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MEDICAL MALPRACTICE AND COMPENSATION IN GERMANY

MARC S. STAUCH*

INTRODUCTION

By way of introduction, and to give some context, it may be helpful to say a few words about how health care provision is organised in Germany. The country has the oldest system of mass health care coverage in the world. Its beginnings stem from one of Otto von Bismarck's social reforms of the 1880s, which established a system of statutory health insurance funds (*Gesetzliche Krankenkassen*) for workers, and were financed partly by the employer and in part by deductions from the worker's salary.¹ In subsequent years, the ambit of the system was gradually extended to other groups in society so that nowadays virtually every citizen has health insurance coverage. Some ninety percent of the population are members of one of the statutory public funds, while the remainder—typically persons in higher income brackets, who are allowed to opt out of the public insurance scheme—are privately insured. In total, about 250 billion euros are spent on health care provision annually (over ten percent of Germany's gross domestic product).²

In recent years, the German federal state has increased the level of control it exercises over the system, above all by establishing quality assurance and auditing initiatives in an effort to reduce costs. This has been expressed in reforms to Title V of the Sozialgesetzbuch [SGB] [Social Code],³ imposing quality assurance duties on deliverers of health care to

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1. Krankenversicherungsgesetz [KVG] [Health Insurance Act], June 15, 1883, Reichsgesetzblatt [RGBL.] at 73.

2. *Germany - National Expenditure on Health*, WORLD HEALTH ORG., <http://www.who.int/nha/country/deu.pdf> (last modified Mar. 2010).

3. See SOZIALGESETZBUCH V GESETZLICHE KRANKENVERSICHERUNG [SGB V] [SOCIAL CODE TITLE V SOCIAL HEALTH INSURANCE], Dec. 20 1988, BUNDESGESETZBLATT [BGBL.] I at 2447. The reforms were introduced by the GKV-Gesundheitsreformgesetz 2000 [GRG] [Public Health Insurance Reform Act of 2000], Dec. 22, 1999, BGBL. I at 2626, available at http://bundesrecht.juris.de/gkvrefg_2000 (inserting new provisions §§ 135 into SGB V).

publicly insured patients. Nonetheless, the system as a whole remains notably decentralized in character. The state provides the underlying statutory framework (in Title V of the SGB), but leaves the detailed ordering and running of the system to the key non-state actors in the area.⁴

Thus the financing of medical treatment is a matter for the health insurance funds, which contract with doctors and hospitals to provide the necessary care. Doctors operating alone or in partnerships and providing primary or specialized care, are private actors, remunerated on a fee-for-service basis by the insurance funds. For their part, hospitals may be either public institutions (run by a given regional municipality or other public body) or private bodies. Of the latter, around half are charitable in nature, including hospitals run by various religious orders, while the rest are commercial, for-profit enterprises.

As regards the regulation of health care providers, this too is devolved, occurring on different levels in line with the federal nature of the German political system. Thus hospitals are primarily regulated by the laws of the individual states (*Länder*), rather than by the federal government (*Bund*). Individual doctors—those working in primary care as well as those employed in hospitals—are subject to a dual system of control. In the first place, they must be licensed to practice by the federal level licensing (*Approbation*) authority. Secondly, they are required to join, and are bound by the professional rules (*Standesrecht*) of, the relevant state-level medical council (*Landesärztekammer*) in their region.⁵

As is the problem in other countries, there has been an increasing recognition in Germany of the prevalence of avoidable patient injury in the course of medical treatment. In 2007 an expert committee charged with monitoring developments presented statistics (compiled on the basis of 184 studies) suggesting an annual rate of preventable adverse events (*vermeidbare unerwünschte Ereignisse*) of 2–4% in hospital care, and a PAE-related mortality rate of 0.1%.⁶ Given that some 17 million in-patient treatments

4. See Ursula Weide, *A Comparison of American and German Cost Containment in Health Care: Tort Liability of U.S. Managed Care Organizations vs. German Health Care Reform Legislation*, 13 TUL. EUR. & CIV. L.F. 60, n.72 (1998). See generally MICHAEL SIMON, DAS GESUNDHEITSSYSTEM IN DEUTSCHLAND 103–07 (3d ed. rev. and updated 2010).

5. ERWIN DEUTSCH & ANDREAS SPICKHOFF, MEDIZINRECHT 19–22 (6th ed. rev. and expanded 2008).

6. SACHVERSTÄNDIGENRAT ZUR BEGUTACHTUNG DER ENTWICKLUNG IM GESUNDHEITSWESEN, [ADVISORY COUNCIL ON THE ASSESSMENT OF DEVELOPMENTS IN THE HEALTH CARE SYSTEM] COOPERATION AND RESPONSIBILITY: PREREQUISITES FOR TARGET-ORIENTED HEALTH CARE 63 (2007), available at <http://www.svr-gesundheit.de/Gutachten/Gutacht07/KF2007-engl.pdf>.

take place each year, this corresponds to half-a-million injuries and 17,000 preventable deaths.⁷

This realization has triggered an interest in recent years in initiatives designed to promote patient safety, in particular through enhanced risk management systems. Specific German measures in this area will be looked at further, towards the end of the paper, in Part III C. First though we shall consider matters from the ex post facto perspective of a case where medical injury to a patient has occurred. In such a situation, what are the potential legal consequences in terms of accountability and redress mechanisms that may follow?

I. THE POTENTIAL LEGAL CONSEQUENCES OF MEDICAL INJURY

A. Criminal Law

The first possibility is that the treating doctor may be subject to criminal proceedings. Indeed, it has been estimated that around 3,000 criminal investigations against doctors are commenced with respect to medical errors each year.⁸ Leaving aside cases where the patient dies (in which a charge of negligent manslaughter (*fahrlässige Tötung*) may arise under section 222 of the Strafgesetzbuch [StGB] [Penal Code],⁹ there are two main offenses that come into consideration. In the first place, German law recognizes a crime of negligent bodily injury (*fahrlässige Körperverletzung*), which is penalized under section 229 of the StGB.¹⁰ Thus even in cases of comparatively minor injury, where a patient suspects the injury arose from negligence, he has the option of reporting the doctor to the police. Secondly, German law places very stringent validity requirements on consent to medical treatment; as discussed in more detail later, any deficit in information (including the non-disclosure of risks and alternatives) may render consent void.¹¹ In such cases, the doctor could potentially face a charge of assault (*Körperverletzung*) under section 223 of the StGB.¹²

7. *Id.*

8. KLAUS ULSENHEIMER, ARZTSTRAFRECHT IN DER PRAXIS [MEDICAL PRACTITIONERS AND CRIMINAL LAW IN PRACTICE] 3 (4th ed. rev. and expanded 2008).

9. See STRAFGESETZBUCH [StGB] [PENAL CODE], Nov. 13, 1998, BGBL. I at 3322, as amended, § 222.

10. StGB § 229.

11. See *infra* Part II B.

12. StGB § 223.

Admittedly, in around ninety-five percent of cases, the action will be stayed for lack of evidence or public interest.¹³ Moreover, in cases that proceed to trial, the doctor will usually secure an acquittal. Here, (in contrast to private law) the prosecution is required to prove subjective fault on the doctor's part (i.e., that he was individually capable of avoiding the mistake in question).¹⁴ Similarly, as regards a charge of assault following inadequate consent, it must be shown that, if the patient had received the wrongfully withheld information, he would have refused the treatment.¹⁵ The onus of proof with respect to all matters remains on the prosecution: the proof modifications or reversals that (as we shall see later) are such a feature of German private law in this area do not apply.

In the relatively rare case of a conviction, the doctor will generally pay a fine. However, if the court finds a gross dereliction of duty on his part and sees a risk of repetition, it may ban him from practicing for up to five years.¹⁶ In principle, commencement of a criminal action against a doctor, as well as its outcome, does not prejudice any private law action the patient has with respect to the same injury. It is true that concerns have sometimes been raised that patients may use the threat of a criminal investigation to pressure the doctor into settling a damages claim. However, this may merely antagonize the doctor and stiffen his resolve to defend the claim. Thus patient-solicitors normally advise their clients against taking such a course.¹⁷

B. Professional and Disciplinary Sanctions

Besides exposure to potential criminal liability, the doctor may have to answer for a medical injury before various professional bodies and/or, in the case of a doctor employed in a hospital, his employer. As noted above, doctors are required to join the medical council of the state in which they practice and will be subject to that council's professional rules. These rules include a duty to treat patients conscientiously and appropriately.¹⁸ How-

13. See ULSENHEIMER, *supra* note 8, at 4.

14. DEUTSCH & SPICKHOFF, *supra* note 5, at 295–96.

15. See Bundesgerichtshof [BGH] [FEDERAL COURT OF JUSTICE], June 29, 1995, NEUE ZEITSCHRIFT FÜR STRAFRECHT [NSiZ] 34, 1996. Again this is in contrast to the position under private law. See Part II B.

