

THE RESPECT FOR HUMAN DIGNITY THROUGHOUT LIFE AS REFLECTED IN THE NEW CIVIL CODE

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ABSTRACT. *During the development of social politics, philosophy and medicine in relation to human dignity, they have been involved in the processes of evolution and involution which unfortunately can still be felt nowadays, both on a global and a national level. The Universal Declaration of Human Rights (adopted by the General Assembly of the U.N. on December 10, 1948), the UNESCO’s Constituting Act (in its Head Note), The Universal Declaration on Bioethics and Human Rights (adopted by the UNESCO on October 19, 2005) also stress out the respect for human dignity. The Law No. 95 / 2006 and the Code of Medical Professional Ethics focuses on the rights of the patient, its quintessence being the right to choose one’s physician, and the respect for the patient’s dignity appears as a corollary of these rights. The key issue of the new Civil Code focuses on “the life, health, physical and mental integrity of any person” which are equally guaranteed and protected. Section 61 (1) “The interest and welfare of the human being must take precedence over the unique interest of society or science” – Section 61 (2).*

Key words: *dignity, human rights, civil code, medical contract, medical error, civil liability*

Introduction

The dignity of the human being is an ethical concept frequently invoked by justice, though not sufficiently well-stated in legal texts. The doctrine defines the dignity of the human being as a person’s affiliation to humanity, having a superior value as compared to that of other beings. It is essentially human, setting humans apart from other living creatures.

The Universal Declaration of Human Rights, adopted by the General Assembly of the U.N. on December 10, 1948, mentions in its *Preamble* the recognition of the inherent dignity of all members of the human race. The

preamble to the UNESCO's Constitutive Act invokes the democratic ideal of dignity, equality in rights and equal respect for the human being. *The Universal Declaration on Bioethics and Human Rights*, adopted by UNESCO on October 19, 2005, mentions that the progress of research must be conducted while respecting the dignity of the human being.

The New Civil Code dedicates its art. 61 to the guaranteeing of the inherent rights of the human being:

“(1) Life, health and the physical and mental integrity of any person are guaranteed and protected equally.

(2) The interest and welfare of the human being must take precedence over the unique interest of society or science”.

Eugenic practices by which the human species is affected or which tends to organize the selection of persons are prohibited by art. 62, and medical interventions on genetic characters that seek to modify the person's natural makeup, with the exception of those aimed at preventing and treating genetic diseases, are prohibited by art. 63 par. (1). Cloning a human being, as well as creating human embryos for research purposes are prohibited by dispositions of par. (2) of the same article. Medically assisted human reproduction techniques cannot be utilized for the purpose of choosing the sex of the future child, with the exception of techniques seeking to avoid severe sex-related hereditary illnesses (art. 63 par. (3)).

The human body is inviolable, and each human being is entitled to its physical and mental integrity, any interference with it being only allowed in cases and under conditions that are expressly and limitingly foreseen by the law (art. 64).

The examination of a person's genetic makeup, as well as their genetic fingerprint-based identification can only be performed for medical or scientific research, expressed within the limits foreseen by the law or, depending on the case, only as part of a civil or criminal procedure.

The human body is sacred; it is outside the scope of the civil circuit and has no patrimonial value, which is true for both it as a whole and for its elements or products, with the exception of express cases foreseen by the law (art. 66). Any patrimonial acts having these values as their object are prohibited.

No human person can be subject to experiments, trials, sampling, treatments or other interventions for therapeutic or scientific research purposes, except in case and under conditions expressly and limitingly foreseen by the law (art. 67). Sampling and transplanting organs, tissues and cells from living persons can only occur in cases and under conditions foreseen by the law, with their written, free, prior and express consent and only following correct

information on the risks incurred by the intervention. The donor may withdraw their consent up until the date set for the sampling (par. (1) of art. 68).

Transplanting or sampling organs, tissues and cells from minors or mentally incapacitated persons are prohibited (par. (2) of art. 68).

The above-mentioned rights and, in general, the respect for the dignity of the human being are ensured by the intervention of justice, which also establishes the amounts of compensation that are owed to the victims (art. 69).

Ways in which the rights provided for by art. 61 in *The New Civil Code* are protected

The patient's freedom of choosing their physician

Dignity is an ethical concept, the content of which is not sufficiently well-stated by legal texts, but frequently invoked by magistrates. It is doctrinally defined as the human being's statement of affiliation to humanity; thus, the human being acquires a superior value with respect to other living creatures. No official definition has been thought out, nor is it obligatory. Dignity pertains to human essence, being a feature that distinguishes humans from other creatures and inanimate things.

As a jurisprudential argument, human dignity has been invoked in the decisions of the French Court of Cassation since 1942 (the Teyssier case) and has continued to be invoked in numerous other cases in our days. The argument was used in connection to the right to information, the necessity of consent and the refusal of care, as well as to the doubly difficult case of knowing whether dignity can legitimate the right to not be born with a handicap or whether the handicap is compatible with a dignified existence. Of major importance was the idea of human dignity in the prospect of death and end of life, as well as after death.

