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Medical Malpractice Law: American Influence in Europe?

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I. Introduction

This article is a comparative study of medical liability in Europe and in the United States. It aims at assessing the present situation in both places and inquiring about the underlying causes. Thus, after highlighting the discrepancy between the American and the European scenes, the article focuses on possible explanations for the differences. The authors conclude that American case law on medical malpractice actually has some influence in Europe: not as an example, but as a deterrent.

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A. A Few Recent European Cases

The latest malpractice case decided by the Swiss Supreme Court and published in official reports is now two years old. This case confirmed previous decisions by the same court, and is typical of the situation in Switzerland. The plaintiff in this case went to the defendant-physician complaining of severe pain in the right iliac fossa. The physician diagnosed acute appendicitis and performed surgery immediately. The surgery revealed no inflammation of the appendix, but disclosed a mass which looked like a tumor. However, the physician merely sutured the wound and did nothing more. By means of further examination, the defendant deduced that the plaintiff suffered from a cancer of the caecum. Three days after the first intervention, he performed a right hemilectomy without disclosing to the patient either the diagnosis of cancer or the exact nature of the surgery. Later, comprehensive examinations revealed that the plaintiff had suffered only from a caecal diverticulum. Complaining of various and persistent troubles, the plaintiff then sued the surgeon for malpractice and lack of informed consent.

In its decision, the Federal Court began by stating that physicians will usually be liable only in case of "obvious mistakes, obviously inappropriate treatment, clear violation of the lex artis or ignorance of the generally known data of medical science." The court then completely followed the opinion of expert witnesses and held that the two erroneous diagnoses did not render the physician liable because these diagnoses were the result of thorough examinations conducted according to usual procedures. In other words, there had been no negligence because any other practitioner faced with the same situation might have made the same mistake.

In England, the case that has caused the most discussion in the past few years is undoubtedly Whitehouse v. Jordan. In Whitehouse, a boy was born on January 7, 1980. In Whitehouse, the case that has caused the most discussion in the past few years is undoubtedly Whitehouse v. Jordan.


2. The Swiss Federal Court held that the physician had the therapeutic privilege to withhold the diagnosis of cancer and the details of the planned surgery from his patient. 105 ATF II at 286. This article will not address the issue of informed consent, but here, too, there are significant and interesting differences between Europe and the United States. For a general overview, see M. Somerville, Consent to Medical Care: A Study Paper Prepared for the Law Reform Commission of Canada (1979); and M. Linzbach, Informed Consent: Die Aufklärungspflicht des Arztes im Amerikanischen und im Deutschen Recht (1980).

3. 105 ATF II at 285.

4. Id.

5. Id.

1970 with severe brain damage. Through his mother, he sued the obstetrician. The claim was that the defendant, in carrying out a "trial of forceps delivery," pulled too long and too hard with forceps on the baby's head, thereby causing severe brain damage. The trial court decided in favor of the plaintiff. However, a year later, the Court of Appeals, led by Lord Denning M.R., reversed the trial judge's finding of fact. The Court of Appeals held that the defendant had not pulled too long and too hard with the forceps, and noted that even had the defendant done so, this act would amount only to an error of clinical judgment, which does not constitute negligence. The House of Lords unanimously dismissed the plaintiff's appeal, stating that there was insufficient evidence to ground a finding of professional negligence. The Law Lords made it clear, however, that Lord Denning's statement that "in a professional man, an error of judgment is not negligent" was untenable. In the words of Lord Edmund-Davies, while some errors of clinical judgment "might be completely consistent with the due exercise of professional skill," others "may be so glaringly below proper standards as to make a finding of negligence inevitable." The test is the standard of the ordinary man exercising and professing to have some special skill.

A brief example illustrates the general principle applicable in malpractice cases in France. A patient suffering from lombosciatica had spinal surgery that caused paralysis of his lower limbs. In the course of the lawsuit brought by the patient against his physician, expert testimony revealed that accidental fraying of the dura mater had occurred during surgery. Grounding its decision on the expert witnesses' opinion, the court dismissed the claim, holding that the plaintiff had not proved any fault chargeable to the defendant. The medical experts had stated that "throughout the operation, the surgeon had been giving the plaintiff attentive and conscientious care in conformity with the acquired data of medical science and had taken all required precautions."

A recent German case is worth mentioning here mainly because it lays out the rules of evidence applied in medical liability cases. The physician performed a

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7. The plaintiff originally sued through his father as next friend; in 1976, his mother was substituted.
8. [1981] 1 W.L.R. 246. The courts did not question the decision to perform a trial of forceps delivery rather than a caesarean section. Id. at 251.
14. Id.
16. Id.
17. Id.
heart catheter investigation on the patient. The following day, the patient asked to be discharged from the clinic, and was allowed to go home. That same afternoon, the patient developed complications which led to his death about three weeks later: a "Pseudomonas-Sepsis" infection had occurred following the heart examination. The widow then sued the doctor. The trial judge held that the physician had acted negligently in allowing his patient to leave the clinic the day after the heart investigation. Since the release amounted to gross negligence, the burden of proof of proximate cause (normally on the plaintiff) was, for equitable reasons, reversed. Since the defendant-physician could not prove that he was not at fault, he was held liable. On appeal, the decision was confirmed. The defendant then sought revision in the Bundesgerichtshof, which stated that since nothing in the case in fact suggested that the early discharge was gross negligence, the plaintiff-widow had to establish the causal nexus between the early discharge and her husband's death. The court concluded that the widow had not done so: the patient might have died even if he had stayed in the clinic longer.

B. The Main Issues

This brief review of a few recent European cases should have made clear that there are two main issues in medical malpractice law: (1) the standards and boundaries of the notion of fault or negligence, namely, when is the physician's conduct negligent, and according to which criteria is it deemed so; or what is the standard of care and when is it violated; and (2) the rules of evidence, and how they are modified to fit the peculiar nature of malpractice claims, namely, which party has the burden of proving what. Since the resolution of these issues varies in the countries discussed, an extensive analysis of the rules on medical liability in these countries is necessary.

II. The Rules on Medical Liability

A. Preliminaries

To the authors' knowledge, no European country has ever enacted any law specifically dealing with medical liability. The applicable principles are thus derived from the general rules of liability. Medical malpractice law is basically

19. Id.
20. Id.
21. Id. at 2514.
22. Id.
23. Id.
24. This article deals exclusively with the civil liability of the physician. It is not concerned with such areas as criminal liability, the liability of physicians as civil servants or vicarious liability.
case law everywhere. Another feature common to the law of the European nations is that fault always is the basis of, and criterion for, liability. The modern trend towards extending strict liability has not yet pervaded the medical area.

The basis for the physician's liability is usually classified as either contractual or tortious. Countries like Switzerland, Germany, France, Belgium and Italy have adopted the contractual approach. The tortious approach applies for the most part in Scandinavia, Eastern Europe and countries which belong to the common law tradition.

Though the contractual and the non-contractual approaches may, at first, appear to be entirely different, the opposition between them is, in fact, somewhat artificial. First, a number of countries allow the injured party to choose whether to sue in tort or for breach of contract. Switzerland, Germany, Italy,

