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Freedom of Contract and Informed Consent as Part of Contract for Healthcare Services

Anatoliy A. Lytvynenko
ORCID: 0000-0001-7410-5292
Doctoral canditate, Baltic International Academy, Latvia
Postgraduate Certificate Research Methods, Law School,
Robert Gordon University, Scotland, UK
anat.lytvynenko@gmail.com

Dr. iur., sworn advocate ***Tatjana I. Jurkeviča***
ORCID: 0000-0002-6242-8411
Baltic International Academy, Latvia
advokatu.birojs@inbox.lv

Abstract

Relationships between patient and physician did not possess a clearly-established form until the late 19th century, being primarly based upon a reciprocal trust. In terms of contemporary civil law, relationship between the patient and the physician or a hospital is based upon a contract for medical services. Thus, liability of the physicians for negligence within exercising their duties is either based on contract (in case such contract is concluded by the parties), or on tort (when there is no such contract). This study discusses freedom of contract with the focus of the patient's informed consent as a part for a contract for medical services between the patient and a physician or a hospital. The aim of this article is to discuss doctrinal views of patient-physician relationships and the informed consent as an inalienable part of a contract for medical services.

Keywords: informed consent, law of obligations, medical liability, patient's rights, patient-physician relationships.

Introduction

It may happen that a healthcare institution proposes the patient to conclude a contract for the provision of healthcare services (under a different name, the gist and the content of the said deed remain the same), and provision of informed consent is

already included into the contract. Usually the contractors choose with whom they will conclude the deed. As known, a contract is a bilateral, or a multilateral deed, and a deed is an act concluded in a legitimate order, which is a result of will that is an expression of the will. The participant of the deed assesses the expression of the will of the other participant, upon which they structurize their acts. Hence, an undoubted principle arises as follows: the deed always corresponds the will of the one who concludes it (*Jāna Liskopa pilnv. ...*, 1931).

The term 'freedom of contract' is both a philosophical and a legal category. The Latvian Civil Law (*Civillikums*) has no provisions which precisely provide for freedom of concluding contracts or observing the forms of expressing this freedom. Legal anchoring of the freedom of contract derives from a surplus of Civil Law provisions, which confirms the right of the contracting parties to a free choice in terms of concluding contracts, its content and form, as well as defines the boundaries in which these rights may be exercised (i.e. limitations). Article 1511 of the Civil Law holds that "A contract within the widest meaning of the word is any mutual agreement between the two or more persons on entering into, altering, or terminating legal relationships. In a narrower sense, a contract is thereby applied as a mutual expression of intent made by two or more persons, based on an agreement with the purpose of establishing obligatory rights" (*Civillikums,* 1937).

In this study, the following research methods have been used: the hermeneutic method for discussing the freedom of contract as a legal concept, the historical-legal method to define the history of the development of patient-physician relationships and the comparative method to discuss the applicable case law.

The main principle of contractual principles in the law of obligations, namely the principle of freedom of a contract holds that the contract may not be concluded or performed without the freedom of the contracting parties. Therefore, this fundamental principle predominantly defines the freedom of forming the will and its expression. Thus, the freedom of a covenant is characterised by the following elements:

1) freedom of choice to conclude, or not to conclude the contract; in conjunction with this, people are considered to be free to conclude the contract. A compulsory contract is not legitimate unless the obligation to conclude a contract is stipulated by law, or is accepted voluntariliy;
2) freedom of choice of a contracting party;
3) freedom of choice of the content of the contract, as the contracting parties are free to define the conditions of the contract which is concluded. The only mandatory rule is that the conditions of the contract must not contradict the law;
4) freedom of choice of the form of the contract (*Torgāns,* 2014, p. 41).

It is indisputable that each of the elements listed above is not perceived absolutely, exceptions are permissible. According to philosophers, freedom is a conscious necessity, and unlimited freedom does not exist at all. When concluding a contract, much attention is paid to the relationship between the contracting parties, and less attention is paid

to circumstances that affect or even limit the free will of each counterparty. In civil law, a contract is interpreted on the basis of a conditional abstraction that the parties are equal in their rights and choice. This treatment is applicable in the legal sense; however, the parties to the contract differ in their financial position and economic capabilities, as well as in the degree to which one or another is interested in concluding the planned contract. This circumstance can be illustrated as follows: if the loan applicant had another chance to receive money, he would not be in a hurry to quickly agree to the strict conditions set by the lender for the borrower (*Torgāns,* 2014, p. 47). In addition, scientific findings describing the project of unification of European contract law should be mentioned (*Torgāns,* 2013, p. 47). Within the framework of the European contract law project, it is established that the parties freely enter into contractual relations and determine their content in compliance with the requirements of good faith and justice and the norms ordering these Principles (Art. 1:102) (*Commission on European Contract Law*, 2002).

