

# **Medical Liability: Canada, England and Wales, Germany, and India**

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### COMPARATIVE SUMMARY

#### MEDICAL MALPRACTICE LIABILITY SYSTEMS IN SELECTED COUNTRIES

*Doctors are usually held liable for malpractice in countries with government-sponsored health care systems, but governments often take measures to ease the related financial burden. This report analyzes physicians' liability laws in Canada, England and Wales, Germany, and India, and reviews relevant national procedures and judicial rulings.*

#### **I. Purpose of Comparison**

This report analyzes medical malpractice liability regulations in Canada, England and Wales, Germany, and India. These countries were selected for the study because they provide their citizens with a government-sponsored health care system. While these countries approach the issue of medical liability differently, there are some commonalities in terms of scope and implementation procedures. The report analyzes the countries' medical malpractice liability insurance programs, grounds for medical malpractice liability, types and amounts of damages awarded by the courts, and certain procedural details.

#### **II. Health Insurance Programs**

Almost all of the residents in the reported countries are covered by government-regulated health insurance programs. Canada has a single-payer health insurance program that is mostly funded by the government. However, provincial health insurance plans may vary with regard to coverage of specific services (e.g., dental care, eye exams, cosmetic surgery), which may be covered by supplemental medical insurance, or provided by employers as a non-mandated health benefit. The health care system in Germany is decentralized and diversified, and consists of more than 200 insurers who, to a certain extent, compete with each other for customers. Germany allows high-income earners to opt out of the statutory system and to be privately insured. Almost 10 percent of the German population exercises this option. In England and Wales, the health care system combines private physicians and hospitals with those who participate in the National Health Service. Similarly, Canada allows private physicians to opt out of the single-payer health insurance program and bill their patients directly. Should they choose this option, they are prohibited from billing the insurance plan for some services while billing patients directly for others. The health care system in India, which is financed through general tax revenues, community financing, out-of-pocket payments, and social and private insurance schemes, combines private and public providers, with public sector health care being divided between federal, state, municipal, and local governments.

### **III. Medical Malpractice Insurance Schemes**

In the countries under consideration, health care is provided either predominantly by private physicians (Canada) or by private and public entities (Germany, England and Wales). In Germany, private physicians and hospitals enter into agreements to become service providers for statutory health insurance schemes. Health insurers may recover expenses attributable to the injury through the statutory subrogation of the plaintiff's claim. Canadian private physicians and those who work for hospitals are required to obtain medical liability insurance (usually through a professional organization). Membership fees in the professional organization depend on the field of medicine in which a physician practices and the region where the medical services are provided. These fees include insurance coverage and the right to be represented in medical malpractice lawsuits. At least a portion of membership fee is reimbursed by provincial governments in order to encourage physicians to practice in the provinces. In England and Wales, all financial liability for the negligence of employees is undertaken by the National Health Service Trusts, which are encouraged to participate in the Clinical Negligence Scheme Trust, which deals with medical malpractice negligence claims. Certain clinicians that are not considered to be employed by the National Health Service typically obtain indemnity through a medical defense organization or private insurance. In India, where health care is delivered through partnerships between the public and private sectors, patients are treated as consumers of medical services, and the law provides them with consumer protection rights.

### **IV. Grounds for Liability**

Medical malpractice claims are typically tort claims brought against an individual physician for negligence, or claims brought against a medical institution under the principle of vicarious liability. In England and Wales, if a physician is employed by the National Health Service, the latter is vicariously liable for the physician's negligent acts and omissions. However, this indemnity covers only the financial consequences of the claim, e.g., legal and administrative costs, plaintiff's expenses and the amount of damages awarded. If a physician is exempted from the indemnity program coverage, he or she can be sued directly for negligence. In Canada, physicians are usually sued individually for negligence. Hospitals can also be held liable for the conduct of their staff. German medical malpractice law is based on the Civil Code provisions on liability and on causes of action developed by case law. Under Indian law, services provided by a physician to a patient are considered to be not merely of a personal, but also of a contractual nature and fall within the Consumer Protection Act of 1986. The law of torts is applied when a case is not covered by the Consumer Protection Act (for example, when the services are rendered for free). A criminal complaint may be filed against a physician if his or her negligent acts result in death. The burden of proof is on the patient to prove that the physician was grossly negligent.

### **V. Types of Damages Awarded**

In Canada, plaintiffs are usually awarded compensatory damages. Punitive damages are very rare and are awarded in exceptional circumstances, such as when compensatory damages are insufficient or unavailable, and when the conduct is malicious or highly reprehensible. In Germany, punitive damages are not awarded at all. This type of damages is almost unknown to

civil law systems. A plaintiff in Germany usually seeks damages for pain and suffering. In England and Wales, damages awarded to patients in connection with clinical negligence claims are paid by the National Health Service Litigation Authority following the settling of most of the claims out of court. In India, claims are adjudicated by consumer dispute agencies in the same manner as all other consumer complaints, and the amount of redress is limited according to the agency's territorial jurisdiction.

## **VI. Amount of Damages Awarded**

Awards against physicians are generally rare and the amount of damages awarded to victims of medical malpractice is relatively low (although in Germany the prevailing trend is toward a slowly increasing number and size of awards for pain and suffering). There are several reasons for this:

- No jury or punitive damages (Germany, India);
- Legally established guidelines for the calculation of damages limit recovery to certain sums (Canada, Germany, India);
- A considerable amount of the losses resulting from personal injury are borne by the social security system;
- The availability of free medical treatment and medications;
- Unlimited paid sick leave, generous pension plans, and welfare benefits (Germany);
- The practical difficulty of establishing professional negligence in court (Canada); and
- Partial recovery of the plaintiff's litigation expenses where the case is not fully satisfied, which discourages plaintiffs from claiming higher amounts of damages in cases where the courts are not allowed to award damages beyond the amount of recovery sought (Germany).

## **VII. Procedural Issues**

Most medical malpractice liability cases are settled out of court. Only 8 percent of these cases are litigated in Germany, and only about 4 percent in England and Wales. In contrast to Germany and England and Wales, where settlement of medical malpractice claims by means of alternative dispute resolution is encouraged, the Canadian Medical Protective Association vigorously defends medical malpractice suits, and has been criticized on a number of occasions for rejecting reasonable settlement offers in order to discourage other lawsuits. A peculiar mechanism of medical malpractice dispute resolution was created by the Indian Consumer Protection Act. The Act provides for a system of special institutions at the national, state, and district levels (consumer councils) that have jurisdiction over medical malpractice claims under certain specific amounts.

## **VIII. Conclusion**

Malpractice lawsuits do not affect the delivery of health care in the countries included in this report, and are not a subject of controversy. Because of an extensive safety net of social laws in the countries reviewed and the active participation of governments and other stakeholders in redressing instances of clinical negligence, liability for medical malpractice generally leads to moderate damage awards. Most of the medical malpractice claims in these countries are settled and, as a rule, cases are only tried when a serious injury has been inflicted. In such cases, awards for pain and suffering tend to be greater.