16. StGB § 70(1).

17. See KARL OTTO BERGMANN & CAROLIN WEVER, DIE ARZTHAFTUNG [MEDICAL MALPRACTICE LIABILITY] 197–98 (3d ed. 2009).

18. See BUNDESÄRZTEKAMMER [BÄK] [FED. MED. COUNCIL], MUSTERBERUFSORDNUNG FÜR DIE DEUTSCHEN ÄRZTINNEN UND ÄRZTE [MBO] [MODEL PROFESSIONAL CODE FOR MEDICAL PRACTITIONERS] § 11 (2006). The BÄK is the umbrella organization for the regional medical councils.

ever, the doctor will not be called to account for an ordinary failure leading to injury, even where there was fault in a legal sense. Rather, a gross failure of care is required, or injury in circumstances that imply a breach of an anterior professional duty, such as the failure to keep up-to-date with medical knowledge by continuing professional training.¹⁹

In these cases, the doctor will be required to appear before one of the professional tribunals (*Berufsgerichte*), attached to the administrative courts.²⁰ Where the allegation is made out, sanctions may include a fine and/or a practice ban.²¹ In addition, where there is a finding against the doctor in the relevant professional proceedings (or indeed in a criminal trial), this may lead the federal level approbation authority to act to remove his general practicing certificate. The authority has this power in cases where the doctor's conduct demonstrates unworthiness or unreliability to such a degree that he no longer commands the trust and confidence required of a doctor.²²

C. *Fault-Based Compensation in Private Law*

The above mechanisms focus upon the doctor, with the aims of securing accountability and reducing the risk to patients from delinquent practitioners. However, they do not offer redress in a direct sense to the patient. Instead, if the latter wishes to obtain compensation for the injury he has suffered, he must turn to the institutions of private law. In Germany an increasing number of patients are availing themselves of this option: today it is estimated that between 20,000 and 40,000 private law claims commence each year.²³

Under the Bürgerliches Gesetzbuch [BGB] [Civil Code],²⁴ the patient generally has the choice of bringing an action in contract or in tort (or in both). Admittedly, in the past there were differences between these two routes, as there were discrepancies in the respective rules; however, the key differences relevant to medical malpractice claims were removed in 2002

19. See BERGMANN & WEVER, *supra* note 17, at 207–09.

20. See *id.* at 207–08.

21. *Id.*

22. Bundesärzteordnung [BÄO] [Federal Medical Practitioners Act], Apr. 16, 1987, BGBl. I at 1218, as amended, § 5(2); See also BERGMANN & WEVER, *supra* note 17, at 210–11.

23. See the discussion of the empirical data *infra*, at Part III A.

24. See BÜRGERLICHES GESETZBUCH [BGB] [CIVIL CODE], Aug. 18, 1896, RGBL. at 195, repromulgated Jan. 2, 2002, BGBl. I at 42, as amended, available at <http://www.gesetze-im-internet.de/bgb/>, translated at BUNDESMINISTERIUM DER JUSTIZ, http://www.gesetze-im-internet.de/englisch_bgb/.

by reforms to the BGB,²⁵ so that now the rules in effect duplicate each other.²⁶

Looking first at contractual liability, the patient can sue on the basis of the doctor's alleged breach of his contractually assumed duties. This applies not only to patients who have private insurance, and pay the doctor in full before recouping this money from their insurer, but also to (the majority of) patients whose treatment is paid for by a statutory public insurance fund.²⁷ The general basis for liability for breach of contract is set out in the BGB as follows:

Section 276 Responsibility of the obligor

(1) The obligor is responsible for intention and negligence, if a higher or lower degree of liability is neither laid down nor to be inferred from the other subject matter of the obligation, including but not limited to the giving of a guarantee . . .

(2) A person acts negligently if he fails to exercise reasonable care.

Section 280 Damages for breach of duty

(1) If the obligor breaches a duty arising from the obligation, the obligee may demand damages for the damage caused thereby. This does not apply if the obligor is not responsible for the breach of duty.²⁸

As these provisions indicate, contractual liability in Germany is based on fault, in the sense that, even after a breach of contract is made out, the defendant has the chance to exculpate himself by showing lack of fault (intention or negligence).²⁹ In fact, with regard to contracts for medical treatment, matters usually do not reach this stage. The reason is that such contracts are generally treated as service contracts, under which the doctor is not held to a strict duty of achieving a given result (such as a cure), but simply one of careful performance.³⁰ In other words, the doctor's fault (i.e. negligent performance) must already be shown at the initial stage of establishing a breach of contract.

25. See Schadensrechtänderungsgesetz [Act Altering the Law of Damages], July 19, 2002, BGBL. I at 2674; Schuldrechtsmodernisierungsgesetz [Act Modernizing the Law of Obligations], Nov. 26, 2001, BGBL. I at 3138. The relevant differences were that damages for pain and suffering used to be available in tort alone and a longer limitation period applied in contract.

26. CHRISTIAN KATZENMEIER, ARZTHAFTUNG [MEDICAL MALPRACTICE LIABILITY] 79–81 (2002).

27. This reflects the non-requirement of consideration in German contract law. Thus a private law contract exists between a doctor and a publicly-insured patient. See SGB V § 76(4).

28. BGB §§ 276(1)–(2), 280(1), translated at BUNDEMINISTERIUM DER JUSTIZ, *supra* note 24.

29. See *id.* at § 280(1). As is made clear by the way the provision is framed, the burden of persuading the court that there was no fault falls upon the obligor (i.e., defendant).

30. See DEUTSCH & SPICKHOFF, *supra* note 5, at 73–74.

In relation to hospital treatment, the effect of the contractual rules is to focus liability upon the hospital authority. In the majority of cases the patient will enter into a contract with both the hospital and the particular doctor(s) treating him. Besides being vicariously liable for the defaults of its employees, the hospital will be directly liable for the conduct of doctors occupying managerial positions.³¹ Moreover, there has been an increasing tendency in malpractice cases to impose direct liability with respect to organizational failures.³²

Moving on to tortious liability, the basis for this is found in section 823 (1) BGB, which provides as follows: "A person who, intentionally or negligently, unlawfully injures the life, body, health, freedom, property or another right of another person is liable to make compensation to the other party for the damage arising from this."³³ Here again, fault in the form of intention or negligence is a precondition for liability. In this regard the same definition of negligence applies as for contract, namely the failure (under section 276 (2) BGB) to exercise reasonable care. Again, the patient may choose to bring his action against an individual doctor and/or the hospital.

As previously hinted, a claim in private law represents by far the most significant way for patients injured during medical treatment to gain redress. Accordingly, in Part II below, we shall look in more detail at the rules that determine the existence and extent of a valid claim in a particular case. There too we shall consider an essential adjunct to the system, in the form of medical liability insurance, as well as the system of extra-judicial 'medical arbitration boards' in Germany, aimed at encouraging the abandonment or settlement of claims.

D. Strict Liability and No-Fault Compensation for Medical Product Injury

In the case of injury attributable to medical products, German law also offers the possibility of compensation independent of fault. First and most significant, are injuries caused by medicinal drugs. Thus in 1976, in the wake of the Thalidomide (*Contergan*) disaster, the German Parliament

31. BGB §§ 31, 89, 278, translated at BUNDEMINISTERIUM DER JUSTIZ, *supra* note 24.

32. See generally Bernd-Rüdiger Kern, *Organisationsverschulden in der Judikatur* [Organizational Fault in the Case Law], in PATIENTENSICHERHEIT, ARZTHAFTUNG, PRAXIS- UND KRANKENHAUSORGANISATION [PATIENT SAFETY, MEDICAL MALPRACTICE, AND THE ORGANIZATION OF PRACTICES AND HOSPITALS] 59 (Dietrich Berg & Klaus Ulsenheimer eds., 2006).

33. BGB § 823(1), translated at BUNDEMINISTERIUM DER JUSTIZ, *supra* note 24.

enacted the Arzneimittelgesetz [AMG] [Medicinal Products Act].³⁴ This provides in section 84 for liability against pharmaceutical manufacturers in cases where a medicinal product, used as prescribed, causes injury that, in light of the overall level of medical scientific development, may be regarded as unacceptable.³⁵ In addition, following initiatives at the EC level, injury from non-pharmaceutical medical products is covered within the more general “strict liability” regime for consumer products under the Produkthaftungsgesetz [ProdHaftG] [Products Liability Act].³⁶

Both the AMG and ProdHaftG regimes are regarded as complex in terms of their scope of application, and are relatively seldom used. One common difficulty has been establishing the causal link between a given product and an injury. In this regard, some reforms were made to the AMG in 2002, easing the patient’s situation. Now, once he shows the medicine was capable of causing the injury he suffered, absent a plausible alternative explanation, the presumption will be that it did so in his case; there is also a right to obtain information from the manufacturer as to the medicine’s known effects.³⁷ Despite these changes, the pharmaceutical industry reported that between mid-2002 and mid-2005, it received just 220 compensation claims under the AMG, and seventy requests for information.³⁸

In the second place, there are two limited pockets of no-fault liability with respect to medicinal product injuries. The first of these covers victims of Thalidomide (*Contergan*) and was set up in 1971 under the Contergan-stiftungsgesetz [ConStiftG] [Thalidomide Foundation Act].³⁹ The relevant scheme provides for compensation (mainly in the form of a fixed monthly pension) from a fund financed by contributions by the federal government

34. See Arzneimittelgesetz [AMG] [Medicinal Products Act], Dec. 12, 2005, BGBl. I at 3394, as amended, translated at BUNDEMINISTERIUM DER JUSTIZ, *supra* note 24.

35. See also DEUTSCH & SPICKHOFF, *supra* note 5, at 844. In this regard, the AMG does not embody strict “causal” liability: a patient who suffers an adverse reaction to the drug in its normal form is not entitled to compensation, if the drug fulfilled an important medical need and alternative treatment was not available.

36. Produkthaftungsgesetz [ProdHaftG] [Products Liability Act], Dec. 15, 1989, BGBl. I at 2198, as amended (transposing the EC Product Liability Directive, 85/374 EC).

