Chicago-Kent Law Review

Volume 86
Issue 3 *Symposium on Medical Malpractice and
Compensation in Global Perspective: Part I*

Article 3

June 2011

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Recommended Citation

Bernhard A. Koch, *Medical Malpractice in Austria*, 86 Chi.-Kent L. Rev. 1027 (2011).
Available at: <https://scholarship.kentlaw.iit.edu/cklawreview/vol86/iss3/3>

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MEDICAL MALPRACTICE IN AUSTRIA

BERNHARD A. KOCH*

INTRODUCTION

Austria is a federal republic. While the judiciary is an exclusive federal power without the competence to create law like in a common law jurisdiction, the legislative and executive powers are shared between the federation and the nine provinces (*Länder*), though with a strong emphasis on the former. Public health, for example, is within the exclusive legislative and executive competence of the federation, whereas only principles of the laws governing hospitals and other healthcare institutions are a federal power, with implementing legislation and execution remaining the business of the *Länder*.

In 2007, Austria spent 10.3% of its GDP on health (as compared to 15.7% in the US).¹ Of this, 76.4% was public spending (compared to 45.5% in the US).² Per 1,000 inhabitants, Austria had 4.53 practicing physicians (2.43 in the US) and 7.8 hospital beds (3.1 in the US).³ There were 6.8 doctor consultations per capita (4.0 in the US).⁴

While there are both public and private healthcare institutions in Austria, the distinction is not easy to make because it depends upon a combination of factors such as ownership and status. There are, for example, privately owned hospitals with public law status as well as provincial or municipal hospitals without. For purposes of this article, the distinction does not matter, however, as both public and private providers are subject to the same rules on medical liability.

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1. Organisation for Economic Co-operation and Development (OECD), *OECD Health Data 2010 – Frequently Requested Data*, INSTITUT DE RECHERCHÉ ET DOCUMENTATION EN ÉCONOMIE DE LA SANTÉ (Oct. 2010), http://www.irdes.fr/EcoSante/DownLoad/OECDHealthData_FrequentlyRequestedData.xls.

2. *Id.*

3. *Id.*

4. *Id.*

I. THE INSURANCE FRAMEWORK

A. *Social Insurance in Austria*

Ninety-nine percent of all Austrians are currently covered by social health insurance.⁵ While offered by several providers, the insured cannot choose among them, but are assigned to one or more of them by law according to their professional status and other characteristics. The system is financed by contributions from the insured and, if applicable, their employers (totaling around eighty percent of the social insurance system's income) but also by the state via general tax monies (thirteen percent in 2009).⁶

Social health insurance provides coverage for most medical needs, including primary health care services, specialized in-patient and outpatient care, emergency care, maternity services, psychotherapy, physiotherapy and other curative therapies, dental services, prescription medicines, medical devices, ambulance services, etc.⁷

Most of this coverage is paid for directly by the social insurance carrier by way of a contract with the respective healthcare provider, so the patients primarily receive benefits in kind. They are free to choose their doctors, including specialists without prior consultation of a general practitioner, so they may also select a doctor or hospital who is not a party to an agreement with the social insurance carrier. In the latter case, however, will patients pay the healthcare provider directly, but they are still eligible for at least partial reimbursement from their social insurance carrier.

Social health insurance benefits are granted irrespective of the cause triggering the need for treatment, and therefore, include cases of bodily harm tortiously inflicted by a third person such as a medical professional. In such cases, the victim's tort law claims are assigned by law to the competent social insurance provider, which thereby acquires a right of recourse. Unfortunately, the extent to which such rights are actually being pursued is not published; however, it seems that the frequency is on the rise.

5. DIE ÖSTERREICHISCHE SOZIALVERSICHERUNG IN ZAHLEN [THE AUSTRIAN SOCIAL INSURANCE BY THE NUMBERS] 9, 13 (Hauptverband der österreichischen Sozialversicherungsträger ed., 25th ed. 2010), http://www.hauptverband.at/mediaDB/703989_Sozialversicherung_in_Zahlen_25_Ausgabe_August_2010.pdf.

6. *Id.* On the Austrian social security system, see Wolfgang Holzer, The Interaction of Tort Law and Social Security under Austrian Law, in *TORT LAW AND SOCIAL LAW* 7 (Ulrich Magnus ed., 2003).

7. See *The Austrian Health Care System*, BUNDESMINISTERIUM FÜR GESUNDHEIT [FEDERAL MINISTRY FOR HEALTH], 10 (June 2010), http://www.bmg.gv.at/home/EN/Topics/The_Austrian_Health_Care_System.

In a medical malpractice scenario, the injured patient will therefore receive treatment as well as other support from her social health insurance provider, which in most cases will already have covered the initial treatment when something went wrong.

B. The Role of Private Insurance

1. First-Party Insurance

While social health insurance already covers all costs of primary and secondary treatment, around thirty-three percent of all Austrians still decide to buy some form of private health insurance.⁸ Depending upon the type and scope of policy, the added benefits of private insurance can include, for example, more pleasant conditions during a hospital stay, such as a single or double room. Private health insurance may also cover, for example, the excess costs of a doctor who is not contractually linked with a social insurance provider and who charges more than what the latter would refund to its insured.⁹

To the extent that a private insurer has paid compensation to a beneficiary, the latter's liability claims against third parties are subrogated by law to the insurer, which shifts the role of the active party, including medical malpractice cases, from the immediate victim to her insurer.

2. Liability Insurance

Since 2010, all practicing doctors are required to take out liability insurance with a minimum coverage of € 2 million.¹⁰ Some doctors have already in the past entered into framework contracts with a commercial insurer, as have some professional organizations of specialists. Most insurers offer policies with such coverage, with premiums calculated according to the area of expertise (with plastic surgeons, gynecologists, radiologists,

8. *Jahresbericht 2008 [Annual Report 2008]*, VERSICHERUNGSVERBAND ÖSTERREICH [INSURANCE ASSOCIATION OF AUSTRIA], 133 (2009), <http://www.vvo.at/jahresbericht-zahlen-und-daten/257.html>.

9. Typical policies would therefore cover either singularly or in combination such items as temporary disability, additional hospital expenses, hospital daily benefits, outpatient and dental treatment expenses beyond those covered by social insurance. Cf. *Types of Health Insurance Contract*, VERSICHERUNGSVERBAND ÖSTERREICH, http://www.vvo.at/index.php?option=com_content&task=view&id=277&Itemid=275&lang=en (last visited Apr. 25, 2011).

10. Hospital staff are typically (but not necessarily) covered by their institution's insurance policy.

and anesthetists in the most expensive group) and professional status (trainee, general practitioner, specialist).¹¹

II. THE REGULATORY FRAMEWORK

A. Professional Law

All doctors are mandatory members of a so-called medical chamber in their respective province (*Landesärztekammer*). These provincial institutions jointly constitute the Austrian Medical Chamber (*Österreichische Ärztekammer*). Dentists are united in the Austrian Dentists Chamber (*Österreichische Zahnärztekammer*). These chambers are established under public law by statute and represent the interests of their members. They are, *inter alia*, in charge of organizing their training and of disciplinary matters.

Austrian doctors are not only answerable to courts of law, but also to their competent local disciplinary commission, which acts under the supervision of the disciplinary council of the Austrian Medical Chamber. However, section 136 of the Austrian *ÄRZTEGESETZ* (*ÄRZTEG*) [ACT ON THE MEDICAL PROFESSION] only rather vaguely defines disciplinary offences as any conduct which may adversely affect the reputation of Austrian doctors, or any violation of professional duties.¹² Details have to be identified by the disciplinary commissions themselves. Apart from temporary injunctions, they can issue anything from written reprimands to permanent bans on practicing medicine.¹³ Decisions of the disciplinary commissions remain confidential, so their impact on liability issues cannot be properly assessed.

While requiring doctors to pursue continuing professional training, section 49 of the *ÄRZTEG* refers to professional standards in a rather broad and unspecific way, pointing to medical science and experience in general as well as “existing rules and specialist quality standards.”¹⁴

A 2005 federal statute (Act on the Quality of Health Services) foresees, among other measures, the development of national quality standards for specific areas.¹⁵ These standards can either be mere guidelines or man-

11. See *Ärzte-Haftpflichtversicherungen*, NEWS4DOCS, at 14, 14–16 (Feb. 2008), http://www.mein-doktor.at/pdf/MD0208n4d_net.pdf (market overview for 2008); see also *Ärzte-Haftpflichtversicherung Verein Ärzte Service*, <http://www.aerzteservice.com/downloadcenter/> (find section *Anträge zur Ärzte-Haftpflichtversicherung* then select pdf *Ärzte-Haftpflichtversicherung Verein Ärzte Service*) (last visited Apr. 25, 2011) (current application form quoting an annual premium of € 448 for gynecologists and other high risk doctors with an insured amount of € 4 million).

12. *ÄRZTEGESETZ* [ACT ON THE MEDICAL PROFESSION] *BUNDESGESETZBLATT* [BGBl.] I No. 169/1998, as amended, § 136.