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## CANADA

### MEDICAL LIABILITY

#### *Executive Summary*

*Canada has a single-payer health insurance scheme that covers virtually all residents. Most physicians are in private practice and they bill the insurance plans for their services. Being in private practice, they require medical liability insurance. This is usually obtained through a professional organization. However, physicians are reimbursed for a large portion of their insurance premiums by provincial governments. Fees are lower than in the United States for a number of reasons. Two of these are that Canada's highest courts have set limits on awards and the country's liability laws make establishing professional negligence more difficult. Another is that the physicians' insurance company defends lawsuits very vigorously.*

#### **I. The Canadian Health Care System**

Although Canada is often characterized as a country that has “socialized” medicine, its system differs considerably from countries in which physicians are essentially employed by the state or the entire medical profession is under unified state control. In Canada, most medical practitioners are in private practice just as they are in the United States. Most physicians have their own offices, set their own schedules, and see patients who have chosen to come to them on a regular basis or for a particular condition. Canadians are not assigned doctors by the government or an insurance plan. They do have choices.<sup>1</sup>

Where the Canadian system differs most significantly from that of the United States is in how health insurance is provided. In Canada, all of the provinces have a single health insurance program that covers virtually all residents. For example, Ontario has the Ontario Health Insurance Plan<sup>2</sup> and Quebec has the Quebec Health Insurance Plan.<sup>3</sup> The federal government subsidizes these provincial health insurance plans through its general revenues. There are no separate payroll deductions to fund the health care plans and Canada does not have a separate old-age health care program like Medicare in the United States.

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<sup>1</sup> Bruce Robinson, Canada's Single-Payer Health Care System—It's Worth a Look, <http://bcn.boulder.co.us/health/healthwatch/canada.html> (last visited June 10, 2009).

<sup>2</sup> Ontario Ministry of Health and Long Term Care, Ontario Health Insurance Plan, [http://www.health.gov.on.ca/english/public/program/ohip/ohip\\_mn.html](http://www.health.gov.on.ca/english/public/program/ohip/ohip_mn.html) (last visited May 27, 2009).

<sup>3</sup> Quebec, Regie de l'Assurance Maladie, Health Insurance: Coverage for Your Health, <http://www.ramq.gouv.qc.ca/en/citoyens/assurancemaladie/index.shtml> (last visited May 27, 2009).

When the provincial health insurance plans were first created in the 1960's and 1970's, the federal government paid for about half of the provincial plans' costs. This percentage fell by more than half in the 1990's, but has gone back up somewhat in recent years.<sup>4</sup> The provincial contributions to the plans are also mostly from general revenues. However, the largest province of Ontario and a couple of other provinces also impose a levy on employers to help pay for their programs.

As can be seen from the above, the Canadian system is more accurately described as a "single-payer" system than a "socialized" one. However, even this description needs to be qualified. Canadian physicians are not required to submit bills for their fees to the provincial health insurance plans. They can "opt out" of the systems and bill their patients directly. However, physicians who do decline to participate in a provincial plan must operate entirely outside it as they are generally prohibited from billing the insurance plan for some of their services and patients for others. In other words, physicians cannot be partial participants. For this reason, the vast majority of Canada's physicians are enrolled in the provincial health insurance plans and earn virtually all of their income from the bills they submit to them.

Canada's provincial health insurance plans are generally similar, but do have some differences. For example, the Province of Quebec has more generous prescription drug coverage than any other province. However, the similarities are far greater than the differences. One of the major reasons for this is that in order to qualify for federal subsidies, provincial health insurance plans must adhere to the guidelines set out in the Canada Health Act.<sup>5</sup> The one guideline that has been the subject of the most controversy over the years has concerned "extra-billing." The Canada Health Act does not allow the provinces to permit physicians to bill patients for a portion of their services through co-payments or other types of additional fees. The federal government has remained firm in this position for many years on the grounds that it does not want to see the creation of two-tiered systems in which patients who could afford to pay for a portion of their health care would receive more comprehensive coverage and preferential treatment compared to those who could not afford additional health costs. In the past, some provinces have lost a portion of their transfer funds for allowing some extra-billing, but a number would still like to be able to allow for extra-billing in certain cases in order to help keep their costs down without having to pay a penalty in the form of reduced transfer payments.

Canada's provincial health insurance plans do not cover all services. Dental care, eye exams, and cosmetic surgery are three examples of services that generally are not covered. However, most Canadian employees have supplemental medical insurance provided by their employers that give at least partial coverage for these services. For example, supplemental insurance will usually cover one eye exam and one pair of glasses per year. Many collective bargaining agreements provide for supplemental insurance. In other cases, supplemental insurance is offered as a non-mandated work benefit, but it is not required.

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<sup>4</sup> Health Canada, Federal Transfers and Deductions, <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/transfer-eng.php> (last visited June 8, 2009).

<sup>5</sup> Canada Health Act, R.S.C. c. C-6 (1985), as amended, available at <http://laws.justice.gc.ca/en/C-6/> (last visited May 27, 2009).

## II. Liability Insurance

Canadian physicians who are in private practice or work for hospitals are required to obtain medical liability insurance. Such insurance is available through the Canadian Medical Protective Association (CMPA). Insurance premiums or “membership fees” are based upon the type of work a physician performs and the region in which he or she practices. The three fee regions are Quebec, Ontario, and the Rest of Canada. The CMPA has published Fee Schedules.<sup>6</sup> Fees are not based upon a physician’s record and are not increased for a history of complaints or on account of claims paid.

Membership fees paid to the CMPA give physicians insurance coverage and a right to representation in medical malpractice lawsuits. However, provincial governments reimburse physicians for at least a portion of their membership fees. These arrangements are not generally made public. However, a recently released Memorandum of Understanding between the Ministry of Health, the Ontario Medical Association, and the CMPA reveals that physicians are currently reimbursed for about 83 percent of their membership fees.<sup>7</sup> It has been reported that the Ontario government paid about Can\$112 million to reimburse physicians for medical malpractice fees in 2008.<sup>8</sup> Government officials in Ontario have explained that the purpose of the reimbursement program is to encourage physicians to practice in the province and not to move to another province or the United States where average incomes may be higher. Critics contend that because the CMPA’s fees are not based upon a physician’s record, the system does little to penalize physicians who are found to be liable for malpractice even on multiple occasions.<sup>9</sup> Physicians who have committed acts of malpractice may, however, be disciplined by their provincial licensing body. Discipline can range from suspensions to losses of the privilege to continue practicing medicine.

The CMPA has also been criticized for defending medical malpractice suits extremely vigorously and turning down reasonable offers to settle claims to discourage other lawsuits on a number of occasions.<sup>10</sup> One judge reportedly referred to the CMPA as pursuing a “scorched earth policy.”<sup>11</sup> In Canada, a losing party is generally required to pay about two-thirds of a successful party’s legal fees. Since the CMPA often incurs large legal expenses in defending claims, this is an additional disincentive to persons who believe that they have been injured through malpractice from bringing an action for damages.

One other feature of Canadian law that tends to discourage parties from suing physicians for malpractice is that the Supreme Court has set out guidelines that effectively cap awards for

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<sup>6</sup> Canadian Medical Protective Association, Membership Fees, available at <http://www.cmpa-acpm.ca/cmpapd04/docs/membership/fees/2009cal-e.pdf> (last visited May 27, 2009).

<sup>7</sup> Steve Buist, *Taxpayers Footing the Bill for Malpractice Insurance*, HAMILTON SPECTATOR, Feb. 7, 2009, available at <http://www.thespec.com/News/Local/article/509183> (last visited May 28, 2009).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

pain and suffering in all but exceptional cases. In a trilogy of decisions released in 1978, the Supreme Court established a limit of Can\$100,000 on general damages for non-pecuniary losses such as pain and suffering, loss of amenities and enjoyment of life, and loss of life expectancy.<sup>12</sup> The Supreme Court did state that there may be extraordinary circumstances in which this amount could be exceeded and courts have allowed the figure to be indexed for inflation so that the current suggested upper limit on awards for non-pecuniary losses is close to \$300,000.<sup>13</sup> Nevertheless, the flexible cap on non-pecuniary losses is a major disincentive to persons considering whether they should sue a physician for malpractice and for lawyers to specialize in or seek out malpractice cases.