37. AMG §§ 84(2), 84a(1). See also Valentin Saalfrank, *Neue Aspekte der Arzneimittelhaftung* [New Aspects of Medicinal Product Liability], in ARZNEIMITTELSICHERHEIT – WUNSCH UND WIRKLICHKEIT [THE SAFETY OF MEDICINAL PRODUCTS - WISH AND REALITY] 90 (Ilse Dautert et al. eds., 2008); Gerhard Wagner, *Die Reform der Arzneimittelhaftung im Entwurf eines Zweiten Schadensrechtsänderungsgesetzes* [The Reform of Medicinal Product Liability in the Draft Second Bill Altering the Law of Damages], 31 VERSICHERUNGSRECHT [VERSR] 1336 (2001).

38. Saalfrank, *supra* note 37, at 91.

39. Conterganstiftungsgesetz [ConStiftG] [Thalidomide Foundation Act], Dec. 17, 1971, BGBl. I at 2018, repromulgated June 25, 2009, BGBl. I at 1537.

and the drug manufacturers.⁴⁰ The second German no-fault scheme was established in 1995 to provide compensation to patients infected with HIV as a result of receiving contaminated blood. This was introduced by the HIV-Hilfegesetz [HIVHG],⁴¹ *inter alia* in the light of the difficulties of proof experienced by such patients in bringing a claim under section 84 of the AMG.

Although no-fault compensation for medical injury thus plays a limited role in modern Germany, it is worth remarking that things were different in the former German Democratic Republic (GDR). There, a partial no-fault scheme of “additional support for victims of medical injury” operated, which covered iatrogenic injury, absent fault, if this was severe and in gross disproportion to the seriousness of the condition being treated.⁴² A rationale that has been suggested for the scheme was of counterbalancing the duty on GDR citizens to seek treatment to safeguard their economic productivity. Be that as it may, after German reunification, the scheme was no longer seen as socially justified, and it was disbanded in 1994.⁴³

E. Social Security, Insurance, and Subrogation Issues

Patients who neither qualify for private law compensation nor fall within one of the limited statutory strict liability and no-fault schemes must fall back on the general system of social security. This provides injured and/or disabled persons with access to collective social protection irrespective of the source of injury, and in Germany is relatively generous. Thus the costs of further remedial treatment are covered by the medical insurance funds in the normal way, as are the ongoing costs of nursing care in cases of long-term disability.⁴⁴

In addition, if the patient was employed and is now unable to work, his employer is required to continue to pay his salary for the first six weeks

40. See Christiane Wendehorst, *Compensation in the German Health Care Sector*, in NO-FAULT COMPENSATION IN THE HEALTH SECTOR 261, 270 (Jos Dute et al. eds., 2004).

41. HIV-Hilfegesetz [HIVHG], July 24, 1995, BGBl. I at 971, last amended by G, Oct. 31, 2006, BGBl. I at 2407. See Wendehorst, *supra* note 40, at 272; Wagner, *supra* note 37.

42. Anordnung über die Erweiterung der materiellen Unterstützung der Bürger bei Schäden infolge medizinischer Eingriffe [Ordinance on the Material Support of Citizens Injured By Medical Interventions], Dec. 16, 1974, GBL. 1975, no. 3, at 53. The scheme was partial in two ways. First, if there was fault (or rather—as, under the GDR-civil code, the onus of proof was here on the doctors—its absence could not be shown), fault-based liability applied. Secondly, the scheme extended to iatrogenic injuries only, not to failures to benefit from deficient treatment. See also, KATZENMEIER, *supra* note 26, at 229.

43. KATZENMEIER, *supra* note 26, at 268–69.

44. *Id.* at 205–06.

of absence; thereafter, he is entitled to statutory invalidity benefit (payable by the medical insurance funds), at seventy percent of his previous salary, for eighteen months.⁴⁵ At a later point he will also become eligible for his statutory pension, albeit in a lower sum.⁴⁶ In some cases, the patient may also have augmented social security benefits through private insurance.⁴⁷

In cases of established medical malpractice, the relevant insurance-providers, having paid out sums to or for the patient, will have a right of recourse against the doctor's or hospital's liability insurer.⁴⁸ Until a few years ago, such cases remained the exception: due to high administrative costs, the preference was for advance global settlements within the insurance sector, by which the liability insurers set aside a sum to cover injuries caused by their insured, and the patient insurance funds waived recourse.⁴⁹ However, latterly, against the backdrop of financial pressure on the social security system, this has changed. Indeed, since 2004, hospitals have been under a duty to inform social insurance providers in cases in which their insured has suffered injury from putative medical negligence.⁵⁰ It is now reported that some fifteen percent of damages in malpractice claims go to patients' social and private insurance providers via subrogation.⁵¹

II. THE SYSTEM OF PRIVATE LAW COMPENSATION

In practice, as previously mentioned, private law provides the patient's primary route to reparation for medical injury. As well as serving to close gaps in social security protection (particularly with respect to persons who

45. *Id.* at 207.

46. *Id.* at 207–08.

47. *Id.*

48. SOZIALGESETZBUCH X SOZIALVERWALTUNGSVERFAHREN UND SOZIALDATENSCHUTZ [SBG X] [SOCIAL CODE TITLE X SOCIAL ADMINISTRATION AND SOCIAL PROTECTION], Aug. 5, 2010, BGBl. I at 1127, § 116(1) (addressing statutory health funds); Versicherungsvertragsgesetz [VVG] [Insurance Contracts Act], Apr. 14, 2010, BGBl. I at 410, § 86(1) (addressing private insurance companies).

49. KATZENMEIER, *supra* note 26, at 212–13.

50. See SOZIALGESETZBUCH V GESETZLICHE KRANKENVERSICHERUNG [SGB V] [SOCIAL CODE TITLE V SOCIAL HEALTH INSURANCE], Dec 20, 1988, BGBl. I at 2477, as amended, § 294a. See also Friedrich-Christian Beck & Axel Hausch, *Das Recht des Patienten auf informationelle Selbstbestimmung im Spannungsverhältnis zum Akteneinsichtsanspruch der Krankenkassen nach § 294a SGB V* [The Patient's Right to Information Autonomy in Tension with the Health Insurance Funds' Right to Access Health Records Under § 294a SGB V], 59 VERSR 1321 (2008).

51. See Anja Krüger, *Im Spannungsfeld Zwischen Ärztlichen Standards und Wirtschaftlichkeitsgebot*, ÄRZTE ZEITUNG, Oct. 14, 2010, at 2, available at http://www.aerztezeitung.de/praxis_wirtschaft/recht/article/623876/arzthaftpflicht-zwischen-behandlungsfehlern-wirtschaftlichkeit.html; see also Jens Flintrop & Heicke Korzilius, *Arzthaftpflicht: Der Schutz wird Teurer* [Medical Liability Cover: The Cost is Increasing], DEUTSCHES ÄRZTEBLATT, Apr. 16, 2010, at A 692, available at <http://www.aerzteblatt.de/v4/archiv/artikel.asp?id=74090>.

are not employed or who suffer long-term disability), it provides the only means for the patient to recover non-pecuniary damages for pain and suffering (*Schmerzensgeld*).

As we saw in Part I C, the legal basis for the treating side's liability is found in key provisions of the German Civil Code [BGB]. However, the rules that then determine the existence, or not, of liability in a given case are largely a product of judge-made law.⁵² Indeed, over the last fifty years, the courts have created a subtle and involved jurisprudence, with a significant number of cases going all the way to the Bundesgerichtshof [BGH] [Federal Court of Justice].⁵³ An important distinction at the outset, as to how claims are classified and dealt with, is between cases of treatment malpractice (*Behandlungsfehler*), and those of disclosure malpractice (*Aufklärungsfehler*).

A. Treatment Malpractice Claims

1. Faulty Treatment

As discussed earlier, fault is a requirement for liability to arise; this is so whether a claim is based on contract or tort. Typically negligence will be at issue, which as we saw is defined as the failure to exercise reasonable care.⁵⁴ In the case of a doctor, the BGH has held the applicable standard of care to be that of "a respectable and conscientious medical professional of average expertise in the relevant field."⁵⁵ This is an objective test, with the result that if a doctor undertakes a task for which he does not (yet) have sufficient competence, he will generally be liable. In a leading decision on the duties of junior doctors, the BGH stated:

[A junior doctor] owes the same duty of skill and care to the patient as any other doctor. . . If he recognises, or ought to recognise, that the patient will be exposed to a heightened risk of injury as a result of his inex-

52. For an account of the relevant rules from a comparative perspective, see MARC STAUCH, *THE LAW OF MEDICAL NEGLIGENCE IN ENGLAND AND GERMANY – A COMPARATIVE ANALYSIS* (2008).

53. The BGH is the final appeal court for private law actions. In the thirty or so years before 2002 (when the German civil procedure rules changed to require leave from the intermediate appellate courts) the BGH typically heard between ten to twenty medical malpractice appeals each year. Since then, the number has fallen to between five and ten each year.

54. BÜRGERLICHES GESETZBUCH [BGB] [CIVIL CODE], Aug. 18, 1896, RGBL. at 195, repromulgated Jan. 2, 2002, BGBL. I at 42, as amended, § 276(2).