In the 16th century, a French surgeon stated that the physician expected the patient to obey them, in the same way that a servant obeyed his senior (De Chauliac 2009:183).

In our days, a French author asserted a similar opinion. In the confrontation between a physician and the inert, passive patient, the physician never feels that they are dealing with a free and equal being whom they may instruct. Any patient is regarded as a child who must be consoled or healed and who cannot consent to what they are told, or to what they are proposed.

In this context, it is paradoxical to talk about the patient's freedom of choosing their physician. However, a famous 19th century character, Henri de Lacordaire (1802-1861), a lawyer and cleric, who re-established the Dominican

Order (1843) in France and was famous for his conferences at Notre Dame de Paris (1835-1836), elected as a member of the French Academy in 1860, made a memorable statement: "*between the strong and the weak, between the rich and the poor, it is freedom that oppresses and it is the law that liberates*". In our days, the patient has obtained a true autonomy and a sufficient power to be accepted as a protagonist in their relationship with the physician that cares for their health. Ever since 1856, in France, a Treatise of medical law affirmed that the rule giving the patient the right to choose their physician was essential.

If the patient is forced to accept a physician they do not know, there is the very serious danger of cutting out the possibility of confidence and instating the physician's authority over the patient, with all its resulting inconveniences.

The idea of freedom to choose one's physician surprises by the complexity of the term "freedom", especially when it used in a juridical context. A dictionary can provide over 20 meaning for the word "freedom", among which is the power to act or not to act, the ability to do as we please, the absence of constraint etc. Freedom may be passive or active, allowing one to choose between action and passivity.

The socialization of medicine leads to an increase in the physician's role, which is designated by society and can no longer be chosen by the patient. Instead of staying personal, medicine is represented by a team and the patient's choice disappears.

The feeling of trust (Turcu 2010: 154-160) underlies the establishment of professional relationships between the physicians and the patient who regards the former as a competent and diligent professional. Art. 35 of the *Code of Medical Deontology* institutes the obligation for the physician to be a model of ethical and professional behavior, contributing to the increase in their professional and moral level, to the authority and prestige of the medical profession *in order for it to be worthy of the esteem and confidence of patients and collaborators*. Here, conscience meets confidence (Swan 2008: 22). The patient confides in their physician and entrusts the latter with their health. The art of communicating with the patient consists of "verbal and nonverbal language, respect and politeness, understanding and warmth, kindness and devotion, benevolence and affection". "Between physician and patient, there must be an intense exchange of feelings". (Dumitraşcu 1986: 25). In exchange for this, the physician makes all decisions that are in their patient's best interest.

Mutual confidence presupposes the establishment of an empathic relationship, to which the therapeutic relationship aspires. The physician shall take interest in all aspects regarding the patient's personality, not only their illness, but also their personal life. This goal is never fully achieved, but it is striven for. *The best guarantee of the patient resides in the physician's conscience*. "A jurist is, in their own way, a physician, even a clinician. The

purpose of their intervention is limited: it cannot be about improving man or society, but releasing them from a concrete evil. Thus is explained the contempt inspired by them in those who can only see them as a mediocre surrogate and, primarily, in theologians, moralists or those holding the highest of views." Not even the famous monolog of the Prince of Denmark forgives the lawyers' trade: "There's another: why may not that be the skull of a lawyer? Where be his quiddities now, his quillets, his cases, his tenures, and his tricks? why does he suffer this rude knave now to knock him about the sconce with a dirty shovel, and will not tell him of his action of battery?" (Shakespeare 1959: 688).

The mutual confidence between physician and patient must not be exhausted during the first contact. It must be rendered permanent and, for this reason, to avoid deception, the physician shall never, throughout his/her entire professional life, cease to inform him/herself on the advances of the medical science, for the purpose of improving their medical knowledge (art. 7 of the *Code of Medical Deontology*). Eleven centuries ago, Avicenna maintained that "the physician must drag the weight of an encyclopedic knowledge, like a camel, and in spite of all this, preserve the freshness of a poet". (Dumitraşcu 1986: 78)

The medical act must sometimes make use of elements from the area of showmanship. The physician renounces him/herself in favor of the patient and adapts their behavior according to the latter's expectations: "for each patient, he/she picks the most appropriate tone, from a wide repertoire of resources ... The physician always presents him/herself in a well-balanced, well-adjusted way, for this is his/her defining feature. He/she always preserves his/her dignity. He/she is, perhaps, solemn; if the situation requires it, he/she may become grave. He/she knows when to be silent, by respecting and understanding suffering. When he/she want to alleviate certain fears, he/she may radiate with optimism. He/she may firm at one time, tolerant at another, energetic or genial, consistent or malleable." (Dumitraşcu 1986:79)

What is the extent of the patient's right to information? - author Marc Horwitz wonders (Dumitraşcu 1986: 79). The physician must inform the patient in a complete, intelligible and loyal manner and receive the latter's informed consent. The limits of information refer to investigations, treatments or other preventive actions and must comprise utility, urgency, consequences, risks, other possible solutions and the consequences of refusal. Usually, after conducting investigations, treatments or preventive actions, new risks are identified. The patient must again be informed. The physician must also analyze, together with the patient, the relation between benefits and risks, including exceptional risks. One might say that the patient has the last word. This is false. The responsibility falls on the physician and he/she is free to choose the

treatment, as the patient cannot impose a certain treatment. Therefore, a serious limit of the patient's consent appears. He/she can only turn to another doctor or refuse care, if he/she cannot agree with the physician's opinion. The latter has the duty to inform the patient on the consequences of their option and respect the patient's will. No medical act can be practiced without the free and informed consent of the patient, who can withdraw his/her consent until the very last moment. If the vital prognostic of the patient is at stake, in his/her best interest and for legitimate reasons, he/she may be kept ignorant to the diagnosis or prognosis, except for the case when the patient's illness poses a risk of contaminating others.