The Supreme Court of Canada has also limited the types of cases in which punitive damages may be awarded, although it has allowed as much as Can\$1 million in punitive damages in an extraordinary case.<sup>14</sup> A Canadian law firm has summarized the holding in this leading case concerning punitive damages as follows:

1. Punitive damages are very much the exception rather than the rule;
2. Imposed only if there has been high-handed, malicious, arbitrary or highly reprehensible misconduct that departs to a marked degree from ordinary standards of decent behaviour.
3. Where they are awarded, punitive damages should be assessed in an amount reasonably proportionate to such factors as the harm caused, the degree of the misconduct, the relative vulnerability of the plaintiff and any advantage or profit gained by the defendant,
4. Having regard to any other fines or penalties suffered by the defendant for the misconduct in question.
5. Punitive damages are generally given only where the misconduct would otherwise be unpunished or where other penalties are or are likely to be inadequate to achieve the objectives of retribution, deterrence and denunciation.
6. Their purpose is not to compensate the plaintiff, but
7. to give a defendant his or her just desert (retribution), to deter the defendant and others from similar misconduct in the future (deterrence), and to mark the community's collective condemnation (denunciation) of what has happened.
8. Punitive damages are awarded only where compensatory damages, which to some extent are punitive, are insufficient to accomplish these objectives, and
9. they are given an amount that is no greater than necessary to rationally accomplish their purpose.
10. While normally the state would be the recipient of any fine or penalty for misconduct, the plaintiff will keep punitive damages as a "windfall" in addition to compensatory damages.

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<sup>12</sup> *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229.

<sup>13</sup> *Koukounakis v. Stainrod*, 23 O.R. (3d) 299 (Ont.) (1995).

<sup>14</sup> *Whiten v. Pilot*, [2002] 1 S.C.R. 595, available at <http://scc.lexum.umontreal.ca/en/2002/2002scc18/2002scc18.html>.

11. Judges and juries in our system have usually found that moderate awards of punitive damages, which inevitably carry a stigma in the broader community, are generally sufficient.<sup>15</sup>

Thus, punitive damages in tort actions in Canada are relatively rare.

### III. Negligence

Despite the above factors that discourage medical malpractice lawsuits in Canada, there are numerous reported cases in which doctors, hospitals, and health care professionals have been found liable for acts of negligence in the delivery of health care. In order to be successful, a plaintiff must show that the defendant owed him or her a duty of care, the defendant did not deliver the standard of care owed, the plaintiff's injuries were reasonably foreseeable, and the defendant's breach of the duty of care was the proximate cause of the plaintiff's injuries.<sup>16</sup> An error of judgment is not necessarily negligence even if it causes injury.<sup>17</sup>

Common types of negligence actions are as follows:

1. Failure to attend a patient
2. Failures in diagnosis
3. Failures in re-diagnosis
4. Failures in Referral or Consultation
5. Failure to Communicate with other Physicians
6. Failure to protect or warn third parties
7. Failure to report abuse
8. Substandard treatment<sup>18</sup>

Hospitals can be held liable under the doctrines of vicarious liability or direct liability for the conduct of their staffs.<sup>19</sup>

### IV. Concluding Remarks

Controversy over the effect that malpractice lawsuits are having on the delivery of health care have never risen in Canada to the levels that they have in the United States. Awards against physicians have, on a per capita basis, been much less frequent than in the United States and awards have generally been much smaller for similar injuries. There are a number of factors as

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<sup>15</sup> Nelligan O'Brien Payne LLP, *Aggravated and Punitive Damages* (2006), available at [http://www.nelligan.ca/e/pdf/Aggravated & Punitive%20 Damages.pdf](http://www.nelligan.ca/e/pdf/Aggravated%20Damages.pdf).

<sup>16</sup> Canadian Health Facilities Law Guide (C.C.H. Can.) ¶ 3815 (2009).

<sup>17</sup> Lapointe et al. v. Chevrette, 90 D.L.R. (4<sup>th</sup>) 7 (S.C.C. 1992).

<sup>18</sup> Canadian Health Facilities Law Guide, *supra* note 16, ¶¶ 4105-4150.

<sup>19</sup> *Id.* ¶ 4151.

to why this is the case. Proving negligence can be harder, the CMPA defends malpractice lawsuits very vigorously, there is a flexible cap on non-pecuniary losses, and punitive damages are seldom awarded. Nevertheless, there is a growing body of case law respecting medical malpractice that demonstrates a tendency of the courts and juries to be somewhat more open to claims that a physician should be held liable for committing an act of negligence that causes injury to a person to whom he or she owes a duty of care.

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**ENGLAND AND WALES**  
**CLINICAL NEGLIGENCE: LEGAL ISSUES**

*Executive Summary*

*Medical liability for staff employed by the National Health Service (NHS) in England is addressed through the tort principle of vicarious liability. Where claims for negligence of employees of the NHS arise a program known as the Clinical Negligence Scheme for Trusts addresses these issues. The program is funded through contributions by NHS Trusts that are members and operates on a “pay-as-you-go” basis, funding claims out of the monies it raises. The NHS Litigation Authority administers this program.*

## **I. Introduction**

This report addresses how the National Health Service (NHS) in England and Wales manages clinical negligence issues. The NHS was founded in 1948 with the aim of providing free health care at the point of use. It has achieved that aim and for the past sixty years has provided health care at no cost for UK residents, with the exception of small charges for prescriptions, dental care, and optical services.<sup>1</sup> It is currently operating on an annual budget of £90 billion (approximately US\$144 billion), and employs more than 1.5 million people. In the country of England alone, the NHS serves more than 50 million people and caters to 463 people per minute.<sup>2</sup> The NHS is funded solely through taxpayer contributions and costs approximately £1,500 per person in the UK.<sup>3</sup>

## **II. NHS Indemnity**

The focus of medical liability in England and Wales is under the law of tort, specifically negligence.<sup>4</sup> It is general practice in cases of clinical negligence that National Health Service

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<sup>1</sup> National Health Service, *About the NHS*, 2009, <http://www.nhs.uk/NHSEngland/aboutnhs/Pages/About.aspx>.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> Tort is “a well established cause of action and ... plays a major part in the arena of healthcare laws. This is mainly due to the fact that as a general principle, there is no contractual relationship between doctor and patient except where the patient seeks treatment privately.” PETER DE CRUZ, *COMPARATIVE HEALTHCARE LAW* 234 (2001), *referring to* *Pfizer Corp. v. Ministry of Health* [1965] AC 512 (HL). There are numerous legal issues that arise during a tort claim, and these are not addressed in this report. Rather, it focuses on the systems that administer medical liability claims.

Trusts and Health Authorities are the bodies that are sued, rather than individual clinicians.<sup>5</sup> Under this practice, NHS Trusts and Health Authorities are vicariously liable for the negligent acts and omissions of their employees – including doctors, nurses, and clinicians. This liability arises from the duty of care that the NHS Trusts owe to their patients.<sup>6</sup> This application of vicarious liability has resulted in a government policy<sup>7</sup> known as NHS indemnification, which arises when an employee of the NHS<sup>8</sup> in the course of their work, is responsible for a negligent act or omission (commonly referred to as “clinical negligence”)<sup>9</sup> that results in harm to an NHS patient or volunteer.<sup>10</sup>

The NHS has provided guidance stating that when it is vicariously liable for the negligent healthcare professional it should “accept full financial liability where negligent harm has occurred, and not seek to recover costs from the healthcare professional involved.”<sup>11</sup> When negligence is alleged, the NHS is responsible for meeting the “legal and administrative costs of defending the claim or, if appropriate, of reaching a settlement; the plaintiff’s costs, as agreed by the two parties or as awarded by the court; [and] the damages awarded either as a one-off payment or as a structured settlement.”<sup>12</sup>

NHS indemnity covers only the financial consequences of a clinical negligence program, not complaints, or disciplinary or regulatory hearings,<sup>13</sup> and does not extend to General Practitioners (primary care physicians), “general dental practitioners, pharmacists or optometrists; other self-employed health care professionals (e.g., independent midwives); employees of private hospitals; local education authorities; or voluntary agencies.”<sup>14</sup> General

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<sup>5</sup> Department of Health, *NHS indemnity arrangements for handling clinical negligence claims against NHS staff* (hereafter *NHS indemnity arrangements*), HSG (96)48, 1996, [http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthserviceguidelines/DH\\_4018270](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthserviceguidelines/DH_4018270); and PETER DE CRUZ, *supra* note 4, at 234.

