Grzegorz Glanowski

How to Regulate a Contract with a Medical Professional? A Comparative Legal Analysis

Grzegorz Glanowski

(born 1988, PhD 2019) Attorney-at-law, Assistant at the Chair of Bioethics and Medical Law, Faculty of Law and Administration, Jagiellonian University, Krakow, Poland.

✉ g.glanowski@uj.edu.pl

https://orcid.org/0000-0001-8221-8051

In the EU Member States whose legal systems recognise the relationship between a patient and a healthcare provider as a private law relationship, the approach to its regulation is not homogeneous. In principle, two regulatory models can be distinguished. The first model consists of a reconstruction of this relationship's content based on all the legal provisions available in a given legal system. The second model regulates the relationship in question in the civil code, as a type of a named contract. Although Poland represents the first regulatory model, it has already taken steps to shift to the latter one, despite the increasingly dwindling enthusiasm to do so. This article presents the development of the conceptual work in Poland regarding this area, the existing regulatory dilemma, as well as conclusions arising from the comparative legal analysis.

Key words: patient, healthcare provider, medical treatment contract, healthcare service

https://doi.org/10.32082/fp.6(80).2023.1250

1. Introduction

In the legal systems of the EU Member States which recognise the relationship between a patient and a healthcare provider as a private law relationship, the approach to its legal regulation is not homogeneous. Essentially, two legislative models can be distinguished. The first model consists in reconstructing the relationship's content based on all the available legal and deontological norms. This approach is represented by the majority of EU Member States, including Poland. The second model consists in the normalisation of the relationship in question within the civil code, as a type of a named contract. This regulatory approach operates in the Netherlands, Lithuania, Estonia, Germany and the Czech Republic. It is also indicated as a model solution in the DCFR.[1]

This is all the more interesting in the case of Poland where a new Civil Code has been in the pipeline

1 Ch. von Bar et al., *Principles, Definitions and Model Rules of European Private Law. Draft Common Frame of Reference (DCFR) Full Edition*, vol. 2 (Sellier, 2009).

for some time now, and where it has not been finally resolved whether to retain the existing regulatory model or to opt for the other one. *De lege lata*, in the Polish legal system, the relationship in question is legally reflected as the so-called medical treatment contract (also referred to as a contract for a healthcare service), which is an unnamed contract for the provision of services. In principle, it is a contract which is bilaterally binding, reciprocal, against payment, unilaterally professional, involving special trust, requiring care and diligence, to which the provisions on contracts of mandate apply, respectively (Articles 734–751 of the Civil Code).[2] In certain circumstances, the relationship in question may qualify as a contract to perform a specific task (Articles 627–646 of the Civil Code)[3] or a mixed contract (provision of services with the elements of sale or performance of a specific task), where either the subject matter of the contract so requires, or the context of contracting, or the intent of the parties. The contract in question is a direct source of the parties' relationship exclusively outside the framework of the public healthcare system. Irrespective of the provisions of the Civil Code, however, the reconstruction of the content of this relationship takes place considering the norms of public law set forth in other legal acts as well as the imperative and semi-imperative norms of private law, which regulate, *inter alia*, the manner of conducting therapeutic activity,[4] the rights of the patient,[5] the manner of exercising the profession by individual medical professionals,[6] and sometimes also the conditions of providing health services of a particular type (e.g. transplants,[7] abortion,[8] infertility treatment[9]). Deontological norms also play an important role as, according to the current line of jurisprudence,[10] they complement the content of legal norms and serve as interpretative guidelines.

The current regulatory model is shaped by the conditions in which the Polish Civil Code (hereinafter: the Civil Code) was created. Its enactment dates back to 1964, when Poland was operating under a different political and economic regime, which also left its mark on the construction of the healthcare system. For many decades, the Polish healthcare system was kept in the socialist Siemaszko model,[11] where there was little space for private initiatives[12] and partnerships. The process of political and economic change started after 1989. Unlike in some of the countries of the communist bloc, work on the new Civil Code did not start immediately, but a different path was taken to remodel the civil law system and it was divided into stages. The first stage (1990-1996) consisted of the most urgent changes and their aim was to remove from the Civil Code the regulations and constructions typical of the socialist system and centrally planned economy. The second stage continues to this day (1997 – present)

2 For a full analysis, see W. Borysiak, "An Act-in-Law as Fundamental Source from Medical Law Relations", in *Medical Law*, L. Bosek ed. (C.H. Beck, 2019), 90–102.

3 *Ibidem*, 102–105.

4 Polish Act of 15 April 2011 on Therapeutic Activity.

5 Polish Act of 6 November 2008 on Patients' rights and patients' ombudsman.

6 Polish Acts: of 5 December 1996 on the Professions of doctor and dentist, of 15 July 2011 on the Professions of nurse and midwife, of 25 September 2015 on the Profession of physiotherapist, of 15 September 2022 on Laboratory medicine, of 1 December 2022 on the Profession of paramedic and the paramedic self-government.

7 Polish Act of 1 July 2005 on the Procurement, storage and transplantation of cells, tissues and organs.

8 Polish Act of 7 January 1993 on Family planning, protection of the human foetus and the conditions of permissibility of abortion.

9 Polish Act of 25 June 2015 on Infertility treatment.

10 Decision of the Polish Constitutional Tribunal U 1/92, 7.10.1992, OTK 1992/2/38; Resolution of the Polish Constitutional Tribunal W 16/92, 17.03.1993, OTK 1993/1/16; Judgment of the Polish Constitutional Tribunal SK 16/07, 23.04.2008, OTK-A 2008/3/45.

11 M. Nesterowicz, E. Bagińska, A. den Exter, "Poland", in *International Encyclopaedia of Laws. Medical Law*, H. Nys ed. (Kluwer Law International, 2013), 20.

12 It should be noted, however, that soon after the entry into force of the Polish Civil Code, the desirability of a normative regulation of the contract between patient and doctor was voiced. with the proviso that it should be done by amending the Law on the Profession of Physician and Dentist rather than the Civil Code. See M. Nesterowicz, "Charakter prawny umowy o zabiegi lecznicze" (Legal Nature of the Contract for Medical Treatments), *Zeszyty Naukowe UMK Prawo* 9 (1969), 128.

and consists in an ongoing extension or modification of the Civil Code, as a reaction to the needs revealed by the market, with conceptual work on a new Civil Code being simultaneously conducted.[13]

ical treatment contract in the Civil Code began to resound more and more loudly. They shared the conviction that the contract in question is a sub-type of a service contract which should be regulated taking

Legislative initiatives are to strengthen the protection of the patient as the weaker party to the contract, to systematise the patient's rights, and to raise the patient's awareness of their content.

The Civil Law Codification Committee has carried out work on the new Civil Code: since 1996 – amendment work, and since 2006 – conceptual work. The initial proposals for the normative framework of the new Civil Code were presented in the Green Book.[14] At that time, there was no provision for a treatment contract as a new type of a named contract. In 2009, Book One, General Provisions of the Civil Code was published.[15] Between 2011 and 2014, work was carried out on the other books of the enactment, including the provisions concerning contract law.[16] At that time, due to an increase in contractual medical law relationships, voices[17] about the need to regulate the med-

this characteristic feature into account. In 2014, the problem-solving team of the Civil Law Codification Committee for the regulation of the provision of services prepared a draft regulation of medical and other healthcare services.[18] However, the draft did not live to see a vote within the Civil Law Codification Com-

13 W. Kocot, "Systematyka prawa zobowiązań umownych w przyszłym kodeksie cywilnym" (Systematics of the Law on Contractual Obligations in the Future Civil Code), *Państwo i Prawo* (2018) No. 3, 82.

14 *Zielona Księga. Optymalna wizja Kodeksu Cywilnego w Rzeczypospolitej Polskiej* (Green Book. The Optimal Vision of the Civil Code in the Republic of Poland), Z. Radwański ed. (Ministerstwo Sprawiedliwości, 2006).

15 *Projekt Kodeksu cywilnego Księga pierwsza Część ogólna* (Draft of Civil Code, Book One, General Part), https://www.projektkc.uj.edu.pl/index.php/projekty (access: 28.02.2023).

16 Kocot, "Systematyka", 85.

17 Z. Radwański, "Wstępny projekt systematyzacji tak zwanej części szczegółowej prawa zobowiązań" (The Initial Draft of the Systematization of the So–called Specific Part of the Law of Obligations), *Transformacje Prawa Prywatnego* (2012) No. 1, 10; M. Pecyna, F. Zoll, "Założenie projektu struktury części szczegółowej zobowiązań. W poszukiwaniu nowego modelu" (The Principles of the Draft of the Specific Part of the Law of Obligations. in the Process of Searching for the New Model), *Transformacje Prawa Prywatnego* (2012) No. 1, 56; R. Szostak, "O potrzebie zachowania typologicznego układu systematyki umów w europejskim prawie kontraktów" (The Need to Preserve the Typological Scheme of Contracts in European Contract Law), in *Kierunki rozwoju europejskiego prawa prywatnego. Wpływ prawa konsumenckiego na prawo krajowe*, M. Jagielska, E. Rott-Pietrzyk, A. Wiewiórowska-Domagalska eds. (C.H. Beck, 2012), 115; R. Szostak, "Problem systematyki umów obligacyjnych w nowym kodeksie cywilnym" (The Problem of the Systematics of the Contracts under the New Polish Civil Code), *Transformacje Prawa Prywatnego* (2012) No. 1, 73; R. Szostak, "O potrzebie usprawnienia kodeksowej regulacji umów o świadczenie usług na warunkach zlecenia" (The Need to Improve the Code Regulation of Rervice Contracts based on Mandate Terms), in *Współczesne problemy prawa zobowiązań*, A. Olejniczak et al. eds. (Wolters Kluwer Polska, 2015), 690–691.

18 I. Karasek-Wojciechowicz et al., "Projekt zespołu problemowego komisji kodyfikacyjnej prawa cywilnego do spraw regulacji świadczenia usług" (Project of the Problem Team of the Civil Law Codification Commission for the Regula-

mittee; hence, it is difficult to consider it as having undergone a broader discussion.

Unfortunately, in the circumstances that are not free from political considerations, in 2015, the Polish Minister of Justice dissolved the Civil Law Codification Committee and dismissed all its members. Despite the fact that at that point the conceptual work on the new Civil Code lost governmental support, by the decision of the academic community the work still continues.[19] Within this framework, recently, there have been voices of scepticism towards the regulation of the treatment contract within the Civil Code. They are based on the argument that the matter is too complex and varied in terms of the subject and the object to create its complete regulation in the Civil Code.[20] However, the complexity of the subject matter of medical law, as well as the fact that it is regulated by many legal acts, is a common phenomenon in EU Member States. Therefore, the argument raised should not be exclusive or decisive. It is worth conducting a comparative legal analysis of the solutions adopted by countries representing the second regulatory approach in order to assess how they regulate the contract in question to gain insights that would make it possible to resolve the issue of the advisability of the normativisation being discussed here. The conclusions from this analysis are valuable not only for Poland, but also for other EU Member States that are considering or may consider taking such a step.

