EDITORIAL

Medical Malpractice Liability: No Easy Solutions

The patient who has suffered damage from medical malpractice, and who wishes to be compensated, is often faced with a difficult task. A necessary condition to hold the doctor (or the hospital) liable for damage, is that the doctor is at fault, that is to say that (s)he failed to satisfy the required duty of care, and that as a result the patient suffered damage. In principle, the burden of proof rests with the patient. This can be a real problem, especially when it comes to proving fault and the causal link between fault and damage. When the patient does not succeed in proving all the requirements of liability law, he will remain empty-handed.

Countries try and find solutions that show points of similarity and differences, as will be exemplified by the four contributions in this special issue of the European Journal of Health Law, coming from Austria, Belgium, England and Spain. Each contributor was asked to choose and analyse four leading or otherwise interesting cases on medical malpractice liability and to place them in perspective: in what way do these cases reflect the characteristics of the civil liability system in their country, which trends in the development of medical civil liability do they reveal, what are the effects on and implications for the functioning of the medical civil liability system and what can be expected in the future? The selected cases relate to the standard of care, informed consent and information errors, the issue of causation, the burden of proof and the extent of compensation.

In most countries the standard applied to medical care is an objective one. Decisive is the competence of the reasonably careful and competent practitioner in his or her area of expertise. In England the classic statement of the required standard of care is the Bolam test: the practice accepted as proper by a responsible body of medical men skilled in that particular art. This formulation fails to make clear who in the final analysis determines the standard of care: the medical profession or the courts. In other words, to what extent are the courts allowed to scrutinize expert evidence? McHale argues that the courts initially showed a “hands off approach”, but that after the Bolitho case of 1997 there were speculations on enhanced judicial scrutiny of clinical decision-making. She concludes, however, that the medical profession is still allowed a wide margin of appreciation in many cases.

It is generally accepted that medical negligence arises not only from wrong diagnosis and treatment, but also from failure to inform the patient properly, more in particular with regard to the risks that are connected with the treatment. This
raises the question as to the extent of the doctor's duty of care to warn patients of the risk of treatment. From case law it generally appears that patients only have to be informed on normal and foreseeable risks. Unusual risks don't have to be told, unless they are serious. The less vital the intervention, the more information will have to be given on less frequent or less serious risks.

The scope of the information will therefore be judged by the seriousness and frequency of the risk, in the light of the necessity of the treatment. This approach is in line with the so-called relevant risk theory, as proposed by some scholars in Belgium. According to this theory, the kind of information a normal person in the same circumstances as the patient would need in order to take a responsible decision about the suggested treatment, is decisive. In this context, the Spanish literature distinguishes between typical risks (risks that can usually be expected) and personalised risks (risks connected with the patients' pathology and the relevant personal and professional circumstances). A more reticent attitude is adopted by the Austrian courts considering the well-being of the patient superior as compared to the right of self-determination, with the result that the scope of information may be reduced in order to prevent the patient to decide against the necessary treatment.

When it is a recognized fact that the physician has insufficiently informed the patient, he is not yet held liable immediately. The physician avoids liability when he can show that the patient also would have agreed with the treatment should he have been sufficiently informed. However, the question rises whether this approach is correct in all circumstances. After all, the fact that one has not been able to prepare for a possible complication might be considered as suffering a loss.

The question of causation remains a difficult one. Many actions fail because the patient cannot prove the causal link between the doctor's breach of duty and the damage the patient has sustained. The requirement of causal relationship relates to the question if there is any liability (the establishment of liability) as well as to the question for which consequences the doctor should be held responsible (the scope of liability). The former issue is normally dealt with by the “but for” test, also called the sine qua non connection (the damage would not have occurred but for the defendant's negligence). This test leads to problems especially in case of several possible causes or when there is a chain of causes. The test is also not suitable for determining what damage is eligible for compensation. An alternative approach is the adequacy theory according to which a causal link is established if the damage reasonably can be attributed to the breach of duty. However, this theory is sometimes considered to be too vague to be applied by the courts. Using criteria like the foreseeability or probability of the damage, the nature of the damage and the nature of the liability may better assess the scope of liability.

In case the damage could also have occurred if the patient had received proper treatment, the theory of loss of chance could provide for a solution. This theory