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Aspects of Contractual Relations in Healthcare

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Abstract

The article aims to determine the scope and limitations of ethical duties and legal responsibilities of the medical practitioner within the professional-patient relationship (PPR), identify shortcomings of the legal framework and gaps in ethical principles, and propose solutions to them.

It argues that in private law the healthcare shares many similarities with contractual law; therefore, the legal basis for physician-patient relationship is the special legal capacity of the contract parties and their free will, but ethical basis – their good faith.

One important finding is that physician right and obligation to refuse is an aspect of patient safety and quality of healthcare and has to be acknowledged by ethics and stipulated by law. In addition, it detects that medical professionals are ethically and legally vulnerable and need special protection. All this calls to carving out the proper place of medical practitioners' professional autonomy and freedom in current legal regulation.

Used materials include literature and scientific publications on clinical and research bioethics, contractual and medical law, regulatory enactments, court judgments. Methods

used in the study include descriptive, analysis, synthesis, dogmatic, induction and deduction; legal interpretation methods such as grammatical and systemic.

Keywords: patient's rights, physician's rights, physician's autonomy, professional-patient relationship, right to refuse, medical liability.

Introduction

Delivering safe and qualitative healthcare currently faces unprecedented challenges globally. There is a rising involvement of the criminal law in investigation of medical cases. On the ground of the medical litigation pandemic the informed consent doctrine has thriven; nevertheless, physicians face enormous pressure in fear of being sued or prosecuted. Attempts to share responsibility for the treatment outcome and to ameliorate the litigation burden led to the development of ethically ambiguous patient contracts (e.g. suicide prevention contracts, contracts promising not to litigate or post defamatory comments on the Internet).

While the patients as vulnerable party enjoy the widespread protection of their rights, the protection of physicians is not developed yet; that has resulted in them being "captive helpers". Deception and abuse of the professional by the malingers seems to be *terra incognita* to ethicists, as well as delivering healthcare in conflicting legal realtionship.

Definition of the legal nature of the professional-patient relationship (PPR) varies: some bioethicists hold that it is a contractual or fiduciary relationship, while others believe that it is a relationship based on the patient's autonomy (Hu, 2016).

When taking PPR as a contract, a set of certain elements of a legally enforceable contract has to be established – the object is legal, the parties have the capacity to enter into a contract, the participants express their intent that originated from their own free will, the agreement on the object is achieved.

According to the doctrine and the Cilvil Law of Latvia, rights shall be exercised and duties performed in good faith (Civil Law, Section 1). In order for a transaction to have legal force, it is necessary that the parties to the transaction have legal capacity and the capacity to act for making such transaction; otherwise the transaction is void (Section 1405). For a lawful transaction to be in force it shall not suffice for the participants to express their intent, but it is also necessary for the intent to originate from their own free will, without mistake, fraud or duress (Section 1440).

To determine the scope and limitations of ethical duties and legal responsibilities of the medical practitioner, the authors scrutinise the PPR from the civil law perspective.

Used materials include literature and scientific publications on clinical and research bioethics, contractual and medical law, regulatory enactments, court judgments. Methods used in the study include descriptive, analysis, synthesis, dogmatic, induction and deduction; legal interpretation methods such as grammatical and systemic.

1 Professional-Patient Relationship as Legally Forceable Contractual Relationship – Object of the Contract, Parties, Their Will, Duties and Rights

In the case of medical treatment, the object of the contract is healthcare (the process of the application of health technologies) to assess, maintain or restore the patient's state of health. The Court of Justice of the European Union (CJEU) in *Christoph-Dornier* judgment provides a definition of the medical care – services have as its purpose the diagnosis, treatment, and, in so far as possible, cure of diseases or health disorders (CJEU, 2003, Case C-45/01).