13. *Id.* at § 139.

14. *Id.* at § 49.

15. *GESUNDHEITSREFORMGESETZ* [HEALTH CARE REFORM ACT] *BGBl.* I No. 179/2004.

datory by way of federal regulations, violations of which can be sanctioned with administrative fines. So far, however, no such standards seem to have been adopted.

Due to recent amendments to the laws governing the medical professions, quality control mechanisms are now mandatory for medical doctors and dentists. There is no compulsory certification procedure, but the market for voluntary certification of doctors and other healthcare providers seems to be expanding.

In November 2009, a nationwide CIRS pilot project was started, initiated by the Austrian Medical Chamber and the Federal Ministry of Health.

B. Criminal Law

Criminal law obviously draws the outer lines of appropriate conduct by medical professionals and deals with the more extreme deviations from acceptable behavior. The classic list of crimes against bodily integrity also applies to the medical profession, including involuntary manslaughter¹⁶ and negligent bodily injury.¹⁷ The latter will not be punished, though, if committed by a member of the medical profession and if its harmful effects lasted for less than two weeks.¹⁸

A special provision of the Austrian Criminal Code deals with unauthorized medical treatment, which is only prosecuted upon the express request of the patient.¹⁹ This provision is of particular relevance regarding informed consent.²⁰

16. STRAFGESETZBUCH [StGB] [PENAL CODE] BGBl. No. 60/1974, as amended, § 80 foresees a maximum sanction of one year imprisonment for involuntary manslaughter, unless it was committed under particularly dangerous circumstances, in which case the maximum is raised to three years imprisonment. *Id.* at § 81.

17. The maximum penalty for negligent bodily injury is three months of imprisonment or a fine of 180 *Tagessätzen* [daily rates]. A daily rate is calculated on the basis of the personal and economic circumstances of the convict and is capped at € 5,000. These sanctions are doubled if the victim was harmed under particularly dangerous conditions, or if her injuries were particularly serious. If those two latter conditions coincide, the sanction can be imprisonment of up to two years even. StGB, § 88.

18. *Id.* at § 88, ¶ 2.

19. *Id.* at § 110.

20. Section 110 of the StGB foresees criminal sanctions of up to six months of imprisonment or a fine not exceeding 360 daily rates. *Id.*; see also *supra* note 17. In case of emergency treatment, the sanction only applies if the urgency of the situation was negligently misjudged by the accused and in fact missing.

C. *Contract Law*

All patients are deemed to be treated on the basis of a contract with a doctor or a hospital. This is not only true for patients who pay out of their own pocket, but also for the vast majority of patients whose treatment is paid for directly by their social health insurance provider.²¹

A contractual relationship between a patient and a hospital can fall under a broad range of varieties, from an 'all-inclusive' contract covering all services connected with the patient's stay at the hospital (including medical treatment) to 'lodging' contracts where the patient merely rents the room and the medical facilities, which are then used by one or more internal or external medical professionals that the patient hires separately. Accordingly, the hospital's contractual duties do not necessarily include all aspects of the patient's treatment. In particular, it will generally not be held responsible for malpractice of an out-house surgeon that the patient has contracted with individually.

The protective scope of a treatment contract, whether concluded with a doctor or a hospital, not only covers the immediate contracting parties themselves, but extends to all persons affected by the treatment. This includes in particular (at first) unborn children, who are also clearly at the focus of a gynecologist's or obstetrician's (or other doctor's) contractual duties primarily owed to the mother. However, the father may also be protected, as well as visitors of patients in a hospital. As a consequence, such third parties can themselves raise direct claims for breach of contractual duties even though these were promised to another.

D. *Tortious and Contractual Liability*

1. Tortious and Contractual Liability Not Mutually Exclusive

The tort law section of the Austrian Civil Code applies equally to contractual liability, as the concept of liability encompasses both bases of a claim for compensation, which is also expressed by the core rule of tort law:

21. Sabine Völkl-Torggler, *Die Rechtsnatur des ärztlichen Behandlungsvertrages in Österreich* [The Legal Nature of the Medical Treatment Contract in Austria], 106 JURISTISCHE BLÄTTER [JBL] 72 (1984); Daniela Engljähringer, *Ärztlicher Behandlungsvertrag* [The Medical Treatment Contract], 48 ÖSTERREICHISCHE JURISTEN-ZEITUNG [ÖJZ] 488 (1993).

Everyone is entitled to claim compensation for a loss from the person whose fault has caused it; the loss may have been caused by the breach of a contractual obligation or irrespective of any contract.²²

Someone injured by another in the course of their contractual relationship may therefore typically sue the latter under both a contract theory as well as a tort law theory, even though the duty breached by the defendant will differ in the two alternatives. In the former variety, the duty is owed to the claimant and arises out of their contract, whereas in the latter variety, the duty of care is owed to everyone, at least in theory. Contractual liability nevertheless holds some (at least strategic) advantages for the claimant, which is why she will most often prefer to pursue her claims on that basis primarily, even though in practice she will also rest her case on a delict possibly committed by the defendant when breaching the contract. In personal injury cases, the contractual duties at stake will typically be so-called protective duties, which are not the core obligations arising out of the contract, but still bind both parties to protect, *inter alia*, the bodily integrity of the respective other. In a medical malpractice scenario, the prime duties of the treatment contract may also be relevant as these immediately affect the health and well-being of the patient.

In the following, tort and contract liability will therefore be presented jointly, even though the specialties in a contract relationship will be highlighted where applicable.

2. Tort Law in General

Austrian tort law is traditionally based on liability for wrongful and faulty conduct.²³ Unlike common law, there is only one basis for a tort law claim in the ABGB [civil code] as opposed to multiple torts, and it is probably most closely related to the tort of negligence.²⁴ However, it also applies if harm is caused intentionally, which is just one (though the most serious) variety of fault in Austrian tort law theory.

22. ALLGEMEINES BÜRGERLICHES GESETZBUCH [ABGB] [CIVIL CODE] JUSTIZGESETZSAMMLUNG [JGS] No. 946/1816, as amended, § 1295 ¶ 1. Cf. Helmut Koziol, Characteristic Features of Austrian Tort Law, in DEVELOPMENTS IN AUSTRIAN AND ISRAELI PRIVATE LAW 159, 159–60 (Herbert Hausmaninger et al. eds., 1999) (emphasizing that “there is no clear dividing line between the core of tort and the core of breach of contract”).

23. ABGB, §§ 1293–1341.

24. There are, however, certain special cases of fault liability also recognized by the ABGB itself such as liability for animals or for certain constructions where specific rules apply, e.g. on the burden of proof.

While there are certain instances of strict liability introduced by special legislation in Austrian law, none of these is of particular relevance to the field of medical malpractice.²⁵

3. Damage

In order to succeed, a victim must prove that she has incurred some damage which is deemed compensable. The latter is not universally true for pure economic loss, which outside a contractual relationship tends to be indemnified only if caused intentionally.

Not only does the victim have to prove a loss, she also needs to quantify it in monetary terms. However, a provision of the Act on Civil Procedure comes to her rescue, allowing the judge to assess the loss according to her discretion if it cannot be proved in every detail or if such proof were unreasonably difficult.

4. Causation

As a rule, the patient needs to convince the court that the deterioration of her condition was caused by someone attributable to the defendant.²⁶ Prima facie proof will suffice, so if she can prove certain facts which are typically linked, even without being able to establish this link as such, the connection will be deemed proven even if the probability thereof is not significantly high (which is the common standard of proof)²⁷ but at least “clearly outweighs” the opposite.²⁸

Courts shift the burden of proving causation if it is evident that something was objectively wrong within the sphere of the defendant that increased the likelihood of adverse effects upon the patient more than just insignificantly. While the latter still has to be established by the claimant,²⁹

25. Only two statutory regimes may come into play at all, including the Act on Products Liability, which inter alia also applies to defective pharmaceuticals or medical equipment or devices, and the Act on Nuclear Liability, which amongst other scenarios also applies to radionuclides used for medical therapy.

26. See, e.g., Oberster Gerichtshof [OGH] [Supreme Court] Mar. 16, 1989, docket No. 8 Ob 525/88, 62 ENTSCHIEDUNGEN DES OBERSTEN GERICHTSHOFES IN ZIVIL-UND JUSTIZVERWALTUNGSSACHEN [SZ] No. 53.

27. The previous standard of “probability close to certainty” is no longer valid. OGH Dec. 12, 2007, 4 ZIVILRECHT AKTUELL [ZAK] No. 212 (2008). However, it is still not just a mere preponderance of the evidence.