55. Bundesgerichtshof [BGH] [Federal Court of Justice], Jun. 13, 1960, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 600, 1961.

perience, he should not proceed to treat against the dictates of his medical conscience and own better judgment.⁵⁶

As this suggests, a junior doctor may be exculpated on the basis that he could not reasonably have known of his own lack of necessary skill. In such a case, liability will be placed exclusively upon the hospital for an organizational failure in deploying him for the relevant task and/or failing to supervise him.⁵⁷

A further effect of the objective approach is that a hospital may not defend itself by pleading a lack of resources. At the same time, some variation in care between hospitals is accepted as inevitable, so that—provided a threshold standard of care is satisfied—a small local hospital need not operate to the same level as a university hospital.⁵⁸ A more controversial issue concerns the standard owed in emergency situations (outside a hospital). Here, on the face of it, the “Good Samaritan” doctor may avail himself of section 680 BGB, which restricts the liability of “rescuers” to cases where their conduct was wilful or grossly negligent. However, the courts have as yet left open how far this provision would apply to someone with professional medical training.⁵⁹

In assessing a particular case, if the doctor has met the required standard of care, the courts will be guided in the first place by the opinion evidence of other doctors as to whether his conduct was justified. Indeed, the BGH has held that a judge is not entitled to find negligence on the basis of ideas of his own, without the support of the experts.⁶⁰ At the same time, the courts are willing to look critically at practices accepted by the medical experts and will sometimes find them wanting. As the BGH stated in a medical negligence case from 1964:

[T]he fact a given practice is customary will not be enough to exclude negligence if at the same time there is a failure to do all that is necessary, according to the rules and experience of medical science, to safeguard the patient from bodily harm.⁶¹

56. Bundesgerichtshof [BGH] [Federal Court of Justice], Sept. 27 1983, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 655 (657), 1984.

57. *Id.*

58. See Bundesgerichtshof [BGH] [Federal Court of Justice], Sept. 22, 1987, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 763, 1988; see also KATZENMEIER, *supra* note 26, at 283–84.

59. See Oberlandesgericht [OLG] [Higher Regional Court] München, 6 Apr. 2006, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 1883, 2006.

60. Bundesgerichtshof [BGH] [Federal Court of Justice], Mar. 2, 1993, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 2378, 1993.

61. Bundesgerichtshof [BGH] [Federal Court of Justice], Oct. 13, 1964, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 345 (346), 1965.

At least as significant, in terms of finding fault, are situations classified by the courts as involving “fully masterable risks” (*voll beherrschbare Risiken*). This covers cases where the harm to the patient stems from a risk arising out of the treatment environment. In such cases the occurrence of the risk per se qualifies as a breach of one of the treating side’s subsidiary obligations under the treatment contract, which—unlike the primary duty of attempting a cure—are construed strictly. As the BGH noted in a leading case from 1977, where a patient suffered brain damage due to a defect in the anaesthetic equipment:

The hospital authority owed a contractual duty of care with respect to the provision of a properly functioning oxygen machine. The objective breach of this led to the damage in question. . . The principle [that the doctor will not be held contractually to the achievement of a given outcome] does not apply to the fulfilment of fully-masterable subsidiary obligations, in particular the guaranteeing of safe technical equipment during treatment.⁶²

Here, in line with the scheme of contractual liability outlined in section 280(1) of the BGB, it will be for the doctor and/or hospital to show they are not liable for the breach.⁶³ Nonetheless, the burden of justification will be a heavy one: the court is frequently able (with the benefit of hindsight) to identify precautions that could and should have been taken against the risk. As commentators have noted, the result is to tighten liability in the direction of strict liability.⁶⁴

In recent years, the German courts have subjected an increasing number of the treating side’s duties to this form of analysis, developing in the process an extensive case law.⁶⁵ In addition to cases of defective equipment, categories where it is applied include injuries stemming from positioning on the operating table, as well as post-operative infections.⁶⁶ More generally, it will encompass a failure of planning or control at institutional level, e.g., the non-availability of sufficiently skilled staff, inade-

62. Bundesgerichtshof [BGH] [Federal Court of Justice], Oct. 11, 1977, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 584 (584–85), 1978.

63. See *supra* text at note 29. This is also consistent with a general approach in the German law of obligations, involving the concept of “*Verkehrssicherungspflichten*” (positive duties on those in control of a situation to ensure a safe environment). See BASIL S. MARKESINIS & HANNES UNBERATH, THE GERMAN LAW OF TORTS: A COMPARATIVE TREATISE 86–87 (4th ed. 2002).

64. See KATZENMEIER, *supra* note 26, at 167–68.

65. See BERGMANN & WEVER, *supra* note 17, at 5 (suggesting that around half of the cases involve such an analysis).

66. As to infections, it must first be shown that the source was within the treating side’s control, such as stemming from a member of the medical team. Bundesgerichtshof [BGH] [Federal Court of Justice], Mar. 20, 2007, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 1682, 2007.

quate supervision of junior doctors, or deficient communication within the medical team. Here there will be a finding of direct liability against the hospital.⁶⁷

2. Causation

Assuming a faulty breach of duty is established, it remains necessary for the patient to show that his injury arose from this, rather than e.g., simply as an unavoidable consequence of his underlying medical condition. Here German law employs the “*conditio sine qua non formula*,” which restricts liability to cases in which the defendant’s fault cannot be “eliminated in thought” (*hinweggedacht*) without the patient’s injury too ceasing to exist.⁶⁸ For practical purposes this is the same as the “but for test” used under the common law. In both cases the key question is whether or not the defendant’s faulty conduct was a necessary condition for the injury—i.e., did it make a difference?

As with the use of the “but for test,” there is little *theoretical* difficulty with this approach in medical malpractice cases. Thus instances of genuine causal over-determination, which can pose trouble for a sine qua non analysis, are very rare.⁶⁹ Similarly, it is unusual, once the factual causation hurdle is satisfied, for objections to be taken on grounds of no legal (or proximate) causation: usually the patient’s injury is squarely within the risk from which the doctor was obliged to protect him.⁷⁰ Nevertheless, as is well known, considerable difficulties remain of an evidential nature, namely how to decide, against a background of concurrent risk factors (the typical situation in medical cases), that it was the doctor’s fault—rather than one of those other factors—that featured in the causal set for injury.⁷¹ The inventive response of the German courts to these difficulties is examined under “proof issues.”

67. See Rüdiger Martis, *Aktuelle Entwicklungen im Arzthaftungsrecht – Behandlungsfehler und Beweislastumkehr* [Current Developments in Medical Liability Law – Treatment Malpractice and Reversals of Proof], 19 MONATSSCHRIFT FÜR DEUTSCHES RECHT [MDR] 1082, 1088 (2009).

68. See MARKESINIS & UNBREATH, *supra* note 63, at 103–04.

69. See Richard W. Wright, *Causation in Tort Law*, 73 CAL. L. REV. 1735, 1775 (1985) (discussing instances where each of two or more independent causal sets would have been sufficient to cause the plaintiff’s injury).

70. *But see* Part II B for a discussion of non-disclosure cases.

71. Wright, *supra* note 69, at 1788. *See also* Marc Stauch, *Causation, Risk and Loss of Chance in Medical Negligence*, 17 OX. J. LEG. S. 205 (1997) (applying this approach to medical malpractice cases).

3. Proof Issues

The burden of showing the faulty breach of duty by the doctor/hospital, as well as the factual causal link between this and his injury, is *prima facie* upon the patient. Moreover, it is a burden he must satisfy to the strict German civil proof standard of “judicial conviction.”⁷² On the face of things, given the notorious normative and factual complexity of medical malpractice claims, this makes life very difficult for a patient-plaintiff. In practice, though, patients in Germany have less to fear from evidential problems than may be supposed. There are three main reasons for this.

In the first place, the civil courts in Germany, rather than simply arbitrating between the respective contentions of the parties, engage actively in seeking the truth as to what occurred. This “inquisitorial” approach is reflected in the way that evidence is gathered and assessed. Thus in the context of a medical malpractice claim, the court will appoint one or more neutral experts to assist it. Such experts, who have access to the full written documentation in the case, such as medical records and the testimony of the patient and treating doctors, are required to prepare a report (*Gutachten*) detailing their conclusions on the relevant factual and normative issues.⁷³ Though not binding on the judges, who will supplement their understanding by oral questioning of the various witnesses (including the experts), such reports will carry strong weight in the decision of the court.

In medical injury claims, with their complex facts and the informational inequality between the parties, judges have taken special account of the patient’s difficulties. This also has a constitutional law dimension, given the patient’s right to a fair hearing under Article 103 (1) of the Grundgesetz [GG] [Basic Law].⁷⁴ Thus in an important decision from 1979, the Bundesverfassungsgericht [BVerfG] [Federal Constitutional Court] affirmed the need for the courts to ensure “equality of arms” (*Waffengleichheit*).⁷⁵ Subsequently, the BGH has stressed that trial judges—

72. ZIVILPROZESSORDNUNG [ZPO] [CODE OF CIVIL PROCEDURE], Dec. 5, 2005, BGBl. I at 3202, as amended, § 286(1). This standard approximates the “beyond a reasonable doubt” standard that common law jurisdictions reserve for criminal proceedings.

73. See Michael Bohlander, *The German Advantage Revisited: An Inside View of German Civil Procedure in the Nineties*, 13 TUL. EUR. & CIV. L. F. 25, 41–42 (1998). The patient at the same time has a general right to access his medical records, and may commission his own expert to give evidence on his behalf. Bundesgerichtshof [BGH] [Federal Court of Justice], Nov. 23, 1982, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 328, 1983.