2. Comparative legal analysis

2.1. The Dutch solution

2.1.1. Characteristics of a medical treatment contract

The second regulatory model under discussion was pioneered by the Netherlands.[21] The normalisation of the provider-patient relationship within the civil code took place on 1 April 1995, when the Act amending the Civil Code and certain other laws came into force in connection with the adoption of the provisions of the medical treatment contract. The provisions of the Dutch Civil Code (*Burgerlijk Wetboek*, hereinafter: the BW) governing the medical treatment contract consist of 23 articles, from Article 7:446 to Article 7:468, structured into a separate section entitled "Medical Treatment Contract." The Section is numbered 5 and located in Title 7 on service contracts, one of the elements of Book 7 covering the detailed part of obligations. The regulation of the medical treatment contract closes Title 7 and is preceded by the general provisions on the supply of services, the contract of mandate, the contract for intermediary services and the commercial agency contract.

The provisions of Articles 7:446–7:468 of the BW are universal. They apply to legal relationships in which a provider performs a medical action,[22] regardless of whether or not an insurer is involved in the billing process. However, these provisions do not apply to situations covered by special provisions, especially when there is no contractual relationship between the parties, e.g. during the provision of healthcare services in prisons, the army, psychiatric hospitals (for forcibly hospitalised patients), in occupational medicine activities, medical jurisprudence for the

tion of the Provision of Services), *Transformacje Prawa Prywatnego* (2014) No. 4, 83–87.

19 Progress can be followed on the Academic Civil Code website: https://www.projektkc.uj.edu.pl/index.php.

20 Kocot, "Systematyka", 107. The author's argumentation refers to the previously expressed views of J. Pisuliński, "Struktura części ogólnej prawa zobowiązań (wprowadzenie do dyskusji)" (On the Systematics of the Specific Part of Law of Obligations [A Voice in the Discussion]), *Transformacje Prawa Prywatnego* (2012) No. 1, 16–17. This author notes the difficulty of juridicalisation in the Civil Code of contracts, which have extensive extra-code regulation, and, further, the difficulty of reconciling both regulations. The author did not comment directly on the medical treatment contract but his observations obviously also apply to it owing to the shape of the Polish legal regulation.

21 On the historical background, see L.F. Markenstein, "The Codification in the Netherlands of the Principal Rights of the Patients: a Critical Review", *European Journal of Health Law* 2 (1995) No. 1, 33–34; S. Gevers, "Making Laws on Patient Rights: the Dutch Experience", in *Recognition and Protection of Patients' Rights International Workshop in Budapest May 19–21, 2000*, J. Fridli ed. (Hungarian Civil Liberties Union, 2000), 12.

22 P. Borry et al., "Legislation on direct-to-consumer genetic testing in seven European countries", *European Journal of Human Genetics* 7 (2012), 718.

assessment of the validity of claims or the granting of insurance or social assistance. However, in view of Article 7:464, the provisions regarding the medical treatment contract should be applied to the extent permitted by the nature of the non-contractual legal relationship between the provider and the patient. This means that, in such situations, the provisions of Articles 7:446–7:468 should at least be taken into account, and a derogation from their full application would require justification.[23]

The location of the provisions in this part of the code systemically implies that this is a contract for the provision of a service distinguished by its specific subject matter, i.e. a medical action within the meaning of Article 7:446 of the BW. The content of Article 7:400 § 2 confirms this conclusion as it stipulates the appropriate application of the general provisions on the supply of services to any type of contract listed in Title 7, if this is not opposed by the law, the content, the nature of the contract or custom. In particular, Articles 7:402, 7:404–7:408, 7:409 § 2, 7:411 relating to remuneration, personal performance of the service, compliance with the patient's instructions and termination of the contract are taken into account.

The medical treatment contract remains a contract of special trust, given the high importance of the legal interests and the disproportion of the parties' knowledge.[24] In principle, it is a contract of diligence, rather than a contract of result, although it may become a contract of result by way of exception.[25] It is also customary that medical activities are paid for. The fee is usually paid after the medical activities have been performed and it is usually charged to the patient or the patient's representative. In fact, the cost is ultimately covered by the insurer.[26] Furthermore, the contract in question is a unilaterally professional and subject-qualified contract, as discussed in more detail below.

2.1.2. Parties to the contract

Article 7:446 § 1 of the BW defines the professional party to a medical treatment contract as the provider of care. According to the wording of this provision, it is a natural person or a legal person who, within the scope of his or her medical professional practice or medical business activity, undertakes towards the other party (the ordering party) to carry out medical activities directly affecting the ordering party or a specified third party. The personal scope of the provisions of Section 5 refers to medical professionals within the meaning of the Dutch Act on Independent Health Professions, excluding related professions (e.g. clinical technologists, medical assistants). In agreement with this, healthcare providers are medical professionals such as doctors, dentists, midwives, nurses, psychologists (within the scope of clinical therapy), physiotherapists, and psychotherapists. Pharmacists are however not considered to be healthcare providers.[27]

Under Article 7:446 § 1 of the BW, a patient is a natural person to whom the medical action directly relates. A patient may be a party to a contract or an authorised recipient of medical actions under a contract concluded on his or her behalf by a third party. The BW contains a comprehensive regulation of the position of a special type of patient, i.e. minors. The Dutch legislator distinguishes between three age categories (minors between 16 and 18 years of age, 12 and 16 years of age, and under 12 years of age) to which the various provisions of Section 5 apply. Two interesting solutions are worth noting here. The first one, contained in Article 7:447 of the BW (a special provision in relation to Article 1:234 of the BW) establishes at 16 years of age a specific age threshold for entering into a contract, exercising the patient's rights independently,[28] and being liable for obligations arising under the contract. Consequently, a minor who has reached the age of 16 years has judicial and procedural capacity in respect of matters relating to the concluded medical treatment

23 Gevers, *Making Laws*, 15.

24 C. Asser, *Handleiding tot de beoefening van het Nederlands burgelijk recht. Bijzondere overeenkomsten* (Wolters Kluwer, 2014), 308–309.

25 Such is the case, for example, in relation to the sterilisation procedure, A. den Exter, M. Buijsen, *Medical Law in the Netherlands* (Wolters Kluwer, 2013), 110.

26 *Ibidem*, 85.

27 E.H. Hondius, "Specific Contracts", in *Introduction to Dutch Law*, J.M.J. Chorus, H. Gerver, E.H. Hondius eds. (Wolters Kluwer, 2016), 233.

28 C. Stolker, S. Slabbers, "The Netherlands", in *Cases on Medical Malpractice in a Comparative Perspective (Tort and Insurance Law)*, M. Faure, H. Koziol eds. (Verlag Österreich, 2001), 149.

contract. The second solution, set forth in Article 7:465 § 3 of the BW, allows for the granting of a medical power of attorney by patients.

2.1.3. Contractual duties and obligations

The Dutch legislator formulates five duties of the professional party: the duty to carry out medical acts (Articles 7:446, 7:453 of the BW), the duty to inform (Articles 7:448 and 7:449 of the BW), the duty to seek consent from the patient (Articles 7:450 § 1–2, 7:451 and 7:466 of the BW), the duty to keep medical records (Articles 7:454–7:456 of the BW), and the duty of confidentiality (Articles 7:457–7:459, 7:467 of the BW).

Medical activity is defined in Article 7:446 of the BW. The legislator uses the adjective "medical" to emphasise that the activities performed as part of the professional practice or business should be based on evidence-based medicine. The definition thereof is complex. It has a positive nature (§ 2 and § 3), as it clarifies the material scope of a medical activity, and a negative nature (§ 4), as it determines what does not fall within it.

The positive part of the definition of the concept of medical activity comprises two groups of activities (§ 2(a) and (b)). The first group comprises all activities, including examination and consultation, relating directly to the patient and aimed at curing him or her of a disease, protecting him or her from it, assessing his or her state of health, or providing obstetric assistance, which indicates their therapeutic nature. The second group includes non-therapeutic activities,[29] as indicated by the linguistic formula used, i.e. activities other than those listed in the first group, relating directly to the patient, and which were undertaken by the doctor or dentist. The provisions of § 3, which stipulate that medical activities also comprise caring, nursing and benefits in kind, complement the catalogue of activities falling into both groups.

Paragraph 4 begins the negative part of the definition by excluding from its scope medical activities undertaken in the field of pharmacy by a self-employed pharmacist.

The provisions of the medical treatment contract are not directly applicable to paramedical activities whose conduct does not comply with the principles of evidence-based medicine.[30] The general provisions on the supply of services may be applied to them, while Article 7:446-7:468 of the BW may only be applied by analogy.[31]

In carrying out medical activities, the healthcare provider is obliged to comply with the prudent provider's standard, which means that he or she should behave in such a way as to satisfy the obligations arising from the professional standard which is established separately for each profession. The Act does not define the concept of such a professional standard or indicate how it should be established. This gap has been filled by legal scholarship and case law.[32] Basically, the professional standard assumes the exercise of due care resulting from the principles of medical knowledge and the professional experience of an average qualified doctor in the same field, acting in the same circumstances, and having ordinary means at his disposal to achieve a specific therapeutic goal.

The other obligations and their content do not differ much from the European standard, so it is worth highlighting only the particularly noteworthy issues, such as: the presence in the legal regulation of the institution of therapeutic privilege (Article 7:448 § 3 of the BW), *pro futuro* declarations (Article 7:450 § 3 of the BW), the presumption of consent to non-invasive medical measures undertaken in urgent cases (Article 466 § 2 of the BW), or the regulations on the processing of patient data with a view to conducting scientific research (Article 7:458, Article 7:467 of the BW).

Insofar as the patient is a contractual party, he or she has a single contractual obligation which is to pay the fee (Section 7:461 of the BW). Additionally, the patient has a duty to cooperate, which is not strictly speaking a contractual obligation (Article 7:452 of the BW). In extreme cases, the failure to do so may lead to a refusal to attribute liability for a breach of an obligation to the

29 Asser, *Handleiding*, 309.

30 G. van Dijk, "Physicians and alternative methods of treatment: Do they go together?", *World Medical Journal* 5 (2011), 179.

31 B. Sluijters, M. Biesaart, *De geneeskundige behandelingsovereenkomst* (Wolters Kluwer, 2005), 6.

32 H.J.J. Leenen, J.K.M. Gevers, J. Dute, *Handboek gezondheidrecht*, (Bohn Stafleu Van Loghum, 2000), 41–42, HR, 09.11.1990, NJ 1991/90.

healthcare provider or may justify the termination of the contract by the healthcare provider.[33]

2.1.4. Form

The legislator does not introduce any specific requirements as to the form in which the contract should be concluded. Similarly, in relation to the general provisions, there is no variation as to how it is concluded.[34]

2.1.5. Evidence issues and the standard of patient protection

The main rule of evidence is expressed in Article 150 of the Dutch Code of Civil Procedure (*Wetboek van Burgerlijke Rechtsvordering*) which stipulates that the burden of proving a fact falls on the person who relies on that fact, unless a different burden of proof is justified by the principle of expediency, equity or a different rule results from special provisions. As a general rule, the patient must demonstrate all the circumstances justifying his or her claim. In particular, the patient has the burden of proving a breach of the prudent provider's standard. However, the healthcare provider has a duty to provide the patient with some assistance in proving the claim in court.[35] Satisfaction of this obligation requires that the healthcare provider should present the course of treatment as precisely as possible as well as provide medical records. In other words, the healthcare provider is obliged to provide the factual basis which, in its opinion, justifies its refusal to accept the patient's claim. The passivity of the professional party may lead, based on the argument of equity, to a relaxation or even a reversal of the burden of proof, which is the case especially if the obligation to keep medical records is not fulfilled, or of the medical records are lost or destroyed.[36] Dutch law, therefore, does not formulate an explicit provision as a basis for placing the burden of proof on the provider to prove certain facts, but it allows for this possibility through the discretionary power of the judge in cases of the provider's lack of cooperation when clarifying the factual basis of the dispute or a clear breach of the contractual obligations incumbent upon it.[37]

The qualification of the contract is uniform as it is regarded as a contract of special trust, consensual, essentially of diligent action, bilaterally binding, reciprocal, and being a variant of a service contract.