28. OGH May 31, 1990, 63 SZ No. 90; OGH Dec. 12, 2007, 4 ZAK No. 212 (2008).

29. OGH Aug. 4, 2009, 65 EVIDENZBLATT DER RECHTSMITTELENTSCHEIDUNGEN [EVBL] No. 9 (2010).

it is up to the defendant to rebut this by proving “with highest probability” that her misconduct did not in fact cause the patient’s loss.³⁰

If the claimant can establish that the loss must have been caused by one of two or more external sources, but it remains unclear which one of them, joint and several liability for all these alternative causes will apply, irrespective of whether they intervened jointly or independently.³¹ This is also true if two causes concur, and each alone would have triggered the full loss (cumulative causation).³²

In cases where not only the defendant may have caused the claimant’s injuries, but where another possible cause for the (full) same damage lies in the claimant’s own sphere, such as a precondition or an illness which brought the patient to the doctor in the first place, the Austrian scholar Franz Bydlinski³³ proposed to split the loss between the two causes, arguing that the aforementioned rule on alternative causation should be read together with the statutory provision on comparative negligence.³⁴ Since he deemed it unfair in such cases of causal uncertainty to leave the risk entirely with one side, Bydlinski proposed to spread it according to the ratio of the respective probabilities,³⁵ but only if it is proven that the defendant violated a duty of care and behaved highly dangerously under the circumstances.³⁶ Therefore, in the medical liability scenario, if a patient suffers injuries in the course of some treatment and it remains unclear whether this happened due to some precondition of the patient herself or whether these injuries were alternatively caused by the (undisputedly) negligent behavior of the physician, both sides will have to share this uncertainty, and there-

30. E.g. OGH Jan. 29, 2008, 4 ZAK No. 244 (2008); THOMAS JÜEN, ARZTHAFTUNGSRECHT [MEDICAL LIABILITY LAW] 241 (2d ed. 2005).

31. See Helmut Koziol, *Causation under Austrian Law*, in UNIFICATION OF TORT LAW: CAUSATION 11, 13–15 (Jaap Spier ed., 2000).

32. *Id.*

33. FRANZ BYDLINSKI, PROBLEME DER SCHADENSVERURSACHUNG NACH DEUTSCHEM UND ÖSTERREICHISCHEM RECHT [PROBLEMS OF DAMAGE CAUSATION IN GERMAN AND AUSTRIAN LAW] 86–90 (1964); see also Koziol, *supra* note 22, at 177, 180–84.

34. BYDLINSKI, *supra* note 33, at 86–90. See also Koziol, *supra* note 22, at 177, 180–81.

35. Bernhard A. Koch & Helmut Koziol, *Austrian report*, in CASES ON MEDICAL MALPRACTICE IN A COMPARATIVE PERSPECTIVE 57, 78–80 (Michael Faure & Helmut Koziol eds., 2001).

36. *Id.*

fore, the loss.³⁷ Austrian courts have meanwhile adopted this theory of proportional liability.³⁸

If it is certain, however, that a precondition of the patient would have led to the same harmful result as the faulty conduct of the doctor, but only at a later point in time, the doctor only has to account for the fact that such damage has occurred earlier than anticipated under the now hypothetical course of events.³⁹ If, for example, a wrongful and faulty treatment brings about the same symptoms that would have arisen anyway due to the patient's predisposition, liability accrues only for the harm incurred during the time period starting from the actual occurrence until the predicted moment when the natural cause would have manifested itself anyway or, if the tortious act has aggravated a precondition, such deterioration.⁴⁰ All this has to be proved by the defendants, who have to meet high standards of proof as imposed by the Austrian courts for such defense.⁴¹

5. Wrongfulness and Fault

While section 1294 of the ABGB requires 'unlawful' conduct by the tortfeasor and thereby looks at the objective deviation from conduct that would be expected under the circumstances (a duty of care in common law terminology),⁴² the fault requirement adds a subjective component and assesses whether the defendant herself could have behaved properly under

37. BYDLINSKI, *supra* note 33, at 89. The theory of a loss of a chance therefore never gained any importance in Austria as this alternative route towards proportional liability already takes care of the problem. See Bernhard A. Koch, *Der Verlust einer Heilungschance in Österreich [Loss of a Chance of Healing in Austria]*, 16 EUROPEAN REV. OF PRIVATE L. 1051, 1057–59 (2008).

38. OGH Nov. 9, 1989, docket No. 7 Ob 648/89, 112 JBL 1990, 524 (1990) critical note Holzer; *cf. also* OGH Nov. 7, 1995, docket No. 4 Ob 554/95, 68 SZ No. 207 (only distribution of the damage ensures "a solution to the problem which is in accordance with principles of justice").

39. Rudolf Reischauer, in II KOMMENTAR ZUM ALLGEMEINEN BÜRGERLICHEN GESETZBUCH [COMMENTARY ON THE ABGB] §1302 no. 14–15 (Peter Rummel ed., 3d ed. 2007); Friedrich Harrer, in VI ABGB RAXISKOMMENTAR [PRACTICE COMMENTARY ON THE ABGB] (Michael Schwimann ed., 3d ed. 2006) §§ 1301–1302 no. 35–43; I HELMUT KOZIOL, ÖSTERREICHISCHES HAFTPFLICHTRECHT [AUSTRIAN TORT LAW] (3d ed. 1997) No. 3/58–3/81 (arguing at no. 3/78 that Bydliniski's theory discussed *supra* note 35 should be applied).

40. OGH Sept. 3, 1996, docket No. 10 Ob 2350/96b, 69 SZNo. 199; OGH May 5, 1998, docket No. 4 Ob 23/98f, 121 JBL246 (1999) note Bumberger; *cf. JÜEN, supra* note 30, at 44.

41. It is therefore not sufficient if the parties to the patient's contract can only prove a "preponderant probability" of the intervening predisposition as to the injuries at issue. Instead, such probability must almost amount to certainty (insofar as possible). OGH Sept. 3, 1996, docket No. 10 Ob 2350/96b, 69 SZ No. 199.

42. "Damage is either caused by some unlawful action or omission of another, or by chance. The unlawful infliction of harm is done either voluntarily or involuntarily. The voluntary infliction of harm is either based upon evil intent, if damage is caused with knowledge and will; or upon neglect, if caused with culpable lack of knowledge, or with lack of due attention or of due diligence. Both is called fault." ABGB, § 1294; *see generally* Helmut Koziol, Wrongfulness under Austrian Law, in UNIFICATION OF TORT LAW: WRONGFULNESS 11 (Helmut Koziol ed., 1998).

the circumstances.⁴³ In theory, therefore, the personal abilities of the tortfeasor still seem to be decisive.⁴⁴ However, at least in medical malpractice cases where the conduct of professionals is at stake who are deemed experts within their trade or occupation, an objective standard of due care applies, enshrined in section 1299 of the ABGB.⁴⁵ Medical and other professionals are expected to possess the training, expertise and abilities of their peers even if they in fact do not, and they have to account for any behaviour deviating from such standard.⁴⁶ As the Austrian Supreme Court has expressed:

[a] doctor has violated his duties of care owed to his patient if he failed to act in accordance with medical science and experience or if he neglected to exercise the usual prudence of a conscientious average doctor in the actual situation. He is not at fault, however, if the method of treatment that he chose is in accordance with the practice of well-respected doctors who are familiar with this method, even if other experts may have chosen a different technique. In such case, the doctor has to take the safest measures according to the state of medical science in order to prevent known risks of such treatment.⁴⁷

The burden of proving fault is reversed according to section 1298 of the ABGB⁴⁸ if the conduct complained of constitutes a breach of duty arising out of some pre-existing special relationship between the parties, particularly in cases of breach of contract. However, this reversal only applies for plain negligence, whereas gross negligence and intent still have to be proved by the claimant.⁴⁹ The latter is of no practical relevance for the medical malpractice scenario, however, as the degree of fault has no impact on damages for personal injury.

43. See generally Helmut Koziol, *Fault under Austrian Law*, in *UNIFICATION OF TORT LAW: FAULT* 11 (Pierre Widmer ed., 2005).

44. See, e.g., Helmut Koziol, *Liability Based on Fault: Subjective or Objective Yardstick?* 5 MAASTRICHT J. EUROPEAN COMPARATIVE L. 111 (1998) (Neth.).

45. This provision reads: "Whoever professes some office, art, business or trade, or who without need takes upon a task whose exercise requires special knowledge or extraordinary diligence thereby indicates that he is confident to have such required diligence and necessary extraordinary knowledge; he therefore had to account for any lack thereof. However, a person who entrusted him with such task knew of the latter's inexperience or should have known with due attention also is to be charged with such oversight." See Koziol, *supra* note 22, at 173–74.

46. Cf. Koch & Koziol, *supra* note 35, at 72–74.

47. OGH Jan. 25, 1994, docket No. 1 Ob 532/94, 67 SZ No. 9; cf. OGH Mar. 16, 1989, docket No. 8 Ob 525/88, 62 SZ No. 53.

48. 'He who claims that he was prevented from fulfilling his contractual or statutory obligation without his fault has to prove it. If he is only liable for grave negligence according to a contractual agreement, he also has to prove that this requirement is missing.' ABGB, § 1298.

49. In case of a contractual exclusion of liability but for gross negligence of the party in breach, the latter has to prove the absence of such qualified fault.