74. GRUNDGESETZ FÜR DIE BUNDESREPUBLIK DEUTSCHLAND [GRUNDGESETZ] [GG] [BASIC LAW], May 23, 1949, BGBl. I at 1, art. 103(1).

75. Entscheidungen des Bundesverfassungsgerichts [BVerfGE] [Federal Constitutional Court], July 25, 1979, 52 BVerfGE 131.

while remaining neutral—should generally be ready to intervene and ask questions or suggest lines of questioning to the patient’s legal representative.⁷⁶

In the second place, and also with the aim of securing “equality of arms,” the German courts have developed a number of specific doctrines in treatment malpractice cases, whose effect is to relax the strict standard of proof, or in some cases to shift the burden of proof from the patient to the treating side. In this regard, we have already noted the existence of the figure of “fully masterable risks,” which in some cases places the onus from the outset on the treating side to explain and justify how a particular injury occurred.⁷⁷ In addition, the courts have applied a formal presumption in cases of inadequate documentation by the treating side. Here, they will assume, in the absence of a record of a given measure, e.g., a diagnostic test or therapeutic procedure, that the same was omitted. In cases where such a measure was normatively indicated, then (assuming the treating side is unable to rebut the presumption by independent evidence), this will lead to a straightforward finding of negligence.⁷⁸

As noted earlier, one area where evidential uncertainty is especially likely is with regard to the question of factual causation: the patient is exposed to several risks, those posed by his illness and by treatment, and it may simply be impossible—on the current state of the science—to identify their respective contributions and say that, but for faulty treatment, the patient would have avoided injury. Here, in some cases, the courts have been prepared to relax the high proof standard of “judicial conviction.” In particular, where the injury may be seen as “secondary” to some earlier infringement of the patient’s bodily integrity or health (caused by the defendant), the courts will assess the putative link between the initial and secondary harm, according to the balance of probabilities.⁷⁹

Far more significantly, though, the courts have developed a doctrine allowing for a full-scale proof reversal on causation in cases of “gross treatment error” (*grobe Behandlungsfehler*). In line with this, where the

76. See KATZENMEIER, *supra* note 26, at 390–92.

77. See *supra* text accompanying note 63; see also STAUCH, *supra* note 52, at 74–76.

78. See KATZENMEIER, *supra* note 34, at 470.

79. This approach derives from the greater freedom the courts have, under section 287 of the ZPO, to assess proof going to the extent, rather than the existence, of liability (normally relevant to fixing quantum). The BGH applied it in the treatment malpractice context, for example, where a doctor misdiagnosed a fractured finger and thus failed to set it in plaster (the primary injury). Subsequently, when the patient re-injured the finger, the result was permanent atrophy of the bone (the secondary injury). Bundesgerichtshof [BGH] [Federal Court of Justice], Feb. 12, 2008, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 1381, 2008.

treatment was particularly negligent and created a more than negligible risk of the injury in suit, the onus shifts to the treating side to prove it was *not* causative. As such a proof reversal will nearly always be determinative as regards the question of liability, it is appropriate to consider further what the courts mean by a gross treatment error. In a case from 1983, the BGH commented on the issue as follows:

A mistake that, while amounting to a breach of duty, is of the type that may on occasion befall even a careful and conscientious doctor, is not sufficient; rather the mistake, while not necessarily subjectively inexcusable—e.g. if attributable to special factors affecting the particular doctor—must be one that, in terms of the training and qualifications objectively required of doctors, is no longer comprehensible—i.e. is a mistake of the sort that a doctor simply ought not to make.⁸⁰

At the same time, it is recognized that the factors making an error “gross” vary with the circumstances so that no conclusive or exhaustive definition is available.⁸¹ In this regard, the views of the medical experts will be crucial: a judge may not find an error to be “gross” if the experts are equivocal as to whether there was even ordinary negligence.⁸² However, the court is entitled to take account of the overall history of the patient’s treatment and may treat a series of smaller mistakes, none of which is gross by itself, as having cumulatively attained this status.⁸³

In relation to misdiagnosis cases, the BGH has noted the ambiguity with which illnesses may appear, and has suggested that a court should find gross fault only in cases of “fundamental error.”⁸⁴ However, such a finding is easier where proper diagnostic tests were not carried out. Indeed, here the degree of the treating side’s culpability (in not conducting the tests) may be irrelevant. This is because the courts have treated purely hypothetical gross errors as a trigger for the proof reversal as to causation. Thus a reversal has been granted in cases where, if the results from a negligently omitted test had been to hand, it would have been grossly faulty for the treating side not to have taken further measures.⁸⁵

80. Bundesgerichtshof [BGH] [Federal Court of Justice], May 10, 1983, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 2080 (2081), 1983.

81. KATZENMEIER, *supra* note 26, at 441–42; *see also* STAUCH, *supra* note 52, at 87–92.

82. Bundesgerichtshof [BGH] [Federal Court of Justice], May 29, 2001, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 2792, 2001.

83. *Id.* at 2793.

84. *See* Martis, *supra* note 67, at 1085.

85. *See, e.g.*, Bundesgerichtshof [BGH] [Federal Court of Justice], Apr. 27, 2004, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 2011, 2004.

As discussed later, the approach of the German courts in relation to gross errors has been the subject of criticism.⁸⁶ One consequence of its use up until now, though, is that it has largely pre-empted interest in responses to causal uncertainty based on proportional recovery for “loss of chance.” Under the existing rules, the patient generally is already better placed, at least where he can show an actual or hypothetical gross error by the treating side: in such a case he will normally achieve full recovery, even where the likelihood that the error played a part in his injury is quite small.⁸⁷

The third and last reason why the *prima facie* tricky proof rules in treatment malpractice cases often do not pose a barrier to the patient recovering compensation is that in a significant number of cases he can side-step them altogether by reformulating his claim as one of “disclosure malpractice.” It is to this form of claim that we now turn our attention.

B. *Disclosure Malpractice Claims*

1. Background

Claims for disclosure malpractice provide an alternative basis of argument in cases of iatrogenic injury. Instead of showing the injury stemmed from fault in the execution of treatment, the patient may argue that, insofar as the risk of such injury was indeed inherent in the treatment, the doctor failed in his anterior duty to warn of it. As a result, so the argument continues, the patient’s agreement to treatment was defective and the doctor should be liable for the injuries arising from it. In Germany the comparative ease of proof and lack of causal limitations in respect of such claims have made them a popular avenue of redress for medical injury: it has been estimated that patients raise arguments based on inadequate disclosure in around one-third of actions.⁸⁸

The starting point for such a claim is the basic rule found in most countries that medical treatment is unlawful in the absence of the patient’s consent. In Germany, as well as giving rise to criminal liability, such treatment will qualify as unlawful bodily injury within section 823(1) of the BGB—the so-called *Körperverletzungsdoktrin*.⁸⁹ Importantly (in contrast

86. See Part III B.

87. See, e.g., BGH, NJW 2011, 2004 (evidence showed that it was ninety percent probable that proper treatment would not have helped the patient).

88. KATZENMEIER, *supra* note 26, at 357 n. 248. Very often the patient will argue the point in the alternative as a back-up to his primary claim of treatment malpractice.

89. *Id.* at 112. At the same time, the doctor will be in breach of his contractual duties to the patient.

to treatment malpractice claims), the proof burden from the outset rests upon the doctor to show that he had the patient's consent, i.e. as a defense rendering the treatment lawful.

A second very significant point is that for consent to be valid, the doctor must not only have provided basic information as to the nature and purpose of treatment, but also must have informed the patient adequately about treatment risks and alternatives. In German law, unlike under the common law, there is no division of actions into battery and negligence; instead any situation of inadequate information disclosure, be it an egregious failure to tell the patient anything at all, or a simple slip in forgetting a trivial but disclosable risk, will equally give rise to an unlawful bodily injury under section 823(1) of the BGB.⁹⁰

2. Standard of Disclosure

The German courts have evolved a high standard of required information disclosure. A subjective approach is taken, according to which the doctor should divulge every matter that may conceivably affect the decision of the individual patient, including quite negligible risks. As the BGH stated in a decision from 2000:

Determinative, as regards the doctor's duty to disclose, is not a given probability of a risk materialising, expressed in statistical terms. Rather, the decisive questions are how far the risk is particularly associated with the treatment and whether its occurrence would have a grave impact upon the patient's lifestyle. . . In principle this means that, on occasion, extremely rare risks may have to be disclosed.⁹¹

On this basis, risks measured in fractions of millions have on occasion been held disclosable.⁹² However, risks that are a matter of common knowledge need not be divulged. Moreover, as regards the detail of information provided, the courts have held it is normally sufficient for the patient to receive a general picture of a given risk (*im Großen und Ganzen*), in terms of what its occurrence could mean for him. A technical disquisition is not required.⁹³

Sometimes consent will also be nullified by a failure adequately to inform the patient of treatment alternatives. At least where these are in

90. BGB § 823(1).

91. Bundesgerichtshof [BGH] [Federal Court of Justice], Feb. 15, 2000, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 1784 (1785), 2000.

92. *E.g., id.* (where the risk of paralysis from the polio vaccine was one in 4.4 million).

