

HEAD TO HEAD

Are large compensation payouts for negligence good for medicine in India?

The Indian Supreme Court recently awarded a record compensation payout for medical negligence that resulted in the death of a patient. **Kunal Saha** says such payments are essential when other accountability is lacking, but **Devi Shetty** fears the emergence of a US style compensation culture that stifles doctors

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Yes—Kunal Saha

The limitless financial compensation and punitive damages often imposed for medical errors in developed countries such as the United States may have some inherent flaws. In India, however, healthcare is supposed to be regulated by a quasi-judicial medical council that has failed to protect against widespread negligent and irrational treatment. Large payouts awarded by the courts of law may therefore be the only way to instil accountability for wayward doctors and to save lives.

Compensation became a hot topic in India after the Supreme Court awarded more than Rs110m (£1m; €1.4m; \$1.8m) in damages (including interest) against several doctors and a private hospital in Kolkata for the wrongful death of a patient.¹ This was by far the biggest payout in Indian medicolegal history. Until now, Indian courts have generally awarded meagre compensation for death from medical negligence, rarely exceeding Rs300 000-Rs600 000, and often less, which has failed to have any deterrent on affluent doctors and hospitals.

For the legal right to compensation (tort liability) to be useful in curbing medical negligence, it should serve at least two purposes. Firstly, it must provide adequate financial support for the victim's family (compensation) to fill the irreparable vacuum created by the wrongful death as best as possible. Secondly, and perhaps more importantly, the award must act as a deterrent against future negligent behaviour by other doctors and hospitals.

Paltry compensation for avoidable loss of human life is unlikely to pose any threat for the errant doctors and hospitals. And a meagre financial payment can never make up for the losses of the dead patient's family. As the two Indian Supreme Court Justices, V Gopala Gowda and C K Prasad, put it in the final sentence of the judgment last October: "We, therefore, hope

and trust that this decision acts as a deterrent and a reminder to those doctors, hospitals, the nursing homes and other concerned establishments who do not take their responsibility seriously."¹

Unfounded fears

Reaction to the record compensation in India is sharply divided. Although most ordinary citizens and victims of medical negligence hailed the verdict, members of the medical community predicted a doomsday scenario for the future of Indian healthcare. Even though the Indian Medical Association was not involved in the lawsuit, it took the unusual step of filing a petition seeking a review of the Supreme Court's decision.²

Indian medical leaders have suggested that the large compensation will promote "defensive medicine," ultimately leading to greater costs for patients. Defensive medicine is often raised by proponents of tort reforms in the United States.³ The real effect of malpractice litigation on defensive medicine remains controversial. Although many US physicians claim that they practise defensive medicine to avoid litigation risk, policy analysts argue that this is nothing but an exaggerated response that results from "misattribution of casual responsibility" by doctors.³ A comprehensive study found that defensive medicine may contribute only 1-2% of the cost of US healthcare.⁴

Unlike in the US, ordinary patients in India have no meaningful insurance to cover healthcare expenses. Most have to pay the medical bill on their own, and an increase in defensive medicine may affect these patients economically. But it is also true that in the absence of any insurance oversight, and without any government regulation, hospital expenses are skyrocketing in India. The apprehension that large compensation may increase defensive medicine is misplaced given the current total lack of regulation and rampant corruption in the Indian healthcare system.⁵⁻⁸

Indian medicos have also claimed that large compensation should not be awarded in medical negligence cases because even the US has a limit in such cases. Although some US states have imposed a cap on “non-economic damages” (for pain and suffering), there is no cap on “economic damages” (direct loss of income) anywhere in the US. More than 95% of the large compensation awarded by India’s Supreme Court in the recent case was for the loss of income from the untimely death of a patient, who was a child psychologist in the US.¹ Putting a limit on non-economic damages would have made no difference.

Deterrent effect will be beneficial

The primary purpose of large compensation payouts must aim to deter medical negligence and unethical practice of medicine. Despite the criticism that excessive malpractice litigations are crippling the healthcare system in the US, a study by the Institute of Medicine found that between 44 000 and 98 000 US residents die each year from preventable medical errors.⁹ This high number of deaths might be used to argue that liability lawsuits have no deterrent effect on medical negligence. But this would be improvident without any knowledge of how much worse US healthcare would have been without the medical liability system. In fact, malpractice liability pressure has been correlated with a modest decline in mortality, indicating a positive role.¹⁰ In contrast, preventable medical complications increased after the cap on damages was adopted.¹¹

Malpractice liability may have a moderate degree of deterrent effect in countries with an effective regulatory system through medical council or board that routinely uses disciplinary action to curb negligence and unethical behaviour by doctors. Unfortunately, medical councils in India have been riddled with incompetence and deep rooted corruption.^{6,7} Disciplinary action against negligent or unethical doctors by medical councils, which comprise only doctors, is almost non-existent in India.