6. Multiple Persons Involved

a. *No Delegation of Treatment as a General Rule*

As a rule, a doctor must obtain her patient's consent before delegating her duties to a colleague, otherwise she will be held responsible for all negative consequences which would not have materialized had she performed her obligations herself.⁵⁰ If the patient agrees to substitution or if it becomes unavoidable, the doctor will only have to account for fault in selecting the substitute (*culpa in eligendo*).⁵¹

b. *Vicarious Liability in General*

Notwithstanding liability for personal fault in selecting an auxiliary (*culpa in eligendo*), (true) vicarious liability for tortious acts committed by employees and other staff outside of special (in particular, contractual) relationships is very limited in Austrian tort law. According to section 1315 of the ABGB, a principal only has to account for the misbehavior of a helper if the latter is either dangerous or unfit.⁵² In the dangerous variety, the victim needs to establish that the principal had known about the dangerousness, which is not required in the unfit variety.⁵³

If the auxiliary was charged with the fulfillment of contractual duties of her principal, however, the principal will be held vicariously liable for her auxiliary's behavior irrespective of the qualifications required in tort law as just mentioned.⁵⁴ Furthermore, a special relationship of social or

50. Doctors have to exercise their profession "personally . . . , at most in cooperation with other doctors." ÄRZTEGESETZ § 49 ¶ 2. A doctor can, however, employ helpers who have to act under his exact orders and permanent supervision. ÄRZTEGESETZ § 49 ¶ 3 allows doctors "in individual cases" to delegate certain duties vis-à-vis their patients to other health service professionals or to trainee doctors, but the delegator bears full responsibility for such delegation. See generally Peter Steiner & Gerald Fleisch, *Ärztliche Substitutionsbefugnis [Doctors' Entitlement to Appoint a Substitute]*, 59 ANWALTSBLATT [ANWB] 702 (1997). Patients may also implicitly consent to being treated by another doctor, the longer the treatment or consultation is meant to last, the more likely this is (and vice versa); cf. Reischauer, *supra* note 39, at § 1299 no. 30.

51. Reischauer, *supra* note 39, at § 1299 no. 30.

52. The provision reads: "On the whole, he who avails himself of an unfit or knowingly of a dangerous person for taking care of his affairs is liable for any harm this person causes to another because of such qualities." ABGB § 1315. See also II HELMUT KOZIOL, ÖSTERREICHISCHES HAFTPELICHTRECHT [AUSTRIAN TORT LAW] 352-65 (2d ed. 1984).

53. *Id.* at 358.

54. Section 1313a of the ABGB reads: "He who owes a duty to another is liable to the latter for any fault of his statutory representative or any person of whom he avails himself for the fulfillment." ABGB § 1313a. On vicarious liability in general, see KOZIOL, *supra* note 52, at 163-4. For the area of healthcare, see I KURT STELLAMOR & JOHANNES STEINER, HANDBUCH DES ÖSTERREICHISCHEN ARZTRECHTS [MANUAL OF AUSTRIAN MEDICAL PRACTITIONERS' LAW] 149-55 (2d ed. 1999); Christian Markl & Raimund Pittl, *Ausgewählte Fragen der Erfüllungsgehilfenhaftung beim ärztlichen Behandlungsvertrag [Selected Aspects of Vicarious Liability in the Context of a Medical Treatment Contract]*, 52 ÖJZ 774 (1997).

economic dependency between the principal and her auxiliary is not of the essence, so that the latter may also be a mere independent contractor.

c. Liability for Other Doctors and Other Medical Professionals

A hospital may be vicariously liable for its staff (including doctors, nurses etc.) to the extent that these acts fall within the scope of their employment in order to fulfill the hospital's obligations vis-à-vis its patients and third parties to whom the duties are extended. If the hospital entrusts a junior doctor or even an intern with tasks that should be assigned to an experienced specialist, or if a specialist in a different field would be required, as far as the hospital's vicarious liability is concerned, the conduct of the employee actually performing the task will be assessed according to the standard of care to be expected from the expert required.⁵⁵

If a doctor operates in a hospital without being employed there and merely rents the space and equipment and contracts for temporary support services of hospital staff (as a so-called *Belegarzt*), she may be liable if the staff assisted her in fulfilling her own obligations towards her patient.⁵⁶ In addition, the Austrian Supreme Court also held such a *Belegarzt* liable for the negligence of a fellow specialist (in the case at hand an anesthetist), even though the latter was also not employed by the hospital but hired directly by the defendant.⁵⁷ In that case, the court held that the anesthetist had acted under the defendant surgeon's (at least general) direction and control, which was particularly disputed because both were independent specialists acting exclusively within the scope of their expertise.⁵⁸

d. Liability of the Auxiliaries Themselves

While the patient may of course not recover the same damage twice, the fact that a hospital or practitioner is vicariously liable for the behavior of its or her staff does not exclude the possibility that these auxiliaries can also be held (jointly and severally) responsible for their own personal acts

55. Reischauer, *supra* note 39, at § 1313a no. 12; OGH Jan. 25, 1994, docket No. 1 Ob 532/94, 67 SZ No. 9.

56. OGH Oct. 27, 1999, docket No. 1 Ob 267/99t, 7 RECHT DER MEDIZIN [RDM] No. 7 (2000) note Pitzl & Huber. In addition, the hospital may be jointly and severally liable for the same misconduct of its staff if the duties owed to the patient by the *Belegarzt* and the hospital overlap. OGH Sept. 29, 2009, docket No. 8 Ob 103/09v.

57. OGH Nov. 23, 1999, docket No. 1 Ob 269/99m, 7 RDM No. 8 (2000) note Kopetzki.

58. See the comment by Christian Kopetzki, *supra* note 57, and the critical remarks by Hans Bruck & Hans Pfersmann, *Wie weit reicht die Haftung des operierenden Chirurgen?* [How Far Does the Liability of the Operating Surgeon Go?] 123 JBL 64 (2001). On the general notion of who should count as an assistant in the meaning of section 1313a of the ABGB, see Reischauer, *supra* note 39, at § 1313a No. 9 (on independent contractors); KOZIOL, *supra* note 52, at 340–42.

and omissions. Since auxiliaries themselves are not personally bound by the contractual or other obligations of their employer,⁵⁹ they can only be held liable for duties of care that they themselves have to fulfill, which, apart from the general duty to protect a person's bodily integrity, includes, *inter alia*, the duty to skillfully complete a task undertaken insofar as necessary to avoid further harm. In a labor law relationship, the Austrian DIENSTNEHMERHAFTPFLICHTGESETZ [DHG] [ACT ON THE LIABILITY OF EMPLOYEES] foresees certain limits to direct liability of the employee in cases of minor degrees of negligence.⁶⁰

e. Recourse

If a hospital has been ordered to pay compensation based on vicarious liability for the behavior of its staff, it has a right of recourse based on section 1313 of the ABGB⁶¹ to the extent that the employees have violated personal obligations vis-à-vis the hospital (in particular those arising from their employment contracts)⁶².

Depending on the degree of the employee's fault, the hospital's contribution claim can be reduced or even denied.⁶³ If, for example, the nurse's or doctor's behavior attributed to the hospital was hardly negligent at all, the hospital will not recover any damages paid to the patient. In other cases of negligence, the judge may mitigate the hospital's claim in light of certain equitable aspects.⁶⁴

If a doctor in a direct tort law action has to pay damages to a patient of the hospital that she is working for (the reverse scenario), she might have a contribution claim against the hospital according to analogous principles if she merely has to account for some minor degree of negligence.

59. Reischauer, *supra* note 39, at § 1299 no. 24.

60. The contribution claim of the employer may be reduced or even inapplicable according to section 4 of the DHG.

61. "Generally, nobody is responsible for the unlawful action of another in which he did not participate. Even in cases where the law provides otherwise, he still has a right of recourse against the person at fault." ABGB § 1325.

62. KOZIOL, *supra* note 52, at 350. The right of recourse mentioned in section 1313 of the ABGB is already founded in the employment contract.

63. Helmut Koziol & Klaus Vogel, Vicarious Liability under Austrian Law, in UNIFICATION OF TORT LAW: LIABILITY FOR DAMAGE CAUSED BY OTHERS No. 58–59 (Jaap Spier ed., 2003); Wolfgang Brodil, *Arzthaftung und Dienstnehmerhaftpflichtgesetz [Medical liability and the Act on the Liability of Employees]*, 1 RDM 50 (1994); STELLAMOR & STEINER, *supra* note 54, at 153.

64. The judge has to take into account: the skill of the employee; the degree of responsibility which the work implied; the dangerousness of the work and the question of whether the employee was paid (extra) for it; finally, also the degree of blameworthiness of the employee's behavior. Cf. Wolfgang Brodil, *Mäßigung der Haftung nach art. 2 DHG im ärztlichen Bereich [Reduction of Liability According to Section 2 DHG in the Medical Context]*, 2 RDM 34 (1995).