Article 7:462 of the BW introduces the principle of joint and several liability. If, during the performance of a medical treatment contract, medical acts are performed in a hospital that is not a party to the contract, the hospital is jointly and severally liable for any breach of the contract as if it were a party to it. The principle of joint and several liability is a response to patients' problems with properly identifying the party with whom they have contracted. The provision identifies the main addressee of the claim, relieving the patient of the need to establish who exactly made the error and on what legal basis they acted on the premises of

33 S. Bartels, I. Giesen, "The Principles of European Law on Service Contracts: the Rules on Medical Treatment in a Future Europe Compared to the Rules in the Netherlands", in *The Future of European Contract Law: Essays in Honour of Ewoud Hondius to Commemorate his Retirement as Professor of Civil Law at the University of Utrecht*, K. Boele-Woelki, W. Grosheide eds. (Wolters Kluwer, 2007), 171.

34 E. Hondius, "Specific Contracts", 233.

35 Bar et al., *Principles*, 1964.

36 *Ibidem*, 2009.

37 C. Stolker, S. Slabbers, "The Netherlands", 161.

the hospital.[38] This facilitation leads to a situation in which it remains irrelevant for the patient with whom he or she has entered into the contract, as he or she can always sue the hospital for damages.[39]

With regard to the standard of patient protection, the regulation set forth in Article 7:463 of the BW is particularly noteworthy, as it declares a statutory prohibition to exclude or limit the liability of a medical treatment provider for breach of contract, regardless of the breach of which duty the damage arose from. The regulation of the medical treatment contract contained in the code decrees a standard of minimum protection of the patient's interests, as it excludes the contractual possibility of a less favourable arrangement of the content of the relationship with the healthcare provider than the one resulting from the BW. The Dutch legislator explicitly confirms this in Article 7:468 of the BW, indicating the semi-imperative nature of the norms under consideration (and Articles 7:404, 7:405 § 2, 7:406 of the BW – provisions of the common part on the provision of services), allowing for deviations from them only in favour of the patient.

2.2. The Lithuanian solution

2.2.1. Characteristics of a contract for personal healthcare services

In Lithuania, in contrast to the Netherlands (as well as the German solution described below), the juridification of the provider-patient relationship did not take place through an amendment, but was already provided for in the original wording of the Lithuanian Civil Code (*Civilinis kodeksas*, hereinafter: the CK). This act is relatively new. It was enacted on 18 July 2000, after 10 years of work by the codification commission, and it entered into force on 1 July 2001. The Lithuanian regulatory solution is thus historically the second oldest in Europe. The CK is very much inspired by Dutch law. In particular, this manifests itself in the provisions of the contract for personal healthcare services, which, barring minor differences, replicate the Dutch regulation.

The Lithuanian solution consists of 22 articles, from Article 6.725 to Article 6.746 of the CK structured into a separate section entitled "Provision of personal healthcare services" (*Asmens sveikatos priežiūros paslaugų teikimas*).[40] The Section is numbered II and located in Chapter XXXV on the provision of paid services. The provisions on providing personal healthcare of services are preceded by the regulation of Section I containing general provisions common to all contracts for the provision of services regulated in Chapter XXXV.[41]

It is noteworthy that the issues falling under medical law have been normalised in various parts of the CK. Two groups of these issues can be distinguished. The first group covers the rights of the patient, also regarded as fundamental human rights. The regulation defines the criteria for determining the beginning and end of a person's life, compulsory hospitalisation, and examination of mentally ill persons, gender reassignment, artificial insemination, scientific research, and confidentiality of health information. The relevant provisions (with the exception of scientific research) are contained in Book II, Part II, dedicated to the specific rights of individuals. The second group includes the regulation of patients' rights which are covered by the content of the contract for personal healthcare services.[42] As a result, the normalisation of the contract for personal healthcare services as a type of a named contract in the CK has enlarged the previous subject matter covered by a positive civil law regulation.[43]

The scope of application of Articles 6.725–6.746 is strongly limited[44] by the wording of Article 6.725 § 3,

38 Bartels, Giesen, *The Principles*, 171.

39 *Ibidem*, 179.

40 On the origins and historical background, see D. Ducinskiene et al., "Awareness and practice of patient's rights law in Lithuania", *International Health and Human Rights* 10 (2006), 1–2.

41 In fact, this section covers only two types of named contracts. In addition to the contract for personal care services, it covers the contract for travel services.

42 T. Birmontiene, "Changes in the Lithuanian Health Law and the influence of the Netherlands Civil Code", *European Journal of Health Law* (2002) No. 4, 384.

43 T. Birmontiene, "Health Legislation in Eastern European Countries: the Baltic States", *European Journal of Health Law* (2004) No. 1, 84.

44 L. Murauskiene et al., "Health Systems in Transition. Lithuania", *Health System Review* 2 (2013), 53, http://www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf (access 28.02.2023).

second sentence. The provisions in question do not apply to the provision of a personal healthcare service, the cost of which is covered by compulsory public insurance, sourced from the state or local government budget. Thus, in contrast to the Dutch solution (as well as the German solution described below), not in every case of the provision of personal healthcare services will a contract arise between the healthcare provider and the patient. In this respect, the CK's regulation of the rights and obligations of the healthcare provider and the patient is superseded by the Lithuanian Act of 3 October 1996 on Patients' Rights and Compensation for Health Damages.[45] The code norms and the statutory norms, thus, exist side by side, referring to private and public treatment, respectively. The regulatory dualism in question is criticised by legal scholars, as the scope and the content of a patient's rights under private and public treatment are the same.[46] Following the example of Dutch law, the Lithuanian legislator stipulates in Article 6.743 of the CK that the provisions in question may be applied to relationships involving the provision of personal healthcare services that have no contractual basis, provided that the nature of the relationship so allows.

The location of the provisions in the CK implies that this contract is a variant of a service contract. The object of the service, which distinguishes it from other contracts, involves the provision of healthcare services. The above conclusion is further supported by the argument that, under Article 6.716 § 3 of the CK, the general provisions on the supply of services for a fee (i.e. Articles 6.716–6.724 of the CK) apply respectively to the contract for personal healthcare services. In particular, Articles 6.717, 6.718, 6.720, 6.721 and 6.723 § 2 of the CK, relating to remuneration, personal performance of the service, compliance with the patient's instructions and termination of the contract, must be taken into account.

Similarly to the Dutch solution, the Lithuanian contract is a contract of special trust,[47] unilaterally professional, reciprocal,[48] against payment and essentially of diligent action. It is worth noting, however, that the Lithuanian legislator, in Article 6.718 § 5, has explicitly provided for the possibility of contracting for result.

2.2.2. Parties to the contract

The personal sphere of the contract is shaped similarly to the Dutch solution. The parties to the contract are referred to as the healthcare service provider and the patient, unless the patient is merely the beneficiary of the contract concluded on his or her behalf, in which case the party ordering the service, who is a party to the contract, is referred to as the client. Pursuant to Article 6.725 § 1 of the CK, a healthcare provider is an entity authorised to perform healthcare services which provides them in the course of its professional or business activity. The patient, on the other hand, is always an individual who is the actual recipient of healthcare services.

Moreover, following the example of the Dutch legislator, the Lithuanian solution contains a comprehensive regulation of the position of underage patients, although it distinguishes two, rather than three age categories. These are minors over 16 years of age and minors below this age limit. In relation to the first category of patients, Article 6.726 of the CK contains a special regulation in terms of a reduced age threshold for full legal capacity. A contract for personal healthcare services may be concluded by a minor who has reached the age of 16.[49] The wording of Article 6:744 § 3 of the CK indicates that Lithuanian law, like Dutch law, allows for the granting of a medical power of attorney.

2.2.3. Obligations and duties

The Lithuanian legislator, like the Dutch legislator, has formulated five duties of the professional party:

45 https://www.e-tar.lt/portal/en/legalAct/TAR.C6E4170DB704 (access: 28.02.2023).

46 Birmontiene, "Changes in the Lithuanian", 387.

47 V. Bankauskaite, I. Jakusovaite, "Dealing with ethical problems in the healthcare system in Lithuania: achievements and challenges", *Journal of Medical Ethics* 10 (2006), 585; V. Grabauskas, E. Peičius, R. Kaminskas, "The patient role in decision-making in Lithuanian healthcare", *Medicina* 40 (2004) No. 11, 1114–1115.

48 Birmontiene, "Changes in the Lithuanian", 387.

49 For more on the status of minors in Lithuanian legislation, see L. Stultiëns et al., "Minors and Informed Consent: A Comparative Approach", *European Journal of Health Law* (2007) No. 1, 32.

the duty to provide healthcare services (Article 6.725 of the CK), the duty to provide information (Articles: 6.727, 6.728, 6.737 of the CK), the duty to seek consent from the patient (Articles: 6.729, 6.744, 6.745 of the CK), the duty to keep medical records (Articles: 6.730, 6.733–6.735 of the CK), and the duty of confidentiality (Articles: 6.736, 6.738 of the CK).

the provision of healthcare services, understood as activities of a therapeutic nature. However, in practice, the provisions also apply to services that do not have a therapeutic purpose.

The provision of services takes place in accordance with the prevailing healthcare standards (medical standards).[50] Under Article 6.732 of the CK, in the

An objection against results of the comparative legal analysis could be the argument that a civil code is not the right place to introduce the discussed law.

Like its counterpart under Dutch law, the Lithuanian concept of the object of the main duty is defined in a positive as well as a negative manner, and it covers only activities based on evidence-based medicine, which does not support, at least not explicitly, the application of the legislation to paramedical activities.

Under Article 6.725 § 2 of the CK, personal healthcare services are activities, including examinations and advice, directly relating to an individual, undertaken for the purpose of treating the individual, preventing illness and assessing the individual's state of health. The term also includes patient care and related activities, as well as benefits in kind that are necessary for the provision of personal healthcare services, excluding pharmaceutical activities. On the other hand, under Article 6.725 § 3 of the CK, the provisions of Section II do not apply to activities aimed at determining the state of health or providing care to a person who is represented by the providers of such care in court disputes or who aim at fulfilling an obligation resulting in the payment of damages or social benefits to him or her, determining this person's potential or ability to study, work or perform a certain type of activity, as well as for forensic medicine purposes. As mentioned above, the provisions under consideration do not apply to healthcare services received within the public healthcare system. At the level of linguistic interpretation, the provisions of the analysed contract, regulate performance of its activities, the professional party is obliged to ensure the level of diligence that can be expected of a diligent provider of such services.

