Comparative medical liability in Europe*

Ewoud Hondius

1. Introduction

A considerable part of the comparative work by Professor *Hans Stoll* is – and in the future hopefully will be – taken up by questions of liability[1]. Comparative law has had a major impact on the development of liability law in many countries. More recently, comparative law has also played a role in paving the way for harmonisation of liability law. In this essay, I want to explore the contribution of comparative law to the harmonisation of one particular area of liability law, e.g. medical liability.

Medical liability is at present mainly a national affair. But there is also an embryonic body of European law. In 1997, the Council of Europe adopted the Convention on Human Rights and Bio-Medicine. In 1991, the European Commission presented to the European Council a Draft directive on the liability for services. In the face of heavy criticism, the proposal had to be withdrawn. But at present, there is a renewed interest in this matter, and it is not inconceivable that the European Commission will once again propose the harmonisation of liability, this time not of services in general, but of services in specific domains such as health care.

Many liability questions are already solved in the same way across Europe. But there are also differences. These differences are perhaps of a temporary nature. The law with regard to medical services is quickly developing; what in one jurisdiction has just been settled may soon become the law in other legal systems. Yet differences there are and in this essay I want to set out some of the main differences, relating to: the standard of care (sub 2.), proof and causation (sub 3.), who is liable (sub 4.), damages (sub 5.), exemption clauses (sub 6.) and patient insurance systems (sub 7.). I will then try to arrive at some conclusions, once again paying special attention to the comparative argument (sub 8.).

---

* The author wishes to express his gratitude towards Mr Peter Morris for his suggestions concerning the English language in this paper.

[1] See *his* Hamburger *Habilitationsschrift* Das Handeln auf eigene Gefahr/Eine rechtsvergleichende Untersuchung, Berlin: De Gruyter/Tübingen: Mohr, 1991, 407 p. and *his* Chapter 8, Consequences of liability: remedies, in: A. Tunc (Ed.), International encyclopaedia of comparative law, Torts 2, Tübingen: Mohr/Dordrecht: Nijhoff, 1986.

It is not possible to deal with all European jurisdictions. I will therefore focus on the three main legal systems in Europe: English, French and German law. In keeping with the preference of *Hans Stoll*, the emphasis will be on the common law of England. Where it is of interest, I will also mention some of the other systems: the Netherlands because of its recent codification of the health care contract and the Nordic countries for their Patient Insurance Schemes.

2. Standard of care

Should doctors inform their patients of the risks relating to the treatment they propose? It nowadays seems a truism to state that they should. And yet, there is at least one jurisdiction in the European Union, where the law is less settled than in other member states, and that, to the surprise of many a student, is English law. In *Sidaway v. Board of Governors of the Bethlem Royal Hospital*[2], it was held (per *Lord Bridge of Harwich*) that „the risk of damage to the spinal cord of such severity as the appellant in fact suffered was, it would appear, certainly less than one per cent. (...). In these circumstances, the appellant's expert witness's agreement that the non-disclosure complained of accorded with a practice accepted as proper by a responsible body of neuro-surgical opinion afforded the respondents a complete defence to the appellant's claim". It is, then, left to the doctors to set their own standards as to the question whether or not they should inform their patients of certain risks. Or, as Lord Scarman observed in the same case: „the law imposes the duty of care; but the standard of care is a matter of medical judgment". This is also called the Bolam principle, after the case of *Bolam v. Friern Hospital Management Committee*[3], where it was held „that in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at the time".

The test is quite distinct from that applied in most continental jurisdictions. According to Article 7:453 of the Dutch Civil Code, a health care provider shall exercise the level of care expected from a conscientious health care provider. At first sight, the two tests are virtually identical. In fact, there is a gulf between them. The „standards of reasonably competent medical men at the time" are radically different from „conscientious health care providers", because in the latter case it is the court which decides, not the medical colleagues as in the first case. The impact of informed consent is but one of the examples by which to demonstrate the difference.

Informing the patient is not the only point on which jurisdictions may differ as far as the standard of care is concerned. Diagnosis, advice and treatment are the three traditional medical functions. Here we find that Europe's small juris-

[2] [1985] 1 All ER 643.
[3] [1957] 2 All ER 118.

dictions are sometimes lagging behind. The reason for this may be precisely the fact that they are small: as two authors have observed, „where a legal system by its size tends to engender less litigation there are fewer occasions on which courts are presented with facts suitable to test or to clarify the application of existing legal rules"[4]. However, when precedents form the ordinary courts are lacking, there are other means of finding the law. One common solution in such a case is to take into consideration the awards of disciplinary bodies. One must of course always bear in mind that disciplinary bodies and liability law serve different functions. But often the factual situations are very similar and practitioners may therefore profit from the body of disciplinary awards. It is therefore of interest that such awards are reported.