The physician's independence

Both the *Law no. 95/2006*, and the *Code of Medical Deontology* proclaim the physician's independence. As regards the content of this independence, it consists, principally, of the free conduct for the exercise of the medical art, including the choice of collaborators and, especially, the choice of technical solutions in the situations they are confronted with. As long as he/she remains within the limits of scientific data, the physician is free to choose his/her means. Freedom is, nevertheless, not absolute. The physician may not propose and administer illusory or evidently inadequate remedies or procedures, as a charlatan would. Likewise, he/she is not allowed to subject the patient to an unjustified risk. Moreover, the physician may not accept that the remuneration he/she receives from the hospital depend on the hospital's profitability.

The courts refuse to control the physician's options from a scientific point of view, but they do ensure that the act was performed in the patient's best interest and in accordance with scientific data. The physician is not allowed to carry out useless acts or acts that are not in accordance with medical knowledge.

While it is true that obtaining the patient's consent is a prerequisite for the medical act, this does not mean that it is also a sufficient condition for the validity of this act. The physician should be guided by the proportionality between expected benefits and the risks incurred.

The European professional ethics allows the physician to refuse to provide care, unless the patient is in danger. The refusal may be grounded on professional or personal reason. Thus, for example, the physician may not be forced to perform an abortion, but must inform the person involved about his/her refusal and indicate other practitioners who can perform this operation.

The medical art also involves an aspect of technical ability, and the increase in technicality entails teamwork and adequate equipment. This objective approach to the medical science was expressed in concepts such as

"the acquired data of science", "the current data of science" or "confirmed medical knowledge". While physicians strive to experiment with new techniques for the purpose of improving their patients' health, jurists have assumed the ungrateful task of protecting patients against those innovations which physicians cannot entirely master.

Involuntary errors must not lead to the inhibition of doctors from the creative effort of experimenting with new methods or remedies, as this would result in the physicians' passivity and would certainly be contrary to the patients' best interest.

The truth is that not all physicians have the same possibilities to instruct themselves, not all have access to specialized publications, but the requirements of good practice also apply to those who do not benefit from these advantages. If, however, the practitioner consciously strays from these recommendations and good practices, he/she must prove the existence of subjective and objective reasons for this conduct.

The mechanism of the medical contract

A. The Law no. 95/2006 and the Code of Medical Deontology

On the *first phase*, which may be longer or shorter, the patient addresses the physician with the request of being informed and, possibly, cared for. This request is often vague and does not have the meaning of a consent generating obligations. It is based on the patient's trust in their doctor. The Code of Medical Deontology stipulates, in art. 21, that the physician may not treat a patient without a prior, personal and direct medical examination. Only in exceptional cases of emergency or in cases of "force majeure" (disease occurring on ships in motion, on airplanes, or inaccessible places), will indications of treatment be given via telecommunication. According to art. 24 from the same code, if, following the examination or in the course of treatment, the physician concludes that he/she does not possess enough knowledge or experience to provide adequate care, he/she shall request to consult, by any means, other specialists or shall direct the patient to them.

On the other hand, the physician's independence and freedom to consent to a contractual engagement, in the sense of medical intervention, is considerably limited.

At the same time, the patient's obligation to pay fees is not the counter performance of the obligation to provide care.

On the *second phase*, the patient consents to be subject to a treatment.

The patient's consent is of a particular nature. It must be elicited in a personalized manner and, in all cases, it takes the form of a will which is neither

spontaneous, nor free. The consent depends, undoubtedly, on the information obtained from the patient by the physician, to the extent where the patient understood this information, but also on the fears tormenting the patient, on his/her vulnerability, accentuated by suffering and fear.

Art. 649 of the *Law no. 95/2006* stipulates that, in order for the patient to be subject to potentially risky methods of prevention, diagnosis and treatment, after having received explanations from the physician, the dentist, the nurse/midwife, according to the provisions of par. (2) and (3), he/she is requested to give his/her written consent.

In obtaining the patient's written consent, the above-mentioned medical staff has the duty to provide the patient with information at a scientific level that is reasonable for the patient's power of understanding (par. (2)).

In order for the patient to consent to the medical intervention, he/she must meet three requirements:

- a) have the capacity to understand what the physician tells him/her;
- b) have the capacity to discern and, if applicable, opt in favor of an alternative;
- c) have the capacity to express their will on the intervention proposed by the physician. In other words, the patient must understand and manifest his/her will on the medical intervention.

