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White Paper

Medical Negligence Cases - What are the alternatives to Consumer Courts?

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1. INTRODUCTION

1.1. Understanding Medical Negligence in India

Medical negligence is broadly defined as a breach of duty of care by healthcare providers that causes harm to patients. In India, the legal framework for addressing medical negligence has evolved, especially with the integration of consumer protection laws into the healthcare sector. Before the landmark *Indian Medical Association v. V. P. Shantha*[1] judgment in 1995, the position regarding the applicability of the Consumer Protection Act, 1986, to medical services was ambiguous.

Different High Courts offered contradictory views on whether medical practitioners and hospitals could be held accountable under the Consumer Protection Act for deficiencies in their services. For example, in *Dr. A. S. Chandra v. Union of India*[2], the Andhra Pradesh High Court held that medical practitioners provide "services" under Section 2(1)(o) of the Act, making patients "consumers" entitled to remedies under the Act. In contrast, the Madras High Court, in another case, ruled that the services provided by medical practitioners or hospitals did not qualify as "services" under Section 2(1)(d) of the Act, and therefore medical negligence cases could not be adjudicated under consumer forums.[3]

This lack of uniformity in judicial interpretations highlighted the need for clarity in determining the legal status of medical services under the Consumer Protection Act. The debate also raised questions about the balance between protecting patient rights and safeguarding medical professionals from frivolous litigation. These considerations set the stage for the Supreme Court's landmark ruling in the *V. P. Shantha* case.

1.2. The V. P. Shantha Judgment and Its Implications

The Supreme Court's decision in *Indian Medical Association v. V. P. Shantha* (1995) was a watershed moment in the jurisprudence of medical negligence. This case brought medical services within the ambit of the Consumer Protection Act, 1986, thereby providing patients with an efficacious remedy for deficiencies in medical care.

1.2.1. Background and Context

The case arose from complaints filed by patients against healthcare providers, alleging negligence in the services rendered. The Indian Medical Association (IMA), representing medical practitioners and hospitals, argued that medical services should not fall under the purview of the Consumer Protection Act. They contended that healthcare services are based on professional obligations rather than commercial transactions and that disputes involving medical negligence required specialized adjudication beyond the capacity of consumer forums.

[1] Indian Medical Association v. V. P. Shantha and others, (1995) 6 SCC 651.
[2] Dr. A. S. Chandra v. Union of India, [1992] 1 ALT 713.
[3] Dr. C. S. Subramanian vs Kumarasamy, 1996 86COMPCAS747 (MAD).

1.2.2. Arguments

The appellants, represented by the Indian Medical Association, argued that medical services do not constitute a "commodity" under the Consumer Protection Act and that doctors and hospitals do not provide a "service" as defined by the Act. They emphasized that medical practitioners operate within the framework of a profession, distinct from a commercial business, and their obligations stem from ethical and professional duties rather than contractual or transactional agreements. Additionally, they highlighted the technical complexity of medical negligence cases, which often necessitate specialized medical expertise for proper adjudication. The appellants contended that consumer forums lack the requisite expertise to evaluate such cases, arguing that these matters are better suited to judicial bodies equipped with the necessary technical knowledge.

In contrast, the respondents, led by V. P. Shantha and others, maintained that medical services fall within the ambit of the Consumer Protection Act because they are rendered in exchange for fees, constituting a "service" as defined under the law. They argued that the Act's primary objective is to protect consumers from deficient services and ensure accountability across all service sectors, including healthcare. The respondents asserted that patients, as consumers, have the right to seek redress through consumer forums when they suffer harm due to negligence or substandard care. By extending the Act's coverage to medical services, the respondents argued, the rights of patients would be safeguarded, and a greater sense of accountability would be instilled within the healthcare system.

1.2.3. Supreme Court's Ruling

The Court rejected the IMA's arguments and held that medical services provided for consideration are "services" under Section 2(1) (o) of the Act. The judgment included the following key clarifications:

(a) Inclusion of Paid Services: Medical services provided in exchange for fees, either directly or through insurance, were deemed to fall within the scope of the Act.

(b) Free Services: Services rendered entirely free of charge, including in charitable or government hospitals, were excluded. However, if any charges were levied, such services were included within the definition of "service."

(c) Accountability of Practitioners: Medical practitioners, hospitals, and nursing homes were held accountable for deficiencies in service under the Consumer Protection Act.[4]

The judgment emphasized that patients should have the right to seek remedies for grievances, including compensation for medical negligence, through consumer courts. The Court also noted that consumer forums, with their composition and adjudicatory mechanisms, were well-suited to handle complaints related to medical malpractice.

1.2.4. Implications

The ruling empowered patients and made healthcare providers more accountable. However, it also led to unintended consequences, such as an increase in "defensive medicine" practices, where

[4]Dilip Kumar Mahapatra and D Jena, 'Issues of Medical Negligence in Implementation of Consumer Protection Act' (2014) 1. 11 *SHRINKHALA* 14 http://www. socialresearchfoundation. com/upoadreserchpapers/3/12/1409200423291st%20dilip%20kumar. pdf accessed 9 November 2024.

doctors take excessive precautions to avoid potential litigation, often at the expense of cost-efficiency and patient trust.

The *V. P. Shantha* judgment recently came under scrutiny when it was referred for reconsideration in *Bar of Indian Lawyers v. D. K. Gandhi PS National Institute of Communicable Disease*[5]. However, the Supreme Court upheld the original decision on November 7, 2024, dismissing the reference as unnecessary. This reaffirmed the judgment's significance in balancing consumer rights with medical accountability.

1.3. Overview of the Consumer Protection Act, 2019

The Consumer Protection Act of 2019 replaced the 1986 Act, introducing significant reforms to strengthen consumer rights and streamline grievance redressal mechanisms. Under this Act, healthcare services provided for consideration remain under the purview of consumer law, continuing the precedent set by the *V. P. Shantha* judgment.

1.3.1. Key Provisions Relevant to Healthcare

(a) Definition of Service: The Act defines "service" to include healthcare services provided for payment, either directly by patients or indirectly through insurance.[6] However, services rendered free of charge, particularly in public or charitable hospitals, remain excluded.[7]

(b) Consumer Disputes Redressal Commissions: The Act provides for a three-tier system of consumer forums—District, State, and National Commissions—empowered to adjudicate disputes related to medical negligence.

(c) Simplified Procedures: The Act includes provisions for mediation and settlement to ensure faster resolution of consumer grievances. However, Rule 4 (a) of The Consumer Protection (Mediation) Rules, 2020 specifically excludes "the matters relating to proceedings in respect of medical negligence resulting in grievous injury or death" from compulsory mediation.

1.3.2. Challenges in Application to Medical Negligence

While the Act provides a robust framework for addressing consumer grievances, its application to medical negligence cases presents unique challenges:

(a) Technical Complexity: Medical negligence cases often involve intricate questions of medical science, requiring expert evidence and specialized adjudication. Consumer forums may lack the expertise to handle such cases effectively.

(b) Ambiguity in Free Services: The exclusion of free services creates inconsistencies, particularly in government hospitals where many services are subsidized but not entirely free.

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[5] Bar of Indian Lawyers v. D. K. Gandhi PS National Institute of Communicable Disease, 2024 SCC OnLine SC 928.
[6] Bhavika Vajawat, Damodaran Dinakaran and others, 'The Consumer Protection Act, 2019: A Critical Analysis from a Medical Practitioner's Perspective' (2023) *Indian Journal of Medical Ethics* https://pubmed. ncbi. nlm. nih. gov/38375645/ accessed on 9th November, 2024.
[7] Dr Madhuri Irene M and Anita Yadav, 'Medical Negligence and Consumer Rights: An Analysis' (2014) *Law Mantra* https://www. researchgate. net/publication/271519519_Medical_Negligence_and_Consumer_Rights_an_ANALYSIS accessed 8 November 2024.

(c) *Risk of Frivolous Litigation:* The inclusion of healthcare services under the Act has led to concerns about frivolous lawsuits, which could burden healthcare providers and disrupt the doctor-patient relationship.[8]

1.3.3. Need for Alternative Mechanisms

The limitations of consumer forums in handling medical negligence cases have led to discussions about alternative models. For instance, adopting a medico-legal screening process, such as the New Mexico model, could help filter out frivolous claims and ensure that genuine grievances are addressed efficiently. Strengthening medical tribunals or introducing no-fault compensation schemes could also provide specialized and patient-friendly remedies for medical negligence.

[8]Dilip Kumar Mahapatra and D Jena, 'Issues of Medical Negligence in Implementation of Consumer Protection Act' (2014) 1. 11 *SHRINKHALA* 14 http://www. socialresearchfoundation. com/upoadreserchpapers/3/12/1409200423291st%20dilip%20kumar. pdf accessed 9 November 2024.

2. CHALLENGES IN THE CURRENT FRAMEWORK

The framework regulating medical negligence in India faces numerous challenges, compounded by increasing litigation, inefficiencies in the legal system, and concerns from the medical community. These challenges can be categorized into four major areas: Litigation-Related Challenges, Systemic Issues, Ethical and Procedural Gaps, and Healthcare-Specific Concerns.

2.1. Litigation-Related Challenges

2.1.1. Rising Medical Litigation

India faces over 5.2 million medical malpractice cases annually, as per a 2022 study by the National Library of Medicines.[9] The Founder-CEO of CoverYou reports a 400% increase in medical litigation.[10] Alarmingly, a study analysing 253 medical negligence cases decided by the NCDRC between 2015 and 2019 found negligence in 53% of the cases (135 cases).[11] Since the inclusion of healthcare under the Consumer Protection Act (CPA), doctors have voiced concerns about rise in lawsuits, many of which they claim to be unsuccessful, i.e. not resulting in a conviction. Such cases burden the judicial system and increase anxiety for practitioners.[12]

2.1.2. Judicial Backlog

India's judicial system is overwhelmed, with nearly five crore pending criminal and civil cases, a backlog that could take an estimated 300 years to clear.[13] Medical litigation adds to this burden, often resulting in delayed resolutions. These delays not only affect patient satisfaction but also increase anxiety and stress for healthcare providers.

2.1.3. Defensive Medicine

The fear of litigation under the Consumer Protection Act has fostered a culture of defensive medicine, where doctors conduct excessive tests or procedures to avoid potential legal challenges. This inflates healthcare costs and shifts the focus from patient-centered care to risk avoidance.[14]

2.2. Systemic Issues

2.2.1. Technical Gaps in Judicial Expertise

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[9] Business Standard, 'Over 5. 2 mn Medical Malpractice Cases Filed in India Annually, Shows Data' (29 April 2024) https://www. business-standard. com/finance/personal-finance/over-5-2-mn-medical-malpractice-cases-filed-in-india-annually-shows-data-124042900073_1. html accessed 9 November 2024.

[10] Ibid.

[11] Sanjay Sukumar, 'Medical Negligence in Cases Decided by the National Consumer Disputes Redressal Commission: A Five-Year Retrospective Review' https://pubmed. ncbi. nlm. nih. gov/36945851/ accessed 9 November 2024.

[12] Sanjay Sukumar, 'Medical Negligence Pertaining to Medical Records: A Retrospective Study' (2022) 16 *Indian Journal of Forensic Medicine & Toxicology* https://medicopublication. com/index. php/ijfmt/article/view/17637 accessed on 12th November, 2024.

[13] *New York Times*, 'India Judicial Backlog' (13 January 2024) https://www. nytimes. com/2024/01/13/world/asia/india-judicial-backlog. html accessed 9 November 2024.

[14] Dilip Kumar Mahapatra and D Jena, 'Issues of Medical Negligence in Implementation of Consumer Protection Act' (2014) 1. 11 *SHRINKHALA* 14 http://www. socialresearchfoundation. com/upoadreserchpapers/3/12/1409200423291st%20dilip%20kumar. pdf accessed 9 November 2024.

Medical malpractice cases require specialized knowledge to determine negligence. Courts and consumer forums are not equipped to independently assess complex medical issues. The Supreme Court issued guidelines whereby upon receipt of a complaint against a doctor in a criminal court, the matter must first be referred to a competent doctor or committee of doctors, and the notice to the respondent doctor must only be issued upon discovery of prima facie negligence.[15] This shows that the court or the forum, by itself is not "experts in medical science, and must not substitute their own views over that of specialists".[16] However, the reliance on external expertise often leads to delays and inconsistent judgments.

2.2.2. Procedural Barriers

Medical malpractice cases are further complicated by:

(a) *Limits on Testimony:* Medical professionals often do not testify against a fellow medical professional, thus preventing complainants from compelling doctors to testify on their behalf, potentially limiting the complainant's ability to present a strong, informed case.[17]

(b) *Socio-Economic Disparities:* Class disparities can further skew outcomes in favour of wealthier patients who have the means to secure expert testimonies. Economically disadvantaged complainants may struggle to obtain the technical opinions necessary to substantiate valid claims.[18]

2.2.3. Exclusion of Government Healthcare Services

Government healthcare services are excluded from the CPA's ambit, creating disparities:

(a) *Inequality in Accountability:* Excluding government healthcare services from the CPA's purview creates a disparity in patient rights. Patients at government hospitals, often from economically weaker sections, lack the same protections as those in private care, undermining the CPA's goal of comprehensive consumer protection.[19]

(b) *Reduced Accountability for Government Healthcare Providers:* There is concern that government doctors, perceiving their services as free of charge, may not feel the same level of duty of care, particularly toward economically disadvantaged patients unable to afford private care.[20]

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[15] Madhav Madhusudhan Singh, Saroj Patnaik and others, 'The Consumer Protection Act: A Review of Legal Perspective' (2014) 2 *International Journal of Research Foundation of Hospital & Healthcare Administration* https://www.google. com/url?sa=t&source=web&rct=j&opi=89978449&url=https://www. jrfhha. com/doi/JRFHHA/pdf/10.5005/jp-journals-10035-1026&ved=2ahUKEwjq8LmzhqWKAxW1xTgGHbraJqsQFnoECBoQAQ&usg=AOvVaw1xZ9UTdTtoJxhcZLXRFtb3 accessed on 12 November, 2024.

[16] Martin F. D'Souza v. Mohd Ishfaq, AIR 2009 SC 2049.

[17] Dilip Kumar Mahapatra and D Jena, 'Issues of Medical Negligence in Implementation of Consumer Protection Act' (2014) 1. 11 *SHRINKHALA* 14 http://www. socialresearchfoundation. com/upoadreserchpapers/3/12/1409200423291st%20dilip%20kumar. pdf accessed 9 November 2024.

[18] Ibid.

[19] Bhavika Vajawat, Damodaran Dinakaran and others, 'The Consumer Protection Act, 2019: A Critical Analysis from a Medical Practitioner's Perspective' (2023) *Indian Journal of Medical Ethics* https://pubmed. ncbi. nlm. nih. gov/38375645/ accessed on 9th November, 2024.

[20] Dr Madhuri Irene M and Anita Yadav, 'Medical Negligence and Consumer Rights: An Analysis' (2014) *Law Mantra* https://www. researchgate. net/publication/271519519 Medical Negligence and Consumer Rights an ANALYSIS accessed 8 November 2024.

2.3. Ethical and Procedural Gaps

2.3.1. Non-Compliance with Ethical Guidelines

The Indian Journal of Medical Ethics found that only 46% of healthcare providers comply with ethical guidelines, pointing to systemic lapses in adhering to professional standards.[21] Such non-compliance erodes trust in the healthcare system and contributes to avoidable medical errors.

2.3.2. Mismanagement and Casualties

Mismanagement alone accounts for 70% of casualties in medical malpractice cases[22], highlighting systemic inefficiencies in healthcare delivery. This statistic underscores the need for reforms that emphasize accountability and quality care.

2.3.3. Challenges with the Consumer Protection Act

The CPA has sparked significant debate within the medical community:

(a) *Professional Autonomy and Trust:* Many doctors feel that their professional autonomy is compromised by being subjected to the same legal standards as businesses. The threat of frequent lawsuits has contributed to a climate of mistrust, with many doctors feeling their professional dignity is compromised, as the consumer-driven litigation system challenges the traditionally respected doctor-patient relationship.[23]

(b) *Deterrence of Complex Cases:* The fear of penalties under the CPA discourages doctors from taking on high-risk or complex cases, potentially limiting patient access to advanced treatments.

(c) *CPA and Government Healthcare Services*: Excluding government doctors from CPA liability undermines its goal of comprehensive consumer protection.

2.3.4. Impact of Recent Judgments

Key judgments have shaped the discourse on the CPA:

(a) *Balram Prasad v. Kunal Saha (2014)[24]:* The Supreme Court awarded significant compensation for medical negligence in this case, which involved the wrongful death of a patient. This case underlined the applicability of the CPA to healthcare services and encouraged a comprehensive examination of medical standards of care. The compensation awarded marked one of the largest payouts in India for medical negligence and set a precedent for high liability in such cases.

(b) *Dr. C. S. Subramanian v. Kumarasamy (NCDRC)[25]:* The National Consumer Disputes Redressal Commission (NCDRC) upheld the accountability of medical practitioners for providing substandard care. In this case, the commission ordered compensation due to

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[21] Business Standard, 'Over 5. 2 mn Medical Malpractice Cases Filed in India Annually, Shows Data' (29 April 2024) https://www. business-standard. com/finance/personal-finance/over-5-2-mn-medical-malpractice-cases-filed-in-india-annually-shows-data-124042900073_1. html accessed 9 November 2024.

[22] Ibid.

[23] Dilip Kumar Mahapatra and D Jena, 'Issues of Medical Negligence in Implementation of Consumer Protection Act' (2014) *SHRINKHALA* http://www. socialresearchfoundation. com/upoadreserchpapers/3/12/1409200423291st%20dilip%20kumar. pdf accessed 9 November 2024.

[24] *Balram Prasad v. Kunal Saha, AIRONLINE 2013 SC 528.*

[25] Dr. C. S. Subramanian v. Kumarasamy (NCDRC), (1994) IMLJ 438.

inadequate postoperative care leading to complications. It reinforced the duty of care expected from doctors when they accept fees for services.

(c) *Bar of Indian Lawyers v. D. K. Gandhi PS National Institute of Communicable Diseases (2024)*[26]*:* The case focused on whether legal services fall under the Consumer Protection Act (CPA). This decision addressed whether the services provided by professionals, specifically lawyers, are subject to the CPA's consumer protection provisions. The court in this case held that legal professionals do not fall under the ambit of the CPA, as they provide what they termed as "contract of personal service," which cannot come under the act's definition of services. The act traditionally applies only in situations where the contract is a "contract for service," which is distinct from a "contract of personal service." In the same judgement, the bench called for a revisitation of the judgment in *V P Shantha* by a larger bench, as the services provided by professionals such as lawyers and doctors are governed by unique ethical frameworks and guidelines, exempting them from the ambit of the CPA.

Groups like the Association of Healthcare Providers India (AHPI) have advocated for excluding doctors from the CPA, arguing that medical practice involves complex, life-impacting decisions distinct from conventional business services. If the Supreme Court decides in the favour of exempting medical professionals from the CPA, it would mark a significant shift in how medical malpractice and negligence claims are handled, potentially leading to alternative mechanisms for patient grievances while aiming to balance patient rights with doctors' interests.

2.4. Healthcare-Specific Concerns

2.4.1. Defensive Practices and Stress

The medical community has reported increasing stress due to litigation under the CPA. Defensive medical practices have resulted in higher healthcare costs, reduced innovation, and a reluctance to take on high-risk cases.

2.4.2. Indian Medical Association (IMA) Criticism

The Indian Medical Association (IMA) has consistently opposed the inclusion of doctors under the CPA, citing:

a) The CPA could undermine the professional autonomy of doctors, as it might subject them to the same legal standards as commercial businesses.

b) Medical practice is inherently different from commercial transactions. The complexity of medical decisions and the potential for unpredictable outcomes make it difficult to apply consumer protection laws.

c) The fear of increased litigation could lead to defensive medical practices, where doctors prioritize avoiding lawsuits over providing optimal care.

d) Defensive medicine can compromise patient care by discouraging innovation, risk-taking, and the provision of comprehensive care.

[26] Bar of Indian Lawyers v. D. K. Gandhi PS National Institute of Communicable Diseases, 2024 SCC Online SC 928.

2.4.3. Lack of Central Protection Laws

India lacks a dedicated Central Protection Act for healthcare workers, leaving them vulnerable to harassment and violence. The IMA has advocated for a Central Protection Act to ensure the safety and well-being of healthcare workers. By addressing the root causes of violence and providing adequate legal protection, such a law can help create a safer working environment for medical professionals and ultimately improve the quality of healthcare in India.

The IMA has demanded[27]:

a) Severe penalties for individuals assaulting medical professionals.

b) Expedited trials and specialized courts to address grievances efficiently.

c) Improved hospital security and legal safeguards to deter violence.

2.5. The way forward

The challenges with the current framework for addressing medical malpractice in India stem from rising litigation, systemic inefficiencies, and procedural gaps. While the CPA has provided an accessible platform for grievances, it has also created concerns around professional autonomy, defensive practices, and judicial overreach. Addressing these issues requires a holistic approach, including legal reforms, the establishment of specialized courts, and the enactment of protective laws for healthcare providers. A balanced framework must ensure accountability, quality care, and the dignity of medical professionals. This is where the deliberation into alternatives to consumer courts comes into the picture. The next part discusses in detail the available alternatives from different jurisdictions.

[27] 'IMA Again Demands Central Law on Violence Against Doctors, Hospitals' *The Hindu* (4 December 2024) https://www. thehindu. com/news/national/ima-again-demands-central-law-on-violence-against-doctors-hospitals/article68589266. ece accessed 6 December 2024.

