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Medical expert witness testimony in France and in Europe

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board - court- European medical laws

Summary

Health care professionals are usually at a loss when it comes to medical “complaints”, essentially because they lack knowledge with regard to existing litigation procedures.

After a short reminder of the different rights of appeal in France, we describe how medical appeals function in other European countries. Next, we give the details of how the evaluation of claims of bodily damage works, a process in which every physician may be called upon to participate several times in a career), either as the defendant, or as a medical counselor, or as an expert. The goal of this update is to understand the different compensation appeal circuits available to patients and help the surgeon demystify and dedramatize the situation while preparing for the medical expert witness testimony. All such testimony reports, *via* whatever appeal circuit, follow a similar procedure, even if they are not exactly identical.

1- Introduction

When a patient, or his or her beneficiary, believes that he or she has been a victim « *following an action of prevention, diagnosis or care* » (article L. 1142–28 of the French public health code (PHC)), they can initiate a process to determine the responsibility of the health care professional, or public or private health care facility, and claim a compensation for the damage incurred. The French law n° 2002–303 (March 4, 2002) concerning the « *rights of patients and quality of health care* » (the so- called Kouchner Law) allows patients to initiate a claim up to 10 years after the date of consolidation. Health care professionals or facilities will be considered responsible for the damage to patients only if a fault (negligence or error) can be proven (article L 1411-2 of the PHC).

In order to place the study of medical accidents under the prism of common law and responsibility, the causality between the fault and the damage alleged by the patient must be analyzed. In this respect the patient has several options to obtain some form of financial compensation for the damage to which he or she has been exposed.

While the patient has the choice of which action to take, the burden lies with the plaintiff to prove that the health care professional(s) have committed a fault that engages their responsibility (according to the responsibility system, which is based on a proven fault). For this, the patient has the right to access his or her medical record according to the articles L1111-7 and L.1110-4 of the PHC. The patient consequently has the right to ask for an out-of-court settlement (direct negotiation with the physician's insurance company), but also to refer the case to an arbitration and compensation board (ACB) or a law court to solicit a counter-testimony from a medical expert witness.

In certain cases, however, the health care professional must actively prove that correct and adequate information was provided to the patient (regime called « reversal of the burden of proof » often invoked by patients, as based on article L.1111-2 of the PHC).

2- The different circuits for adjudication of claims (Figure 1) [1]

2.1 Out-of-court settlements

This circuit is strongly encouraged by judges and insurance companies because of the rapidity of settlement, much more expeditious than when

the procedure goes to court or through an ACB (especially the ACB of the Greater Paris region).

Following this procedural stream, the patient refers the case directly to the physician or the health care facility that he or she believes is responsible for the damages, by registered mail with acknowledgement of receipt. The goal is to obtain an out-of-court settlement, initiated by either the patient him- or herself, or the juridical insurance protection of the victim.

This settlement approach should be preferred whenever the fault is unquestionable, and a compromise solution can be easily found.

Accordingly, a medical examination of the plaintiff should be performed by the medical officer (most often designated by the patient's insurance company) who then addresses a medical expert witness testimony to the defendant. Based on this report, the judicial protection system of the defendant can propose either an out-of-court medical counter-medical expert witness testimony to identify and evaluate the damages, or propose a compensation, or even, contest that any damage occurred.

If the patient accepts the compensation, the settlement procedure is terminated by a compromise proceeding protocol that forbids any further contention for the same damage (articles 2044 and following of the civil code), EXCEPT in case of aggravation.

If the out-of-court solution fails, the patient still has the right to present his or her case to an ACB or refer the matter to a court of law.

2.2 Out-of-court circuit after referral to an ACB [2]

The ACB, instituted by the French law of March 4, 2002, can be consulted directly by the patient, without any cost to the patient, with or

without a lawyer (there is a standardized blank form letter that the patient must fill in, and send *via* registered mail and acknowledgement of receipt).

