DUTY, BREACH, AND DAMAGES: A TRI-JURISDICTIONAL ANALYSIS OF MEDICAL MALPRACTICE LAWS

Ayush Goel, Law College Dehradun, Uttaranchal University

(Dr.) Anil Kumar Dixit, Law College Dehradun, Uttaranchal University

ABSTRACT

Medical malpractice law serves as a crucial safeguard for patient rights, ensuring accountability when healthcare providers fail to meet accepted standards of care. This paper conducts a **tri-jurisdictional analysis** of medical malpractice laws in the **United States, the United Kingdom, and India**, focusing on the core elements of **duty, breach, and damages**. While these principles are universally recognized, their interpretation and application vary significantly across legal systems.

In the **United States**, medical malpractice claims hinge on establishing a **duty of care**, **breach of the reasonable physician standard**, and **compensable harm**, often requiring expert testimony. The U.S. permits **punitive damages** in egregious cases, though some states impose statutory caps[1]. According to the Bolam-Bolitho test, which is used in the UK, a physician is not considered negligent if their acts are consistent with a credible body of medical opinion[2]. UK courts emphasize **informed consent**[3] and rarely award punitive damages. In **India**, medical malpractice is adjudicated under **consumer protection laws**[4] and tort principles, with courts imposing liability for **deficiency in service**[5].

A comparative analysis reveals that while all three jurisdictions require proof of **duty, breach, causation, and damages**, the **standard of care, burden of proof, and damage awards** differ substantially. The U.S. emphasizes **patient autonomy and punitive deterrence**, the UK prioritizes **professional medical standards**, and India blends **consumer rights with negligence principles**. These variations highlight the need for potential legal harmonization to strengthen global healthcare accountability while respecting jurisdictional nuances.

[1] *BMW v. Gore*, 1996
[2] *Bolam v. Friern Hospital*, 1957
[3] *Montgomery v. Lanarkshire*, 2015
[4] *Indian Medical Association v. V.P. Shantha*, 1995
[5] *Kunal Saha v. Sukumar Mukherjee*, 2013

Introduction

Medical malpractice law serves as a critical mechanism for ensuring accountability in healthcare while compensating victims of negligence. The foundational elements of a malpractice claim—**duty, breach, and damages**—are universally recognized, yet their application varies across jurisdictions. This article conducts a tri-jurisdictional analysis, examining medical malpractice laws in the **United States, the United Kingdom, and India**, highlighting key legal principles, landmark case laws, and legislative frameworks.

I. The Legal Framework of Medical Malpractice

Medical malpractice arises when a healthcare provider deviates from the accepted standard of care, causing harm to a patient. The plaintiff must establish:

1. **Duty of Care**: The existence of a physician-patient relationship imposing a legal obligation.
2. **Breach of Duty**: Failure to meet the requisite standard of care.
3. **Causation**: A direct link between the breach and the injury.
4. **Damages**: Quantifiable harm suffered by the patient.

These elements are interpreted differently across jurisdictions, influenced by statutory laws and judicial precedents.

II. Medical Malpractice in the United States

A. Duty of Care

In the U.S., a duty of care is established once a physician-patient relationship is formed[6]. The standard of care is defined as the level of care a reasonably competent professional would provide under similar circumstances[7].

B. Breach of Duty

[6] *Canterbury v. Spence*, 1972
[7] *Heinrich v. Sweet*, 2001

The plaintiff must prove that the defendant failed to adhere to the standard of care. Expert testimony is typically required[8]. Courts assess whether the provider's actions were consistent with the **"reasonable physician"** standard.

C. Damages

U.S. courts award compensatory damages (economic and non-economic) and, in cases of gross negligence, punitive damages[9]. Some states impose **caps on non-economic damages** (e.g., California's Medical Injury Compensation Reform Act (MICRA) limits pain and suffering awards to $250,000).

Key Case Law

- ***Helling v. Carey*** (1974): Established that adherence to customary practice does not absolve negligence if the standard itself is deemed inadequate.
- ***Tarasoff v. Regents of the University of California*** (1976): Extended duty of care to third parties when a patient poses a foreseeable danger.

