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The Development of  
Medical Liability in Germany,  
1800–1945



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Frankfurt am Main  
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Bench dispensing scales, 19th century  
S. Maw, Son and Thompson (1870–1901)  
Type commonly used through the 19th century  
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## Preface

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Somerset House, November 2018  
C. P. McGrath

# Introduction

‘Every method has its adherents and detractors’<sup>1</sup>

## 1. The subject at hand

Liability for negligent harm caused by medical treatment is a subject familiar to all legal systems, although not all systems treat it alike. It seems customary when discussing the subject at any length to note that such liability is an ancient feature of legal systems given the Code of Hammurabi contained both harsh sanctions for such liability alongside provisions fixing the cost of treatment;<sup>2</sup> even in ancient Mesopotamia, it seems, the legal regulation of medical practice and the consequences of injurious practice went hand in hand. Evaluating the strength of that connection during a different period of legal history lies at the heart of what follows.

This work is a legal history of the development of civil liability for medical error in Germany between 1800 and 1945. Within that, it focuses on one central aspect of that subject: the definition and interpretation of the requirement that the defendant medical practitioner was at fault. The aim of this inquiry is to examine the development of the law in relation to changes within the legal system and the broader context of medical practice and regulation, identifying, where possible, the drivers behind legal change. Thus, it investigates the relationship between the legal and medical discourses concerning what may be termed medical error and, in doing so, reveals a rich interaction between the two out of which the law-in-practice emerged. It aims to provide not simply an understanding of what the law was and how it changed, but rather what drove its development; why and how did it come to be?<sup>3</sup>

Having set out, briefly, what this book does, it is important to be clear as to what it does not do. Medical liability is here circumscribed to errors in diagnosis and treatment, its classical core. We do not consider the closely-related topic of liability based on failure to obtain the patient’s consent. Furthermore, we are concerned only with the substantive doctrinal understanding of fault; we do not consider the various tools developed to provide the plaintiff (as they will be referred to) with a procedural indulgence. These are valuable in their own right, but must await further study. It is hoped that unpacking how liability for errors

1 *RG 09.10.1936*, Hübner/Warneyer (1939) 113.

2 §§ 215–225; H-D Viel (2002) 647.

3 On development and legal change, see Bell/Ibbetson (2012) 1–10.

in diagnosis and treatment was understood provides much groundwork towards such efforts.

From this, three choices must immediately be defended: Why focus on medical liability? Why in Germany? Why during the period 1800–1945?

As to the first, the genesis of this study was as a contribution to an emerging literature within European private law, which seeks to better understand the developmental patterns within different doctrinal areas, often by adopting a historical analysis, as the basis for better understanding the modern law.<sup>4</sup> The fact that medical liability is a common and, inevitably, long-standing problem with which legal systems have had to wrestle suggests a natural testing ground for those interested in how private law has developed over time; in a mature legal system it is a subject that is likely to present a rich amount of data over a long enough period. Furthermore, if one wishes to test the relationship between legal change and extra-legal changes, then medical liability, again, naturally suggests itself given the ever-present but ever-changing nature of medicine and medical practice across different systems; just as there are clearly different approaches to law across the legal systems of the world, there are different national approaches to medicine, medical practitioners and medical provision. This last point may not be immediately obvious to some, certainly in the developed world. Nevertheless, even within Europe, the process of medicine's development has varied in line with various cultural and historical contingencies, no less so in the case of Germany.<sup>5</sup> Finally, these matters are often intimately related to choices (or, at least, inertia) within the legal system: Who can practice medicine? What is it they are offering? How do patients access healthcare? These are all susceptible to the unintended interference of, or regulation by, the legal system, and offer an excellent chance to study the relationship between legal and extra-legal change.

But why turn to Germany as the focus of this study? The answer to this is that there are several features of Germany's respective medical and legal histories that suggested a study of the relationship between them here would yield a suitably rich result. First, the modern German law on medical liability is a voluminous and, increasingly, systematised body of specific rules within broader private law. Whilst the *Patientenrechtegesetz* 2013 – long in coming<sup>6</sup> – has now codified much

4 Hondius (2010).

5 In Germany's case this revolves centrally around the considerable degree of state control over medical practice maintained well into the nineteenth century, the role of the university and, associated with it, the laboratory in medical education, and the persistence of unorthodox medical practice, see Kater (1985); Huerkamp (1990); Bonner (1995) 232, 281; Weisz (2006) 60–63, 243. In the absence of further detailed comparative work it is important not to overstate the case for a German *Sonderweg* in all medical matters, see Maehle (2009) 129–130.