Not every health-related intervention is concidered to be healthcare – according to the CJEU judgment in line with the EU VAT law, aesthetic medicine services (plastic surgery or cosmetic treatment) without a purpose to diagnose, treat or cure diseases or health disorders or to protect, maintain or restore human health are not "medical care" (CJEU Judgment, Case C-91/12, 2013). Services consisting of medical examinations and the drafting of expert medical reports and certificates do not provide medical care in terms of EU VAT law as well (CJEU Judgment, Case C-212/01, 2003).

Healthcare professionals or practitioners and medical institutions are subjects of private law – natural persons and legal entities. They possess a special legal capacity – the right to engage in medical treatment and provide healthcare services (they are qualified to do so after registration in the state medical intstitutions' and practitioner's registers). The obligation to adhere to a certain standard of care is ensured by the formal recognition via licensing and accreditation of healthcare professionals and healthcare institutions in almost all EU countries (European Commission, 2018). Medical practitioners are obliged to check patients' capacity – decisional and performative or executive capacity (Naik et al., 2009) – before initiation of treatment, during the treatment and at termination of PPR.

Only competent patient can be an active participant of the treatment process, otherwise the informed consent must be obtained from the surrogate decision maker (Grisso & Appelbaum, 1998). In the opinion of the authors of this study, it shares similarities with the contractual competency assessment in contract law, required in certain types of transactions. Excluding emergency situations, failure to obtain a patient's valid consent constitutes criminal assault or battery; resp., treatment without consent is a criminal assault (Russell, 2009). Duty to inform and assess the patient's competency and, if needed, to involve a representative is stipulated by the Law on the Rights of Patients (1) part of Section 7 (Right of Another Person to Agree to Medical Treatment or to Refuse from It). Thus, in healthcare one of the contract parties – namely, the professionals – is legally obliged to ensure legality of the contract-to-be; otherwise, the contract has to be postponed and efforts to restore or improve the patient capacity have to be taken (Grisso & Appelbaum, 1998).

However, zero harm in healthcare is still a goal, pitfalls and unfavourable treatment outcomes do happen and that is where the so-called duty of candour becomes relevant, ensuring that patients harmed by a healthcare service are informed of the fact, and that an appropriate remedy is offered whether or not a complaint has been made or a question asked about it (Francis, 2013).

The concept of candour is mainly based on the foundational virtue of honesty or truthfulness (Gardiner & al, 2022). The duty of candour has been enacted at the legislative level in England and Wales. In November 2014, Regulation 20: Duty of Candour of the Health and Social Care Act 2008 (Regulated Activities) came into effect and it was the first legislation of its kind in the world (Wijesuriya & Walker, 2017). In the EU, the principles of candour and patient right to qualitative healthcare are enacted via the European Parliament resolution on safer healthcare in Europe 2014/2207(INI), among other things, through developing reporting and learning systems. In Latvia, every medical institution is ought to establish and maintain an internal patient safety reporting-learning system that provides the collection and analysis of on patient safety incidents to prevent their recurrence (Cabinet Regulations "Regarding Mandatory Requirements for Medical Treatment Institutions and Their Structural Units", 2009). For the time being, this innovation is far from being successful.

Physicians possess their professional rights also:

> "*In order to advise and act, the doctor must have full professional freedom and the technical and moral conditions allowing him or her to act with complete independence. The patient must be informed if these conditions have not been fulfilled.*" (Principles of European medical ethics, 1987)

> "*Physicians must have the professional freedom to care for their patients without interference. The exercise of the physician's professional judgment and discretion in making clinical and ethical decisions in the care and treatment of patients must be preserved and protected. Physicians must have the professional independence to represent and defend the health needs of patients against all who would deny or restrict needed care for those who are sick or injured.*" (Declaration of physician independence and professional freedom, 1986)

> "*A physician has the right to the legal protection of his professional independence, both in times of war and peace.*" (Principles of European medical ethics, 1987)

The law of Latvia comprises a statement on the professional freedom of a physician:

> "*A doctor shall be independent in his or her professional activities. All doctors have the right to provide an opinion on the state of health and treatment of a patient.*" (Medical Treatment Law, Section 38, 1997)

The concept of physician autonomy, independence, its scope and protection is not well developed. In the field of legislation, this protection most often arises in the context of abortion and medical assistance in dying (the right of a physicians to assert their

own self-determination interest by refusing to provide requested care – the so-called conscientious objection) (Wicclair, 2016).

