Medical Malpractices and Law

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Although medical negligence claims are an off-shoot of industrial capitalism, given the circumstances, the existing negligence law can serve a useful purpose in imposing a certain accountability on the part of the doctors and providing redressall for injuries. The legislation should thus be seen not just as a reflection of bourgeois ideology but also as a bourgeois democratic right which requires to be extended and expanded.

MEDICAL negligence litigation has in the past too decades risen sharply in England and the US. Especially in the US it has reached such a stage that a strong and active lobby has come up against this. It has also led to the increasing practice of 'defensive medicine' and a rise in doctors' insurance rates. In India, of course, there is no correspon-ding trend. The Indian law on this aspect, however, slavishly follows the British and the American law. These trends therefore become very relevant in India not only for gaug-ing the potentialities of this type of litigation in India but also to highlight the positive and negative aspects of this system. Though the medical systems in the US and in UK are very different—complete privatisation in the one while state health services in the another—the law is virtually iden-tical. These trends cannot be viewed in a vacuum but only in the context of the socio-economic aspects of medical-malpractice liability and the reasons why its development has been stagnant in India.

Medical negligence litigation is a response to the follow-ing types of questions:

What are the rights of patients vis-a-vis the doctors and hospital?

What if the doctor wrongly diagnoses a disease?

What is the level of competence expected of a doctor?

Does a doctor have to take the consent of the patient before an operation?

If many doctors have handled a patient which of them is ultimately liable?

The common issue in all this is the patient's allegation that the doctor has been negligent.

Negligence and Torts

Medical negligence is a branch of the law of negligence which in turn is a branch of the law of Torts. The Tort law is not based on any act of Parliament. It is mainly a judge-made law developing over the years through changing judicial decisions. It is not possible to define Torts but broadly speak-ing tort is a wrong done by one person to another for which the law provides a remedy. The idea is to monetarily com-pensate the victim rather than punish the offender—as would be the case in criminal law. It includes disparate events such as a car accident, injuries due to emission of poisonous gas, doctor's negligence causing death of a patient, defamation of a person, compensation for injuries suffered by a wife at the hands of her husband, etc. The motives of the offender are not very relevant. The focus is on the victim...

A person is said to be negligent when s/he acts without due care in regard to the harmful consequences of his/her action. When we say that a person has been negligent we are saying that s/he acted in a way that s/he ought not to have acted. This assumes that we know how s/he ought to have acted. The way in which we consider that s/he ought to have acted is the norm or standard which entitles us to condemn the person for being negligent when s/he fails to comply with the standard.

The tort of negligence is made up of three components:—

(1) A duty or obligation recognised by the law requiring the person to comply with certain standards of conduct for the protection of others against unreasonable risks. Initially charitable hospitals used to claim that they could not be held negligent as they had no duty to take care of patients since they were not charging them. Now of course the courts always disregard such defences.

(2) A failure on the part of the person to conform to the standard required—what is known as a 'breach of duty'.

(3) A reasonably close causal connection between the con-duct and the resulting injuries.

(4) Actual loss or damage resulting to the other.

So, negligence ultimately is a matter of risk—that is to say, of recognisable danger or injury. Persons are supposed to meet with certain standards of conduct. This standard is sup-posedly based on what society demands of its members, rather than upon the actor's personal morality. A failure to conform to the standard is negligence even if it is due to clum-siness, forgetful nature, an excitable temperment or even sheer ignorance. In other words, the state requires of a person not to be awkward or a fool.

In negligence, the actor does not desire to bring about the consequences which follow nor does s/he know that they are certain to occur, or believe that they will. There is merely a risk of such consequences sufficiently great for a 'reasonable person' in his/her position to anticipate them and to guard against them. Risk can be defined as a danger, which is apparent or should be apparent, to one in the position of the actor.

Nearly all human acts, of course, carry some recognisable or remote possibility of harm to another. No person so much rides a horse without some chance of a runaway nor does any surgeon perform an operation without some chance of himself suffering a heart attack and messing up the opera-tion. These are of course, 'unavoidable accidents' for which there is no liability. As the gravity of the possible harm in-creases, the apparent likelihood of its occurrence needs be correspondingly less to generate a duty of precaution. Thus the standard of conduct which is the basis of the law of negligence is normally determined upon a risk-benefit form of analysis by balancing the risk in the light of the 'social value' of the interest threatened, and the probability and the extent of the harm, against the value of the interest which the actor is seeking to protect and the expedience of the course pursued.