6 Kubella (2011) 15–25; Katzenmeier (2001) 85 f.

of the law within the *Bürgerliches Gesetzbuch (BGB)*,<sup>7</sup> this was possible only because of considerable work by the German courts in shaping the contours of liability before that point.<sup>8</sup> Thus, there is sufficient legal material to provide a thicker account than would be possible in other legal systems.<sup>9</sup> Secondly, substantive German doctrine has proven itself willing to strongly challenge the claim that the defendant medical practitioner was not at fault because they did what other practitioners would have done in the same circumstance;<sup>10</sup> their analysis of fault has now restricted this essentially sociological approach, replacing it, at least in part, with what may be termed an ethical approach;<sup>11</sup> it is now based on a court-driven ethic that stands analytically separate from internalised, medical views of appropriate behaviour. This represents a key doctrinal shift, yet how and why this process occurred is poorly understood. When one examines the standard German texts, explanations of this process, brief as they are, often focus on a change in terminology in the latter half of the twentieth century, from ‘*Kunstfehler*’ to ‘*Behandlungsfehler*’, which reflected the shift away from an older interpretative model that indulged ideas of *medically* accepted practice, to the current interpretative model.<sup>12</sup> Given there is no specific historical treatment of the relevant German law here, indeed there has been surprisingly scant scholarship on this topic generally,<sup>13</sup> there is a gap in the literature that invites further detailed study of how and why the German law reached this position, which is what this book seeks to provide. Indeed, as will be shown below, the explanation for this takes the legal historian to a much earlier period than has, up to now, been thought worth studying, a rebuke to the idea

7 *Gesetz zur Verbesserung der Rechte von Patientinnen und Patienten*, BGBI I (2013) 277.

8 Stauch (2015). Not that some had gone unnoticed beforehand, see Shaw (1968); Stauch (2008).

9 Hondius (2010) 13.

10 Stauch (2008) 43–45.

11 Montrose (1958).

12 ‘The “*Kunstfehler*” was, for a long time, the foundation of medical liability’, Katzenmeier/Laufs/Lipp 335; Katzenmeier (2002) 273 f; Giesen (1983) 11 f; Riegger (2007) 15–17.

13 An unpublished German doctoral thesis amounts to the closest available literature, which covers some of the same ground. In contrast to the present study, that thesis offers an essentially descriptive, historical account of the whole scope of medical liability in Germany to 2000, Riegger (2007). Other works offer brief commentaries on individual parts of the history here, but none in a comprehensive fashion and none offer more than a cursory recounting of the terminological shift identified above. An indicative example is Katzenmeier (2002) 273–274. A broader account of the surrounding legal, intellectual development in liability law as a whole is available in Jansen (2003). By contrast this study offers only a specific, contextualised analysis of medical error.

that medical liability, ‘...is a rather new phenomenon’.<sup>14</sup> Thirdly, turning to the relevant features of Germany’s medical history, Germany’s position (commonly alongside the United Kingdom, the United States and France)<sup>15</sup> as one of the powerhouses behind modern, scientific,<sup>16</sup> hospital-based medicine suggests that the legal system would be presented with sufficiently numerous challenges throughout that process, as the nature and delivery of medicine changed, to justify a developmental study. It allows the study of a key player within the western medical tradition.<sup>17</sup> Fourthly, the occupational development of what we refer to in this study as orthodox medical practitioners – those who sought to establish themselves as the intellectual and occupational guardians of medical services – has long been thought to differ in Germany in key ways from that of their counterparts in similar systems.<sup>18</sup> The extended, delayed path of orthodox practitioners away from considerable control by the state towards the freedom of occupational hegemony is a unique feature of German medical history,<sup>19</sup> and, as such, it is important to understand the degree, if any, to which it influenced legal change here. Fifthly, that this came at the cost of decades of medical practice being defined in law as a ‘trade’ open to anyone meant the medical marketplace in Germany remained populated by a bewildering range of unorthodox practitioners, from the homeopathist to the empiricist to the outright charlatan, well into the twentieth century. A measure of the extremity of this situation was that there was no necessary bar on allowing such practitioners to play a role in the emerging, modern public health structures. Given access to orthodox, scientific medicine was also largely dependent on whether one lived in a city or the countryside throughout the early twentieth century, the lived experience of German medical practice demands a better understanding of whether and how, in assessing the question of fault, German courts accounted for the vastly differing occupational and intellectual models of medicine on offer.