Professional autonomy is a concept with many meanings, interpretations, and applications (Dupuis, 2000). The main concept of individual professional clinical independence stands for the freedom of physicians to deliver healthcare according to their own clinical judgment and ethics, without interference by public authority, insurance companies, policymakers, society, etc. In terms of contractual law, professional autonomy stands for the free access to resources (information, equipment, time, advice – generally speaking, "technical conditions") and psychological conditions ("moral conditions") essential to execute the contract – to construct a judgment and conclusion, and to proceed with a treatment plan proposal.

It corresponds the statement of André Tunc, Professor at the Faculty of Law and Economic Sciences of the University of Paris, who emphasised that the assessment of circumstances and resources is essential to establish the fact of negligence:

> "*.. for such specific circumstances as the urgency of the situation, the impossibility of transportation to a hospital, the scantiness or complete lack of drugs, instruments or disinfectants, and even the physician's frame of mind as affected by the pressure and other stress conditions. Only in the light of all these specific circumstances can it be determined whether or not negligence exists*." (Tunc, 1973)

Hence, professional autonomy can be divided into technical and moral one. To the opinion of the authors of current study, the concept of moral professional autonomy shares many similarities with the free will of the contractors in civil law. The conditions and situations, that preclude a physician from exercising their duties and fulfilling the contractual obligations, are: patient aggression (verbal, physical, defamation), clash of values, competing legal relationship, conflict of interests, injured physicians' legal consciousness and confidence in legal certainty. It is well known that physicians should avoid conflict of interests (financial or other) that can influence their clinical judgment, prescribing, and treatment decisions (or, if inevitable, at least to disclose it to the patient and colleagues) (Xie & Cong, 2016).

Competing legal relationship (existing or previous) is a reasonable cause to refuse to establish PPR or to terminate it (in a case of necessity the continuity of care has to be provided). For instance, the person directing the criminal proceedings applies for a physician who is a participant in this proceedings soon after the search at a physician's homeplace has been performed and shortly before the interrogation date. As the principle of nonmaleficience can not be guaranteed, it is beneficial for the potential patient to be redirected to another physician.

Describing clash of values, allows to refer to the recent history: during the pandemic a physician's duty to provide care to patients came into conflict with their obligations to protect their families, and their right to protect their own health and refuse to work in hazardous conditions (Davies & Shaul, 2010).

For the time being, the circumstances that exclude criminal liability (e.g., extreme necessity, justifiable professional risk) are not well described in healthcare cases, which can affect legal consciousness of professionals to reduce their legal certainty, discourage them from action in case of necessity, and practice the so-called defensive medicine.

The abovementioned conditions are so common in practice, that it justifies discussion about physician vulnerability (Delgado, 2021). Medical practitioners' professional activity brings their rights at constant violation risk, but their autonomy – at risk of constriction (inability to defence symmetrically in case of claim or defamation, probability to act under extreme necessity condition or undertake justifiable professional risk, act under the condition with the clash of values, conflict of interest or competing legal relationship, candour under the risk of criminal liability).

Therefore, physicians have a right to enjoy their professional autonomy and freedom; it ensures their ability to perform within the PPR and fulfill the contractual obligations. This merits closer attention in medical negligence cases, as only an autonomous and free professional can provide qualitative care and be fully accountable for the performance.

According to the Medical Treatment Law of Latvia, a patient is "*…a person who receives health care services or seeks them*" (Section 1, point 11). The definition of "*health care services*" is not provided, but it can be derived from other definitions, e.g.: "*medical treatment – professional and individual prophylaxis, diagnosis and medical treatment of diseases, medical rehabilitation, and care of patients*" (Section 1, point 1), "*care of patients – part of health care which is directly or indirectly related to the maintenance, promotion, protection and recovery of health of the public, a family or a person*" (Section 1, point 12).

