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Introduction

In Germany in recent years there has been a notable jump in the number of civil actions for pecuniary damages and damages for pain and suffering, applications to expert commissions and arbitration tribunals, and even criminal investigations in connection with medical malpractice. While rapid progress in the field of medicine certainly ensures a higher standard of service, it also brings with it much stricter criteria for the diligence and care required of the medical practitioner. And inevitably this increases the third-party liability risk. Every doctor – whether head consultant, senior physician or intern – must bear in mind that any error, no matter how minor, can have consequences under civil law (liability) and may end in criminal prosecution.

The reform of the German health care system, which has been in progress for some years now, and the various changes this has caused in hospital care and administration will in coming years bring about profound restructuring (e.g. as regards pre- and post-hospital treatment, ambulatory operations, etc.). This restructuring poses a whole range of questions concerning organisation and liability and will involve doctors to a much greater degree than previously in hospital management.

Against this backdrop we will see a considerable increase in the need for consultation services for hospital administrators, the medical profession and providers of nursing care alike. On top of this, hospitals must meet many new requirements in relation to quality assurance and their legal obligation to detect weak points in their systems (e.g. infections, mortality, duration of stays, hygiene). The same applies to the rectification of the existing deficiencies and the ongoing training and motivation of staff. Effective quality assurance hinges upon quality awareness.

Legal requirements cannot be adequately met without a concerted effort to detect and analyse potential losses well in advance and to take the necessary precautions.

Legal liability: the current situation

The courts are exercising more and more control over the actions of the medical profession, a fact which can lead to an increasing number of legal actions. The legal profession, by contrast, is eager to play down the importance of this development by pointing out that in absolute terms the number of legal actions is negligible when compared with the actual number of operations performed day in day out; that in Germany, for instance, the ratio of legal actions to treatments performed is 1:1000; and that only 5% of all investigations initiated end in final convictions on the grounds of medical malpractice.

However, these arguments miss the point and are thus of no help to those actually close to the problem. For the prospect of an impending court case or proceedings, an accusation or complaint to the police with potential civil-law or penal sanctions/consequences is in itself enough to disconcert the medical profession. At worst it can lead to an undersupply of certain medical services.

The main sources of error leading to legal disputes are:

- errors in diagnosis and treatment;
- failure to inform the patient;
- organisational errors;
- documentation errors.

Errors in diagnosis and treatment

Under both contract law and the law of torts doctors are bound to provide their patients with proper medical treatment and care. In this respect a doctor's duty to take due care under the contract of treatment is identical with the due care demanded of him by the law of torts on the basis of the position of trust he assumes diagnosing and treating a patient. A doctor undertaking to treat a patient accepts responsibility for this decision and to that extent must guarantee that the treatment is properly carried out. In so doing he also undertakes to do for the patient all that is medically possible. If he culpably breaches his contractual or legal obligations, he must make amends for any damage or loss thus caused. Should as a result of the treatment the patient suffer damage to his health or even die, the doctor can be charged with negligent bodily injury or negligent homicide respectively.

An error in diagnosis or treatment is present if, for example, during his work the doctor does not properly carry out a measure objectively necessary under the given circumstances and on the basis of the available knowledge of medical science. Thus, to have committed an error, the doctor must have failed to show the diligence that in general may be expected of a prudent and conscientious doctor in a concrete situation.

Failure to inform the patient

The doctor is obliged to provide the patient with the due information. Over the last three decades the significance of breaching this obligation, and with it the severity of the potential consequences, has steadily increased. In fact, more and more legal disputes now centre on a patient's claim of not having been (adequately) informed by the doctor, the other major cause being errors in diagnosis and treatment. Although the doctor's duty to inform the patient has its basis in civil law, it can quite conceivably also result in criminal proceedings or sanctions from a professional tribunal.

In both civil and criminal proceedings the patient's most effective weapon is the accusation that the doctor failed to inform him or provided only insufficient information. Although the onus is on the patient to prove that the damage to his health is the result of surgery the possible consequences of which were not fully explained beforehand, the doctor for his part must set forth and prove that he informed the patient as required by law. Should the doctor fail to do so and should the risk involved have actually resulted in bodily injury, the patient has every chance of asserting his claim. This is any case true should the doctor fail to prove that the patient would still have risked the treatment even if he had been properly informed.

The question of having been properly informed is also of relevance in criminal proceedings since the patient's true consent to the treatment will only be assumed provided the doctor has sufficiently fulfilled his obligation to inform. As it is usually easier to prove objectively that the doctor failed to inform the patient properly than to prove that errors were made in the actual treatment, this plea is now tending to be preferred in criminal proceedings, too.