The information must contain: the diagnosis, the nature and purpose of treatment, the risks and consequences of the proposed treatment, the viable treatment alternatives, their risks and consequences, the prognosis of the disease without application of the treatment.

Thus it may be concluded, in virtue of the provisions of art. 649 and succeeding articles in the *Law no. 95/2006*, that neither the information, nor the consent shall be pre-printed and drafted in general terms, but they will be personalized, in order not to trivialize the legal norm and its purpose, and, first of all, the patient's rights.

B. The application norm for the *Law no. 95/2006*. Mockery as a national sport

It is with great regret and disappointment that we find that the Methodological Norms for applying the *Law no. 95/2006* have trivialized the text of art. 649 of the law, a phenomenon which can also be found in other fields of activity, not only in medicine. The habit of reading only thinner texts, under the pretext of saving time, is well known. But the filiform variant of the law, comprised in these methodological norms is particularly dangerous for medical practice and evidently prejudices the patients' rights.

Thus, in chapter II, dedicated to the patient's informed consent, the

methodological norms stipulate, in art. 8, that the patient's written consent, necessary according to art. 649 in the *Law no. 95/2006*, with its subsequent amendments, must contain at least the following elements:

- a) the last name, first name and domicile or, depending on the case, residence of the patient;
- b) the medical act to which he/she will be subject;
- c) the brief description of information provided by the physician, dentist, nurse/midwife;
- d) the unequivocally expressed consent for the performance of the medical act;
- e) the signature and date of the expression of consent.

We observe that decisive aspects were omitted from art. 649, such as, for example: the diagnosis communicated to the patient, the nature and purpose of treatment, the risks and consequences of the proposed treatment, the viable alternatives of treatment, their risks and consequences, the prognostic of the disease without application of the treatment.

C. The patient's right to a personalized information

By removing these essential elements from the personalized information communicated to the patient beforehand, his/her consent is evidently vitiated by error or even deception by reticence (Ogien 2009: 57). The specific nature of the patient's consent is also expressed in the possibility of it being retracted at any moment.

For this reason, it is a consent that is devoid of legal engagement.

A disease is more than an illness or suffering for the patient, it is an experience that he/she undergoes. His/her consent is not free because he/she is under the pressure of suffering, of the desire to survive, of the disastrous consequences of illness on his/her family, profession etc. This is why the presence of the patient's written consent does not count as a contract in itself, either.

The French jurisprudence established that the failure to adequately inform the patient is a detriment to the latter. Even if the risk is exceptional, for example, the risk of drug toxicity, the physician had to inform him/her, and by not doing so he/she is liable for the damage undergone by the patient (The French Court de Cassation 1999: 250). Without this information of the patient, his/her consent will not be informed. Failure to comply with this obligation is a grave infringement of the patient's rights. Therefore, the obligation to inform stems from the essential quality of the respect for the human person and its inherent rights.

Since the patient is the beneficiary of the right to have his/her dignity

respected, he/she must be considered as an interlocutor with full rights, capable of understanding the information and of using it to give his/her consent. As a rule, the patient and the physician adopt the decisions regarding the patient's health together. After having informed the patient, the physician must respect his/her will. If the patient's will is to refuse or cease all medical treatment, and this would endanger his/her life, the physician will have to use all means to convince the patient to accept the treatment. To this end, the physician might request support from another physician. In all situations, the patient will have to reiterate his/her decision after a reasonable while. These episodes shall be noted in the patient's medical file. No medical act can be practiced without the person's free and informed consent, and this consent may be retracted at any moment.

Jurisprudence has established the span of the obligation to inform and of the evidence as to the latter. The information must be clear, honest and appropriate. Clear information is that which the patient can understand; honest information is that which does not hide anything intentionally, and appropriate information is that which adapts to the specificity of the individual's condition and does not have a generic character.

The information contains risks that are inherent to medical care, especially for those that are susceptible to be the object of liability based on proven guilt. The content of this obligation to inform has been gradually and continually enlarged, first by the contribution of jurisprudence, and then through legal norms. If, initially, it was believed that information must refer to grave risks, it subsequently extended to grave risks stemming from suggested investigations and care, even if risks only occur in exceptional cases, and, at present, the information is expected to refer also to all of the operation's inconveniences.

The legal nature of medical contracts

The physician's action (Turcu 2010: 178-183) has two components: 1) diagnosis and recommendation; 2) medical caregiving.

The physician's obligation is qualified in the science of law as an obligation of means, which is distinguished from the obligation of result.

Jurisprudence tends to attribute to the patient the burden of the proof of detriment, guilt and causality relation, especially in those situations in which both the cause and the detriment remain uncertain or even unknown.

By its very object, obligations of means and those of result are mutually exclusive.

In the case of an obligation of means, the physician will do what he/she

must do, without promising a desired outcome (Le Tourneau 2006: 735). He/she will act competently, diligently and conscientiously.

Even the best of physicians, possessing the latest scientific information in the field and applying high-end investigation and treatment techniques, will not always be able to avoid the patient's death, just as no lawyer can guarantee that a trial will be won.