3. APPLICABILITY OF ALTERNATIVE MODELS IN INDIA

3.1. Strengthening the National Medical Commission (NMC) – NHS UK Model

3.1.1. Overview of the NHS Redress Mechanism

The NHS is one of the leading healthcare services in the world in public healthcare. It seeks to provide free and standard healthcare to the population free of cost or provide services at less cost than private providers. The redress mechanism of National Health Service functions under a statutory framework, that addresses health complaints and medical negligence claims about redress medical negligence and substandard care; It is governed mostly by the Act of the National Health Service 2006 and then the Health and Social Care Act 2012, by which laws describe the rights as well as the responsibilities assigned to care providers.

The redress system is composed by the Parliamentary and Health Service Ombudsman (PHSO) as well as the NHS Resolution, which was formerly known as NHS Litigation Authority. The former looks into complaints that are not resolved by the internal complaints procedures of NHS trusts and offers an independent review to ensure patients get fair and impartial settlements, while the latter Resolution deals with clinical negligence claims and compensation, focusing on dispute resolution such as mediation to settle claims efficiently, thus reducing litigation, encouraging learning, and enhancing patient safety. Further, the General Medical Council (GMC) is a statutory body that regulates doctors in the UK. It has a very important role to play in ensuring professional accountability and maintaining medical standards. Cases of serious misconduct, incompetence, or negligence by professionals in the health sector are referred to the GMC for investigation. The GMC screens referrals to determine whether cases qualify for formal investigation. They further conducts fitness-to-practice hearings through the independent Medical Practitioners Tribunal Service (MPTS). These hearings can result in a range of sanctions, from warnings to suspension or removal from the medical register.

This statutory framework ensures an all-rounded redress mechanism that balances the rights of patients with healthcare accountability. It gives access to both civil remedies and professional regulatory oversight to patients, thereby ensuring trust and the integrity of the NHS.

The key aspects of NHS Civil Redress Mechanism are as follows:

a) *Eligibility to file a claim*: Firstly, if any person receives treatment below minimum standard of competence and he suffers an injury as a result of, he can file a suit or medical negligence[28]. Further, The next of kin of someone who has died due to the negligence in medical care or they are unable to take action themselves, they can file a suit for compensation on their behalf[29].
b) *The procedure for filing the claim*: The NHS has an extremely well-defined and robust system for patients who want to complain about their poor standard of care. Raising a complaint

[28] 'Medical Negligence' (Patient. info, 2023) https://patient. info/treatment-medication/medical-negligence accessed 16 October 2024.
[29] 'Advice for Claimants - NHS Resolution' (NHS Resolution, 2023) https://resolution. nhs. uk/services/claims-management/advice-for-claimants/ accessed 18 October 2024.

is different from raising claims against the NHS. Every NHS organization has to have a clearly defined complaints procedure. A claim can be made to an NHS complaint in writing or in oral to the NHS trust.

(i) Internally: If a person believes that he had not been given the standard level of care, he can approach the hospital management regarding the same. The resolution provided by the management is usually an apology or an assurance that the patient will not be subjected to the same poor treatment again or any other person will not be subjected to the poor treatment again in the future[30].

(ii) Formal NHS Complaint: If the complaint remains unresolved, the next step is to follow formal NHS complaints procedure. The NHS constitution has quoted that each patient has the right to complain, pursue their compensation from the NHS, and receive a full investigation. The patient may raise his grievance to the Parliamentary and Health Service Ombudsman when dissatisfaction continues in the way of complaint[31].

After collecting the independent medical reports and appointing a solicitor, a formal letter of claim will be sent to the NHS trust. A person needs to firstly write an official written letter to complaint to the NHS Trust. After which the trust usually takes three months in which they have to investigate and respond. The investigation includes an interview with the accused, staff members, and other people in the department.

Many times, the Trust provides an acceptable explanation, apology and assurance that the same poor conduct will not happen again to other patients. If the person remains dissatisfied with the explanation and the apology, they can file a claim with the help of the solicitors. The claimant issues a compensation claim and gets started with the formal proceedings[32].

c) *Principle of duty of care***:** The principle of duty of care was established in the case of Donoghue v Stevenson[33] where Lord Atkin outlined a general obligation to exercise reasonable care to prevent foreseeable harm to a "neighbour". A "neighbour" was defined as someone who could be reasonably foreseen as being directly and closely affected by an action.

d) *Breach of duty of care***:** Breach of duty of care is to fell 'short of acceptable professional standard'.[34] The test is known as the *'Bolam'* principle, the principle focuses on 'what should have been done' instead of 'what could have been done'. The test is whether the action taken by the professionals was the one that a "responsible body" of competent professionals would endorse as acceptable. what other professionals might have chosen as

[30] 'Advice for Claimants - NHS Resolution' (NHS Resolution, 2023) https://resolution. nhs. uk/services/claims-management/advice-for-claimants/ accessed 18 October 2024.
[31] 'Medical Negligence' (Patient. info, 2023) https://patient. info/treatment-medication/medical-negligence accessed 16 October 2024.
[32] 'NHS Complaints Procedures in England – House of Commons Library' (UK Parliament, 2019) https://commonslibrary. parliament. uk/research-briefings/cbp-7168/ accessed 20 October 2024.
[33] Donoghue v Stevenson, 1932 AC 562.
[34] NHS Resolution 2023 (n 30).

a different course of action instead of the one chosen by the professional doesn't establish negligence.[35]

There is another test known as *'Bolitho'* evolved from the case of Bolitho v. City and Hackney Health Authority.[36] The principle holds that the responsible body's opinion must also withstand logical analysis. In simpler terms it establishes that the professional opinion supporting the defense of 'reasonable', 'respectable' or 'responsible', must also sound logical, this adds as an extra layer of scrutiny, it ensures that even widely accepted medical practices must be logically defensible to avoid negligence claims.[37]

The injury must be directly linked with the failure of professionals to meet appropriate standards to such work. The rationale is on balance of probabilities it would be unlikely that an unsuccessful claim could be prosecuted against the health professional if at least there was a probable or good chance that without this conduct, the harmful occurrence would not have materialized. In order to make a successful claim a person needs to establish that a duty of care was breached and causation.

e) *To prove negligence*: The patient must succeed the 'three – part test' and prove that, *firstly*, the clinician owed a duty of care to the patient; *secondly*, that the duty was breached through standard care below a reasonable level; *thirdly*, that the breach has caused harm to the patient, that has been proved on the balance of probabilities more likely than not.[38] Further, in Montgomery v. Lanarkshire Health Board, a patient's right to consent was shifted away from a "reasonable doctor standard" to that of a "particular patient." Now, the doctors have to assure patients that they are made aware of any material risks and alternatives.

f) *The quantum of the compensation awarded*: The compensation is given to put the person back to the position as close as possible to where he was before the negligent care. The damages awarded are of two types: General damages and special damages. A person is eligible for general claim or a specific claim based on the specifics of the claims and the impact of the injury. General damage claim will award compensation both for the pain suffered and also for the loss of your quality of life, the sum awarded under general damages will depend on the nature and gravity of the injury and also prognosis for recovery while special damages will include other additional losses such as lost income, increased care needs, medical costs, funeral cost and any other related expense.[39] For special damage claims, supporting receipts are required. Such judicial studies board guidelines, and similar decisions in courts shall be resorted to for arriving at the figure.[40]

All personal injury claims are submitted to the Compensation Recovery Unit at the Department for Works and Pensions.[41] This means that any compensation that may be

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[35] Bolam v Friern Hospital Management Committee 1957 1 WLR 582.
[36] Bolitho v. City and Hackney Health Authority, 1996 4 All ER 771.
[37] 'Advice for Claimants - NHS Resolution' (NHS Resolution, 2023) https://resolution. nhs. uk/services/claims-management/advice-for-claimants/ accessed 18 October 2024.
[38] Arlene Conelly and Mick Serpell, 'Criminal Negligence' (2020) Anaesthesia and Intensive Care Medicine https://www. anaesthesiajournal. co. uk/article/S1472-0299(20)30144-2/fulltext accessed 24 October 2024.
[39] NHS Resolution 2023 (n 37).
[40] 'NHS Medical Negligence Payouts Guide: What is the Average NHS Payout?' (Patient Claim Line, 2024) https://www. patientclaimline. com/medicalnegligence/nhs-negligence-claims/nhs-negligence-payouts/ accessed 22 October 2024.
[41] NHS Resolution 2023 (n 37).

awarded is reduced by any government awarded benefits that a person may have received because of the injury suffered. Clinical negligence claims are often very complex and even require expert evidence, mostly when it comes to causation. Once compensation is accepted, all claims are final, meaning that no further claims can be made even if the wound worsens later. These factors include the type, location, and severity of an injury, the lifestyle effects and the effect on the individual's work capabilities, age, as well as the recovery time. Another very relevant one would be the "condition and prognosis report," as this states the nature of the injury as well as the extent, recovery, and usually forms a basis for negotiations in settling the case. The judicial college also sets out the industry standard guidelines to determine the compensation amounts.

g) *The limitation period for filing compensation claims*: There is a limitation period of three years for compensation claims for personal injury. The three years of limitation are counted from the time the alleged negligence takes place or the time a person becomes aware of the fact that something has gone wrong. Moreover, exceptions have been provided to the limitation rule for the individuals that lack capacity including the people under the age of 18 years or without mental capacity to make decisions.
h) *Evidence required for compensation claims*: Evidence includes copies of medical records, independent medical reports, and financial evidence of past or future monetary losses, amongst others.[42]

The key aspects of NHS Criminal Mechanism are as follows:

a) *Conditions prerequisite for further procedure*: Firstly, that it is in public interest and the Crown Prosecution Service CPS thinks that it has a good possibility of winning. Secondly, to prove negligence in a criminal court, the proof must be beyond reasonable doubt. Thirdly, the clinician's actions need to be so poor as to amount to a criminal offense to reflect extreme recklessness or a callous indifference to patient safety.[43]
b) *Police Investigation*: In cases of criminal complaint, a police investigation takes place before the CPS makes an application for a charge.[44]
c) *General Medical Council Referral Process*: Often criminal cases are remitted to the General Medical Council, although generally the GMC awaits the legal process to be finalised before action is taken. There is an initial screening of the referrals, out of which about 80 percent are not formally investigated. This is due to the cases either being below the GMC thresholds or lack the grounds to do so.[45] The General Medical Council scrutinizes the evidence by two senior decision makers, one *medical* and the other *non – medical.*
d) *Outcomes of the Complaint*: The possible outcomes of the complaint are that either the case may be dismissed and the matter is closed; or the doctor is given a warning or enters into

[42] 'Advice for Claimants - NHS Resolution' (NHS Resolution, 2023) https://resolution. nhs. uk/services/claims-management/advice-for-claimants/ accessed 18 October 2024.
[43] R v. Adomako 1994 UKHL 6.
[44] 'Police Procedures' (Nidirect Government Services, 2024) https://www. nidirect. gov. uk/articles/police-procedures#:~:text=A%20police%20investigation%20will,appointed%20to&text=police%20speaking%20to%20you,appointed%20to&text=incident.%20If%20the%20crime,appointed%20to&text=or%20sensitive%2C%20then%20a,appointed%20to accessed 5 November 2024.
[45] Arlene Conelly and Mick Serpell, 'Criminal Negligence' (2020) Anaesthesia and Intensive Care Medicine https://www. anaesthesiajournal. co. uk/article/S1472-0299(20)30144-2/fulltext accessed 24 October 2024.

a *performance improvement undertaking*.[46] If the case is grave, the case may be referred to the Medical Practitioners Tribunal Service (MPTS) for formal hearings.

e) *Medical Practitioners Tribunal Service (MPTS) Hearings*: The MTPS is an independent General Medical Council (GMC) committee which holds a hearing in public and, in its absolute discretion, can impose further sanctions that would be conditions on practice, suspension or erasure from the medical register.[47]

3.1.2. Pros and Cons of the NHS Model for India

CIVIL COURT MECHANISM WITHIN THE NHS REDRESSAL MECHANISM	
PROS	**CONS**
The NHS Litigation Authority (NHSLA) handles claims related to poor care, with 98% resolved out of court through mediation, fostering amicable resolutions and learning opportunities. Mediation does not bar individuals from pursuing legal action if dissatisfied. Additionally, the NHS mandates all organizations to have a straightforward complaint process separate from claims.[48]	The onus of proof poses a problem as even if the facility admits a breach of duty on their part, causation still must be proved in order to be successful in suing the NHS for medical negligence.[49]
The NHS allows individuals to represent themselves as litigants in person, avoiding representation costs. A letter of claim must be submitted to the responsible NHS trust, detailing the breach of duty, the clinician involved, dates, symptoms, and the compensation sought. This process ensures clarity and accessibility for claimants.[50]	In a compensation claim, the individual does not receive an apology or any guarantee that the trust will implement measures to prevent the same issue from affecting others in the future. Once the compensation is accepted, it is final, meaning the individual cannot pursue further action or claims, even if the injury worsens over time.[51]
A person is entitled to the medical health services and treatment under the NHS even after filing a	Even though one is given the liberty to represent oneself in the court of law, the medical negligence

[46] May McCreaddie, Bethan Benwell, and Alice Gritti, 'A Qualitative Study of National Health Service (NHS) Complaint-Responses' (2021) *BMC Health Services Research* https://doi. org/10. 1186/s12913-021-06733-5 accessed 6 December 2024.

[47] General Medical Council, 'About Us: Legislation: Medical Act 1983' (17 September 2014) https://www. gmc-uk. org/about/what-we-do-and-why/our-mandate#1 accessed 6 December 2024.
General Medical Council, 'Professional Standards for Doctors' (4 May 2018) https://www. gmc-uk. org/professional-standards/the-professional-standards accessed 6 December 2024.

[48] 'NHS Litigation Authority' (GOV. UK, 2024) https://www. gov. uk/government/organisations/nhs-litigation-authority accessed 26 October 2024.

[49] 'Medical Malpractice Cases | National Claims' (National Claims, 2023) https://national-claims. co. uk/the-burden-of-proof-challenges-in-establishing-clinical-negligence/ accessed 28 October 2024.

[50] 'Advice for Claimants - NHS Resolution' (NHS Resolution, 2023) https://resolution. nhs. uk/services/claims-management/advice-for-claimants/ accessed 18 October 2024.

[51]'NHS Complaints Procedures in England – House of Commons Library' (UK Parliament, 2019) https://commonslibrary. parliament. uk/research-briefings/cbp-7168/ accessed 20 October 2024. Also see. , Arlene Conelly and Mick Serpell, 'Criminal Negligence' (2020) Anaesthesia and Intensive Care Medicine https://www. anaesthesiajournal. co. uk/article/S1472-0299(20)30144-2/fulltext accessed 24 October 2024.

compensation claim. Additionally, under the medical negligence claim, a person is also entitled to claim for the costs of any private treatment that a person needs.[52]	claims against the NHS are often difficult to prove and require expert advice. The expert advice is needed because in certain cases the staff and professionals often try to cover up errors and even fabricate the medical records. Moreover , the claimants in most cases require the lawyers or expert opinion to instruct or draft a formal letter of claim.[53]
If uncomfortable filing a complaint with the trust, individuals can submit claims to the NHS commissioning body within 12 months of the incident or awareness. While this process doesn't provide compensation, it offers guidance for pursuing damages claims, commonly arising from errors like surgical mistakes, misdiagnoses, delayed care, or inadequate personal care. This mechanism supports patients in addressing negligence effectively.[54]	The inadequacy in implementing the NHS redress scheme was highlighted by the Health Committee in its 2009 report into Patient Safety. The committee recommended the implementation of the scheme immediately and the committee also emphasized that the NHS procedure is often lengthy and distressing. It disincentivize the complainants to obtain justice and compensation.[55]
The NHS Never Event List outlines preventable safety incidents caused by failure to follow prescribed procedures, such as wrong-site surgery, foreign objects left post-surgery, or incorrect chemotherapy administration. These incidents highlight serious lapses in care, increasing NHS liability. Regular updates aim to enhance safety and minimize risks.[56]	There is a lack of transparency, as the NHS fails to take accountability of the incidents. A report of the research carried out by insight agency Opinium has found out that making claims against the NHS can be a difficult task and is in some cases inhumane, with the worst cases seeing staff trying to proactively cover up errors and even fabricating medical records.[57]
The NHS offers an alternative redress scheme for negligence claims, focusing on investigation,	Some of the patients while making a compensation claim against the NHS receive a

[52] 'Department of Health and Social Care' (The NHS Constitution for England, 2023) https://www. gov. uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england accessed on 29 October 2024. Also see. , 'Recovery of Benefits and Lump Sum Payments and NHS Charges: Technical Guidance' (Department for Work & Pensions, 2024) https://www. gov. uk/government/publications/recovery-of-benefits-and-or-lump-sum-payments-and-nhs-charges-technical-guidance/recovery-of-benefits-and-lump-sum-payments-and-nhs-charges-technical-guidance accessed 18 October 2024.
Jennifer S Schulz, 'Reforming Negligence in England: Lessons About Patients' and Providers' Values from Medical Injury Resolution in New Zealand and the United States of America' (2022) 9(3) Future Healthcare Journal https://doi. org/10. 7861/fhj. 2022-0112 accessed 5 November 2024.
[53] 'Advice for Claimants - NHS Resolution' (NHS Resolution, 2023) https://resolution. nhs. uk/services/claims-management/advice-for-claimants/ accessed 18 October 2024.
[54] Ibid.
[55] R Furniss and S Ormond-Walshe, 'An Alternative to the Clinical Negligence System' (2007) 334(7590) BMJ 400–402 https://doi. org/10. 1136/bmj. 39050. 696192. 94 accessed 10 November 2024.
[56] 'NHS England » Never Events Data' (NHS England, 2024) https://www. england. nhs. uk/patient-safety/never-events-data/ accessed 7 November 2024.
[57] 'I Witnessed an NHS Cover-Up First-Hand' (The Guardian, 2024) https://www. theguardian. com/society/2024/mar/26/i-witnessed-an-nhs-cover-up-first-hand accessed 9 November 2024.

liability assessment, and remedies, especially allowing smaller value cases to be settled more quickly.[58] While not a substitute for civil court proceedings, it allows quicker resolution without needing expert consultants and provides free independent legal advice for those with limited resources.[59]	much less empathetic attitude in comparison to others.[60]
NHS trusts are responsible for handling claims made against hospital doctors, with all compensation claims directed toward the trust itself. Furthermore, a new NHS legislative authority has been established to provide insurance coverage for these trusts. Research, including two U.S. studies and one from the U.K., indicates that NHS negligence in England may lead to approximately 90,000 adverse incidents annually, of which around 13,500 result in fatalities. Despite these high numbers, only about 7,000 claims are filed, with around 2,000 cases resulting in compensation payments.[61]	The British government in 2021 announced that they are considering replacing the current medical negligence system with an alternative, such as an administrative no – fault compensation model.[62]
The opportunity to represent oneself, moreover many solicitors representing the patients also work on No win No fee basis. If the claim is successful, the legal fees is to be paid by the other party.[63] That means that a party can file a claim without facing any financial risk.	The appeals in this system are usually reserved for when there is an issue with the legal process or procedure.
The overwhelming majority of compensation claims against the NHS (98%) are resolved outside of court. In around 1% of cases, there are usually	

[58] R Furniss and S Ormond-Walshe, 'An Alternative to the Clinical Negligence System' (2007) 334(7590) BMJ 400–402 https://doi. org/10. 1136/bmj. 39050. 696192. 94 accessed 10 November 2024.
[59] 'NHS Redress Act 2006' (PSNet, 2005) https://psnet. ahrq. gov/issue/nhs-redress-act-2006 Accessed on 28 October 2024.
[60]The Guardian 2024 (n 57).
[61] 'Clinical Negligence Scheme for Trusts - NHS Resolution' (NHS Resolution, 2024) https://resolution. nhs. uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/ accessed 20 October 2024.
[62] Jennifer S Schulz, 'Reforming Negligence in England: Lessons About Patients' and Providers' Values from Medical Injury Resolution in New Zealand and the United States of America' (2022) 9(3) Future Healthcare Journal https://doi. org/10. 7861/fhj. 2022-0112 accessed 5 November 2024.
[63] 'Home: NHS Compensation Payouts in Claims for Medical Negligence' (Medical Negligence Assist, 2024) https://www. medicalnegligenceassist. co. uk/medical-negligence-claims/how-much-could-my-medical-negligence-claim-be-worth accessed 22 October 2024.

no valid grounds for a claim, leaving just a small 1% chance of the case proceeding to court.[64]	

3.1.3. Scope for Strengthening National Council of Clinical Establishments (NCCE) in India

a) *Improvement of Standard Treatment Guidelines*: While India does have Standard Treatment Guidelines which are similar to the Never End List of the NHS and UK's National Institute for Health and Care Excellence (NICE) guidelines, it is recommended that these guidelines are regularly revised and drafted in a way that avoids multiplicity, tailored according to the level of healthcare available and disseminated to all healthcare service providers. It is further recommended that only the National Health Systems Resource Centre has the sole power and duty to set STGs to ensure streamlining and to enable better reviewing and analysis. It is also recommended that the guidelines be aligned with those of WHO. To allow for the centralising of STGs it is further recommended that health is moved from the state to the concurrent list. It is further recommended that this move of lists should be built upon to strengthen the statutory power of the National Council of Clinical Establishments to allow for the standardisation of Standard Treatment Guidelines and their enforcement.

b) *Establishment Of Mandates And Education Regarding Documentation*: One tool of internal frameworks for accountability and quality control that has been successfully implemented in the NHS system is stringent documentation of medical actions taken by a doctor. Some recommendations regarding implementing the mandate of stringent documentation in India are that:

   (i) There are National Council of Clinical Establishment-mandated classes held at the MBBS level about stringent documentation to ensure the practice is imbibed from the formative level to minimize questions about whether negligence occurred in the future.

