical practitioners and health care administrators. This issue has gone through a paradigm shift from one nation to another and has matured gradually over the last decade witnessing huge medical compensation being granted to litigants. It is also seen as a business opportunity by law professionals and media. It largely affects the sentiments and belief of general public. However, critical changes at legislative and judicial levels along with amendments in the medical curriculum can jointly reduce the agony and fear of health care providers. Sensitizing the medical practitioner's public at large has to be taken up in mission mode by organizations like Consortium of Accredited health care organization (CAHO), National Accreditation Board for Hospitals and health care providers (NABH) and Association of health care providers India (AHPI).

Keywords: Medical malpractice, compensation, litigation, negligence, enterprise

Introduction

In U.S. health care the role of the malpractice system has grown significantly over the last four decades with a sharp increase between 1999 to 2000. The majority of the practitioners carry malpractice insurance which covers the defense costs of claims and any award that is paid. However, significant variation is seen among different geographic areas and specialties. For example, in 2009, premiums in Suffolk County, New York, for specialists in internal medicine and obstetrics were $33,000 and $178,000, respectively, whereas premiums in Colorado were approximately one-third as much (Medical Liability Monitor, 2009): Daniel. P. Kessler, Professor of Law, Stanford law school

begins explaining the fact[1] that US system of medical malpractice compensation is based on two principal objectives, firstly to compensate patients who are injured through the negligence of health care providers and secondly to deter providers from practicing negligently[2]. In practice, the system, however, does not meet this objective. The results of an opinion survey of physicians revealed the fact that they are forced to practice defensive medicine due to fear of legal procedures. The question is being raised on the effectiveness of in achieving its intended goal and curbing the problem of defensive medicine among the care provider. According to an estimate the indemnity payments and administrative expenses of the system amount to less than 1 percent of health spending however the costs of practicing defensive medicine are far greater approximating to 2–3 percent of health spending, or over $50 billion per year[3]. In this situation even if medical malpractice tort law allocated the burden of medical injuries perfectly, insensitivity to the true costs of care would lead physicians (and their patients) to prefer socially excessive precautions against iatrogenic injury (injury related to medical treatment). This loophole in the system has led a number of states to customize their laws in order to reduce malpractice liability—to adopt "tort reforms[2]. Studies have also evidenced that wisely chosen reforms to have the potential to reduce health care spending significantly with no adverse impact on patient health outcomes.

In general, malpractice claims are adjudicated in state courts according to state laws, which typically require three elements for a successful claim: 1) the patient actually suffered an adverse event; 2) the provider caused the event due to action or inaction; and 3) the provider was negligent, which essentially entails showing that the provider took less care than that which is customarily practiced by the average member of profession in good standing, given the circumstances of the doctor and the patient[4]. Theoretically, this rule should both provide compensation to iatrogenically injured patients as well as lead doctors to take appropriate precautions against accidental harm however this rule performs poorly in practice. According to the landmark Harvard Medical Practice Study[5], only 1 in 15 patients who suffer an injury because of medical negligence receive compensation, and five-sixths of the cases that receive compensation have no evidence of negligence. A more recent research by Studdert, Thomas, Burstin, Zvar, Orav, and Brennan[6] (2000) also replicated these results. Also, the awards for medical malpractice claimants are subject to lengthy delays: on average, it takes around four years to resolve a malpractice claim[7] (Cohen and Hughes, 2007). In nutshell, it can be said that malpractice system has not been able to produce expected results and has failed to meet the requirements. On the other hand, the system has created incentives for too much precaution, or defensive medicine. Defensive medicine may take two forms: positive and negative. Positive defensive medicine involves supplying care that is unproductive, not cost effective, or even harmful, while negative defensive medicine involves refusing to supply care that could be beneficial; it may also include physicians deciding to exit the profession altogether.