<sup>6</sup> NHS – Leeds Teaching Hospital, *Indemnity Arrangements*, [http://www.leedsth.nhs.uk/sites/research\\_and\\_development/indemnity.php#negligent](http://www.leedsth.nhs.uk/sites/research_and_development/indemnity.php#negligent) (last visited May 20, 2009).

<sup>7</sup> Department of Health, *Research in the NHS: indemnity arrangements*, 2005, Gateway Reference: 5957.

<sup>8</sup> Employees covered include: locums, medical academic staff with honorary contracts, students, those conducting clinical trials, charitable volunteers, and people undergoing further professional education, training, and examinations. *NHS indemnity arrangements*, *supra* note 2, at 3.

<sup>9</sup> “Clinical negligence” is defined as “a breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgments made by members of those professions acting in their professional capacity in the course of their employment, and which are admitted as negligent by the employer or are determined as such through the legal process.” *Id.*

<sup>10</sup> RICHARD WEST ET AL., *CLAIMS HANDLING LAW AND PRACTICE: A PRACTITIONERS GUIDE* ¶ 10.1.1 (2008).

<sup>11</sup> *NHS indemnity arrangements*, *supra* note 5, at 3.

<sup>12</sup> *Id.*

<sup>13</sup> *New Trainee Doctors Warned About Pitfalls Of Relying On NHS Indemnity Scheme*, UK, MEDICAL NEWS TODAY, July 18, 2008, <http://www.medicalnewstoday.com/articles/115372.php>.

<sup>14</sup> *NHS indemnity arrangements*, *supra* note 5, ¶ 9; Cambridge University Hospitals NHS Foundation Trust, *Guidance Note – NHS Indemnity* (2007), [www.cuh.org.uk/resources/word/research/guidance\\_note\\_NHS\\_Indemnity.doc](http://www.cuh.org.uk/resources/word/research/guidance_note_NHS_Indemnity.doc).

Practitioners typically belong to a medical defense society or union (discussed briefly below) that will provide advice and may undertake the defense and settlement of the case.<sup>15</sup>

### III. Clinical Negligence Program for Trusts

With the current operation of NHS indemnity, NHS Trusts, rather than the Department of Health, are expected to meet the costs of damages awarded against them. Given that damages awarded could reach millions of pounds, which would negatively affect the budget of these Trusts in providing healthcare to the population, a number of programs (known as “schemes” in England) were established to address claims for medical negligence.<sup>16</sup> The current program is the Clinical Negligence Scheme for Trusts, which was established to deal with claims made after April 1, 1995.<sup>17</sup> Claims prior to this date are addressed by the Existing Liabilities Scheme, which is centrally funded by the Department of Health.<sup>18</sup> These programs were created to streamline the management of claims and thus reduce legal costs.<sup>19</sup> The Clinical Negligence Scheme for Trusts is a voluntary risk pooling program,<sup>20</sup> and Trusts can opt into it and “pay a determined premium in order to achieve financial cover, as an insurance scheme.”<sup>21</sup> Discounts of up to 30 percent of the premium are available for NHS Trusts that take appropriate risk management steps.<sup>22</sup> The Department of Health recommends that NHS Trusts join this program,<sup>23</sup> and currently “all NHS trusts, Foundation trusts and Primary Care Trusts (PCTs) in England ... belong to the scheme.”<sup>24</sup>

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<sup>15</sup> PETER DE CRUZ, *supra* note 4, at 235.

<sup>16</sup> The basis for the creation of these programs is the National Health Service and Community Care Act 1990, c. 19 § 21.

<sup>17</sup> There are a number of other programs that continue in operation to provide coverage for clinical negligence claims prior to this date. As the Clinical Negligence Scheme for Trusts is currently the main program in operation, this report will focus on its operation. It was originally established by the National Health Service Act 1977, c. 49, as amended, and the NHS (Clinical Negligence Scheme) Regulations 1996, SI 1996/251, as amended. The National Health Service Act 1977, c. 49 was repealed by the National Health Service (Consequential Provisions) Act, 2006 c. 43; however, the regulations continue in force.

<sup>18</sup> NHS, THE NATIONAL HEALTH SERVICE LITIGATION AUTHORITY: REPORT AND ACCOUNTS 2008 (hereafter NHS REPORT AND ACCOUNTS 2008) at 9 (July 15, 2008), available at <http://www.nhsla.com/NR/rdonlyres/3F5DFA84-2463-468B-890C-42C0FC16D4D6/0/NHSLAAnnualReport2008.pdf>.

<sup>19</sup> RICHARD WEST ET AL., *supra* note 10, ¶ 10.13.

<sup>20</sup> The NHS Litigation Authority, *Factsheet 2: Financial Information* (2008), <http://www.nhsla.com/NR/rdonlyres/465D7ABD-239F-4273-A01E-C0CED557453D/0/NHSLAFactsheet2financialinformation200708.doc>.

<sup>21</sup> SHIRLEY JONES & ROSEMARY JENKINS, *THE LAW AND THE MIDWIFE* 103 (2d ed. 2004).

<sup>22</sup> NHS REPORT AND ACCOUNTS 2008, *supra* note 18.

<sup>23</sup> Department of Health, *supra* note 4.

<sup>24</sup> NHS REPORT AND ACCOUNTS 2008, *supra* note 18, at 9.

#### IV. NHS Litigation Authority

The Clinical Negligence Scheme for Trusts is administered by the NHS Litigation Authority, which was established amid concern of the rising cost of clinical negligence claims.<sup>25</sup> The Litigation Authority is a Special Health Authority, meaning that it is part of the NHS. It manages the legal side of claims through panel solicitors and is responsible for the payment of any damages or legal costs.<sup>26</sup>

The costs of any award of damages against the NHS are provided for out of each Trusts' budget, loans, or through the Clinical Negligence Scheme for Trusts. The Clinical Negligence Scheme for Trusts provides for the costs of meeting damages awarded under the program "through members contributions on a 'pay as you go' basis"<sup>27</sup> to minimize "the impact on cash available for patient care in any given financial period."<sup>28</sup>

The NHS Litigation Authority is required to operate within a budget set by the government (known as the Revenue Resource Limit) of £2,642.36 million (approximately US\$3,700.00 million) for financial year 2007-08. During this period, the Litigation Authority had a surplus of £3.13 million (approximately US\$4.3 million). Additionally, at the end of 2007-08 the Litigation Authority had a cash balance of £124.9 million (approximately US\$175 million). This cash is from contributions collected for the Clinical Negligence Scheme for Trusts that were not used for the 2007-08 period. The way that the Litigation Authority manages this program means that it is required to "take into account possible variations to planned expenditure for example where a case is concluded earlier than originally forecast by collecting sufficient contributions to cover eventualities which have an adverse impact on cash flow."<sup>29</sup> As a result of the cash balance, the Authority has reduced contributions to the program for 2008-09 "by making rebates to members and thus plans to collect some £70m [approximately US\$100 million] less than originally anticipated in the 2008/09 financial year."<sup>30</sup>

Part of the mandate of the NHS Litigation Authority is to avoid litigation, where possible. Its Framework Document notes that it aims to "maximise the resources available for patient care, by defending unjustified actions robustly [and] settling justified actions efficiently."<sup>31</sup> Furthermore, the Litigation Authority notes that it "encourage[s] NHS bodies to offer patients explanations and apologies."<sup>32</sup> We seek to avoid formal litigation as far as possible and our

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<sup>25</sup> SHIRLEY JONES & ROSEMARY JENKINS, *supra* note 21, at 102.