Another way of filling the gap is by having recourse to comparative law. French and German case law especially are so all-embrasive, that it will not be difficult to find precedents which may be useful in other jurisdictions. Once again, these decisions have no decisive authority, but their arguments may be persuasive. In fact, small jurisdictions such as this author's home country often find inspiration from legislation, case law and doctrinal works from other countries. Small jurisdictions seem to have an advantage on this point which emanates from the very fact that they are small. In the larger jurisdictions, courts are less inclined to look abroad for guidance or inspiration. One of the hindrances is that of language of course. Not all French judges read German and the reverse is probably also true. It is therefore of some importance that case-law is made available not only in one's own language, but in other languages as well[5].

In discussing the standard of care, I have so far only referred to the care of individual providers of health care. We should also take into account the standard of care of institutions, such as hospitals and – social and private – insurance companies. When looking at the statistics of complaints filed in various hospitals, one is sometimes appalled at the fact that in some hospitals much more, up to tenfold, complaints are lodged than in others. This may of course be a matter of complaint consciousness: urban patients may find it easier to complain than those in rural areas. But a better explanation is that the organisation of certain hospitals lags behind. No protocol has for instance been developed on the taking over of patients by the day shift[6]. It is therefore interesting that in new regulations on tort liability, such as the Swiss draft legislation, liability for organisational faults are especially dealt with.

---

[4] *Reinhard Zimmermann/Simon Whittaker* (Eds.), Good faith in European Contract Law, Cambridge: Cambridge University Press, 2000, p. 655.

[5] This is one of the major functions of the new wave of European private law journals such as the European Review of Private Law (Europäische Zeitschrift für Privatrecht) and the Zeitschrift für Europäisches Privatrecht.

[6] On organisational mistakes see *E. Deutsch*, Das Organisationsverschulden des Krankenhausträgers, NJW 2000, 1745–1749.

3. Proof and causation

In common law, the traditional position regarding proof of medical malpractice is well stated in *Wilsher v. Essex Health Authority*[7] by *Lord Bridge of Harwich*: „whether we like it or not, the law, which only Parliament can change, requires proof of fault causing damages as the basis of liability in tort". This position, which lies at the basis of a large number of malpractice cases, has increasingly come under attack. The common law itself does help plaintiffs with the doctrine of *res ipsa loquitur*: the case speaks for itself, in other words the mere fact that the accident has occurred raises the inference of the defedant's negligence. There is also the procedural technique of discovery, which has been in use in the United States for some time: the court requires the defendant to make available to the plaintiff all documents pertaining to the question at stake.

The most radical solution – apart from liability – is a reversal of the burden of proof: the health care provider must prove that the medical misfortune of his patient was not caused by any mistake of his. This is the solution of the 1991 Draft Directive on Services Liability, which caused so much dissatisfaction in the medical profession. Indeed, it may be argued that a reversal of the burden of proof is unnecessarily blunt. *Res ipsa loquitur*, together with the court's discretion to impose the burden of submitting evidence and of offering proof upon the party who is in the best position to submit or offer this, should deal with the matter.

Another problem is that of causation. Here once again we find major differences between various European jurisdictions. In some jurisdictions, causation is little more than a *conditio sine qua non* test, of a mainly physical nature. In others, causation is the major criterion for deciding whether or not someone will be held liable. The wrongful birth cases mentioned below offer an illustration of this thesis.

4. Who is liable

Cases similar to the following are known in all jurisdictions[8]: after surgery, a patient complains of unbearable pain. An X-ray shows that a needle has inadvertently been left in his stomach before it was stitched up. Health care providers, says the textbook, should always count the number of foreign objects which they put into the person and the number they take out – and preferably these numbers are equal[9]. Suppose this is not the case, how can the patient prove which member of the surgery team committed the fault. The patient will most

[7] [1988] 1 All ER 871.

[8] BGH NJW 1989, 2943, Hoge Raad (Nuboer).

[9] Only in cases of life and death is it defensible to willingly leave behind an object in the person.

probably have been unconscious during the surgery[10] and so will not have been in a position to see with his own eyes. This was the reason why actions for compensation were denied in the past.