Professional Negligence

Uptil now what we have talked about is the minimum standard below which the individual is not permitted to fall. But if a person in fact has knowledge, skill or even intelligence superior to that of the ordinary person, the law will demand of that person's conduct be consistent with it. Professional persons are not only required to exercise reasonable care in what they do, but also a standard minimum of special knowledge and ability.

Let us look at how in practical situations the law applies to doctors. A doctor may, of course, contract to cure a patient, or to accomplish a particular result, in which case he may be liable for breach of contract. This is not, however, what generally happens. In the absence of such an express agreement, the doctor does not warrant or insure a correct diagnosis or a successful course of treatment and a doctor will not be liable for an honest mistake of judgment where the proper course is open to reasonable doubt. But by undertaking to render medical services, even though gratuitously, a doctor will evidently be understood to hold himself out as having standard professional skill and knowledge. The formula which is used is that the doctor must have and use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing, and a doctor will be liable if harm results because he does not have them. Sometimes this is called the skill of the 'average' member of the profession, but this is clearly misleading. Since only those in good professional standing are to be considered; and of this it is not the middle but the minimum common skill which is to be looked to. If the doctor claims to have greater skill than this, as when the doctor holds himself out as a specialist, the standard has to be modified accordingly.

Of course, there are areas in which even experts differ. Where there are different schools of medical thought and alternative methods of acceptable treatment, it is held that the dispute cannot be settled by the law and the doctor is entitled to be judged according to the facts of the school the doctor prefers to follow. This does not mean that any quack or a crackpot can let himself be known as a 'school' and so apply his individual ideas without liability. A 'school' must be a recognised one within definite principles and it must be the line of thought of a respectable minority of the profession. In addition there are minimum requirements of skill and knowledge, which any one who holds himself out as competent to treat human ailments is required to have, regardless of his personal views on medical subjects.

Since judges/juries are essentially lay people, they are held to be normally incompetent to pass judgment on questions of medical science or technique and so only in certain types of cases findings of negligence are given in the absence of expert medical evidence. Normal reluctance of doctors to testify against co-professionals came in the way in US and UK and is likely to be a big hurdle even in India. Now of course, in US and UK more and more doctors came forward to give evidence on behalf of patients. Also, where the matter is regarded as within common knowledge of the lay people, as when the surgeon saws off the wrong leg or where injury is caused to a part of the body not within the operative field, the judges often infer negligence without expert evidence.

The cumulative effect of all this is that the standard of conduct becomes one of 'good medical practice' i e, what is customary and usual in the profession.

This, of course, gives medical profession a privilege denied to others, of setting their own legal standards of conduct, merely by adopting their own practices, except in certain cases like in the cases of sponges left in the patient's abdomen after an operation where the task of keeping track of them has been delegated by the surgeon to a nurse. Though this was and is still a routine practice, the doctor was found to be negligent.

Some Specific Trends

In one of the earliest decided cases, in 1767, an English court felt that the surgeon was liable as he had acted contrary to the known rule and usage of surgeons. What happens if the patient is injured because of the omission to carry out an available test, which is not generally conducted by doctors for such patients? In 1974 an American Appeal Court was faced with this issue. Barbara Helling suffered from primary open angle glaucoma. This is a condition of eye where there is an interference in which nourishing fluids flow out of the eye. There can be a resultant loss of vision. The disease has few symptoms and in the absence of 'pressure test', is often undetected till irreversible damage is done.

Helling contacted two opthamologists—Carey and Laughlin—at that time believing that she was suffering from myopia (shortsightedness). From 1959 to 1968 she consulted these doctors, who fitted contact lenses and believed that irritation caused in her eyes was because of complications associated with the lenses. For the first time in 1968 they tested the patient's eye pressure and field of vision. This indicated that she had glaucoma. By that time the patient, who was 32, had essentially lost her peripheral vision and her central vision was reduced. She filed a case for damages.