<sup>26</sup> RICHARD WEST ET AL., *supra* note 10, ¶ 10.1.1.

<sup>27</sup> NHS REPORT AND ACCOUNTS 2008, *supra* note 18, at 9.

<sup>28</sup> *Id.* at 34.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> The NHS Litigation Authority, *Framework Document* ¶ 2.2(i) (hereafter *Framework Document*), <http://www.nhs.uk/NR/rdonlyres/D872241A-43E3-492B-8F74-32FB0586608F/0/Frameworkdocument.pdf>.

<sup>32</sup> A circular issued by the NHS Litigation Authority notes that "We encourage [the use of apologies], and stress that apologies do not constitute an admission of liability. In addition, it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology.... [T]he NHS is keen to encourage both

historical data show that only about 4% of our cases go to court, including settlements made on behalf of minors, which must be approved by a court.”<sup>33</sup>

The mandate of the NHS Litigation Authority further requires it “to minimise the risk that patient care in a particular community is jeopardised by a large settlement against a local NHS body.”<sup>34</sup> It thus aims “to spread the costs of settlements more evenly over time”<sup>35</sup> through the use of periodical payments made to the claimant throughout their life, as it considers that this is the fairest method of settling the costs of personal injury claims when costs are significant.<sup>36</sup>

## V. Operation of the System

In 2007-08 the NHS Litigation Authority received 5,470 claims of clinical negligence against NHS bodies<sup>37</sup> and closed 6,679 claims.<sup>38</sup> During the same period, damages awarded to patients in connection with clinical negligence claims and legal costs paid by the NHS Litigation Authority amounted to £633.3 million (approximately US\$886 million).<sup>39</sup> The average time it took the NHS Litigation Authority to deal with a claim, either to the point of conclusion or discontinuation, was 1.46 years.<sup>40</sup> The policy of the NHS Litigation Authority in seeking to avoid litigation is demonstrated in the statistics of the cases that it has processed. It reports that 96 percent of cases it handled were settled “out of court through a variety of methods of ‘alternative dispute resolution’ ”<sup>41</sup> and that over the past ten years, from all clinical claims it handled, 41 percent were abandoned by the claimant; 41 percent settled out of court; 4 percent settled in court, with these being mainly court approvals of negotiated settlements; and 14 percent remain outstanding.<sup>42</sup> It notes that fewer than fifty clinical negligence cases a year are contested in court.<sup>43</sup>

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clinicians and NHS bodies to supply appropriate information whether informally, formally or through mediation .... We consider that the provision of such information constitutes good clinical and managerial practice.... This ... is intended to encourage scheme members and their employees to offer the earlier, more informal, apologies and explanations so desired by patients and their families.” NHS Litigation Authority, *Apologies and Explanations* (May 1, 2009), available at <http://www.nhsla.com/NR/rdonlyres/00F14BA6-0621-4A23-B885-FA18326FF745/0/ApologiesandExplanationsMay1st2009.pdf>.

<sup>33</sup> NHS REPORT AND ACCOUNTS 2008, *supra* note 18, at 9.

<sup>34</sup> *Framework Document*, *supra* note 31, ¶ 2.2 (iii-iv).

<sup>35</sup> *Id.*, ¶ 2.2 (iii-iv).

<sup>36</sup> NHS REPORT AND ACCOUNTS 2008, *supra* note 18, at 14. As of March 2008, periodical payments were made for 548 cases, totaling £900,775,621 (approximately US\$662,964,855).

<sup>37</sup> NHS Litigation Authority, *Factsheet 3: Information on Claims* at 1 (Nov. 2008), <http://www.nhsla.com/NR/rdonlyres/C1B3F310-E13D-4C71-B248-C5384438E603/0/NHSLAFactsheetclaimsinformation200708.doc>.

<sup>38</sup> NHS REPORT AND ACCOUNTS 2008, *supra* note 18, at 14.

<sup>39</sup> *Id.*

<sup>40</sup> NHS Litigation Authority, *About the NHS Litigation Authority*, <http://www.nhsla.com/home.htm> (last visited May 2009).

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

## VI. Indemnity Through Medical Defense Organizations

As noted above, certain clinicians that are not considered to be employed by the NHS are not indemnified by the NHS. These individuals typically obtain indemnity through a medical defense organization, such as the Medical Defence Union or the Medical Protection Society, or, in certain instances, insurance obtained on the open market.<sup>44</sup> The indemnity provided by some of the medical defense organizations is “discretionary indemnity,” meaning that the individual has only the right to request assistance and that the organization makes the decision whether to indemnify the medical practitioner, a decision that can only be made when it is presented with the facts of the case.

## VII. NHS Redress

The government has legislated for a new program to come into operation to redress instances of clinical negligence.<sup>45</sup> The technicalities of this program have yet to be determined, but it initially appears that it will be limited to claims of under £20,000 (approximately US\$28,000). The legislation granting the Secretary of State for Health the authority to establish this program requires that it must, in addition to providing for offers of compensation, include provisions that necessitate the giving of an explanation, an apology, and a report “on the action which has been, or will be, taken to prevent similar cases arising.”<sup>46</sup> The aim of introducing this additional program is not only to reduce litigation costs, but also to address concerns that the older program is:

- Complex and slow;
- Costly both in terms of legal fees and diverting clinical staff from clinical care;
- Negatively affecting NHS staff morale and public confidence;
- Dissatisfying patients with the lack of explanations and apologies or reassurance that action has been taken to prevent the same incident happening to another patient; and
- Encourages defensiveness and secrecy in the NHS, which stands in the way of learning and improvement in the health service.<sup>47</sup>

Regulations implementing the program have yet to be issued; thus, as of May 2009 it is not in force.

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<sup>44</sup> RICHARD WEST ET AL., *supra* note 10, ¶ 10.1.1.

<sup>45</sup> The enabling legislation for this program is the NHS Redress Act 2006, c. 44.

<sup>46</sup> *Id.* § 3(2).

<sup>47</sup> Department of Health, *NHS Redress: Statement of Policy* ¶ 7 (2008).

## LAW LIBRARY OF CONGRESS

### GERMANY

#### MEDICAL LIABILITY IN A UNIVERSAL HEALTH CARE SYSTEM

##### *Executive Summary*

*Medical malpractice claims are mostly settled with the liability insurers, often after mediation services of the medical associations or the social health insurers have given expert opinions. Only 8 percent of medical malpractice cases are litigated.*

*The causes of liability for medical malpractice under German law are similar to those encountered under the laws in the United States. German damage awards, however, are still much lower than those awarded in the United States, even though the German awards have increased in recent years. At the same time, there has been an increase in medical malpractice claims in Germany to about 40,000 claims per year, out of a population of 82.5 million.*

*German awards for tangible damages are low, because most of the losses resulting from a personal injury are borne by the social security system. Treatment and care is provided by the health insurers, and disability pensions by the pension insurers. These insurers, however, may recover the expenses attributable to the injury through the statutory subrogation of the plaintiff's claim.*

*German awards for pain and suffering are low because of several features of the legal system: there are no juries in civil cases and a plaintiff who claims a higher award than the court adjudicates must bear part of the litigation cost. Moreover, in determining damages for pain and suffering, the judges are guided by standardized tables that compile the going rates for various types of injuries.*