Conversely, an obligation of results focuses on the success of the intervention, on obtaining the expected outcome. Thus, for example, the obligation of a center for blood transfusion is an obligation of results ((Le Tourneau 2006: 734).

Also differently is defined the failure to carry out the two categories of obligations.

For the physician and the rest of the medical staff, the obligation of means is not carried out whenever the procedures and techniques employed were either inappropriate, or incorrectly applied. The terms that are used in such situations are incompetence, awkwardness, unskillfulness, negligence or imprudence.

The failure to carry out an obligation of result is evidenced simply by the failure to reach the expected purpose.

In the case of an obligation of means, the burden of proof for the physician's failure to carry out the obligation falls on the patient. He/she will have to prove that the physician was unskillful, negligent etc. It is a very difficult task. Conversely, in the case of an obligation of result, it is easier for the patient to prove that the expected result was not reached, whereas the physician must prove that the failure to reach the expected result was due to an external cause, which cannot be imputed to him/her. The science of law has yet to identify a satisfactory and unanimously accepted criterion of distinction between the obligation of means and the obligation of result. Nevertheless, the list of obligations of means has not ceased to shrink.

Not any medical error can be constituted as guilt and not any detriment is repairable. The physician's civil liability is generally based on the proof of a fault that was committed.

Cases of civil liability based on the presence or absence of guilt from the physician

To exemplify, we shall present three cases of civil liability based on the presence or absence of guilt from the physician.

The first case, for which the decision no. 6 of January 7, 1997 (Bull. civ. 1 no 6) was pronounced, occurred in the following circumstances of fact. Patient

J.P. manifested a simple discomfort on the left arm, caused by the compression of vascular-nervous elements in the thoraco-brachial outlet and underwent surgery, performed by surgeon M. Y., consisting of the resection of the first rib on the left and the release of the vascular-nervous pack of the upper limb.

When the first rib was subject to posterior sectioning by use of an extremely hard and sharp instrument, in accordance with the density of the rib, the left sub-clavicular artery, which is in contact with this rib, was injured. The consequence was a massive hemorrhage and the deactivation of the cardiac pump, and the patient died.

The court of the first instance pronounced the surgeon guilty, believing him to have proven himself awkward, by perforating the sub-clavicular artery.

The court of appeal, on the second instance, although it found that during the surgeon's intervention the artery was injured, and the consecutive hemorrhage caused the death, concluded that the surgeon did not commit any blamable or inadmissible awkwardness, and that the patient's death, as a consequence of the artery being injured, was caused by an exceptional and, therefore, unpredictable complication.

We remark here a surprising distinction that the decision of the court of appeal made between ordinary awkwardness and inadmissible or blamable, that is, imputable awkwardness.

In this case, the surgery was extremely difficult and entailed a predicted risk which was, unfortunately, fulfilled. The hardness of the rib that had to be sectioned involved an energetic, forceful action; the instrument used for sectioning was extremely hard and sharp, that is, appropriate to the task of sectioning; the artery was in contact with the rib and was of an extreme fragility.

The case raises numerous questions as to the logical mechanism of the decision of the court of appeal.

Is the surgeon automatically responsible, without a necessity for the court to establish whether his deed, albeit not blamable, was the cause of detriment?

Is it possible to state that the physician disregarded his contractual obligations because the particular difficulty of intervention forbade all failure?

Must the surgeon be condemned only because he has certain obligation with respect to the patient's health?

In *the second case*, on which the French Court of Cassation, civil section I, pronounced itself on February 25, 1997, the patient underwent cardio-vascular surgery.

In order to perform the intervention, the surgeon introduced an intra-aortic counterpulsation balloon pump in the patient's body, which he then removed, and the patient did not survive the intervention.

The French Court of Cassation concluded that introducing the device in the patient's body was an obligation of means. The technique used by the surgeon was the most recommendable one, according to the scientific data of the time. The device did not have any malfunctions and was verified before use. No awkwardness was committed when the balloon pump was introduced and removed, respectively. The intervention was conscientious, scrupulous and in accordance to the scientific data of the time.

Consequently, the surgeon did not commit any fault in the medical act.

The third case was solved by the same court through the decision of November 8, 2000 (Bull. Civ. 1, no. 287). The merit of this decision is that of having emitted the principle according to which repairing the consequences of a random therapeutic factor did not pertain to the field of the physician's obligations to the patient, based on the contract.

This principle is a topical one because art. 643 par. (2) let. a) of the *Law no. 95/2006* stipulates that the medical staff is not responsible for the detriment caused in exercising their profession:

a) when it is due to work conditions, inadequate diagnosis and treatment equipment, nosocomial infections, adverse effects, generally accepted complications and risks associated with the investigation and treatment method, hidden flaws of sanitary materials, medical equipments and devices, medical and sanitary substances employed;

b) when he/she acts in good faith in emergency situations, in compliance with the competence bestowed upon him/her.

The facts were as follows.

Patient M.Y., suffering from hydrocephaly, underwent surgery, performed by neurosurgeon M.X.

The intervention consisted of diverting the cerebrospinal fluid by lumbar-peritoneal shunt. Immediately after the intervention, the patient suffered an irreversible paralysis of the lower limbs, associated to urinary and anal incontinence.