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25 See generally Giesen, La responsabilité civile par rapport aux nouveaux traitements et aux expérimentations, in La responsabilité civile des médecins 63, 64 (1976).
26 Id. See also Tunc, La responsabilité civile in I lIE Congrès international de morale médicale 23, 25 (1966).
27 Proposals for strict liability have, however, been made; see, e.g., Tunc, L'Assurance tous risques médicaux, in Le médecin face aux risques et à la responsabilité 161 (M. Eck ed. 1968) [hereinafter cited as Tunc].
29 In Germany, the contract is a contract for services. Art. 611 BürGERLICHES GESETZBUCH [BGB]; Lotz, supra note 28, at 108; D. Giesen, ARZTHAFTUNGSMEDICAL MalPRACTICE LAW 158 n.16 (1981) [hereinafter cited as Giesen].
30 In France and in Belgium the relationship is a contract sui generis. This has been so since the famous Mercier case: Judgment of May 20, 1936, Cass. ch. civ. [1936] Dalloz Péridodique et critique [D.P.] 188. Previously the French courts had applied the rules on tortious liability (Art. 1382 Code Civil [C.c.]; see, e.g., Carbonneau, The Principles of Medical and Psychiatric Liability in French Law, 29 Int'l & Comp. L.Q. 742, 744 (1980). Belgium adopted the French rule: see, e.g., Meirntzahagen-Limpens, La responsabilité civile des médecins en droit belge, in Rapports belges au Xe Congrès international de DROIT COMPARÉ 685, 689 (1978) [hereinafter cited as Meirntzahagen-Limpens].
31 In Italy the relationship is a contract for the prestation of intellectual work, Arts. 2229-2238 Codice Civile [C.c.]; Bianchi d'Espinosa & Zhara Buda, La responsabilité médicale en Italie (aspects de droit privé), 28 R.I.C.D. 531, 532 (1976) [hereinafter cited as Bianchi].
32 Zepos & Christodoulou, Professional Liability, in XI-6 INTERNATIONAL ENCYCLOPEDIA OF COMPARATIVE LAW 9 (A. Tunc ed. 1978) [hereinafter cited as Zepos].
33 Id.
34 Id. at 9-10; W. Prosser, THE LAW OF TORTS, 162-63 (4th ed. 1971) [hereinafter cited as Prosser].
35 For an extensive comparative analysis of this issue, see P. SLECHTRIEM, VERTRAGSORDNUNG UND AUSFERVERTRAGLICHE HAFTUNG (1972).
36 P. Engel, TRAITÉ DES OBLIGATIONS EN DROIT SUISSE 508 (1973) [hereinafter cited as Engel]; M. Ney, LA RESPONSABILITÉ DES MÉDECINS ET DEURS AUXILIAIRES NOTAMMEN À RASON DE L'ACTE OPÉRATOIRE 31 (1979) [hereinafter cited as Ney]; Judgment of June 10, 1892, 18 ATF II 336.
38 Bianchi, supra note 31, at 234.
England\textsuperscript{39} and the United States\textsuperscript{40} allow such a choice; however, this is not true in France\textsuperscript{41} nor Belgium.\textsuperscript{42} Technical reasons will often lead claimants to choose one or the other cause of action.\textsuperscript{43} Second, even where medical liability is solely or predominantly contractual, its rules derogate from the general principles of contractual liability and borrow to some extent from the frame of analysis typical of delictual liability. This derogation is particularly apparent with respect to the burden of proof: contrary to the usual rule in a contract case, the plaintiff in a malpractice case has to establish the physician’s negligence.\textsuperscript{44} Finally, it should be emphasized that, whatever the legal nature of the plaintiff’s claim, medical liability is grounded in the fact that the practitioner’s conduct fell short of the standards required by law. The “legal duty of care”\textsuperscript{45} remains the same, regardless of its origin. This duty arose as an independent idea, lying beyond any formal, narrow classification. For this reason, the question of the nature of medical liability is largely irrelevant and can be set aside in order to study the content of the duty of care owed by the physician to his patient.

B. When Is the Physician at Fault?\textsuperscript{46}

Every legal system has long admitted that the physician does not normally promise a specific result, such as recovery or success of an operation, but only assures that he will be fully diligent in treating the patients who consult him.\textsuperscript{47} This premise corresponds roughly to the distinction first drawn in French jurisprudence within the contractual field by Demogue\textsuperscript{48} between “obligation de résultat” and “obligation de moyens.” Similarly, in England Chief Justice Tindal stated as early as 1838 that “Every person who enters into a learned profession...”

\textsuperscript{39} The leading case is Brown v. Boorman, [1844] 8 Eng. Rep. 1008; see also Lord Kilbrandon, Questions d’assurance et l’aspect procedural, in Le médecin face aux risques et à la responsabilité 25, 30 (M. Eck ed. 1968) [hereinafter cited as Kilbrandon].

\textsuperscript{40} See, e.g., J. Fleming, The Law of Torts 176 (1977) [hereinafter cited as Fleming].


\textsuperscript{42} Meinertzhagen-Limpens, supra note 30, at 688.

\textsuperscript{43} One of these technical reasons is the Statute of Limitations: In Switzerland, it is 10 years for a breach of contract (Art. 127 C.o.) and 1 year for a tort (Art. 60(1) C.o.); in Germany, it is 30 years (Art. 195 BGB) and 3 years (Art. 852 BGB) respectively; in Italy, it is respectively 10 years (Art. 2946 C.c.) and 5 years (Art. 2947 C.c.); by contrast, it is 3 years throughout England and in most American jurisdictions: Miller, The Contractual Liability of Physicians and Surgeons, 1933 Wash. U. L.Q. 418, 429; see also Tierney, Contractual Aspects of Malpractice, 19 Wayne L. Rev. 1457 (1973).

\textsuperscript{44} See generally Zepos, supra note 32, at 25 for further references.

\textsuperscript{45} Id. at 4.

\textsuperscript{46} This part of the article and the next one on the burden of proof, are not intended as critical analyses of the various legal systems reviewed. Instead, they are a mere statement of the positive law of a few European countries which will serve as a reference when assessing what accounts for the present difference between the American and the European malpractice situations.

\textsuperscript{47} See generally Zepos, supra note 32, at 12 for further references.

\textsuperscript{48} 5 R. Demogue, Traité des obligations en général 536-44 (1925).
undertakes to bring to the exercise of it a reasonable degree of care and skill."49 The main justification for this view, which is generally held, is that medicine is not an exact science and that some hazard is involved in any medical procedure. Otherwise stated, even the best physician cannot guarantee a result and should, therefore, not be liable for any failure or mishap.

According to French courts, the physician is required to give his patient "cautious, attentive and conscientious care in conformity with acquired medical knowledge."50 As a matter of principle, any fault, even the slightest, that causes some damage engages the physician's liability.51 The French Cour de Cassation has somewhat relaxed this rule and has held that "the physician's liability presupposes that, given the state of science and the well-established rules of medical practice, the imprudence, inattention or negligence complained of reveals a positive ignorance of [the physician's] duties."52 This rule still does not mean that a physician will be liable only for inexcusable or gross negligence as some lower courts have inferred.53

In order to determine the duty of care owed by the physician, French courts have resorted to the concept of the "wary physician" (médecin avisé). Negligence exists when the defendant did not behave as a prudent practitioner in the same field would have under the same circumstances.54 One of the consequences of this concept is that a specialist will be expected to exercise a higher degree of care than a general practitioner.55 Another result is that a general practitioner has a duty to direct his patients to specialists when he thinks that he is not fully competent himself.56

With respect to diagnosis, the issue is whether the defendant-physician employed all the reasonable diagnostic methods a wary physician can be expected to use, not whether his diagnosis was erroneous.57 A similar principle applies with respect to treatment, the result of which should never be the test of the physi-

54. See, e.g., Penneau, supra note 41, at 81.
56. See, e.g., Boyer, supra note 50, at 162; compare with Wadlington, supra note 55, at 321 for American law.
57. See, e.g., Penneau, supra note 41, at 72-73 and cases there cited.
cian's care. All of these tests are closely connected with the notion of the "standards of the profession" (usages). 58 Although French courts usually refer to these standards in order to define the extent of the doctor's duties, they have also repeatedly stated that courts are independent of them, and have the power to control the standards. In other words, French courts have retained the right to say that the standards of the profession may occasionally be inadequate. 59

The wary physician standard is objective; the court will not take circumstances personal to the defendant-physician into account. This standard is also abstract and normative; it expresses what physicians ought to do, not what physicians actually do. 60 The court then applies the standard in the exact external circumstances the defendant faced to ascertain whether his conduct was negligent.