*Damages for pain and suffering have been increasing slowly under this system. The highest recent awards have been in the vicinity of €500,000 (U.S.\$650,000), and these have been awarded for severe physical and mental disabilities resulting from medical malpractice at birth. For lesser injuries, such as the loss of an eye or a limb, awards have stagnated at below €40,000 (U.S.\$52,000) during the last two decades.*

## I. The German Health Care System

The German health care system provides universal access and coverage for the entire population. It is, however, a decentralized and diversified system that consists of more than 200 insurers that compete with each other to some extent.<sup>1</sup> These insurers are corporations with a public law status and they govern themselves, albeit within the limits of a statutory framework,<sup>2</sup> and under the oversight of a federal agency.<sup>3</sup> Some 90 percent of the population is covered by the statutory health insurance scheme (the German term for the social health insurance system). Yet Germany allows high income earners to opt out of the statutory system and to be privately insured, an option that close to 10 percent of the population exercises.<sup>4</sup>

On the side of the health care providers, there is also much diversity and decentralization. Health care is provided by hospitals (and this includes treatment by physicians within hospitals) and by private practice physicians. Hospitals may be owned by various entities, both private and public. Both private physicians and hospitals conclude agreements to become service providers for statutory health insurance schemes and these agreements are negotiated between the head associations of the health care providers and the head associations of the health insurers.

German physicians are regulated primarily by state law. They form medical associations at the state level, and these state associations are affiliated with a Federal Medical Association.<sup>5</sup> The medical associations are self-governing bodies. They shape the responsibilities of the medical profession in many ways, among them, by defining standards of care for medical treatments.

## II. German Medical Malpractice Law

### A. Bases of Liability

Although Germany is a civil law country, the concepts of medical malpractice law are not very different from those encountered in the United States. German medical malpractice law is

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<sup>1</sup> For a description of the German health care system, see U. Weide, *Health Care Reform and the Changing Standard of Care in the United States and Germany*, 20 N.Y. L. SCH. J. INT'L L. 249 (2000).

<sup>2</sup> Statutory health insurance is funded through employer/employee contributions. The terms of coverage and the benefits to be provided are governed by Title 5 of the Social Code, i.e., Sozialgesetzbuch Fünftes Buch [SGB V] Dec. 20, 1988, BUNDESGESETZBLATT [BGBl, official law gazette of Germany] I at 2477, art. 1, as amended. Currently employers and employees together pay a contribution of 15.5 percent of the wage. The insurers, however, have some leeway in determining benefit levels. See *15,5% Beitragssatz – bleibt es dabei?*, KRANKENKASSENINFO.DE, <http://www.krankenkasseninfo.de/zusatzbeitrag-krankenkassen.php> (last visited June 1, 2009).

<sup>3</sup> The oversight agency is the Bundesversicherungsamt, see its website, <http://www.bva.de/>.

<sup>4</sup> Mitgliederzuwachs bei den privaten Krankenversicherung weiter rückläufig (Mar. 31, 2007), <http://www.pkv-financial.de/wblog/2007/03/31/mitgliederzuwachs-bei-den-privaten-krankenversicherungen-weiter-ruecklaeufig/>.

<sup>5</sup> The federal medical association is the Bundesärztekammer; see its website, <http://www.bundesaerztekammer.de/>.

based on the Civil Code provisions on liability arising from contracts<sup>6</sup> and torts,<sup>7</sup> yet the various causes of liability that can arise within the context of medical treatment have been developed by case law.<sup>8</sup> The most common causes of liability are defective treatment, wrong diagnosis, wrong medication, lack of disclosure, and unauthorized treatment.<sup>9</sup>

Damages in medical malpractice cases are awarded on the basis of the Civil Code provision on indemnity for losses suffered.<sup>10</sup> Damages are entirely compensatory; punitive damages are not awarded in Germany. Even though restitution is the primary mode envisioned by the Civil Code for “making a plaintiff whole,” monetary damages can be claimed instead, and both forms of indemnification are common in medical malpractice cases.<sup>11</sup>

The cost of treatment, rehabilitation, mitigation of the consequences of permanent damage, and long-term care can be awarded in medical malpractice cases and in personal injury cases in general.<sup>12</sup> In addition, earnings losses are compensated,<sup>13</sup> and damages for pain and suffering are awarded.<sup>14</sup> Since a major law reform in 2002, damages for pain and suffering are awarded irrespective of whether liability is based on contracts or torts,<sup>15</sup> and this change in the law has increased the number of medical malpractice cases for which damages for pain and suffering can be awarded.<sup>16</sup>

## B. The Influence of the Social Security System on Damage Awards

Due to the extensive safety net provided by the German social security system, a German personal injury victim has fewer out of pocket losses than his American counterpart. The benefits that mitigate the losses of the German victim include health care as provided by the social or private insurer, unlimited paid sick leave as provided either by the employer or the health insurer, generous disability pensions from the social pension insurance scheme, and, if applicable, welfare benefits.<sup>17</sup> This social net has a mitigating effect on damage awards<sup>18</sup> even

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<sup>6</sup> Bürgerliches Gesetzbuch [BGB], repromulgated Jan. 2, 2002, BGBI I at 42, as amended, § 280.

<sup>7</sup> BGB, § 823.

<sup>8</sup> M. QUAAS & R. ZUCK, *MEDIZINRECHT* 284 (München, 2008).

<sup>9</sup> E. DEUTSCH & A. SPICKHOFF, *MEDIZINRECHT* 129-35 (Berlin, 2008).

<sup>10</sup> BGB, § 249.

<sup>11</sup> M. Tamm, *Der Haftungsumfang bei ärztlichem Fehlverhalten und Rechtsdurchsetzungsfragen im Arzthaftungsrecht*, *JURA* 81 (2009).

<sup>12</sup> O. PALANDT, *BÜRGERLICHES GESETZBUCH* § 249, notes 8, 10.

<sup>13</sup> BGB, § 252.

<sup>14</sup> BGB, § 253.

<sup>15</sup> Gesetz zur Modernisierung des Schuldrechts, Nov. 26, 2001, BGBI I 3138, effective date Jan. 2, 2002; M. Gehrlein, *Neuere Rechtsprechung zur Arzt-Berufshaftung*, *VERSICHERUNGSRECHT* [VERS] 1488 (2004).

<sup>16</sup> H. Strücker-Pitz, *Ausweitung der Arzthaftung für Schmerzensgeld bei Schwerstschäden*, *VERS* 1466 (2007).

<sup>17</sup> W. PFENNIGSTORF, *PERSONAL INJURY COMPENSATION* 65 (London, 1993).

though the social insurers can seek recourse against the tortfeasor or the contractually liable party, by exercising the statutory right of subrogation to the claim of the victim.<sup>19</sup>

The damage-lowering effect of this social safety net is twofold. First, medical expenses that are incurred through treatment provided through a social health insurer are more standardized than those that might incur in a private setting, and private medical treatment will not be reimbursed, unless it is medically indicated.<sup>20</sup> Second, a German personal injury victim may have less reason to pursue a claim than his American counterpart, because the German victim has few, if any, out-of-pocket losses.

### C. Damages for Pain and Suffering

Due to the usual absence of significant tangible losses, a German victim of personal injury will make a medical malpractice claim primarily to obtain damages for pain and suffering. The German awards, however, are very low by American standards, even though in recent years German damage awards have increased for the most serious of injuries.<sup>21</sup> In the last six years, pain and suffering awards for severe physical and mental disabilities caused by defective treatment at birth have increased from €250,000 (U.S.\$325,000) to €500,000 (U.S.\$650,000).<sup>22</sup>

For lesser injuries, however, the awards for pain and suffering have stagnated over the last two decades by amounting, for instance, to no more than €20,000 (U.S.\$26,000) for the loss of a limb, and to no more than €40,000 (U.S.\$52,000) for the loss of an eye.<sup>23</sup> German attorneys argue that German damages for pain and suffering are still too low, and they attribute this stagnation to the low number of pain and suffering awards made by the courts. Only 8 percent of the malpractice cases are litigated and only these cases can lead to a further development of the law.<sup>24</sup>

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<sup>18</sup> *Id.*; see also R. Rollo, Note, *Products Liability: WHY THE EUROPEAN UNION DOESN'T NEED THE RESTATEMENT (THIRD)*, 69 BROOKLYN L. REV. 1073 (2004).