   (ii) The National Council of Clinical Establishment is to set a format for stringent documentation to be done by doctors and mandate it among existing medical service professionals. Awareness programs must ensure that the professionals are aware of the same.

   (iii) Since Indian hospitals are often flooded with patients and there is sometimes lack of time for doctors to fill in the documentation, qualified nurses who have also undergone the documentation training like the doctors and were present during the addressing of a patient's medical issues can also be delegated this task.

c) *Two Fold Complain Filing System*: Like in the NHS system, the National Board of Clinical Establishments can also work on adopting a two-fold complaint filing system which relies mostly on mediation to reduce costs and time taken in the process of addressing complaints of medical negligence which involves:

[64] 'Home: NHS Compensation Payouts in Claims for Medical Negligence' (Medical Negligence Assist, 2024) https://www. medicalnegligenceassist. co. uk/medical-negligence-claims/how-much-could-my-medical-negligence-claim-be-worth accessed 22 October 2024.

(i) Internal Complaint Facility: This involves raising a ticket regarding inadequate standard of care by the medical service providers at the hospital with the administration which primarily results in apology and assurance rendered by the administration. This course of action can be taken for minor issues.

(ii) Formal Complaint Facility: It is recommended that a Medical Negligence Tribunals be established in all Indian States with a National Medical Negligence tribunal with appellate jurisdiction be established to enable filing of formal complaints for serious instances of medical negligence. It is recommended that these tribunals along with judicial officers also include medical professionals as part of the adjudicating panel. Qualification requirements such as a PG Diploma in medical law may be imposed on medical professionals to be inducted into the Tribunal.

d) *Education of Medical Professionals of Mandated Standard of Care*: To address the Indian Medical Fraternity's biggest issue regarding medical negligence which is a lack of knowledge about the legal mandates regarding standard of care, it is recommended that the National Council of Clinical Establishments publish precise, regularly updated guidelines regarding patient safety regarding various possible scenarios such as leaving foreign objects inside a patient after surgery along the lines of the NHS's never end list.

e) *Enabling Patient – Centric Approach***:** One of the most important stakeholders in medical negligence cases is the aggrieved patients themselves. It is recommended that the National Council for Clinical Establishments works on establishing a few things:

(i) A Litigation Authority: A litigation authority along the lines of the NHS Litigation Authority must be established to enable mediation to resolve medical negligence claims in a manner that brings speedy justice to the patient in a cost-effective manner.

(ii) A Commissioning Body: It is recommended that a commissioning body along the lines of the NHS Commissioning Body be established in India to provide legal aid, guidance and support to the patient in pursuing a claim for damages.

3.2. Establishing Dedicated Medical Tribunals

3.2.1. Role and Structure of Medical Tribunals

A cross – jurisdictional analysis of developed economies having robust legal frameworks for adjudication of medical malpractice claims helps in understanding the key roles of the medical tribunals in their respective legal frameworks.

a) *United States*: In the United States, *State Medical Boards* (SMBs) *regulate health professional licensure and handle complaints about conduct*. These boards investigate allegations by reviewing medical records and consulting experts. Complaints may be settled before hearings or proceed to formal adjudication, where evidence is presented, and the professional has an opportunity to respond. Disciplinary actions, such as fines, warnings, or license suspension, may follow if violations are proven. Medical malpractice in the US operates under a "fault-based" system,

requiring the plaintiff to prove negligence through expert testimony and adherence to the standard of care (SOC), particularly in emergency situations.[65]

b) *United Kingdom*: The United Kingdom's National Health Service (NHS) provides tax-financed healthcare, offering most services free to residents. Complaints can be raised through NHS procedures, with appeals to the independent Parliamentary and Health Service Ombudsman. Regulatory bodies like the *General Medical Council* (GMC) *oversee legal matters concerning health professionals*, with the Medical Act 1983 granting the GMC authority to investigate misconduct and poor performance. Complaints against doctors may lead to warnings or referrals to the *Medical Practitioners Tribunal Service* (MPTS), which can *restrict or revoke a doctor's registration*. UK negligence law, established in Donoghue v Stevenson, requires proof of duty, breach, causation, and damage, with the "Bolam test" protecting professionals who follow accepted practices. This was refined in Bolitho v City and Hackney Health Authority, allowing judges to find treatment unreasonable if it cannot withstand logical analysis.

c) *Sweden*: Sweden's healthcare system, largely taxpayer-funded, handles patient complaints through the *Health and Social Care Inspectorate* (IVO). IVO *assesses complaints, and if a care provider fails to meet obligations, it may impose fines or prohibit activities*. However, IVO's decisions cannot be appealed by patients. Separate from the disciplinary system, the Patient Injury Act ensures compensation for patients harmed by medical care, provided causality is established.[66]

d) *Denmark*: In Denmark, patients can file complaints with a disciplinary board or seek resolution through dialogue with regional municipalities. Complaints are reviewed by a committee of laypeople, health professionals, and a judge. Case decisions are final unless brought before a court. Denmark's Patient Insurance Association provides compensation for injuries, with no financial repercussions for health professionals unless gross negligence or intentional harm is involved.[67]

e) *Netherlands*: In the Netherlands, the Healthcare Quality, Complaints, and Disputes Act ensures patients can file complaints, which are first assessed by healthcare providers. Disputes may be resolved through a disputes body, which can award compensation up to €25,000. The Individual Health Care Professions Act establishes regional disciplinary tribunals for patient complaints, where actions are judged based on professional standards, with penalties including warnings, fines, or license suspension.[68]

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[65] B Sonny Bal, 'An Introduction to Medical Malpractice in the United States - PMC' (PMC Home) https://pmc. ncbi. nlm. nih. gov/articles/PMC2628513/ accessed 7 November 2024.

[66] World Bank, 'Medical malpractice systems around the globe: examples from the US- tort liability system and the Sweden- no fault system' (World Bank, 1 July 2010) https://documents. worldbank. org/en/publication/documents-reports/documentdetail/421621468779085220/medical-malpractice-systems-around-the-globe-examples-from-the-us-tort-liability-system-and-the-sweden-no-fault-system accessed 7 November 2024.

[67] Fryd Birkeland, 'Health Care Complaints and Professional Legal Responsibility — A Cross-Country Comparative Review' (European Journal of Health Law, 2022) 1, http://dx. doi. org/10. 1163/15718093-bja10100 accessed 7 November 2024.

[68] Berber Laarman and Arno Akkermans, 'Innovating Compensation for Medical Liability in the Netherlands. Compensation Schemes for Damages Caused by Healthcare and Alternatives to Court Proceedings' (Springer 2021) https://research. vu. nl/ws/portalfiles/portal/147710209/Laarman_Akkermans_2021_Innovating_Compensation_for_Medical_Liability_in_NL_Chapter_12. pdf accessed on 27 October 2024.

	NON- MONETARY SYSTEM (E.G. ISSUING REPRIMANDS, WARNINGS, RESTRICTIONS, WITHDRAWAL OF LICENCE)		MONETARY/INJURY COMPENSATION AWARD SYSTEM	
	ORGANISATION	**ASSESSMENT AND NORMS**	**ORGANISATION**	**ASSESSMENT AND NORMS**
UNITED STATES	*State Medical Boards*	Different composition of SMBs but professional and lay person representation, expert opinion and board decision. State Medical Practice Act provisions	Case settlement or jury trial	In trial, judge or jury weighs evidence. Negligence test (Duty of care, breach of duty, causation and damages as a result of breach)
UK	*GMC and other councils*	Health professional and non-professional medical council seniors Medical Act 1983 provisions, GMC standards	NHS Resolution	Formal court proceedings if not solved in-house (negotiation). Negligence test (Duty of care, breach of duty, causation and damages as a result of breach)
DENMARK	*The Health Professional Disciplinary Board*	The Board, consisting of two health professionals, two laypersons, and a judge, makes decisions following expert opinion under the Authorization Act's requirement for "carefulness and conscientiousness.	The patient insurance company	Decision following expert opinion. Specified criteria in Act on complaint & compensation.
SWEDEN	*Health and Social Care Inspectorate*	Administrative decision Requirement in Patient Safety Act for providing competent and careful care in accordance with science and proven experience	The regions' mutual insurance company	Decision following expert opinion Specified criteria in Patient Injury Act
NETHERLANDS	*Regional disciplinary tribunals and a central disciplinary Tribunal*	Acts or omissions necessary care or contrary to proper exercise of professional practice (Individual Health Care Professions Act)	The Disputes Committee	Chairperson (lawyer), lay member, and three health professionals. Negligence test

3.2.2. Advantages of Specialized Forums for Medical Negligence

a) *Faster Resolution - ADR*

The Indian judicial system of the adversarial model often leads to longer trials of matters, which go on for months and sometimes several years. Additionally, court cases involve a number of appeals, which can delay the proceedings. The alternate dispute resolution system, like a medical tribunal, can reduce delays and offer a faster resolution process.[69] As per the report by the U.S. Department of Justice for the fiscal year 2017, the ADR system saved nearly 2000 months of combined time in one year.

For instance, the UK's Medical Practitioners Tribunal Service(MPTS) within the first year of its implementation the MPTS heard over 350 case. It operates independently from the General Medical Council (GMC) to ensure impartiality. This is to ensure that cases are resolved in less time and more quickly as compared to in a general court. The tribunal uses case management hearings and strict timelines, which help streamline the resolution process, reducing delays.

b) *Enhanced focus on Professional Standards*

Medical tribunals prioritize upholding medical standards and fostering improvements in healthcare quality over simply assigning blame. Unlike traditional courts, tribunals assess a practitioner's actions in the context of professional guidelines, ethical norms, and evidence-based practices, using clinical experts to ensure informed evaluations. This corrective rather than punitive approach emphasizes accountability and encourages targeted professional development. By focusing on systemic trends and quality assurance, tribunals support both patient safety and continuous professional growth, enhancing overall healthcare standards.

c) *Medical Expertise*

To hold health establishments accountable, tribunals should include professionals with both specialized medical and legal knowledge. Currently, judges or India's consumer courts, which deal with medical negligence cases often lack the expertise needed to assess medical practices thoroughly, resulting in decisions that may not adequately address the nuances of healthcare provision. These forums are limited to assessing the fault of services and awarding compensation without medical input. In contrast, Massachusetts tribunals incorporate physicians from a pool of volunteer medical professionals, ensuring that specialists relevant to the case are involved. Medical negligence involves cases of wrongful discharge of medical practice, which involves complex issues of medical knowledge that only a qualified practitioner or expert can answer, which can often lead to wrongful judgment. Through the institution of medical tribunals, this issue can be resolved as medical tribunals would include a trained medical expert.

For instance, the UK's Medical Practitioners Tribunal Service (MPTS) has a pool of around 300 medicals and lay panellists who adjudicate the matters presented before them for medical negligence. Medical experts are better able to access the context of each case in regard to genuine negligence and unfortunate outcomes within accepted medical risk leaves.

[69] Catherine Struve, 'Doctors, the Adversary System, and Procedural Reform in Medical Liability Litigation' (2004) 72(4) Fordham Law Review https://ir. lawnet. fordham. edu/flr/vol72/iss4/4/ Accessed on 29 October 2024.

d) *Greater Accessibility*

Tribunals are structured to be more accessible and user-friendly for both patients and practitioners, offering a more streamlined and informal approach compared to traditional courts. With a focus on dispute resolution rather than adversarial litigation, tribunals foster an environment where both parties can engage in dialogue rather than confrontation. This approach not only reduces the stress and complexity often associated with courtroom procedures but also emphasizes fair, impartial outcomes. By encouraging open communication, tribunals make it easier for patients to voice concerns and for practitioners to explain their actions, often leading to faster, more satisfactory resolutions that maintain trust and respect within the healthcare system.

e) *Privacy and Confidentiality*

Court cases are generally recorded for matters of public record, and the general public can easily access those documents. Through the arbitral tribunal, the process ensures the privacy and confidentiality of the injured parties.

For instance, Canada's provincial Colleges of Physicians and Surgeons oversee medical tribunals that emphasize confidentiality in case proceedings. They often hold hearings in private when there is a sensitive issue involved to ensure confidentiality and provide a secure environment for both the patient and the professionals.

f) *Integration with Preventive Measures*

Medical tribunals, with their emphasis on professional standards and practice quality, play a critical role in integrating preventive measures to reduce the likelihood of future malpractice. Rather than focusing solely on punitive outcomes, tribunals often evaluate cases to identify underlying issues, such as gaps in training, resource allocation, or adherence to updated clinical guidelines. By offering constructive feedback and recommendations, tribunals can help practitioners improve their practices and align with evolving medical standards. This preventive approach is particularly well-implemented in countries like Germany, where medical arbitration often includes sessions aimed at constructive criticism, peer review, and professional development. Such proactive measures not only address individual cases but also contribute to systemic improvements within the healthcare sector, reinforcing a culture of learning and continuous quality enhancement that benefits both practitioners and patients.

g) *Patient-Centric Resolution Models*

Medical tribunals, with their adaptable structure, offer an avenue for patient-centred resolutions that focus on timely and tailored responses to patient needs. Unlike traditional courts, tribunals emphasize mediation and negotiation, creating a supportive environment where patients' voices are central to the process. This approach allows for quicker resolutions and remedies that can be customized to address the specific concerns and well-being of patients, such as formal apologies, corrective actions, or adjustments in medical care plans. By prioritizing patient experiences and

outcomes, tribunals can foster trust and satisfaction, enhancing the overall perception of fairness and responsiveness in healthcare dispute resolution.

h) *Quick Redressal*

Indian courts face significant backlog issues, and cases involving medical malpractice often need urgent attention, especially when patients or their families are in vulnerable positions. The slow pace of resolution, compounded by delays in consumer forums, adds to the distress of individuals facing medical debts. Advocacy groups have called for fast-track procedures to address these challenges.

3.2.3. Challenges in Implementation

a) *Resource extensive*

Creating a specialized tribunal system for medical negligence entails significant capital, skilled workforce, and supportive facilities. India's healthcare and judicial systems already face resource limitations, with issues like understaffed courts and underfunded healthcare facilities. Setting up a medical tribunal system would require significant investment in infrastructure, personnel, and training. If resources are inadequate, the system might struggle to function effectively, potentially increasing delays and lowering the quality of judgments.

For instance, nations such as the U.K. have made partial efforts to resolve this by incorporating the Health Service Ombudsman and General Medical Council (GMC) actions, but still face challenges. The GMC brings on-board doctors trained to investigate medical complaints; however, this is a very expensive and lengthy process. This could be a potential concern in India too where the healthcare system and the judicial system can be very limited in terms of funding and skilled manpower.

b) *Potential bias and partiality*

Medical boards generally consist of both lawyers and doctors. However, if tribunals are less transparent with respect to their composition or voting processes, there might be actual or perceived bias in favour of the doctors.

For example, in France, members of the National Authority for Health (the government body responsible for managing health care complaints) also serve on panels to resolve healthcare disputes. Such a system has raised concerns about bias due to the dominance of the medical members of the panel in some cases leading to the perception of doctors being favoured.

If tribunal members are perceived as too closely associated with the medical profession, there could be public outcry over potential bias.[70] Establishing a system that is impartial, with balanced representation from medical, legal, and patient advocacy fields, would be crucial for maintaining credibility.

[70] Emily Chow, 'Health courts: an extreme makeover of medical malpractice with potentially fatal complications' (2007) 7(2) Yale Journal of Health Policy, Law, and Ethics 387 https://pubmed. ncbi. nlm. nih. gov/17824408/ accessed on 29 October 2024.

c) *Increased Claims Volume*

While tribunals are designed to reduce individual claim costs and provide quicker resolutions, their increased accessibility could lead to a surge in claims, including those without merit. With easier and potentially lower-cost avenues to file complaints, patients might be more inclined to pursue legal action, even in cases where the alleged malpractice is not material. This could overwhelm the system with frivolous or baseless claims, straining resources and leading to delays in processing legitimate cases.[71]

For instance, New York's workers' compensation system saw a rise in claims following expanded tribunal access, many of which were fraudulent or lacked evidence. This surge overwhelmed the system, causing delays and diverting resources from legitimate claims, highlighting the risks of making claims more accessible without safeguards.

d) *Uncertain Impact on Healthcare Costs*

The implementation of medical tribunals, while aimed at streamlining dispute resolution, could have unintended financial consequences, particularly with respect to insurance premiums and overall healthcare costs. The presence of specialized tribunals might lead to an increase in the frequency of malpractice claims, prompting insurance providers to raise premiums for healthcare professionals and institutions. This could result in higher costs for both providers and patients. For instance, in certain states, such as California, where malpractice caps exist, premiums have still increased due to the perception of heightened litigation risks, demonstrating how the presence of a specialized tribunal system could similarly impact the broader healthcare cost structure.[72]

3.2.4. Applicability in the Indian Context

The proposed tribunal system is designed to address and adjudicate medical malpractice claims in India through a streamlined, impartial, and multi-tiered framework. The structure consists of three layers: The State Medical Council (SMC), the Ethics and Medical Regulation Board (EMRB), and the National Medical Council (NMC).

a) *State Medical Council (SMC)*

(i) Composition: The SMC will be composed of the State Health Secretary, the Health Commissioner, and the Director of Health Services, the district medical officer will conduct hearings and send the findings to the SMC. Their only role is to review complaints of medical malpractice and determine whether there exists a prima facie case of negligence and does NOT extend to determining liability or adjudicate the matter.

[71] Michelle M Mello and others, 'National Costs Of The Medical Liability System' (2010) 29(9) Health Affairs 1569, http://dx. doi. org/10. 1377/hlthaff. 2009. 0807 accessed 6 November 2024.
[72] California Raises Medical Malpractice Damage Cap. Is It Enough?' (Philadelphia Personal Injury Lawyers | Feldman Shepherd, 7 September 2022) https://feldmanshepherd. com/blog/california-micra/ accessed 6 November 2024.

(ii) Procedure*:*

1. Prima Facie Review*:* : If the SMC finds no prima facie case, the complainant has the right to appeal to the EMRB. However, the EMRB has discretionary authority to accept or dismiss the appeal following a preliminary hearing.
2. Referral to EMRB*:* If the SMC identifies a prima facie case, it must refer the matter to the EMRB, which is then required to proceed with a full inquiry, conducted as a formal hearing akin to court proceedings.

b) *Ethics And Medical Regulation Board (EMRB)*

(i) Composition: The EMRB will include a medical professional nominated by the State Chapter of the Indian Medical Association (IMA) and an Advocate (preferably of senior designation) nominated by the State Bar Association. Additionally, a member nominated by the Indian Council of Medical Research (ICMR).

(ii) Procedure:

1. Inquiry and Hearing: If a case is accepted by the EMRB, it will conduct a comprehensive inquiry and hearing, including examination of evidence and witness testimonies. This process will be conducted with procedural standards similar to court practices.
2. Appeal Process: Decisions of the EMRB can be appealed to the NMC, ensuring a final review at the national level.

c) *National Medical Council (NMC)*

(i) Composition: The NMC will comprise of two members nominated from the Supreme Court Bar Association; two senior medical professionals nominated by the National IMA; and a representative from the ICMR.

(ii) Authority: NMC would be the final decision making body in malpractice claims. Consequently, the appeals to the High Court and Supreme Court only in cases of substantial questions of law.

d) *Qualifications for medical members of EMRB and NMC*:

(i) Have at least 10 years of experience in medical practice.

(ii) Hold specialization or super-specialization credentials to address complex malpractice cases.

(iii) Serve on a rotational basis, with panel composition tailored to the specific medical expertise required for each case.

3.3. Adopting a No-Fault Compensation Scheme

3.3.1. Concept and Global Examples

No-fault liability is a legal concept that allows individuals who have been hurt or injured to receive compensation without having to show that another person was at fault or negligent.[73] No-fault liability is common in police injury cases and workmen compensation schemes and is also used in cases of medical malpractice.[74] No-fault liability is a desirable structure in the healthcare sector since it provides many benefits from multiple perspectives. From the patient's perspective, no-fault liability offers a simplified procedure to claim damages in medical injury cases without having to go through lengthy court procedures. It also helps doctors to feel less anxious about being sued and having their reputations harmed by malpractice allegations allowing them to concentrate on providing quality healthcare. Furthermore, from a social point of view, no-fault liability encourages openness, responsibility, and equity in the healthcare system. Patients and healthcare professionals can develop trust by shifting the focus from blaming to compensating damaged parties, which boosts public trust in the healthcare system.[75] The no-fault liability system is designed to provide a more efficient and equitable way to compensate people for their injuries and to reduce the burden of litigation on both the parties and the healthcare system.[76] This system is particularly prominent in countries like New Zealand (1972), Denmark (1992), Sweden (1975), Norway (1988), France (1994), and Finland (1992), who have adopted their own versions of no-fault liability in their healthcare sector.[77] Therefore, a no-fault liability system has the potential to be quicker, fairer, and cost-effective contributing to patient safety.

The key provision of the mechanisms adopted in New Zealand, Denmark, Sweden, and Norway are as follows:

a) *New Zealand*

New Zealand enacted legislation in 1972 that established the Accident Compensation Corporation, or "ACC" for short. Initially, the coverage was limited to employees injured at work or outside work; injuries sustained in vehicle accidents and other forms of injury. Subsequent reforms have succeeded at expanding coverage to include medical accidents.[78]

The ACC scheme covers all citizens, residents, and temporary visitors who suffer personal injuries due to accidents, regardless of how those injuries occurred. This includes injuries from motor vehicle accidents, workplace incidents, and medical treatment errors. Injured individuals can submit claims directly to the ACC. Claims can be made up to *12 months* after the injury occurs, and

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[73] Nelson EL, 'Commentary: Some Questions about No-Fault Reform of the Medical Liability System' (Healthcare policy Politiques de sante, August 2021) https://www. ncbi. nlm. nih. gov/pmc/articles/PMC8437253/ accessed 6 November 2024.