93. Bundesgerichtshof [BGH] [Federal Court of Justice], Feb. 7, 1984, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 1397, 1984; KATZENMEIER, *supra* note 26, at 327–28.

general use, then, where the risks attaching to each option are distinct, they should be discussed with the patient, e.g., if there is a choice between surgery and more conservative treatment.⁹⁴ Moreover, where an alternative (to the treatment the doctor proposes) is favoured by mainstream medical opinion, this too should be made clear.⁹⁵

3. Causation

The positioning of non-disclosure of risk cases in German law, as akin to a battery under the common law, leaves relatively little room for factual causal limitations. Thus the question of whether the patient would have agreed to treatment if he had known of the risk is of subordinate importance: the unlawful act is the treatment, and the injury flowed from that. On other hand, the courts have allowed the doctor to raise the argument that the patient would have agreed to treatment anyway, as a form of defense known as “hypothetical consent” (*hypothetische Einwilligung*).⁹⁶

Here, though, the burden of proof will be upon the doctor (and to the strict section 286 ZPO standard); in line with this, even if the doctor establishes that it would have been objectively against the patient’s interests to refuse the treatment (notwithstanding knowledge of the risk), it will be sufficient in rebuttal for the patient to persuade the court that he would have been placed in a dilemma (*Entscheidungskonflikt*) as to whether to consent. He need not show that he would actually have refused.⁹⁷

In addition, the doctor may sometimes try to plead the absence of legal causation. This possibility arises in cases where the risk whose non-disclosure made the treatment unlawful did not materialise, and the injury instead stemmed from a different and non-disclosable risk. Here it may be argued that the prevention of such injury was not within the protective purpose (*Schutzzweck*) of the disclosure rule. Generally, though, the courts

94. DEUTSCH & SPICKHOFF, *supra* note 5, at 176.

95. Bundesgerichtshof [BGH] [Federal Court of Justice], Mar. 18, 2003, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 1862, 2003.

96. See BGH, NJW 1395 (1397), 1984. The defense is an instance of the general doctrine of *rechtmäßiges Alternativverhalten* [lawful alternative conduct], under which a defendant can argue that the unlawful aspect of his conduct did not cause the ensuing harm. KATZENMEIER, *supra* note 26, at 347–48.

97. Bundesgerichtshof [BGH] [Federal Court of Justice], Dec. 11, 1990, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 1543, 1991; KATZENMEIER, *supra* note 26, at 349.

have been unwilling to accept such arguments,⁹⁸ which they see as inimical to patient autonomy. As the *BGH* stated in a case from 1989:

Consent to medical treatment is something that can only be given or withheld in its entirety . . . Accordingly, where there is a deficit in disclosure, the treatment as a whole is unlawful, regardless of whether the risk that materialised was itself disclosable or not; to the extent that the lack of disclosure involved fault on the doctor's part, he will thus be liable in principle for all of the treatment's injurious consequences.⁹⁹

C. Damages and Liability Insurance Issues

Where the patient establishes liability for his injury, be it on the basis of treatment or disclosure malpractice, he is entitled to full reparation under section 249(1) of the BGB. This provides: "(1) A person who is liable in damages must restore the position that would exist if the circumstance obliging him to pay damages had not occurred."¹⁰⁰

As in other countries, damages will encompass both a pecuniary aspect, based on the financial loss occasioned by the injury to the patient (*materielle Schäden*), and a non-pecuniary element, reflecting the patient's pain and suffering (*immaterielle Schäden / Schmerzensgeld*). As regards the former, this will include past and future nursing care, necessary adaptations to the patient's home, lost earnings, and legal costs. Such sums can be very significant, especially for the long-term disabled. In recent years there has been a rise in pecuniary damages awarded by the courts, with compensation sometimes running into several million euros.¹⁰¹

As to damages for pain and suffering, German courts had in the past a reputation for awarding fairly modest sums in comparison to courts in other countries. However, while this still appears to be so at the lower end of the personal injury spectrum, it is no longer true in relation to more serious

98. See STAUCH *supra* note 52, at 118–20. One situation where such an argument was accepted was where the risk that materialised and injured the patient (in the course of overall unlawful treatment) had itself been disclosed. See BGH, NJW 1784 (1785), 2000.

99. Bundesgerichtshof [BGH] [Federal Court of Justice], Feb. 14, 1989, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 1533 (1535), 1989.

100. BÜRGERLICHES GESETZBUCH [BGB] [CIVIL CODE], Jan. 2, 2002, BGBL. I at 42, as amended, § 249(1), translated at http://www.gesetze-im-internet.de/englisch_bgb/index.html.

101. See Michael Petry, *Entwicklung der Schadenaufwendungen im Heilwesenrisiko* [Developments in the Costs of Compensating Injury in the Health Care Sector], in ARZTHAFTUNG – MÄNGEL IM SCHADENSAUSGLEICH? [MEDICAL PRACTITIONER LIABILITY - FAILINGS IN REPARATION?] 93 (Ilse. Dautert & Alexandra Jorzig eds., 2009).

harm.¹⁰² A significant development was a BGH decision in 1992, which recognized such damages also for gross mental impairment, where the plaintiff remains subjectively unaware of his situation.¹⁰³ As a result, high sums of damages are now awarded in cases of severe brain-damage leading to minimal consciousness. In recent decisions concerning severely disabled neonates, awards of half-a-million euros and more appear to have become the norm.¹⁰⁴

Naturally, a critical issue in such cases is the doctor's and/or hospital's ability to pay. In this regard, while not a statutory precondition to practice, the *Standesrecht* of the doctors' medical councils requires them to carry liability insurance (*Haftpflichtversicherung*).¹⁰⁵ Similarly, the vast majority of hospitals, though not strictly required, have taken out such an insurance policy.¹⁰⁶ In the past this non-mandatory approach does not appear to have created major problems.¹⁰⁷ However, in the light of the higher awards, and an associated rise in premiums, there is now concern that some doctors may no longer be adequately insured:¹⁰⁸ this and other liability insurance issues are considered further in Part III A.

D. The Medical Arbitration Boards

In Germany, a mechanism exists that is designed to clear the way towards settlement, by the treating-side's liability insurer or the patient abandoning his legal action, in the form of a system of medical arbitration boards (*Gutachterkommissionen* and *Schlichtungsstellen*). The formation of these boards began on the initiative of the regional medical councils in the mid-1970s—a time of a marked rise in malpractice litigation and growing

102. See Hans-Berndt Ziegler & Matthias Ehl, *Bein ab - arm dran. Eine Lanze für höhere Schmerzensgelder in Deutschland* [Left Without a Leg to Stand on: A Plea for Higher Awards for Pain and Suffering in Germany], JURISTISCHE RUNDschau [JR] 1, 1 (2009).

103. Bundesgerichtshof [BGH] [Federal Court of Justice], Oct. 13, 1992, NEUE JURISTISCHE WOCHENSCHRIFT [NJW] 781, 1993.

104. Ziegler & Ehl, *supra* note 102. Taking account of pecuniary damages and the child's putative loss of future earnings, total settlements in such cases are typically between one and two million euros. See also Petry, *supra* note 101.

105. BÄK, *supra* note 18, § 21; see also BERGMANN & WEVER, *supra* note 17, at 241–42.

106. BERGMANN & WEVER, *supra* note 17, at 241–42. In the case of a few large public hospitals funded by the *Länder*, these remain “self-insurers”, i.e., they pay damages out of their overall (publicly-financed) budget.

107. KATZENMEIER, *supra* note 26, at 197–98.

108. See Markt: Medizin: Ärzte ohne Haftpflicht [Medicine: Doctors Without Liability Insurance] (Westdeutscher Rundfunk broadcast Feb. 8, 2010) (wherein the medical lawyer and commentator, K.-O. Bergmann, suggested that up to five percent of doctors may be practicing without adequate insurance).

distrust between doctors and patients. By establishing them, the profession hoped to defuse these tensions and demonstrate openness.¹⁰⁹

Today there are twelve such boards, attached to the *Landesärztekammer*, which operate across Germany. Their general remit is to offer an expert report (*Gutachten*) outside the formal process of litigation, as to whether there was faulty treatment causative of injury. The proceedings remain cost-free for the patient, being financed by the *Landesärztekammer*, with contributions from hospital authorities. Typically, a claim will be assessed by expert panels of between three-to-five members, one whom is legally qualified and the others doctors (including one from the relevant specialty).¹¹⁰

A key principle is that submitting to a board's adjudication is voluntary. Patients retain the option of bringing legal proceedings (though if this occurs, the board will stay its own investigation)¹¹¹; the doctor too is not required to agree to the proceedings—albeit in practice they are usually happy to do so. Subsequently, the board's decision as to whether there was faulty treatment is not binding on the parties. The boards are not surrogate courts, and will avoid contentious points of fact or law.¹¹² Instead, they reach their findings on a review of largely agreed evidence (including the patient's medical records and affidavits from the patient and doctor); on average, it takes around fourteen months for them to issue a decision.¹¹³

The working of the medical arbitration boards has generally been perceived as a success, at least in less complex cases, and the take-up upon them has increased steadily over time. Statistics published on the website of the *Bundesärztekammer* show that in 2009, nearly 11,000 new applications were made.¹¹⁴ On average the boards identify medical negligence as the cause of injury in around a quarter of the cases they investigate; and in around seventy percent of these, the doctor's liability insurer will then pro-

109. See CHRISTINA MEURER, AUßERGEGERICHTLICHE STREITBELEGUNG IN ARZTHAFTUNGSSACHEN [THE OUT-OF-COURT SETTLEMENT OF MEDICAL LIABILITY ISSUES] 16 (2008).