The doctors argued and proved that the standard of the profession did not require the giving of routine pressure test to persons under the age of 40 as the incidence of glaucoma is 1 out 25,000 persons under the age of 40. They argued that since they had acted in accordance with the standard practice of the profession they had acted with reasonable prudence. The court, however disregarded this defence. The judges held: "In most cases reasonable prudence is in fact common prudence, but strictly it is never its measure. A whole calling may have unduly lagged in the adoption of new and available devices. Courts must in the end say what is required: there are precautions so imperative that even their universal disregard will not excuse their omission."

The court felt that despite the fact that a pressure test was not used generally by opthalmologists, the doctors ought to have used it. Barbara received compensation.

The importance of the case lies in the fact that the standard of care required of the doctors is widened. Normally, of course the standard adopted in the profession would be acceptable as the standard required of each doctor. But this case for the first time obliged doctors to conduct certain known tests even if they were not being conducted in the profession generally.

This case created a storm in the USA. Attempts were made through courts and legislature to change the law laid down by the case, but ultimately they have proved to be futile. However, the application of this case is only confined to a

narrow field of possibilities and that of 'general practice' within profession is still widely applied.

Hospital Liability

A question of immense significance is whether a hospital can be made to pay for negligence of doctors, nurses and other staff. This is an issue of great importance in India. Many times it is not possible to point out the person whose negligence led to injury. Take the example of a patient who is given saline by a number of doctors and nurses from time to time. A particular needle may not be sterilised causing gangrene. It is not possible to know who exactly was negligent. Can one then sue the hospital? Or many times it may so happen that the negligent staff member does not have means to pay. Can one sue the hospital and recover?

The most important American case on this point was Darling vs Charleston Community Memorial Hospital decided in 1966. In November 1960, Darling, 18 years old, broke his l[illegible] while playing college football. He was taken to emergency ward of Charleston Hospital and treated by Dr. Meroander, who applied traction and placed the leg in a plaster cast. Soon after, Darling was in great pain and his toes which protruded from the cast, became swollen and dark in colour. His condition kept on worsening and ultimately the leg had to be amputated.

As to the question whether there was negligence or not, the court held that the nurses had not checked sufficiently, and as frequently as necessary, the blood circulation in the leg. Skilled nurses would have promptly recognised the condition, and would have known that they would have become irreversible in a matter of hours.

The question was whether the hospital was liable. The judges held: "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and patients, but undertakes instead simply to procure them upon their own responsibility, no longer reflects the fact. The present day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly the person who avails himself of hospital facilities expects that the hospital will attempt to cure him not that the nurses and other employees will act on their own responsibility". The hospital was made to pay damages.

The Darling case became a landmark decision in medical malpractice claims as it places a direct responsibility on the hospital for the maintenance of an acceptable standard of care for patients. Subseqently, the scope of even this decision has been widened and charitable hospitals have also been held to be responsible.

Is the hospital liable if the patient's infection is traced to blood products supplied during his operation? In a 1970 Illinois state case, the hospital was held to be strictly liable for supplying contaminated blood. A hospital will also be liable for negligence of any honorary doctors or specialists it calls but not for private doctors called by the patients themselves. Hospitals, in same case have been held guilty even when its employees have acted in direct contradiction of the hospitals' instructions or prohibitions causing injury.

Strict Locality Rule

The standard of care expected of doctors is generally speaking that prevalent in the profession. They are not only required to perform tests generally performed, but also to be informed sufficiently about the new develonments in the field.

One of the most debated issues in the US and UK arose out of a presumption that the rural and small time practitioners would be less adequately informed and equipped than their big city colleagues. To adjust to this the courts came out with a theory that there could not be any national standard of care but the standard varies from locality to locality. They applied the strict locality rule which meant that the standard of care expected of doctors depended on the general standard of that particular locality. However, in recent times this rule has been given up and national standard applied on the basis that "new techniques and discoveries are available to all doctors within a short period of time through medical journals, closed circuit television, special radio networks for doctors, tape recorded digests of medical literature and current correspondence course".

This situation is prevalent only in developed capitalist countries. In backward countries like India with uneven development, it is very likely that when cases come up, the strict locality rule will be applied.