1 Development of Patient-Physician Contractual Relationships in History of Civil Law

M. Carril mentioned that in Ancient Rome, the relationships between the patient and the physician were based upon an 'act of kindness' (Fr. '*fait d'obligeance*') providing reciprocal promises – skill and care from the medical practitioner and the remuneration of costs from the patient, and the only responsibility the physician could incur is the so-called Acquillan fault that is a fault for gross negligence (Carril, 1966, pp. 1–2). One of the oldest judgments on the physician's liability in France, which are well-preserved in the case books, namely *Leullier c. Calle* (1768) and *Foucault c. Helie* (1830) showed that doctors could be liable for damages in case of gross negligence, but courts did not discuss the issue of relationships between the patients and physicians and deduced the liability of physicians in civil reparation order, and occasionally, the doctors were punished (mostly fined) in penal order for causing severe injuries to patients due to gross negligence (*La Dame David*, 1817).

In the following decades, responsibility of physicians was transformed into a primarily civil fault under Art. 1382–1383 of the Civil Code (*Cour de Cassation* (France), 1862), and penal liability could be incured only in case of severe negligence, which caused the death of the patient, or the doctor's negligence (or omission to provide medical assistance) brought hazard to his life and health (*R… c. Docteur X…,* 1927). The issue of informed consent arose in French and Belgian law mainly upon the case of *Demarche c. Dechamps* (1889–1890) heard before the Civil Court of Liege (and the Liege Court of Appeals on appeal), where the courts firmly recognised that medical interventions must be performed only with the patient's consent, or the consent of his legal representatives).

Demogue (1932) in his sixth volume of the treaty of obligations held, that in principle, the doctor has a duty to provide the patient with information on the gravity of

the forthcoming medical intervention (usually a surgical operation), unless there is a specific reason for not providing such information (he indicated emotionality of the patient (*Demogue*, 1932, p. 187). The emergency state was firmly recognised to be an immunity from civil liability, in case the doctor proceeded to extend the operation, being unable to interrupt the already ongoing medical intervention in order to ask for the patient's consent to extend it, as he did his best to save the life and health of the patient, i.e. well displayed by the case of *Epoux N. c. docteur Lanormant* (1923).

In fact, a contract for medical services, as a form of agreement between the patient and the physician was known in France in the 19th century; for instance, the Amiens Court of Appeals ruled in a 1889 judgment that remuneration of medical expenses may be calculated by the courts in case of absence of a contract between the patient and physician (*Loisel c. Duchéne*, 1889). In the case of *Mercier* (1936), the French Court of Cassation denoted that the issue of patient-physician relationship was not clearly defined (as contractual, or anyhow else) in case law, and most claims against doctors for negligence were based upon Art. 1382–1383 of the Civil Code, thus alleging tort or quasi-tort liability for negligence. The Court of Cassation discussed the past doctrine, outlining that the authors have confirmed the contractual nature of the patient-physician relationship: "I note the agreement of all the authors to recognise the existence of a contract between the client who seeks care and pays the fees and the doctor who receives the fees and provides the care." (*Docteur M. c. Epoux Mercier,* 1936)

Simultaneously, the Court of Cassation held that the doctor does not possess and obligation of result but an obligation of means that in terms of the case at stake, the presence of the doctor by the patient, and the provision of medical care. The fact that the patient was not successfully cured from the illness, or an injury would not mean that the doctor was negligent, but it could be caused by other factors, i.e. the severity of the illness (*Docteur M. c. Epoux Mercier,* 1936). The Court also cited *Demogue* (1932), who concluded that the patient-physician relationship is contractual upon the judgment of the Swiss Federal Tribunal in 1892. This case has been examined within the context of the present study. This was a case, where a cabinetmaker litigated with a physician, who undertook an anticeptic syphilitic treatment, which did not succeed. The plaintiff's condition got worse in the course of the treatment, plaintiff was diagnosed with cancer, and his penis was amputated in the hospital. When the defendant appealed to the Federal Supreme Court of Switzerland, his appeal was dismissed, and the court held that the doctor was not only liable for the damages deriving from a failure to perform his contractual obligations, but for a moral damages as well (*Meister c. B.*, 1893). In fact, the Federal Supreme Court of Switzerland defined the patient-physician relationships as contractual a year earlier in the case of *Dormann* (1892) (*Dormann gegen Hochstraßer*, 1892).