110. DEUTSCH & SPICKHOFF, *supra* note 5, at 357; BERGMANN & WEVER, *supra* note 17, at 176.

111. BERGMANN & WEVER, *supra* note 17, at 180.

112. Thus where there is a factual disagreement—for example, as to what was said in a non-disclosure case—the board will not adjudicate. Similarly, faced with complex and disputed evidence on the issue of causation, it will leave its findings open. Unlike a court, it is not required to make positive findings of fact.

113. See MEURER, *supra* note 109, at 62–63. During this time, the limitation period in respect of potential legal proceedings will be suspended.

114. See BÄK, STATISTISCHE ERHEBUNG DER GUTACHTERKOMMISSIONEN UND SCHLICHTUNGSSTELLEN [STATISTICAL SURVEY OF THE MEDICAL ARBITRATION BOARDS] (2009), available at http://www.bundesaerztekammer.de/downloads/Gutachterkommission_Statistik_2009.pdf. As noted, *supra* note 18, the BÄK acts as the umbrella organization for the *Landesärztekammer*.

ceed to settle. Conversely, where no error is found, the large majority of patients will abandon their claim.¹¹⁵

III. ASSESSMENT OF THE CURRENT SITUATION

A. Empirical Data

As noted earlier, it has been estimated that between 20,000 and 40,000 private law claims commence in Germany every year.¹¹⁶ In the absence of a central collection point for such statistics, the precise figures remain uncertain, but information from the insurance sector may be indicative. With regard to cases against hospitals, data compiled over several years by the Ecclesia Insurance Group, the leading hospital liability insurer, indicate a claim-rate of just under 0.1% per patient-treatment.¹¹⁷ Extrapolated to the overall number of hospital treatments in Germany, this produces an annual figure of around 17,000 claims for that sector alone.

In terms of historical development, there was a sharp rise in the rate of litigation over the last four decades of the twentieth century, with the estimated annual number of claims rising from a few hundred at the end of the 1950s to 6,000 at the end of the 1970s and reaching the present figure by the beginning of the new century.¹¹⁸ In the last decade the numbers have apparently remained fairly stable: this is supported by the figures collated by the *Bundesärztekammer* in respect of the estimated one-third of claims that go before the arbitration boards. As noted, in 2009, there were some 11,000 such proceedings, only a small increase over the figure (10,500) for 2005.¹¹⁹

Only eight percent of claims will go to trial (and even fewer to judgment). The rest are settled by the doctor/hospital's liability insurer or abandoned, in some cases following adjudication by an arbitration board. According to figures released by the medical liability insurer *DBV-Winterthur* for 2005, it settled 47% and rejected the other 53% of the

115. See DEUTSCH & SPICKHOFF, *supra* note 5, at 362–63.

116. See Part I C; KATZENMEIER, *supra* note 26, at 41 (suggesting a figure of 20,000 to 35,000); MARTIN HANSIS & DIETER HART, MEDIZINISCHE BEHANDLUNGSFEHLER IN DEUTSCHLAND [MEDICAL TREATMENT MALPRACTICE IN GERMANY] (2001), available at http://www.gbe-bund.de/gbe10/owards.prc_show_pdf?p_id=7130&p_sprache=d&p_uid=gasts&p_aid=70384018&p_lfd_nr=1.

117. See Petry, *supra* note 101, at 105.

118. KATZENMEIER, *supra* note 26, at 40–41.

119. See BÄK, *supra* note 114.

claims notified to it.¹²⁰ Of cases that end up in court, the patient will succeed in around thirty to forty percent of them. A survey in 2009, which examined medical malpractice cases dealt with at first instance by the *Landgericht* in Dortmund, found the patient was successful in part or whole in 50 out of 130 cases; of these, 36 involved late settlements (9 with the court's assistance).¹²¹

Measured against the total number of medical treatments performed, it is apparent that the rate of malpractice litigation in Germany even today remains relatively low.¹²² What by contrast has increased dramatically in recent years is the overall cost to the system of such litigation. This is due not least to the higher sums of damages payable in cases of proven causative negligence, reflecting increased awards both for pecuniary and non-pecuniary losses, as well as longer life expectancies.¹²³ Above all there has been a leap in the size of awards in the most serious cases of injury, which, while making up less than one percent of claims, now account for two-thirds of total sums paid out.¹²⁴

Thus from 1981–2001, the average cost to the liability insurers of each claim (including those that were settled or abandoned) trebled, and the sum appears to have doubled again in the last decade.¹²⁵ Overall, liability insurers probably now pay out in excess of a billion euros each year in respect of medical injury claims.¹²⁶ The consequence has been a drop in the number of companies willing to offer such insurance, as well as an escalation in the premiums required by those that remain.¹²⁷

In fact, in April 2010, the *Deutsche Ärzteversicherung* announced a premium rise for doctors in general practice from 350 to 770 euros per

120. Patrick Weidinger, *Aus der Praxis der Haftpflichtversicherung für Ärzte und Krankenhäuser – Statistik, neue Risiken und Qualitätsmanagement* [Lessons from Liability Insurance Practice for Doctors and Hospitals – Statistics, New Risks, and Quality Management], 24 MEDIZINRECHT [MEDR] 571, 572 (2006). DBV-Winterthur was subsequently absorbed by the AXA insurance concern to form the *Deutsche Ärzteversicherung*, which is now the leading German medical practitioner liability insurer.

121. See Gisela Kothe-Pawel, *Die Erfolgsaussichten von Klagen im Arzthaftungsprozessen anhand der Ergebnisse vor dem Landgericht Dortmund im Jahr 2009* [The Prospects of Success for Medical Malpractice Claims Based on the Experience of the Dortmund Regional Court in 2009], 28 MEDR 537, 537 (2010).

122. See *supra* text accompanying note 117.

123. See Part II C; Petry, *supra* note 101, at 95.

124. Petry, *supra* note 101, at 96.

125. KATZENMEIER, *supra* note 26, at 42. According to the *Deutsche Ärzteversicherung*, the average payout per medical injury claim rose from 9,400 euros in 1998 to 21,100 euros in 2008. Flintrop & Korzillius, *supra* note 51.

126. In 2003, the annual costs to hospital liability insurers alone stood at 400 million euros. BERGMANN & WEVER, *supra* note 17, at 2.

127. Petry, *supra* note 101, at 97.

year.¹²⁸ In high-risk specialties the figures are many times higher: thus, even before the latest rises, obstetrical gynaecologists were paying over 10,000 euros per annum for coverage.¹²⁹ In July 2010, a compromise saw the health insurance funds¹³⁰ agree to subsidize the premiums of childbirth midwives after the latter raised doubts as to their continuing viability as a profession.¹³¹ In light of such developments, it may not be too much to speak of an incipient crisis in the medical liability insurance sector. A possible response that has been mooted is for a cap on damages to be introduced for medical injury cases.¹³²

B. *Evaluation of the Private Law Redress Rules*

Returning to the legal redress rules examined in Part II, and in particular those that go to the existence as opposed to the extent of a claim, there have been various criticisms of the case law of the German courts over the years. As regards treatment malpractice, this is true especially of the reversal of proof as to causation in cases of gross errors. As commentators have pointed out, this is a judicial inroad into the proof rules laid down by the legislature, which lacks a convincing theoretical basis. In addition, the difficulty of defining what counts as a “gross” error has led to unpredictable outcomes.¹³³ Some writers (and judges) defend the courts’ approach as a matter of practical justice, noting that otherwise patients would often find it impossible to win their claims.¹³⁴ However, the views of those who urge its abandonment in favour of a proportionate approach to recovery in doubtful causation cases appear to be gaining ground.¹³⁵

128. Flintrop & Korzilius, *supra* note 51. The concern reported a loss (i.e., shortfall in premiums collected relative to its liabilities) of some 100 million euros for each of the previous three years.

129. Petry, *supra* note 101, at 97.

130. I.e., the funders of medical care in Germany as described in the Introduction.

131. See Press Release Ass’n of German Liability Insurers, *Statement of Chairman of the Ass’n of German Liability Insurers* (July 13, 2010), available at http://www.gdv.de/Downloads/Pressemeldungen_2010/PD28_Halbzeitbilanz_SU_Rede_Pohlhausen.doc.

132. Petry, *supra* note 101, at 104.

133. See KATZENMEIER, *supra* note 26, at 454–55; Thomas Steiner, *Der grobe ärztliche Behandlungsfehler in der Praxis [The Gross Medical Treatment Error in Practice]*, 60 VERSR 473 (2009).

134. See Gerda Müller, *Neue Perspektiven beim Schadensersatz [New Perspectives in the Law of Compensation]*, 57 VERSR 1289, 1296 (2006).

135. See Gerhard Wagner, *Schadensersatz - Zwecke, Inhalte, Grenzen [The Law of Compensation – Aims, Substance, Limits]*, in 35 KARLSRUHER FORUM 2006, 93 (Egon Lorenz ed., 2006); Oliver Dopheide, *Der Grobe Behandlungsfehler, eine Beweislastverteilung nach Kollektiven? [Gross Treatment Errors – Shifting the Burden of Proof on a Collective Basis?]*, 58 VERSR 1050 (2007); Steiner, *supra* note 133; but see *infra* Addendum to this article.