Res Ipsa-Loquitor

Ultimately it is for the patient to prove that it was negligence which caused her/his injuries. It many times becomes difficult to do so for varied reasons like information hiding by the doctors, etc. What happens in some cases, however, is that after presenting all evidence, though directly negligence is not proved, it is still pretty obvious that the patient could not have suffered injuries except through negligence. In such cases the legal doctrine of *'Res Ipsa Loquitor'* or 'the thing speaks for itself' is applied. Negligence is presumed to have been proved and the doctors held liable.

In a case decided in an American court in 1975, a patient Anderson was admitted to hospital for a back operation. During the operation, the tip or cup of a forcep like instrument (angulated rongekur) broke off while it was being manipulated in the patient's spinal chord. It could not be recovered and the patient suffered permanent injury. Anderson sued the doctor, the hospital, the manufacturer and the distributor. Each tried to push the blame on the other and it could not be proved as to whose negligence had led to this complication. It was not established whether the rongekur broke because of manufacturing defect, certain problems during transit or due to the doctor's negligence. If it was merely a case of determining negligence from amongst the hospital staff and doctors then even without establishing who exactly was negligent, the hospital could have been saddled with damages. Here of course, the hospital was saying that it was not the neglect of staff or doctors which caused the rongekur to break but that of the manufacturer or dealer.

It was just not possible to establish what caused the breakage. The court, however, came to the rescue of the patient and observed, "In the type of case we consider here, where an unconscious or helpless patient suffers an admitted mishap not reasonably foreseeable and unrelated to the

scope of surgery (such as cases in which foreign objects are left in the body of the patient), those who had custody of the patient, and who owe him a duty of care as to medical treatment, or not to furnish a defective instrument for use in such treatment can be called to account for their default. They must prove their unculpability or else risk liabilities for injuries suffered". All of them were held jointly liable.

The doctrine of *Res Ipsa Loquitor* has been extensively used in 'swab cases' where after the operation, an instrument is left inside the patient's body. It has also been used for other types of cases—for instance in the Canadian case of MacDonald vs York County Hospital Corporation, the patient was admitted for treatment of fractured ankle and left with an amputated leg. Heavy damages were awarded to MacDonald despite there being no direct proof of negligence.

Misdiagnosis

A liability will be imposed when the doctor fails to conduct tests which a competent practitioner would have considered appropriate or when the doctor fails to diagnose a condition which would have been spotted by a competent practitioner. In Langley's case the patient had returned from East Africa shortly before the development of symptoms. The general practitioner failed to diagnose malaria and this was considered as negligence. Similarly in Tuffil's case the patient had spent many years in a tropical climate, the doctor failed to diagnose ameobic dysentry which proved fatal. This failure to diagnose was held to be negligence.

A question which arises is whether a new doctor would have the same responsibility as a seasoned doctor? The law makes no distinction in this regard. In Wilsher vs Essex Area Health Authority, the patient had been born prematurely and had been admitted to a special unit where extra oxygen was administered to him over a long period. His sight was badly affected as a result of a junior doctor's failure to monitor properly the supply of oxygen. The hospital was held to be liable.

In many cases it is a part of the duty of the doctors and nurses to predict that the patients may damage themselves as a result of their medical condition. For instance in one case the patient had been admitted to hospital after a drug overdose. Although he had known suicidal tendencies he was not kept under constant observation and he climbed on the hospital roof and fell incurring injuries, while the two nurses on duty were out of the ward. He was awarded damages of £ 19,000.

Informed Consent

One of the most rapidly growing medical malpractice litigation is in the areas of 'informed consent'. This concerns the duty of physician or surgeon to inform the patients of the risk involved in treatment or surgery.

The principle behind this is the classical bourgeois democratic ideal of individual autonomy, i e, that every person has a right to determine what will be done to her own body and the right to have bodily integrity protected against invasion by others. Only in certain narrowly defined circumstances can this integrity be compromised without the individual's consent.