The court of appeal concluded in this case that the patient's post-surgery state resulted from a spontaneous infarction of the medullar cone, directly imputable to the surgery, any guilt from the neurosurgeon being excluded.

However, in the juridical logic of the court of appeal, the physician was obligated to repair the detriment stemming from the random therapeutic factor, because a physician is bound by a contractual obligation of *safety* since, regardless of whether a fault was committed or not, *on the occasion* of performing the intervention, he caused a detriment to the patient's physical or mental integrity.

This detriment possesses the following characteristics:

- it is not connected to the failure of medical care to the result of the investigation;
- it is not connected to the known history of the patient;
- it does not originate in a fact that is detachable from the medical act.

Nevertheless, since without the medical act that was performed, this detriment would not have occurred, it appears as being purely accidental.

The French Court of Cassation annulled the decision of the court of appeal and pronounced that the neurosurgeon was not responsible, since the detriment was the consequence of an accidental risk inherent medical act, which could not be controlled, and the repairing of its consequences was not among the physician's contractual obligations.

If the physician's obligation is an obligation of means, this means that he/she is exonerated from liability whenever an accidental risk occurs, inherent to the medical act and which cannot be controlled. This risk is also called therapeutic accident. One may indicate, as examples of such therapeutic accidents, iatrogenic artifacts or nosocomial infections. The burden of compensating for the detriment in such situations is on the insurance agency, and not on the physician, as it also results from the text quote in art. 643 par. (2) let. a) of the *Law no. 95/2006*.

Grave medical error and simple medical error

In order to establish the liability of the public hospital service for medical acts which caused detriment to the patients, French jurisprudence underwent an evolution from the requirement of grave error to medical error pure and simple, which represented a unification of the medical error regime towards a unique error concept. The illustrious clinician Corrigan, quoted by *D. Dumitraşcu* in quoted works, p. 44, said: "The trouble with most physicians is not that they do not know as much as they should know, but that they do not see everything", and the great clinician Chauffard, quoted by the same author, maintained that "a physician may err by ignorance, but he must not err by negligence". A Belgian jurist expressed his impression that medical liability somewhat escaped jurists, for two equally wrong reasons: 1) the faith of the great public in the physician's omnipotence, nurtured by the immense and media-covered progresses of medicine; 2) youth tending to deny illness, aging and death, although these are natural phenomena. As soon as one of these natural phenomena occurs, a tendency arises to blame the one believed to be all-powerful, the physician.

(Vilanova 2008 : 31). A French lawyer, who was also a doctor of medicine, duly concluded as follows: "as long as physicians fail to understand that magistrates demand to understand medicine, know their problems and see before them other sorts of people than those who repeat 'I did not do anything' or 'it is not me, but another', we should not be surprised that solutions are chosen for them and that these solutions are negative; they only have themselves to blame for it." (Lubrano-Lavadera 46).

The opinion of a neurosurgeon on the influence of jurisprudential evolution regarding medical practice is that it is headed in the right direction, because it makes physicians be more aware of the quality of their act. There are also situations in which the impact has perverse effects, especially as regards the patient's information. It is well-known that the demand of giving an infinite list of possible complications is impossible to begin with and negatively alters the physician-patient relationship. This demand may incite physicians into burying themselves in extremely voluminous documents which, however, do not provide veritable information.

The physician's decision must always be oriented to the benefit of the patient, even if it always implies an analysis of risks that are inherent to any medical intervention. The physician has a contractual obligation to provide conscientious, attentive care to patient, in accordance with scientific data. The physician's civil liability is not necessarily intentional; it may also consist of negligence, imprudence or error. At the same time, imprudence or negligence, as well as inattentiveness, cannot engage the physician's civil liability unless they reflect an indubitable ignorance of his duty (Administrative Court of Luxembourg 1972: 189). Apart from negligence or imprudence, which may occur to any person, the physician does not respond of the detrimental consequences of his/her acts, whether this is about the care being provided or only a diagnosis without treatment. Imprudence, inattentiveness or negligence is imputed only if they reflect an indubitable ignorance of his/her obligations (Administrative Court of Luxembourg 1967: 190). Any error, including failure to perform an act engages the physician's liability as soon as its existence was established with certainty (Administrative Court of Luxembourg 1972: 192). The physician will not be held liable for the detrimental consequences of a medical act if the latter was performed in compliance with scientific regulations, but caused damage on the patient (Liège Court of Appeal 2004: 190).