7. Informed Consent⁶⁵

The doctrine of informed consent is of utmost importance for medical malpractice claims in Austria, as it traditionally seems to have served as a buffer for those cases filed against healthcare providers where the deviation from medical standards cannot be established for whatever reason, but where one is still left with the feeling that something went wrong during treatment. Shifting the blame to an entirely different aspect of the relationship may lead to the same result: if the patient can prove that she was not properly informed before or in the course of her treatment, the healthcare provider may be held liable for all adverse consequences thereof irrespective of whether it is to blame for them. Oddly enough, this is not only advantageous for the patients, but one is left with the impression that even doctors deem this a much less bitter pill to swallow than being accused of having failed as a medical professional.

The contract for medical treatment requires doctors or hospitals to inform the patient not only about the diagnosis⁶⁶ and the recommended therapy,⁶⁷ but also about all possible risks of the treatment⁶⁸ and to offer her adequate and proper medical care.

If she subsequently rests her claim solely upon the breach of the doctor's or hospital's duty to inform, she must not only prove that such breach did indeed occur, but also that it led to the damage which she has suffered because she would have abstained from going on with the treatment had she been properly informed.

Instead, she might follow another line of reasoning which helps to avoid potential difficulties that such a burden of proof could produce. She can alternatively sue on the grounds that she was physically injured through the acts of the practitioner, hospital, or its staff. Such effect by itself indicates wrongful behavior on their part because it implies that they have acted in violation of the claimant's interest in her own bodily integrity. This interest is not only protected under general principles of delict, but further specified by contractual duties. The doctor or hospital could still justify such acts by claiming that the patient had validly consented to the treatment beforehand, but in this case, they would have to prove that fact since this

65. See generally KARIN PRUTSCH, DIE ÄRZTLICHE AUFKLÄRUNG [INFORMED CONSENT] (2d ed. 2004).

66. E.g. OGH Jan. 29, 2001, docket No. 3 Ob 87/00s, 8 RDMNo. 21 (2001).

67. See JÜEN, *supra* note 30, at 118.

68. E.g. OGH Aug. 4, 2009, docket No. 9 Ob 64/08i, 65 EVBLNo. 9 (2010). On the issue of whether this is a primary or collateral duty of the contract, see DANIELA ENGLJÄHRINGER, ÄRZTLICHE AUFKLÄRUNGSPFLICHT VOR MEDIZINISCHEN EINGRIFFEN [DOCTORS' DUTY TO INFORM BEFORE MEDICAL TREATMENT] 59–60 (1996).

argument now would serve as defense.⁶⁹ Consequently, the hospital would further have to establish that the patient previously had received sufficient information about the upcoming treatment and the risks involved therewith, which is a prerequisite to her informed choice. Without such consent, the doctor or hospital is liable for the claimant's damage, even if caused accidentally in the course of proper and careful treatment.⁷⁰

Information must be given early enough so that the patient can thoroughly consider the pros and cons of the treatment⁷¹, which enables her to decide on the basis of ample background knowledge whether she wants to go ahead with the planned treatment or not. A mere standard form letter or leaflet including printed information is not enough: the patient must have the option of asking questions.⁷²

While there are no generally applicable criteria for determining what complications need to be disclosed, the Austrian Supreme Court (OGH) has developed a few guidelines on how to observe the patient's right of self-determination while still respecting the superior goal of her well-being.⁷³ The more urgent the treatment is for the patient's health, the less extensively she has to be informed, especially if an overly anxious patient might opt against the treatment, which in turn would constitute a much higher risk to her health.⁷⁴ On the other hand, if treatment is not imperative (such as purely diagnostic measures)⁷⁵, information has to be given as extensively as

69. E.g. OGH Mar. 20, 1997, docket No. 6 Ob 2391/96b, 4 RDM No.29 (1997); see also Georg Gaisbauer, *Zur Beweislast für Einwilligung des Patienten und Erfüllung der ärztlichen Aufklärungspflicht* [On the Burden of Proving the Patient's Consent and the Fulfillment of the Doctor's Duty to Inform], 116 JBL 352 (1994). Cf. OGH Aug. 7, 2007, docket No. 4 Ob 137/07m, 2007 SZ No. 122 (no reversal of the burden of proof if the risk not disclosed concerns the chance of a relapse or the failure of the treatment, since doctors do not owe the success of the treatment).

70. E.g. OGH Nov. 11, 1997, docket No. 7 Ob 355/97z, 120 JBL 443 (1998) note Bernat.

71. If there is no imminent danger, a rule of thumb might say that the higher the risks involved, the more time the patient will need. ENGLJÄHRINGER, *supra* note 68, at 166; Albert Heidinger, *Die ärztliche Aufklärungspflicht in der Rechtsprechung des Obersten Gerichtshofes* [The Doctor's Duty to Inform in the Jurisprudence of the Supreme Court], in *ÄRZTLICHE VERANTWORTUNG UND AUFKLÄRUNG* 17, 37–38 (Friedrich Harrer & Anton Graf eds., 1999). See also OGH June 23, 1994, docket No. 6 Ob 555/94, 2 RDM No. 1 (1995) note Kopetzki (information given on the eve of the operation still timely).

72. See, e.g., OGH Jan. 30, 1996, docket No. 4 Ob 505/96, 3 RDM No. 24 (1996). Cf. Heidinger, *supra* note 71, at 39–41.

73. See in particular the landmark case of OGH June 23, 1982, docket No. 3 Ob 545/82, 105 JBL 373 (1983) note Holzer. Cf. the overview given by Kurt Hofmann, *Die Aufklärungspflicht des Arztes im Lichte der Rechtsprechung des Obersten Gerichtshofes* [The Doctor's Duty to Inform in Light of the Jurisprudence of the Supreme Court], 76 ÖSTERREICHISCHE RICHTERZEITUNG [ÖRZ] 1998, 80; see also Koch & Koziol, *supra* note 35, at 61–65.

74. ENGLJÄHRINGER, *supra* note 68, at 215.

75. OGH Sept. 16, 2009 docket No. 1 Ob 80/08h, 16 RDM No.62 (2009) note Leischner.

possible.⁷⁶ Typical risks always have to be disclosed, even if chances of such complications are remote.⁷⁷ Statistical probabilities thereby play a role, but are just one factor amongst others:⁷⁸ The paramount test is whether the patient might be specifically interested in the particular risk at stake⁷⁹ and to what extent knowledge thereof might influence her decision.⁸⁰

Even if the patient was not sufficiently informed and could not therefore give any valid consent to her treatment, she will nevertheless have to bear her own loss if the defendant can prove that the patient would still have gone ahead with the treatment had she known all possible complications thereof.⁸¹

8. Remedies

a. Pecuniary Losses

Austrian law bears no surprises when it comes to the list of compensable heads of damage.⁸² Apart from expenses for medical treatment,⁸³ medication, medical aids, nursing, rehabilitation and the like, even the costs relatives incurred while visiting the victim and other comparable extras can

76. See, e.g., OGH Sept. 3, 1996, docket No. 10 Ob 2350/96b, 69 SZ No. 199; OGH July 10, 1997, docket No. 2 Ob 197/97b, 5 RDM No.(1998) 18; see further Georg Gaisbauer, *Ärztliche Aufklärungspflicht bei kosmetischen Eingriffen* [Doctor's Duty to Inform in Case of Cosmetic Surgery], 48 ÖJZ 25 (1993).

77. E.g. OGH Jan. 17, 2001, docket No. 6 Ob 318/00h, 8 RDM No. (2001) 16; ENGLJÄHRINGER, *supra* note 68, at 189.

78. This does not mean that rare risks never have to be disclosed. OGH Sept. 7, 1993, docket No. 10 Ob 503/93, 1 RDM No. 1 (1994) note Kopetzki. Even if the risk of infection is close to one in a thousand, the patient still has to be informed if the doctor realizes that the patient would otherwise believe that the treatment is without any danger at all.

79. OGH Jan. 29, 1997, docket No. 7 Ob 12/97h, 4 RDM No.18 (1997).

80. OGH Oct. 24, 1996, docket No. 6 Ob 2211/96g, 4 RDM No.28 (1997).

81. OGH Jan. 31, 1995, docket No. 4 Ob 509/95, 117 JBL 453 (1995) note Steiner. *But see* Koziol, *supra* note 39, at no. 8/72, who does not grant the doctor such a possibility to justify his acts if "the practitioner has substantially violated his duties", for example if he 'completely failed to disclose risks'. In contrast to Germany, Austrian courts do not require patients to substantiate a decisional conflict whether they would have gone ahead with the treatment had they been fully informed. OGH Oct. 14, 2008, docket No. 4 Ob 155/08k, 20 ECOLX No. 77 (2009).

82. Cf. Bernhard A. Koch & Helmut Koziol, *Comparative Analysis, in COMPENSATION FOR PERSONAL INJURY IN A COMPARATIVE PERSPECTIVE* 407, 419–20 (Bernhard A. Koch & Helmut Koziol eds., 2002).