A survey of French case law reveals a somewhat confusing array of apparently inconsistent decisions. At the very least, it seems hard to foresee the outcome of a malpractice claim in France. But it is probably right to say that French courts are rather strict with physicians and apply a broad concept of negligence. 61

The discussion of French law is equally valid for Swiss and Italian law. The Swiss Federal Court has its own malpractice formula: the physician will be liable in cases of "obvious mistakes, obviously inappropriate treatment, clear violation of the lex artis or ignorance of the generally known data of medical science." 62 However, the court usually adds that the physician will not be liable "for the bare mistakes [méprises] which are to some extent inherent in the practice of a profession in which opinions may be so numerous and diverse." 63 Thus, not every mistake will lead the court to find negligence; in practice, even though courts do not expressly say so, the physician will ordinarily be held liable for gross negligence only. 64 Since the physician-patient relationship is a mandate, however, the physician should, in principle, be responsible for any error. 65 The Federal Court has stated nonetheless that a strict approach would hinder the practice of medi-

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58. For an extensive discussion on this point, see J. PENNEAU, FAUTE ET ERREUR EN MATIÈRE DE RESPONSABILITÉ MÉDICALE 57-80 (1973).
61. Tunc, supra note 27, at 30. Belgium has generally retained the French solutions with respect to the definition of negligence: see 1 R. DALCQ, TRAITE DE LA RESPONSABILITÉ CIVILE 329 (Novelles, tome V, 1959) [hereinafter cited as DALCQ]. Overall, however, Belgian courts seem somewhat stricter. See, e.g., F. JEANSON, LA RESPONSABILITÉ MÉDICALE EN PSYCHIATRIE 51 (1980) [hereinafter cited as JEANSON]. In Luxembourg, the principles worked out by French courts also apply: see Arendt, La responsabilité médicale et l'assurance-maladie au Grand Duché du Luxembourg, 2 112 CONGRÈS INTERNATIONAL DE MORALE MÉDICALE II (1966).
62. See, e.g., Judgment of Nov. 13, 1979, 105 ATF II 284, 285 and cases there cited.
63. Id.
64. Von der Mühll, supra note 1, at 290; but see two exceptions: Judgment of Nov. 23, 1927, 53 ATF II 419, and Judgment of July 5, 1957, 1958 Semaine Judiciaire [Sem. Jud.] 475, Cour de Justice Civile, Genève, in which physicians were held liable for slight negligence.
65. 105 ATF II at 284-85.
cine to an unbearable extent, given the "imperfections of science and human fallibility, and would "work to the detriment of patients as well as doctors."66

In Italy, the doctor-patient relationship is governed by the rules on intellectual professions, and Article 2236 of the Italian Civil Code applies.67 This Article provides that, when the matter in question involves solving technical problems of special difficulty, the practitioner will be liable for gross negligence only.68 Most medical activity is considered to lie within the scope of this Article.69 Article 2236 thus leads more directly to a result which resembles the Swiss solution.

Both Swiss and Italian laws derive the standard used to measure negligence from the Roman concept of the bonus pater familias. In medicine, this concept embraces the notion of a prudent physician practicing in the same field and acting diligently under the same circumstances.70 Here again, the standard is an objective, abstract and normative one, quite similar to the standard used in French law.

In defining negligence, Swiss case law appears more consistent and more predictable than French case law. Both Italian and Swiss courts are undoubtedly more favorable to physicians than the French ones in requiring some degree of negligence before holding the physician liable.71 By contrast, German courts are closer to French courts in finding negligence. German courts consider that the patient is in a patently inferior bargaining position vis-à-vis the physician, and therefore try to reestablish some parity by protecting the patient more thoroughly.72 Thus, German courts adhere strictly to the rules of contractual liability, especially by holding that any fault may lead to a physician's liability.73 The physician's duty of care is measured by what a colleague would normally do under similar circumstances.74 Once more the same objective and abstract standard emerges, leaving no room for personal excuses.75 German courts generally appear to be the most severe of those continental European countries reviewed here.

66. Id. at 285.
68. Id.
70. Engel, La responsabilité civile du médecin, 26 Médecine et Hygiène 901, 905 (1968) [hereinafter cited as Engel]; Ney, supra note 36, at 153-54; Bianchi, supra note 31, at 533.
71. However, the present trend in Switzerland (and elsewhere in Europe) is towards extending the physician's liability. See, e.g., Von der Mühll, supra note 1, at 295-97, who writes of an unpublished 1981 case decided by the Federal Court in which the court stated that "the accumulation of even slight shortcomings may actually express a lack of attention or an ignorance of the lex artis which makes it proper to engage the physician's liability." Id. at 297.
72. See, e.g., Tunc, supra note 27, at 31.
73. See, e.g., Deutsch, Reform des Arztrecht, 31 NJW 1657, 1659 (1978).
74. Deutsch, Rechtswidrigkeitzusammenhang, Gefährhöhung und Sorgfaltausgleichung bei der Arzthaftung, in Festschrift für Ernst von Caemmerer 329, 331 (1978) [hereinafter cited as Deutsch, Festschrift]; Deutsch, supra note 37, at 2289.
75. Deutsch, Festschrift supra note 74, at 331.
In England, even though medical liability is usually based on tort, the concept of negligence worked out by the courts is quite similar to that of the other countries reviewed here. Traditionally, courts have held that the physician makes himself liable when he fails to act with the care and skill owed by the ordinary man exercising and professing to have a special skill. Here, too, the standard is abstract and objective: courts compare the reasonably skillful medical practitioner with the actual physician in the actual circumstances of the case in order to determine whether negligence existed. The process which leads to a finding of negligence is, therefore, the same in all the countries surveyed.

It should, nevertheless, be noted that there are no longer degrees of negligence in English law since certain courts have decided that there is no legal difference between negligence and gross negligence. There is still a tendency to draw some kind of distinction, as Lord Denning's strong opinion that an error of clinical judgment should not be considered negligent demonstrates. But this view has clearly been rejected by the House of Lords.

This short survey of European negligence law shows that the physician's liability in all countries is based on fault, that is, on careless or incompetent conduct. Furthermore, in all countries, negligent conduct is nothing but the failure to observe the reasonable standard of care normally owed his patient by the average prudent and diligent practitioner. American case law is no exception to this standard, since courts generally hold that "the physician has the duty to his patients to possess and employ such reasonable skill and care as are commonly had and exercised by reputable, average physicians in the same general system or school of practice in the same or similar localities."

C. Who Bears the Burden of Proof?

In every legal system, expert testimony is usually the basis for a determination of fault, since judges lack the scientific knowledge necessary to evaluate medical acts. In both common and civil law countries and regardless of whether the claim arises in contract or tort, the plaintiff must allege and prove the doctor's negligence, his damages and the causal nexus between them. For a number of reasons, direct evidence of the fault and the causal connection may be hard to

77. See, e.g., Lord Denning, The Discipline of Law 237 (1979) [hereinafter cited as Denning].
80. See also Zepos, supra note 32, at 40.
81. Waddington, supra note 55, at 319.
82. This is a derogation from the ordinary rule of contractual liability, which presumes fault and requires the defendant to bring forward exculpatory evidence.
prove. Because physicians have a tendency to band together, it is sometimes very difficult for people who do not belong to the profession to learn what really happened in a given situation: members of the medical team do not discuss the matter, and medical records are not always readily available. Furthermore, most experts do not want to testify against their colleagues. The purported independence of the courts when dealing with expert opinion is, in practice, too theoretical to correct the situation effectively. Courts have, therefore, sought to alleviate the burden of proof cast on patients who sue their physicians for malpractice.

Switzerland is probably one of the strictest countries with respect to the rules of evidence in malpractice cases. Generally speaking, the plaintiff must prove the physician at fault, the damage the plaintiff sustained and the causal nexus between these facts. The Federal Court has for a long time held that strict and absolute proof of causal connection cannot be required in every case. A high probability of causality, measured according to the rules of logic and experience, may be sufficient. But the possibility that anything else caused the damage complained of must then be drastically reduced. Under Swiss law, whenever the judge is in doubt about causation, he should not hold the physician liable.

With regard to the doctor's negligence, Swiss courts have intermittently departed from the rule which places the burden of proof of negligence on the plaintiff. In at least three reported cases, one of which was tried by the Federal Court, the judges based their finding of fault on common experience. In the latter case, a surgeon had tied off the carotid instead of the thyroidian artery. The court held that, in such a case, the burden of proof was reversed, and the

83. This has been called the conspiracy of silence. See, e.g., Salgo v. Leland Stanford University, 159 Cal. App.2d 560, 568, 317 P.2d 117 (1957); see also Belli, An Ancient Therapy Still Applied. The Silent Medical Treatment, 1 Vill. L. Rev. 250 (1956).
84. Zepos, supra note 32, at 28-29.
85. See, e.g., Tunc, supra note 27, at 29. Tunc states that physicians told him they thought it was their duty systematically to reach conclusions beneficial to their colleagues when they were called as expert witnesses.
88. See, e.g., Judgment of Dec. 5-6, 1983, 59 ATF II 434; Ney, supra note 36, at 135 for further references.
89. The rule is the same in Italian law: see Bianchi, supra note 31, at 537.
90. Actually, the mere possibility of a causal nexus is not sufficient. See 1 K. Oftinger, Schweizerisches Haftpflichtrecht, Allgemeiner Teil 81 (4th ed. 1975) [hereinafter cited as Oftinger]; Ney, supra note 36, at 135.
93. Id. at 209.
defendant surgeon had to establish that his mistake was not due to negligence. 94 He was unable to do so and was, therefore, held liable. 95 Such cases are exceptional, however, and the Federal Court apparently wants them to remain so. 96