As in the case of the Dutch solution, the other obligations as well as their content do not differ significantly from the European standard. What is worth emphasising, though, is the institution of the therapeutic privilege (Article 6:727 § 2 of the CK), and, compared with the Dutch solution, the lack of the regulation of *pro futuro* declarations.

In principle, the patient has a single contractual obligation to pay remuneration (Art. 6.740 of the CK). Additionally, the patient has a duty to cooperate, which is not strictly a contractual obligation,[51] (Art. 6.731 of the CK), and which is understood as a duty to provide all possible information and assistance that can be reasonably expected to help achieve the contractual objectives.

2.2.4. Form

The legislator does not impose any specific requirements as to the form in which the contract is concluded. The contract comes into effect on general principles through the submission of consensual declarations of intent.

50 J. Gumbis et al., *Medical Law in Lithuania* (Wolters Kluwer, 2015), 123.

51 On this formulation, see *ibidem*, 122.

2.2.5. Evidence and the standard of patient protection

The regulation contained in the KC creates neither legal nor factual presumptions. Modelled on Dutch law, Article 6.741 of the CK introduces merely the principle of joint and several liability, indicating a healthcare institution as the main addressee of claims for damages.[52] A healthcare institution is an institution or undertaking in which healthcare services and services of a different type are provided in accordance with the procedures for the provision of such services laid down in this law and in separate legislation, as well as any institution or undertaking in which activities of a different type are carried out, including their branches or divisions in which healthcare services are provided. It appears that the concept of a healthcare institution as a central addressee of claims is broader than the concept of a hospital found in Dutch law.

Moreover, the Lithuanian legislator explicitly emphasises that the patient enjoys the protection provided for any consumer. This is indirectly stated in Article 6.716 § 4 of the CK, which refers to the appropriate application of Articles 6.188 of the CK (prohibited contractual clauses) and 6.350–6.370 of the CK (consumer sales), as well as Article 6.724 of the CK, which mandates the application of Articles 6.672–6.680 of the CK (contract for the performance of a task on behalf of a consumer), if their provisions do not infringe the general provisions on the supply of services and the provisions regulating the contract for personal healthcare services.

Finally, the Lithuanian legislator, following the example of the Dutch legislator, introduces in Article 6.742 of the CK a statutory prohibition to exclude or limit the liability of a provider for breach of contract, irrespective of the breach of which obligation the damage arose from.

The regulation in question creates a standard of minimum protection of the patient's interests, although the Lithuanian legislator, unlike the Dutch legislator, does not explicitly specify the nature of the individual norms. The conclusion of the semi-imperative nature of most of them must be deduced from the purpose they serve.

52 More extensive discussion of the concept can be found in Birmontiene, "Changes in the Lithuanian", 392.

2.3. The German solution

2.3.1. Characteristics of the treatment contract

In Germany, as in the Netherlands, the normalisation of the provider-patient relationship took place through an amendment to the Civil Code (*Bürgerliches Gesetzbuch*, hereinafter: the BGB). As of 26 February 2013, the provisions introduced by the law for the improvement of patients' rights became effective.[53] The German solution consists of eight provisions starting with § 630a-630h structured as Sub-title 2 labelled *Behandlungsvertrag*, included in Title VIII of the BGB, concerning service contracts and similar contracts.

As in Dutch legislation, the provisions of § 630a–630h are universal. They are also applicable to legal relationships established under public health insurance.[54] However, the provisions of the medical treatment contract do not apply to contracts regulated by special laws that are exclusively aimed at the provision of nursing or care, or to those concerning accommodation combined with nursing and care[55] (*Gesetz zur Regelung von Verträgen über Wohnraum mit Pflege- oder Betreuungsleistungen*). The provisions in question do not apply to public law medical law relationships, either. Examples of public law relationships in the literature include the relationship between a military doctor and a soldier[56] or a patient placed in an inpatient ward and a federal psychiatric hospital (*Landeskrankenhaus*).[57]

The location of the provisions in the code implies that this contract is a variant of a service contract. The

53 On the historical background, see *Grundlagenpapier: Patientenrechtegesetz in Deutschland, Der Patientenbeauftragte der Bundesregierung Bundesministerium für Gesundheit*, Bundesministerium der Justiz, http://www.hamburg.de/contentblob/3152236/data/bgv-patientenrechte-grundlagenpapier.pdf (access: 28.02.2023).

54 *Entwurf eines Gesetzes zur Verbesserung der Rechte von Patientinnen und Patienten*, Bundestages-Drucksache 17/10488, 18–19, https://dserver.bundestag.de/btd/17/104/1710488.pdf (access: 28.02.2023).

55 *Ibidem*, 17.

56 B.R. Kern, A. Laufs, *Handbuch des Arztrecht* (C.H. Beck, 2010), 621.

57 A. Laufs, Ch. Katzenmeier, V. Lipp, *Arztrecht*, 7 ed. (C.H. Beck, 2015), Beck online: III. A. Rn 1.

object of the service that distinguishes it from other contracts is that of medical treatment. This conclusion is substantiated by the content of § 630b of the BGB which prescribes the appropriate application of the provisions of the service contract to the extent not regulated by the provisions of the medical treatment contract. However, those provisions on the supply of services which relate to the employment relationship within the meaning of § 622 of the BGB (§ 611–§ 630)[58] do not apply in a subsidiary manner.

Similarly to the Dutch and Lithuanian solutions, it is a contract of special trust,[59] unilaterally professional,[60] subject-qualified, against payment[61] and essentially of diligent action.[62] In the case of medical law relationships concluded within the framework of public health insurance, the contract loses the feature of mutuality.[63]

2.3.2. Parties to the contract

The parties to the contract are referred to as the treating party and the patient, unless the patient is merely the beneficiary of the contract made for his or her benefit. The treating party remains the professional party to the contract.

The provisions on the medical treatment contract apply to all those who provide medical treatment, i.e. medical and other treatment-related professions regulated pursuant to Article 74 (1) (19) of the Constitution of the Federal Republic of Germany as well as legal persons.[64] According to the wording of the explanatory memorandum to the draft law, the provisions of the contract do not apply to pharmacists and veterinarians.[65] Caregivers of the elderly are also outside the scope of the provisions to the extent that their care does not amount to hospital treatment.[66] The category of treating parties does not include piercers and tattoo artists, or expert witnesses appointed by the court to ascertain the health of a participant in the proceedings.[67] The contract does not apply to representatives of technical health professions such as dental technicians, hearing aid acousticians, opticians, medical, technical and dental assistants, and activities carried out by beauticians, visagists and make-up artists.[68]

The patient is the natural person receiving the treatment. In contrast to the solutions analysed so far, the German legislator does not lower the age threshold for legal capacity for the purposes of the medical treatment contract.

2.3.3. Obligations and duties

The German legislator formulates five duties of the professional party: the duty to provide medical treatment (§ 630a of the BGB), the duty to inform (§ 630c of the BGB), the duty to seek consent to treatment (§ 630d of the BGB), the duty to explain (§ 630e of the BGB), and the duty to keep medical records (§ 630f, § 630g).

Unlike the Dutch and Lithuanian solutions, which defined the object of the professional party's primary

58 B. Bergman, M. Middendorf, "Bürgerliches Gesetzbuch (BGB) § 630b Anwendbare Vorschriften", in *Gesamtes Medizinrecht*, B. Bergman, B. Pauge, H.D. Steinmeyer eds. (Nomos, 2014), 431.

59 Kern, Laufs, *Handbuch*, 584–585.

60 K. Kubella, *Patientenrechtegesetz* (Springer, 2011) 6–8, 11–12.

61 A. Laufs, Ch. Katzenmeier, V. Lipp, *Arztrecht*, 7 ed. (C.H. Beck, 2015), Beck online: III. A. Rn 1.

62 D. Griebau, "Der Behandlungsvertrag", in *Handbuch Medizinrecht*, R. Ratzel, B. Luxenburger eds., 3 ed. (C.F. Müller, 2015), 711. The provisions of the work contract apply in the alternative when the provider is left to perform a purely technical element, see: R. Müller-Glöge, "§ 611 [Vertragstypische Pflichten beim Dienstvertrag]", in *Münchener Kommentar zum Bürgerlichen Gesetzbuch, Schuldrecht. Besonderer Teil*, M. Hennsler ed. (C.H. Beck, 2012), 36. Dental prosthodontic activities may be regarded as a specific work, but only if, as technical activities (unrelated to installation), they constitute an independent subject of the contract, see Kern, Laufs, *Handbuch*, 589–590.

63 L. Jaeger, "Bürgerliches Gesetzbuch – BGB § 630a Vertragstypische Pflichten beim Behandlungsvertrag", in *Fachanwaltskommentar Medizinrecht*, D. Prütting ed. (Luchterhand, 2014), 576.

64 Entwurf eines Gesetzes zur Verbesserung der Rechte von Patientinnen und Patienten, Bundestages-Drucksache 17/10488, 18, https://dserver.bundestag.de/btd/17/104/1710488.pdf. (access: 28.02.23).

65 *Ibidem*, 18.

66 Ch. Lafontaine, "§ 630a BGB Vertragstypische Pflichten beim Behandlungsvertrag", in *PraxisKommentar BGB: Schuldrecht*, R.M. Beckmann ed. (Juris, 2015), 2228.

67 E. Deutsch, A. Spickhoff, *Medizinrecht. Arztrecht, Arzneimittelrecht, Medizinprodukterecht und Transfusionsrecht* (Springer, 2014), 92, 101.

68 Lafontaine, "§ 630a BGB", 2228.

duty, the BGB does not explain what is to be understood by the concept of medical treatment. An attempt to define it is made in the explanatory memorandum to the draft law, which stipulates that medical treatment is to be generally equated with an action that includes diagnosis, therapy and all acts and treatments on the human body undertaken for the prevention, diagnosis, treatment or alleviation of illness, suffering, injury, ailment or mental disorder. In addition, treatment may not be directed towards the eradication of the illness, but may serve to achieve cosmetic goals.[69]

According to § 630a(2), unless otherwise agreed, treatment is provided according to generally recognised professional standards. Although paragraph 1 of this provision uses the concept of medical treatment, paragraph 2 already refers to professional (rather than medical) standards.[70] Not only does the Act fail to clarify the concept of medical or professional standards, but it also fails to indicate how to determine their meaning.[71] Guidance must again be sought in the explanatory memorandum to the draft law, which refers to the concept of the medical standard developed over the years by case law and legal scholarship It is based on the assumption that in medicine, as in any scientific discipline, there is a certain competent group of people who represent a common belief in the correctness of certain actions. The standard, therefore, is what objectively in the discussions of the participants in these groups, as well as in practice, is considered to be the behaviour leading to a promising diagnostic and therapeutic outcome. At the same time, subjectively, this behaviour can be carried out by an average qualified, conscientious and reasonable provider, whose knowledge, abilities and diligence at each level of care can or must be maintained.[72]

As in the case of the Dutch and Lithuanian solutions, other obligations are in line with the European standard, although a few points are worth emphasising. Firstly, the German legislator differentiates between various information duties by dividing them into the information duty (*Informationspflichten*) and the duty to explain in order to provide the patient with the possibility of self-determination (*Aufklärungspflichten*). Implementation of the first duty presupposes the presentation of the patient's clinical situation to the patient. Implementation of the second duty presupposes providing the information necessary for the patient to consent to the treatment (disposing of one's assets). As part of the implementation of the first one of the information obligations, the necessity to provide information on the medical error committed in the course of the previous treatment (*Fehleroffenbarungspflicht*), as well as information on the economic consequences of the treatment (*wirtschaftliche Aufklärung*), in particular the costs that will not be covered by the insurer, are worth noting. Secondly, the lack of regulation of the obligation of confidentiality is noteworthy compared with the laws analysed so far. Thirdly, the admissibility of *pro futuro* declarations is regulated by the BGB, but not in the provisions dedicated to the medical treatment contract, but in § 1901a of the BGB (*Patientenverfügung*). Fourthly, in contrast to the Dutch and Lithuanian laws, the BGB does not regulate in § 630a–630h of the BGB the status of minors, their legal representatives, the rules for the withdrawal of consent in emergencies or issues related to the release of information for research purposes. There is also no explanation of the nature of the legal norms contained in the indicated provisions.