In United kingdom, the United States Congress defined Defensive medicine and expand this definition to include the action of ordering tests, procedures and visits, or avoidance of high-risk patients or procedures with the primary (but not sole) aim, of reducing malpractice liability[8]. In a national survey carried out in the USA among neurosurgeons 96% reported practicing defensive medicine. The spread of defensive medicine has also taken place in Europe where 94% of gastroenterologists and 83% of surgeons and anesthetists in Italy reported practicing defensive medicine[9,10]. The situation is even severe in Japan where 98% of surveyed gastroenterologists have been practicing at

least one or another form of defensive medicine[11]. In United Kingdom (UK) an observational study[12] was conducted to compare the prevalence of negative defensive medical practices in 1999 to those by the same doctors in 1994 and concluded that GPs were significantly more likely to undertake diagnostic testing, refer patients and avoid treating certain conditions at the later date. The cost of defensive medical practice is difficult to estimate due to the many conflicting and overlapping factors. While there have been attempts to estimate the cost of litigation and malpractice on the total health budget[2,13], only a few studies assessed the cost of defensive medical practice on heath system budget specifically. In the USA it is estimated that the national cost of defensive medicine for the specialty of orthopedic surgery is $2 billion annually[14].

The fear of litigation among health care providers leads to the practice of defensive medicine, which is resource intensive and non-productive at the same time. A survey found in 2005 that 93% of "high-risk" specialists in Pennsylvania reported practicing defensive medicine[15]. A study conducted in 2008 also elicited comparable results from 83% of Massachusetts physicians[16] and revealed that between 20% and 30% of plain film x-rays, CT scans, MRI studies, ultrasound studies, and specialty referrals and consultations were ordered primarily for defensive purposes[16]. There are also several alternative contributors to the practice of defensive medicine. The reason could range from the culture of medical practice driven by higher reimbursement for the procedure to use of technology-intensive management to meeting the departmental revenue targets by imposing high-end investigations on insured patients.

The practice in the Indian subcontinent is governed by the consumer protection act 1986. The Consumer Protection Act was passed on 24th December 1986 for the better protection of the interest of consumers and to make provisions for the establishment of consumer councils and other authorities for the settlement of consumer's dispute and for matters connected therewith. Till 1995, even courts were not clear whether doctors are covered under consumer protection act or no. In a landmark case in 1995, the Supreme Court decision in Indian Medical Association v/s VP Shantha, medical profession has been brought under the Section 2(1) (o) of Consumer Protection Act, 1986 and also, it has included the following categories of doctors/hospitals under this Section[17]:

1. All medical/dental practitioners doing independent medical/dental practice unless rendering only free service.
2. Private hospitals charging all patients.
3. All hospitals having free as well as paying patients and all the paying and free category patients receiving treatment in such hospitals.
4. Medical/dental practitioners and hospitals paid by an insurance firm for the treatment of a client or an employment for that of an employee.

It exempts only those hospitals and the medical / dental practitioners of such hospitals which offer free service to all patients. As a result of this judgment, virtually all private and government hospitals and the doctors employed by them and the independent medical / dental practitioners except primary health centers, birth control measures, anti-malaria drive and other such welfare activities can be sued under the CPA.

The maximum time limit for a claim to be filed under CPA is 2 years from the date of occurrence of the cause of action. There are no court fees to be paid to file a complaint with a Consumer Forum / Commission. Further, a complainant/opposite party can present his case on his own without the help of a lawyer. **The structure of the consumer forums/ commission** depends on upon the amount of compensation and decided by the government from time to time

1. District consumer redressal forum

2. State consumer redressal forum
3. National consumer redressal forum
4. Supreme court: final appeal

The legal avenues (other than CPA) available to aggrieved patients to sue against health professionals:

a) Medical Council of India and Dental Council of India.
b) Civil Courts.
c) MRTP (Monopolies and Restrictive Trade Practices Commission)
d) Public Interest Litigation.
e) Sections of Indian Penal Code, 1860

In the civil court, the aggrieved patients can file a case against the doctor for monetary compensation for which the patient to pay court fees that depend upon the compensation sought. Probably, due to near acceptance of medical negligence as inevitable by the patients and their relatives or local settlements, not many cases have reached the apex court of law in the past. The legal remedies are based on the law of Torts, Section 1-A of the Fatal Accidents Act, 1855 and the Section 357 of Cr. P.C., 1973. But to avail it, an aggrieved patient has to wait for years and spend a considerable amount of money on litigations. The civil court cases take care the route of Sub-Court, District Court, High Court and Supreme Court.