In France, the burden of proof in contractual claims depends on the now famous distinction between obligation de résultat, in which a presumption of fault arises when the result contracted for is not attained, and obligation de moyens, in which the plaintiff must establish a violation of the duty of care, as in malpractice cases. 97 Here also, the mere failure of an operation or treatment is not normally proof of negligence: French courts presume that a doctor acted diligently. 98 This rule, however, has sometimes been weakened by the concept of "virtual negligence" (faute virtuelle). 99 "Virtual negligence" theory maintains that, when a physician, under the circumstances, "must have made a mistake," it is unnecessary to demonstrate that he was actually at fault. 100 In such exceptional cases, the physician bears the burden of proving he did not do so. 101

With respect to causation, French courts also accept the idea that a number of concordant presumptions based on logic and common experience may be sufficient to exempt the plaintiff from the necessity of presenting a direct and absolute proof of causation. 102 Since 1965, French courts have gone even further, repeatedly holding that, when the doctor's negligence causes the patient to lose some chance of recovery or survival, damages will be awarded even though the causal connection between the negligence and the loss is not established. 103 The award will be proportional to the loss experienced by the patient. 104 Many authors consider this theory legally very questionable since it is arbitrary and runs against the procedural guarantees offered the parties. 105 During the last

94. Id. at 211.
95. Id.
96. Recently, however, the rule has been increasingly questioned. See especially the decision of the Obergericht Zürich (one of the most influential state courts in Switzerland) Judgment of Feb. 15, 1979, 78 BLZR 202 (1979), and the controversy caused by it. For this, see Stevert, Zur Haftung des Arztes — Kritische Bemerkungen zum Entscheid des Zürcher Obergerichts vom 15. Februar 1979, 77 Revue Suisse de Jurisprudence (RSJ) 109 (1981), and the reply of Ileri, Zur Haftung des Arztes — Eine Entgegung, 77 RSJ 353 (1981).
97. See, e.g., R. Savatier, Tracté de droit médical 290 (1956).
98. See, e.g., Savatier, Responsabilité, supra note 53, at 11.
99. See Penneau, supra note 41, at 77, 133 and cases there cited.
100. Id. at 80.
101. The physician is then in the same situation he would be in if he were bound by the obligation de résultat; this is, at least in part, why a number of French writers have spoken of a "sliding toward the obligation de résultat"; see, e.g., Martin, Le danger; la glissade vers l'obligation de résultat, 2 Ile Congrés international de morale médicale 301 (1966); Boyer, supra note 50, at 82.
103. See, e.g., Penneau, supra note 41, at 114-15; Boyer, supra note 50, at 92; Ney, supra note 36, at 139-44.
105. In fact, it amounts to a reversal of the burden of proof; the physician must actually make a negative proof if he is not to be held liable. See the sharp criticism of Savatier, Une faute peut-elle engendrer la responsabilité d'un dommage sans l'avoir causé?, 1970 Dalloz Chroniques 125; see also Ney, supra note
few years, however, use of this theory has abated.\textsuperscript{106}

Interesting developments on the burden of proof have also arisen in Germany. A \textit{prima facie} case for both the causal nexus and the physician's fault is established under conditions which are similar to those applied in French law, that is, when the result is of the sort which occurs when some negligence exists.\textsuperscript{107} Contrary to the rule in French case law, however, the plaintiff's burden of proof is only lightened, not reversed.\textsuperscript{108} The doctor may introduce any evidence that is proper in order to "shake the court's \textit{prima facie} conviction."\textsuperscript{109} Such evidence will be sufficient to shift the burden of proof back to the plaintiff. The claimant thus still bears the burden of producing complete proof.\textsuperscript{110}

The lower standard for the burden of proof placed on the plaintiff can amount to a complete reversal of that burden when the physician was grossly negligent.\textsuperscript{111} Reversal is no longer rigidly required but arises out of considerations of equity.\textsuperscript{112} The courts thus have a prerogative which may be of the utmost importance in deciding the outcome of the lawsuit, but courts will refrain from using it when the physician's mistake is not major.\textsuperscript{113} It is worth noting, however, that German courts have also lowered the burden of proof and even reversed it in cases where the physician did not keep comprehensive medical records, or altered or "improved" the existing ones.\textsuperscript{114}

The equivalent in common law countries of the \textit{prima facie} evidence rule of civil law systems is the \textit{res ipsa loquitur} doctrine.\textsuperscript{115} The doctrine applies when a layman can infer, as a matter of common knowledge, that a specific injury would


\textsuperscript{107} See, e.g., Deutsch, \textit{Festschrift}, supra note 74, at 332-34.

\textsuperscript{108} Zepos, supra note 32, at 31 for further references.

\textsuperscript{109} Id.

\textsuperscript{110} Id.

\textsuperscript{111} Laufs, \textit{Die Entwicklung des Arztrechts} 1978/79, 32 NJW 1230, 1232 (1979); Judgment of June 27, 1978, 72 BGHZ 132 (1978). Previously the burden of proof was reversed whenever there was gross negligence; this scheme has now been abandoned, particularly in the light of the difficulty of distinguishing gross from mere negligence. Laufs, \textit{Die Entwicklung des Arztrechts} 1980/81, 34 NJW 1289, 1292 (1981) [hereinafter cited as Laufs].


\textsuperscript{113} 34 NJW 2513, 2514 (1981).

\textsuperscript{114} Stürner, \textit{Entwicklungstendenzen des zivilprozessualen Beweisrechts und Arzthaftungsprozess}, 32 NJW 1225, 1226-27 (1979); Laufs, supra note 111, at 1293; Judgment of June 27, 1978, 72 BGHZ 132; cf. Judgment of Oct. 31, 1945, Obergericht, Zürich, 44 BLZR 326, where it was held that the physician's duty of care involves keeping records to the extent necessary to allow a colleague to review and analyze the case; but this view has never really been sanctioned in Switzerland. See generally Stauffer, \textit{Civil Liability of Physicians}, RECUEIL DES TRAVAUX SUISSES PRÉSENTÉS AU XE CONGRÈS INTERNATIONAL DE DROIT COMPARE 41, 55 (1979) [hereinafter cited as Stauffer].

\textsuperscript{115} See Zepos, supra note 32, at 28 for further references.
not have occurred had the doctor exercised due care. Its typical applications are in so-called foreign object cases, i.e., when swabs or surgical instruments are left in a patient's body — and in remote injury cases, i.e., when the patient sustains an injury outside the area of medical treatment. The res ipsta rule is limited by the "calculated risk" and "poor result" theories which state that a poor result alone is insufficient to allow an inference of negligence when the same type of injury might occur even though a physician exercised reasonable care.

The res ipsta doctrine is applied somewhat differently in England and in the United States. English courts may give the rule a greater effect than a mere permissible inference of fact. Under some circumstances, the res ipsta rule will actually cast the burden of proof onto the defendant-physician, who must then exculpate himself by proving that he acted without negligence. American courts, however, seem more ready to resort to the res ipsta doctrine than are English ones.

In conclusion, one may say that the rules of evidence which apply in various countries express a similar concern: the balancing of the interests of physicians and patients. In every country the failure of the treatment or the bare fact of a poor result is insufficient to substantiate a finding of negligence; everywhere, the plaintiff-patient bears, as a matter of principle, the burden of proving the practitioner's negligence and the causal connection between that negligence and the harm complained of. But everywhere, too, there is a tendency to lighten the burden of proof which patients must bear. The United States is no exception to these trends.

