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Book Review of Medical Malpractice Law: A Comparative Law Study of Civil Responsibility Arising from Medical Care

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Book Review

MEDICAL MALPRACTICE LAW: A COMPARATIVE LAW STUDY OF CIVIL RESPONSIBILITY ARISING FROM MEDICAL CARE (ARZTHAFTUNGSRECHT: DIE ZIVILRECHTLICHE VERANTWORTLICHKEIT DES ARZTES IN RECHTSVERGLEICHENDER SICHT), BY DIETER GIESEN,* GIESEKING-VERLAG, BIELEFELD, WEST GERMANY, 1981, Pp. 514.

*By Paul Marcus***

Many books and articles have been written in recent years exploring the issues involved in medical malpractice law. Professor Giesen's book is a particularly timely and important one, for the malpractice dilemma continues to be very significant both in the United States[1] and in many other countries. As explained in the Preface to the book, there are now "numerous Court decisions—which show an ominous increase; in the United States they can now scarcely be assimilated—on the civil liability of the doctor for damages arising from failures in treatment or inadequate consultation with the patient. . . ."[2] The problem is stated somewhat more strikingly later in the book when it is pointed out that "malpractice and other medical actions having shown a rapid increase which, if experiences in the United States also become true in Europe, will continue in the future and will perhaps make us shiver one day."[3] While the medical malpractice problem is accurately described in this book as both serious and intensifying, the author incisively notes that "the proportion of *successful* claims for damages in

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1. The medical malpractice columnist for the NEW YORK LAW JOURNAL reports that the New York medical insurance company is requesting a 71% increase in premiums for this year. As a consequence, the premium for a general practitioner in New York City would go from $3,185 to $5,306. For a surgeon it is currently $15,176 and would become $23,749. For the highest category of physician, an orthopedist or a neurosurgeon, the premium is currently $23,350 and would jump to $35,314. *See* Kramer, *Letters to the Editor*, N.Y. Times, May 22, 1981, § A, at 26, col. 3.

2. D. GIESEN, MEDICAL MALPRACTICE LAW 150 (1981). The Preface appears at p. 150 because the first 148 pages of the text constitute the German version of the textual material.

3. *Id.* at 277.

tort seems to be much lower for *medical* negligence than for all (other) negligence cases."[4]

The book has been written with several different audiences in mind. It is "intended equally for Doctors and Lawyers."[5] It is also designed for the comparative law specialist. Particular emphasis is placed on countries which follow the common law tradition (England, Australia, New Zealand, Canada, United States), and countries "of the continental tradition of codified legal systems both from the Roman and Germanic law families" (France, West Germany, Switzerland); references are also made to measures and resolutions of the Council of Europe and the European Community.[6] For all audiences who may have occasion to read this book, the author has succeeded in his purposes admirably. The book is well written, to the point, and fascinating in its analysis of legal and medical principles as applied in numerous different countries.

Medical Malpractice Law is divided into two parts. The first discusses civil liability of physicians in general, setting forth the basic rules and problems in connection with medical malpractice law. The second part explores civil liability with respect to new methods of treatment and experimentation, looking to recent trends and also to potential developments in the future. Almost 200 pages of appendices are found in this book, making it an extremely valuable research tool. The appendices consist of a wide range of materials, including the Code of Nuremberg, the Declaration of Helsinki, the Patient's Bill of Rights, and the European Community's Resolution on Organ Banks. In short, the book is quite helpful on many different levels ranging from the most basic explanation of the law, to a concise comparative analysis of legal and medical practices, to the source materials which can be the basis for research in the area.

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4. *Id.* at 185. Recent research in Germany points out that the plaintiff patient was wholly successful in only 16% of the medical malpractice cases to reach the highest German court in a 16 year period. *Id.* at 333 n.321. These figures reflect United States experience as well. *See, e.g.*, Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1179, 1187:

> On the basis of data from twenty-six of the largest malpractice insurance carriers, the staff of the Commission on Medical Malpractice estimated that a malpractice incident was reported or alleged by physician or patient for one of every 158,000 patient visits. A claim was made for one of every 226,000 visits. Only one in ten claims ever reached trial, and one half of the payments made in response to claims in 1970 were for less than $2,000. Although the dollar amounts have escalated somewhat in the past few years, the basic point still holds true that the vast majority of awards are relatively small.