[74] Gaine WJ, 'No-Fault Compensation Systems' (BMJ Clinical research ed. , 10 May 2003) https://pmc. ncbi. nlm. nih. gov/articles/PMC1125962/#:~:text=A%20no-fault%20system%20in%20clinical%20negligence%20care%20would%20not,workmen's%20compensation. accessed 6 November 2024.

[75] Pai SN and others, 'Beyond Blame: Is India Ready for No-Fault Liability in Healthcare?' (Cureus, 12 April 2024) https://www. cureus. com/articles/243126-beyond-blame-is-india-ready-for-no-fault-liability-in-healthcare#!/ accessed 6 November 2024.

[76] Ibid.

[77] 'Liability, No-Fault and Workers' Compensation Reporting' (CMS. gov) https://www. cms. gov/medicare/coordination-benefits-recovery/beneficiary-services/liability-no-fault-workers-compensation-reporting#:~:text=No%2Dfault%20insurance%20is%20insurance,in%20an%20accident%2C%20regardless%20of accessed 6 November 2024.

[78] '50 Years of ACC New Zealand: A Legacy of Care and Innovation' (ACC) https://www. acc. co. nz/newsroom/stories/50-years-of-acc-new-zealand-a-legacy-of-care-and-innovation accessed 6 November 2024.

they are typically assisted by healthcare providers. Upon receiving a claim, the ACC has specific timeframes for processing:

(i) For standard claims, ACC must make a decision within *21 days*.

(ii) For more complex claims (e.g., sensitive claims involving mental injury), the decision timeframe extends to *two months*, with possible extensions if additional information is needed.

The initial assessment is conducted by ACC Service Centre Staff who determine whether the claim is covered under the scheme. Claims are categorised based on risk levels, which are[79]:

(i) *No Risk*: Simple Claims (e.g., medical fees) are paid immediately.
(ii) *Low to Medium Risk*: Managed by case coordinators.
(iii) *High Risk*: Serious injuries requiring extensive management are handled by case managers.

The Scheme provides various entitlements, including[80]:

(i) Medical costs: Covers expenses related to medical treatment.

(ii) Weekly Compensation: Offers up to 80% of pre-injury earnings for lost wages.

(iii) Rehabilitation Support: Includes vocational retraining and costs for disability aids.

(iv) Lump-Sum Payments: For permanent impairment or loss.

(v) Support for Dependents: Financial assistance for surviving spouses and children under 18.[81]

The ACC is primarily funded through a combination of levies on employers and general taxation. These funds are allocated into specific accounts based on the type of injury (e.g., work-related, motor vehicle) and are used to cover associated costs. In terms of administrative efficiency, the ACC prides itself on low administrative costs, which account for approximately 10% of total expenditures—much lower than the typical costs seen in tort systems (50-60%). This efficiency allows a greater portion of funds to be directed toward compensating victims.[82]

Importantly, under this no-fault system, individuals relinquish their right to sue for damages arising from personal injuries in most cases. Legal action is only permissible in rare instances involving reckless conduct or exceptional circumstances.[83]

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[79] Dean MR (Independent-review-acclaim-otago-july-2015-REPORT-ACC- . . .) https://www. mbie. govt. nz/assets/bb3b087c54/independent-review-acclaim-otago-july-2015-report-acc-dispute-resolution. pdf accessed 6 November 2024.

[80] Accident Compensation Act, 2001. No 49 (as at 30 June 2024), Public Act – New Zealand Legislation https://www. legislation. govt. nz/act/public/2001/0049/latest/whole. html accessed 6 December 2024.

[81] Farrell AM, Devaney S and Dar A, 'No-Fault Compensation Schemes for medical injury: A Review' https://www. gov. scot/binaries/content/documents/govscot/publications/consultation-paper/2012/08/consultation-recommendations-fault-compensation-scotland-injuries-resulting-clinical-treatment/documents/volume-2-fault-compensation-schemes-medical-injury-review/volume-2-fault-compensation-schemes-medical-injury-review/govscot:document/00403703. pdf accessed 6 December 2024.

[82] Miller RS, The Future of New Zealand's Accident Compensation Scheme https://scholarspace. manoa. hawaii. edu/server/api/core/bitstreams/82416b79-c1c0-4245-a01c-2eefdb46ccc9/content accessed 6 December 2024.

[83] Forster W, Back to the Future: Compensating Injured Workers for Lost Income https://www. otago. ac. nz/ data/assets/pdf file/0033/326958/back-to-the-future-compensating-injured-workers-for-lost-income-036356. pdf accessed 6 December 2024.

b) *Denmark*

In 1992, Denmark introduced a no-fault compensation scheme for compensating patients who suffer from medical injuries. This scheme was introduced by enacting the Patient Insurance Act (PIA) (Patientforsikringsloven), which compensates patients for personal injuries that might have resulted from the medical care provided by hospitals owned and run by County Administration.[84] The PIA and the No-Fault Compensation scheme is financed by the government according to the requirements mentioned in the PIA. The Danish Compensation for Injuries Caused by Drugs Act covers those injuries caused by drugs.[85]

The purpose of the Act is to provide compensation for medical injuries resulting from negligent or erroneous medical care and the compensation under the PIA is intended to be based on objective grounds as under it the injury needs not to be described as negligent or wrongful. Under the Act, the owner and administrator of each hospital are vicariously liable for any adverse events caused by the employed physicians.[86]

Everyone who receives healthcare treatment or purchases medicine in Denmark is covered by the Danish Patient Compensation - regardless of where the injury happens and it takes nine months to reach the adjudication of the case from the moment the claim of compensation is filed.[87] The patients or their representatives report injuries to the Danish Patient Insurance Association, which investigates the cause and extent of the injury.[88] The Association determines eligibility and compensation, which is paid by the government.[89] Also, the compensation for injuries which has been caused by side effects of drugs is paid by the Danish Ministry of Interior and Health. Healthcare providers are encouraged to learn from these incidents and implement preventive measures.

Denmark's Patient Compensation Scheme covers injuries occurring in public and private hospitals, clinics, or during treatment by a wide range of authorized healthcare workers, including doctors, dentists, chiropractors, nurses, and other specialists, as well as during ambulance care, medical trials, or healthcare in prisons and military bases. It also includes preventative healthcare, rehabilitation, and injuries in the Faroe Islands (as of 2012). Exclusions include treatments abroad without referral, treatments in Greenland or the Faroe Islands before 2012, and side effects from herbal medicines or supplements purchased abroad.[90]

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[84] Ulrich A, 'An Evaluation of the Danish No-Fault System for Compensating Medical Injuries' https://lawecommons. luc. edu/cgi/viewcontent. cgi?article=1352&context=annals accessed 6 December 2024.

[85] Farrell, Devaney, Dar (n 84).

[86] Ulrich A, 'An Evaluation of the Danish No-Fault System for Compensating Medical Injuries' https://lawecommons. luc. edu/cgi/viewcontent. cgi?article=1352&context=annals accessed 6 December 2024.

[87] 'Danish Patient Compensation - Official Website' (Patienterstatningen) https://eng. patienterstatningen. dk/ accessed 6 December 2024

[88] SP, TJMK, 'Existing Data Sources for Clinical Epidemiology: The Danish Patient Compensation Association Database' (Clinical epidemiology) https://pubmed. ncbi. nlm. nih. gov/26229505/ accessed 6 December 2024.

[89] 'Denmark Covid Vaccine NFCS' (Faculty of Law) https://www. law. ox. ac. uk/nofault-compensation-schemes-for-covid-19-vaccines/denmark-covid-vaccine-nfcs#:~:text=Introduction,comes%20from%20central%20government%20funds. accessed 6 December 2024.

[90] 'Who Is Covered by the Compensation Scheme?' (Patienterstatningen) https://eng. patienterstatningen. dk/entitled-to-compensation/who-is-covered-by-the-compensation-scheme accessed 6 December 2024.

The processing of a compensation claim involves *firstly* collecting case information, *secondly* investigating and assessing the injury, *thirdly* adjudicating the claim, *fourthly* calculating compensation if acknowledged, and *lastly* finalizing the case.[91]

c) *Norway*

Norway implemented a voluntary no-fault compensation scheme for medical injuries in public hospitals starting in 1988, and later extended it to municipal authorities in 1992. This scheme was formalized into law with the Patient Injury Compensation Act of 2001, which came into effect in 2003 for public sector healthcare and in 2009 for private sector healthcare.[92] The Norwegian Patient Injury Compensation (NPE) (Norsk Pasientskadeerstatning) is an independent national organization that is responsible for handling compensation claims from patients who have been harmed by medical treatment in Norway. It operates under the Norwegian Ministry of Health and Care Services and is funded by contributions from hospitals and municipal authorities.[93]

To file a compensation claim with the NPE, patients must do so within three years of becoming aware that their injury may be linked to medical treatment. The NPE typically takes up to a year to decide on a claim's eligibility, depending on its complexity. The NPE employs a team of medical experts and may consult with external specialists to assess the validity of each claim. If a patient is dissatisfied with the NPE's decision regarding their claim, they can appeal to the Patient Injury Compensation Board (PICB). The PICB will review the decision and make a final determination. It's important to note that the NPE's decisions are legally binding on hospitals and municipal authorities. Patients who successfully file a claim with the NPE are eligible for compensation for financial losses resulting from their medical injury. These losses may include lost earnings, additional medical expenses, and transportation costs. To be eligible, the patient's financial loss must exceed NOK 5000 and the amount of compensation awarded is determined based on Norwegian Damages Act.[94]

Norway's no-fault medical injury scheme focuses on patient well-being by simplifying compensation and easing financial and emotional burdens on patients. It encourages transparency and accountability by promoting the reporting of medical errors, improves patient safety through system-wide quality enhancements, and reduces overall healthcare costs by cutting down on litigation expenses and streamlining procedures.[95]

Norway's no-fault medical injury scheme offers comprehensive coverage for a range of medical mishaps. Patients can claim compensation for injuries resulting from incorrect or unforeseen treatment outcomes, including diagnostic errors, surgical complications, and medication side

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[91] 'How Do We Process Your Case?' (Patienterstatningen) https://eng. patienterstatningen. dk/how-do-we-process-your-case accessed 6 December 2024.

[92]Accident Compensation Act, 2001. No 49 (as at 30 June 2024), Public Act – New Zealand Legislation https://www. legislation. govt. nz/act/public/2001/0049/latest/whole. html accessed 6 December 2024.

[93] Ministry of Health and Care Services, 'The Norwegian System of Patient Injury Compensation' (Government. no) https://www. regjeringen. no/en/dep/hod/organisation-and-management-of-the-ministry-of-health-and-care-services/etater-og-virksomheter-under-helse--og-omsorgsdepartementet/Subordinate-institutions/the-norwegian-system-of-patient-injury/id279763/ accessed 6 December 2024.

[94]'About NPE' (Norsk pasientskadeerstatning) https://www. npe. no/en/About-NPE/#:~:text=The%20Norwegian%20System%20of%20Patient,in%20the%20health%20care%20treatment. accessed 6 December 2024.

[95]RG; J, 'The Norwegian System of Compensation to Patients' (Medicine and law) https://pubmed. ncbi. nlm. nih. gov/15795996/ accessed 6 December 2024.

effects. The scheme also covers injuries caused by faulty medical equipment and procedural errors. Additionally, it provides compensation for certain preventable hospital-acquired infections and delays in diagnosis or treatment that lead to worsened health conditions. Even adverse reactions to vaccinations may be eligible for compensation under specific circumstances. On the other hand, injuries resulting from known and unavoidable risks of treatment, as well as minor or temporary side effects, are typically not eligible for compensation. Similarly, injuries primarily caused by pre-existing conditions or those arising from experimental or non-standard treatments may not be covered. Additionally, the scheme does not cover injuries or conditions unrelated to medical interventions, such as those resulting from personal health habits or accidents.[96]

If the NPE approves a claim, the claimant is also eligible for reimbursement of reasonable legal expenses incurred during the claim process. To avoid unexpected costs, claimants can seek prior approval from the NPE regarding the anticipated legal expenses.[97]

d) *Sweden*

Sweden's no-fault compensation scheme, known as the Patient Injury Act (Patienträttighetslagen), was established to provide compensation for patients who suffer harm due to medical treatment without the need to prove fault or negligence. This system aims to ensure that patients who suffer harm due to medical treatment receive compensation quickly and fairly, without the lengthy and often adversarial litigation process.[98]

It covers medical expenses, loss of income, and other related costs for patients who suffer harm due to medical treatment. Originally a voluntary scheme in 1975, it became mandatory in 1997 with the enactment of the Patient Injury Act of 1996. This legislation expanded the scheme's scope, including the right to compensation for medical injuries and the obligation of both public and private healthcare providers to carry patient insurance.[99] The Patient Injury Act of 1996 mandates that healthcare providers in Sweden must have insurance to cover claims arising from medical injuries. Insurance companies providing this coverage are also part of the Patient Insurance Association.[100]

The Swedish Patient Insurance Association is a public company that oversees the country's medical injury compensation scheme. It's funded by contributions from county councils, which are responsible for healthcare services.[101] While the scheme covers injuries resulting from drug

[96] 'What Are the Criteria to Qualify for Compensation for a Patient Injury?' (Norsk pasientskadeerstatning) https://www. npe. no/en/information-compensation-claimants/information-making-application-patient-injury/criteria-to-qualify-for-compensation/ accessed 6 December 2024.
[97] Excerpts from the patient injury act https://www. npe. no/globalassets/skjema/infoskriv-eng/excerpts-from-the-patient-injury-act. pdf accessed 6 December 2024.
[98] Hellborg S, 'Liability for Medical Injuries in Sweden' (SHS Cairn. info, 2 November 2020) https://shs. cairn. info/revue-journal-du-droit-de-la-sante-et-de-l-assurance-maladie-2019-2-page-72?lang=fr accessed 6 December 2024.
[99] Johansson H, 'The Swedish System for Compensation of Patient Injuries' (Upsala journal of medical sciences, May 2010) https://pmc. ncbi. nlm. nih. gov/articles/PMC2853784/ accessed 6 December 2024.
[100] Patient injuries act (1996:799) https://lof. se/filer/PSL-from-2021-07-01. pdf accessed 6 December 2024.
[101] 'PatientFörsäkringsFöreningen' (Patient Insurance Association) https://www. pff. se/extra/information-in-english/ accessed 6 December 2024.

administration or prescription errors, pharmaceutical product defects are handled by the Swedish Pharmaceutical Insurance Association.[102]

If a claimant is dissatisfied with the PFF's decision regarding their eligibility or compensation, they can appeal to the Patient Claims Panel. The panel is chaired by a former judge and includes six other members with various medical and legal expertise.[103]

Independent Patients' Advisory Committees operate throughout Sweden to assist patients facing difficulties in their interactions with healthcare providers while these committees don't have decision-making authority, they adopt a practical approach to resolving complaints.[104] Meanwhile, a Medical Responsibility Board ((Hälso- och sjukvårdens ansvarsnämnd, HSAN) handles complaints from patients who believe healthcare professionals have been negligent. HSAN can issue warnings or initiate disciplinary proceedings against these professionals.[105]

The Swedish no-fault scheme primarily covers treatment and diagnostic injuries, which account for about 85% of claims. For treatment injuries, the harm must be "avoidable" and assessed by experienced specialists, considering both the original treatment and potential alternatives. For diagnostic injuries, the harm must be "avoidable" and assessed by experienced specialists, without considering retrospective factors. The scheme also covers material-related injuries, which are "unavoidable" but have specific circumstances, such as defects in medical products or equipment. Infection injuries which are "unavoidable," must involve an external source of infection along with a severity outweighing the patient's underlying condition and treatment necessity and accident-related injuries on healthcare premises are covered under specific circumstances, despite being "unavoidable."[106]

Sweden promotes patient safety by analysing medical errors through root cause analysis of claims made under the no-fault scheme. The national medical injury insurance company, LOF, incentivizes this analysis. Senior hospital staff receive regular updates on medical injury claims originating from their hospitals. LOF representatives visit these hospitals to discuss the reasons for the claims and explore strategies to prevent future incidents.[107]

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[102] Hellborg S, 'Liability for Medical Injuries in Sweden' (SHS Cairn. info, 2 November 2020) https://shs. cairn. info/revue-journal-du-droit-de-la-sante-et-de-l-assurance-maladie-2019-2-page-72?lang=fr#:~:text=If%20a%20patient%20suffers%20damage%20from%20a,safety%20risks%20with%20respect%20to%20the%20medicine. accessed 6 December 2024.

[103] 'Om Patientskadenämnden Och Vårt Uppdrag' (Om Patientskadenämnden och vårt uppdrag - Patientskadenämnden) https://www. patientskadenamnden. se/vart-uppdrag/ accessed 6 December 2024.

[104] 'The Patient Advisory Committee - in Other Languages' (Västra Götalandsregionen) https://www. vgregion. se/halsa-och-vard/Patientnamnden/Complaint/#:~:text=The%20Patient%20Advisory%20Committee%20can,with%20the%20responsibility%20for%20healthcare. accessed 6 December 2024.

[105] Wallensten R, 'Legislation Covering All Medical Malpractice in Sweden' (Orthopedic Proceedings, 1 March 2006) https://boneandjoint. org. uk/Article/10. 1302/0301-620X. 88BSUPP_I. 0880014 accessed 6 December 2024.

[106] 'För Dig Som Patient' (PFF) https://www. pff. se/patient/#vem-kan-fa-ersattning accessed 6 December 2024.

[107] Ying-qi W and Yu-ming C, 'Review and Implication of Swedish Medical No-Fault Compensation System' (Medicine & Philosophy) https://yizhe. dmu. edu. cn/en/article/id/a1ab68c1-16f7-4459-9a12-5b8146138ca2 accessed 6 December 2024.

There is Swift financial relief for patients affected by medical errors and Rapid, litigation-free compensation helps victims.	There is an increased claims potential as higher claim volumes and simplicity in claiming compensation may increase overall costs and claim volume.
It reduces litigation and administrative expenses by eliminating fault-based aspect which improves outcomes and facilitates efficient fund allocation with minimal overhead resulting in low administrative costs.	There is a risk of frivolous claims due to non-fault nature.
The streamlined processes ease workloads for providers.	Caps on compensation may leave some patients under-compensated
It minimizes patient burden by removing blame component.	There might arise administrative inefficiency and consequently delays.
It encourages error reporting, enhancing system transparency and accountability.	There is a limited scope as it may not fully cover the non – medical losses.
It encourages safe practices by minimizing defensive medicine.	It limits ability to sue, possibly reducing provider vigilance and presents a hurdle in balancing compensation and provider accountability.
The coverage offered is broad, and covers citizens, residents and visitors for various injuries.	Defining eligible injuries for compensation can be complex.

3.3.2. Balancing Patient Rights and Doctor Accountability

No-fault compensation in healthcare is a dramatic departure from traditional fault-based systems, offering a balanced approach to patient rights and clinician accountability. The concept reduces the adversarial aspect of litigation by allowing patients to seek compensation for medical damage without having to establish negligence, and it also gives quick financial relief to impacted persons. Countries such as New Zealand, Sweden, and Denmark have successfully implemented this strategy. For example, New Zealand's no-fault Accident Compensation Corporation offers full coverage for medical errors and personal injuries, allowing compensation to be paid quickly and efficiently at a minimal administrative cost.[108] More emphasis has been placed in Denmark and Sweden on systemic accountability through financing and learning from errors to improve practice in institutions of healthcare.[109]

[108] Accident Compensation Corporation, 'Health and Disability Commissioner' https://www. acc. co. nz/about-us/who-we-are/our-history accessed 6 December 2024.

[109] Scottish Government, Consultation on Recommendations for a Fault Compensation Scheme for Injuries Resulting from Clinical Treatment: Volume 2 - Fault Compensation Schemes for Medical Injury Review (August 2012) https://www. gov. scot/binaries/content/documents/govscot/publications/consultation-

The strength in the no-fault model lies in its ability to improve patients' rights since claims might not be emotionally or financially strenuous. In that, simplicity has led to other criticisms that accountability might decline within the health practitioners. The balancing in this regard incorporates mechanisms that include independent oversight bodies. For instance, New Zealand uses the Health and Disability Commissioner to investigate complaints with an aim of ensuring accountability amongst providers without undermining the no-fault principles.[110] In Sweden, enterprise liability will have healthcare institutions rather than individual practitioners responsible, encouraging systemic safety improvement.[111]

Despite these benefits, however, there are some problems: caps on damages do not provide sufficient assistance for patients in some cases; and the lack of fault-based accountability makes doctors careless. To address these concerns, countries such as India who are pursuing a no-fault approach should incentivise error reporting, guarantee effective supervision systems, and conduct pilot projects in chosen health institutions to test the model.[112] This will allow India to borrow best practices from around the world, achieving the right balance between proper patient care and provider responsibility. Finally, no-fault compensation has the potential to change health-care systems into more people-friendly models that prioritise openness and systemic accountability.[113]

3.3.3. Applicability in the Indian context

a) *Government Funding With Employer Contributions*: In New Zealand, the Accident Compensation Corporation (ACC) is funded by general taxation and employer levies, which helps keep administrative costs low and ensures a broad funding base. [114] India could consider a similar approach, where funding comes from a mix of public contributions and levies from private healthcare providers. Large hospitals and corporate healthcare chains could contribute proportionally based on their revenue, while smaller clinics and independent practitioners may pay a nominal premium. Government hospitals could be funded through state and central health budgets. Unlike indemnity insurance, this no-fault model would provide compensation without requiring proof of negligence, ensuring faster relief. A transparent regulatory body would oversee fund management, ensuring financial sustainability and efficient claims processing.
b) *Integrating Accountability With No-Fault Compensation*: One key concern with no-fault systems is the risk of reduced accountability for healthcare providers. In New Zealand, the

paper/2012/08/consultation-recommendations-fault-compensation-scotland-injuries-resulting-clinical-treatment/documents/volume-2-fault-compensation-schemes-medical-injury-review/volume-2-fault-compensation-schemes-medical-injury-review/govscot:document/00403703. pdf.