Equally controversial has been the approach of the judiciary in cases of disclosure malpractice. Here, there has been criticism of the courts' *Körperverletzungsdoktrin* (classifying medical treatment *prima facie* as assault).¹³⁶ In addition, with regard to the standard of information disclosure, commentators have pointed to the legal uncertainty created by the courts' highly subjective approach to the risks that they hold disclosable. Doctors as well have expressed disquiet at the encroachment upon their clinical autonomy: the perception they have is of duties imposed by medical laymen, which take little account of the patient's best interests.¹³⁷

Overall, what seems clear is that the redress rules lead to over-compensation from the standpoint of corrective justice.¹³⁸ Thus in some cases, fault has arguably been replaced by a *de facto* strict liability standard: this is true both in disclosure malpractice cases, where as noted, it is difficult to anticipate what risks doctors are required to disclose, and in relation to the application of the fully masterable risks doctrine in treatment malpractice cases.¹³⁹ Secondly, the approach taken to factual causation issues in both types of claims gives rise to a significant number of "false positives": the patient will sometimes be compensated for an injury he would have suffered anyway, even if the doctor/hospital had performed impeccably.¹⁴⁰

Up until now, though, this "patient friendly" approach has met with a large degree of acceptance. The courts have addressed key problems for patients in medical injury litigation (as to information deficits and proof). Insofar as over-compensation results, this has been seen by many as acceptable "loss-spreading" within a social democratic society.¹⁴¹ Another important point relates to the access of justice enjoyed by patients. Thus the costs of bringing a claim remain broadly in line with those for other forms of private litigation, and are often covered by legal costs insurance held by

136. See Dieter Hart, *Autonomiesicherung im Arzthaftungsrecht – Ein Beitrag zur Entkoppelung von ärztlicher Aufklärungspflicht und Körperverletzung* [Securing Autonomy in Medical Malpractice Law – A Contribution to Decoupling Disclosure Malpractice from the Law of Assault], in Festschrift für Heinrichs 291 (Andreas Heldrich ed., 1998); Katzenmeier, *supra* note 26, at 114–15.

137. Katzenmeier, *supra* note 26, at 350.

138. From that standpoint, the defendant should be liable for injury arising from his faulty conduct, and not otherwise.

139. See Katzenmeier, *supra* note 26, at 167, 539.

140. As discussed in Part II A, where a gross treatment error is found, even in case of a modest risk, it is for the doctor to show (*per impossibile*) that this did not cause the injury. Similarly, in a disclosure malpractice action, the doctor's prospects of successfully raising the defense of "hypothetical consent" are only slightly better.

141. See Katzenmeier, *supra* note 26, at 539–40.

the patient.¹⁴² In addition, as noted in Part II D, the patient always has the option of referring his claim to one of the cost-free medical arbitration boards.

This general satisfaction is reflected in the relative lack of interest in replacing the present approach to compensating medical injury with a “no fault” insurance-based scheme. Though there were some initiatives in this direction in the 1970s, the consensus is that such a scheme would be both difficult to design equitably and too expensive.¹⁴³ As noted in Part I D, after Germany reunification, the former partial no-fault scheme in the German Democratic Republic was wound up. Nevertheless, as suggested in further below, the established consensus is now under increasing pressure.

C. Patient Safety Initiatives

Recently, there has been growing interest in initiatives aimed at improving patient safety: as noted in the introduction, this has been triggered in part by evidence from international studies as to the true incidence of injury in the context of medical care.¹⁴⁴ Though in Germany the private law system has not been seen as part of the problem (indeed it is credited in some respects with promoting safety)¹⁴⁵, it is clear that alone it is not sufficient. One problem is that its impact depends on the patient bringing a legal action; however, only a small proportion of problems can be identified in this way.

A major impetus in the direction of improved safety has come from within the medical profession itself. This is reflected in the bodies that have come into being in recent years with the remit of addressing the issue. Thus in 1995 the *Bundesärztekammer* and the association of public health insurance doctors formed the *Ärztliches Zentrum für Qualität in der Medizin* [ÄZQ] (Center for Quality in Medicine); in 2005, the Center inaugurated a

142. As a rule, legal fees in Germany are calculated as a proportion of the amount of damages claimed, as set by the *Rechtsanwaltvergütungsgesetz* [RVG] [Lawyers Remuneration Act]. See Matthias Kilian, *Alternatives to Public Provision: The Role of Legal Expenses Insurance in Broadening Access to Justice: The German Experience*, 30 J. L. & Soc’y 31 (2003) (discussing the prevalence of legal costs insurance).

143. KATZENMEIER, *supra* note 26, at 259; STAUCH, *supra* note 52, at 144–45.

144. For a fuller account of such initiatives, see Marc Stauch, *Patient Safety and Clinical Risk Management in Germany*, in PATIENT SAFETY, LAW POLICY AND PRACTICE 165 (John Tingle & Pippa Bark eds., 2011).

145. For example, the courts’ use of the “fully masterable risks” approach, discussed *supra* text accompanying notes 56–59, arguably has encouraged a more proactive approach to risk management by hospitals. See also Dieter Hart, *Patientensicherheit, Risikomanagement, Arzneimittelbehandlung und Arzthaftungsrecht* [Patient Safety, Risk Management, Pharmaceutical Treatment and Medical Malpractice Law], 25 MEDR. 383, 390 (2007).

Forum Patientensicherheit (Forum for Patient Safety).¹⁴⁶ The same year also saw the formation of the *Aktionsbündnis Patientensicherheit* (German Coalition for Patient Safety), a charitable association whose membership comprises doctors, professional organizations, health care institutions, insurers, and patient organizations.¹⁴⁷

Central to efforts at improving patient safety are gathering information as to past incidents, and the formulation and dissemination of strategies to reduce repetition in the future.¹⁴⁸ Here, a significant source of information in Germany is represented by the records of the medical arbitration boards, which, as noted, deal with a significant proportion of cases where patients suspect negligence. Most of the boards publish regular case studies bringing particular incidents that they have dealt with to the attention of doctors in the region. Since 2006, data as to all cases dealt with by the boards, have been the subject of systematic collation and analysis.¹⁴⁹

In addition, the *Forum Patientensicherheit* and the *Aktionsbündnis Patientensicherheit* have been involved in setting up critical incident reporting systems, allowing healthcare professionals to register near misses anonymously on-line. Germany now has two main systems of this kind: *cirsmedical.de*, aimed mainly at health professionals in hospitals, and *jeder-fehler-zaehlt.de* (“every mistake counts”), for doctors in private practice.¹⁵⁰ An ongoing project is the creation of an Institute for Patient Safety at the University of Bonn to do further research, using systems and root-cause analysis, into the background to medical injuries.¹⁵¹

CONCLUSION

Overall, the German system for compensating for medical injury illustrates the imagination and freedom of the courts in developing the rules they deem necessary to do justice in this complex area. The case law is characterized by considerable subtlety, as well as a tendency to assist the

146. See FORUM PATIENTENSICHERHEIT, <http://www.forum-patientensicherheit.de/english> (last visited Apr. 12, 2011).

147. See AKTIONBÜNDNIS PATIENTENSICHERHEIT [APS], <http://www.german-coalition-for-patient-safety.org/> (last visited Apr. 12, 2011). Among other things, it has formed several working groups. The APS is dedicated to drawing up protocols on the avoidance of common categories of mistakes, e.g., wrong-site surgery and drug prescription errors.

148. See Hart, *supra* note 145, at 383.

149. MEURER, *supra* note 109, at 142–43.

150. See CIRS MEDICAL, <http://www.cirsmedical.de/> (last visited Apr. 12, 2011); JEDER FEHLER ZAEHLT!, <http://www.jeder-fehler-zaehlt.de/> (last visited Apr. 12, 2011).

151. See AKTIONBÜNDNIS PATIENTENSICHERHEIT, AGENDA PATIENTENSICHERHEIT 2008, 10–11 (2008), http://www.aktionsbuendnis-patientensicherheit.de/apsside/Agenda_2008.pdf.

patient. As noted, the effect is over-compensation (on a corrective justice approach), but this has been seen as an aspect of permissible loss redistribution. At least in the past, in the context of the affluent conditions of German society, with costs shared between the social security system and liability insurers, this was a stable solution with broad support, which kept reform initiatives in this area largely off the political agenda.

This position is now under threat in light of the ever higher sums of damages awarded in a minority of cases, as well as the increasing tendency for patients' social and private insurers to invoke their rights of subrogation. As noted above, this is beginning to produce a crisis in the medical liability insurance sector. Although some commentators have expressed the hope that patient safety initiatives, once they bear fruit, may lead to a fall in such cases, this seems unlikely: as noted, one of the findings underlying the patient safety movement is how rarely cases of medical injury lead to a compensation claim. It will at any rate be interesting to see how matters develop in the future.

ADDENDUM

In late March 2011, the German government introduced a Whitepaper on "Patient Rights in Germany" [Grundlagenpapier: Patientenrechte in Deutschland] before the German Parliament.¹⁵² The paper aims to improve the patient's position in the health care system, including his ability to make good claims in cases of putative medical malpractice: an important aspect of this is improving transparency, by consolidating the existing disparate sources of law into a single dedicated statute. It is planned that the statute will codify many of the rules developed by the courts in this field, such as the rule shifting the burden of proof as to causation in cases of "gross" treatment errors. Patient safety initiatives, including systems of near-miss reporting, are also to be put on a statutory footing. Again, the progress of this statute, which arguably has potential to further strain the compensation system, not least by raising claims awareness, will be watched with interest.

152. The Whitepaper is available (in German) at: http://www.bmj.de/SharedDocs/Downloads/DE/pdfs/Grundlagenpapier_Patientenrechte.pdf?__blob=publicationFile.