5. D. GIESEN, *supra* note 2, at 150.

6. *Id.* at 281 n.2.

I. PRINCIPLES OF MEDICAL MALPRACTICE

In the first major section of the book, Professor Giesen sets forth the basic principles of medical malpractice. While significant differences exist between countries in dealing with some of the principles, it is extraordinary how many of the important rules of medical malpractice law are the same throughout much of the world. Virtually everywhere the modern law of physician liability is largely case law created by the courts, to the exclusion of statutory law.[7] In spite of some of the contract notions which are increasingly being litigated in medical cases, most rules of liability for doctors are governed by negligence principles.[8] And, these principles are uniform in application: the physician must show a fair, reasonable, and competent degree of skill, but if he holds himself out as a specialist a higher degree of skill is required. As stated in one Scottish case—though the principle could just as easily have been drawn from an English, American, or German case:

> [T]o establish [civil] liability . . . where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly . . . that the defender [= defendant] has not adopted that practice; and thirdly (and this is of crucial importance) . . . that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.[9]

The key determination will be whether the physician took action according to the proper and reasonable standards of the profession. While the doctor is not an insurer against every conceivable harm which may arise, he must use reasonable caution which in many situations will mean that he has an absolute obligation "to keep abreast of the advances in medical sciences [by which we] may discover that his tried and true outdated tools, techniques or treatment are found wanting."[10] In short, whether the negligence allegation is based upon the failure to provide the most up-to-date care, sloppiness with respect to examination proceedings, or negligent prescription of medication, the trier of fact must strike "a careful balance . . . between the magnitude

7. There are, of course, numerous statutes in many countries which play an important part in this area. These include English and Tasmanian statutes which confer on the courts the power to override statutory time limitations. *Id.* at 159. The United States cases are somewhat more stringent regarding the statute of limitations questions. *See, e.g.*, Bosworth v. Plummer, 510 F. Supp. 1027 (W.D. Pa. 1981).

8. Under present French law the rules of tortious liability apply in medical malpractice cases only if there is no contract. D. GIESEN, *supra* note 2, at 159.

9. Hunter v. Hanley, [1955] Sess. Cas. 200, 206.

10. D. GIESEN, *supra* note 2, at 163.

of the risks and the burdens to the physician in doing (or not doing) what it is alleged he should (or should not) have done."[11] This rule will apply in the most standard of cases—such as the taking of x-rays—as well as in the very unusual cases involving research treatment or new methods of care.

Professor Giesen nicely tracks these basic principles of medical malpractice, but additionally points out the serious difficulties which can arise in litigating such matters. Chief among these problems is the dilemma counsel faces in proving a medical malpractice claim. The burden of proving fault on the defendant's part, is, of course, on the plaintiff. Because of the great difficulties in sustaining that burden, American law has turned to the "commonsense notion" of *res ipsa loquitur*, or in German, the *Anscheinsbeweis*. As pointed out by the author, in numerous medical malpractice cases the plaintiff is able to show the accident is such that it would not ordinarily happen without negligence, and hence inferences of negligence by the defendant can be drawn.[12] Closely related to this proof problem is the question of the role played by expert witnesses, both on the part of the plaintiff patient and on the part of the defendant physician. As noted by the author, while the traditional "conspiracy of silence" among doctors is changing considerably, real questions remain as to the availability of experts and their trial functions.