According to the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, a patient "*…means any natural person who seeks to receive or receives healthcare…*"; while healthcare "*…means health services provided by health professionals to patients to assess, maintain or restore their state of health, including the prescription, dispensation and provision of medicinal products and medical devices*". The Directive 2001/83/EC on the Community code relating to medicinal products for human use provides us a notion that those who are non-patients may receive healthcare as well: *"A clinical trial is any systematic study of medicinal products in human subjects whether in patients or non-patient volunteers…"*

Therefore, not everyone, who receives health-related interventions, is a patient – it is determined by the purpose of application of health services and characteristics of a natural person:

1) patients have medical needs that arise from their medically recognised disorder or condition (including medically unexplained symptoms and need for prevention);
2) non-patients – do not have medical needs, do not have the intent to assess, maintain or restore their state of health (their main intent is to contribute to science or other social need).

Thus, it is proposed to detect the patient's (as a natural person) characteristics – objective or external and subjective or internal features (in line with criminal law) and to classify those who apply to medical institutions.

A patient – a person with medical needs who receives the corresponding healthcare or applies for it. This includes both licenced and non-licenced treatment, examination or prevention. The patient enjoys all patients' rights in full and owns patient duties. The physicians own him or her legal and ethical duties. The healthcare is delivered for the patient within the contractual obligations – a contract can be either expressed or implied. Establishing the fact and time of entering into the transaction and therefore iniciation of PPR is crucial in medical negligence claims.

Ethics provides the following definition of the physician-patient relationship fact: "*A patient-physician relationship exists when a physician serves a patient's medical needs*" (American Medical Association [AMA], 2016) and name the patient-physician relationship as "*a relationship of medical need and provision of care*" (Beauchamp & Childress, 2012). Hence, the definition of PPR emphasises that the patient has to possess some medical needs (not financial or social ones). The PPR are not established while assisting those undergoing emergencies in the streets (life-saving care requires just common sense and a reasonable level of skill, not the application of health technologies, regardless of the education of the stranger). After entering the PPR, the patient qualifies his or her patient rights, duties, and responsibilities.

There is a different approach in terms of legally defining and implementing patients' rights in European Union. They can be classiffied:

1) basic individual rights or classic patient rights to self-determination and confidentiality (the rights to consent, right to privacy, information and accessing medical records);
2) consumer based rights – right to choice (second opinion, choice of the provider, quality/safety/timeliness, information about treatment options);
3) procedural rights – right to complain, right to redress, right to participate in clinical decision-making (European Commission, 2018).

Implicitly, after entering into PPR, the patient can enjoy the rest of his or her rights on maternity and sickness insurance (sickness benefit), social services, etc.

There is little consensus among schoolars on definition and scope of patient duties and responsibilities; in general, the moral component of it is "honesty" – by providing a complete medical history to the extent possible, to give the most complete and correct information about health, to cooperate with the treatment plan. As Dan C. English, M.D., from the Center for Clinical Bioethics at Georgetown University, stated, "*Honesty is inarguable. Active engagement in PPR is a reasonable duty…*" (English, 2005).

The authors of the current study understand "active engagement in PPR" as activities that contribute to achieving the goals of care – e.g., adherence to treatment plan, self care, reporting side effects, etc. In Latvia, the patient's duties and responsibilities are listed in the Medical Treatment Law, Section 5, and the Law on the Rights of Patients,

Section 15 (Obligations of Patient). The prohibition of abuse of patient rights is not specially emphasised. In terms of civil law, in a case of unfaurable treatment outcome, the breach of patient obligations can be considered as the concept of contributory negligence (English, 2005). The patient receives healthcare within the treatment process that is constructed according to their medical needs (medical needs is the objective patient's feature), and within the contractual relationship, they perform with the implied covenant of good faith (subjective patient feature – an intent to accomplish the goal of treatment), provides correct and complete information about their health and past medical history.