Surgeons and other doctors have to provide their patients sufficient information to permit the patient to make an informed and intelligent decision on whether to submit to a proposed course of treatment or surgery. So, even if a procedure is skillfully performed, the doctor may nevertheless be liable for an adverse consequence about which the patient was not adequately informed. Of course, the patient has to show a causal link between the non-disclosure and her injury by proving that she would not have undergone the treatment if she had known the risk of harm that in fact occurred. The courts believe that all patients in retrospect would say this and so even here they have evolved the criteria of 'reasonable patient', i e, whether this hypothetical patient in the actual patient's place would have withheld consent to the treatment had the material risks been disclosed. This, of course, is problematic because the individual patient's characteristics are totally ignored. Slowly, the courts in US are trying to incorporate even this subjective factor.

What risks have to be disclosed? All the material risks, i e, the nature of pertinent ailment, the risks of proposed treatment, including the risks of failing to undergo treatment, have to be disclosed. Even if the risk is a remote possibility it should be disclosed. However, unexpected risks may not be communicated. For instance, in an American case a patient suffered cardiac arrest during amniocentesis. There were no prior documented cases like this. The doctor was not held to be negligent.

Even otherwise there are cases where the risk disclosure may be precluded by an emergency situation or the patient's incapacity. In fact in the US all states have passed what are called 'Good Samaritan Laws' aimed at protecting doctors giving emergency roadside treatment.

The disputed issue is whether for the benefit of the patient, the doctor can withhold information from them. This happens many times when doctors feel that the patient will suffer mental shock or nervous breakdown if the risk is communicated. Such withholding is called 'theraupeutic privileges'. But there is another school which believes that all information should be disclosed so that the patient can make up her/his mind in the light of all the circumstances. The courts are divided in this point.

A problem which has not arisen in the western countries but which can arise in India is if the patient is conscious and does not consent to a treatment which is necessary to save her/his life. Can forcible treatment be justified? In most of the western countries suicide is no longer a crime and so doctors cannot forcibly treat anyone. In India, of course, this question is likely to cause some problems.

The case of minors also raises a perplexing problem. Since minors are considered by law incapable of giving consent the parents' consent has to be obtained. But what happens if a minor who is of understanding age gives instruction contrary to that of the parents? In one English case, a school girl aged 15 wanted an abortion but the parents refused to grant permission. The court held that the girl was entitled to abortion as she was capable of understanding its implications.

Nowadays, at least before surgery, a patient is normally required to sign a consent form. But the patient can still prove

that no consent or informed consent was taken and the doctor will then be liable to pay damages.

Indian Cases

In spite of making a detailed survey, the writer could find only three reported cases on medical negligence in India.

(1) The first case was decided by the Lahore High Court in 1935. R N Rao, a lawyer, suffered from high fever and sores on his face. Dr Whitamore, the Civil Surgeon, treated him. He diagnosed the disease as syphillis and gave injection of Sulphatab. Later Dr Rao suffered from gangrene and had to have his fingers amputated. His eyesight was affected and he lost his strength. He never had any syphyllis and he was informed that he had contacted peripheral nueritis because of a mistaken injection of arsenic.

The court, however, did not find the doctor guilty. The reason given was that though the diagnosis was wrong specific carelessness was not proved. The court adopted a reasoning which would be totally unacceptable today. It did not go into the question as to whether the doctor had performed the required tests before concluding that there was syphllis. Neither did it try to a answer the question as to what caused the gangrene.

(2) The second case was one decided by the Supreme Court in 1969. Anand met with an accident on the beach at Palshet in Maharashtra which resulted in the fracture of the femur of his left leg. The only treatment the local physician gave was to tie wooden planks on his legs for immobilisation. The follwing day he advised removing Anand to Poona for treatment. He also substituted splints for the planks. After that, in a taxi, Anand was shifted to Poona. Dr Joshi got him screened and found that he needed pin traction. He was then taken to Dr Joshi's hospital. Dr Joshi asked his assistant to give Anand two injections of morphia and hyoscine HB at ½ hour interval. Dr Irani gave only one injection. Anand was then taken to the X-ray room, and after taking two X-rays removed to the operation room. After about ½ hour when the treatment was over, he was shifted to the room he was allotted. On an assurance given by Dr Joshi that Anand would be out of the effect of morphia in 1½ hours, Anand's father went back to his village. Anand's mother remained with him. After about an hour she found that Anand was having difficulty in breathing and was coughing. The doctors were called, Dr Irani, Dr Joshi's assistant gave emergency treatment upto 9.00 pm when the boy died. Dr Joshi issued a certificate saying that Anand had died of fat-embolism.