A recent report comparing data on medical negligence cases in the US, the UK, Australia, Canada, and India found no record of any doctor being disciplined for medical errors by Indian medical councils.¹² In the absence of any effective non-judicial forum to protect vulnerable patients, large compensation by court of law may be the only way to prevent medical negligence and improve the quality of healthcare in India.

No—Devi Shetty

Although the Supreme Court of India has rightly upheld the law of the land, its recent award of medical compensation of Rs110m (£1m; €1.4m; \$1.8m) in Kolkata has raised several issues related to the medical profession and its practice.

In 2030 BC, the code of Hammurabi, the king of Babylon, was to chop off a doctor’s hand for making a mistake. This approach may prevent future mistakes but after some time few doctors would be left with hands to operate. India’s current legal position on medical negligence is not vastly different from Hammurabi’s code.

Consider this huge compensation from a different perspective. Gynaecologists are the most susceptible to litigation.¹³ Eighty four per cent of hospitals in India have fewer than 30 beds, and they are where more than 60% of our children are born. Most of these “nursing homes,” owned by gynaecologists after toiling for decades, do not even have a medical records department to protect them in case of litigation. However sincere the effort to save the life of a patient, incomplete documentation may hamper a successful defence in a court of law. So were an unfortunate small town gynaecologist to be sued for say Rs20m—nowhere

near Rs110m—he or she may have to sell every asset and still not find the money.

Dealing with human life, doctors are in an insecure profession. Add financial insecurity, and doctors are potentially bankrupt. A couple of stray claims of 10-20 million rupees and associated media publicity would shake the medical community. Small town gynaecologists would move to big city hospitals that offer better protection. Maternal mortality could double quickly.

Although policy makers boast of having 600 000 doctors, nearly 200 000 are busy preparing for exams for elusive postgraduate seats and see no patients for two to five years. There are no junior doctors doing night duties in small towns. Specialists in small towns also work without trained nurses and technicians, which can lead to mistakes.

Lessons from the United States

Malpractice compensation reached mammoth proportions in the early ’90s in the United States. As expected, malpractice insurance premiums rose, to three months of doctors’ salary.^{14,15} Doctors responded by deciding to stop deliveries in small towns in the US. The government had to airlift pregnant women to city centres during childbirth. Obviously, it was unsustainable and risky. So several states in the US capped malpractice compensation at \$250 000 (Rs15m).¹⁶ This cap reduced malpractice suits considerably. Nevertheless, in the US today one in 14 doctors (7.4%) is sued every year, and there is a lawyer for every 300 people.¹⁷⁻¹⁹ India is not too far behind: Delhi has one advocate for every 300 citizens.²⁰

Several European countries also cap malpractice compensation to protect the interests of patients and citizens. And capping compensation would not be new to Indian law: government officers cannot be fined more than a third of their basic monthly salary.²¹

Life is precious. Even if a family is paid billions of rupees it cannot compensate for the loss of a loved one, but the question is, what can we afford? Medical malpractice deserves punishment; doctors must be deterred from neglecting patients. The Indian Medical Council’s provision to withdraw the right to practice temporarily or permanently is one of the worst punishments for a doctor. Additionally, financial compensation is required. However, with ruinous compensation we are close to Hammurabi’s rule.

We cannot implement a first world regulatory structure with third world infrastructure. We must first understand the realities of offering healthcare when we have a shortage of one million doctors, two million nurses, and three million beds at the grass roots. Better infrastructure, more skilled health workers, and the right regulatory framework can provide the necessary protection for patients and doctors.

Compensation culture

In the US it is common to find law firms’ billboards outside hospitals, with provocative statements, such as, “If you have visited a doctor please visit us.” They don’t even suggest you should be unhappy with your care to seek advice. We will see this replicated in India if we do not take immediate action.

Professional bodies such as the IMA and the Association of Healthcare Providers of India should ask the Ministry of Law to cap compensation for malpractice. Compensating a family by Rs20m instead of Rs2m will not revive the lost life. But it can wreck the doctor’s family and close down small nursing homes in rural areas, putting the lives of thousands of people at risk.

Negligent doctors should be punished financially—however, this should not result in bankruptcy. Serious financial hardship will encourage doctors to practise defensive medicine and discourage young people from choosing the profession.

Healthcare comes under the purview of the Consumer Court, which may not be best placed to judge the quality of complex medical care. Rather, the Ministry of Health should convene a committee with representatives of doctors and civil society to decide the maximum compensation for malpractice.

Competing interests: Both authors have read and understood BMJ policy on declaration of interests and declare the following interests. KS declares that the Supreme Court of India's highest compensation award was given for the wrongful death of his wife, the child psychologist Anuradha Saha. He is also the founding president of the humanitarian organisation People for Better Treatment, which helps victims of medical negligence and promotes a better healthcare system in India.

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