Healthcare is guided (the appropriate healthcare services and medical technologies are selected and applied) by healthcare professional; but the treatment plan is constructed in order to achieve the patient-set goals. The professional duties in constructing and guiding the treatment process are fiduciary and have to be exercised with good faith, loyalty, care, and bearing in mind vulnerability of the beneficiary (Hall, 2019). On the other hand, it must be admited that in contagious diseases and psychiatric emergencies, the individual goals (subjective patient features) may contradict with the public safety requirements. In these cases, duties of health professionals are guided by public law and deserve a special notion that is beyond the scope of the current article.

The patients are vulnerable – in ethical (Delgado, 2021) and someones in the legal aspect as well (Salm, 2016) – so they enjoy special legal protection. Vulnerability of patients is not a prerequisite, and it does not mean that they cannot be negligent and contribute significantly to bad health outcomes; relative vulnerability does not confer inability to do wrong (Draper & Sorell, 2002); e.g., to malinger, to abuse the right to compensation, etc.

1. A volunteer – a person without medical needs who submit themselves to medical interventions (not healthcare) due to psychological or social reasons: receives plastic surgery or other aesthetical interventions that are not reconstructive or corrective ones; participates in clinical research as a healthy volunteer; undergoes gender reassignment therapy. Before the interventions, the decision making capacity assessment (like risk-weighting and long-term outcome prediction ability) has to be performed with special care (e.g. to minimise regret rates after gender reassignment therapy iniciated in adolescence) and the intent of the person has to be clear.

2. An expertee / evaluee / assessee – the person who receives health check (for administrative puproses or within criminal proceedings, in person or *in absentia*, including *post mortem* examination), as a result of that the eligibilty for certain legal criteria is detected. These health checks are conducted by the request of third parties (state or insurance company) or are the prerequisite for exercising other rights (e.g. right to privilege to drive), the informed consent is not applicable (in criminal proceedings informed refusal of the accused person is even dismissable). During the health check expert-expertee (or evaluator-evaluee) relationship are established (Appelbaum,1997); rights and duties of both parties are limited and strict; the application of healthcare

services is determined by the methodology of the health check procedure. The relationship is ruled by the public law.

3. A client or customer – a person who has medical needs and receives healthcare service or medical interventions that is not part of the treatment plan in the specific institution (e.g., test for vitamin D level, chest Xrays). The person remains in PPR with their general practitioner (GP) or with the referring specialist. The client mainly enjoys their consumer rights (e.g., for safe product). While delivering the service, the professionals also own a client or customer a duty not to do harm by act or omission.

To demonstrate this type of relationship, for the purpose of the curent study, the folllowng cases have been used for reference: M.D. donated blood at The State Blood Donor centre blood donation site at P. Stradins Clinical University Hospital. The screening test turned positive for hepatitis C infection, but M.D. was not informed about it (nor the hospital, neither the State social health agency, which received the notification about the possible reportable disease case, approached M.D.). Some years later, M.D. discovered he had C hepatitis and had subjected his family to the risk of contracting the infection for years. M.D. and his family sued the hospital and the agency (Senāta Administratīvo lietu departamenta spriedums 26.06.2008. lietā nr. SKA-155/2008). As at the moment of blood donation M.D. was not in PPR with any of the hospital staff, the court faced difficulties to detect the legal entity responsible for informing him about test results and treatment opportunities. As a client of the hospital within the private law, at the moment of medical encounter, M.D. had a medical need for a safe blood sampling procedure and precise screening tests. After the screening tests turned positive, M.D. qualified a right not to be harmed with inaction (omission) within the public law on epidemiologic safety. The case demonstrantes the duty of a responsible entity not to harm a person with inaction (omission).

