COMPENSATION BY STATE

Eliminating Legislation Against Doctors.

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Basics of such a scheme

Patients sue their doctors principally to gain sums of money as compensation for damage done to them. The victims of such litigation suffer considerably when they are innocent. One consequence of this sorry state of affairs has been the practice of 'defensive medicine', which, in turn, imposes worsening burdens in terms of escalating costs of investigation and therapy on the patients themselves,

Another important consequence: patients who suffer damage for whom no one can be held liable (as when the harm follows medical accident rather than negligence) have no recourse to compensation at present.

Some countries are experimenting with a system of 'liability without fault'. Here **compensation is sought and granted on the basis of extent of damage irrespective of its cause** and is related to the need of the patient. At one stroke this relieves doctors and courts of litigation and ensures that the majority suffering the consequences of medical accident also receive help. Instead of having to prove malpractice by an individual, evidence of harm would suffice. 'Inevitably, if the state has to pay, the current trend towards massive compensation awards would be reversed' (McClean 1989).

Such a system necessitates the setting up of a fund for this specific purpose using contributions by the state, the medical profession, insurance agencies, philanthropic institutions and the community at large.

Why should the medical profession contribute? The system outlined above would bar all civil proceedings which relate to damages arising from personal injury and death by accident: misadventure and negligence. The benefits to doctors in the form of peace of mind, ability to concentrate on treatment of the patient and savings in settlements provide sufficient reasons.

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The Accident Compensation Scheme of New Zealand restricted such compensation to personal injury by accident including medical, surgical, dental or first aid misadventures but excluded damage caused by sickness, disease or the ageing process.

This has been disputed. Since the aim is to help all those in need, to exclude those handicapped as a natural consequence seems unfair. On the other hand, the funds needed to help all those handicapped by accident or ill health will be enormous and may be beyond available resources.

The individual patient will gain less money from such a system. The more equitable distribution of money to all those in need, based on the extent of need should, however, be generally welcome.

A review of decisions in New Zealand under the Accident Compensation Scheme shows that patients suffering harm from to failure to diagnose or treat accurately, risks known to the doctor but not to the patient and failure by the doctor to provide sufficient information to permit the patient to make an autonomous decision were not compensated. Thus, in practice, sonic forms of medical negligence were not covered, lending themselves to action in courts of law. Here, the principle (based on common sense and natural justice) that *where an injury is caused which should never*

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have been caused, compensation should be paid by the person causing such harm has been applied.

Is such a system feasible in India?

The answer depends on the extent to which society and the medical profession are willing to bear the financial burden.

The medical and legal professions, social service agencies and the population at large would do well to ponder this alternative to the present system that sows the seeds of distrust and antagonism between patient and doctor.

Refererice

McLean Sheila AM: A patient's right to know. Information disclosure, the doctor and the law. Medico Legal Series, Dartmouth Publishing Co., Hants, England. 1989. Chapter 8, pages 140-161.

MOTHER vs FETUS

The front page of the *Indian. **Express*** on Sunday, 20 June 1993 featured a story on a pregnant woman, seriously ill with tetanus, admitted to the Sir J. J. Group of I-Iospitals in Bombay_ The patient and fetus were being monitored in the medical intensive care unit and appropriate care was being administered. Despite this, on the day before the mother died, she had cardiac and respiratory (arrests. She was revived briefly. Attempts at resuscitation continued but to no avail. Once death was confirmed, an emergency Caesarian section was carried out and the fetus delivered .

The news report states that the fetus is in a precarious condition and may have suffered brain damage when the mother had cardiac and respiratory arrest. The doctors in charge of the patient were asked why the Caesarian section was not done earlier. They replied that they worked on the principle that the life of the mother gains precedence over that of the fetus. Since the mother's life was in grave danger and a Caesarian section might have resulted in her death, they felt it wiser to do all they could for her.

It has been asked why the Caesarian section was not done once it was apparent that the mother was unlikely to survive. The obstetrician has a valid argument in favour of his stand: if he had operated whilst the patient had any chance of survival whatsoever, the trauma of surgery in her critical state would certainly have tipped the balance against her survival. He could, then, have been accused of having caused her death.

The reporter points to the added tragedy of this infant surviving with severe brain damage.

Here is a real life dilemma for the practicing doctor. Was it possible to determine with precision the point of no return as far as the mother was concerned? Should the criteria for the diagnosis of brain death have been used? What would you have done under the circumstances?

We welcome your responses and will analyse them in a forthcoming issue of this newsletter.