The patient's main obligation as a contractual party is to pay the agreed remuneration, unless a third party is obliged to pay it. Furthermore, § 630c (1) of the BGB obliges the parties to cooperate. Co-operation is a duty of the parties, serving to deepen trust for an optimal therapeutic outcome.[73] The literature states that, depending on the situation, lack of cooperation

69 Entwurf eines Gesetzes zur Verbesserung der Rechte von Patientinnen und Patienten, Bundestages-Drucksache 17/10488, 17, https://dserver.bundestag.de/btd/17/104/1710488.pdf (access: 28.02.2023).

70 Ch. Katzenmeier, "Patientenrechtegesetz – Risiken und Nebenwirkungen", *Neue Juristische Wochenschrift* (2012) No. 6, Editorial.

71 Jaeger, "Bürgerliches Gesetzbuch – BGB § 630a", 576.

72 *Ibidem*, 578.

73 Entwurf eines Gesetzes zur Verbesserung der Rechte von Patientinnen und Patienten, Bundestages-Drucksache 17/10488 21, https://dserver.bundestag.de/btd/17/104/1710488.pdf (access: 28.02.2023).

on the part of the patient may justify, among other things, the termination of the contract by the treating party.[74] lead to a change in the distribution of the burden of proof with the determination of the patient's contribution to the damage, or even the exclusion of the attribution of liability for the error.[75]

2.3.4. Form

In principle, the law does not provide for any specific form for the conclusion of a contract. As a rule, the form is oral and the conclusion of the contract is brought about by the concurring statements of intent of the parties. This is usually achieved upon commencement of the patient's treatment.[76]

2.3.5. Evidence and the standard of patient protection

In contrast to the Dutch and Lithuanian regulations, the German solution contains numerous evidentiary provisions. They are included within a single drafting unit located as the last provision of Subtitle 2. Paragraph 630h consists of five paragraphs, each devoted to a different evidentiary issue. In total, the legislator has formulated four legal presumptions relating to medical treatment errors and information deficits, and has placed the burden of proof on the treating physician to prove that he or she has obtained the patient's legally valid consent.

Firstly, pursuant to Section 630h (1) of the BGB, a breach of the contractual duty to treat is presumed if the exposure to loss of life, bodily injury or health disorder was caused by an event originating in an area of treatment organisation that the treating party could objectively control,[77] by eliminating the risk of such an event occurring. The body of jurisprudence and legal scholarship presents various classifications of risks, the materialisation of which gives rise to the presumption in question. However, its essence is best illustrated by the examples[78] in which it has been applied. These include damage caused by faulty medical equipment or damage caused by its faulty use (e.g. burns during irradiation), incorrect patient protection (e.g. failure to protect the patient from falling out of bed), failure to observe hygiene standards (e.g. using contaminated test tubes or needles) or organisational errors (e.g. administering expired medicine or failing to provide a stock of medicines, allowing extremely tired staff to work). Establishing in the course of the proceedings, where a risk of a given hazard has materialised due to the occurrence of an event that objectively should have been under the control of the treating party, gives rise to a presumption of breach of obligation. On the other hand, in accordance with § 280 (1), second sentence of the BGB, there is also a presumption of fault on the part of the treating provider, as if the breach of obligation occurred for reasons dependent on him.

> **Certainly, it is a priority that the elaborate provisions find real and wide application on a daily basis.**

Secondly, § 630h (2) of the BGB places the burden on the treating party to prove two prerequisites in the course of litigation: the due performance of the duty to explain (§ 630e of the BGB) and the duty to withdraw consent (§ 630d of the BGB). These circumstances constitute contractual obligations of the treat-

74 D. Griebau "Der Behandlungsvertrag", 726.

75 W. Weidenkaff, *Art. 630c*, in: *Palandt Bürgerliches Gesetzbuch* (C.H. Beck, 2016), 1007.

76 Deutsch, Spickhoff, *Medizinrecht*, 91.

77 Entwurf eines Gesetzes zur Verbesserung der Rechte von Patientinnen und Patienten, Bundestages-Drucksache 17/10488 28, https://dserver.bundestag.de/btd/17/104/1710488.pdf (access: 28.02.2023).

78 Ch. Lafontaine, "§ 630h BGB Beweislast bei Haftung für Behandlungs- und Aufklärungsfehler", in: *PraxisKommentar*, 2272–2273, 2400.

ing party, from which he or she derives for himself or herself the legal effect of the legality of the intrusion into the patient's personal rights, and it places therefore the burden of proof for their fulfilment on the treating party and not on the patient. The treating party may prove the fulfilment of the obligations in question by any means, in particular by means of medical records, which require the patient's consent to be recorded and the fact that the relevant information was previously presented to the patient. In the absence of any means of proving the fulfilment of the indicated duties, as well as the absence of their actual fulfilment, the legislator has left to the treating party a means of defence in the form of a plea of hypothetical consent. The treating party may prove that the patient, properly informed, would have agreed to undergo the treatment anyway. The essence of proof presupposes a reference to a specific motivational situation and not to the objectified standard of a reasonable patient. The treating party has to show that, in the case at issue, the patient had no choice but to agree to the treatment and that his or her decision would not have been affected by the provision of complete information. The treating party's claim fails if the patient demonstrates that the proper communication of the information conditioning consent would have led to a serious decision-making conflict on his or her part,[79] and, more precisely, that, with the right knowledge, he or she would have seriously considered the reasonableness of undergoing the treatment or would have refrained from it. The claim of hypothetical patient consent is a procedural allegation that must be raised at the appropriate stage of the proceedings. Otherwise, it is subject to procedural preclusion.[80]

Thirdly, § 630h (3) of the BGB decrees the presumption of non-performance in the absence of entries in the medical records. All actions and their results relevant to the current and future treatment process are recorded in the documentation. A medical record plays not only an archiving and informative role but also a key evidentiary role. Its general absence or the absence of individual entries often makes it difficult for the patient to prove his or her claims. A breach of the treating party's duties leads to the worsening of the patient's procedural situation. Therefore, according to § 630h (3) of the BGB, if medical records do not contain the entries required under § 630f (1) and 2 of the BGB and fail to show the relevant activities, or if it cannot be ascertained that they contained such entries, because they were lost or destroyed due to improper storage, it is presumed that these activities were not undertaken by the treating physician at all. A prerequisite for the updating of the presumption is that the patient first demonstrates a breach of the regulations governing the keeping of medical records as set out in § 630f of the BGB.

Fourthly, § 630h(4) of the BGB establishes a presumption of a causal connection between the damage and the action of a treating party who formally lacks qualifications. The presumption in § 630h(4) of the BGB refers to the provisions of § 630a(2) of the BGB, requiring the treating party to comply with the standard of conduct prescribed for the relevant professional group. The provision will apply, in particular, to cases of treatment performed by persons without specialised training, as well as those providing treatment during the period of training, who actually perform activities as part of their specialised preparation, but do not formally hold the title of specialist. For the application of the presumption, the patient should demonstrate that the treating party did not complete the relevant training. Consequently, it may be argued that the treating party could have acted in a manner that did not correspond to the professional standard. Failure to comply with the standard of conduct breaches the contractual primary duty to provide treatment, implying the breach of obligation. It remains for the treating party to prove that, although formally unqualified, he or she mastered the skills necessary to properly perform the service, adhering to the required standard of conduct. In other words, he or she acted just as a fully qualified treating party would have acted in the same situation.

79 L. Jaeger, "Bürgerliches Gesetzbuch – BGB § 630h Beweislast bei Haftung für Behandlungs- und Aufklärungsfehler", in *Fachanwaltskommentar*, 603.

80 C. Wever, "§ 630e Aufklärungspflichten", in *Gesamtes Medizinrecht*, B. Bergman, B. Pauge, H.D. Steinmeyer eds. (Nomos, 2014), 441, points out that a plea of hypothetical consent must be raised in the proceedings before the court of first instance under pain of forfeiture.

Fifthly, § 630h (5) of the BGB introduces the legal category of a significant treatment error, the occurrence of which justifies the presumption of a causal connection between the event and the damage. A substantial error of treatment is deemed to be an unequivocally erroneous procedure which, taking into account the level of training and knowledge of the treating party from an objective point of view, is not comprehensible and absolutely should not take place. Paragraph 630h (5), second sentence of the BGB also recognises the type of error referred to as *Befunderhebungsfehler* as a substantial error of treatment, thereby extending the limits of the concept. The *Befunderhebungsfehler* is an error distinguished from diagnostic errors, to which the literature and case law have given an autonomous status. A typical diagnostic error is accepted when the treating party has carried out the necessary diagnostics, looking for the cause of the ailment, but has made a wrong assessment of the results, making a wrong diagnosis as a result.[81] A *Befunderhebungsfehler*, on the other hand, occurs in a situation where the treating party, despite the ambiguity of the symptoms of the illness, has neglected to carry out investigations, the result of which would have either obliged him or her to continue the diagnostics (further search) or would have directly allowed him of her to determine the cause of the patient's ailment. The *Befunderhebungsfehler* is deemed to be a significant treatment error if the treating party failed to carry out diagnostic tests in due time or failed to document the results, the result or content of which, respectively, would with reasonable probability have formed the basis for the implementation of further measures, the failure to take which is a fundamental omission. Demonstrating the commission of a substantial treatment error places the burden on the patient. The treating physician, on the other hand, may argue that the error is not of this nature or, even if it is perceived as such, does not constitute a source of harm, or that the probability of implementing further investigations was not justified at all.[82]

81 Lafontaine, "§ 630a BGB", 2264.

82 A. Schneider, "Der Behandlungsvertrag", *Juristische Schulung* (2013) No. 2, 108.

2.4. The Czech solution

2.4.1. General characteristics of the healthcare contract

The Czech legislative solution is last to be discussed, yet historically it is most recent. *Smlouvou o péči o zdraví*, i.e. a healthcare contract, as a named contract, was regulated in the new Czech Civil Code (*Občanský Zákoník*, hereinafter: the OZ), which became effective on 1 January 2014. The manner of introduction of the provisions is therefore similar to that in Lithuania. There are 16 paragraphs devoted to the contract in question, starting with § 2635 and ending at § 2651. The provisions are drafted in Chapter 9, entitled "Healthcare", which as one of the 16 chapters forms Title II on obligations arising from legal transactions. Title II is located in Book IV on relative property rights.