In recent years, as well traced by the author, there has been an increasing shift of emphasis from medical negligence allegations to claims involving omitted or deficient information given to patients by doctors. The physician must explain to the patient the material risks involved with the medical procedure. Consent to such procedure is valid only when it is given by a patient who has legal capacity to do so and has received sufficient information by the physician as to the nature of the treatment to be provided or the operation to be performed. "[T]he test for informed consent is *not* whether a prudent person would have accepted the risks but whether this particular patient in his particular circumstances would have had he been informed properly."[13] Whether the procedure is for a very routine, well accepted surgical procedure, or for wholly new and experimental treatment, the doctor must explain to the patient the risks involved. Indeed, in a recent decision by the German Federal Supreme Court, it was held that the physician, when he discovered the increased risk from the operation about which

11. *Id.* at 164.
12. *Id.* at 262-64.
13. *Id.* at 172.

the patient had not been informed, should have stopped the operation if it could have been interrupted or stopped without endangering the patient's health, in order to obtain the patient's informed consent.[14] Most courts are quite stringent in their requirements regarding informed consent[15] except in the true emergency situation where consent cannot be obtained or in the situation where information would in fact worsen the patient's state of health. This latter point arises most often in the field of psychiatry.

In addition to the obligations imposed by the tortious negligence standards and the doctrine of informed consent, physicians traditionally have had a duty of secrecy.

> The physician requires personal data from the patient in order to be able to give proper advice and treatment, and the patient has a responsibility to cooperate by providing them. The patient may, however, assume that his confidences will not be revealed to third parties without his prior permission (doctor-patient privilege). Hence the physician's duty (and right) of secrecy, and a physician who violates this duty may be liable for damages thus caused to the patient. He also may be indicted for a criminal offence, subjected to disciplinary proceedings by his profession for conduct unbecoming a physician and be reprimanded, suspended or even struck off the register.[16]

This duty of disclosure has been supported in most countries discussed in the book, and is found, of course, in the Hippocratic Oath.

New obligations, and limits on obligations, are beginning to be developed through statutory responses in many countries. For instance, the traditional model for medical malpractice litigation has been significantly curtailed under the statutory schemes developed in New Zealand and Sweden. While it may be too early to appraise the effects of these no-fault compensation systems, Professor Giesen points to these as significant alterations of the traditional approaches.[17] In the United States, many states have adopted statutes which impose ceilings on damages, shorten statutes of limitations, impose mandatory screening of malpractice claims, or encourage voluntary arbitration systems.

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14. Judgment of Nov. 2, 1976, Bundesgerichtshof, [1977] NEUE JURISTISCHE WOCHENSCHRIFT 337, discussed in the text of the book at 172-73.

15. It is interesting that English and U.S. courts ask whether the patient would have consented had he been properly informed. The French and German courts, on the other hand, ask whether or not damage was sustained as a result of the lack of informed consent. D. GIESEN, *supra* note 2, at 175.

16. *Id.* at 183.

17. The author notes that in New Zealand the old tort action was completely eliminated in favor of a no-fault compensation scheme, while in Sweden the no-fault compensation scheme was introduced alongside the old negligence action for medical injury. *Id.* at 192.

Similarly, German doctors, in cooperation with insurance companies, have also set up arbitration boards to alter the dispute resolution mechanism and to compensate for damages, but with recourse to the normal channels of litigation should arbitration fail.[18] The discussion of the statutes in the book points to one of the few difficulties this reader encountered with Professor Giesen's work. While the discussion in this area, as elsewhere, is effective and highly informative, it is somewhat disjointed due to the exhaustive number of footnotes.[19] One would have hoped, particularly in this area, that more of the pertinent information would have been discussed in the text itself. No doubt, the footnotes are as extensive as they are in order to keep the text readable for the non-lawyer audience and yet maintain the information for those interested in further investigation.[20]

II. THE EXPANDED SCOPE OF THE MALPRACTICE CLAIM

Supplementing the traditional questions of medical malpractice liability, Professor Giesen explores a host of recent developments which have had significant impact both on the obligations of physicians and on the practice of lawyers. Particularly in the United States and Germany, many physicians have been sued for damages because a female patient or the wife of a male patient has given birth to a child after being ineffectively sterilized by the physician. While the courts are in considerable conflict as to the basis for such a claim—and the amount of damages awardable for a successful claim—the number of claims continues to increase.[21]

Perhaps the most striking development in recent years regarding medical malpractice has come in the area of products liability litigation concerning pharmaceuticals. The legal requirements for products liability actions vary from country to country; nevertheless, it is clear that the area of products liability is one of great concern. For example, in the United States within the last two years damage awards in excess of several million dollars have been given for complications arising from drugs which were prescribed or recommended by physicians.[22] Other

18. *Id.* at 190-92.