117. WADLINGTON, supra note 55, at 612; FLEMING, supra note 40, at 304.
118. FLEMING, supra note 40, at 304; WADLINGTON, supra note 55, at 613.
119. Zepos, supra note 32, at 28; WADLINGTON, supra note 55, at 616-17; Canadian courts go even further in the scope of application of the res ipsta rule, using it even with respect to treatment. However, they significantly relax the standard of proof; the defendant physician will win if he produces an explanation consistent with either negligence or lack thereof. See generally Azard, L'évolution actuelle de la responsabilité médicale au Canada, 10 R.I.D.C. 16 (1958). It is interesting to note that the province of Quebec also applies the res ipsta loquitur doctrine even though it has a civil law system. See the leading cases Elder v. King, [1957] Recueil des arrêts de la Cour du Banc de la Reine [Que. C.B.R.] 87 (Cour d'Appel de la province de Québec, March 28, 1956) and Mellen v. Dr. X, [1957] Que. C.B.R. 389 (Cour d'Appel de la province de Québec, February 21, 1957).
120. Zepos, supra note 32, at 29-30.
121. A few American courts hold likewise, see id.
122. Id.
123. See, e.g., the remarks of Lord Denning in a British case, Hucks v. Cole, Court of Appeal Transcript No. 1968/181 at 6: "It is not right to invoke against... [the physician]... the maxim res ipsta loquitur save in an extreme case." Id.
124. For a discussion of the interests involved, see Zepos, supra note 32, at 20.
125. Id. at 12, 25; Savatier, Responsabilité, supra note 53, at 493-510, 497-98.
127. Id. at 27-31.
III. The Present Discrepancy Between the American and European Situations

A. The Similarities

Over the last few years, critics in every western country have noted a rather sharp increase in the number of lawsuits brought against physicians for malpractice. Different factors, common to both Europe and the United States, have contributed to this phenomenon.

First, the number of medical treatments performed each day has increased steadily, although this fact alone obviously does not account for the increasing number of claims. Second, the practice of medicine has grown more complex and technical, using sophisticated procedures and extremely powerful drugs. Complexity has made medicine more efficient, but more risky as well, thus increasing the probability that something will go wrong. Finally, medicine in western civilization has become largely anonymous: the doctor is no longer a "bosom friend," but a technician. In addition, the complexity of modern medicine often requires a team to perform surgery, though the patient has usually dealt with one practitioner alone; and the patient will have fewer scruples when he sues a physician he does not know.

The media have played a significant role in the increase in claims as well. On the one hand, the media have tried to popularize medicine and its recent achievements. This approach has led the public to believe that medicine is omnipotent and that a physician is incompetent if treatment fails. On the other hand, by reporting lawsuits against doctors, the media have inevitably encouraged some people to bring lawsuits of their own.

128. For France, see, e.g., Jodin & Cazac, Evolution de la responsabilité médicale au cours des vingt dernières années, 21e Congrès International de morale médicale, 83 (1966); Guérin, supra note 15, at 6. For Belgium, see, e.g., Meinertz-Hagen-Limpens, supra note 30, at 705. For Switzerland, see, e.g., Stauffer, supra note 114, at 54; Ney, supra note 36, at 257. For Germany, see, e.g., Laufs, Fortschritte und Scheidewege im Arztrecht, 29 NJW 1121 (1976) [hereinafter cited as Laufs, Fortschritte]. Franzki & Franzki, Waffengleichheit im Arzthaftungsprozess, 28 NJW 2225 (1975) [hereinafter cited as Franzki]. For England, see, e.g., Grey-Turner, Le docteur, son client et leur relation dans le service national de la santé en Grande-Bretagne, 21e Congrès International de morale médicale, 62, 63-64 (1966). For the United States, see, e.g., Wadlington, supra note 55, at 317-18.
129. Wadlington, supra note 55, at 317-18; see also Penneau, supra note 41, at 2.
130. Penneau, supra note 41, at 2; Boitard & Fontaine, La responsabilité médicale et son évolution récente, in Le médecin face aux risques et à la responsabilité 105, 106 (M. Eck ed. 1968) [hereinafter cited as Boitard].
131. Boitard, supra note 130, at 105-06.
132. Id.
133. Id. at 105; see also Lombard, supra note 105, at 267.
134. Boitard, supra note 130, at 106; see also Jeanson, supra note 61, at 363.
135. Boitard, supra note 130, at 106; see also Guérin, supra note 15, at 5. Trial publicity is particularly important in France because one usually begins with a criminal procedure, since the Public Prosecutor, who has wide powers, does all the evidence-gathering. In addition to the fact that the procedure is easier, cheaper and usually quicker, the plaintiff can take advantage of the rule le criminel tient le civil en
An additional significant contribution to increased claims is the fact that most physicians now carry some form of malpractice insurance. This fact makes patients worry less about suing their doctor; if the patient wins, he will collect his judgment from an insurance company, not from his doctor. 136 Furthermore, the existence of social security benefits has infused people with the notion that they have a right to health, whereas they have a right only to health care. 137 Another factor, which must be added to these elements is the general mentality currently pervading western material and technical society. This mentality exists on two levels. First there is the common feeling that whenever something goes wrong, someone must necessarily be responsible. 138 (Our forefathers left plenty of room for the intervention of fate.) Second, there is the general pursuit of financial gain; 139 Why shouldn't you sue a physician, whom you barely know, if a slightly crooked little finger can bring you $50,000?

The features briefly described here are common to both Europe and the United States. Yet, from basically the same premises, Europe and the United States have grown widely apart: the United States faced an acute malpractice crisis in the 1970's. 140 Europe did not.

B. The Dissimilarities

For a European lawyer, three features of the present American situation are particularly striking: (1) the number of physicians involved in malpractice suits; (2) the amount of damages awarded to plaintiffs; and (3) the rate of malpractice insurance premiums.

Some twenty years ago, about one in seven physicians had been the object of a malpractice claim in the United States. 141 In 1973, Lombard stated that every other physician could expect to be the subject of a malpractice claim in the course of his professional career. 142 The 1973 Report of the Malpractice Commission

l'Etat, which means that the civil judge will later be bound by the criminal judge's holding. See generally J. PENNEAU, FAUTE CIVILE ET FAUTE PÉNALE EN MATIÈRE DE RESPONSABILITÉ MÉDICALE (1975). The same rule applies in Belgium (DALCOQ, supra note 61, at 340) but not, for example, in Switzerland (Art. 55 C.o.) nor in England (Kilbrandon, supra note 39, at 28).

136. Kilbrandon, supra note 39, at 28. See also PENNEAU, supra note 41, at 3. This assumption is even shared by judges. See the remarks of Judge J. Skelly Wright in Brown v. Keaveny, 326 F.2d 660, 663 (D.C. Cir. 1965) (dissenting opinion): "[T]oday, with insurance, financial responsibility is not one of the dangers to the doctor in a malpractice suit." The notion that insurance will pay is sometimes called the "deep pocket" theory. See Zepos, supra note 32, at 41.

137. PENNEAU, supra note 41, at 3; see also H. ANRYS, LES PROFESSIONS MÉDICALES ET PARAMÉDICALES DANS LE MARCHE COMMUN 420 (1971) [hereinafter cited as ANRYS].


139. GUÉRIN, supra note 15, at 8.

140. These developments were widely reported both in the United States and Europe. See, e.g., News from the World of Medicine, The Malpractice Mess, Reader's Dig., Jan. 1971, at 144; see also Zepos, supra note 32, at 41-44.

141. WADLINGTON, supra note 55, at 418.

142. LOMBARD, supra note 105, at 258-59.
indicated a total of 18,000 claims in 1970.\textsuperscript{143} In 1980, Waltz wrote that every single medical school graduate could expect to be charged with, or actually sued for, professional negligence.\textsuperscript{144} Of course, this does not mean that every physician sued will be held liable, as other data provided by the Report of the Malpractice Commission show. Only about ten percent of all claims were ever brought to court; the remaining ninety percent were settled amicably. In addition, plaintiffs were successful in approximately thirty percent of the cases that did reach the courtroom.\textsuperscript{145}

Comparable data are lacking for European countries. As to France, one author reports that in 1970 the three biggest insurance companies, covering more than half of French practitioners, had to deal with 155 requests for damages.\textsuperscript{146} More recently, Von der Mühl noted that 350 million medical acts occurred yearly and 1,500 court files were opened.\textsuperscript{147} Thirty-three percent of the cases filed — i.e., 500 decisions — held the doctor liable.\textsuperscript{148} The ratio of cases reaching court to the overall number of claims is unknown. A study in Germany of fifty-four claims filed in the Oberlandgericht Celle during the seven years from 1968 to 1975 showed that plaintiffs were successful in thirty-six cases — i.e., sixty-six percent of the total.\textsuperscript{149} In Switzerland, one writer estimated in 1979 that the number of malpractice claims for damages was fewer than 200 a year.\textsuperscript{150} Since the beginning of the century, the Swiss Federal Court has had to deal with malpractice cases fewer than twenty times; Plaintiffs have won, partly or entirely, in approximately half of these cases.\textsuperscript{151}

The main conclusion to be drawn from these fragmentary, very imperfect and sometimes even contradictory data is that the main difference between Europe and the United States lies in the number of claims filed, and not in the rate of success for plaintiffs in court. In fact, the plaintiffs’ rate of success is higher in European countries.