Unlike the legislative solutions analysed so far, Chapter 9 introduces subheadings: "General provisions", "Explanation, contractual rights and obligations", "Medical records." It is worth making a few observations at this point. Firstly, the subtitles do not fully reflect the substantive layer of the provisions contained therein. Secondly, an analysis of the isolated subtitles gives the impression that the provider's explanation or maintenance of medical records is not a contractual obligation. The impression is illusory, because, as described below, the Czech regulation does not introduce any significant differences in terms of the professional party's obligations as compared with the previously discussed legislative solutions. Rather, it should be stated that the subtitle "Rights and Obligations of the Parties" focuses on the core obligations, which are considered to be the main contractual obligations of the service provider and are therefore covered by a separate subtitle. Thirdly, and somewhat as a consequence of the second, one might be under the impression that the provider's contractual duties do not include the duty of confidentiality. This, too, is a premature conclusion.

In addition to the normativisation of the contract itself, it is noteworthy that the Czech legislator has regulated part of the issues falling within the scope of medical law in the general provisions of the HCS (Book One, Title II "Persons", Chapter 2 "Natural Per-

sons"). Here, there are paragraphs on gender reassignment (§ 29), declarations in the event of incapacity of will (§ 38–44), protection of the human body (§ 92, § 113–117), consent (§ 93–102), compulsory treatment (§ 104–110), disposability of isolated parts of the human body (§ 111–112).

The systematics of the OZ differs from the one adopted in the BW, the CK or the BGB. Title II of Book IV on obligations arising from legal transactions does not distinguish a group of service contracts and therefore does not formulate provisions common to such services and specific provisions governing a service of a certain type. Nevertheless, on the basis of § 2637 of the OZ, it can be argued that healthcare is conceived by the Czech legislator in terms of a service, and thus the contract itself is an example of a service contract. The Czech legislator has expanded the casuistry of named contracts, among which it has placed the healthcare contract, making it an independent type. Therefore, the corresponding application of common provisions or provisions of another named contract to the relationship between the provider and the patient does not take place. Instead, as for any contract distinguished in Title II, the provisions of Title I containing general provisions on obligations apply. As was the case with the solutions analysed so far, the contract is a contract of special trust, unilaterally professional,[83] reciprocal, against payment[84] and essentially of diligent action.[85]

2.4.2. Parties to the contract

According to § 2636(1) of the OZ, healthcare is provided by an authorised entity engaged in a professional or business activity, referred to as a provider. A healthcare provider can be either a natural person or a legal entity. Under § 2637(2) of the OZ, it should be concluded that a healthcare provider on the basis of a healthcare contract is not an entity selling medicinal products, as this has been excluded from the material scope of the concept of healthcare.

The formal counterparty of the healthcare provider is the ordering party. Healthcare can be ordered for oneself as well as for a third party. If it is ordered for oneself, the ordering party is referred to as the patient. In terms of regulating the position of the healthcare recipient, the Czech solution is closer to the German regulation than to the Dutch and Lithuanian ones. Firstly, it does not specifically normativise the position of the minor patient, addressing this issue in separate legislation. Secondly, the Czech legislator does not lower the age threshold, the attainment of which triggers the acquisition of full legal capacity for the contract under analysis.

2.4.3. Obligations and duties

The Czech legislator formulates five duties of the professional party. These are: the duty of care, the duty to respect autonomy (§ 2642 and § 2643(1) of the OZ), the duty of information (§ 2638, 2639, 2640, 2641, as well as § 2646(1) of the OZ, the duty to keep medical records (§ 2647–2650), the duty of confidentiality and the derived duty to respect patient privacy (§ 2644 of the OZ).

The reconstruction of the content of the duty of care is based on § 2636(1), § 2637, § 2643, § 2645 of the OZ. The provisions are located in the subtitles "General Provisions" and "Rights and Obligations of the Parties." Healthcare includes activities, examination, advice and other services that directly relate to the patient and whose purpose is to improve or maintain the patient's health. However, healthcare is not an activity that predominantly consists of the sale or other transfer of ownership of therapeutic agents. The drafting of the provision suggests that healthcare refers only to services of a therapeutic nature. In practice, despite the lack of an explicit normative reference, the provisions are applied accordingly to non-therapeutic services. On the basis of § 2643(1) of the OZ, the healthcare provider is obliged to act with professional diligence as well as in accordance with the principles applicable in its field. Thus, we are talking about the diligence expected of a model representative of a given

83 Pursuant to § 2636(1) of the OZ.

84 This is indicated by § 2636(2) of the OZ.

85 This feature can be derived from § 2639(2) of the GZ. If the healthcare provider is aware that the patient has become convinced that a certain result will be achieved by the healthcare provided, and knows or should know that such a result may not be achieved, the provider remains obliged to explain this circumstance to the patient. At the same time, it can be deduced from the above-quoted provision that Czech law does not exclude the possibility of including a specific result in the content of such a contract.

profession, who acts in accordance with the principles of current medical knowledge in the field of medicine in which he or she provides services.

The content of the other obligations is in line with the European standard. However, a few remarks are worth making. Unlike the German legislator, the Czech legislator does not emphasise the distinction between the duty to inform and the duty to explain for the purpose of self-determination. These in a general way provide for an obligation to inform the patient, the purpose of which may vary depending on the situational context. The solution applied is therefore similar to that which exists in the Netherlands and Lithuania. Paragraph 2640(1) of the OZ introduces the institution of the therapeutic privilege. In this respect, the way the therapeutic privilege is normalized resembles more the Dutch regulation than the Lithuanian one, whose provisions do not require the provider to consult another professional. In § 2650 of the OZ, the Czech legislator, following the example of the Dutch and Lithuanian solutions, has included provisions on the sharing of medical data for the purposes of scientific research.

According to § 2636(2) of the OZ, the primary obligation of the patient, who is the ordering party, is to pay the agreed remuneration, unless this obligation is assumed by a third party on the basis of separate regulations. The patient is also burdened with the duty to cooperate, which is known from earlier legislation. This is mandated by § 2643(2) of the OZ. In order to enable the healthcare provider to fulfil its contractual obligations, the patient is obliged to provide all necessary information as well as to cooperate with the healthcare provider in a manner that can be reasonably expected.

2.4.4. Form

The OZ regulations do not impose any specific requirements as to the form in which the contract is concluded. The contract comes into effect in agreement with general principles through the submission of consensual declarations of intent.

2.4.5. Evidence and the standard of patient protection

Compared with the provisions of the BGB, Czech law (as well as the Dutch and Lithuanian laws) lacks provisions that are intended to strengthen the procedural position of the patient.[86] Following the models of the regulation adopted in the Netherlands and Lithuania, the § 2646 of the OZ rule of joint and several liability has been introduced to facilitate the bringing of an action. However, the Czech regulation does not assume joint and several liability in its pure form, i.e. treating the operating entity as if it were a party to the contract. It allows one to evade liability as a party to a contract if a transparent contractual situation has been provided to the patient in due course.

Unlike the Dutch and Lithuanian solutions, the Czech legislator did not explicitly determine the degree to which the norms contained in § 2636–2651 of the OZ operate. It did so only with regard to the aforementioned § 2646 of the OZ, making it a cogent norm.

In addition, in § 2645 of the OZ, a sanction of invalidity was introduced for arrangements lowering the level of diligence below the due diligence threshold, as well as for a provision aiming at excluding or limiting the liability of the provider for failure to exercise due diligence.

In terms of concern for the standard of protection of the patient, one can also read § 2639(2) of the OZ, which sets out the conduct of a good patient service practice by making the patient aware of the object of the provider's obligation, above all by explaining that the performance of the obligation may not lead to the subjectively imagined result.

3. Conclusions

A comparative legal analysis makes it possible to juxtapose the issues viewed in each of the above mentioned legislations equally. Firstly, the legislative initiatives in question had similar objectives. These were to strengthen the protection of the patient as the weaker party to the contract, to systematise the patient's rights,

86 It should be noted, however, that the jurisprudence allows for a change in the distribution of the burden of proof in special cases, such as when a healthcare provider has failed to keep medical records, thus making it difficult for the patient to prove his or her claim. For further discussion, see P. Šustek, "Current Debates on Medical Liability in the Czech Republic", *Journal du Droit de la Santé et de l'Assurance – Maladie* 2 (2019), 67.

and to raise the patient's awareness of their content. Secondly, all the discussed provisions have been contained in the civil codes of their respective countries. Thirdly, the qualification of the contract is uniform as it is regarded as a contract of special trust, consensual, essentially of diligent action, bilaterally binding, reciprocal, and being a variant of a service contract. However, the legislators acknowledge the contract's "dual nature", which results in a situation where, in certain factual circumstances, the performance of the same service may aim to achieve a therapeutic or a non-therapeutic objective, or where, in certain circumstances, the contract may be either a contract of diligence or a contract of result. Fourthly, all the discussed legislators agree that it is the essence of the service provider's activity that is the influence it exerts on human life and health, which distinguishes this type of contract from other contracts. This activity hinges on evidence-based medicine, as reflected in the linguistic layer of the laws. Consequently, all legislators have effectively excluded the practice of unconventional medicine from direct regulation. Fifthly, all legislators focus primarily on the normalisation of the provider's activity that is therapeutic in nature. In doing so, they give expression to the primary vocation of medical practitioners. Sixthly, the common denominator of the discussed regulations is that none of them directly regulates the relationships between providers of cosmetic services on the fringes of medicine. Seventhly, the subjects have been similarly shaped in each legislation. The contract is unilaterally professional. The professional party involves medical practitioners or entities engaging such persons in their business activities. The party receiving the service is a layperson, commonly referred to as the patient. Lastly, the basic rights and obligations of the parties are mostly uniform.

Despite the above mentioned similarities, several issues have been handled differently. Firstly, the nomenclature used varies. The contract in question operates under different names. The concept of the provider's main obligation and the professional side are also described differently. Secondly, the language used in the provisions shows in different ways the reliance of the provider's activity on the principle of evidence-based medicine. To this end, the adjective "medical" is used, referring linguistically to the concept of treatment, the concept of practice or business, the concept of the object of the primary duty or the concept of the standard to which the provider is to adhere. Thirdly, different approaches are noted with regard to the standardisation of the provider's activities that do not have a therapeutic purpose. Sometimes the legislator explicitly provides for them in the text of the law, and sometimes the rules of such activities result from the market practice rather than from the explicit wording of the law. Fourthly, there is no explicitly worded instruction on how to apply the provisions in question to the medical law relationships entered into without a contractual basis. Fifthly, only some legislators have decided to clearly delineate the nature (scope of bindingness) of the norms governing the medical law relationship. Sixthly, the age threshold, whose attainment would entitle one to conclude the contract in question, was shaped differently. Seventhly, the belief in the contractual source of the medical law relationship established within the public healthcare system is not commonplace. Eighthly, the laws under discussion vary in terms of volume and their specificity. This is mainly due to the differences in the location, scope and detail of the standardisation of issues indirectly related to the essence of the basic rights and obligations of the parties, i.e. the status of minors and legal representatives, medical powers of attorney, declarations in case of incapacity, transplantation, or collection of medical data for scientific research. Some provisions concerning the medical law relationship have been located in other parts of the respective civil codes. The regulation of procedural and evidentiary institutions designed to strengthen the weaker party is also different.