The problem mainly arises because of the intricate organisational pattern within the hospital. There will be no problem when all members of the team are employed by the hospital. As *Lord Denning* observed in *Roe v. Minister of Health*, hospital authorities are responsible for the whole of their staff[11]. In hospitals where private enterprise is tolerated or even recommended, the *Roe approach* is not available. One solution is provided by the Dutch Civil Code, which holds the hospital liable for whatever happens on its premises. This of course leaves open the possibility of redress by the hospital against the doctor concerned.

5. Damages

Another case situation has become a classical one in teaching comparative law. Angela and Bernd have four children. They want to move to a larger house. In order to pay the higher mortgage, Angela takes up her former position. Angela and Bernd do not want any more children. Bernd has himself sterilised by way of a vasectomy in the hospital. A year later, Angela is pregnant again. Angela and Bernd decide to keep the baby, but they claim compensation from the hospital. Are they entitled to do so? – First, a factual question has to be solved. What went wrong with the sterilisation? This may be either medical malpractice or it may be the fault of nature. But in the case of the latter, the hospital may still be liable for misinformation. A second, more interesting question is what kind of damages Angela and Bernd can claim. There is now little doubt that Angela is entitled to immaterial damages for having to suffer the pain of giving birth. But what about the couple's claim for the costs of bringing up their newborn baby? It is with some regret that I have to refrain from going deeply into this question, but I have to remind the reader of the question which I have taken up in this essay: to what extent does the comparative law element play a role. What is highly interesting to see, is that comparative law does play such role, although not always a deciding one.

A first example is a Dutch case on wrongful birth from 1997[12]. The *Hoge Raad* expressed the opinion that the award of compensation for expenses to raise the child – born normal and healthy – was not in conflict with the human dignity of the child, or with its right to life. In line with the general rules on com-

[10] This is not always the case: in *Phelan v. East Cumbria Health Authority*, [1991] 2 Med LR 419, a patient complained that during surgery he woke up and suffered unbearable pain – but was unable to communicate this to the doctor involved.

[11] [1954] 2 All ER 131.

[12] Hoge Raad, 21 February 1997, Nederlandse Jurisprudentie 1999, 145 (Note by *C.J.H. Brunner*).

pensation, no non-material damages are awarded[13]. Apart from expenses for raising the child, the Dutch court also acknowledges the possibility of compensation for loss of income for the mother. This case has had considerable influence in other European jurisdictions, among other things owing to the fact that it has been translated into other languages. The fact that it is one of the very few Dutch cases dealt with in the first volume of Van Gerven's *Ius commune casebooks for the common law of Europe*, has contributed to its influence on Scottish law[14]. It has in turn been influenced by German law, witness the Conclusion of Advocate-General Vranken, who in his dissenting conclusion repeatedly referred to an essay by *Hans Stoll*[15].

This brings us to the second example of a wrongful birth case, the Scottish case of *McFarlane v. Tayside Health Board*[16]. Here, comparative law also plays a role, although the House of Lords in the end opted against the German and Dutch approach. A third example is a Norwegian wrongful conception case, in which both Dutch and German precedents were considered – and also rejected[17].

6. Exemption clauses

In health care, exemption clauses are not widespread. Unlike attorneys, medical doctors usually do not use stationary with a printed exemption clause at the bottom. Were they to employ such clause, it is doubtful whether it would be valid. Under the Dutch Civil Code, such an exemption clause is plainly invalid. Where jurisdictions have no such rule, the unfair contract terms legislation will usually take care of this.

Personally, I do not fully agree with the invalidity of all exemption clauses. If we take the example that Professor Hans Stoll, instead of becoming a comparative lawyer, would have become a professional footballer, he would undoubtedly also have belonged to the upper echelons of the profession. Now if this famous footballer had presented himself to a hospital for a knee operation, without disclosing the fact that incorrect surgey could result in an income loss of Euro 100 million, in my opinion the hospital, for lack of causation, would not necessarily be liable to the full extent. But if this is the case, why not codify this into the contract. Perhaps this is a clause dealing with liability, but it does not derogate from the law as I see it and therefore would not be subject to unfair

[13] General remedies against non-pecuniary harm are available only in a limited number of legal systems, s. *Hans Stoll*, (s. Fn. 1), Nr. 17.

[14] *Walter Van Gerven et al.*, Tort Law/Scope of Protection. Oxford: Hart, 1998, p. 161.

[15] *Hans Stoll*, Haftungsfolgen im bürgerlichen Recht/Eine Darstellung auf rechtsvergleichender Grundlage, 1993, p. 280–286.

[16] [1999] 4 All ER 963.