Dr Joshi was sued. Anand's father contended that Dr Joshi did not perform the essential preliminary examination of the boy before starting his treatment and injecting morphia. It was also alleged that while putting the leg in plaster manual traction was used, using excessive force with the help of three men though such traction is never done under morphia alone, but under proper general anaesthesia. Dr Joshi in his reply denied the allegations by saying th. t no general ahaesthesia was given considering the exhausted condition of patient. It was decided to immobilise the fractured femur by plaster of Paris bandage, and no excessive force was used. However, on evidence the court felt that Dr Joshi was negligent. It came to the conclusion that it was due to shock resulting from reduction of fracture attempted without taking the elementary precaution of giving anaesthetic to the patient.

Speaking about the duties of doctors the court repeated the British and American law saying, "The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of these duties gives a right of action for negligence to the patient".

(3) The third case was decided by the Bombay High Court in 1975. This case reads like a doctor's apology. Philips India had appointed a doctor to give treatment to the employees. One employee contacted smallpox and died. The doctor had treated him for veneral disease. The court felt that there was a genuine error of judgment and since the particular variety of smallpox was fatal, the doctor anyway could not have done much. The problem with the case is not that it exonerated the doctor, especially considering the peculiar facts of the case, but the extent to which it sought to protect doctors. The court expressed the view that negligence for doctors should be interpreted much more narrowly than negligence of others, i e, the doctor has to be placed on a high pedestal and held to be negligent only if it is totally unavoidable.

Of course, this case is not likely to have any impact on subsequent cases, but still it shows the attitude of the judges. The important point decided by this case, however, was in holding that if the doctor had been proved to be negligent, the company which employed him would also automatically be negligent.

All the three cases relied only on English law books—by of course picking and choosing what suited the court's conveniance.

Politics of Torts

A proper understanding of the rise of 'negligence law' requires an analysis of the development and rise of the Tort Law. An extensive application of tort law is found only in developed capitalist countries. Developments at similar scale cannot be expected in third world countries. Let us therefore look at the causes which gave rise to tort law in developed capitalist countries.

In the earlier period, law was largely preoccupied with personal status, control over resources (primarily land) and the development of contractual relations (mercantile capitalism). Industrial capitalism transformed the entire social structure, engendering urbanisation which enormously increased the frequency of interaction among strangers. Important, because unlike aquaintances or intimates strangers would have less incentive to exercise care not to injure one another inadvertently and would find it more difficult to resolve the differences when injury occurred. At the same time interaction between friends and intimates became progressively limited—ultimately confined to the nuclear family. Intimates commit most intentional torts. But within the nuclear family they are rarely resolved by the legal system; (a) because they would destroy the relationship (b) the persons committing torts are sufficiently powerful.

Industrialisation gave capitalists the power to effect extensive damages first through domination of unprecedented

amount of physical force (factories, railways, etc) and now through toxic chemicals. Concentration of capital and mass production increased the number of workers, consumers and others who might be harmed by capitalists' indifference or miscalculation.

Capitalism also shapes the experience of injury. It must create a proletariat which must sell its labour for wages to live. It simultaneously destroys the obligation of mutual support outside the nuclear family and pays those within it who are gainfully employed at a level of wages too low to support non-production members. As inability to work becomes tantamount to destitution or dependence upon charity, the core of damages is compensation for loss of earning capacity.

Second, capitalists, middle classes and even industrial workers acquire consumer goods which require protection against inadevertent destruction.

Third, family is no longer able to care for injury or illness, partly as members must seek employment outside and partly because care itself is commodified and monopolised by the emergent medical profession. As the monopoly allows professionals to command high fees, injuries 'cost' a great deal more.

Finally, commodity form is progressively extended to nonproductive experience.

Capitalist tort law exploits and alienates the victims in ways parallel to exploitation and alienation of labour. In precapitalist society, injury like work creates use value, it elicits cure from intimates who are motivated by concern and promotes demand for apology backed by threat of retribution. The capitalist state which asserts its monopoly of force to obstruct the latter response also creates a market for injuries in torts and legal system. It separates through the legal proffession tort victims from means of redressing their wrongs and medical profession disabled victims and intimates from caring for the ill. In each instance, a faction of the ruling class mobilises the power of the state in its own interests to protect the monopoly of expertise of lawyers and physicians. The lawyer then combines legal expertise with the victim's injury (as the capitalist combines capital with the workers' labour) to produce a tort (a commodity) that has exchange value both in the state-created market (the court) and in the dependent markets (negotiated settlements).