Very little is known concerning relationships between patients and physicians in the First Republic of Latvia (1918–1940). The treatment of patients in hospitals was a public-legal obligation of the Latvian cities, which contracted the hospitals (or medical

universities which governed the hospitals) to provide medical assistance for the patients (from the judgment of the Senate in the cases of *White Star Dominion Line v. City of Riga* (1930) and *Grzibovsky v. City of Riga* (1937) (*Rīgas pilsētas pilnvarnieka...*, 1930; *Prasītāja Vacslava Gržibovska...*, 1937).

Provision of the medical treatment was free of charge in terms of contagious diseases (Ministry of Interior, Regulations for the free-of-charge hospital treatment (Iekšlietu ministrija, 1921); de-facto superseded by the provisions of the 1928 Law on Social Maintenance (*Latvijas Saeima*, 1928), and the provision of medical assistance and all treatment costs in terms of treating patients from contagious diseases was born by the local governments, which frequently caused disputes relating to define the municipality, which is under an obligation to pay the treatment costs of the patient who was treated not in his municipality but in a different city (*Zigismunda Cirīša...*, 1928; *Ventspils pilsētas...*, 1930). The nature of such disputes was quite justified owing to the costs of the treatment which were relatively high (*Cesvaines piensaimnieku...*, 1934).

In terms of medical malpractice cases, the plaintiffs usually filed complaints against doctors for negligent treatment by starting a private prosecution for a misdemeanor, but frequently failed to provide sufficient evidence for the defendant to be fined and to recover damages, and mostly they joined the case as civil plaintiffs (*Ermana Kurta sūdzība...,* 1935). Not much medical malpractice cases were heard by the Senate, with *Grzibovsky* as as one of the few outstanding examples, who, however, chose to sue for loss of working capacity rather than complain for the doctors' negligence (*Prasītāja Vacslava Gržibovska...*, 1937). In a 1924 case, an owner of a horse, which unfortunately died several weeks after an operation by a veterinarian employed to operate and treate the horse, recovered damages arising from the defendant's non-performance of a service contract (*Jazepa Megņa lūgums...*, 1924).

2 Legal Nature and Peculiarities of Contract for Healthcare Services and Place of Informed Consent in It

M. Carril found that the model of relationships between the patient and physician developed into a contractual one, supposing to be qualified as: (1) mandate for receiving a remuneration; (2) an employment contract; (3) a contract for services; (4) management of business; (5) a *sui generis* contract, whose ill-performance may result in damage deriving from a breach of contract (Carril, 1966, pp. 1–4). Thus, when a physician performs the medical procedures within the medical contract, they perform an *acte matériel utile dans l'intérët d'une autre personne*, e.i., a "useful material act in the interest of another person", which lets Carril presuppose that such relationships could be described as a "quasi-contract of business management". Carril also explained that it may be incomprehensible to invoke the contractual theory in case the doctor has to intervene in emergency situations (Carril, 1966, pp. 2–3).

Canadian case law gave a certain answer to this question: in the 1957 case of *X. v. Mellen*, the Quebec Court of Queen's Bench (per. Bissonnette, J.) held that "…from the time the patient enters a doctor's consulting room, there arises by itself and for itself a contract of professional care between the doctor and the patient" (*X. v. Mellen*, 1957). Upon W. G. (1974), an anonymous commentator in the case report of *G… c. Societe Anonyme "Le Lloyd Belge", W… et V.* (1974), adjudicated by the Belgian Court of Cassation, held that in case a doctor has concluded a contract with the patient, they become a "debtor of obligation" towards him, and bear personal responsibility for their acts.

This principle was approved by the French Court of Cassation earlier in a 1960 judgment, where a surgeon was held responsible for bringing for assistance an anesthesiologist to replace his duties for anesthesia within a hysterectomy operation; the injection caused an edema with a hematoma in her right hand, causing permanent paralysis; the assistant was called upon the choice of the surgeon without authorisation or notice of the plaintiff; the Court held that the one who has concluded the contract would be responsible for the faults of their "substitute", concluding to dismiss the surgeon's appeal. Concerning the actual legal nature of the contract between the patient and the physician, the Court declared: "Whereas the surgeon, invested in the confidence of the person [the patient], upon whom he is going to perform and operation, is obliged, by virtue of the contract binding him to this person, for the whole of the [medical] intervention, [and] the conscientious, attentive care in conformity with the data of the [medical] science", adding the following: "That he [the doctor] therefore responds for any faults that the doctor to whom he [delegated] the [injection] of anesthesia may commit, and that he replaces himself, outside any consent of the patient, for the accomplishment of an inseparable part of his obligations" (*Cour de Cassation* (France), 1960).