The claim is usually seen and examined fairly quickly (quicker than the normal judiciary route even though sometimes, the delays can be almost the same). As indicated by its name, the ACB has a double function: arbitration and compensation, but only for damages that attain a certain level of severity as fixed by law (articles L1142–1 through L.1142–3 and 1142–3 of the PHC) :

- permanent functional deficiency (PFD) >24 %
- temporary sick leave > 6 consecutive months or 6 non-consecutive months over a period of one year
- _disability considered to be particularly severe for activities of daily living
- definitive incapacity to exercise one's previous profession
- temporary functional deficiency \geq 50% for 6 consecutive months or 6 non-consecutive months over a period of one year.

If the claim is considered acceptable, the counter-medical expert witness testimony is set up, usually with a single expert. This person should be on the official list of the National commission for medical accidents (Commission Nationale des Accidents Médicaux (CNAmed)). The expert's report should be sent to the ACB within three months of the consultation with the patient.

After reception of the observations from the parties on the expert's report (the claim statements), the commission meets, interviews each of the parties, and pronounces either a notice of rejection, or a notice of responsibility fixing the different points of damage requiring compensation. It is then the responsibility of the company that insures

the professional or health care facility to either make an offer or refuse to do so, within a delay of four months.

If the claim is rejected by the ACB, the plaintiff can still bring the matter to a court of law (administrative or high court, *cf infra*) or else, the National Office of Compensation of Medical Accidents (Office National d'Indemnisation des Accidents Médicaux (ONIAM)).

The ONIAM replaces of the dependant's insurance company, by initiating a recusal of the defaulting insurance company of the health care professional or facility (with the risk of a 15% penalty).

2.3 The judicial circuit: High Court or Administrative Court

The victim has the possibility of bringing the case to court: either directly from the start, or after failure to come to an out-of-court settlement (*cf supra*). The litigation will then be treated according to jurisdictions of common law where the presence of a lawyer is mandatory. The financial burden of the procedure and medical expert witness testimony must be beared by the plaintiff.

Litigations between the patient and a physician in private practice or/working in a private institution are judged in Supreme Court (or in a district court if the damages are < €10,000). For physicians who work in the public sector, litigations are handled by an Administrative Court.

Once the case is registered and deemed receivable, the judge designates an expert from an official list. The expert is expected to organize a counter-medical expert witness testimony and provide a report with substantiating reasons (*cf. infra*). This report with substantiating reasons provides the grounds for debate to determine the responsibility with the administrative judge either after a judiciary medical

expert witness testimony has taken place or after rejection of the previous mandatory request.

A judgement is usually made within one year after the final decision has been taken.

2.4 Referral to the Board of Medicine

Although there is no possibility of counter-testimony by a medical expert witness through this circuit, alerting the Departmental Board of Medicine concerning a conflict is being used increasingly today when physicians are involved in law suits. Of note, the debate within the Departmental Board is centered on the deontological aspect of the management offered to the patient, not the quality of care (medical expert witness testimony). Patients and their counsellors may not be aware of this aspect, thinking that once again, the goal of this referral is to determine the responsibility of the physician but this is not the role of the Board. The Departmental Board is obliged to organize an arbitration once it has been solicited according to the article L.4124-2 of the PHC (relative to hospital practitioners) or the article 4123-2 of the PHC [4].

3- Comparison with other countries in Europe

In France, victim compensation for therapeutic accidents reposes on the common law principles of medical responsibility. Responsibility, however, differs according to where the health care professional works (public or private sector) and the nature of the medical procedures.

In the first scenario, the physician is not held responsible personally for the damage he or she causes during his or her professional activity, unless it is proven that the fault was done outside of any professional norms. In principle, the responsibility falls upon the hospital, and since 1992, according to administrative justice, this is considered a simple negligence by act of the State council decision of 10 April 1992, by which the High French court over-ruled the necessity of a serious offense to engage the responsibility for a procedure performed in a public hospital.

Moreover, since 1993, French justice acknowledges that hospitals are accountable for “therapeutic hazards” or “random therapeutic events”, according to the ruling of State Counsel BIANCHI (April 9,1993). According to this decision, the high administrative jurisdiction laid down the principle according to which hospitals are accountable for any procedure leading to severe damage, regardless of any relationship to the patient’s initial status, even in the absence of any negligence or error, as long as there was no particular reason to think that a given patient was particularly exposed.