As capitalists have to maximise profit in a competitive market, they must sacrifice health and safety of others. Another reason why capitalism fosters injury is that it must expand its market and increase consumption; torts contribute to it just like planned obsolescence and warfare.

Tort law, following legal liberalism, eliminated formal legal discrimination. So, with its development discrimination between patients who are victims of charitable hospitals and those of non-charitable hospitals, etc, were eliminated. But it could not and cannot remove certain deeper inequalities.

First, of course, the inequality in the incidence of injury and illness: capitalists and professionals are subjected to totally different hazards than those suffered by workers at the work place or women at home. The rich can avail of the best medical facilities, equipment and medicines, not so the poor.

Secondly, the class and gender will affect the extent to which and the way in which the experience of injury is transformed into a claim for legal redress, the sense of entitlement to physical, mental and emotional well-being (women only recently began to legally resist abuse by their husbands, workers are only now coming to view hazards at work place as a negotiable demand), the feeling of competence to assess a claim, the capacity to mobilise legal process, ability to overcome delay, etc.

Third, the law also discriminates in the availability and generosity of the remedies it offers, the biggest difference being between tort damages and other compensation systems. An industrial worker is far more likely to be injured at work than a person from another occupational category: such injuries are relegated to workmen's compensation, which pays only a fraction of tort damages and rejects altogether certain tort categories. Other oppressed categories—women, children, dalits, religious minorities—are also excluded from tort recovery. They are most frequently the victims of violent crimes and other social crimes whose assailants are either unidentifiable, unavailable, financially irresponsible or simply too powerful. Women and children injured by relatives are left without any remedy.

Another type of discrimination is internal to the tort system. Pecuniary damages are paid on the basis of income of the person. Even the damages for pain and suffering are often expressed as multiples of pecuniary damages. So a poor person will get much less damages than a rich person. Women will get much less than men.

Production of Illness

Capitalist tort law systematically encourages unsafety. The dynamic of capitalism—the pursuit of profit impels the enterprise to endanger the workers, its employees and those who inhabit the environment it pollutes. As the cost of safety reduces profits a capitalist must be as unsafe as he can get away with being.

Apparently the Tort law curbs these destructive tendencies through the threats of damages. But this is not what actually happens.

First, compensation is paid on the basis of the status of the victim not of the offender—the doctor for instance.

Second, the insurance mechanism goes a long way in virtually nullifying the burden on the offender.

Third, as seen above, due to the discriminatory aspect of Tort law many injuries and victims are excluded from its purview.

In fact Tort law motivates the entreprenuers and the professionals to seek to evade the consequences of carelessness not to enhance safety. Their response to the threat to tort liability is to strive to externalise accident costs by concealing information. For instance, the market deterrence, by mandating the payment of money damages, subverts collective efforts to exert control over safety—damages are paid only for an injury caused by the offender's act. This means that unsafe conduct causing no injury is not deterred and that the legal attention is focussed on the temporarily delineated act of an individual rather than on the ongoing activity of a collectivity. Capitalist Tort law, like capitalist medicine, is obsessed with individual care at the expense of collective prevention because capitalism creates a market only for the former.

In fact the medical profession is not even interested in curing patients, only in 'treating' as many as possible. Also the costs of damages are externalised by increased professional

fees and insurance. In England, various Medical Defence Societies have been established. It there is a successful claim involving negligence of a hospital employee, the amount will be shared by the authority and society. As regards nurses, the Royal College of Nursing holds an insurance policy, idemnifying every member. So, ultimately the costs are passed on to citizens.

The Tort law is significant for the reproduction of bourgeois ideology. The fault concept upon which the law was built reinforces a central element of bourgeois ideology, individualism. Predicating liability upon the offender's fault and denying recovery because of the victim's fault perfectly express the bourgeois belief that each person controls his or her own fate.