Finally, why only study the German law between 1800 and 1945? The answer here is that to understand the relationship between legal and medical change over time, a sufficiently broad period is required to account for a suitable degree of dynamism in both spheres. The period covered here allows us to study their relationship to one another at a time when both were in flux and going through the final iterations before settling in their broadly current forms, and easily satisfies this. Even so, four immediate further questions arise: First, why study

14 Hondius (2013) 8.

15 Bonner (1995).

16 Broman (1997); Cunningham/Williams (2002).

17 On the idea of a discrete *western* medical tradition see, Jacyna (2006) 28 ff.

18 Kater (1985); Huerkamp (1990); Neal/Morgan (2000).

19 Huerkamp (1990) 66-67; Weindling (1986) 290.

the law before 1945? In answer to this, it is immediately clear that many of the key changes in this subject had taken place by the early 1950s. As the *Bundesgerichtshof* (BGH) put it succinctly in *BGH 27.11.1952* when discussing how to assess whether the defendant practitioner was at fault:<sup>20</sup>

‘From the fact that expert practitioners of dentistry ordinarily work with unsecured needles, the conclusion may be drawn that the defendant demonstrated the degree of care *customary* within his occupation. Yet, as noted, this is not determinative. Rather, more decisive is whether the objective required care has been observed. Presently, the protection of patients from incidents during treatment, which threaten avoidable injury, is the highest imperative.’

That they cited a range of earlier decisions from the era of the *Reichsgericht* in justifying this makes clear that any account of our chosen topic must seek its answers in that era. Secondly, why then study the law before the enactment of the *BGB*? It, after all, is the touchstone of modern German civil law. To this we can say that in focusing on the development of the law here – the why, not simply the what – it is necessary to pre-empt the code to understand the extent to which codification, one of the key moments of formal change in the basis of the law here, made any difference at all.<sup>21</sup> Thus, some coverage of the nineteenth century is necessary at least. Thirdly, then, why stray into the murky, fractured world of the law before unification in 1871? Or, if one is interested in the impact of the *Reichsgericht*, why not begin in 1879? The answer here is that both the medical discourse surrounding error and the beginning of efforts to standardise medical education and regulation emerged at the start of the nineteenth century and continued throughout it. There is considerable discussion of the appropriate definition given to medical error in both the relevant legal and medical sources in the early part of the century, and in the latter half, the vast Pandectist literature provides a window into the emerging civil rather than criminal treatment of medical error. Thus, 1800 presents itself as a natural starting point to ensure these matters are given proper attention. Finally, and returning to the twentieth century, why include the post-1933 law as it developed under the Nazi regime? More detailed justification may be found in chapter five, but a brief explanation is required here: In short, the increasing use of technology and reach of medicine into the human body repeatedly came before the courts throughout the 1930s. Including this period allows us to present the two case studies on these questions that conclude this volume and demonstrate the role of technology as a driver of change here. Furthermore, both the early case law of the *BGH* and the literature of that post-war era as it relates to the subject matter at hand draw on cases from

20 BGHZ 8, 138, 141, emphasis added.

21 Zimmermann (2001) 98, sagely noting the possibility that in some areas the *BGB* brought no change at all.

that period without prejudice or comment; they played a key contemporary role in understanding the development of the law here. As to why we end at 1945, there is no point at which the narrative presented in this study can be easily broken, any such point is artificial at best and, at worst, blinds us to a possible explanation for the shape of the law. Once it is recognised that the post-1933 law is a necessary part of understanding the development of the law here, 1945 suggests itself as a suitable terminus given both the abolition of the *Reichsgericht* and the natural break in Germany's constitutional history that it heralds. Whilst further study of the post 1945-era, particularly given the establishment of the 1949 Basic Law, would greatly enrich the findings presented here, we offer only a brief comment on this era in the conclusion and leave that work for later scholars. As we will demonstrate, the issue of medical error was very much alive in the pre-1945 German law, itself dominated by the arrival of the *BGB*, and, earlier, throughout the jurisprudence of the *Reichsgericht*. As will be shown, it is in this earlier period that a clear break with a sociological approach to fault was made, even if sustaining it required the later courage of others.