4. A visitor – these are relatives and friends, support persons, stakeholder representatives, journalists, malingers. Persons who approach their GP or psychiatrist for non-healthcare advice or social support are also considered to be visitors. Visitors do not possess medical needs (in the context of the current encounter), their intent is not to reach medical treatment goals or solve personal medically-related issues, but receive some other benefits. It can be concluded that a person, applying to a GP for a disability and work capacity assessment solely, does not request healthcare as such and has to be considered a visitor.

The issue of malingers deserves special attention. Determining that a patient is acting in bad faith is difficult (especially if not falsification, but exaggeration of the existing disorder is performed; in these cases it has to be distinguished from abuse of patient rights) and there is no clear ethical guidance on malinger management since they are identified (Bishop & Chau, 2011). A malinger does not posess patient objective and subjective features (although they can have medical concerns and suffer from psychological discomfort) but has a guilty mental state (*mens rea*).

In a case of malingering, the PPR is not established: a malinger's intent is to receive benefits illegally (seeking drugs, avoiding trial, faked disability-related financial support); they provide false information about their health, intentionally misdirect the contractor about the purpose of the transaction to make the professional use healthcare services and medical technologies; as a contract party their intent is not to achieve the goals of medical treatment – in terms of contract law, authenticity of intent is lacking; according to the law, such a transaction is not in force.

It is extremely challenging to identify malingering in clinical practice – it requires additional tests, prolonged direct observation and obtaining objective data from third parties (the tools normally used by experts); some of the information is not subject to scrutiny (e.g., pain, nausea, anxiety, drug intolerance). On the other hand, detecting malingering brings a risk of potential liability for professionals and institutions (Weiss & Landon, 2017). Hereby, identifying malingering is not a physician's duty. On the contrary, in such situation professional autonomy of the physician is violated and the psysician can not restore it by their own efforts. Hence, in this assymetrical legal situation, the professionals' vulnerability and need for legal protection is evident.

2 Right to Refuse

Under the concept of two-component physician autonomy and vulnerability, obligation of non-maleficence and beneficence, issue of a physician right to refuse to treat a patient, deny access to certain medical services, or even obligation to do it can be discussed. According to medical professor Sarah C. Hull, physicians can ethically refuse to treat patients who are abusive when such treatment falls outside their scope of practice, and when a patient's care comes into conflict with the physician's duties (Hull, 2019).

The authors of the current study partially agree with – if patient autonomy and self-determination rights come into conflict with the physician duty to avoid doing harm, the physician is justified to uphold physician duties by withdrawing certain kinds of medical interventions only, in line with patient medical needs (e.g., refuse to prescribe antibiotics for viral disease), without termination of PPR as such (e.g., continue palliative treatment after denial of medically assisted suicide). In turn, recommendation to apply to another practitioner for specific treatment is not a refuse to treat; in this case, the physician makes their clinical judgment, and referral is part of the proposed treatment plan (or it ensures continuity of care); in some cases and circumstances the situation corresponds the advice in contract law. The authors of this study support professor Hull's statement on violent patients – when physician professional duties and rights come into conflict with the situation and patient demand for care. It is seen as a conflict of interests or moral conditions that violates physician autonomy.

However, the law in Latvia does not provide for the physician a right to refuse elective treatment for other conditions than abortion (conscientious objection) – even

a full load (and therefore a predictable shortage of resources and deteriorated quality of care) does not justify a general practitioner (GP) to refuse registration for a new patient, whether they live in the corresponding district or are next of kin or spouse of the existing patient (Cabinet Regulation No. 555 Procedures for the Organisation of and Payment for Health Care Services, 2018). Only the patient severely abusing their duties to themselves can be excluded from the list of patients of a GP (Medical Treatment Law, Section 42, 1997). Breach of other patient duties is not provided in the law, as well as conflict of interests and other ethical reasons. Thus, the state constricts GPs' technical autonomy and does not provide for the right to protect their moral autonomy.