<sup>19</sup> Zehntes Buch Sozialgesetzbuch, repromulgated Jan. 18, 2001, BGBI I at 130, as amended, § 116. The private health insurers have the same statutory right. See *Versicherungsvertragsgesetz*, Nov. 23, 2007, BGBI I at 2631, as amended, § 86.

<sup>20</sup> PALANDT, *supra* note 12, § 249, note 8.

<sup>21</sup> *Id.* The increase in damage awards in Germany is also indicated by the liability insurance coverage that is recommended to physicians. Whereas in the 1980s a physician should have carried a coverage of between 1 and 2.5 million Deutsche Mark (1 Deutsche Mark was then valued at U.S.\$0.50), it is now recommended that, depending on the specialty, physicians should carry insurance coverage of between 1 and 5 million Euro. DEUTSCH & SPICKHOFF, *supra* note 9, at 105.

<sup>22</sup> W. Wurmnest, *Recognition and Enforcement of U.S. Money Judgments in Germany*, 23 BERKELEY J. INT'L L. 175 (2005); Strücker-Pitz, *supra* note 16.

<sup>23</sup> H. Ziegler & M. Ehl, *Bein ab – arm dran. Eine Lanze für höhere Schmerzensgelder in Deutschland*, JURISTISCHE RUNDschau 1 (2009).

<sup>24</sup> *Id.*

#### D. Procedural Reasons for the Low Pain and Suffering Awards

The main reasons for the low awards for pain and suffering in Germany are procedural. In German civil proceedings there are no juries or other forms of lay participation. The cases are decided by professional judges and, even though Germany has no *stare decisis* doctrine, damages for pain and suffering are often awarded according to precedent, even though each case is supposed to be adjudged according to its merits. Commercial publishers compile tables of damage awards for pain and suffering for various injuries, and the judges use these as guideposts.<sup>25</sup>

The plaintiffs and their attorneys also study the pain and suffering award tables, so as to avoid being ordered to pay part of the trial costs. In Germany, the cost of litigation in civil cases is borne by the losing party, who has to pay not only the court costs but also the attorney costs and other necessary expenditures of the winning party.<sup>26</sup> If, however, the winning party makes a higher monetary claim than is awarded, the victory is deemed to be a partial one<sup>27</sup> and the costs are split in proportion to the non-awarded claim.<sup>28</sup> If a plaintiff asks for slightly more than has been awarded, no cost penalty attaches, because the partial loss is classified as minimal.<sup>29</sup> If, on the other hand, the plaintiff asks for twice the amount awarded, he will have to split the costs with the losing party.

### III. The Disposition of Medical Malpractice Claims

#### A. The Process

A victim of medical malpractice is most likely to start the process of claiming damages with the liability insurer of the physician or hospital. If the victim cannot obtain satisfaction at this level,<sup>30</sup> he may go to court or use the services of a mediation center. The latter path has the advantage of being free of charge,<sup>31</sup> whereas in litigation the plaintiff bears the risk of being ordered to pay the costs if he loses, and these consist of court fees, the costs of the winning party, and the fees of his own attorney. Contingency fees are not permitted in Germany.<sup>32</sup>

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<sup>25</sup> A. SLIZYK, *BECK'SCHE SCHMERZENGELD-TABELLE* (München, 2006). The same publisher, Beck-Verlag, also provides an online database of the most recent pain and suffering awards, <http://beck-online.beck.de/default.aspx?modid=79>.

<sup>26</sup> Zivilprozessordnung [ZPO], repromulgated Dec. 5, 2005, BGBl I at 3202, as amended, § 91.

<sup>27</sup> ZPO § 92

<sup>28</sup> H. MUSIELAK, *ZIVILPROZESSORDNUNG KOMMENTAR*, § 92, note 2 (München, 2005).

<sup>29</sup> ZPO § 92.

<sup>30</sup> AXA Winterthur, a major liability insurer, reported for 2005 that 53 percent of the medical malpractice claims made were rejected as unfounded. See P. Weidinger, *Aus der Praxis der Haftpflichtversicherung für Ärzte und Krankenhäuser*, *MEDIZINRECHT* 571 (2006).

<sup>31</sup> C. Katzenmeier, *Aussergerichtliche Streitbeilegung in Arzthftungssachen*, *ANWALTSBLATT* 319 (2008).

<sup>32</sup> S. Butler, *Models of Modern Corporations: A Comparison Analysis of German and U.S. Corporate Structures*, 17 *ARIZ. J. INT'L & COMP. LAW* 555, 601 (2000).

If the mediation center is of the opinion that there is an injury for which the health practitioner is liable, the victim may again approach the liability insurer. In 85 percent of such cases, a settlement will be achieved on the basis of the opinion of the mediation center. In 15 percent of such cases, the plaintiff will go to court, where, most commonly, the court will rule as indicated by the mediation center.<sup>33</sup> Under this German practice, most medical liability claims are settled out of court, either immediately or after a mediation center has given its opinion.<sup>34</sup>

The mediation centers are operated by the state medical associations, yet they are independent organizations that enjoy much respect for their independent judgment. The centers are staffed by lawyers and physicians, and evaluations are often carried out on a pro bono basis by volunteering physicians.<sup>35</sup> In addition to advising plaintiffs on their claim, they also compile statistics on the claims brought to their attention and these are consolidated annually by the Federal Medical Association. The main purpose of these statistics is medical, to avoid errors in the future.<sup>36</sup>

The social health insurers also provide consultative services for the insured, as required by law.<sup>37</sup> These institutions also provide evaluations in medical malpractice cases. The service centers are organized at the state level.<sup>38</sup>

## B. Statistics

There are no official statistics on the incidence of medical malpractice or its cost, and the figures that have been randomly provided by the various stakeholders on the number of claims and their disposition are not always in agreement. There are no statistics on the size of damage awards, except for the above-described tables on damages for pain and suffering that were awarded in court proceedings.<sup>39</sup>

There is much disagreement on the incidence of medical malpractice. Consumer advocacy organizations have stated that medical malpractice is committed in 400,000 cases, or even 650,000 cases per year.<sup>40</sup> According to estimates made by a medical mediation center,

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<sup>33</sup> Tamm, *supra* note 11.

<sup>34</sup> Weidinger, *supra* note 30.

<sup>35</sup> Katzenmeier, *supra* note 31.

<sup>36</sup> Press Release, Bundesärztekammer, Statistische Erhebungen der Gutachterkommissionen und Schlichtungsstellen für das Statistikjahr 2007 (Berlin, 2008), available at <http://www.bundesaerztekammer.de/page.asp?his=2.59.5301.5961&all=true> (last visited May 26, 2009); M. Merten, *Den Ursachen auf der Spur*, DEUTSCHES ÄRZTEBLATT A1140 (2007).

<sup>37</sup> SGB V § 66.

<sup>38</sup> D. Psathakis et al., *Die Rolle des MDK bei Beratung und Prüfung vorgeworfener ärztlicher Behandlungs- und Pflegefehler*, ANWALT/ANWÄLTIN IM SOZIALRECHT 79 (2008).

<sup>39</sup> SLIZYK, *supra* note 25, and accompanying text.