[17] Høyesterett 15. 2. 1999 – Nr. 190/1998, Norsk Retstidende 1999, S. 203.

contract terms legislation, witness §311 (3) of the Draft German Civil Code: „Diese Vorschrift sowie die §§312 und 313 gelten nur für Bestimmungen in Allgemeinen Geschäftsbedingungen, durch die von Rechtsvorschriften abweichende oder diese ergänzende Regelungen vereinbart werden" (= §8 AGB-Gesetz).

Another point which is much debated at present is the question to what extent the loss of an opportunity should be compensated[18].

7. The Nordic Patient Insurance Scheme

In 1971, Sweden adopted a radically different approach towards medical accidents. The model has also been adopted in the other Nordic countries. Basically, the system leaves liability rules untouched, but it provides for extra insurance coverage. Hospitals contract insurance for the benefit of their patients. Whenever something happens which in other jurisdictions could lead to liability, both the hospital and the patient – jointly – turn to the insurance company for monetary compensation. The system has the advantage that hospital and patient are not forced into litigation, which admittedly is not a positive element in their relationship. It has the disadvantage that it is expensive, at least if it were to be transplanted to continental European countries. A matter of doubt is whether the Nordic model – the patient insurance system has been adopted in the other Nordic states as well – is sufficiently open to accommodate new developments both with regard to medical techniques and ideas in society as to who should bear the risk.

Since the details of the patient insurance model are not well known, it may be of interest to give some further explanation. I will base this on the most modern Patient Insurance Scheme, the *Finnish Patient Injuries Act*, which entered into effect on May 1, 1999[19]. Pursuant to this Act, which replaces an earlier Act of 1987[20], patient insurance covers bodily injuries sustained by patients in connection with medical treatment and health care provided in Finland. Bodily injury refers to illness, injury or other weakening of health or death. Donors of blood or organs are also covered by the Act. Under section 2 of the Act, the insurance only covers bodily injuries which are likely to have resulted from treatment and

[18] *Thierry Vansweevelt*, De civielrechtelijke aansprakelijkheid van de geneesheer en het ziekenhuis, Antwerpen, 1992.

[19] The following is mainly taken from a brochure entitled „Finnish Patient Insurance", published by the Finnish Patient Insurance Centre in Helsinki.

[20] See *Raimo Lahti*, Towards a Comprehensive Legislation Governing the Rights of Patients: The Finnish Experience, in: Lotta Westerhäll/Charles Phillips (Eds.), Patient's Rights, Stockholm, 1994, p. 207–221; *Riamo Lahti*, The Finnish Patient Injury Compensation System, in: Sheila A.M. McLean (Ed.), Law Reform and Medical Injury Litigation, Aldershot, 1995, p. 147–161.

which meet any one of seven conditions: 1 Treatment injury, resulting from examination, treatment or similar action: the test is that of the experienced health care professional; 2 Equipment-related injury, caused by a defect in medical equipment or instruments; 3 Infection, originating from an examination, treatment or similar action, although no compensation will be paid if the patient is expected to tolerate the injury, 4 Accident-related injury, 5 Fire and burns injury, resulting from an incident affecting either the premises where the patient was being treated or the equipment used for the treatment was located, 6 Pharmaceuticals incorrectly supplied, that is contrary to the prescription or in violation of applicable regulations[21], 7 Unreasonable injury, caused by examination, treatment or similar action, if the action has caused permanent illness, injury or death.

Compensation must be claimed within three years of the date on which the patient became or should have become aware of the injury, and within ten years of the event (section 10). Patient insurance covers medical treatment expenses, loss of income or maintenance, pain and suffering, permanent loss of function and permanent cosmetic injury. The administration of the Act has been entrusted to the Patient Insurance Centre. Any patient who is dissatisfied with a decision of the Centre may ask the Patient Injuries Board to review the case. The Board may also provide general recommendations (section 11).

In 1999, the Finnish Patient Insurance Centre received a total of 7,215 claims. The amount paid in claims in 1999 was FIM 77.7 million. Claims handling costs totalled FIM 15,2 million. Twenty-three tort law suits were brought to court in 1999. The volume of premiums written in 1999 was FIM 167.8 million, of which a part is reserved for future claims[22].

The Patient Insurance Model has attracted widespread attention in other European countries, such as Austria[23], Belgium[24], Germany[25], the Netherlands[26] and the United Kingdom[27].

---

[21] Injuries caused by pharmaceuticals correctly supplied or prescribed are covered by pharmaceutical insurance and handled by the Pharmaceuticals Insurance Pool.

[22] Annual Report 1999.

[23] *J. W. Pichler*, Rechtsentwicklungen zu einer verschuldens-unabhängigen Entschädigung im Medizinbereich. 1. Die Patientenversicherungsrechte in Schweden, Finnland und Dänemark, Wien/Köln/Weimar, 1994.