The second striking aspect of the American situation is the amount of money

\textsuperscript{143} DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE 8 (1973) [hereinafter cited as COMMISSION REPORT].

\textsuperscript{144} WADLINGTON, supra note 55, at 418.

\textsuperscript{145} See Hausheer, \textit{Arztrechtliche Fragen} 73 RS] 245, 255 (1977) [hereinafter cited as Hausheer]. Zepos, supra note 32, at 42 gives slightly different data: Eight percent of all claims go to court and 8 lawsuits in 10 are dismissed; thus plaintiffs would be successful in 20% of the cases.

\textsuperscript{146} Hausheer, supra note 145, at 255.

\textsuperscript{147} Von der Mühl, supra note 1, at 294.

\textsuperscript{148} Id.

\textsuperscript{149} Franzki, supra note 128, at 2226.

\textsuperscript{150} Stauffer, supra note 114, at 54.

\textsuperscript{151} See Lotz, supra note 28, at 125. Unfortunately, these data are not very good, first because they concern only published cases, and many decisions of the Federal Court are never reported; second, because, owing to the costs involved, people appeal to the Federal Court only if chances of winning the case are good. Von der Mühl might, therefore, be closer to the truth when he states that “a majority” of the claims brought to court are dismissed. Von der Mühl, supra note 1, at 294. Nobody, however, has ever precisely quantified the “majority.”
courts award as damages to plaintiffs. In 1975, Lord Kilbrandon spoke of two English cases, one involving partial paralysis following spinal surgery with £35,000 awarded,152 the other involving brain damage following cardiac arrest under anesthesia with £50,000 awarded,153 and compared them to an American case in which a child paralyzed after an arterial hemorrhage was awarded $4,025,000.154 More recently, in Whitehouse v. Jordan, the trial court awarded £100,000, or approximately $185,000, to the plaintiff, but the Court of Appeals overturned the decision.155 In December, 1981, an English court awarded a record £414,563, or approximately $775,000, to a thirty-eight year old woman who had been given a permanently paralyzing spinal injection while giving birth to her son.156 Comparable amounts are awarded in the other European countries, where seven-figure verdicts in U.S. currency never occur. Such awards are far from such recent American awards as the $7.1 million awarded to a mentally handicapped child whose condition deteriorated after a tonsillectomy157, or the $7.6 million awarded to a girl of 18 who became nearly quadriplegic.158

The last point that puzzles Europeans is the cost of American malpractice insurance premiums. In the United States, annual premiums of over $20,000 dollars seem quite common.159 In 1973, the Report of the Malpractice Commission stated that premiums had increased by 800 percent over the last ten years.160 Reports exist which indicate that physicians quit their jobs, and that insurance companies refused to renew malpractice insurance policies for a large number of practitioners in Hawaii and in New York.161

By contrast, in 1973, premiums for malpractice insurance in France were, on the average, 230 francs for a general practitioner and 2200 francs for a surgeon.162 By 1978, premiums had increased to 500 francs, or approximately $100, for a general practitioner and 6600 to 7000 francs, then approximately $1320 to $1400, for a surgeon.163 In Switzerland, in 1980 a general practitioner had to pay 390 Swiss francs, or approximately $215, and a surgeon 1860 Swiss francs, or approximately $1025, for coverage of up to one million Swiss francs per case.164 Premiums for malpractice insurance surprisingly had not changed between 1970 and 1978.165

152. Kilbrandon, supra note 39, at 34-35.
153. Id.
157. See A. Tunc, La responsabilité civile 2 (1981) [hereinafter cited as Tunc, responsabilité].
158. Id.
159. Lombard, supra note 105, at 268, alluded to such premiums in 1973.
160. Franzki, supra note 128, at 2225.
163. Id.
164. Von der Mühll, supra note 1, at 294.
165. Stauffer, supra note 114, at 54.
IV. Analysis of the Phenomenon

The most commonly advanced explanations for the discrepancy between the American and European situations, which are often advanced without further analysis, are: (1) the contingent fee system (which is forbidden in Europe); (2) the extreme specialization of American lawyers; (3) the "American specter" which alarms Europeans; (4) the medical revolution that developed first in the United States and reached Europe only ten to fifteen years later; (5) the res ipsa loquitur rule in American law; (6) the role of juries; (7) the American mentality; and (8) punitive damages; i.e., the very high money damage awards to plaintiffs. The following discussion assesses the pertinence of each of these explanations.

A. Punitive Damages — The American Mentality

As previously discussed, American damage awards are much higher than those granted in European countries. This discrepancy is due to the fact that an American judge may allow punitive damages, i.e., damages beyond the actual loss experienced by the plaintiff. Such damages are unknown, or rather forbidden, in the countries of continental Europe. In the United States, punitive damages may act as a significant incentive for certain people in suits against physicians for malpractice.

Writers have also tried to ascribe the discrepancy to factors that are supposed to be typically "American." One author argued that Americans are accustomed to thinking of everything in terms of dollar value, and contrasted "strong French good sense" with "congenital American eccentricity." Another author believed that the Swiss were more respectful of physicians. Such arguments, which turn on alleged differences in national mentality, seem like sociological quackery. No data are ever provided to support them. These arguments are, at the least, most suspicious.

In summation, the real influence of higher damage awards and the role that differences in national mentality may play will remain debatable as long as specific and comprehensive data which demonstrate them are not provided. Although these factors may have had some influence on the recent American evolution of malpractice, there are strong reasons to believe that they are not the key to the problem.

166. Tunc, responsabilité, supra note 157, at 85; Prosser, supra note 34, at 9-14.
167. For Swiss law, see, e.g., Optinger, supra note 90, at 63; Engel, supra note 36, at 341. For French law, see, e.g., H., L., & J. Mazeaud & F. Chabas, 3 Traité théorique et pratique de la responsabilité civile delictuelle et contractuelle 614 (6th ed. 1978). For German law, see, e.g., 1 K. Larenz, Lehrbuch des Schuldrechts, Allgemeiner Teil 390 (13th ed. 1982).
168. Punitive damages are an old common law institution and have been widely used in the United States. They have, however, been narrowly limited in England. See Tunc, responsabilité, supra note 157, at 85.
169. Lombard, supra note 105, at 257, 268.
170. Stauffer, supra note 114, at 55.
B. The Role of Juries

Juries do not sit in civil matters in continental European countries, nor usually in England.\textsuperscript{171} Since they do so in American courts, it has been stated that juries have played a significant role in bringing about the present situation.\textsuperscript{172} Authors generally note that juries favor plaintiffs because, as laymen, they are more sensitive to the patient’s misfortune.\textsuperscript{173} These authors contend that juries make their decisions more on emotional than on rational, legal grounds; consequently, juries are more inclined to grant plaintiffs what they ask for.\textsuperscript{174}

This argument may be valid; patients may fare better with juries than with professional judges. Yet the argument is not pertinent as an explanation of the discrepancy between the United States and Europe. The influence of juries is actually relevant only to an assessment of the plaintiffs’ chances of success in court.\textsuperscript{175} Thus the argument fails to account for the difference in the sheer number of malpractice claims brought by patients, which is the main difference between the American and European situations.