Conversely, physicians exercising in private practice are personally responsible, but generally the judge establishes the medical responsibility in the common law scheme of a proven error. This means that the physician can be held responsible only if the patient can prove and/or demonstrate that an error was committed.

The principal characteristics of compensation systems in our European neighbors (Germany, Denmark, Italy, United Kingdom, Sweden, and Switzerland) vary somewhat, but, excepting Italy, these countries have specific procedures that allow for patient compensation without having to go to court.

Generally speaking:

- in **Italy**, compensation of therapeutic accidents continues to be ruled by common law courts. The judges determine the amount of damages based on medical experts reports.
- In **Germany** and in **Switzerland**, physicians have set up an extra-judiciary system of mediation. In Germany, the regional medical boards have established mediation panels since 1975. In Switzerland, the Federation of Helvetic physicians (Fédération des Médecins Helvétiques) set up their extra-judiciary panels in 1982.

Patients can bring their case to these panels if they think they have been a victim of a medical error. This leads to an evaluation and decision with regard to the existence or not of a medical error. In Germany, where the statute of mediation panels varies from one region to another, some even reach decisions on the amount of compensation to be awarded. In Switzerland, however, the panels of extra-judiciary mediation never evaluate the amount of damages, but their conclusions can be used for the out-of-court settlements between the parties.

In both countries, the systems are practically cost-free for the patients. Although the German panels have been criticized, in particular because some of them do not involve the patients in their procedures, they seem to function satisfactorily, since attribution of civil liability to physicians has practically disappeared. Conversely, in Switzerland, the activity of the extra-judiciary panels is more restricted.

In any event, in both of these countries, even if the parties choose to have follow an extra-judiciary process, they are still free to bring the case to court, since the conclusions of the mediation panels are not legally binding.

- in the **United-Kingdom**, the 1999 reform of the civil procedure established a “pre-judicial protocol” to resolve medical conflicts. This protocol invites both parties, first, to search for an out-of-court solution before taking any legal action and also to respect a very precise calendar of events. Non-adherence to this protocol can give rise to severe penalties, as the judge can consequently refer the case to civil jurisdiction if the out-of-court solution fails.

- in **Denmark** and **Sweden**, the law exempts the victim of a therapeutic accident from having to prove that there was negligence or error. Sweden was the first European country to separate the notion of “medical responsibility” and “right of compensation”. Starting in 1975, the county councils, who manage the hospitals, and the insurance companies, agreed on a compensation protocol for therapeutic accidents providing the victims with compensation even in the absence of a negligence or error. With this as an example, the Danish government adopted a similar law in May 1991, effective July 1, 1992, by which most of the victims of medical mishaps could be compensated in the absence of any negligence or error or notion of liability. All that is necessary is to establish that the prejudice sustained by the patient could have been avoided (if the physician had clearly adhered to *secundum Artem*, in the absence of equipment failure or if other methods had been established) or that the damage is the consequence of a true therapeutic hazard (that is, a very rare complication or one much more severe than could be expected).

All these requests for compensation are treated by the Patients' Association for Insurance that includes all the insurance companies of health care givers as covered by law. This association checks that all requests are receivable, and evaluates the damages. An *ad hoc* commission examines any recourse made against the decisions of the Association. In its turn, Sweden followed Denmark and replaced the compensation protocol of therapeutic accidents by the law of 1996 relative to patient insurance, which came into effect Jan 1, 1997. The Swedish law foresees a similar system, even if the criteria of eligibility are not exactly the same.

Conclusion:

Management of medical misadventures is common topic in all countries in Europe and has privileged out-of-court settlements in case of conflicts between patients and health care professionals. In all countries studied, except Italy, the medical contention is not (either partly or completely) under the jurisdiction of common law rights. The solutions, although quite variable, have some common characteristics: a concern to compensate victims by a simple and inexpensive procedure and speedy settlements [4]. However, as there are always exceptions to the rule in the assessment of therapeutic misadventures that can lead to compensation, the French system probably is one of the most accomplished and complete that exists today.

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Figure 1: Possible actions after a medical accident