83. This may include the additional costs for treatment by a private doctor who is under no contract with a social insurance provider and/or a stay in a more expensive hospital room (so-called *Sonderklasse*), if appropriate to the patient's situation, or if it is otherwise adequate under the circumstances of the case (e.g. if treatment by a specialist working for a private hospital is required by the patient's medical condition). OGH Apr. 24, 2003, docket No. 2 Ob 284/01f, 49 ZVR No. 38 (2004). In the medical malpractice scenario, this is obviously the case if the deterioration of the patient's condition happens while staying in the *Sonderklasse*, but also otherwise if the more expensive treatment is expected to lead to a more satisfactory result. OGH June 28, 2005, docket No. 10 Ob 24/05k, 12 RDM No. (2005) 106.

be recovered.⁸⁴ The same is true for increased expenses such as adaptations of the house and loss of income.⁸⁵ If the victim can count on relatives to take care of her voluntarily and for free, she can still recover the (fictitious) expenses of a professional nurse because the gratuitous services are not meant to benefit the tortfeasor.⁸⁶

Apart from the reduction of previous income, loss of earning capacity is also compensable due to the objective approach to calculating the damage. Therefore, even if the victim suffers no actual loss of earnings, her reduced ability to theoretically generate income according to her educational background and other circumstances determining that ability has to be indemnified by the tortfeasor.⁸⁷ The costs of housekeeping and childcare have to be compensated as well according to labor market value to the extent that the injuries prevent the victim from rendering such services herself.⁸⁸ A so-called *abstrakte Rente* [abstract annuity] has to be paid for any likely diminution of future income⁸⁹ due to the victim's lasting handicap, or if her physical or mental efforts to maintain the previous level of income have to be increased, both criteria in light of her deteriorated standing when competing with others on the labor market.⁹⁰

The so-called *Verunstaltungsentschädigung* [compensation for disfigurement] foreseen by section 1326 of the ABGB⁹¹ is meant to indemnify reduced chances of future income and other pecuniary consequences, including weaker prospects of finding a marital partner,⁹² whereas the emotional effects of disfigurement may (additionally or instead) be claimed as non-pecuniary loss. A mere slight possibility of an impact upon the advancement of the victim suffices to give her a claim under section 1326 of

84. This may even include tips for the nursing staff of a hospital or flowers and other small presents. Karl-Heinz Danzl, in *KURZKOMMENTAR ZUM ABGB* [CONCISE COMMENTARY ON THE ABGB] 1539, § 1325, no. 7 (Helmut Koziol et al. eds., 3d ed. 2010).

85. *Id.* at § 1325, no. 10–12.

86. *Id.* at § 1325, no. 8.

87. Helmut Koziol, *Damages under Austrian Law*, in *UNIFICATION OF TORT LAW: DAMAGES* 7, no. 47 (Ulrich Magnus ed., 2001); Danzl, *supra* note 84, at 1541, no. 12.

88. Danzl, *supra* note 84, at 1546, § 1325 no. 24.

89. It cannot be claimed for additional efforts made in the past. *e.g.* OGH Apr., 29, 2009, docket No. 2 Ob 234/08p, 20 ECOLEX 1057 (2009) (with detailed analysis of further aspects).

90. Danzl, *supra* note 84, at 1544–45, § 1325 no. 22.

91. “If the injured person was disfigured by the maltreatment, this has to be considered particularly if it was a female person whose advancement may be hindered.” ABGB § 1326. Despite its wording, the provision is nowadays applied in a gender-neutral way, of course.

92. Not the emotional bonds are at focus here, but the fact that a spouse at least contributes to the family income and assumes maintenance duties.

the ABGB; such impact also need not be permanent.⁹³ The highest award under section 1326so far amounted to € 30,000.⁹⁴

If medical malpractice causes the death of the patient, section 1327 of the ABGB⁹⁵ is the statutory basis for claiming not only funeral expenses and other costs relating to the death as such (including unsuccessful efforts to save the life), but also for maintenance claims of surviving relatives if recognized by law.⁹⁶ The latter are calculated on the basis of the deceased's income after taxes.⁹⁷ The tortfeasor also has to indemnify the loss of services that the deceased would have provided in fulfillment of her maintenance duties (e.g. childcare or household activities).⁹⁸

b. Non-Pecuniary Loss

Irrespective of whether the claim is based on contractual liability or on tort law, persons suffering personal injuries are entitled not only to compensation for their pecuniary losses, but also for pain and suffering "as adequate under the circumstances".⁹⁹ Even if it does not amount to a medical condition in itself (such as a shock, trauma or depression), significant mental suffering is included in the notion of 'personal injury', either as a consequence of actual bodily harm or due to a massive threat to the physical integrity.¹⁰⁰ This is why, for example, under certain circumstances the fear of dying can also constitute a compensable material loss.¹⁰¹

Damages for non-pecuniary loss are calculated on the basis of the duration and intensity of the actual suffering. Since the latter can hardly be measured, the assessment in practice primarily focuses on more objective criteria like the type and seriousness of the injury.¹⁰² While one could imagine further including subjective elements like sensitivity of the injured person (to the extent objectively assessable), most courts decline to do

93. OGH May 7, 2003, docket No. 7 Ob 36/03z, 49 ZVR no. 39 (2004).

94. *Id.* Like non-pecuniary loss, it is typically compensated by way of a lump sum payment, except it may also be in the form of an annuity. Danzl, *supra* note 84, at 1553, § 1326 no. 9.

95. "If bodily injury results in death, not only all costs must be compensated, but also the dependants whose maintenance had to be paid by the deceased under the law shall be indemnified for all they thereby lost." ABGB § 1327

96. Danzl, *supra* note 84, at 1555, § 1327no. 5. This excludes, *inter alia*, fiancé(e)s or lifetime companions, and also those whom the deceased had contractually promised to provide support.

97. *Id.*

98. Danzl, *supra* note 84, at 1557–59, § 1327 no. 11–18.

99. ABGB§ 1295.

100. Danzl, *supra* note 84, at 1547, § 1327 no. 28; ERNST KARNER, DER ERSATZ IDEELLER SCHÄDEN BEI KÖRPERVERLETZUNG [COMPENSATION FOR NON-PECUNIARY LOSS RESULTING FROM BODILY INJURY] 106 (1999).

101. OGH Jan. 14, 2010, docket No. 6 Ob 248/09b, 6 ZAK No. 197 (2010).

102. KOZIOL, *supra* note 39, at no. 11/19.

so.¹⁰³ Neither do they take into account the degree of the defendant's fault when calculating non-pecuniary loss.¹⁰⁴ Personal (in particular economic) circumstances of the victim are generally not considered either¹⁰⁵; this is subject to substantial criticism.¹⁰⁶

Damages are typically awarded in the form of a lump sum for all pain and suffering sustained.¹⁰⁷ Nevertheless, in practice, courts consider statistical data, which is published regularly on the basis of prior awards.¹⁰⁸ Such tables list average 'rates' determined according to the severity of pain ('agonizing', 'severe', 'medium', and 'slight') as well as its duration (given in days).¹⁰⁹ While such rates are certainly not used as mathematical constants, they at least regularly serve as guidelines for the assessment of damages for pain and suffering.¹¹⁰ The maximum compensation currently attributable for non-pecuniary loss probably is around € 250,000.¹¹¹

Apart from the immediate victim, Austrian courts have meanwhile acknowledged that close relatives and loved ones¹¹² can claim damages for bereavement in wrongful death cases.¹¹³ However, so far courts insist on

103. Reischauer, *supra* note 39, at § 1325 no. 45; KARNER, *supra* note 100, at 123. Only more recent cases award damages despite lack of sensitiveness. OGH Jan. 14, 1993, docket No. 2 Ob 66/92, 38 ZVR No. 150 (1993); Karl-Heinz Danzl, in *DAS SCHMERZENGELD IN MEDIZINISCHER UND JURISTISCHER SICHT* [DAMAGES FOR PAIN AND SUFFERING FROM A MEDICAL AND LEGAL PERSPECTIVE] 144 (Karl-Heinz Danzl et al. eds., 9th ed. 2009).

104. E.g. OGH Apr. 11, 1956, docket No. 3 Ob 162/56, 2 ZVR No. 6 (1957); see also Danzl, *supra* note 103, at 105–07.

105. OGH Nov. 15, 1989, docket No. 1 Ob 43/89, 62 SZNo. 176; OGH Dec. 19, 1990, docket No. 1 Ob 27/90, 63 SZ no. 223; *contra* OGH May 9, 1985, docket No. 7 Ob 566/85, 58 SZNo. 80.

106. KOZIOL, *supra* note 39, at no. 11/21.

107. Reischauer, *supra* note 39, at §1325 no. 49. Exceptionally, annuity payments are also possible in case of severe bodily injuries with particularly grave and lasting painful consequences: OGH Nov. 21, 1968, docket No. 2 Ob 330/68, 41 SZNo. 159; OGH Aug. 8, 2002, docket No. 2 Ob 145/02s, 47 ZVR No. 95 (2002). On the practice of compensation of future pain, see, for example, Christian Huber, *Globalbemessung, Teilbemessung und Teilglobalbemessung bei zukünftigen Schmerzen* [Global Assessment, Partial Assessment and Partial Global Assessment of Future Pain and Suffering], 63 ÖJZ 83 (2008).