[110] Michael J. McKee et al. , 'A New Argument for No-Fault Compensation in Health Care' (2021) 107 Journal of Health Politics, Policy and Law 1 https://link. springer. com/article/10. 1007/s10728-021-00430-4.

[111] DWF Group, 'No Fault Compensation' (2021) https://dwfgroup. com/en/news-and-insights/insights/2021/2/no-fault-compensation.

[112] Australian Medical Association, 'A No-Fault Compensation System for Medical Injury is Long Overdue' (2012) 197 Medical Journal of Australia 5 https://www. mja. com. au/journal/2012/197/5/no-fault-compensation-system-medical-injury-long-overdue.

[113] British Medical Association, No-Fault Compensation Systems: Experience Elsewhere Suggests It Is Time for Change (2003) https://pmc. ncbi. nlm. nih. gov/articles/PMC1125962.

[114] Pai SN and others, 'Beyond Blame: Is India Ready for No-Fault Liability in Healthcare?' (Cureus, 12 April 2024) https://www. cureus. com/articles/243126-beyond-blame-is-india-ready-for-no-fault-liability-in-healthcare#!/ accessed 6 November 2024.

Health and Disability Commissioner was established to address this by investigating complaints and promoting patient rights. India could adapt this by creating an independent oversight body to ensure provider accountability, especially in cases of severe negligence, without compromising on the no-fault compensation principles.[115]

c) *Affordable And Efficient Administrative System*: A notable advantage of the no-fault system is its low administrative cost—only about 10% of expenditures in New Zealand's ACC model compared to the 50-60% typical in tort-based malpractice systems.[116] For India, designing a streamlined, centralized system with minimal bureaucracy could help keep operational costs low and speed up compensation timelines.

d) *Error Reporting And Quality Improvement Mechanisms*: No-fault models are often paired with systems that encourage healthcare providers to report errors openly. Sweden, for example, incentivizes safe practices through "enterprise liability," holding healthcare institutions rather than individual providers responsible for errors. India could pilot similar incentives, promoting safety without placing an excessive burden on individual clinicians.[117]

e) *Pilot Programs To Assess Feasibility And Impact*: Implementing pilot programs in selected regions, focusing on both urban and rural areas, would allow India to study how the model works within diverse healthcare environments.[118] These pilots could provide valuable insights into cost management, safety improvements, and patient satisfaction before broader implementation.

3.4. Exploring Tort Reforms

3.4.1. Current Tort Law Framework in India

Tort law in India functions under the common law framework which primarily focuses on providing justice to patients harmed by negligent medical practice. Medical negligence is considered a tort involving the failure to perform an action that a reasonable person would or performing an act that a reasonable person wouldn't, resulting in harm. It is a legal duty to exercise reasonable skill, knowledge, and care. If failed to do so, it constitutes a breach of that duty and will be consequential to damages arising from such breach.[119]

Any patient availing the services of healthcare providers, such as hospitals, clinics, individual medical practitioners, pharmacies, and diagnostic centres, who suffers damage by the act/omission of the service provider can file a claim under the Consumer Protection Act, 2019 within 2 years from the date of such incident , as it recognizes patients as consumers entitles to seek redress for damages sustained due to negligent medical services.[120] The Act provides a robust mechanism for

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[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Pai SN and others, 'Beyond Blame: Is India Ready for No-Fault Liability in Healthcare?' (Cureus, 12 April 2024) https://www. cureus. com/articles/243126-beyond-blame-is-india-ready-for-no-fault-liability-in-healthcare#!/ accessed 6 November 2024.
[119] Ashok R Patil, 'Landmark Judgements on Consumer Law and Practice 2008-2020' (1905) Books 18 https://repository. nls. ac. in/books/18 accessed 7 November 2024.
[120] R Goel, M Amarnath, RI James and A Amarnath, 'Legal mechanisms and procedures in alleged medical negligence: A review of Indian laws and judgments' (2024) 37 Natl Med J India 39–45 https://doi. org/10. 25259/NMJI_955_2021 accessed 5 November 2024.

addressing grievances related to deficiencies in service, including healthcare.[121] Under Section 2(42) of the Act, even services provided at a subsidized cost are included unless rendered entirely free of charge. The 2019 Act also introduces provisions such as mediation for dispute resolution, addressing the growing need for efficiency and fairness in legal proceedings.[122] Though mediation is an alternative dispute resolution mechanism for faster and more efficient settlements, there lies certain exceptions, however, this mediation recourse is not mandatory in all cases, particularly cases related to *"medical negligence resulting in grievous hurt or death"*[123]. Furthermore, for other disputed, the commission President may refer the matter to mediation with both parties consent, selecting a mediator from an approved panel. If successful, the mediated settlement is formalized as a judgment within seven days. However, parties retain the right to withdraw from mediation at any stage. If mediation fails, the case proceeds to regular adjudication, with appeals possible up to the supreme court. Despite these safeguards, the ongoing reliance on judicial precedent creates disparities in case outcomes, leading to a lack of predictability for both plaintiffs and defendants.[124] Furthermore, calculating compensation for medical negligence is also another major challenge within the current tort framework, as it also depends on the discretion of judges. Consumer fora and courts have observed deficiencies ranging from poor medical records and inadequate infrastructure to delays in treatment.[125]

Moreover, the procedural delays inherent in the Indian judicial system exacerbate the plight of victims seeking redress, often resulting in prolonged litigation that can exceed a decade before resolution.[126] In such a situation, high litigation costs and protracted judicial processes disproportionately affect economically disadvantaged patients, preventing them from pursuing claims for medical negligence.[127]

Defensive medicine practices, driven by the fear of litigation and large compensation payouts, have emerged as a consequence of the current tort law framework for medical negligence, where public awareness of medical negligence has grown.[128] This practice can lead to unnecessary medical

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[121] Oishani Deb, 'Medical Negligence and Consumer Protection Act' (2024) Int J of Adv Res (Sep) 1464–1471 http://www. journalijar. com accessed 8 November 2024.

[122] B Vajawat, D Dinakaran, OV Nandimath, AH C, CN Kumar, C Basavarajappa and SB Math, 'Commentary: The Consumer Protection Act, 2019: A critical analysis from a medical practitioner's perspective' (2024) IX(1) Indian Journal of Medical Ethics 65–69 https://doi. org/10. 20529/IJME. 2023. 073 accessed 2 November 2024.

[123] Section (4), The Consumer Protection (Mediation) Rules, 2020.

[124] C Hodges, 'Delivering justice' (2019) International Journal of Procedural Law, ORA- Oxford University Research Archive https://ora. ox. ac. uk/objects/uuid:8c3ca8fc-13a2-45ab-b635-644c49788c9c accessed 4 November 2024.

[125] MM Singh, SK Patnaik, PN Kapoor, M Chaturvedi, P Srivastava, SK Gupta and S Kant, 'The Consumer Protection Act: A Review of Legal Perspective' (2014) https://www. google. com/url?sa=t&source=web&rct=j&opi=89978449&url=https://www. jrfhha. com/doi/JRFHHA/pdf/10. 5005/jp-journals-10035-1026&ved=2ahUKEwio6YCIjZWKAxVh1zgGHSZ1N2QQFnoECBEQAQ&usg=AOvVaw1xZ9UTdTtoJxhcZLXRFtb3 accessed 5 November 2024.

[126] R Goel, M Amarnath, RI James and A Amarnath, 'Legal mechanisms and procedures in alleged medical negligence: A review of Indian laws and judgments' (2024) 37 Natl Med J India 39–45 https://doi. org/10. 25259/NMJI_955_2021 accessed 8 November 2024.

[127] P Bertoli, 'Medical Malpractice in Public Healthcare Systems: An empirical investigation of scheduled damages' (30 June 2014) EDLE - The European Doctorate in Law and Economics programme http://hdl. handle. net/1765/51564 accessed 2 November 2024.

[128] JC Bester, 'Defensive practice is indefensible: how defensive medicine runs counter to the ethical and professional obligations of clinicians' (2020) 23(3) Medicine, Health Care and Philosophy 413–420 https://doi. org/10. 1007/s11019-020-09950-7 accessed 3 November 2024.

procedures, thus increasing healthcare costs and potentially compromising patient care.[129] Furthermore, such medical negligence cases have heightened fears among medical practitioners, prompting calls for a more balanced approach that safeguards both patient rights and the professional autonomy of healthcare providers.[130]

As tort law continues to evolve in India, it serves as a tool for redressal and a mechanism to uphold accountability and ethical standards in the profession. Apart from this, there are significant challenges that still occur, and thereby, there is a need for tort reforms in this area to address the challenges.

3.4.2. Scope for Reform to Address Medical Negligence

In the last few decades, several countries have brought in tort reforms to address the medical malpractice crisis in situations of a sudden increase in medical malpractice lawsuits from patients in the trend of the last 15 years, a.k.a. *"malpractice crisis."*

Key reforms enacted are as follows:

a) Capping of non-economic damages

Capping of non-economic damages places limits on compensation for intangible harms. This measure seeks to bring more predictability to damage awards while addressing concerns about excessive jury verdicts, as it would separate quantifiable economic damages (medical costs, lost wages) from subjective non-economic damages (pain and suffering), implementing caps on the latter to address current inconsistencies.

b) Shortening the time for filing case

Shortening the time for filing malpractice claims ensures cases are brought while evidence remains fresh and reduces prolonged legal uncertainty for healthcare providers. Currently, India's Consumer Protection Act 2019 allows two years from the date of the cause of action, while civil courts permit three years from the act of negligence or its discovery.

c) Insurance set off

Insurance set off rules that prevent overcompensation by deducting a plaintiff's insurance benefits from their malpractice award, ensuring they do not recover both tort damages and insurance payouts for the same loss. This rule is an exception to the collateral source principle in medical malpractice cases, which currently India follows implicitly, allowing plaintiffs to cover both tort damages and insurance payouts, which leads to overcompensation.

d) Affidavit of qualified experts

The requirement for plaintiffs to submit expert affidavits certifying malpractice claims seeks to filter out frivolous lawsuits early in litigation.

PLACING CAPS ON NON – ECONOMIC DAMAGES

[129] TK Mackey and BA Liang, 'The role of practice guidelines in medical malpractice litigation' (2011) 13(1) The AMA Journal of Ethics 36–41 https://doi. org/10. 1001/virtualmentor. 2011. 13. 1. hlaw1-1101 accessed 2 November 2024.
[130] Nola M Ries, 'Choosing Wisely: Law's Contribution as a Cause of and a Cure for Unwise Healthcare Choices' (2017) 25 Journal of Law and Medicine 210–228 https://ssrn. com/abstract=2992449 accessed 4 November 2024.

PROS	CONS
When caps are high, the chance of out of court settlement was found to be higher.[131] Caps on non-economic damages—such as those for pain and suffering or emotional distress—are associated with a significant reduction in the value of these claims, averaging a 19% decrease in non-economic damage payouts. By limiting the maximum awards for non-economic harm, these caps reduce the overall value that plaintiffs can expect from litigation. This reduction not only decreases the average non-economic claim size but also discourages some plaintiffs from filing claims, as the potential recovery may no longer justify the cost of litigation. Consequently, the cap affects both the financial compensation for non-economic harm and the frequency of lawsuits, as claimants with cases centered on non-economic losses may be less likely to pursue legal action under capped conditions.[132] With caps potentially dissuading plaintiffs from litigation, there could be a push for "alternative dispute resolution" or compensation schemes to address non-economic losses effectively. Further it would limit the discretion of the Judge, and create some predictability.[133] In an analysis of various studies conducted on the effect of capping on non-economic damages, it was found that damage caps reduced liability premiums during the medical insurance crisis in the US. This finding was based on 9 different studies.	Limiting recovery in medical malpractice lawsuits by itself is an arbitrary classification that violates the plaintiff's constitutional guarantee to equal protection. There is a challenge to the *'equal protection clauses'* by the capping of non-economic damages as it causes differential treatment to plaintiffs in medical malpractice actions on two grounds: 1. differential treatment of plaintiffs in medical malpractice cases versus plaintiffs in other personal injury cases (who can obtain full recovery), 2. plaintiffs severely injured through medical malpractice with large non-economic damages versus those with small or non-existent non-economic damages from medical malpractice (who can obtain full recovery).[134] North Dakota SC held in Arneson v. Olsen[135] damage caps preclude full recovery for patients with meritorious claims, do nothing toward the elimination of non-meritorious claims, and actually encourage physicians to practice at the expense of patients with meritorious claims. The likelihood of a high jury verdict for malpractice is a key motivating factor for physicians to practice 'good' medicine. Taking this away would mean subsidizing the insurance for physicians who practice bad medicine.[136] If victims cannot recover their full losses, they may absorb a portion of the costs themselves (e.g.,

[131] R Avraham and ÁE Bustos, 'The Unexpected Effects of Caps on Non-Economic Damages' (31 March 2010) Northwestern Law & Econ Research Paper No 08-09, U of Texas Law and Econ Research Paper No 139, International Review of Law and Economics 30 https://ssrn. com/abstract=1125182 accessed 5 November 2024.
[132] MJ Browne and R Puelz, 'Statutory rules, attorney involvement, and automobile liability claims' (1996) Journal of Risk and Insurance 77–94. JSTOR, https://doi. org/10. 2307/253517 accessed 5 November 2024.
[133] MS Chandra and SB Math, 'Progress in Medicine: Compensation and medical negligence in India: Does the system need a quick fix or an overhaul?' (2016) 19(Suppl 1) Annals of Indian Academy of Neurology S21–S27 https://doi. org/10. 4103/0972-2327. 192887 accessed 1 November 2024.
[134] Browne, Puelz (n 134).
[135] Arneson v. Olsen 270 N. W. 2d 125 1978.
[136] Kevin J Gfell, 'The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions' (2004) 37 Ind L Rev 773, 784 https://www2. stetson. edu/law-review/wp-content/uploads/2020/08/42-1richards. pdf accessed on 5 November 2024.

However, it is to be noted that these studies are based on the reduction of medical malpractice insurance, not exactly the size of the compensation itself. However, The most important factor in rising medical liability premiums appears to be the size of the awards rather than the frequency of lawsuits. Therefore, an inference can be drawn that due to caps, essentially, the size of the awards (i.e., the compensation) is reduced. Further it would limit the discretion of the Judge, and create some predictability.	medical bills, lost income). This can lead to significant personal financial strain.[137]
SHORTENING THE TIME FOR FILING THE CLAIMS	
PROS	**CONS**
Shortening the limitation period reduces new claims. Furthermore it helps in reducing overall legal and compensation cost. Moreover, this led to faster resolutions of cases and reduced administrative backlogs.[138] Therefore, it shortened long waits for compensation and decreased administrative expenses.[139] It protect healthcare providers from the prolonged fear of litigation. This gives medical professionals more certainty and stability in their practice.[140] Furthermore, the prompt filing of claims sooner help in ensuring both evidence and witness testimony remain fresh. This not only helps the patients but also medical professionals, as the prompt litigation will also reduce the chances of frivolous cases.[141] Furthermore, it will discourage plaintiffs from filing	It might lead to cases not being filed in time, which possible result in uncompensated claims, especially for patients who are unaware of the error until later. It can place additional stress on administrative systems, which might not be adequately resourced. Fear of litigation from disclosing medical errors is there to the healthcare providers, as they concerts that such admissions might increase their legal liability.[143] It might exacerbate defensive medicine, as healthcare providers seek to avoid potential lawsuits by ordering extra tests, which increases healthcare costs.[144] Additional stress on under-resourced administrative systems due to increased claims in a short span.

[137] MJ Browne and R Puelz, 'Statutory rules, attorney involvement, and automobile liability claims' (1996) Journal of Risk and Insurance 77–94. JSTOR, https://doi. org/10. 2307/253517 accessed 5 November 2024.
[138] Theodore Eisenberg, 'The Empirical Effects of Tort Reform' (1 April 2012) Research Handbook on the Economics of Torts (Forthcoming), Cornell Legal Studies Research Paper No 12-26 https://ssrn. com/abstract=2032740 accessed 1 November 2024.
[139] A Kachalia, SR Kaufman, R Boothman, S Anderson, K Welch, S Saint and MA Rogers, 'Liability claims and costs before and after implementation of a medical error disclosure program' (2010) 153(4) Annals of Internal Medicine 213–21 https://doi. org/10. 7326/0003-4819-153-4-201008170-00002 accessed 7 November 2024.
[140] Melanie Fitzgerald, 'The Continuous Treatment Rule: Ameliorating the Harsh Result of the Statute of Limitations in Medical Malpractice Cases' (2001) 52(4) South Carolina Law Review art 9 https://scholarcommons. sc. edu/sclr/vol52/iss4/9 accessed 6 November 2024.
[141] Christine M Benson, 'Statutes of Limitations in Tort: Who Do They Limit?' (1988) 71 Marq L Rev 769 https://scholarship. law. marquette. edu/mulr/vol71/iss4/4 accessed 3 November 2024.
[143] Kachalia, Kaufman, Boothman, Anderson, Welch, Saint, Rogers (n 141).
[144] F Patrick Hubbard, 'The Nature and Impact of the "Tort Reform" Movement' (2006) 35(2) Hofstra Law Review art 4 https://scholarlycommons. law. hofstra. edu/hlr/vol35/iss2/4 accessed 3 November 2024.

old claims that are being challenged due to loss of evidence over time, thereby preventing medical practitioners from such non-meritorious claims. Healthcare providers report a greater sense of security with the knowledge that claims must be filed promptly, enabling them to focus more on patient care rather than legal concerns.[142]	Restrictive statutes can unfairly deny rights to a medical malpractice victim due to the patient's delay in discovering the injury.[145] Furthermore, patients may feel pressured to initiate claims prematurely to preserve their right to compensation, potentially straining the physician-patient relationship. It is unfair to bar a legitimate claim because of the patient's trust in the physician or the latent nature of the injury. Also, Implementing doctrines such as continuous treatment as an exception could lead to more complex litigation, as it would need the court's special attention to evaluate the continuity of care and patient knowledge more thoroughly. Some states may resist adopting flexible interpretations, citing legislative intent to limit liability strictly.[146] Furthermore, there are often challenges in differentiating the terms "injury" or the "discovery" of an injury occurrence, especially in cases of progressive diseases or medical errors that only manifest symptoms years later.[147] This can lead to inconsistencies in court rulings and "confusion in the application of the discovery rule". Also, Implementing discovery rules or continuous treatment exceptions can make litigation complex
INSURANCE SET OFF RULE	
PROS	**CONS**
The rule of benefit offset helps in preventing overcompensation by ensuring that plaintiffs do not receive both tort damages and insurance payouts, which may exceed their actual losses.[148] The amount of the insurance benefits received by the victim is	By reducing the financial liability on defendants, insurance set-off can lessen the deterrent effect of tort law, which will lead to lower safety standards. Plaintiffs who carry insurance might receive less than uninsured individuals, as their tort awards are reduced by insurance payments.

[142] G Boehm, 'Debunking medical malpractice myths: unravelling the false premises behind tort reform' (2005) Yale J Health Pol'y L & Ethics https://heinonline. org/hol-cgi-bin/get_pdf. cgi?handle=hein. journals/yjhple5&section=13 accessed 2 November 2024.

[146] Ibid.

[147]Melanie Fitzgerald, 'The Continuous Treatment Rule: Ameliorating the Harsh Result of the Statute of Limitations in Medical Malpractice Cases' (2001) 52(4) South Carolina Law Review art 9 https://scholarcommons. sc. edu/sclr/vol52/iss4/9 accessed 6 November 2024.

[148] Fernando Gomez and José Penalva, 'Tort Reform and the Theory of Coordinating Tort and Insurance' (2015) 43 International Review of Law and Economics https://doi. org/10. 1016/j. irle. 2015. 04. 005 accessed 4 November 2024.

deducted from the damage payment the injurer is liable for. Set off rule helps to control the costs associated with litigation by simplifying compensation calculations. Set off helps as an advantage in terms of administrative costs over other methods, like subrogation.	Knowing their insurance could lower their tort recovery, plaintiffs might be discouraged from obtaining adequate coverage, which can leave them financially vulnerable in severe cases.[149]
AFFIDAVIT OF QUALIFIED EXPERTS	
PROS	**CONS**
The requirement for expert certification may discourage parties from pursuing weak claims, thereby promoting more meritorious litigation.[150] Certificates of merit and expert opinions enable an early assessment of the case's viability. They help filter out frivolous claims by providing preliminary expert insights before a case progresses further in the legal system.[151]	Obtaining an expert opinion or certificate of merit adds an initial cost to the plaintiff, which can be particularly burdensome in complex cases requiring specialized expertise. This was also the concern expressed by the Supreme Court in *V Kishan Rao v. Nikhil Super Speciality Hospital*[152]. It would dilute the speedy and simple remedy envisaged under the consumer protection legislation This requirement can deter plaintiffs with limited financial resources from pursuing legitimate claims, particularly in cases where experts are expensive or difficult to access.[153] Since the expert is chosen by the plaintiff, there's a risk that opinions may lack objectivity. Critics argue this could lead to partial assessments, potentially influencing early case outcomes improperly. Therefore, the experts need to be panelled by the CPA, 2019.