19. The book contains 1,030 footnotes which fill 116 pages.

20. In addition to the footnotes, there are 14 appendices totalling 156 pages.

21. D. GIESEN, *supra* note 2, at 170. The author indicates a number of good sources in this area. *Id.*

22. In Wolfe v. United States, No. 77-2083-NE-CV (M.D. Tenn., filed Mar. 19, 1981), *discussed in* 24 ATLA L. REP. 153 (1981), the federal district court awarded plaintiffs, wife and husband, a total of $2,922,799.61 for injuries involved with vaccine-associated polio and

new areas of medical malpractice have had somewhat less of an impact, but Professor Giesen also discusses transsexual surgery, organ and tissue transplants, embryo transfers, and numerous other emerging matters.[23]

III. DAMAGES

Medical Malpractice Law is a comprehensive and thorough discussion of the law in virtually all significant areas. Indeed, there is only one major area in which this reader would have preferred further coverage: damages. While Professor Giesen does touch upon the problem of damages in malpractice cases, the coverage is somewhat too concise for a full understanding of its impact. The book explores the limited damages which are available in many countries and simply makes reference to the far greater potential for damage awards in the United States. One would have hoped for a more complete coverage of the United States experience. Considering that many European countries are now experiencing trends in medical malpractice which have existed in the United States for some years, a thorough discussion of damages might have proved useful in comparing the trends in those countries and contrasting the limits of liability.

While awards exceeding $100,000 may be relatively unusual in many countries throughout the world, they are far from unusual in the United States. Indeed, one can point to many cases involving awards in the millions of dollars for individuals who successfully allege medical malpractice.[24] The extent of this potential liability may explain the

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flu paralysis. In Gallagher v. Valley Children's Hospital, No. 211139-1 (Fresno [Cal.] Super. Ct., filed June 20, 1980) *discussed in* 23 ATLA L. REP. 475 (1980), two four-year-old children were given a damage award with a present value of $3,000,000 for paraplegia resulting from exposure to penicillin which allegedly contained a caustic agent. For an interesting discussion of the pharmacist's liability, *see* Cerullo, *The Pharmacist's Responsibility to the Patient*, 17 TRIAL 31 (1981).

23. Professor Giesen also considers the psychotherapist's duty to warn third persons of possible danger from psychiatric patients, especially looking to Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976). D. GIESEN, *supra* note 2, at 161, 184. *See also* McIntosh v. Milano, 168 N.J. Super. 466, 402 A.2d 500 (1979); 6 AM. J. L. & MED. 190 (1980).

24. For instance, in recent editions of the *American Trial Lawyers' Association Reporter* (the newsletter of the plaintiff's bar) the following trial cases were discussed: Cook v. County of Contra Costa, No. 184-932 (Contra Costa Cty [Cal.] Super. Ct., filed Nov. 12, 1980) (2.25 million dollar settlement for a 32-year-old teacher's aide who suffered cardiac arrest during routine surgery) 24 ATLA L. REP. 185 (1981); Clark v. University Hosp., No. 80-2246 CA (Duval Cty. [Fla.] Cir. Ct., filed Jan. 15, 1981) ($77,000 verdict for the wrongful death of an 85-year-old man whose rare allergic reaction to sodium fluorescein was improperly treated) 24 ATLA L. REP. 185 (1981); Gray v. Schildkraut, No. 7440/49 (Queens Cty.