India needs to adopt the policies being practiced in developed countries to its own requirements and can benefit greatly from their experience. A comparative analysis of health care spending in India, China, and the USA is done in Table 1:

Table 1: In 2003, President George W. Bush addressed the medical community's concerns by endorsing legislation that would place a $250,000 cap on non-economic damages at the national level.

	India	**China**	**USA**
Health expenditure per capita (current US$)	61 USD	322	8895
Health expenditure total (% of GDP)	4	5.4	17.9
Out-of-pocket health expenditure (% of private expenditure on health)	86	78	20.7
Insurance coverage	15%	Urban- 65 Rural- 89	> 60%
GDP per capita (current US$)	1498	6807	53042
Cap on non-economic damages at the national level (USD)	No	Data not available	250000

Critics who contest tort-reform laws argue that medical malpractice awards account for only one percent of the total yearly national health care expenditures. They also claim that such reforms protect insurance companies and physicians, and not the patients. Trial attorneys point the finger at the insurance companies. They claim that insurers keep prices artificially low while competing for market share and new revenue. When the economy is sluggish and the market is slow, they increase premiums because they are no longer able to use stock market gains to subsidize low rates. Proponents of reform continue to maintain, however, that a federal cap will ultimately result in lower medical costs and greater medical access for the general population.

Conclusion: Voluntary organizations like Association of health care providers India

(AHPI) and Consortium of Accredited health care organization (CAHO) can take a lead role in this regard. The legal procedure involved in the capping of compensation is likely to be a long drawn process. Though we should follow this rigorously, we should simultaneously work for improving the scenario in this regard. Some of the desired steps could be as under:

1. Amendments to the consumer protection act (which may again be a long and tedious process) or development of consumer protection rules and guidelines by state level committees
2. The guidelines should be made in light of the following
   - ✓ Mandatory screening of cases of medical negligence, before the case is admitted in the consumer court
   - ✓ Mandatory provision of seeking expert medical opinion by the court before giving verdict on the technical issues
   - ✓ Defining/ triaging the complaints into frivolous/ injurious/ grievous etc before submitting to the court of law
   - ✓ Provision of penalty to be proportionate to the amount of compensation claimed
3. Guidelines-based systems: Standard treatment guidelines to be developed and implemented so that these guidelines become the basis for judgment.
4. Enterprise liability to be entrusted: healthcare organizations such as hospitals or healthcare providers to have the ability to monitor physicians at comparatively low cost, so these organizations could serve as an efficient intermediary between physicians and the tort system.
5. Healthcare Arbitrator: Just like insurance disputes are sent to arbitrators an alternative dispute resolution mechanism can be looked into. The provision will for providers and patients to submit disputes over alleged malpractice to a third party other than a court. This will help compensates victims faster, more equitably, and with lower transaction costs (As of now the administrative cost of such lawsuits is approximately 53% of the total compensation claimed).
6. Administrative Compensation Systems: this is the most radical proposed change. It proposes to replace the current tort system with an administrative compensation system. The "health courts" model substitutes a specially trained judge as the finder of fact and arbitrator of law for the current system's generalist judges and juries.
7. Judicial audits of the lower courts to assess fairness and judicious application of mind by the lower court
8. A comparative analysis of the outcome of judicial verdicts given in past should also be carried out for a better understanding of the effectiveness of the compensations awarded till date.
9. A sample survey of the awareness of judiciary (or KAP study) about the provisions of consumer protection act, the law of tort w.r.t medical malpractice will also give a clear understanding of the scope of improvements among this fraternity towards the issue.
10. Training and sensitization of the medical professionals about medico- legal aspects are also the need of the hour

Acknowledgment

The conception and culmination of this study would not have been possible without unconditional support and guidance given by the Medical Director of Indian Spinal Injuries Centre, Dr. H. S. Chhabra and Dr. Girdhar Gyani, Director General, Association of health care Providers India. We would take this opportunity to thank him and the management of ISIC for allowing us to conduct the study.

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