## 2. Why study this at all?

This study provides an account of why and how German law concerning medical error developed as it did, uncovering the intimate link between the legal development and parallel changes in the medical arena. By doing so, it rehabilitates this earlier period as deserving as much attention for this aspect of the development of medical liability as it commonly receives when one considers other aspects of German medical liability.<sup>22</sup> It achieves this by demonstrating that the medical and legal discourses surrounding medical error were, for a considerable period, entwined across contract law, criminal law, the law of delict, and the medical regulatory sphere. The *Reichsgericht* came to exploit the tension within that medical discourse, and, in doing so, provided analytical space for courts to challenge accepted medical behaviour. Whilst the law was, for a long period, passively receptive, it was the existence of that medical discourse and its interrelation with the legal discourse that played a key role as a driver of legal development, albeit to the eventual chagrin of its originators.

The last century has witnessed three fundamental changes in healthcare. It has become institutionalised, its reach has intensified,<sup>23</sup> and a highly self-organised and regulated class of practitioner bound to a collective ethic of practice has emerged. No less than in other western countries, the contemporary German

22 See, for example, *RG 31.05.1894* RGSt 25, 375; Franzki (1982) 57–61; Helbron (2001) 23–23, 80–82.

23 Katzenmeier (2002) 11–17.

law is commonly accompanied by a rhetoric of crisis;<sup>24</sup> litigation rates have jumped in recent decades and there is a pressing need to focus on the present, not explain its genesis.<sup>25</sup> The knowledge offered in this book will not provide better rules; it does not offer any normative solution to this ‘crisis’ and may be thought useless as a result; such is the risk of any academic endeavour, particularly – if unfairly – legal history. In asking whether the law’s development here is the product of legal or extra-legal factors, a German with an interest in the positive law may respond that understanding *how* and *why* the law developed is superfluous. Indeed, there may be few insights to be gained from this endeavour for those from other systems with a different iteration of medical or legal history; inevitably, further study will be required before more detailed comparative insights can be made. But to the extent that what follows offers a commentary on contemporary law, it is as a reminder that formal legal rules can be easily changed, but if the formal rules are not themselves drivers of the law, they are susceptible to be undermined by those drivers, unnoticed, which are.

### 3. A brief map of what follows

The course of argument may be stated briefly: The German civil law in the nineteenth century was heavily imprinted with long-irrelevant Romanist ideas about medical practice and the value of labour, with medical error largely sidelined. The criminal law, however, had historically maintained a considerably more specific treatment of medical liability and, in that context, an ongoing debate over conceptually defining error amongst the rapidly self-organising orthodox medical practitioners resulted in the *Kunstfehler*, a view of error rooted in the medical discourse. This internal medical discourse was readily co-opted by the nineteenth-century law as the formal fault standard shifted from gross to simple fault. The result was, thus, an informally indulgent stance towards orthodox medical practitioners. As the twentieth century progressed, an increase in the frequency of civil law actions placed that understanding of a *Kunstfehler* under pressure. But the concept provided the courts with a standard to push back against and, in the context of institutionalised and advancing medical practice, they did just that, adopting their own variation to help patients receive appropriate treatment. The book progresses as follows:

Chapter one traces the organisation of healthcare throughout this period, as well as the changing nature of medical practice, practitioners and regulation. It does this by mapping the emergence of modern orthodox medical practice

24 Giesen (1983) 7; Katzenmeier (2001) 40; Stauch (2008) 2; Oliphant (2013) 551.

25 Katzenmeier (2001) 40–41, noting the jump from 6,000 claims per annum in the 1960s to 20,000 by late 1990s. The trend continues, see Stauch (2013) 204.



alongside their less orthodox brethren, marked by the *Gewerbeordnung* 1869. It will be shown that, even in its modern institutional form, German medicine and medical practice was intensely pluralist in terms of the actors who provided medical services. The chapter then examines the emerging internal disciplinary and regulatory apparatus of the Honour Courts (*Ehrengerichte*), established as part of the paraphernalia of occupational development surrounding the orthodox practitioners. We identify the emergence of a lively internal medical discourse surrounding the definition of error, in the medical parlance a *Kunstfehler*, spurred by a single prosecution in 1811, the so-called *Fall Horn*. Internal medical discussion of what constituted an error worthy of legal reproach continued throughout the nineteenth century before settling on a broad acceptance of the idea of a failure to comply with generally accepted rules of medical science. Finally, the chapter traces the development of the procedural rules that governed how this medical discourse entered courts, drawing on published medical opinions presented in evidence. It becomes clear that as the modern procedural rules emerged, this internal medical discourse on error played a central role in the liability process.