Tort law offers symbolic support for inequality—by compensating owners for property damage it upholds the notion of private property and its concomitant, i e, the person's we[illegible] as a tort plaintiff is proportional to the value of the property he owns.

Also, by relegating injured employees to worker's compensation, which is limited to a fraction of the lost wages, the law treats workers like pure labour value, implicitly denying that they undergo the pain and suffering for which tort victims are given compensation.

Finally, Tort law assumes that for every pain suffered there is some equivalent pain which will erase it, a pleasure that can be bought with money and, therefore, the judges must simulate a market in sadomasochism by asking themselves what they would charge to undergo the victim's misfortune.

Also the Tort law treats all relationships as forms of prostitution—the semblance of love exchanged for money: Tort law thus generalises the feminist critique of marriage. Just as society pays 'pain and suffering' damages to the injured victim who is shunned (so s/he can purchase the commodified care and companionship that will no longer be volunteered out of love and obligation), so it pays damages to those who loved him, compensating them for their lost 'investment' in the relationship (so that they can invest in other human capital).

The Socialist Approach

The primary concern of a socialist alternative should be to ensure that those at risk regain control over the threat of injury and illness: compensation must be subordinated to safety, although the former goal remains important.

Even if all defects in the capitalist compensation system are removed—100 per cent damages, etc—two defects are irremediable.

First, it would mean spreading the costs across society through a social welfare scheme but does not mean spreading the risk of accidents more equally.

Secondly, valuation of injury and illness is still done by the state and not by people who suffer it. These are the problems in New Zealand where since 1974, in place of negligence they have what is called a 'no fault' compensation system.

A just system should be based on substantive equality. It should respond to all victims. Equality amongst victims would mean response to their needs whether or not their misfortunes were caused by fault or by human actions. The second is that the qualities of wealth and income should not be reproduced in the level of compensation.

It is obvious that tort law can develop extensively only in developed capitalist societies—only where there is a strong dominant ideology of bourgeois individualism, extensive and all-pervading commodity production (where everything is measured in term of money) and certain minimum standard of living where victims have the 'staying power' in courts, and offenders have sufficient means of payment. This, of course, is not the case with India, where we have a backward capitalist economy. Even then with the growth of capitalism more and more actions in torts are likely to arise.

Conclusion

Medical malpractice is already a well entrenched litigation sphere in western countries. Though in India uptil now there has been precious little happening on this front, it seems that more and more medical malpractice claims are being filed since the past five years, and over the next decade or so this branch will acquire at least some significance.

One cannot deny the fact that medical negligence claims are an offshoot of industrial capitalism and premises on the bourgeois ideology. Accountability of doctors coupled with redress for the victim can be much better tackled through and for a greater extent solved in societies not based on competition, treating injuries as commodities. The existing negligence law is not a panacea. But given the circumstances, it serves a useful purpose at least to an extent to mitigate the victims and bring accountability to doctors. In fact it should be seen not just as a reflection of bourgeois ideology but also as a bourgeois democratic right which requires to be extended and expanded. Also, in a country like India, where especially the poor receive extremely negligent medical treatment, extensive application of medical negligence law by people and by progressive groups can be very helpful to people and at least some way of improving health services. Also, surveys in US indicate that medical practice litigation provokes greater care at least in diagnosis.

One can only end by saying that despite its limitations, the law of medical negligence should be as widely used in India as possible.

Notes

[For many of the ideas expressed in this article I am deeply obliged to the following works:]

1 Article by Richard Able in *Politics of Law—A Progressive Critique.*

2 Hugh Collins: *Marxism and Law.*

3 Fire: *Democracy and the Rule of Law.*

4 Ronald Dwarking: *Taking Rights Seriously.*

5 Paul Philips: *Marx and Engels on Law and Laws.*

6 Pashukanis: *Marxism and Law.*

7 Curran Shopiro: *Law, Medicine and Forensic Science*

8 Mason and McCall Smith: *Law and Medical Ethics*

9 Keetortn: *Torts.*

10 Christie: *Cases and Materials on Law of Torts.*

11 Charlesworth: *Negligence.*

12 James: *General Principles as the Law of Torts.*

13 K. Bingham: *Modern Cases on the Law of Negligence.*