Organisational errors

As in many other walks of life, a growing trend towards a division of labour is discernible in the medical field, too. The speed of medical progress and the increasing use of ever more complex apparatus, together with the simultaneous deepening and broadening of knowledge and experience mean that specialisation has become inevitable. Specialisation, however, brings with it specific dangers for patients and liability risks for doctors. Sometimes, for instance, the exchange of information is inadequate or unclear, the measures taken have not been coordinated properly, individual personnel lack the necessary knowledge or experience, or during treatment of the patient potentially dangerous overlaps in responsibility become evident. What this means in practice is that suddenly no-one feels responsible for particular tasks.

Organisational risks can thus be traced to four main sources:

- Lack of communication
- Inadequate co-ordination
- Insufficient qualifications of medical staff
- Problems in assigning responsibility for tasks

Documentation errors

Although the fact that documentation is incomplete or even totally absent does not in itself constitute grounds for claiming ordinary damages or damages for pain and suffering, it makes it easier for patients to prove their case in court and may even cause the onus of proof to be reversed to the patient's advantage. This is why thorough documentation can often provide valuable support in liability suits.

The courts make great demands on the content and scope of medical documentation. It must be commensurate with the medical situation and conform to the principles of truth, clarity and completeness. The salient medical facts must be presented in a form which can be readily understood by a medical professional but not, as has often been demanded, by a layperson. The doctor himself, or a colleague taking over treatment of the patient, must be able to comprehend the progress of treatment to date.

Proper documentation is one of a doctor's professional obligations, the fulfilment of which is monitored by professional tribunals. But proper documentation is not only helpful in avoiding negative legal consequences, it is also an invaluable aid – particularly in a clinic environment – to communication and quality assurance in medicine. Thus, medical documentation is above all important from the therapeutic point of view, but is also gaining in significance in the context of legal disputes.

Defects in equipment

Rapid medical progress and the use of more and more complicated machinery mean that almost every doctor is confronted in his daily work with sophisticated technical apparatus.

However, the ongoing automation of medicine has not only provided the basis for new diagnostic and therapeutic procedures, thus broadening the range of possible treatments, it has also increased the number of potential dangers to patients. Studies carried out in clinics, medical institutions and doctors' surgeries have revealed that human error was by far the greatest cause of the incidents which occurred. The causes of damage in the context of medical equipment are to be found in incorrect operation due to ignorance, lack of instruction, insufficient training and excessive physical or psychological strain.

It is the duty of the chief medical director as user to check and monitor the equipment and to ensure that staff are instructed how to use it correctly. As the operator of the equipment, the commercial management of the hospital is obliged to heed the advice of the head physicians and technical supervisors and replace any equipment which is worn out and no longer meets the requirements of modern medicine.

Ambulatory operations

One of the aims of the recent hospital reform in Germany was to keep costs down by encouraging that minor operations be carried out in day clinics, outpatient sections of hospitals and in doctors' surgeries. For doctors this practice has a variety of legal implications. Ambulatory operations must not pose a greater risk to the patient's well-being than inpatient surgery. The doctor carrying out such operations, therefore, must not only possess the requisite theoretical medical knowledge, he must also have had enough practical experience to recognise and understand the potential complications, dangers and risks involved in ambulatory operations.

Pre- and post-operative care for ambulatory patients are the areas presenting quite special legal problems; in particular the question of whether the patient has been adequately informed of the dangers associated with the operation and whether the patient receives the proper post-operative care at home.

Since it is the surgeon who is responsible for organising high-quality post-operative medical and nursing care for the patient, this constitutes a major liability risk for doctors carrying out ambulatory operations.

Tips for the underwriter

Liability insurers cannot rely on legislative reform to improve their claims experience. On the contrary, legal requirements for doctors, hospital administrators and nursing staff have been steadily made more stringent over recent years. In addition to this, the sense of legal entitlement of both the community at large and individual claimants is nowadays much more pronounced, with the result that people are much more inclined to press their claims before a court of law. The future must not see fewer and fewer insurers prepared to insure hospitals and doctors, and those few demanding very high premiums. Rather the trend should be towards risk containment and loss prevention.

Risk-management methods – such as analysing the causes of past losses and taking appropriate measures to prevent future ones – are what need to be implemented. In the USA a number of organisations representing doctors and hospitals as well as universities have carried out such loss analyses and derived preventive measures from the findings. Losses were analysed for common features and examined to see whether or not they could have been avoided. Avoidable losses were categorised according to typical features and the results used to devise loss prevention programmes.

The decisive question for insurers will be whether they can convince hospital administrators and physicians to face the problem of medical malpractice liability so that they succeed in getting the claims situation under control. A risk analysis cannot only be used to compile a loss prevention programme, it is just as important a means of sharpening sensibility and transforming the awareness of risk factors into active risk control. The result is intensive risk communication between doctors, hospital administrators and insurers.

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