Chapters two, three and four examine the analysis of medical error during the nineteenth century within criminal law, contract law and the law of delict respectively.

Whilst the focus of this study is upon German civil law and its approach to fault, chapter two provides important context in that it examines the history of the *Carolina*, from which the root of the *Kunstfehler* may be traced, the treatment of liability for medical error within the various criminal codifications of the era and the availability of the criminal law as a route for compensation in the form of a fine (*Buße*) in opposition to the civil law. It then considers the *Fall Horn* in greater detail. It demonstrates that, in parallel with some civil law scholars, an often-indulgent standard of fault appeared to apply before the *Reichsstrafgesetzbuch* 1871. Post-1871, however, the *Reichsgericht* adopted the language and logic of the *Kunstfehler* as it had been defined by the medical discourse, most visibly in a series of decisions in the 1880s, concerning antiseptics.

Turning to the civil law, chapter three begins by considering Roman medical practice and law before addressing the categorisation of the practitioner-patient relationship and, finally, the attendant fault standard that would result. Beginning in *Rome* is necessary to fully understand the nature of the debate surrounding medical error in nineteenth-century contract law and scholarship, which was frequently driven by discussion concerning different forms of labour, medicine's place within them, their respective categorisation within Roman law and the appropriateness (or not) of the author's chosen modern analogy. The contemporary debate is captured in one part, which examines the two leading scholarly contributions beyond mainstream Pandectists. Amongst Germanist

scholarship there was considerably greater clarity, albeit variously expressed, and realism about how the relationship should be categorised. This modernist approach was also visible in the contemporary codifications. As to fault, the approach differed depending on the nature of the contractual solution being advocated, and in some cases a prejudicial choice about the fault standard led an author analytically back to the category rather the other way around. The idea of compliance with the standards of one's occupation, judged against expert evidence, was often relied on to fill out how various contractual standards would be applied in practice, whether codified or not, and, although the language of the *Kunstfehler* was largely absent, the underlying logic was often present. The result was that continued conceptual confusion about the nature of the contractual relationship left this part of the civil law slow to develop any specific approach to the practitioner-patient relationship and, ultimately, weak against the encroachment of the extra-legal influences on the subject.

In chapter four, again working from the Roman inheritance, we find that in delict there was markedly less confusion as to whether and how a claim against a medical practitioner might sound, but whether it offered recovery beyond what might be claimed under a contract, specifically damages for immaterial harm, was, beyond the various codified pockets of law in the era, contested. As such there was less discussion of delictual liability, but the fault standard, as in contract, settled on simple fault assessed against expert evidence drawn from orthodox medical practice. The chapter then turns to a discussion of the *sui generis* solution proposed by *Zimmermann* in 1873, which posited medical liability as being based on the old Roman *actio in factum contra mensorem qui falsum modum dixerit*. The supposed advantage of this was the higher degree of fault required to sustain a claim against a medical practitioner. Whilst there is some evidence that this quasi-delictual solution was adopted elsewhere in Germany, there are cases which suggest that it was, at best, exceptional. The chapter then considers the liability of unorthodox practitioners and notes an emerging tendency to hold such practitioners to the standards of their orthodox brethren, thus demonstrating a quasi-regulatory use of the private law to deal with pluralism in the medical marketplace. As with chapter three, the long reach of the Roman law appears to have stunted discussion of medical error as a specific legal problem, again opening the civil law to outside influence from the medical discourse.

Chapter five then examines the categorisation of medical liability in the *BGB* and the resulting standard of fault. As to the former, the *BGB* settled the default contractual position for the bulk of medical practice and, with some minor contortions, provided a flexible solution for the modern model of insurance-based practice, which had come to dominate healthcare. Equally, the unrelated decision to restrict damages for immaterial harm to claims in delict, and the fact