great sense of urgency that is felt in the United States regarding the so-called medical malpractice crisis which may not exist in other countries. As explained by one attorney, the potential for damages in United States medical malpractice cases is very great:

> Although the language and the particularities will vary from jurisdiction to jurisdiction, the following would seem to serve as a checklist of damages to be considered in the pursuit of the maximum and complete damage award:
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> 1) Any medical expenses the plaintiff has incurred;
>
> 2) Any loss of earnings, earning capacity, or profits suffered by the plaintiff;
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> 3) Physical pain and mental suffering by the plaintiff and the extent and duration of bodily injuries sustained;
>
> 4) Disfigurement or deformities and any humiliation or embarrassment associated therewith and the effects of the injuries on the overall physical and mental health and well-being of the plaintiff;
>
> 5) Medical expenses that will probably be incurred in the future;
>
> 6) Physical pain and mental suffering and any inconveniences or discomforts that will probably occur in the future; and
>
> 7) Any monetary loss the plaintiff will probably suffer in the future.[25]

IV. THE FUTURE

In his book, Professor Giesen has highlighted problems and circumstances which are just beginning to surface and will likely be major issues in the future. For example, he points to the actions of legislatures beginning to deal with malpractice problems, such as the no-fault systems in New Zealand and Sweden, and the arbitration systems commonly found in the United States. He also explores the need—which he perceives will be great—for judges who will be both more expert and more interested in dealing with malpractice cases.[26] Finally, in

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[N.Y.] Sup. Ct., filed Jan. 29, 1981) ($600,000 settlement following the trial for a 67-year-old woman who suffered a massive stroke after taking prescribed diet pills) 24 ATLA L. REP. 187 (1981); Campbell v. United States, No. 77-2504 WA I (N.D. Cal., filed May 30, 1980) (1.64 million dollar settlement for a nineteen-year-old woman who sustained brain damage in a suicide attempt in a Navy hospital) 23 ATLA L. REP. 474 (1980). In addition, U.S. courts are not at all hesitant to step in and order reconsideration of damages awards where the judges believe the jury was unnecessarily restrictive in its award of damages. *See, e.g.*, Venes v. Heck, 642 F.2d 380 (10th Cir. 1981).

25. Nace, *A Checklist for Maximizing Damages*, 17 TRIAL 43 (1981).

26. After discussing the impact that U.S. juries have had, the author would much prefer to limit the involvement of juries in malpractice actions. D. GIESEN, *supra* note 2, at 276-77.

discussing transplants, he analyzes the still very limited efforts by nations to define death, obviously a central concern in this area of medical malpractice litigation.[27]

V. CONCLUSION

Medical Malpractice Law is an excellent book on many different levels. It is a first-rate source book containing many materials which will be helpful to the lawyer engaged in medical malpractice litigation. It is also a thoughtful discussion of the obligations of physicians *vis-à-vis* burgeoning medical malpractice litigation. Finally, it is a fine analysis of the similar, yet often contrasting, systems of medical malpractice law found in a large number of countries. Perhaps the book's greatest contribution is the attempt to formulate a balance between the interests of the patient (and his legal advocate) on the one hand and those of the physician on the other. Professor Giesen's own conclusion is a very apt ending to a review of his book.

> We should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure. On the other hand, of course, the physician must recognise the fact that according to private law, and for the reason that there must be a suitable distribution of risk, even a slight carelessness in the exercising of his profession or common calling, something of which anyone could at some time in his career be guilty, leads to civil liability; but he should also recognise that a charge of negligence or malpractice is no deathsentence [sic]. He is not to be stripped of his professional reputation. It is only when he realizes this that he can secure that inner freedom which enables him to cooperate towards finding the explanation for what has occurred, answer for his conduct and methods, and regard the trial or malpractice action (which certainly is no ordeal) not as an affair in which prestige is at stake but rather as the risk inherent in his profession and against which he will as a rule have insured himself.[28]

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27. Only Finland, Italy, and Spain have at this time provided national statutory criteria for determining death. *Id.* at 244.

28. *Id.* at 279.