In order to establish medical error, the physician's behavior is appraised abstractedly, by relating to the attitude that another physician, of comparable training and professional experience, would have adopted in a given situation, under similar circumstances, understanding that the importance of the physician's traineeship and degree of specialization only serves to lift the

threshold of prudence and attention expected from this physician (Luxembourg Court of Appeal 2000: 133). A guilty negligence is committed, in causal relationship with the detriment incurred by the patient, when, after a flawless surgery, the patient is not given appropriate medical care. If the physician abandoned all surveillance of the patient when the latter needed most attention, he/she may be deemed guilty. The need to intervene in favor of another patient did not prevent the physician from ensuring, in a different way or through another person, the continuation of this surveillance (Mons Court of Appeal 1987: 195). In medical emergencies, responsibility reaches its maximum. The circumstances in which the medical act had to be performed in an emergency service, under less favorable conditions, is irrelevant for the assessment of guilt, since it does not have to have repercussions on the quality of medical care in those working settings afforded by the polyclinic (Luxembourg Court of Appeal 1991: 134). The physician must, as a rule, prefer the most secure and efficient treatment, as compared to a more risky method (Court of Antwerp 1994: 134). A medical act is not justified unless the operation is balanced out by the expected outcome (Court of Antwerp 1993 134). The physician cannot afford to postpone a decision, and his/her memory is the library that he/she consults spontaneously. If a computer may aid him/her, he/she may not, at any rate, share responsibility with the former. Among the easements of current medicine, characterized by the explosion of scientific information, is iatrogeny. The proliferation of medications led to threatening number of adverse reactions.

Renouncing the condition of grave error as a premise for liability was marked by the decision of the State Council of France on April 10, 1992, in the case of spouses V (CE 1992: 507).

On May 9, 1979, a few days before the predictable birth, Mrs. V was hospitalized for cesarean section under peridural anesthesia. During the intervention, a few abrupt drops in blood pressure occurred, as well as a half-hour cardiac arrest. After on-the-spot reanimation, she was taken to the reanimation service in Rouen, where she remained hospitalized until July 4, 1979, that is, for almost two months. After being released from hospital, she was left with important neurological and psychological disorders, as a consequence of the cardiac arrest that occurred during the surgery. Apart from the risk of arterial hypotension, related to peridural anesthesia, the expertise ordered by the Administrative Court of Rouen also found that the cesarean section performed on Mrs. V entailed a well-known risk of hemorrhage, susceptible of causing hypotension and a drop in heart rate, due to the *praevia* placenta highlighted by the ultrasound scan. The administrative court considered a series of errors characterizing erroneous behavior. Before the intervention, the anesthetist administered the patient an excessive dose of a hypotensor. Half an hour later, an

abrupt drop in blood pressure occurred, accompanied by cardiac disorder and nausea. Still, the practitioner administered the anesthetic product with a hypotensive effect and the second drop in blood pressure was produced. After the cesarean section and birth, the third such drop occurred. The patient was then given defrosted plasma, which was inadequately re-heated. Strong pain and cardiac arrest were the immediate consequences. On these deeds, the administrative court concluded, according to a constant jurisprudence, that no grave error was committed and refused to engage the liability of the public hospital service for the medical act.

The Plenum of the State Council decided, on April 10, 1992 that the errors committed, which were the cause of the accident incurred by Mrs. V, constituted a medical error likely to engage the hospital's liability. Thus, the State Council of France abandoned the requirement of grave error, which had been necessary for engaging the liability of the public hospital service. At the same time, the prior distinction between simple error and grave error was erased.

This distinction was a subtle one. For detriment caused by defective organization or service malfunctioning, or by faulty management of non-medical services, simple error was sufficient for engaging hospital liability.

On the contrary, detriment caused by a faulty performance of medical or surgical care required the evidence of grave error in order to engage hospital liability.

Acts of medical care, according to a decision by the State Council of June 26, 1959, are those acts which have a current character: injections, perfusions, massages and all other acts likely to be performed by auxiliary medical staff. Therefore, the distinction was operated between organization and functioning (simple error) and medical or surgical acts (grave error).

Simple error was considered in the case of the hospital failing to carry out one of its duties:

- insufficient staff or material means;
- delays in managing cares;
- misuse of materials;
- inadequate surveillance;
- failure to inform the patient, including on financial aspects.

For medical acts, administrative courts demanded evidence of grave error.

This grave error had an abnormal character, assessed by the court in the concrete circumstances of the case. For example, misdiagnosis was considered a grave error, as well as misprescription of drugs, inappropriate choice of therapy or examination, treatment and care, or flawed surgical interventions. In the case

of nosocomial infections, guilt was presumed.

The decision pronounced in the case of spouses V. unified the liability regime, re-establishing the equality of treatment between victims and between the clients of private clinics and those of public clinics.

Law 2002-303 of March 4, 2002 unified, in principle, the liability of error in sanitary matters, so that, subsequent to this law, a simple error is sufficient to engage the liability of the author, whether healthcare professional, public hospital or private hospital. However, jurisprudence marked a certain survival of the idea of grave error, in the sense that, in some cases, grave error is invariable, and in others it is subject to assessment from the court in the concrete circumstance of the case.

In the former situation are those activities for which the court does not verify the concrete circumstances in order to qualify them as grave errors, so that, in such situations, it has a residual character (penitentiary services, ambulance services and firefighting).

Police services are held liable for simple error when their bureaucratic activity is involved.

Abandoning the idea of grave error is a simplification favorable to the victims.

The physician's personal liability is engaged by a wide range of errors, which can nevertheless be classified into technical medical errors and human medical errors.