3.4.3. Mitigating Defensive Medicine Practices

Defensive behaviour in medical treatments is the actions of physicians that lack medical necessity and which lead to no benefits to the patients, i.e., Positive Defensive Medicine, a.k.a. Assurance behaviour. It also counts the rejection of the high-risk procedures that are medically warranted

[149] Fernando Gomez and José Penalva, 'Tort Reform and the Theory of Coordinating Tort and Insurance' (2015) 43 International Review of Law and Economics https://doi. org/10. 1016/j. irle. 2015. 04. 005 accessed 4 November 2024.
[150] Jeffrey A Parness, 'Expert Opinion Pleading: Any Merit to Special Certificates of Merit?' (1997) Brigham Young University Law Review 1997(3) https://ssrn. com/abstract=1154769 accessed 7 November 2024.
[151] Patricia W Moore, 'The Effect of "Tort Reform" on Tort Case Filings' (2009) 43(2) Valparaiso University Law Review https://ssrn. com/abstract=1429609 accessed 4 November 2024.
[152] V Kishan Rao v. Nikhil Super Speciality Hospital 2010 SCC 5.
[153] Moore (n 153).

and could have been beneficial for the patient, i.e., Negative Defensive Medicine, a.k.a. Avoidance behaviour.[154] The primary reason behind this is the fear of legal lawsuits, which makes them opt for defensive medicine to evade such consequences. Unfortunately, like many other countries, defensive medicine is also increasing in India, and there is an escalation of healthcare costs and compromise on the quality of services rendered.

To reduce defensive medicine, the most common solutions and strategies are: structured training and education, restoring physician-patient relationships, reform of the health system, and reform of the liability system.[155]

One of the root causes of defensive medicine is the reduced trust between doctors and patients. In this situation, structured training programs focused on improving communication skills, empathy, and ethical decision-making can help rebuild this relationship.[156] Physicians equipped with these skills are less likely to engage in unnecessary practices to appease patient anxieties or pre-empt potential complaints. Furthermore, it is crucial to teach medical personnel about tort law's restrictions on their liability as well as medical legislation. Misconceptions regarding legal dangers are the root cause of many defensive tactics.[157] Unfounded concerns can be reduced by educating physicians on the true limits of carelessness and the safeguards provided by laws such as the Consumer Protection Act of 2019.

Furthermore, the current liability system in India is often unpredictable and encourages defensive practices. In such a scenario, tort reforms focused on reducing uncertainties can provide significant relief.

One of the most effective ways to reduce defensive medicine is to cap non-economic damages, such as pain and suffering, which are harder to quantify and often lead to disproportionate awards. [158] By introducing standardized compensation formulas and imposing a reasonable cap, the judge's discretion is limited, which will lead to greater predictability.[159] For instance, in states like Texas and California, caps on damages led to a measurable decrease in defensive medical practices.[160]

Mandating a pre-filing affidavit with a qualified expert's opinion can filter out frivolous cases early in the legal process.[161] This reform ensures that only cases with a prima facie basis of negligence

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[154] MH Eftekhari, A Parsapoor, A Ahmadi and others, 'Exploring defensive medicine: examples, underlying and contextual factors, and potential strategies - a qualitative study' (2023) 24 BMC Medical Ethics 82 https://doi. org/10. 1186/s12910-023-00949-2 accessed 21 October 2024.

[155] E Kakemam, M Arab-Zozani, P Raeissi and others, 'The occurrence, types, reasons, and mitigation strategies of defensive medicine among physicians: a scoping review' (2022) 22 BMC Health Services Research 800 https://doi. org/10. 1186/s12913-022-08194-w accessed 25 October 2024.

[156] Ibid.

[157] PL Williams, JP Williams and BR Williams, 'The fine line of defensive medicine' (2021) 80 Journal of Forensic and Legal Medicine 102170 https://doi. org/10. 1016/j. jflm. 2021. 102170 accessed 29 October 2024.

[158] A Moghtaderi, S Farmer and B Black, 'Damage Caps and Defensive Medicine: Re-examination with Patient-Level Data' (2019) 16(1) Journal of Empirical Legal Studies 26–68 https://doi. org/10. 1111/jels. 12208 accessed 1 November 2024.

[159] RT Emery, 'Unwise and unnecessary: statutory caps on non-economic damages in medical malpractice cases and the appellate review alternative' (2006) 69(3) Albany Law Review 913–946 https://www. albanylawreview. org/article/69352-unwise-and-unnecessary-statutory-caps-on-non-economic-damages-in-medical-malpractice-cases-and-the-appellate-review-alternative accessed on 2 November 2024.

[160]FC Spencer, 'The malpractice crisis' (2005) 7(4) The AMA Journal of Ethics https://doi. org/10. 1001/virtualmentor. 2005. 7. 4. oped2-0504 accessed 3 November 2024.

[161] 'Department of Health and Social Care' (The NHS Constitution for England, 2023) https://www. gov. uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england accessed on 29

proceed, reducing the burden on medical practitioners and courts. The Oklahoma Insurance Department report suggests its effectiveness in curbing defensive medicine.

Furthermore, establishing clear, evidence-based medical protocols and adherence to these guidelines as a defense against negligence claims can reassure physicians.[162] When doctors are confident that following standardized protocols will protect them legally, they are less likely to engage in excessive testing or procedures.

India's implicit practice of the collateral source rule often leads to overcompensation of plaintiffs, which incentivizes defensive medicine. Implementing a formal insurance set-off rule can address this issue by deducting insurance payouts from compensation awards.[163] This reduces the financial burden on healthcare providers and aligns compensation more closely with actual losses.

The Current limitation period of two to three years for filing medical negligence cases under the Consumer Protection Act and civil courts provides ample opportunity for frivolous claims to arise. Shortening the filing period to one year, as seen in the California Medical Injury Compensation Reform Act (MICRA), can prevent stale claims and reduce prolonged litigation fear among healthcare providers.[164]

High malpractice insurance premiums are a major driver of defensive medicine. Tort reforms, such as capping damages, can lower insurance premiums, allowing doctors to focus on providing quality care without undue financial pressure.[165]

These combinations of tort reforms, systemic healthcare improvements, and educational initiatives can significantly mitigate the root causes of defensive medicine.[166] However, these reforms must be balanced to ensure that patient's rights are not unduly compromised. By fostering trust, enhancing legal predictability, and creating a supportive environment for healthcare professionals, India can reduce defensive medicine while ensuring equality and equitable healthcare for all.

3.4.4. Applicability in the Indian context.

October 2024. Also see. , 'Recovery of Benefits and Lump Sum Payments and NHS Charges: Technical Guidance' (Department for Work & Pensions, 2024) https://www. gov. uk/government/publications/recovery-of-benefits-and-or-lump-sum-payments-and-nhs-charges-technical-guidance/recovery-of-benefits-and-lump-sum-payments-and-nhs-charges-technical-guidance accessed 18 October 2024.
Jennifer S Schulz, 'Reforming Negligence in England: Lessons About Patients' and Providers' Values from Medical Injury Resolution in New Zealand and the United States of America' (2022) 9(3) Future Healthcare Journal https://doi. org/10. 7861/fhj. 2022-0112 accessed 5 November 2024.

[162] Melanie Fitzgerald, 'The Continuous Treatment Rule: Ameliorating the Harsh Result of the Statute of Limitations in Medical Malpractice Cases' (2001) 52(4) South Carolina Law Review art 9 https://scholarcommons. sc. edu/sclr/vol52/iss4/9 accessed 7 November 2024.

[163] Fernando Gomez and José Penalva, 'Tort Reform and the Theory of Coordinating Tort and Insurance' (2015) 43 International Review of Law and Economics https://doi. org/10. 1016/j. irle. 2015. 04. 005 accessed 8 November 2024.

[164] Nancy Kubasek and Tiffany Durham, 'Remodelling Federal Medical Malpractice Act: A Possible Improvement to the Affordable Care Act' (2015) 48 Loyola of Los Angeles Law Review 1143 https://digitalcommons. lmu. edu/llr/vol48/iss4/2 accessed 9 November 2024.

[165] PL Williams, JP Williams and BR Williams, 'The fine line of defensive medicine' (2021) 80 Journal of Forensic and Legal Medicine 102170 https://doi. org/10. 1016/j. jflm. 2021. 102170 accessed 29 October 2024.

[166] E Kakemam, M Arab-Zozani, P Raeissi and others, 'The occurrence, types, reasons, and mitigation strategies of defensive medicine among physicians: a scoping review' (2022) 22 BMC Health Services Research 800 https://doi. org/10. 1186/s12913-022-08194-w accessed 25 October 2024.

A Study conducted by NLSUI Bengaluru in 2015 showed that medical litigation is on the rise by 400% in India. Furthermore, in 2019 a report of the government panel found that only 15% of the complaints received involved actual cases of medical negligence, and thereby it is evident that there is a surge of frivolous medical negligence cases and can be termed as the malpractice crisis in India. To address such crisis, the following reforms can be brought in the tort system in India:

a) *Standardized formula should be adopted to calculate compensation along with a cap on non – economic damages.*

In medical negligence cases, the method for determining the quantum of compensation is entirely within the Judge's discretion in India.[167] Although the Supreme Court in Raj Kumar v. Ajay Kumar[168] laid down certain general principles relevant foe the assessment of compensation for personal injuries, they are not always followed for determining the quantum in cases of medical negligence. The general principle as laid down in Raj Kumar v. Ajay Kumar[169], should be adopted universally in India for assessing the medical negligence compensation so as to establish a standardised formula.

Therefore, the formula would be Total Compensation = Economic Damages/Pecuniary Damages + Non-Economic Damages/Non-Pecuniary Damages. For Pecuniary damages, the grounds for compensation are *"Treatment, hospitalization, medicines, transportation, nourishing food, and miscellaneous expenditure. Loss of earnings and other gains, which would include loss during the period of treatment, future earnings, and future medical expenses",* and for Non-Pecuniary damages, the grounds for compensation are *"Pain, suffering, trauma, loss of amenities (and/or loss of prospects of marriages), loss of expectation of life".*

Further, a cap could be placed on the non -economic damages, ensuring that no court award beyond that amount.

b) *Shortening the statute of limitations for filing cases related to malpractice and compensation*.

The limitation period for filing a case before Consumer Commissions as the Consumer Protection Act, 2019 provides, is 2 years from the date of cause of action, whereby a complaint needs to be filed before the concerned consumer Commission having competent jurisdiction. However, filing of a case before a civil court is 3 years from the date of the act of medical negligence or from the date when the patient first became aware of the negligence. As India is facing a malpractice crisis situation, where there is a surge of frivolous medical negligence cases in India, Shortening the time for the filing period, i.e., the limitation period, can be a solution.

c) *Insurance Set Off Rule To Prevent Overcompensation*.

Although India does not explicitly use the Collateral Source Rule, the plaintiff might be overcompensated by receiving both tort damages and insurance payouts. To address this issue, the

[167] MS Chandra and SB Math, 'Progress in Medicine: Compensation and medical negligence in India: Does the system need a quick fix or an overhaul?' (2016) 19(Suppl 1) Annals of Indian Academy of Neurology S21–S27 https://doi.org/10. 4103/0972-2327. 192887 accessed 6 November 2024.
[168] Raj Kumar v. Ajay Kumar, AIRONLINE 2010 SC 125.
[169] Ibid.

implementation of Set off rule can be done. The amount of the insurance benefits received by the victim is deducted from the damage payment the injurer is liable for.[170]

d) *Mandating pre – filing of an affidavit with qualified expert(s) opinion to validate claims of professional negligence.*

Expert evidence is crucial in medical negligence cases.[171] However, in many cases, it has been observed that the requisite expert evidence has not been taken into account by the consumer forums before awarding the compensation to the plaintiffs.[172] To address this issue, a reform can be brought which requires a plaintiff filing a medical negligence action to attach an affidavit that plaintiff obtained a written opinion from a qualified expert that the acts or omissions of the health care provider against whom the action is brought constituted professional negligence.

3.5. Learning from the New Mexico (US) Model

3.5.1. Overview of the Model and Its Features

The New Mexico Medical Malpractice Act was developed in response to a rise in malpractice lawsuits, designed to balance patient rights with protections for healthcare providers. It aims to prevent frivolous cases from reaching trial while ensuring that legitimate claims are addressed efficiently. Historically, New Mexico relied on a "community standard of care," judging a physician's actions against local medical norms. Over time, as medical practices became more uniform, discussions emerged around adopting a national standard of care to allow broader expertise in malpractice cases.

Key aspects of the New Mexico Model are as follows:

a) *Medico-Legal Screening Panel***:** The statute establishes the New Mexico Medical Review Commission, which after 1st July 2022 is empowered to only entertain review of claims brought against independent providers only (independent provider is a health care provider not employed by an independent clinic or a hospital[173]). The panel reviews evidence and offers a "non-binding assessment" of the case's merit. This process serves as a filter, allowing only well-supported cases to proceed.[174]

b) *Selection of panel***:** The director of the medical review commission causes the respondent-independent provider's professional society or association and the state bar association to nominate three members each so sit in the panel. In cases where such a professional society or association doesn't exist or where the respondent-independent provider is not a member of

[170] Fernando Gomez and José Penalva, 'Tort Reform and the Theory of Coordinating Tort and Insurance' (2015) 43 International Review of Law and Economics https://doi. org/10. 1016/j. irle. 2015. 04. 005 accessed 8 November 2024.
[171]SK Jhunjhunwala v. Dhanwati Kau Anr (2019) 2 SCC 282.
[172] CMO, Nehru Shatabdi Central Hospital v. Puja Sahu R. P. No. 1353/2022.
[173] N. M. Stat. Ann. § 41-5-3 G (1978).
[174] Ibid § 41-5-14 & 15.

it, the director of the medical review commission causes the state licensing board to nominate three professionals of the respondent-independent provider.[175]

c) *Panel deliberations*: The statute binds the panel to only deliberate on two issues, namely, *firstly* whether there is substantial evidence that the acts complained of occurred and that they constitute malpractice, and, *secondly*, whether there is a reasonable medical probability that the patient was injured thereby. The panel so deliberates based on majority vote. Although the report of the panel is not binding on either parties, the report of the panel is transmitted to the state licensing board of the health care provider.[176]

d) *Expert Testimony*: In cases where the panel has found malpractice in the cases complained of, the panel, the director of the review commission and the professional association concerned cooperate and help the complainant by identifying and recommending am appropriate expert who helps the complainant with the trial.[177]

e) *Limitation of recovery*: The statute differentiates between an independent clinic and a hospital or hospital-controlled clinic.[178] The law further also differentiates the amount of damages recoverable from a clinic in 2024 to be maximum one million dollars and from a hospital or hospital-controlled clinic in 2024 to be maximum five million dollars. The amount of damages are subject to revision for an independent clinic and a gradual increase per annum for a hospital or hospital-controlled clinic.[179]

f) *Recognizes insurances indemnifying against claims of medical malpractices*: The statute expressly recognizes that insurers can indemnify a clinic or a hospital or hospital-controlled clinic against claims of damages recovered for medical malpractices.[180] However, punitive damages claimed against a health care provider are a personal liability of that health care provider, unless expressly mentioned in the insurance contract.[181]

g) *Medical benefits prior to judgement*: The health care provider who is a defendant in a suit of medical malpractice in a court, or a respondent before the medical review commission can pay the complainant's medical care and related benefits before the judgement is pronounced.[182] This is not meant to be an out-of-court settlement between parties.

h) *Working Mechanism*: The medical review commission, composed of lawyers and healthcare providers, presently decides the maintainability of suits of medical malpractices brought against private practitioner, which as a judicial opinion is not binding upon the parties. The statute provides for the maximum compensation which may be awarded to the aggrieved complainant.

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[175] Ibid § 41-5-17.
[176] N. M. Stat. Ann. § 41-5-20 (1978).
[177] Ibid § 41-5-23.
[178] Ibid § 41-5-3 H.
[179] Ibid § 41-5-6.
[180] Ibid § 41-5-3 E & F.
[181] Ibid § 41-5-7.
[182] Ibid § 41-5-8.

Cases entertained by professional healthcare providers and lawyers will reduce cases which do not lead to convictions.	It causes administrative burden as maintaining an effective and unbiased committee system involves significant administrative effort and cost, potentially increasing system inefficiencies.
Expert Evaluation i.e. having a balanced panel of medical and legal professionals offers a fair and informed assessment of claims.	There may be perceived or real bias, as healthcare professionals or attorneys on the panel could lean towards protecting their professional peers.
There is reduction in defensive medicine as frivolous lawsuits are reduced. The physicians may feel less compelled to practice defensive medicine, which can lead to more cost -effective patient care.	A standard panel may not always have specialists suited to the nuances of every case, leading to potentially inaccurate assessments.
Causes for persons of a medical profession to decide on what is and what is not acceptable as a code of conduct in their respective profession, therefore making them accountable to their colleagues and service beneficiaries.	In the Indian Judicial system, an even judicial bench to adjudicate cases is not preferred. Therefore, a panel based on New Mexico medical review commission would require to be either five or seven, and not six. This would mean that there would be either lawyers or medical professionals will outnumber each other in any given panel. This may affect the outcome of the decision of bench.
A legislation intending to establish the medical grievances tribunals on the lines of the New Mexico legislation, would also explicitly define the pecuniary jurisdiction of such tribunals and the damages which can be recovered.	Usually, the quantum of damages in tort is not decided by the legislature and is left to the knowledge of the courts. If a legislation is introduced to establish medical grievances tribunals and decides the maximum recoverable damages for medical malpractices, complainants and right groups may perceive it to be ultra vires to longstanding common law practices in civil disputes.
It results in improved healthcare standards as regular vetting of healthcare protocols can highlight patterns of negligence, prompting improvements in healthcare protocols and training.	Critics may argue that the model limits patients' access to justice, as cases may be prematurely dismissed without a full trial.

3.5.2. Addressing Concerns of Affordability and Accessibility

Affordability to the healthcare providers is addressed by the top non-economic damages under this Act, which are, at present, set at $600,000, thereby keeping liability premiums for medical providers in check. It brings predictability to pay-outs and prevents costs from getting out of hand, making malpractice insurance readily available to providers. Otherwise, the absence of caps led to a sharp rise in litigation costs and decreased physicians' participation in other states as well. Furthermore, the Patient Compensation Fund (PCF) reduces the financial risk for providers by paying settlements that exceed the primary insurance limits, thereby ensuring that patients receive compensation without overburdening practitioners.[183]

Accessibility concerns are especially evident in rural areas, where physician shortages often are an issue. The Act's stability mechanisms include predictable insurance costs and the protection of occurrence policies, which helps keep providers in the underserved regions. But increased premiums or removing the cap will result in physicians retiring early, reducing hours, or leaving for states with more favourable malpractice environments. This will most disproportionately affect rural communities, who already have less access to healthcare.[184]

Recommendations to improve the model are to create a different liability cap for hospitals and big business to address equitably their higher exposure, increasing primary coverage minimums for physicians, and conducting actuarial studies to ensure that the PCF will last. By balancing fair compensation for patients with the need to retain affordable insurance for providers, New Mexico can continue to improve its healthcare accessibility while addressing affordability challenges.[185] In terms of affordability, the Act's cap on non-economic damages, currently at $600,000, plays a crucial role in controlling liability premiums for healthcare providers. This cap limits unpredictable pay-outs, ensuring that malpractice insurance remains accessible to providers. In the absence of caps, premiums are likely to rise sharply as witnessed in other states where caps are not imposed and the costs of litigation have risen with decreased participation among physicians. Furthermore, PCF has cushioned financial risks for providers as they offset settlements that are over primary insurance limits and thereby patients get compensation without being too costly on the practitioners.

3.5.3. Applicability in the Indian Context

a) *Legislative Amendments Required*

(i) Consumer Protection Act Revisions: To adapt the NM model, the Consumer Protection Act (CPA) in India would require amendments. This includes explicitly excluding medical practice from CPA and enacting a separate and specific legislation for this matter.

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[183] Ece Amber Özçelik, *A Case Study on the Use of Pay-for-Performance Contracts in Turkey to Reduce Geographic and Social Disparities in Access to Primary Health Care* (Working Paper 3, Harvard School of Public Health, 24 October 2023) https://content. sph. harvard. edu/wwwhsph/sites/2216/2023/10/Working-Paper-3-Turkey-2023. 10. 24. pdf accessed 6 December 2024.

[184] New Mexico Medical Society, Amending the Medical Malpractice Act (Revised 2009) www. nmms. org accessed 5 November 2024.

[185] F Soto Mas and others, 'Impact of Health Care and Socioeconomic Needs on Health Care Utilization and Disease Management: The University of New Mexico Hospital Care One Program' (2019) 22(2) *Population Health Management* 113 https://www. liebertpub. com/doi/abs/10. 1089/pop. 2018. 0048 accessed 6 December 2024.

(ii) Definition And Scope Of Medical Negligence: Clear legislative guidelines are needed to define "medical negligence" consistently, distinguishing between malpractice and non-negligent adverse outcomes. This clarity is essential for the screening process to evaluate cases effectively, as seen in the NM model.

(iii) Inclusive Jurisdiction: Unlike the New Mexico medical review commission which from 1st July 2022 only reviews cases against private practitioners and not hospitals, the medical review commissions in India should include all types of healthcare providers under its ambit, to bring about a meaningful change from the present system.

b) *Establishing Medical Grievances Tribunals*

For India, this process should incorporate both national policy frameworks and localized governance to account for regional disparities. Building panels with experts across various specialties would ensure comprehensive case assessments.

(i) Establishing As a Two-Tier Tribunal: Each district should have minimum one medical review commission which decides the issues of medical malpractice brought before it. There should be a second tier of the said tribunal at the state level, which will entertain appeals arising from the district commission. All appeals from the state-level tier should be heard in the Supreme Court.