<sup>40</sup> Weidinger, *supra* note 30, at 571.

some 130,000 malpractice incidents occur in German hospitals and clinics per year.<sup>41</sup> The number of claims submitted to the liability insurers has been estimated as amounting to 40,000 per year.<sup>42</sup> Germany has a population of 82.5 million inhabitants.<sup>43</sup>

On the disposition of medical malpractice claim, there is agreement between the insurers and the mediation centers that about one half of the cases are not justified and are therefore rejected.<sup>44</sup> There also appears to be agreement that not more than 8 percent of the claims are litigated, whereas 92 percent of the cases are settled by the liability insurers.<sup>45</sup> On the outcome of litigation, however, there is much disparity between liability insurers and trial attorneys. Whereas the former state that the plaintiff wins only in 6 percent of the litigated cases,<sup>46</sup> a trial attorney stated in 2008 that the plaintiff wins in 50 percent of the law suits brought against private practitioners and in one-third of the lawsuits brought against hospitals.<sup>47</sup>

#### IV. Concluding Remarks

Although Germany has experienced an increase in medical malpractice claims in recent years and also an increase in damages for pain and suffering for very serious injuries, liability for medical malpractice generally leads to very moderate damage awards. The main reason for this state of affairs is the extensive safety net of German social law that covers medical expenses and the loss of earnings of the victim. Other contributing factors to the predictably low damage awards are the absence of juries in civil cases and the liability for litigation costs that are imposed on the losing party and on a party that claims more than is awarded.

Most of the medical malpractice claims are settled by the liability insurers and the low incidence of litigation is attributable to the role of the mediation centers of the medical associations and the consultative services of the social health insurers. These highly respected institutions evaluate claims and make it easier for claimants and liability insurers to reach agreement on a suitable settlement.

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<sup>41</sup> *Krankenhaus-Statistik Jährlich 130.000 Behandlungsfehler*, STERN-DE, Nov. 15, 2007, <http://www.stern.de/wissenschaft/medizin/:Krankenhaus-Statistik-J%EA4hrlich-130.000-Behandlungsfehler-Kliniken-/602683.html> (last visited May 28, 2009).

<sup>42</sup> K. Bergmann, *Jede zweite Klage gegen Ärzte hat Erfolg*, FRANKFURTER ALLGEMEINE ZEITUNG FAZ, Nov. 15, 2008, at C2; Weidinger, *supra* note 30.

<sup>43</sup> WHITACKER'S ALMANACK 2008 at 845 (London, 2007).

<sup>44</sup> DBV Winterthur Versicherungen, *Ärztliche Behandlungsfehler: Mehr als die Hälfte aller Vorwürfe unberechtigt*, Apr. 23, 2006, <http://www.pressecho.de/wirtschaft/3730813832.htm> (last visited May 27, 2008); Merten, *supra* note 36.

<sup>45</sup> Weidinger, *supra* note 30; Ziegler & Ehl, *supra* note 23.

<sup>46</sup> Weidinger, *supra* note 30.

<sup>47</sup> Bergmann, *supra* note 42.

# LAW LIBRARY OF CONGRESS

## INDIA

### MEDICAL MALPRACTICE LIABILITY

#### *Executive Summary*

*The Consumer Protection Act, 1986, provides protection of the interests of consumers. The Act brings within its ambit the services of the medical profession and treats patients as consumers of such services. For expeditious disposal of complaints of negligence or deficiency in service, a consumer may file a complaint in a District Forum for recovery of damages. Appeals from the District Forum may be filed before the State Commission and then before the National Commission. Decisions of the latter are appealable to the Supreme Court.*

#### **I. The Indian Health Care System**

The health care system in India combines private and public providers, who establish partnerships of varied forms to deliver medical services. Public sector health care is divided between federal, state, municipal, and local governments. It is financed through general tax revenues, community financing, out-of-pocket payments, and social and private insurance schemes. In both the public and private sectors, patients are treated as consumers of medical services and the law provides them with consumer protection rights.

#### **II. The Consumer Protection Act, 1986<sup>1</sup>**

The Consumer Protection Act (the Act) seeks to better protect the interests of consumers and for that purpose, establishes consumer councils and other authorities for the settlement of consumer disputes. In addition to providing protection against defective goods sold in the market, the Act protects consumers against deficient or negligent services provided by physicians. The services of the medical profession became subject to adjudication for damages under the consumer protection law in 1995,<sup>2</sup> when the court ruled that the services provided to a patient by a physician are also contractual and not merely of a personal nature.

The Act establishes consumer councils at the national, state, and district levels. The objective of the council is to promote and protect the rights of the consumers.<sup>3</sup> The Act establishes Consumer Dispute Redressal Agencies at the national, state and district levels for the

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<sup>1</sup>The Consumer Protection Act, No. 68 of 1986.

<sup>2</sup> Indian Medical Association v. V.P. Shantha, A.I.R. 1996 S.C. 550.

<sup>3</sup> The Consumer Protection Act, No. 68 of 1986, §§ 4-8B.

adjudication of consumer disputes.<sup>4</sup> The pecuniary jurisdiction of a district forum is limited to two million Indian rupees (approximately US\$40,000), while that of a state commission may not exceed ten million Indian rupees (approximately US\$210,549). The district forum consists of a person who is qualified to be a District Judge, and two other members.

Complaints for redress of a grievance against the supply of defective goods or the negligent service of a professional may be filed at the district level. Any person aggrieved by a decision of the district forum may appeal its decision within a period of thirty days to the State Commission.<sup>5</sup> The State Commission must consist of at least three members, one of whom is or has been a Judge of a High Court. Decisions of the State Commission are appealable to the National Commission.<sup>6</sup>

The National Commission must consist of at least five members, one of whom must have been a Judge of the Supreme Court, and at least one member must be a woman. In addition to its jurisdiction as an appellate forum from decisions of a state commission, the National Commission has original jurisdiction where the claimed amount exceeds ten million Indian rupees (approximately US\$210,549). Appeals of decisions of the National Commission are made to the Supreme Court of India.<sup>7</sup>

After the expiration of the period for filing an appeal, the decision of any forum or commission, if no appeal is filed, is final. Each forum or commission, notwithstanding the provisions of the Code of Criminal Procedure, 1973, exercises the powers of a Judicial Magistrate of the First Class for the trial of offenses under this Act. The provisions of the 1986 Act are in addition to and not in derogation of any other law for the time being in force.<sup>8</sup>

### III. Alternate Remedies

#### A. Law of Torts

The law of torts takes over where the protection of the Consumer Protection Act ends. Resort to the law of torts enables recovery, and provides a remedy even where a physician provides free service. Therefore, where the services offered by the doctor or hospital do not fall within the ambit of “service” as defined in the Act, patients may rely on the law relating to negligence under the law of torts and successfully claim compensation.

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<sup>4</sup> *Id.* §§ 9-10.

<sup>5</sup> *Id.* § 15.

<sup>6</sup> *Id.* § 19.

<sup>7</sup> *Id.* § 23.

<sup>8</sup> *Id.* § 3.

## **B. Criminal Liability**

A criminal complaint may be filed against a physician alleging commission of rash and negligent acts causing death.<sup>9</sup> The burden of proof is on the patient is to prove that the physician was grossly negligent.

## **IV. Conclusion**

In the very nature of the profession, physicians are vulnerable to liability under civil and criminal law. The consumer law in India enables patients to obtain a quicker recovery of damages than traditional tort law, as the action under a civil lawsuit is lengthy and time-consuming. Moreover, the provisions of the consumer protection law are in addition to and not in derogation of other laws.

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<sup>9</sup> The Indian Penal Code, Act 45 of 1860, § 304A, Suresh Gupta v. Govt. of NCT of Delhi, 2004 (6) SCC 422.