III. Medical Malpractice in the United Kingdom

A. Duty of Care

UK law follows the **Bolam Test[10]**, which states that a doctor is not negligent if acting in accordance with a responsible body of medical opinion. This was refined in ***Bolitho v. City and Hackney Health Authority*** (1997), requiring that the medical opinion must be logically defensible.

B. Breach of Duty

The UK employs a **two-stage test**:

1. Whether the defendant owed a duty of care[11].

[8] *Daubert v. Merrell Dow Pharmaceuticals*, 1993
[9] *BMW v. Gore*, 1996
[10] *Bolam v. Friern Hospital Management Committee*, 1957
[11] *Caparo v. Dickman*, 1990

2. Whether the conduct fell below the standard expected (*Montgomery v. Lanarkshire Health Board*, 2015), which emphasized **informed consent**.

C. Damages

UK courts award **general damages** (pain and suffering) and **special damages** (financial losses). Unlike the U.S., punitive damages are rare (*R (on the application of Maughan) v. HM Senior Coroner for Oxfordshire*, 2020).

Key Case Law

- ***Chester v. Afshar*** (2004): Held that failure to disclose risks invalidates consent, even if the patient might have still undergone the procedure.
- ***Darnley v. Croydon Health Services NHS Trust*** (2018): Reinforced that hospitals owe a duty to provide accurate information to patients.

IV. Medical Malpractice in India

A. Duty of Care

Indian medical malpractice law is governed by **consumer protection laws** and tort principles. The Supreme Court in ***Indian Medical Association v. V.P. Shantha*** (1995) held that medical services fall under the **Consumer Protection Act, 1986**, making doctors liable for deficiencies in service.

B. Breach of Duty

The standard is similar to the Bolam Test but with greater scrutiny[12]. The court emphasized that **reckless disregard for patient safety** constitutes negligence.

C. Damages

Indian courts use consumer forums and Section 357 of the CrPC (criminal negligence) to grant

[12] *Dr. Balram Prasad v. Kunal Saha*, 2014

compensation. Although seldom, punitive damages are awarded in extreme circumstances[13].

Key Case Law

- ***Jacob Mathew v. State of Punjab*** (2005): Laid down guidelines for prosecuting doctors under criminal negligence (Section 304A IPC).
- ***Kunal Saha v. Sukumar Mukherjee*** (2013): Awarded ₹11 crore in compensation, India's highest medical negligence verdict.

V. Comparative Analysis

Jurisdiction	**Standard of Care**	**Burden of Proof**	**Damages**
U.S.	Reasonable physician standard	Plaintiff (preponderance of evidence)	Compensatory + Punitive (capped in some states)
UK	Bolam-Bolitho Test	Plaintiff (balance of probabilities)	General + Special (rare punitive)
India	Bolam Test + Consumer Protection	Plaintiff (consumer forums/courts)	Compensation (rare punitive)

VI. Conclusion

This tri-jurisdictional analysis reveals how medical malpractice laws in the U.S., U.K., and India differently interpret the core elements of duty, breach, and damages. The U.S. emphasizes patient rights through rigorous standards and substantial damages, though facing criticism for encouraging defensive medicine. The U.K.'s Bolam-Bolitho test prioritizes professional judgment while ensuring informed consent, with a more restrained approach to compensation.

[13] *Martin F. D'Souza v. Mohd. Ishfaq*, 2009

India uniquely blends tort principles with consumer protection laws, though suffers from systemic delays in adjudication.

While all systems aim to balance patient protection with medical practice, their distinct approaches reflect varying legal traditions and healthcare contexts. The U.S. model favors litigious redress, the U.K. emphasizes professional deference, and India focuses on consumer rights. Future reforms should address common challenges: reducing frivolous claims, expediting resolution, and adapting to telemedicine and cross-border healthcare. An ideal system would incorporate clear standards from the U.S., professional balance from the U.K., and accessibility from India, while maintaining fairness for both patients and practitioners in our evolving medical landscape.