(ii) Appointment and Training of Panel Members: Expert panels should include qualified medical practitioners and legal experts who are well-versed in medical jurisprudence. This involves training programs and a standardized selection process to ensure impartiality and high-quality assessments. The states in India are in the process of implementing the Health and Allied Professionals Act, which serves as a basis for forming regulatory professional bodies.

(iii) Allocation of Resources: Legislative bodies would need to allocate sufficient funds to support the infrastructure, staffing, and operational costs of these panels. In resource-constrained settings, collaboration between public and private entities could also be explored.

c) *Judicial And Regulatory Support*

(i) Judicial Cooperation: For smooth adaptation, India's judiciary would need to support the integration of pre-litigation screening panels. Courts may need to adjust case intake processes to incorporate panel recommendations.

The Indian judiciary's cooperation in adjusting case intake processes and supporting the integration of these panels would be crucial. Collaboration with regulatory bodies like the NMC could ensure adherence to established medical standards.

(ii) Setting A Standard Of Care: India would need to define either a regional or national standard of care to align with the NM model's approach. This standard would help ensure consistency across cases, especially considering India's wide healthcare disparity between urban and rural areas. India may benefit from setting either regional or national standards of care, considering its diverse healthcare landscape. Such standards would aid in fair and consistent evaluations across cases.

(iii) Judicial Weightage of Commission's Findings: Unlike the medical review commission of New Mexico, which is not legally binding, the commission in India should act as a tribunal and have the authority to allow the suit or reject it, with a chance of appeal against such an order.

d) *Executive Challenges In Policy Implementations*

(i) Cross-Ministry Coordination: Implementing such a model requires collaboration across multiple ministries, including Health and Family Welfare, Law and Justice, and Consumer Affairs. This would demand a coordinated policy framework and shared objectives.

(ii) Role of Medical Councils and Professional Bodies: Organizations like the National Medical Commission (NMC) could play an essential role in framing guidelines and overseeing the implementation of standards for these panels. Their involvement would be critical to ensuring compliance and maintaining accountability.

(iii) Public Awareness and Accessibility: For successful implementation, awareness campaigns are needed to inform both medical professionals and the public about the model's objectives and processes. This would require engagement with medical associations, legal bodies, and consumer rights organizations. Outreach initiatives, potentially through partnerships with medical, legal, and consumer organizations, could enhance trust and understanding of the model among the public and healthcare providers.

(iv) Ethical And Legal Challenges: Consider ethical implications and access to justice concerns, especially for disadvantaged patients. Ensuring transparency and avoiding perceived biases in the screening process are key to broad acceptance.

(v) Financial And Administrative Feasibility: Implementing medical grievances tribunals panels across a diverse and populous country like India would require significant administrative and financial resources. Collaboration with public and private sectors could support feasibility and sustainability.

4. A PERSPECTIVE OF STAKEHOLDERS'

The stakeholders for this study hold the essential experience and know-how of the practical implications and ground realities of the law and its shortcomings. We gathered insights from their experience through the the National Convention on Medicine and Law (NCML) 2024 held online convening experts in healthcare, law, policy and patient advocacy upon presentation of the five models discussing potential reforms to the Indian medical negligence law in India.

4.1. The Healthcare Professionals

As key stakeholders, healthcare professionals are directly impacted by the legal framework surrounding medical negligence in day-to-day life therefore encountering challenges to which our experts provided potential reforms that help alleviate the lacunae in the existing law.

4.1.1. Impact of the Consumer Protection Act and Defensive Medicine

One of the primary concerns raised by the healthcare professionals was the rise in defensive medicine in response to the rise in medical litigations especially the cases of medical negligence under the Consumer Protection Act. Defensive medicine can be understood as the practice of prescription of extra tests, referrals or treatments as a safeguard against potential legal liability. This results in increased healthcare costs straining resources and oftentimes subjecting patients to unnecessary treatments, which is an undesirable response to the Consumer Protection regime that aims at protecting the patients in the first place and also for efficient medicinal practice. The cause behind defensive practices was stated to be caused by the broad application of CPA to medical malpractice claims. It was highlighted that the cost of healthcare has been raised by up to 40% because of such practices.[186] Additionally pointing out that the growing number of lawsuits between doctors and patients creates an atmosphere of distrust with medical professionals focusing more on minimizing litigation risks than delivery of optimal care under this regime. Experts also pointed that reports suggest rising defensive medicinal practices also have negative impact on patient satisfaction in events of poor health outcomes by diverting attention from effective and necessary treatments. This is often supplemented by longer hospital stays, higher costs and less patient engagement.[187]

The country has witnessed a steep rise in medical malpractice claims with annual medical malpractice cases in India reaching 5.2 million annually according to a report of 2022.[188] This rise in medical litigation is followed closely with rise in defensive practices arguably caused by the broad

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[186] Dudeja S and Dhirar N, "Defensive Medicine: Sword of Damocles" (*The National Medical Journal of India*, October 31, 2018) https://nmji. in/defensive-medicine-sword-of-damocles/ accessed December 6, 2024; Kumar M and Mohan S, "Defensive Medicine and Medical Malpractices in India: An Economic Analysis" (*Gnlu Journal of Law & Economics*, July 30, 2020) 33 https://gjle. in/wp-content/uploads/2023/01/Edited-Defensive-Medicine-and-Medical-Malpractices-in-India-An-Economic-Analysis-3. pdf accessed December 6, 2024.

[187] Vento S, Cainelli F and Vallone A, "Defensive Medicine: It Is Time to Finally Slow down an Epidemic" (*World journal of clinical cases*, October 6, 2018) https://pmc. ncbi. nlm. nih. gov/articles/PMC6163143/ accessed December 6, 2024.

[188] Singh SG, "Over 5. 2 Mn Medical Malpractice Cases Filed in India Annually, Shows Data" *Business Standard* (April 29, 2024) https://www. business-standard. com/finance/personal-finance/over-5-2-mn-medical-malpractice-cases-filed-in-india-annually-shows-data-124042900073_1. html accessed December 6, 2024.

application of Consumer Protection Act to medical malpractice claims. While the CPA provides important recourse for patients, the rise in medical negligence cases under the CPA has made doctors more vulnerable to litigation, even in instances where no negligence occurred. The increase in lawsuits has caused many doctors to become risk-averse, placing a significant burden on both healthcare system and the patients it serves. Given these concerns healthcare professionals deem a reform as urgent as desirable against rising costs for patients and against frivolous litigations for doctors.

4.1.2. On Specialized Medical Tribunals

The discussion on the need for a specialized adjudicatory body to deal with cases relating to medical negligence was also extensively discussed by the experts. Model 2 was endorsed by the doctors in the convention on the premise that specialized medical tribunals comprised of both medical and legal experts should address medical negligence cases considering both the medical complexities and legal aspects of each case. In this regard the UK was deemed a fit example of this model. The Medical Practitioners Tribunal Service resolves cases through a screening mechanism,[189] making it significantly faster than the current system in India where cases often drag for years before being resolved causing both loss of time, reputation and practice for doctors on one hand and long drawn financially burdensome battles for the patients.

The UK's MPTS is recognized globally for its efficiency in dealing with medical negligence claims owing to direct involvement of medical and legal experts in decision making ensuring application of legal principles in consonance with medical realities. The experts were of the view that medical tribunals aided the transparency, fairness and procedural expediency in adjudicating cases relating to medical negligence and misconduct along with being more equipped to resolve complex medical cases compared to consumer courts which lack the specialized expertise thereof.

According to the response received from the healthcare professionals in the convention Model 2 suits Indian context for establishment of specialized medical tribunals ensuring complex medical cases get handled by the experts who understand the nuances of medical practice which existing Consumer Courts often fail at. This view was supported by the representatives of the bar as one that should aide in reducing the delays in adjudication and ensure informed judgements.

The establishment of medical tribunals would certainly reduce the already overburdened judicial system of the country further helping reduce judicial backlog relating to the medical malpractice or negligence cases. As of 2023, Indian Consumer Courts have a cumulative backlog of over 545,000 cases[190] while being special courts themselves including a significant number of medical negligence claims. The National Consumer Disputes Redressal Commission itself acknowledges that such backlogs lead to delays and diminished access to justice in the country. Needless to say, this also adds upon the burden on parties litigating the case with medical professionals often losing time, money and sometimes even their reputation in practice over the dilated time period in litigating cases which further exacerbates in frivolous or malicious cases.

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[189] Medical Practitioners Tribunal Service, "Report to Parliament 2023" (*Medical Practitioners Tribunal Service*, 2024) 24 https://www. mpts-uk. org/-/media/mpts-documents/mpts-report-to-parliament-2023 pdf-108064501. pdf accessed December 6, 2024.

[190] "No of Pending Cases in Consumer Courts Falls to 5. 45 Lakh from 5. 55 Lakh in Dec Last: Govt" *Economic Times* (September 29, 2023) https://economictimes. indiatimes. com/news/india/no-of-pending-cases-in-consumer-courts-falls-to-5-45-lakh-from-5-55-lakh-in-dec-last-govt/articleshow/104047864. cms?from=mdr accessed December 6, 2024.

However, it is noteworthy here that the need for separate medical tribunals was negated by the policy experts arguing that this shall be an additional burden on the exchequer that could very well be addressed by including the reforms required for medical negligence and malpractice within the existing Consumer Protection regime possibly by treating medical cases within the CPA but separately by expert adjudicators in medicine and law.

4.1.3. Documentation Mandates

The New Mexico Model gained attention for its strict documentation mandates regarding medical procedures that could be an effective strategy to prevent frivolous claims and protect medical professionals as well as patients that experience a dooming lack of evidence to substantiate their cases in India as of now due to the lack of sufficient documents. Under the New Mexico Medical Malpractice Act healthcare providers and institutions are mandated to maintain comprehensive patient records for all procedures ensuring transparency in evidence of patient care. This evidence acts as a critical defense in cases of alleged negligence and provides clarity in determining whether medical standards were upheld.

A 2020 study revealed that 22% of medical negligence cases in India arise due to inadequate or incomplete documentation.[191] The report also noted that poor documentation not only increases the likelihood of legal disputes but also undermines the trust between healthcare providers and patients.

Implementation of such documentation mandates in India could help reduce the frequency of claims based on ambiguous or incomplete evidence. Alongside the healthcare providers, ensuring proper, detailed and accurate record-keeping system in India shall also give patients access to clear evidence that reduces the chances of prolonged litigation. The Indian Medical Association already advocates the implementation of detailed record-keeping protocols emphasizing that better documentation ensures patient safety, reduces malpractice claims and leads to better healthcare outcomes overall.[192]

4.1.4. Screening of Frivolous Complaints

Another prominent suggestion from the healthcare professionals came in the form of complaint screening. Alleging that most of the complaints made under the Consumer Protection Act for medical malpractices and medical negligence are frivolous or baseless, however, due to the delays in judicial litigation these too take months and years to dispose causing substantial loss of time and resources. In suggesting complaint screening, the experts advocated for a pre-litigation review mechanisms for determination upon a prima facie case before the complaint reaches the final forum of adjudication upon merits. These were based on the idea that only meritorious claims proceed to full litigation thereby reducing the costs in defending against baseless claims as well as reducing the burden on the courts by preventing frivolous cases from clogging the system.

A prominent proposal was in favor of establishment of pre-litigation review panels. These panels constituted by both medical and legal experts shall assess the strength of medical negligence claims

[191] Sukumar S, "Medical Negligence in Cases Decided by the National Consumer Disputes Redressal Commission: A Five-Year Retrospective Review" (2023) VIII Indian Journal of Psychological Medicine 273, 275 https://ijme. in/wp-content/uploads/2023/02/Medical-negligence_273_Final. pdf accessed December 6, 2024.

[192] Aggarwal KK, Gupta I and Gupta R, "Is It Obligatory for Hospitals to Provide Copy of the Case Record to Patient or His Legal Representative?" (*Indian Medical Association*, September 14, 2023) https://www. ima-india. org/ima/archive-page-details. php?pid=483 accessed December 6, 2024.

before they are formally proceeded in courts. This mechanism bears resemblance to the UK's NHS Redress Scheme[193] serving as a filter allowing only claims with sufficient evidence of malpractice or negligence to progress.

Additionally, the introduction of mandatory Internal Complaints Redressal System within healthcare institutions was also discussed. This two-tier approach was deemed to be of help in resolving minor grievances internally before they escalate into legal disputes. As observed from the UK NHS model, a two-tier complaints system allows patients to initially voice concerns at a forum within the institution giving the institution an opportunity to address the issues proactively and without delay. The aim is to avoid litigation through settlements for less serious grievances as experts suggested that a good number of cases are aimed not at receiving hefty compensations or punitive action rather the victims or their family seek sincere redemption and apology for the wrong committed. This model works best in preserving the delicate fabric of trust in the doctor-patient relationship while also reducing the burden of the courts.

4.2. Patient Advocacy Groups

The primary concerns of patient advocates were based on the delays, inefficiencies and barriers to access within the current legal system for timely justice delivery. Advocates for patients' welfare have long been calling for reforms that make justice more accessible and equitable. Following were the key ideas that prominently surfaced from the experts' discussion:

4.2.1. Delays and Barriers in Consumer Courts

One of the most pressing issues for patients was highlighted to be the prolonged litigation and endless delays in obtaining justice through consumer courts. Experts hinted at the estimate that the average time to resolve medical negligence cases in India is estimated to be five years with many cases taking even longer due to procedural bottlenecks and backlogs of already pending cases. This slow-paced delivery of justice exacerbates the suffering of victims and hurdles the timely payment of compensation.

It is also noteworthy to understand that many patients lack the financial resources to engage in prolonged legal battles oftentimes defeating the very object to justice delivery.

Experts thus suggested reforms that expedite the process reducing both burden of the cost of litigation on victims and delays in disposal of claims to ensure that those who have suffered harm receive compensation in timely manner.

4.2.2. No-Fault Compensation

Model-3 on the No-Fault Compensation Scheme received overwhelming support form advocacy groups who viewed it as a compassionate solution to the challenges of the current system. This model found its inspiration from the Swedish and New Zealand systems eliminating the need for patients to prove the negligence or malpractice instead focusing on compensating victims of medical malpractice and provide support for their rehabilitation.

[193] The NHS Redress Act, 2006.

4.2.3. Cap on Non-Economic Damages

The issue of non-economic damages encompasses the compensation for pain, suffering and emotional distress. The same was discussed in understanding the concept of fair compensation in medical negligence cases. Non-economic damages are recognized as an essential component of compensating victims of intangible harms consequent to medical negligence or malpractice.

Within the Indian system, the proposal of tort reforms included what is a common practice in jurisdictions like California and Floride in the United States imposing caps on non-economic damages. Capping non-economic damages is seen as a way to reduce overall value of medical-negligence claims. Proponents of this reform argue this helps reduce the liability insurance premiums and frequency of lawsuits.[194]

While it is argued that imposition of such caps may dissuade patients for filing claims for non-economic compensation entirely as the outcomes may no longer justify the high costs of litigation thus making it difficult to see this reform as one that shall suffice as a standalone development.[195] Therefore, a balanced approach was deemed fit where a moderate cap can be imposed especially in cases where distress is in fact the primary harm. This shall allow victims to receive compensation while avoiding the disproportionate financial awards under tortious liabilities. This can be seen as a plausible solution to the practice of defensive medicine as a result of fear of potential drain of healthcare providers' resources in paying excessive compensations.

In India, where medical negligence claims often take years to resolve, incorporating a cap on non-economic damages within the legal system would ensure that victims are compensated for their emotional and psychological suffering that oftentimes only gets aggravated due to prolonged legal battles against powerful defendants that may take years to resolve while balancing the interests of the healthcare providers as well.

4.2.4. Universal Healthcare Fund

A suggestion that emerged towards the end of the convention in response to the issues of rising costs of healthcare in the country and the no-fault compensation scheme in countries like New Zealand where public funding ensures timely and adequate compensation for medical injuries. Highlighting the stark disparities in Indian public healthcare system of the urban and rural areas due to which patients in rural areas often have to jump through hoops and face extreme financial hardships in affording the treatments unavailable in their localities. The lack of universal healthcare coverage exacerbates these inequalities and divides leaving the marginalized communities particularly vulnerable to financial distress in the face of medical emergencies. It is also often seen a peculiar unwillingness to medical treatments for this reason further snowballing the health conditions into serious conditions that could be avoided by early medical care. This complicates the nature of treatment required adding onto the reluctance of healthcare providers in addressing the cases and leading to defensive practices to avoid liabilities fueling the despair of patients if the treatment fails or doesn't provide desired results.

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[194] Nelson LJ III, Morrisey MA and Kilgore ML, "Damages Caps in Medical Malpractice Cases" (*The Milbank quarterly*, June 2007) https://pmc. ncbi. nlm. nih. gov/articles/PMC2690332/ accessed December 6, 2024.

[195] Browne MJ and Puelz R, "The Effect of Legal Rules on the Value of Economic and Non-Economic Damages and the Decision to File" (*Journal of Risk and Uncertainty*, 1999) https://link. springer. com/article/10. 1023/A:1007842714849#citeas accessed December 6, 2024.

Experts suggested that availability of a public fund in India could abate all of these issues by addressing the financial needs of the patients directly thereby fostering trust and consequently reducing litigation for medical injuries. This was suggested to be a step forward in bridging the gap in healthcare access and ensuring financial justice. In providing such comprehensive support, the existing legal mechanisms could be complemented to reduce the adversarial nature of litigations in healthcare and promoting a more patient-centric approach to healthcare justice.

4.3. Legal and Judicial Professionals

The legal experts underscored certain structural inefficiencies of consumer courts in handling medical negligence cases stressing the need for more specialized mechanisms to address the unique challenges of such claims with an approach tailored to its demand.

4.3.1. Tort Reforms

Legal experts also endorsed the Tort Reforms' Model which proposed to introduce a more streamlined and predictable system for resolving medical negligence claims. The experts, however, noted the need to strike the fine balance between expediency with fairness in accountability of medical professionals.

(a) Limitation

The stakeholders deliberated on the suggestion to shorten the period for filing medical negligence claims which is currently 2 years under the Consumer Protection Act and 3 years for civil suits. The suggestion aimed at aligning with the international examples like California's MICRA which shortened the statute of limitations to one year, resulting in fewer new claims and reduced administrative cost.[196]

Legal experts underscored that shorter filing periods could ensure freshness of evidence and testimonies thereby increasing the pace of adjudication. Shorter limitation periods encourage timely filings consequently reducing the chances of the claims being dismissed due to loss of evidence over time.[197] However, restrictive timelines could also unfairly bar legitimate claims, particularly on cases where the negligence in treatment only becomes evident long after the treatment. To prevent this, continuous treatment rule[198] which allows for the limitations period to commence only after the last treatment were proposed to protect the victims under prolonged care.

While from the perspective of healthcare providers the reform is crucial in protecting medical practitioners from prolonged fear of litigation, from the perspective of the patients such reforms must be balanced with mechanisms like the discovery rule[199] to allow victims to file claims within reasonable time period after realizing the harm. If applied equitably, this reform may help alleviate the systemic backlog of cases in courts, enabling faster resolutions and reduced costs for all parties involved.

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[196] Wailes RE, "MICRA 2022: A Sustained Era of Stability" (*California Medical Association*, 2023) https://www.cmadocs. org/micra2022 accessed December 6, 2024.
[197] Benson CM, "Statutes of Limitations in Tort: Who Do They Limit?" (*Marquette Law Review*, 1988) 771 https://scholarship. law. marquette. edu/mulr/vol71/iss4/4/ accessed December 6, 2024.
[198] Ibid 776.
[199] Ibid 784.

(b) Expert Certification

Legal experts supported the reforms requiring affidavits and expert certification to filter out frivolous claims emphasizing that this should help in streamlining litigation to save the time of the already overburdened courts. However, they also raised concerns regarding the potential financial burden these requirements could impose on economically disadvantaged plaintiffs possibly deterring genuine claims. Thus, this suggestion for expert evidence was coupled by a caveat to be made in such a manner as to ensure equitable representation of parties despite their difference in access to the resources required to obtain such expert evidence.

(c) Insurance set-off

The insurance set-off proposal in tort reforms was made to address overcompensation in medical negligence claims. This rule deducts any benefits received from the insurance payouts from the total damages awarded by the court. This appears to be a fair reform preventing duplication of compensation received from tort damages and insurance payments exceeding the actual loss incurred by the patient. This could help protect the healthcare providers from excessive claims, reduce financial liabilities and simplify compensation calculations. However, according to the legal experts, while the rule could streamline litigation costs and administrative burdens, this might deter plaintiffs from seeking adequate insurance coverage, leaving them vulnerable in several cases. The insurance set-off must be applied in a manner that ensures equitable outcomes for insured and uninsured individuals, especially keeping in India the economically weaker litigants.

4.3.2. Adjudication Delays

While the consumer courts are special courts themselves their primary role and expertise lies in handling consumer rights cases and experts are of the view that they are insufficient in meeting the requirements suited to the medical and scientific complexities demanded by cases of medical negligence. The experts were of the view that 40% of medical negligence cases in consumer courts are dismissed due to lack of medical expertise in evaluating the evidence leading to erroneous conclusions. Additionally, the experts deemed the existing system slow and expensive contributing to delays and burden in obtaining justice.

4.3.3. Mediation under Consumer Protection Act

The Consumer Protection Act provides for referral to mediation under S.37 of the 2019 Act. However, Rule 4(a) of the Consumer Protection (Mediation) Rules, 2019 excludes cases of medical negligence that result in death or grievous injury from being referred for mediation. The experts suggested that not all medical negligence cases that result in grievous injury or death are essentially inappropriate for settlements and thus should not be treated as exceptions. The presiding officer at the commission responsible for determining whether or not any case is appropriate for mediation should be the authority determining regarding the medical negligence cases as well. The adversarial system befits the kind of disputes that require declaration of rights while oftentimes in cases of medical negligence the claims are mere apology and a form that accommodates to the views and feeling of the aggrieved while the system under the CPA the stress of the proceedings is on fact-finding rather than lasting solution to the problems. The fiduciary nature of doctor-patient relationship requires a system that allows dispute resolution without creating a rift in the doctor-patient relation as a culture.