[24] Various publications by *J. L. Fagnart* and *N. Fraselle*.

[25] *Christoph Kranich/Jan Böcken* (Eds.), Patientenrechte und Patientenunterstützung in Europa, Baden-Baden, 1997.

[26] *B. A. J. M. de Mol*, Medisch letsel in het ziekenhuis no-faultverzekering/Een verkennende studie, Ph. D.-thesis Rotterdam 1988.

[27] See *M. Brazier*, The Case for a No-Fault Compensation Scheme for Medical Accidents, in: S. A. M. McLean (ed.) *Compensation for Damage/An International Perspective*, Aldershot Hants 1993, (ed.), p. 51–74 (*pro*) and S. A. M. McLean, Can No-Fault Analysis Ease the Problems of Medical Injury Litigation?, loc. cit., p. 75–90, as well as *M. A. Jones*, *Medical Negligence*, London 1991, p. 6–9 (*contra*).

Although the Nordic model leaves compensation under general tort – or contract – rules intact, it has nevertheless caused a basic demarcation line in the actual handling of medical claims.

8. Conclusions

Having analysed a number of issues of medical liability, we may arrive at the conclusion that on these issues some of the European jurisdictions are still in considerable disagreement. But at least they are becoming more interested in one another.

Seemingly small differences in the wording of, for instance, the standard of care test (s. *Bolam v. Europe*) do in fact hide a channel of differences between various European jurisdictions. Problems of proof and causation are dealt with in different ways, as is the question who may be held liable and what kind of damages may be awarded. Only as to exemption clauses does there seem to be widespread consensus.

What is perhaps even more important than these legal differences, is that our analysis has shown that infrastructures also diverge. There is the factual difference between the Nordic countries with their Patient Insurance Schemes and the other jurisdictions with their traditional liability systems. There are the countries where private law is the only part of the law which is relevant and those where administrative and criminal law are of interest (France). Yet another difference is between those member states where the general rules of private – or administrative – law apply and those which have adopted specific legislation (Finland, the Netherlands). Where general rules apply, these may be those of tort or – increasingly – contract law. May patients choose between the two regimes or is there no choice (*non-cumul*)? In some countries, doctrine (France) or legislation (Netherlands) no longer consider the distinction to be of major importance.

Even where case-law is concerned, structural differences may be discerned. Although most continental jurists believe the contrary, the common law may become very inflexible in the hands of the courts. The cases decided in the House of Lords are evidence thereof. Another structural difference is that in the techniques of developing the law (*Rechtsfortbildung*), courts' opinions may vary a lot. And yet on another point, fundamental rights have quite different impacts in various jurisdictions.

So far, I have discussed the official law makers who hold public office. And what about self-regulatory schemes? Here we also find a gulf, this time not between common and civil law, but between those jurisdictions where self-regulation is held in high esteem (the UK) and those where intervention by non-State bodies is – or rather was – eyed with suspicion.

So where does this lead us? Is the harmonisation of medical liability on a Eu-

ropean level to be abandoned? The recent idea of resuscitating the draft directive on liability for services, albeit for a limited number of domains, demonstrates that this is not a purely academic question.

The question whether or not to harmonise may be subdivided into three subquestions.

(a) Is the European Union competent?
(b) Is harmonisation feasible? And
(c) is it desirable?

The first question is not difficult to answer: there is a clear basis for a directive in the Treaty of Amsterdam. As for the feasibility, this essay shows that many issues have to be solved before true harmonisation will succeed. The last question is the most political one: do we really want to see a liability system, in which doctors and hospitals may be held liable under exactly the same circumstances in Denmark and Greece, in Ireland and Portugal? Once again, the answer is positive. The need for the mobility of doctors and patients is no less than that of producers and consumers of products. The arguments against this are somewhat diverse: there is supposedly no need for harmonisation, witness the scarcity of present cross-border hospitalisations, and law is a part of culture and culture is simply different in the various European jurisdictions. The first argument is not very impressive. It may indeed be turned around. The present lack of mobility on the part of patients – doctors seem slightly more adventurous – may also be caused by the lack of harmonisation.

The latter argument is more difficult to refute. For indeed there are cultural differences between the various countries. The organisation of health care – private practice or National Health Service –, the division of labour between first line and second line, the acceptance of second opinions, of abortion and euthanasia, not to think of legal differences, are there to prove this. And yet, can this not also be said for most other sectors of European society? Freedom of persons appears to be of overriding importance. For that purpose, harmonisation – not complete unification – is essential.