108. Robert Fucik & Franz Hartl, *Schmerzensgeld für seelische Schmerzen* [Damages for Emotional Suffering], 72 ÖRZ 148, 151 (1994); cf. the latest list in Franz Hartl, *Schmerzensgeldsätze in Österreich* [Rates of Damages for Pain and Suffering in Austria], 7 ZAK 47 (2011) (with € 100–120 per day of light pain, € 200–250 per day of medium pain, and € 300–360 per day of severe pain).

109. Hartl, *supra* note 108.

110. Karl-Heinz Danzl, *Schmerzensgeldsätze in Österreich?* [Rates of Damages for Pain and Suffering in Austria?] 35 ZVR 295 (1990); JUEN, *supra* note 30, at 16–17; KARNER, *supra* note 100, at 91.

111. The highest published award so far was around € 218,000 in 2002. OGH Apr. 18, 2002, docket No. 2 Ob 237/01v, 2002 SZ No. 50.

112. So far, courts have recognized parents, children, siblings, and life-time companions as eligible for such claims. Amounts awarded are, for example, € 20,000 for each parent and up to € 15,000 to siblings; cf. OGH June 26, 2008, docket No. 2 Ob 55/08i, 19 ECOLX 907 (2008).

113. Danzl, *supra* note 84, at 1547–49, no. 29. This has to be differentiated from cases where the relatives have suffered a shock when learning about the (fatal) injuries of one of the family, which leads to a medical condition and therefore personal injury of themselves. On both types, see Ernst Karner &

qualified fault on the side of the tortfeasor, therefore claims based upon merely slight negligence or strict liability are not granted to such third parties. Furthermore, until recently, only damages for bereavement, i.e. in fatal cases, were granted. However, the Supreme Court has already indicated *obiter* that it may look more favorably upon cases in the future where the immediate victim has survived but suffered severe and lasting injuries, though still only if caused by qualified fault.¹¹⁴

III. COMPENSATION CLAIMS IN PRACTICE

A. General Remarks

Before addressing special ways to pursue claims based upon medical malpractice in Austria, it seems important to highlight just some of the most fundamental differences between Austrian and U.S. civil procedure.

To begin with, there are no juries in civil procedure, so in first instance, it is always a single judge alone who hears the case and decides both about liability and remedies. Furthermore, experts are typically appointed by the court, even though the parties may bring in further expert evidence. There is nothing equivalent to discovery in Austrian civil procedure.¹¹⁵ Finally, Austria follows the loser-pays principle, which means that whatever side wins the case is eligible to claim costs from the opponent in proportion to the percentage of success. This includes lawyers' fees, even though these are limited by statutory amounts linked to the value in dispute. So if the patient loses her case, she has to pay not only her own dues, but also court fees and the doctor's and/or hospital's attorneys' fees. If she succeeds only in half, the corresponding success of the defendant(s) effectively offsets the respective claims for reimbursement of costs.¹¹⁶

Helmut Koziol, *Der Ersatz ideellen Schadens im österreichischen Recht und seine Reform [Compensation for Non-pecuniary Damage Under Austrian Law and its Reform]*, in 11/1 VERHANDLUNGEN DES 15. ÖSTERREICHISCHEN JURISTENTAGS INNSBRUCK 2003 at 74 (2003).

114. E.g. OGH June 14, 2007, docket No. 2 Ob 163/06v, 2007 SZ No. 96.

115. On the taking of evidence in Austrian civil procedure, see *Taking of Evidence and Mode of Proof* – Austria, EUROPEAN JUDICIAL NETWORK, http://ec.europa.eu/civiljustice/evidence/evidence_aus_en.htm (last visited Apr. 14, 2011).

116. On the costs of litigation in Austria, see generally Benedikt Spiegelfeld, *Country Report Austria*, in STUDY ON THE TRANSPARENCY OF COSTS OF CIVIL JUDICIAL PROCEEDINGS IN THE EUROPEAN UNION (Jean Albert ed., 2007), available at https://e-justice.europa.eu/attachments/cost_study_austria_en.pdf.

B. Patient Advocacies

As required by federal law,¹¹⁷ all provinces have installed so-called *Patientenanwaltschaften* [patient advocacies]¹¹⁸, which offer, *inter alia*, free advice and support to patients who believe they have been wronged in the course of medical treatment at a hospital.¹¹⁹ These independent bodies, which are part of the executive branch and staffed by the provincial government, are not competent to represent patients before courts, but their services may prevent cases from going there inasmuch as they offer guidance to patients about their options, negotiate on their behalf with liability insurers, appoint experts to assess the facts, and so on. The patient advocacies serve an important buffer function, filtering out unsubstantiated cases, while at the same time, at least offering an official place to be heard to these complainants.¹²⁰

117. BUNDESGESETZ ÜBER KRANKENANSTALTEN UND KURANSTALTEN [KAKUG] [FEDERAL ACT ON HOSPITALS AND SANATORIUMS] BGBl I No. 69/2005, § 11(e) provides: “Provincial law has to foresee that independent patient representations (patient spokespersons, ombuds-institutions or other such representative bodies) are made available to assess possible complaints and to ensure patient interests upon request.”

118. Though misleading in light of the missing right of representation before courts, this German term is used in five provinces (Burgenland, Carinthia, Lower Austria, Vienna, Vorarlberg), whereas others speak of “Patientenvertretung” (Salzburg, Tyrol, Upper Austria) or “Patientinnen- und Pflegeombudsschaft” (Styria). On the history, see BELINDA JAHN, AUßERGEGERICHTLICHE KONFLIKTLÖSUNG IM GESUNDHEITSWESEN [OUT-OF-COURT SETTLEMENT OF DISPUTES IN THE HEALTH CARE SECTOR] (2009). See generally Gerald Bachinger, *Patienten helfen – The System of the Patient Advocacies in Austria*, NÖ PATIENTEN- UND PFLEGEANWALTSCHAFT (LOWER AUSTRIAN PATIENT ADVOCACY) (Nov. 2005), http://www.patientenanwalt.com/fileadmin/dokumente/09_english_documents/legal_information/05101egalinfo_patient_advocacies_DrBachinger.pdf.

119. In Burgenland, Carinthia, Lower Austria, Styria, Vienna, and Vorarlberg, the patient advocacy is also competent to handle claims concerning individual doctors. *Patientenanwaltschaften* [Patient Advocacy], PUBLIC HEALTH PORTAL OF AUSTRIA, available at https://www.gesundheit.gv.at/Portal.Node/ghp/public/content/Patientenanwaltschaften_LN.html (last updated Jan. 3, 2011).

120. In 2008, of all 673 complaints filed with the Lower Austrian patient advocacy, for example, 563 (eighty-four percent) upfront turned out to be unsubstantiated from a liability perspective. However, of the remaining 110 cases, 98 led to compensation payments, either through direct talks with the insurers (seventy-five cases) or after consulting the Medical Chamber’s conciliation panel (twenty-three cases). See *Tätigkeitsbericht* [Activity Report] 2008, NÖ PATIENTEN- UND PFLEGEANWALTSCHAFT, 27(f) (2008), http://www.patientenanwalt.com/fileadmin/dokumente/04_publikationen/tatigkeitsberichte/noe_ppa/T%C3%A4tigkeitsbericht_2008.pdf. While the number of patient complaints has doubled over the past ten years in Vorarlberg, only eight cases on average go to court each year. *Patienten klagen seltener wegen Kunstfehlern*, ORF (Feb. 9, 2010), <http://vorarlberg.orf.at/stories/422006/>; cf. *Pavement Planning New Album Release*, GLIDE MAGAZINE (Nov. 06, 2009), <http://www.glidemagazine.com/articles/55317/pavement-planning-new-album-release.html>.

C. Conciliation Bodies

All provinces with the exception of Salzburg¹²¹ have established so-called *Schiedsstellen* or *Schlichtungsstellen* (conciliation panels¹²²) in order to provide a forum for both patients and doctors to resolve disputes arising from or in the course of the treatment. They can therefore not only be called upon by patients, but also by doctors.¹²³ These panels are typically organized at the seat of the respective medical chamber.¹²⁴ The number of members varies and typically includes at least one doctor and one judge each.

The proceedings are entirely voluntary for both sides¹²⁵ and can be initiated by an informal request. The panel tries to resolve the matters in dispute by offering a forum for discussion. In some cases, it will request a formal independent expert opinion.¹²⁶ The decisions of the panel are mere non-binding recommendations, so that the patient can still file suit before a regular court of law. The decisions (if in the patient's favor) primarily recommend lump-sum payments.

Doctors or dentists who participate in the fact-finding process of the conciliation procedure are not deemed to thereby violate an obligation under their liability insurance policy, which otherwise might lead to a release from the obligation to cover the incident.¹²⁷

121. In Salzburg, the *Patientenvertretung* (patient advocacy) is entrusted with similar functions. See JAHN, *supra* note 118, at 74–75.