C. The Res Ipsa Loquitur Rule

In addition to the contingent fee, the \textit{res ipsa loquitur} rule is the most frequently advanced explanation for the malpractice discrepancy.\textsuperscript{176} For many authors, \textit{res ipsa} has become a kind of magical shibboleth explaining everything. Yet, as previously illustrated, European countries have developed special rules on the burden of proof in malpractice claims that are closely akin to the \textit{res ipsa loquitur} rule.\textsuperscript{177} However, two possible differences remain. First, courts in the United States might apply the \textit{res ipsa} doctrine more extensively than courts in Europe apply the rules alleviating the burden of proof. In fact, there does seem to be a trend toward extending the scope of the \textit{res ipsa} rule in the malpractice field.\textsuperscript{178} In addition to the two typical applications — foreign body and remote injury cases — courts have begun to apply the doctrine in cases involving asserted errors in diagnosis or in the choice of a method of treatment\textsuperscript{179} and have increasingly applied the rule when the patient has been harmed by the administration of an anesthetic or by injection of a drug.\textsuperscript{180} The second possible difference is a question of timing; developments on the burden of proof are more

\textsuperscript{171} Kilbrandon, \textit{supra} note 39, at 36.
\textsuperscript{172} \textit{E.g.}, Tunc, \textit{responsabilitée}, \textit{supra} note 157, at 2-3; Franzki, \textit{supra} note 128, at 2226; Lombard, \textit{supra} note 105, at 265; Kilbrandon, \textit{supra} note 39, at 36-37.
\textsuperscript{173} Franzki, \textit{supra} note 128, at 2226.
\textsuperscript{174} Id. at 2226-27.
\textsuperscript{175} Studies would probably show that it increases them.
\textsuperscript{176} \textit{See note 172 supra} and authorities there cited.
\textsuperscript{177} \textit{See § II.C supra}.
\textsuperscript{178} \textit{See, e.g.}, Wadlington, \textit{supra} note 55, at 618.
\textsuperscript{179} Id. at 615-16. Fleming, \textit{supra} note 40, at 304, advocates such an extension.
\textsuperscript{180} Wadlington, \textit{supra} note 55, at 614-15.
recent in Europe and may have been inspired in the malpractice field by the *res ipsta* doctrine. Thus, *res ipsta* might have played a role in the increase of malpractice claims in the United States while the rules of evidence for plaintiffs in Europe still remained strict.

Even if one takes these two differences for granted, making the *res ipsta loquitur* rule responsible for the present American situation is unrealistic. First, the rule does not explain why England, which has long had the same doctrine and even affords it wider effect, did not evolve in a similar fashion. 181 Nor does it explain why Canada, which has also applied the *res ipsta loquitur* rule for a considerable period and in a broader way than the United States, 182 did not face a malpractice crisis either. But the argument previously advanced regarding the role of juries 183 also contradicts the *res ipsta* explanation. The *res ipsta loquitur* rule has an influence on the lawsuit's outcome only, whereas the discrepancy between Europe and the United States lies primarily in the number of claims brought by patients. Of course, one might argue that if every lawsuit won by a patient encourages others to bring a claim, the *res ipsta* doctrine will indirectly contribute to a general increase in the overall number of suits by raising the ratio of successful to unsuccessful suits. This effect would be true for the role of juries as well, yet one is compelled to admit that such an influence is, at best, limited.

D. The European Delay — The American Specter

Authors sometimes comment that Europe is about to face the situation the United States had to deal with ten years ago because medical developments occurred in the United States before reaching Europe. 184 This is a strange prediction. The commentators who hold this view either consider the malpractice crisis as the unavoidable consequence of medical progress, which is untenable, or as a kind of fad, as if it were suddenly fashionable to sue one's physician, which is hardly more credible. These authors seem to think the fad will then cross the Atlantic after some time, like blue jeans or the hippie movement.

By contrast, other authors argue that the specter of the American malpractice crisis acts as a deterrent in Europe. 185 They suggest that Europeans are quite frightened of following the path that led Americans to the crisis of the 1970's. This view is not surprising, since, when the malpractice crisis was reported in Europe, all of its bad aspects were stressed, especially the rapidly increasing cost of medical care and what has been broadly called "defensive medicine." 186 Most

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181. See notes 120-23 and accompanying text supra.
182. See note 119 supra.
183. See § IV.B supra.
184. See, e.g., Franzki, supra note 128, at 2225; Lombard, supra note 105, at 258.
185. A survey of the European literature on the malpractice issue reveals that almost every single writer alludes to it.
186. D. Harney, Medical Malpractice 92 (1973) [hereinafter cited as Harney]; see also Zepos, supra note 32, at 42.
American doctors were said to think more of their own safety than of the good of their patients, multiplying costly and often superfluous examinations or failing to intervene in difficult cases to ensure that they would not later be charged with malpractice. 187

Those commentators who affirm the view that it is mainly the American specter that prevented Europeans from implicating themselves in the same crisis overlook a logical element: since the premises were basically identical in both places, there should have been a contemporaneous evolution. Some additional factor must, therefore, explain the timing issue. This factor might be the so-called "European delay" with respect to medical progress — which hardly seems convincing — or any other element thought to have favored the earlier evolution of the American malpractice field. But if one adds this other element, one implicitly admits that this factor, and not the American specter, is primarily responsible for the dissimilarity. The specter cannot explain the development of the basic difference, though it may explain why the American situation will never reproduce in Europe. Nevertheless, the argument's weight in this framework requires discussion.

There are strong indications that the American specter is indeed vivid throughout Western Europe. In England, for example, the American specter is alluded to in Lord Denning's view that, as a matter of policy, medical negligence claims ought to be discouraged. 188 Lord Denning justifies this policy in two ways: (1) the need to protect the physician's reputation which "is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body:" 189 and (2) as he expressly stated in Whitehouse v. Jordan, the fear of a crisis such as exists in the United States. 190

It would seem difficult to deny that a doctor's reputation can be badly hurt by a successful malpractice suit against him. Nevertheless, the disturbing results of a study conducted in Connecticut on sixty-four malpractice suits brought against physicians during the period 1945-1959 may be worth mentioning here. 191 Fifty-two out of fifty-eight physicians who could be interviewed reported that their practice improved after the lawsuit. In fact, the heaviest loser in court, a radiologist, reported the largest gain. 192 Only one doctor, a winner in court, reported adverse consequences indirectly traceable to the malpractice suit. 193

The prospect of an American-style crisis is another matter, despite the fact

187. Harney, supra note 186, at 92.
188. See Robertson, supra note 6, at 458-59.
189. Denning, supra note 77, at 243.
192. Id. He commented: "I guess all the doctors in town felt sorry for me because new patients started coming in from doctors who had not sent me patients previously." Id.
193. Id.
that the Pearson Commission recently considered the issue and reported that there was no reason to fear such developments in England.\textsuperscript{194} Similarly, writers have stated that a malpractice crisis was not to be feared in Germany.\textsuperscript{195} Everyone is not convinced that this is so, however, and some positive action has been taken in an attempt to curb the rising number of malpractice suits reaching the courts. For example, conciliatory bodies were created in 1975 to decide malpractice claims, mainly on the medical profession's initiative.\textsuperscript{196} These bodies are still too new to allow a valid assessment of their activities, but until now they seem to have operated satisfactorily.\textsuperscript{197}

In conclusion, there undoubtedly is a widely shared concern in Europe that Europeans should not follow the American example. Although this view does not explain the development of the difference between Europe and the United States, it actually constitutes a strong, present deterrent, which may act at two levels: (1) knowledge of the American situation may pervade the minds of judges and other peoples, thus making them cautious, even timorous when dealing with malpractice claims; and (2) such knowledge evidences a strong contrast between the European and the American situations, thus leading (and partly misleading) patients to think that in the United States it would be easy to sue one's physician and win, whereas in Europe all the plaintiff is likely to get is huge attorney's fees.

E. The Organization and the Methods of the Legal Profession

The authors believe that the differing organization and methods of the legal profession in Europe and the United States are the major key to the divergence between what has happened in Europe and in the United States. Four aspects seem to be significant in this context: the specialization of American lawyers, the possibility of legal advertising in the United States, the search for clients and the contingent fee system.\textsuperscript{198}

In the United States, a number of lawyers have specialized in the malpractice field, assuming, no doubt, that there is a large and largely unexploited market available.\textsuperscript{199} In Europe, such specialization is a recent occurrence, and in some countries there is still no such thing as a specialization in medical litigation.\textsuperscript{200} A survey in one Swiss canton revealed that, for a population of slightly over one half-million, there were about 1800 doctors and 125 lawyers.\textsuperscript{201} The latter were,
on the average, consulted once in every five years by a dissatisfied patient. This amounts to twenty-five cases a year, but about half of these immediately appeared groundless.202 Thus, even if one lawyer alone “cornered the market,” he could hardly make a substantial living.

Advertisements by lawyers and law firms are not forbidden in the United States.203 By contrast, in Switzerland, professional codes forbid attorneys and law firms to advertise.204 The same is true of France205 and of the other European countries.206 Advertisements certainly may influence people to consult a lawyer.