3 Practical Application of Ethical and Legal Issues – a Case Study

A public electronic mass media journalist A. decided to elucidate the issue of how easy it is to fake disease and receive a sick leave from a GP. He conducted an experiment – approached five GPs in Latvia, complained about back pain, headache and leg weakness, reported problems at work, requested a sick leave, offered a bribe and made audio-recordings without a doctor's consent. Doctors refused the bribe, performed the clinical examination, issued a short-term sick leave, and referred to additional examinations (for a lumbar spine Xrays or to a neurologist).

After broadcasting on national TV in January 2015, the Health Inspectorate performed scrutiny and found violations of the Cabinet Regulation on Procedures for Issuance of Sick-Leave Certificates, as the clinical examinations were not performed in adherence to the "Recommendations for General Practitioners on diagnosis and treatment of low back pain" (2001). Based on the Health Inspectorate's judgment and fines, the National Health Service terminated contractual relations with the GPs involved (as they lost credibility) which led to closure of their surgeries (Rēzeknes tiesu nams, Administratīvā rajona tiesa, 2016. gada 18. februāra spriedums, Lietas Nr. A420250815; Latgales apgabaltiesa, anonimizēts 2015. gada 21. septembra spriedums, Lietas Nr. 112015515; Daugavpils tiesa, 2015. gada 5. jūnija sprieduma noraksts, Lietas Nr. 112015515, Lietas arhīva Nr. 1-0155-15/14).

Legal pitfalls in these cases are obvious: quality of the healthcare assessment was doubtful; as it is well known, in most modern legal systems, criterion of negligence is objective. The standard is that of the "prudent and competent physician" – a physician must not only exercise reasonable care but also attain the standard of a reasonably competent practitioner (Cruz, 2001). In other words, what the conduct of a prudent and competent GP in the given circumstances would have been (the anatomical features, clinical and radiological findings and complaints of the malingerer). The court ignored the principles of contract law as well. The intent of the journalist was to conduct an experiment with GPs without informing study participants. Naturally, such exeperiment shall be considered to be the illegal object of the contract.

Thus, the encounter between journalist A. and GPs lacked elements of lawful contract: the patient was not a patient but a visitor (a malinger, conducting an experiment), the object of the contract was illegal, the contracting parties have not agreed on the object, the physicians were mistaken about the object of the contract and were involved in the contract by fraudulent misrepresentation.

According to the Civil Law of Latvia, "*An impermissible or indecent action, the purpose of which is contrary to religion, laws or moral principles, or which is intended to circumvent the law, may not be the subject-matter of a lawful transaction; such a transaction is void*" (Section 1415) and "*Fraud is the illegal deception of another person for the purpose of inducing him or her to perform acts in contravention to his or her interests or to refrain from such acts*" (Section 1459). Therefore, contracts between journalist A and GPs were void starting from the time it was created (since A has been registered for the appointment). The PPR was not formed, and healthcare was not initiated. All legal effects, which arise from the contract, are void or null: the sick-leave certificates shall be canceled, as well as the Health Inspectorate's judgments and fines.

As it was elucidated above, the law of Latvia does not provide a right to refuse to treat a patient due to conflict of interest, clash of values, or inability to guarantee not doing harm; so physicians remain in the "captive helpers" position and, hypothetically, the victim GPs would be obliged to provide care for journalist A in future (although it would be in A's interests to receive care somewhere else).

Conclusions

Physician-patient relationship share many similarities with civil law (contractual and commertial law). The legal basis for physician-patient relationship as the contractors within the private law is their special legal capacity and their free will, but ethical basis – their good faith.

To fulfill the obligations and to be fully accountable for the outcome, medical practitioners have to enjoy their right to professional autonomy and freedom. Physician right and obligation to refuse is an aspect of patient safety and quality of healthcare and has to be acknowledged by ethics and stipulated by law. Medical profesionals are ethically and legally vulnerable and need legal protection.

Proposal

Amend the Law on the Rights of Patients (2) part of Section 15 (Obligations of Patient) as follows: "If the state of health of the patient allows it, he or she has an obligation to actively participate in medical treatment and to provide the attending physician with *accurate and complete* information within the limits of his or her abilities and knowledge: …".

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