Physicians are held liable by the obligation to keep their professional knowledge up to date throughout their lifetimes. This necessity for continuous professional training is based both on the relativity of continuously changing scientific knowledge, and on the physician's obligation to utilize the most appropriate means for giving care to the patient. In other words, the physician's obligation is a medical competency. The duty of being competent regards both the establishment of a diagnosis and the choice of treatment

In two decisions pronounced by the French Court of Cassation on May 23, 2000 (Cass. Ire. Civ. 2000: 100), the concept of technical error was introduced. In the first case, the patient's claim was rejected, as it was established that the physicians employed all necessary means, and the complication whose victim the patient was resulted from a non-imputable surgical act. In the second case, the physician was made responsible although he proved that the abnormal trajectory of the patient's nerve, which he sectioned, could not have been detected by any means available to science. The Court of Cassation decided, in this case, that the simple fact of touching an organ or tissue, under conditions where this touch was not necessary in order to perform the medical intervention, is a technical error if it is not established that the organ

or tissue had an anomaly that made it inevitable for it to be touched.

By this decision, the French Court of Cassation expressed a very broad view on medical error, as mere awkwardness may engage the physician's liability. The judges deemed that in this particular field of work, where the success of the medical act is based on the greater or lesser ability of the physician, depending on the complexity of this intervention, a solid technique almost entirely limited the random factor. *Randomness* is the determining criterion of error. If we accept that the patient is entitled to expect an exemplary precision from the part of the surgeon, whose primary competence is the operating technique, it is illusory to believe that the best technique could eliminate that *randomness* entirely, the latter being intrinsic the medical activity itself. Even if the technique is perfect, reality proves that the particularities of a human body can sometimes justify awkwardness.

This conclusion, of maximum importance for jurisprudence, did not emerge on a ground with no precedents. In 1997, the same Court of Cassation established the surgeon's responsibility for a wound he caused on the patient, raising concern among physicians on the possibility of liability without guilt, and a few months later, another decision stated that any awkwardness of the surgeon engages his/her liability. On October 13, 1999, the same court proclaimed the principle according to which any awkwardness of the surgeon engages his/her liability.

Therefore, the two decisions of May 23, 2000 did not establish an objective liability, but they did establish a presumption of guilt if an organ or a tissue is touched, although it was supposed to remain extraneous to the operation.

Over the following period, the *random* factor reappeared in the jurisprudence of the Court of Cassation. Thus, in a decision of November 29, 2005, it was established that there is also an inherent risk to the technique being employed, which cannot be imputed to the practitioner. More recently, on September 18, 2008, the Court of cassation qualified it as an inherent risk to the intervention, which does not engage the physician's liability in the case of a surgeon who injures a nerve. On the same day, the same court, in another case, seems to have returned to the idea of presumption of guilt. Consequently, at present there is no clear position as to the assessment of technical error by the practitioner.

As regards medical humanism, the term was introduced from morals and it stands for the intimate moral preoccupation in the exercise of medicine, as expressed by Hippocrates.

The main ethical obligations whose infringement may engage the recognition of the practitioner's guilt refers to medical secrecy, the duty to

inform and the patient's consent. If the physician does not carry out his/her obligation of humanism and this omission causes detriment to the patient, the physician engages his/her personal liability.

A physician detected a disease in a patient and foresaw a long-term treatment, which involved inserting a vesical catheter. The patient refused the treatment, and the physician recorded this refusal. As the patient's state aggravated, the physician performed an enteroplasty. After the intervention, the patient complained of certain disorders and asked for compensation in civil courts, invoking the physician's personal liability. The court of appeal rejected his action, on grounds that he refused to submit to the initial treatment and that this refusal deprived him of the chance of avoiding the mutilating operation. The Court of Cassation admitted the recourse, as the court of appeal did not verify if the patient was informed by the physician on the grave risks of opposing the foreseen treatment, which would have meant that the patient had to make an option based on the full knowledge of all aspects, as a consequence of being informed by the physician.

The patient's consent must be obtained by any physician, for any surgery or act of medical care. Respect for this consent is essential, and it must be freely expressed and informed. It goes without saying that this consent cannot be validly obtained if any pressures are exerted on the patient. This consent is the result of prior, sufficiently accurate and reliable information, provided by the physician. Information also contains data regarding the risks of treatment, both the normally predictable, and the exceptional ones, as results from the decisions of the French Court of Cassation of October 7, 1998. As the patient is free to choose between the possible solutions of suggested medical care, so can he/she refuse not only any of the suggested solutions, but even listening to the information provided by the physician. However, it would be wrong to believe that if the physician conforms to the patient's refusal, he/she no longer has to insist. The moral duty of the physician is to convince the patient to accept the suggested medical care.

Conclusions

A better understanding is necessary between the medical world and the judiciary one, based on reciprocal confidence and knowledge. Physicians must be better informed on the law, whereas magistrates and lawyers must acquire more profound knowledge of the issues of medical responsibility.

As long as physicians are unaware of the fact that lawyers and magistrates wish to know about medicine and to understand their problems, they do not have the right to reproach anyone that other choose solutions for them and that these solutions are sometimes unfavorable.

Finally, to paraphrase Malraux, we dare say that the 21st century will be the century of HUMAN and ENVIRONMENTAL protection or will not be.

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