Furthermore, a comparative legal analysis allows further universal arguments to be formulated against as well as in favour of the normalisation of the relationship in question within the Polish Civil Code, thus enriching the ongoing legal discourse. On the one hand, it can be argued that that most EU countries have not done so. This may indicate that healthcare services can operate well without the code-based normalisation of the contractual medical law relationship. In addition, lack of further proposals for legislative initiatives after 2014 may reflect the belief that prospective legislation will not affect the market of healthcare services

anyway. Still, no broader international research has been conducted on whether the legal awareness of society where the civil code regulates the type of the named contract in question is greater than the legal awareness of society of a country where such contracts are regulated outside the civil code. In addition, no studies have been carried out indicating whether such a regulation has a real effect on reducing the volume of patients' claims or increasing patients' sense of security. Therefore, the claim of the advisability of juridising such a relationship in a civil code remains unverifiable.

However, on the other hand, it may be argued that the process of legal development is never complete. It is impossible to assume that no new provisions introducing the type of a named contract into the civil codes of the EU Member States will arise. Meanwhile, comparative legal studies show that over the last 30 years, a tendency to juridise the relationship in question on the basis of civil codes has developed. Similarly, comparative legal studies show that the second regulatory model has also gained recognition among academics, as reflected in the DCFR private law unification project.[87]

It may be argued that just because some EU Member States have introduced relevant provisions into their civil codes and the DCFR advocates such a procedure, it does not mean that one has to blindly follow European trends, especially as the content of the rights and obligations of the parties was consolidated years ago. The current issues of healthcare services are completely different from those existing at the beginning of the 1990s. Thus, it seems that the mere introduction of a new type of a named contract into the Polish Civil Code will not, by default, result in the empowerment of the patient, the systematisation of his or her rights, their clarification and the dissemination of knowledge about them to the public. Rather, it seems, the means of achieving such objectives should involve a legislative initiative aimed at modifying the environment in which this relationship is established, for example by making the process of providing healthcare services safer and more transparent for the patient. The changes should focus on increasing expenditures on the healthcare system, increasing competition among insurers, clarifying the oral formulas of guaranteed benefits, which describe the procedures included in them, and increasing expenditures on the training of medical personnel. This would be a step towards shortening the patient's waiting period for the possibility of having his or her needs met and, if this is not possible, devoting more time to him or her, so that, through proper communication, misunderstandings are minimised, as it is misunderstandings that in many cases cause mutual resentment that subsequently escalates into litigation. In other words, it can be argued that the juridisation of the contract under discussion merely manifests superficial thinking about the interests of the patient. Meanwhile, an individual patient's problems tend to remain anchored in the flawed systemic solutions. Only by changing the systemic solutions will it be possible to permanently reduce the economic and time pressure on healthcare providers and thereby eliminate the source of the majority of court actions in this area of law.

However, advocates of normativisation might counter that, in general, thorough systemic reforms are necessary anyway, and that they have the potential to realistically improve the situation of both the provider and the patient. However, there is nothing to prevent changes from being made in two ways as one solution does not exclude the other. Both paths go in the same direction of safeguarding the interests of the patient. While systemic changes presuppose the elimination of situations in which the potential for conflict lies, a code regulation of a new type of a named contract would perhaps allow it to be abolished more quickly and easily, should it arise (especially in view of the strengthening of the patient's procedural position).

The results of the comparative legal analysis may lead to further criticism, expressed in the argument that the essence of the medical law relationship is

87 The provisions of the DCFR which govern the medical treatment contract consist of 11 articles, starting with Articles 8:101 to 8:111, and are structured into a separate chapter called 'Treatment'. The chapter is numbered VIII and located in Part C dealing with services, which is one of the elements of Book IV regulating special contracts and the rights and obligations arising therefrom. The regulation of the treatment contract closes Part C, being preceded by chapters on general provisions, rules relating to the provision of services, the construction contract, the processing contract, the storage contract, the project contract and the consultancy contract.

uncontested in the EU. The content and scope of the rights and obligations of the parties are derived from commonly held values and are thus not affected by significant regulatory differences. This shows that each national legislation has achieved the same result, but with different regulatory methods. The use of public or private law norms turns out to be irrelevant in determining the content of this relationship, and depends almost exclusively on the vision of the state's role in the healthcare system. The greater its presence the higher the degree of public law regulation that reflects it. Nowadays, with European healthcare systems already well established, national medical law scholarship strongly developed and the rich body of jurisprudence, it does not make much sense to change the way this relationship is regulated.

In response to such an argument, it may be posited that although the content and scope of rights and obligations have a common axiological root, the degree of their social awareness and understanding may vary precisely depending on the method of regulation adopted. The conviction that certain issues are self-evident for lawyers does not cause the rest of society to perceive a given relationship in the same way. For this part of society and this appears to be a vast majority, solutions should be sought and implemented so that they can understand their legal position more quickly and easily.

Another objection formulated against the results of the comparative legal analysis could be the argument that the civil code is not the right place to introduce the law under discussion. The catalogue of all patient rights is very extensive and it reflects the casuistry of medical law issues. For this reason, the systematics of the civil code and the concise regulatory method preclude the drafting of norms whose content will satisfactorily standardise the entirety of this issue. The Dutch, Lithuanian, German and Czech solutions are fragmentary, addressing the issues at hand only partly, and do not describe any of them comprehensively. It is more appropriate to leave the issues of the patient's rights and the provider's obligations to be dealt with in separate laws. Moreover, the code regulation of the relationship in question cannot at present stabilise the content of the relationship or clarify patients' rights or spread awareness of them. The scope of rights and obligations has been developed by legal scholarship and case law, their content has long since become clear, and their dissemination has already been achieved through the power of the media, and especially the Internet. Nowadays, the basic rights and obligations of the parties have become entrenched in the consciousness of an average patient, as shown by the ever-increasing number of litigations. Even if one assumes that this is still not the case, it is naïve to believe that, in the age of a global and completely digitised society, a layperson will seek answers in the code, rather than on the Internet.

In addressing this argument, it should be pointed out that the legislatures of all countries where a new type of a named contract has been juridised, did not accidentally do so in the civil code. It was rightly assumed that it is the civil code, as the legal act regulating the basic private law relations, and not any other enactment, that provides the easiest access to the knowledge of how the relations most frequently established in legal transactions are normalised. Of course, it may be argued that the assumption that the average citizen's legal awareness is formed by reading the civil code is illusory. However, taking it as a starting point, it remains questionable to put anything in normative form. Besides, online popular studies do not stand alone, but are based on the content of legal norms, including the provisions of the civil code, so they popularise them anyway. Certainly, the volume and comprehensiveness of the emerging legal regulations may cause difficulties in recognising the legal acts and provisions applicable to a given state of facts, but it does not change the basic assumption that the law is created primarily for the benefit of all participants in the trade, and not for lawyers only. No other legal act is so socially recognisable and offers such an opportunity (regardless of the gravity of the dispute) to disseminate basic knowledge of the content of the relationship in question as the civil code. From a systemic perspective, especially the potential to increase public awareness of legal norms, this location for such new provisions is entirely appropriate. It cannot be denied that the provisions introduced in the BW, the CK, the BGB or the OZ are general in nature, but they must be so because of the assumptions underlying the construction of the civil code. Excessive expansion of the content of each named contract would lead to a loss

of clarity in the legal text and a decrease in its informative value. The civil code, especially with regard to the regulation of named contracts, presents basic information. This is owing to the assumption that only those issues are included in the content of the norms which are considered fundamental, characteristic and thus distinguishing a given relationship from others. The drafting of the provisions on a named contract draws its justification precisely from the fact that the given relationship reveals certain features, characteristic only of it or of a group of such relationships. A detailed regulation of casuistic issues may be made by a separate act to which the code's provisions may explicitly refer.

The conclusions presented so far, especially the part which contains the criticism of the content of the provisions regulating the types of named contracts, do not mean that it is too late and thus pointless to launch a similar initiative in other countries. Rather, it would be advisable to draw on the experience of these countries in order to reflect on the significance of the contract, resolving in the process the most important problems revealed in the national medical law on a daily basis, while avoiding the juridicalisation of clichés.

Such a challenge is currently faced by Poland, which can still benefit from the potential inherent in the regulation in question to the fullest extent possible. However, in order to do so, it is necessary to be aware of the Polish regulatory problems affecting the contractual relationship of medical law as such, and it would be necessary for the normativisation of the provisions of the treatment contract to be included in the broader discourse on the shape of the code's regulation of services as such. Certainly, it is a priority that the elaborate provisions find real and wide application on a daily basis and, consequently, they cannot be limited to merely prescribing what we already know about the most important rights and obligations of the parties. With a high degree of probability, this would be the case if the legal system allowed for the redress of non-pecuniary damage *ex contractu*.[88] The medical treatment contract is an excellent example of a contract through which the non-pecuniary interest of the patient is pursued. This interest can hardly be fully protected if the patient is only able to seek compensation rather than damages. Making the contractual regime an avenue of redress for the full harm resulting from a breach of contract would significantly strengthen the patient's position. This regime would not be limited to the tort pathway only. Furthermore, the scale of application of the provisions in question would be increased by the acceptance of the view that a contractual relationship exists between the parties to a medical law relationship, even if that relationship is established within the public health system.[89] Implementation of the two observations above would harmonise the scope of application of the provisions, including the range of possible legal responses in the event of their breach. Additionally, the provisions of the contract in question must give the patient the chance to benefit from a warranty for defects, where a material component is involved in the process of the performance of the healthcare service. What is more, the provisions of the medical treatment contract would merit making them the point of reference for contracts whose performance involves interference with a person's personal rights (possibly performed on or affecting the recipient's body, e.g. tattoos, piercings, cosmetic services, unconventional medicine). By means of an instruction to apply these provisions respectively, it would be possible to provide some level of protection[90] to recipients of such non-therapeutic services. Finally, the inclusion of solutions cutting across doubts as to the patient's status as a consumer, doubts as to the degree to which the parties to the contract are bound by particular standards and doubts as to the applicability of particular institutions of the law

88 In Poland, *de lege lata*, redress under the contractual liability regime is only possible for property damage. The proposed new Civil Code envisages a change in this state of affairs. More extensive discussion can be found in U. Walczak, "Art. 19 [Naprawienie szkody niemątkowej]" (Compensation for non-pecuniary damage) in *Wykonanie i skutki naruszenia zobowiązań. Projekt z uzasadnieniem* (Performance and Consequences of Breach of Contract. Draft with Justification), M. Pecyna ed. (Wydawnictwo Uniwersytetu Jagiellońskiego, 2009), 437–445.

89 In Poland, *de lege lata*, the existence of a contract directly between a service provider and a patient within the public healthcare system is not accepted.

90 Its detailed scope would have to be left to case law to be determined on a case-by-case basis.

would significantly facilitate trade (e.g. regulation of *pro futuro* declarations, medical powers of attorney, or procedural and evidentiary facilitation).