Inasmuch as there is usually no contractual relationship between the patient and the physician, who acts as a substitute of the physician with whom the patient concluded the contract, the second physician is considered as an executive agent, and thus the physician who concluded the contract with the patient is liable for the faults done by the substituting physician – this notion was affirmed in Belgian case law by the judgment of the Civil Court of Bruges in 1996 (*Trib. civ. de Bruges*, 1996).

The obligation of *result* is usually not applicable to physicians. The French Court of Cassation in its 1986 judgment held, that the doctors are obliged for the provision of the means but not of the result (*Cour de Cassation* (France), 1985). Simultaneously, an exception may be made in terms of medical interventions, which presuppose a specific action by the physician, which does not pose a scientific difficulty for carrying out the medical intervention, according to the *dictum* of the Liege Court of Appeals in its 1998 judgment. In the case at stake, determining of whether a caesarian section was an *obligation of means*, or an *obligation of means and result*, the court found that the performance of the caesarian section should be considered as an obligation of means, but not result, as such medical intervention is performed in case normal birth cannot take place, and may involve unexpected accidents and complications (*P., s.a. Royale Belge*, 1998).

In civil law, a contract is interpreted based on a conditional abstraction that the parties are equal in their rights and choice. This is how it looks in the legal sense, but in fact the parties to the contract differ in their financial situation and economic capabilities, as well as in the degree to which one or another is interested in concluding the planned contract. This circumstance can be illustrated as follows: if the loan applicant had another chance to receive money, he would not be in a hurry to quickly agree to the strict conditions set by the lender for the borrower (*Torgāns*, 2013, p. 47).

According to the authors, this is a good example that can also be used in the case of informed consent: if the patient were not sick, he would not go to the doctor and would not sign anything to receive medical services and ensure access to treatment. It is understandable and objective that in real life the interests of each party cannot be fully respected. However, the legality of contracts should be assessed based on whether the most influential party to the contract abuses its superiority to force the other party to act contrary to its interests (Furmston *et al.*, 2012, p. 98).

Examining the elements of the principle of freedom of contract with regard to the patient and the contract for healthcare, the following can be concluded: the patient has no choice to enter into a contract with a medical institution, consent (which in the case described in this Chapter shall be included in the text of the contract) which shall be drawn up in writing at the request of the patient or the attending physician (Art. 1(2) (1) and Art. 6 (1)–(2) of the Law on the Rights of Patients (*Pacientu tiesību likums*, 2009).

Nevertheless, the authors' practice allows to state that comonly before performing more serious medical manipulations rather than treat runny nose or undergo analyses (oddly, such activity is not treated as medical intervention), this informed consent is offered in writing and included in the contract for healthcare services, as in the event of a dispute this is undeniable written evidence. The choice of medical institution is influenced by the economic factor or the factor of the treating doctor (good reviews, etc.). The content of the healthcare contract is not discussed with the patient: if there is an objection, the patient is free to go without treatment and another patient will come (without objection) and sign – such conditions do not create equity. Only the form of the contract remains, and, as stated, the written form usually remains as well.

When evaluating the European case law on informed consent, it should be noted that within the proceedings relating to disputes on lack of informed consent, the court must ascertain whether the patient's informed consent was based on relevant documents. There is an overall support for the idea that informed consent should be in writing, with as detailed a description as possible of the doctor's explanations, otherwise the patient may complain that he did not have enough information to make the will and expression unreasonable. A written document is always better evidence than giving oral informed consent: this fact has been repeatedly ascertained in various court decisions: for instance, a number of judgments by the Supreme Court of Czech Republic are a good example of the aforesaid statement (*Nejvyšší soud České Republiky*, 2007; 2012; 2015).

Conclusions

If the text of the informed consent is included in the contract for healthcare services, only two of the four elements of the principle of freedom of contract listed above are respected: the freedom of choice of contractor and freedom of the form of the contract. However, the following elements are not respected: the freedom to choose whether to conclude a contract and the freedom to choose the content of the contract. This leads to the conclusion that the fundamental principle of contractual principles in contract law, namely the principle of freedom of contract, is not fully complied with the result that the freedom of the contractor, which includes the text of informed consent, cannot be concluded, and obligations in the context of law cannot be fulfilled. Namely, the institute of informed consent cannot be realised within the concept of freedom of contract this way. In addition, the inclusion of informed consent in a healthcare contract does not make such consent an integral part of the contract but confers on it the status of a distinct clause.

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