4.4. Policymakers

4.4.1. Burden on Exchequer

Policymakers at the NCML 2024 voiced concern regarding the financial burden of implementing some of the reforms like the no-fault compensation and specialized medical tribunals' infrastructural costs upon the public exchequer. While systems akin to New Zealand and Sweden funded through public taxation and employer contributions have proven successful in countries with smaller populations and robust economies, India's vast population coupled with resource constraints would present challenges in sustaining such a system. Therefore, it was suggested that any adoption of such models must be done in consonance with the realities of Indian economy and preferably should begin with pilot programs to assess financial feasibility to avoid overwhelming the exchequer which might also reduce the odds of such reform from being implemented in the first place.

4.4.2. Incorporation of Reforms Within Consumer Protection Regime

The policy makers were in favor of amending the existing Consumer Protection Act to address the issues raised instead of creating new legislations and tribunals that shall add to the already complex network of laws relating to healthcare in India. They argued that modifications to the current laws would be more practical and effective in addressing the challenges posed by the medical negligence claims. Instead of establishing specialized tribunals or no-fault models, experts proposed amending the CPA to include provisions for specialized medical panels or pre-litigation review mechanisms to help ensure speedy adjudications and screening of frivolous claims. These amendments, in their opinion, would allow us to retain the core principles of consumer protection while streamlining the litigation and reducing delays as well as frivolous claims without any drastic overhaul of the system or creating new institutions. This was deemed both cost-effective and suitable for India's existing legal and healthcare systems while avoiding the potential complications of new laws or tribunals imported from countries significantly different from India.

5. THE WAY FORWARD

After understanding the different Models and Stakeholders' Perspectives on the issue of medical negligence and malpractice litigations in India and the issues in the proposed Models, we gained perspective on insights of experts as well as the researchers that form well-rounded actionable suggestions that may be applied in addressing the challenges arising in the medical negligence cases in India.

In light of the same, the following suggestions came up as part of NCML 2024 with respect to changing the framework regulating civil medical negligence in India.

5.1. Establishment of Specialized Medical Panels under the Consumer Protection Act, 2019

The primary suggestion regarding the issues of delay and lack of specialization or technical understanding in adjudication of medical negligence cases through the consumer courts taken upon by the researchers, healthcare professionals, patient rights advocates as well as legal professionals was that of the Medical Tribunal. The limitation marked therein by the policy making experts in the NCML 2024 was that of burden on exchequer in addition to the burden and delay in providing the infrastructure along with the legal and policy formalities and procedural bottlenecks that gnaw at the very efficiency of the system contemplating efficiency. The simple resolution to this policy making dilemma could be incorporation of specialized panels within the consumer protection regime instead of creating a new medical dispute resolution infrastructure. Both medical and policy experts agreed on the idea of specialized medical panels included within the Consumer Protection Act which is also cost-effective for the state.

We can take inspiration form the UK's Medical Practitioners Tribunal Service (MPTS) that serves as a dedicated body to address complaints against healthcare professionals[200] that has successfully improved resolution timelines and quality[201] setting a benchmark under the NHS. The basic idea is to form expert panels authorized to adjudicate upon the medical negligence cases in place of the consumer forums constituted by medical and legal experts[202] along with at least one senior medical practitioner with reputation of extensive, contemporary and practical expertise in the same field of medicine relevant to the case given that the field of medicine is in itself too wide to be adjudicated without case-specific expertise.[203] This shall ensure accuracy of technical know-hows

[200] The United Kingdom, "The General Medical Council (Constitution of Panels, Tribunals and Investigation Committee) Rules Order of Council 2015" (2015) <https://www. legislation. gov. uk/uksi/2015/1965/pdfs/uksiem_20151965_en. pdf> accessed December 13, 2024.

[201] Medical Practitioners Tribunal Service, "Report to Parliament 2023" (*Medical Practitioners Tribunal Service*, 2024) 24 <https://www. mpts-uk. org/-/media/mpts-documents/mpts-report-to-parliament-2023_pdf-108064501. pdf> accessed December 13, 2024.

[202] The judgement of Indian Medical Association v. V. P. Shantha & Ors, 1995 (6) SCC 651, did not address the issue of specialised forums directly but its observation regarding the lack of expertise of consumer forums in the fields and burden on the parties to explain the basis of their pleading highlighted the inefficiency in the existing system and the need for one that can redress complex medical disputes on its own.

[203] Similar legal assessors are found under The United Kingdom, "The General Medical Council (Legal Assessors and Legally Qualified Persons) Rules Order of Council 2015" <https://www. legislation. gov. uk/uksi/2015/1958/contents/made> accessed December 13, 2024.

in evaluating the merits of the case and determine claims more effectively than the generic consumer disputes. For the purpose of transparency, a list of panelists can be maintained for appointment through the National Registry under the National Medical Commission[204] devising a mechanism that ensures impartiality towards the parties in any case with no access or predictability in the process of appointment of panelists.

Like the MPTS in the UK the jurisdiction of these specialist panels shall be exclusively over cases involving medical negligence removing them from the jurisdictions of the consumer forums generally speaking.[205] The objective therein shall be reinstated to avoid prolonged litigations and erroneous adjudications expediting and streamlining medical litigations.

The procedure shall be one that avoids any new complications by being the same for the parties with the initial filing point being the consumer courts through which the medical negligence cases get referred to the specialized panel. For timely resolution of disputes, a timeframe of 3-4 months maybe provided for the panel to issue a resolution or recommendation ensuring expediency without compromising equity. For all other purposes the powers and duties of the specialized panel shall be the same as any consumer court that may have dealt with such case.

Therefore, amendment to the Consumer Protection Act to create specialized panels as a statutory requirement operating under the State Consumer Redressal Commissions supplemented by the regional NMC offices turns out to be the primary suggestion on the issue of adjudicatory bodies.

5.2. Introduction of Pre-Litigation Review Mechanism

In addition to the specialized panels a truly effective remedy to the issue of backlog and delays in the medical negligence cases only could be achieved through a complementary mechanism for pre-litigation screening of complaints. Drawing from the suggestions based on the experiences shared by the experts in the NCML 2024, it can be understood that a systematic filter to keep the frivolous claims are rejected at the very outset from proceeding to full trials. This measure ensures courts are only taking up the complaints with merits saving its precious time and reducing backlogs in the process. This also addresses the concerns of the healthcare providers regarding the malicious and frivolous complaints instituted solely for the purpose of targeting them. Any complaint that is not substantiated by relevant evidence gets marked so at the very beginning leaving both parties with a definitive result that saves them from litigating through a long trial dragging time and resources of both the court and the parties through mud consequently freeing them from the binds of the law and open for private settlements as well. In the recent rise and impetus given by the government and judiciary in favor of settlements, this measure could ensure a significant push to the dispute resolution through mutual agreements.[206]

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[204] As can be drawn from the panel of legal assessors under the GMC in the UK, Ibid.

[205] The basis of the MPTS is found under The United Kingdom, "Medical Act" (July 26, 1983) <https://www. legislation. gov. uk/ukpga/1983/54> accessed December 13, 2024

[206] Ministry of Law and Justice, "Use of Alternate Dispute Resolution Mechanisms to Reduce the Burden on the Judiciary and Thereby Enable Timely Justice Dispensation to Citizens of the Country" (August 2, 2024) <https://pib. gov. in/PressReleaseIframePage. aspx?PRID=2040661> accessed December 13, 2024; Ministry of Law and Justice, "Government of India at Forefront to Promote Alternative Dispute Resolution Systems" (February 8, 2024) <https://pib. gov. in/PressReleaseIframePage. aspx?PRID=2003844> accessed December 13, 2024; Gupta A, "ADR: A Viable Alternative for Expeditious Dispensation of Justice?" (*Times of India Blog*, January 3, 2023)

The pre-litigation screening can be done as under the UK Pre-Action Protocol for Resolution of Clinical Disputes[207] model where complaints are screened for eligibility under administrative framework preventing unnecessary litigation.

The constitution of this screening commission can be statutorily specified as a body that goes through the claim on reference from the consumer court before referring it to the special medical panel as recommended above or in the event of consumer courts only, this body could screen the claims before committing them to the forum for resolution. This body shall be constituted by medical, legal and social experts. The body shall have the limited role of evaluating the complaints based on the evidence available in the case including medical records, expert affidavits and patient testimony. Claims meeting the minimum threshold of a prima facie case such as one with clear evidence of deviation from established medical norms or documentation of harm caused, or anything of like nature shall only be committed forward for trial. Frivolous cases with unsubstantiated allegations, absence of any evidence of malpractice, etc. shall get dismissed at this stage with reasons ascribed to that effect.

The point to be noted, however, is that this dismissal shall not bar a subsequent claim filed with proper evidence or evidences that could not have been presented earlier even after due diligence on the part of the claimant. This proviso is necessary to assure a guarantee that the rights of the patients are not defeated in ensuring expediency of trial. Since the dismissal was only summary in nature without assessing the merits of the case, it shall not be in the spirit of justice to bar re-institution of any claim with additional evidences or amendments made to it fulfilling the gaps highlighted by the earlier dismissal in screening.

Another important element of this mechanism shall be a short time frame as 30 days to render a decision upon complaints to ensure that the screening process itself doesn't become another prolonged proceeding before a forum.

One possible way to implement this mechanism maybe to pilot this scheme first in high-pendency states and metropolitan cities to assess the scale and feasibility of this process. Any implementational impediments thus surfacing in the pilot shall help identify challenges and refine the process before a nationwide application.

A combination of specialized panels with pre-litigation screening mechanism shall create a layered arrangement for streamlining and expediting the trials of medical negligence cases. Through amendments in the existing consumer protection regime and oversight from the NMC using global precedents as pointed out under NHS and MPTS examples of the UK model India can create a system that addresses the needs of patients, reduces court backlogs and fosters trust among the healthcare providers.

5.3. Internal Complaints Committees within Healthcare Institutions

<https://timesofindia. indiatimes. com/readersblog/justjournaled/adr-a-viable-alternative-for-expeditious-dispensation-of-justice-48783/> accessed December 13, 2024.

[207] The UK Court Rules, "Pre-Action Protocol for the Resolution of Clinical Disputes – Civil Procedure Rules" (*Justice*) <https://www. justice. gov. uk/courts/procedure-rules/civil/protocol/prot_rcd> accessed December 13, 2024.

Another worthwhile idea that surfaced from the discussion at the convention was the proposal for the establishment of an internal dispute resolution forum within every healthcare institution as the primary access point for complaint redressal. As pointed out by our experts from healthcare as well as patient advocacy experts, certain grievances among the medical negligence cases are simply aimed at receiving a sincere apology or acts of redemption by the wrongdoer. This stands testimony of the emotionally charged responses healthcare providers face in our country even in events of absolutely no negligence or malpractice done by them. The relationship between patient and healthcare providers is that of utmost good faith. In such transaction some cases do not meet the legal criteria of violations but they end up fueling anger within the parties on either side. Such disputes can be prevented by addressing grievances at the very outset within the healthcare institution under a cost-effective and non-adversarial forum for patients and healthcare providers.

While it might appear counter intuitive to some for an interested party to assume the authority in resolution of a dispute, however, with the forum not being a binding authority in law it shall endeavor to work as a conciliator in this resolution that shall be largely based on mutual understanding. Also, with the concerned institution being the interested party in the actions of its people the forum shall also be in the position to take appropriate action against any allegations of malpractice or negligence that may sometimes save any need to escalate a formal legal action in its entirety.

The NHS Patient Advise and Liaison Services (PALS) in the UK model[208] can be seen as a precedent of accessible complaint redressal before formal legal proceedings for this recommendation.

This can be effected through amendments in the Clinical Establishments (Registration and Regulation) Act, 2010 to mandate healthcare institutions to establish such fora. National Medical Commission can provide uniform guidelines for their constitution and functioning under its supervision.

The composition of the forum can be statutorily mandated to include representative as well as independent persons with healthcare, legal and mediation experts. The patients shall be able to lodge complaints directly at this forum for resolution of minor grievances reducing litigation and preserving the delicate bond of trust between the providers and the patients. The healthcare institution shall be mandated to proceed on day-to-day basis and resolve the dispute within a stipulated time frame as of 60 days to maintain efficiency and avoid multiplication of grievances pending at its doorsteps.

This institutional addressing of the dispute shall act as a screening mechanism on its own making the system herein a three-tiered one if adopted along with the above two recommendations. This three-tier system shall include one private and two public dispute settlement bodies that shall give ample room for remedy at the earliest instance for minor disputes as well as a streamlined and technically adept proceeding to hear and finally decide the more complex and serious disputes arising out of well made-out cases of medical negligence or malpractices. This framework aligns with the broader push for reducing court backlogs and expediting grievance redressal.

[208] NHS, "What Is PALS (Patient Advice and Liaison Service)?" (*nhs. uk*, May 29, 2024) <https://www. nhs. uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/> accessed December 13, 2024.

A pilot could be run at large public and private hospitals to evaluate the real-world effectiveness of such an internal body in resolution of complaints; smaller establishments maybe given incentives to implement this scheme before making it mandatory based on its performance. These committees may act as the first line of redressal for remedial action against healthcare providers making it more flexible in its approach to resolve a dispute or remedy a wrong.

5.4. Revise Mediation Exemption for Grievous Injury Cases

Under the current framework Rule 4(a) of the Consumer Protection (Mediation) Rules, 2019 excludes cases involving grievous injury or death are mandatorily excluded from reference to mediation. The object behind this exclusion is to keep the cases of such grave nature within the framework of formal adjudication only. However, based on the suggestions of the stakeholders at the NCML exclusion of mediation entirely in such cases of medical negligence narrows the scope of private settlements which are in fact more cost effective and convenient to aggrieved as well as the healthcare providers when such is mutually agreeable. Thus, an amendment in this rule to allow mediation grievous cases when both parties freely consent to the same with the ultimate decision in the hands of the presiding officer to assess the suitability of mediation for such cases.

For the purpose of these mediations specialized mediation cells constituted by trained mediators that have expertise in healthcare law and patient rights may also be created.

Having a mediation policy for high-value and severe medical injury cases before formal litigation shall significantly impact the quantum of pendency in the courts and shall also preserve the trust between patients and healthcare providers.

This rule can be further supplemented by the exception of gross criminal negligence as ground for disqualification of a case for mediation. At the end of the day, the very authority that determines the dispute in grievous cases of medical negligence shall determine whether or not the case is one that can be settled through mediation which shall ensure no injustice is done with the parties.

5.5. Mandate Comprehensive Documentation Standards

The most undisputed of the suggestions was regarding the challenge of incomplete or inconsistent medical records causing both delay in proceedings and injustice to the patients in adjudication of medical negligence cases. The suggestion thus made in this regard insists on Amendment to the Clinical Establishments (Registration and Regulation) Act, 2010 to make maintenance of comprehensive medical records by the healthcare institutions mandatory for all treatments and procedures. To ensure transparency of such records is maintained, these must be mandatorily shared with the patients, on denial of which or upon failure to comply with the record-keeping requirements the institution maybe subjected to penal action. Another mandate to maintain digital records of the above for minimum 10 years could be added within the Act.

To implement these, rules providing for a standardized template to ensure consistency in documenting patient history, treatments and outcomes maybe formulated. An Electronic Health Records (EHR) System could be developed to enforce the mandatory digitization for all registered healthcare providers ensuring accessibility and transparency in record-keeping with the patients retaining their right to access their medical records through this EHR system.

The precedents for this system can be drawn from the New Mexico model and the Integrated Health Information System (IHIS) now Synapxe in Singapore[209] with high quality documentation of digitized patient records nationwide creating ease of medical and legal use.

Pilot programs and staff training shall be the primary goal in achieving compliance of documentation mandate nationwide.

5.6. Tort Reforms

5.6.1. Cap Non-Economic Damages with Safeguards

The implementation of reasonable cap on the compensation that can be claimed for pain and suffering under non-economic damages must be included to ensure consistency in awards and in prevent over-inflation of claims. The cap on such non-economic damages shall be limited to cases that do not include gross negligence or severe injury to the patient to maintain fairness in the awards.

This reform can be taken from the MICRA in California that caps damages at $250,000 significantly reducing the risks in litigation.[210] This model followed by the exceptions shall ensure justice as well as fairness to both parties.

5.6.2. Inclusion of Insurance Set- off

Another suggestion within the tort reforms is surrounding the deduction of insurance payouts or other compensatory sources in calculation of damages awarded for medical negligence. The main objective shall be to ensure fairness to the insured and uninsured claimants alike and to prevent actions aimed at double recovery by the insured claimants. This rule can be enforced through a procedural mandate requiring mandatory disclosure of compensations received by the claimant before adjudication.

With respect to the concerns surrounding the effective penalization of insured claimants by deductions in damages, these can be remedied by capping such deductions while calculation of award or limiting the setoffs to only specific damages such as the non-economic categories to reduce systemic exploitation of the tort system balancing the rights of the patients and the healthcare providers.

5.6.3. Reduction in the Limitation Period

Inspired form regulations as under the MICRA in California[211], the limitation period for filing medical negligence cases (currently two years under the CPA) may be amended to one year along with the inclusion of continuous treatment rule and the discovery rule[212] to prevent unfair bar upon

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[209] Synapxe, "About Us" (*Synapxe*) <https://www. synapxe. sg/about-synapxe/our-role> accessed December 13, 2024; Ang A, "Singapore's iHIS Rebrands to Synapxe, Announces New AI Solutions" (*Healthcare IT News*, July 31, 2023) <https://www. healthcareitnews. com/news/asia/singapore-s-ihis-rebrands-synapxe-announces-new-ai-solutions> accessed December 13, 2024.

[210] Nelson LJ III, Morrisey MA and Kilgore ML, "Damages Caps in Medical Malpractice Cases" (*The Milbank quarterly*, June 2007) <https://pmc. ncbi. nlm. nih. gov/articles/PMC2690332/> accessed December 6, 2024.

[211] Wailes RE, "MICRA 2022: A Sustained Era of Stability" (*California Medical Association*, 2023) <https://www. cmadocs. org/micra2022> accessed December 6, 2024.

[212] Benson CM, "Statutes of Limitations in Tort: Who Do They Limit?" (*Marquette Law Review*, 1988) 776, 784 <https://scholarship. law. marquette. edu/mulr/vol71/iss4/4/> accessed December 6, 2024

claims where negligence becomes evident much later during the treatment or post recovery sometimes.

The objective here shall be to avoid stale or frivolous claims and ensuring freshness in evidence and testimonies reducing delayed proceedings. Along with protecting patients' rights in preventing loss of merit in the case through loss of evidence, this shortened limitation period shall also help in removing the Damocles Sword hanging over the healthcare providers by reducing the time frame for filing claims. Nevertheless, the usual safeguards to late filings of genuine claims as available for any other civil law remedy[213] shall continue to remain open to the patients making it both equitable and efficient to consider.

5.6.4. Affidavit of Merit before Initiation of Lawsuit

In line with the suggestion for pre-litigation screening of the claims there is a suggestion that can be introduced within the existing framework to reduce the possibility of frivolous and baseless claims from choking the system. We recommend the introduction of mandatory certificates of merit verifying negligence through an expert opinion that shall be submitted by the claimants before initiating a lawsuit. This shall help reduce caseloads in the courts and protect healthcare providers from defending frivolous litigation for years.

The potential drawback in this requirement shall be the additional cost and the practical differences in access to expert opinion for different people. Therefore, a complementary reform in access to low-cost public offices of expert panels maybe implemented for its implementation.

5.7. Universal Healthcare Fund

The reduction of financial inequity among different regions and social groups was one of the underlining concerns forming the basis of all reforms proposed for patients' rights. Inequitable access to healthcare and justice pushes the vulnerable populations further on the edge. The risk in loss over healthcare expenditure is huge for those at the margins. Therefore, the suggestion of Universal Healthcare Fund could complement the abovementioned reforms in providing timely compensation and treatment support. This can be implemented through three modes of funding-public/state funding, healthcare levies and insurance sector contributions. This shall also be in consonance with the thrust areas of the National Health Policy 2017.[214]

The contributions from the state funds shall be the primary source of the funds that shall be supplemented by a small proportion of hospital profits earmarked for the fund. The fund can be further supported by allocation of medical liability insurance policies to cover for such costs. This shall be a blend of the models in existence in New Zealand's Accident Compensation Corporation (ACC) used for no-fault liabilities[215] and Swedish public funds[216] in a manner that best suits Indian conditions.

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[213] The Limitation Act, 1963.

[214] Ministry of Health and Family Welfare, Government of India, "National Health Policy" (2017) <https://mohfw. gov. in/sites/default/files/9147562941489753121. pdf> accessed December 13, 2024.

[215] ACC, "What We Do" (*ACC*, April 16, 2024) <https://www. acc. co. nz/about-us/who-we-are/what-we-do> accessed December 13, 2024.

[216] Janlöv N, Blume S, Glenngård AH, Hanspers K, Anell A, Merkur S (2023). Sweden: Health System Summary, 2023. , "Sweden Health System Summary 2023" (Anna Maresso ed, WHO Regional Office for Europe on behalf of

This fund can be established under the oversight of NMC that shall be entrusted with transparency and accountability in its distribution subject to regular audits and impact assessments to refine its utility.

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the European Observatory on Health Systems and Policies) <https://iris. who. int/bitstream/handle/10665/374191/9789289059459-eng. pdf?sequence=1> accessed December 13, 2024.

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