122. The literal translation would be “arbitration panel”. Despite their name, however, they do not offer arbitration in the formal sense since their decisions are not binding: JAHN, *supra* note 118, at 67.

123. On details see Maria Leitner, *Schiedsstelle in Arzthaftpflichtfragen* [Conciliation Panels in Medical Liability Cases], 5 RDM 7 (1998); Marianne Roth & Johann Sperl, *Außergerichtliche Konfliktlösung in Medizinischen Schadensfällen* [Out-of-Court Dispute Resolution in Medical Loss Cases], 62 ANWBL 387 (2000).

124. This is true for Burgenland, Lower Austria, Styria, Tyrol, Upper Austria and Vienna. In Carinthia and Vorarlberg, they are seated at the offices of the patient advocacy. The same is true for Salzburg with respect to hospitals, whereas the competent body for self-employed doctors is at the seat of the Salzburg Medical Chamber.

125. In some provinces, hospitals have filed general ex ante-submissions so that it is entirely up to their patients whether they want to have their cases heard before the competent conciliation panel or go straight to court. Cf. JUEN, *supra* note 30, at 294.

126. In Tyrol, this is true for about half of all cases handled. JUEN, *supra* note 30, at 296.

127. *ÄRZTEGESETZ* § 58(a) ¶ 2; *ZAHNÄRZTEGESETZ* [DENTAL ACT] BGBl. No. 126/2005, as amended, § 48 ¶ 2.

D. Compensation Funds

A federal law introduced in 2001¹²⁸ initiated the creation of compensation funds (*Patientenentschädigungsfonds*) for hospitals.¹²⁹ As this falls under the jurisdiction of the provinces themselves, the federal legislator only laid down the principles for its provincial counterparts; thus there are some differences in the models ultimately adopted by the various *Länder*.¹³⁰ The fund is financed by contributions from the patients (i.e. the potential victims!) themselves, who must pay an extra € 0.73 per day spent in hospital.¹³¹

The fund was created for patients who have suffered material or immaterial harm in the course of medical treatment (or the omission thereof) at a hospital.¹³² It is not meant to replace liability regimes, in fact, it is quite the contrary. The primary focus of the fund is cases of hardship, where liability cannot be clearly established (particularly due to problems involved in proving causation or fault¹³³), or if a rare but severe ('catastrophic') complication has occurred, even if the patient had been warned of its possibility before. Patients may still try to pursue their claims in court, even if already (partially) indemnified by the fund, but they have to return payments in case of success.¹³⁴ The application process is suspended, on the

128. KAKuG § 27(a) ¶¶ 5, 6. To some extent, this was modeled after the Viennese fund created earlier. See JAHN, *supra* note 118, at 133. The Freiwillige Wiener Härtefonds [Ex gratia Viennese Hardship Fund] continues to exist alongside the general fund and offers payments up to € 50,000 for people domiciled in Vienna who have suffered damage in the course of a treatment in a Viennese hospital; see *Freiwilliger Wiener Härtefonds*, VIENNA CITY ADMINISTRATION, <http://www.wien.gv.at/gesundheit/wppa/haertefonds.html> (last visited Apr. 25, 2011).

129. Practitioners outside hospitals are not covered by this fund.

130. Wolfgang Kossak, *Der Entschädigungsfonds gem § 27a Abs 5 und Abs 6 Krankenanstaltengesetz [The Compensation Fund According to section 27a, paragraph 5 and 6 Hospitals Act]*, 9 RDM 111 (2002); Eckhard Pitzl & Gerhard Huber, *Verschuldensunabhängige Patientenentschädigung [No-Fault Compensation for Patients]*, 10 RDM 100 (2003).

131. The fund's means vary from province to province: In 2003, the funds in Vienna and Lower Austria stood at almost € 1 million each (with payments totalling about € 400,000 in the latter province during that year). In comparison, the monies collected in the same period in the Burgenland amounted to only one tenth. See *Patientenentschädigungsfonds- Tätigkeits Bericht*, NÖ PATIENTEN- UND PLFEGEANWALTSCHAFT, 18 http://www.patientenanwalt.com/pdf/Patientenentschaedigungsfonds_Taetigkeitsbericht_2003.pdf (last visited Apr. 11, 2011).

132. On details of this causation requirement, see Pitzl & Huber, *supra* note 130, at 103.

133. As expressly stated in the guidelines of the Viennese fund, for example, payments out of the fund are excluded if the facts are clear (whether in the patient's favour or not). See *Richtlinien des Patientenentschädigungsfonds*, VIENNA CITY ADMINISTRATION (2009) (hereinafter *Richtlinien*), <http://www.wien.gv.at/gesundheit/wppa/patientenfonds-richt.html>.

134. This works either way, so if a patient is awarded € 10,000 by the fund and subsequently obtains judgment in the amount of € 5,000, she only has to pay back the latter amount, whereas if the court award in her favour exceeds € 10,000, this is the maximum she has to repay. Repayment may be waived in cases of social hardship. See *Richtlinien*, *supra* note 133.

other hand, while a court trial is pending, or as long as the parties try to find an out-of-court settlement.

As cases typically do not reach the commission before the *Patientenanwalt* has decided on the tort law merits of the cases in the negative, the success rate of these filings is rather high.¹³⁵ Payments out of the fund are capped, but the threshold amounts vary from province to province.¹³⁶

The Austrian Medical Chamber has also installed a *Solidarfonds* [solidarity fund] as required by the Federal Act regulating their profession. It is meant to absorb losses that are not recoverable despite a valid claim, particularly due to the lack of liability insurance coverage. Eligible claimants are patients who have been harmed by wrongful and faulty medical treatment provided by doctors in private practice.

E. Outlook

Medical malpractice became a hot topic for legal scholars and judges in the last quarter of the past century, even though there had been court cases long before, of course. At least in part, this may have been the logical consequence of changes in society. A significant growth in the number of doctors coupled with a decline of the one-stop-shop concept of medical treatment offered by general practitioners who were being replaced by more and more diverse specialists, the local family doctor in the community was superseded by some anonymous service providers, whose quality of service was being more and more questioned. Awareness of and belief in the progress of science at the same time raised patients' expectations with regard to the outcome of a treatment, however unrealistic those expectations might have been.¹³⁷

135. The 2008 statistics show that 94 percent of applications were successful in Vienna. *Bericht über das Jahr [Annual Report] 2008*, VIENNA CITY ADMINISTRATION, 57 (2009), available at <http://www.wien.gv.at/gesundheitswppa/pdf/bericht-2008.pdf>. Seventy-six percent succeeded in Lower Austria. *NÖ Patienten-Entschädigungsfonds, Tätigkeitsbericht 2008*, NÖ PATIENTEN- UND PFEGEANWALTSCHAFT, 5 (2009), http://www.patientenanwalt.com/fileadmin/dokumente/04_publikationen/taetigkeitsberichte/noe_patienten_entschaedigungsfonds/Patienten_Entschaedigungsfonds_Taetigkeitsbericht_2008_Publikationen_Taetigkeitsberichte.pdf.

136. While the maximum in Vienna currently stands at € 100,000 (exceptions possible, see Richtlinien, *supra* note 133), awards in Lower Austria generally must not exceed € 21,801.85 (in cases of extraordinary hardship € 36,336.417, but in special cases of permanent harm of extraordinary dimensions, the exceptional ultimate maximum is € 150,000. See *Geschäftsordnung der Entschädigungskommission*, NÖ PATIENTEN- UND PFEGEANWALTSCHAFT, 4 (2007), available at http://www.patientenanwalt.com/fileadmin/dokumente/02_ihre_rechte/Geschäftsordnung_08_NOE_Patienten-Entschaedigungsfonds.pdf.

137. See Bernhard A. Koch, *The Development of Medical Liability in Austria*, in THE DEVELOPMENT OF MEDICAL LIABILITY 108, 108–09 (Ewoud Hondius ed., 2010), in particular the statement by a doctor that “95 fatalities among 100 cancer patients were considered an inevitable matter

The media has certainly also had its share in the growing alertness of patients that not all adverse outcomes of their treatment may be fateful. The introduction of ombudsmen and conciliation panels, both very active in cultivating public relations, not only attracted a growing number of complaints (at least initially) but at the same time served as a buffer to keep unfounded claims out of the court system.¹³⁸

While further reform of medical malpractice law has been discussed repeatedly over the past decades, including a shift towards the Scandinavian models, there is no reform plan in sight at present that has any chance of immediate legislation. This lack of reform also seems to indicate that political pressure to proceed is low, and therefore, dissatisfaction with the system as it stands is rather low as well.

of fate in the old days when a doctor was praised for the five survivor. With today's knowledge and technology, 50 % may be healed, while already five patients with constant or deteriorating condition are nowadays often presumed to be a clear-cut indication of the doctor's failure." *Id.* at 109 n.5.

138. See *supra* note 120; Koch, *supra* note 137, at 129–31.