Related to this point are some methods apparently used by a few American lawyers to search out clients. Although “ambulance chasing” is considered unethical, some authors suggest that this kind of activity does nevertheless occur in the United States.207 In European countries, where such a behavior is also strictly forbidden by deontological rules,208 lawyers seem to abide more scrupulously by the rule. They do not, therefore, “happen” to contact patients in the hospital, upon discharge or even after it. This might well be an additional factor, since at those moments, patients are undoubtedly more ready to listen to a persuasive person advising them to make a claim against the physician or the hospital. And, of course, if something, somehow, did go wrong in the course of the treatment, the patient’s dissatisfaction will then be at its peak because the problem is still very close, both mentally and physically. The patient is, therefore, in a fragile psychological state: disappointed and angry, he is in need of comfort, help or a way to satisfy his aspirations for revenge.209 If European lawyers did contact patients under these circumstances, there would almost certainly be more malpractice claims.

In addition, if in the course of an interview with an attorney the patient could be guaranteed that he would have nothing to pay if he decided to press a claim, there is no doubt that a still larger number of medical negligence claims would be

202. Id. at 294.
203. This has been so since the Bates case. Bates v. State Bar, 433 U.S. 350 (1977). Advertising by attorneys is still subject to state regulation. For guidelines, see In Re R.M.J., 102 S. Ct. 929 (1982).
204. M. Guldener, Schweizerisches Zivilprozessrecht, 641 (3rd ed. 1979) [hereinafter cited as Guldener]; W. Habscheid, Droit judiciaire privé suisse 79 (2d ed. 1981) [hereinafter cited as Habscheid]; Judgment of Oct. 4, 1961, 87 ATF 1262. For Swiss law, see also Art. 29 Loi vaudoise sur le barreau (November 22, 1944) and Art. 2 Us et Coutumes du barreau neuchâtelois (April 10, 1962). Exceptions are usually provided for the opening of the law firm, a change of address, a new association or a long absence. See 87 ATF 1262, 265.
206. Union Internationale des Avocats, Les barreaux dans le monde 100 (1959) [hereinafter cited as Union Internationale des Avocats].
207. See, e.g., Lombard, supra note 105, at 245.
208. Union Internationale des Avocats, supra note 206, at 104; see also Art. 2 Us et coutumes du barreau neuchâtelois, Apr. 10, 1962.
209. This is one of the strong motivations for patients bringing a malpractice claim. See Jeanson, supra note 61, at 367.
brought. This in effect is the result of the contingent fee system in the United States: American lawyers can assume all the financial risks of the lawsuits. If the claim is dismissed, the client will have no fees to pay his attorney; if it is granted, the latter takes a certain percentage of what the client is awarded, usually from twenty-five to fifty percent. This system is clearly a powerful incentive for both the client and the attorney. By taking the financial risks of the lawsuit from the client, the system obviously encourages clients to decide to bring one and makes the opportunity of getting high, and often very high fees available to lawyers. The system thus also makes lawyers more audacious and more willing to take risks.

A contingent fee system is deemed contrary to the ethics of the legal profession and is expressly forbidden in France, Germany, Italy, Sweden, England, Switzerland and more generally throughout Europe. It is regarded as a serious violation of deontological rules, because a lawyer should act according to principles of justice and equity, and ought to collect his fees in the most impartial way. An attorney violating this rule would be sanctioned, probably with severity, by the professional instances. In one case in Switzerland, a fine of 200 Swiss francs, or approximately $100, was levied. An English lawyer could be suspended.

The direct consequence of this position is that in Europe patients usually do not want to take the financial risk of bringing a lawsuit, and lawyers have no real motive to encourage such action. Indeed, as illustrated, lawyers discourage any positive action in approximately half of the cases and try to settle most of the remaining ones amicably. The ultimate result is a significantly smaller

210. Franzki, supra note 128, at 222. The contingent fee arrangement should not be used where a client is able to pay a regular fee. See Model Code of Professional Responsibility EC 2-20 (1979). It is not permitted in criminal cases. Model Code of Professional Responsibility DR 2-106(c) (1979). Some states have limits on the percentage of the fee set either by court (e.g., American Trial Lawyers’ Association v. New Jersey Supreme Court, 330 A.2d 350 [1974]) or by statute (e.g., CAL. BUS. & PROF. C. § 6146 (West Supp. 1982)).

211. Some writers have stated that American lawyers actually are more audacious than their European counterparts. See, e.g., Tunç, Responsabilité, supra note 157, at 86. See also Smit, La procedure civile comme instrument de reforme sociale, 28 R.I.D.C. 449, 453 (1975).

212. Lombard, supra note 105, at 265.

213. Kilbrandon, supra note 39, at 37.

214. Id.

215. Id.

216. Id.


218. See Guldener, supra note 204, at 642, 637.

219. See 98 ATF Ia at 144.

220. Kilbrandon, supra note 39, at 37.

221. Von de Mühll, supra note 1, at 294.

222. Id.

223. In Switzerland, this is the most convenient way of settling the case for both the client and his lawyer: in such a case, the insurance company usually pays the expert’s fees and those of the patient’s
number of medical negligence claims. This argument is supported by the Canadian situation. There, no crisis has occurred, although most of the legal rules and general social circumstances are quite similar to those of the United States. But in Canada the contingent fee is prohibited.224

V. Conclusion

Over the last few decades, medicine has evolved according to a similar pattern in both Western Europe and in the United States. This evolution, especially the rising complexity of modern medicine, its "dehumanization," as well as the public’s new perception of medicine and physicians, has inevitably entailed some increase in the number of malpractice claims. But the ultimate result of the process can vary widely, in both scope and intensity, from one place to another.

Just as medicine has developed, medical malpractice law has evolved, too. In Europe especially, there has been a trend toward extending medical liability. Typical examples of this tendency are the principles developed by European courts with respect to the burden of proof or the seemingly broadening concept of negligence.225 The law in European countries has now become quite comparable to that of the United States. Negligence is defined in basically the same way and established according to the same criteria in both places, and the rules of evidence tend to be similar as well.

Contemporaneously with the general tendency toward extending the physician’s liability, Europeans have grown more aware of the potential risks involved in the recent evolution of medicine, as exemplified in the United States. This attitude has led a number of people to propose various schemes in an attempt to curb the rising number of claims.226 Some have advocated reversing the recent trend of case law, such as by distinguishing an error of clinical judgment from negligence.227 Others have proposed more fundamental changes, either in the very principle of medical liability or in the judicial process.228 Thus, authors have advocated making physician's liability "no fault liability" and creating special insurance.229 New procedural mechanisms, usually designed to simplify and

attorney. Thus, the client has nothing to disburse and the attorney gets as much money as he would had he actually litigated the case, but does considerably less work.

224. LOMBARD, supra note 105, at 270.
225. See note 71 supra.
226. On the conciliatory bodies set up in Germany, see notes 96-97 and accompanying text supra. Arbitration panels have also been set up in some of the American states on a voluntary basis. See Zepos, supra note 32, at 44. For other possible legislative solutions see id. at 43.
227. See note 71 supra.
228. See note 226 supra and authorities there cited.
229. See, e.g., Tunc for French law, Mourveau, for Belgium law, Weyers, for German law as discussed in Zepos, supra note 32, at 42, 412; cf. for American law, Ehrenzweig, Compulsory "Hospital-Accident" Insurance: A Needed First Step toward the Displacement of Liability for Medical Malpractice, 31 U. Chi. L. Rev. 279 (1964).
accelerate the settlement of claims, have also been created, as in Germany.230 Still other proposals have encouraged the implementation of binding arbitration.231

It appears desirable not to grant physicians too great a privilege with respect to other professionals as was customary, and still is to some extent, in Switzerland.232 One should, therefore, welcome the present trend in Europe. Equity requires that a patient be fully compensated every time he sustains injuries as a result of negligence in the course of medical treatment. The law in European countries has moved slowly toward this goal. Despite some commentators' predictions, attainment of this goal will not be synonymous with arriving at an American-style malpractice crisis. The structure of the legal profession, as well as the warning the American situation offers to Europeans, will prevent its happening. Attempts at limiting the physician's liability, such as to gross negligence only, should, therefore, be discarded because they try to grant doctors an excessive privilege. These attempts are unjust, and especially unjustifiable when made in the name of preventing a crisis that will never happen.

The overall conclusion may be summarized in a few words: the differences between Europe and the United States in the field of medical litigation have little or nothing to do with medicine or the medical profession, and not even much to do with the substantive law on tortious or contractual liability. These distinct differences in malpractice law result from the differing structures, legal regimes and ways and means of the legal profession in Europe and the United States.

230. See notes 143 and 144 supra.
231. See Zepos, supra note 32, at 44. In the United States, such arbitration must remain voluntary for constitutional reasons. See id.