Certainly, this initiative should not be carried out without taking into account the current problems of domestic legal transactions and the already existing body of legal scholarship and jurisprudence. Otherwise, the code-based standardisation of the contract in question as a type of a named contract will become a mere reiteration of what we already know, limiting itself to fulfilling the postulate that the Polish Civil Code should be the legal act whose content reflects the contractual relationships most frequently concluded in legal transactions, which seems to be of little value.*

References

Asser, Carel, *Handleiding tot de beoefening van het Nederlands burgelijk recht. Bijzondere overeenkomsten* (Wolters Kluwer, 2014).

Bankauskaite, Valda, Jakusovaite, Irayda, "Dealing with ethical problems in the healthcare system in Lithuania: achievements and challenges", *Journal of Medical Ethics* 10 (2006), 584–587.

Bar, Christian von et al., *Principles, Definitions and Model Rules of Europeqan Private Law. Draft Common Frame of Reference (DCFR) Full Edition*, vol. 2 (Sellier, 2009).

Bartels Steven, Giesen Ivo, "The Principles of European Law on Service Contracts: the Rules on Medical Treatment in a Future Europe Compared to the Rules in the Netherlands", in *The Future of European Contract Law: Essays in Honour of Ewoud Hondius to Commemorate his Retirement as Professor of Civil Law at the University of Utrecht*, Katharina Boele-Woelki, Willem Grosheide eds. (Wolters Kluwer, 2007), 169–181.

Bergman, Karl Otto, Middendorf, Max, "Bürgerliches Gesetzbuch (BGB) § 630b Anwendbare Vorschriften", in *Gesamtes Medizinrecht*, Karl Otto Bergman, Burkhard Pauge, Heinz-Dietrich Steinmeyer eds. (Nomos, 2014), 416–431.

Birmontiene, Toma, "Changes in the Lithuanian Health Law and the influence of the Netherlands Civil Code", *European Journal of Health Law* (2002) No. 4, 381–395.

Birmontiene, Toma, "Health Legislation in Eastern European Countries: the Baltic States", *European Journal of Health Law* (2004) No. 1, 77–85.

Borry, Pascal et al., "Legislation on direct-to-consumer genetic testing in seven European countries", *European Journal of Human Genetics* 7 (2012), 715–721.

Borysiak, Witold, "An Act-in-Law as fundamental source from medical law relations" in *Medical Law*, Leszek Bosek ed. (C.H. Beck, 2019), 75–118.

Deutsch, Erwin, Spickhoff Andreas, *Medizinrecht. Arztrecht, Arzneimittelrecht, Medizinprodukterecht und Transfusionsrecht*, 7 ed. (Springer, 2014).

Dijk, Gert van, "Physicians and alternative methods of treatment: Do they go together?", *World Medical Journal* 5 (2011), 178–182.

Ducinskiene, Danute et al., "Awareness and practice of patient's rights law in Lithuania", *International Health and Human Rights* 10 (2006), 1–6.

Entwurf eines Gesetzes zur Verbesserung der Rechte von Patientinnen und Patienten, Bundestages-Drucksache 17/10488, https://dserver.bundestag.de/btd/17/104/1710488.pdf (access: 28.02.2023).

Exter, André den, Buijsen, Martin, *Medical Law in the Netherlands* (Wolters Kluwer, 2013).

Gevers, Sjef, "Making Laws on Patient Rights: the Dutch Experience", in *Recognition and Protection of Patients' Rights International Workshop in Budapest May 19–21, 2000*, Judit Fridli ed. (Hungarian Civil Liberties Union, 2000), 12–17.

Grabauskas, Vilius et al., "The patient role in decision-making in Lithuanian healthcare", *Medicina* 40 (2004) No. 11, 1109–1115.

Griebau, Dirk, "Der Behandlungsvertrag", in *Handbuch Medizinrecht*, Resch Ratzel, Bernd Luxenburger ed., 3 ed. (C.F. Müller, 2015), 711–727.

Grundlagenpapier: Patientenrechtegesetz in Deutschland, Der Patientenbeauftragte der Bundesregierung Bundesministerium für Gesundheit, Bundesministerium der Justiz, http://www.hamburg.de/contentblob/3152236/data/bgv-patientenrechte-grundlagenpapier.pdf (access: 28.02.2023).

Gumbis, Jaunius, Petkeviciene, Migle, Vienazundte, Jevgenija, Sileikyte, Guoda, *Medical Law in Lithuania* (Wolters Kluwer, 2015).

Hondius, Ewdo, "Specific Contracts", in *Introduction to Dutch Law*, Jeroen Chorus ed. (Wolters Kluwer, 2016), 201–220.

Jaeger, Lothar, "Bürgerliches Gesetzbuch – BGB § 630a Vertragstypische Pflichten beim Behandlungsvertrag", in *Fachanwaltskommentar Medizinrecht*, Dorothea Prütting ed. (Luchterhand, 2014), 566–576.

Karasek-Wojciechowicz, Iwona et al., "Projekt zespołu problemowego komisji kodyfikacyjnej prawa cywilnego do spraw regulacji świadczenia usług", *Transformacje Prawa Prywatnego* (2014) No. 4, 75–88.

* This article is the result of a research project funded by the National Science Centre in Poland granted to the author by decision DEC-2014/15/N/HS5/01926.

Katzenmeier, Christian, "Patientenrechtegesetz – Risiken und Nebenwirkungen", *Neue Juristische Wochenschrift* (2012) No. 6, Editorial.

Kern, Bernd-Rüdiger, Laufs, Adolf, *Handbuch des Arztrecht*, (C.H. Beck, 2010).

Kocot, Wojciech, "Systematyka prawa zobowiązań umownych w przyszłym kodeksie cywilnym", *Państwo i Prawo* (2018) No. 3, 82–109.

Kubella, Kubella, *Patientenrechtegesetz* (Springer, 2011).

Lafontaine, Christoph, "§ 630a BGB Vertragstypische Pflichten beim Behandlungsvertrag", in *PraxisKommentar BGB: Schuldrecht*, Roland Michael Beckmann ed. (Juris, 2015), 2386–2444.

Lafontaine, Christoph, "§ 630h BGB Beweislast bei Haftung für Behandlungs- und Aufklärungsfehler", in *PraxisKommentar BGB: Schuldrecht*, Roland Michael Beckmann ed. (Juris, 2015), 2204–2297.

Laufs, Adolf, Katzenmeier, Christian, Lipp, Volker, *Arztrecht*, 7 eds. (C.H. Beck, 2015).

Leenen, Henricus Jacobus Josephus et al., *Handboek gezondheidrecht*, (Boomjuridisch, 2000), 41–42.

Markenstein, Loes F., "The codification in the Netherlands of the principal rights of the patients: a critical review", *European Journal of Health Law* 2 (1995) No. 1, 33–43.

Müller-Glöge, Rudi, in *Münchener Kommentar zum Bürgerlichen Gesetzbuch, Schuldrecht. Besonderer Teil*, Martin Hennsler ed. (C.H. Beck, 2012).

Murauskiene, Liubove, Janoniene, Raimonda, Veniute, Marija, Ginneken, Ewout van, Karanikolos, Marina, "Health Systems in Transition. Lithuania", *Health System Review* 2 (2013), 1–150.

Nesterowicz, Mirosław, "Charakter prawny umowy o zabiegi lecznicze", *Zeszyty Naukowe UMK Prawo* 9 (1969), 117–128.

Nesterowicz, Mirosław, Bagińska, Ewa, Exter den, André, "Poland", in *International Encyclopaedia of Laws. Medical Law*, Herman Nys ed. (Kluwer Law International, 2013), 1–144.

Pecyna, Marlena, Zoll, Fryderyk, "Założenie projektu struktury części szczegółowej zobowiązań. W poszukiwaniu nowego modelu", *Transformacje Prawa Prywatnego* (2012) No. 1, 25–59.

Pisuliński, Jerzy, "Struktura części ogólnej prawa zobowiązań (wprowadzenie do dyskusji)", *Transformacje Prawa Prywatnego* (2012) No. 1, 15–22.

Projekt Kodeksu cywilnego. Księga pierwsza Część ogólna, https://www.projektkc.uj.edu.pl/index.php/projekty (access: 28.02.2023).

Radwański, Zbigniew, "Wstępny projekt systematyzacji tak zwanej części szczegółowej prawa zobowiązań", *Transformacje Prawa Prywatnego* (2012) No. 1, 5–13.

Radwański, Zbigniew, *Zielona Księga. Optymalna wizja Kodeksu Cywilnego w Rzeczypospolitej Polskiej*, Zbigniew Radwański ed. (Ministwerstwo Sprawiedliwości, 2006).

Schneider, Angie, "Der Behandlungsvertrag", *Juristische Schulung* (2013) No. 2, 104–108.

Sluijters, Bernard, Biesaart, Monique, *De geneeskundige behandelingsovereenkomst* (Wolters Kluwer, 2005).

Stolker, Carel, Slabbers, Shirin, "The Netherlands", in *Cases on Medical Malpractice in a Comparative Perspective (Tort and Insurance Law)*, Michael Faure, Helmut Koziol eds. (Verlag Österreich, 2001), 147–171.

Stultiëns, Loes, Goffin, Tom, Borry, Pascal, Dierickx, Kris, Nys, Herman, "Minors and Informed Consent: A Comparative Approach", *European Journal of Health Law* (2007) No. 1, 21–46.

Šustek, Petr, "Current Debates on Medical Liability in the Czech Republic", *Journal du Droit de la Santé et de l'Assurance – Maladie* 2 (2019), 63–71.

Szostak, Ryszard, "Problem systematyki umów obligacyjnych w nowym kodeksie cywilnym", *Transformacje Prawa Prywatnego* (2012) No. 1, 61–74.

Szostak, Ryszard, "O potrzebie usprawnienia kodeksowej regulacji umów o świadczenie usług na warunkach zlecenia", in *Współczesne problemy prawa zobowiązań*, Andrzej Olejniczak, Joanna Haberko, Agnieszka Pyrzyńska, Dorota Sokołowska eds. (Wolters Kluwer Polska, 2015), 680–694.

Szostak, Ryszard, "O potrzebie zachowania typologicznego układu systematyki umów w europejskim prawie kontraktów" in *Kierunki rozwoju europejskiego prawa prywatnego. Wpływ prawa konsumenckiego na prawo krajowe*, Monika Jagielska, Ewa Rott-Pietrzyk, Aneta Wiewiórowska-Domagalska eds. (C.H. Beck, 2012), 109–116.

Walczak, Urszula, "Art. 19 [Naprawienie szkody niemajątkowej]", in *Wykonanie i skutki naruszenia zobowiązań. Projekt z uzasadnieniem*, Marlena Pecyna ed. (Wydawnictwo Uniwersytetu Jagiellońskiego, 2009), 437–445.

Weidenkaff, Walter, *Art. 630c*, in *Palandt Bürgerliches Gesetzbuch*, (C.H. Beck, 2016), 1007–1008.

Wever, Carolin, "§ 630e Aufklärungspflichten", in *Gesamtes Medizinrecht*, Karol Otto Bergman, Burkhard Pauge, Heinz-Dietrich Steinmeyer eds. (Nomos, 2014), 431–455.