Vilnius University Press

Contents lists available at Vilnius University Press

Teisė
2024, Vol. 131, pp. 126–141

ISSN 1392-1274 eISSN 2424-6050
DOI: https://doi.org/10.15388/Teise.2024.131.9

Negotiorum Gestio: the Element of Emergency in the Doctrine of Informed Consent

Anatoliy A. Lytvynenko

http://orcid.org/0000-0001-7410-5292
Doctor of Legal Sciences,
Lecturer at the Baltic International Academy
Room 216, Lomonosova st. 4/1, Riga, Latvia
E-mail: anat.lytvynenko@gmail.com

Jevgenij Machovenko

https://orcid.org/0000-0003-2930-3526
Professor at the Department of Public Law
Vilnius University Faculty of Law
Doctor of Social Sciences (HP)
Saulėtekio al. 9, Building I, LT-10222 Vilnius, Lithuania
Phone: +370 5 236 61 75
E-mail: jevgenij.machovenko@tf.vu.lt

Tatjana I. Jurkeviča

https://orcid.org/0000-0002-6242-8411
Doctor of Legal Sciences, Associate Professor at
Baltic International Academy
Room 216, Lomonosova st. 4/1, Riga, Latvia
E-mail: advokatu.birojs@inbox.lv

Negotiorum Gestio: the Element of Emergency in the Doctrine of Informed Patient's Consent

Anatoliy A. Lytvynenko

(Baltic International Academy (Latvia))

Jevgenij Machovenko

(Vilnius University (Lithuania))

Tatjana I. Jurkeviča

(Baltic International Academy (Latvia))

Summary. The rule of an obligatory consent of a patient for a medical procedure has its exceptions, one of the most cited of which is a condition of emergency, under which the physician is not under the obligation to seek for the patient's consent, but to provide the treatment, which is strictly necessary upon the physician's best judgment, and will not be liable for an unconsented medical procedure in such case. In many legal cases on the issues regarding consent to medical procedures, the courts expressed the view that consent to medical treatment is a prerequisite to its legitimacy, unless an

Received: 21/01/2024. **Accepted:** 29/04/2024
Copyright © 2024 Anatoliy A. Lytvynenko, Jevgenij Machovenko, Tatjana I. Jurkeviča. Published by Vilnius University Press
This is an Open Access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

emergency occurs and hence it would be impossible to obtain the patient's consent. In some early 20th century cases, the emergency exception was also invoked when patients were unconscious under anesthesia, and the physicians found a serious health impairment during the operation, which differed from the purpose of the previously agreed operation. In this article, the authors have analyzed the exception of emergency within the Roman law concept *negotiorum gestio*, focusing on the details of the legal cases, in which an emergency was invoked, being either alleged, or proved. The authors have also examined the historical legal foundations of the right of physicians to carry out medical treatment (which in some cases includes surgeries), and found that the legal doctrine has no uniform answer to this question, whereas various legal doctrines, including customary law, were historically used to describe these legal foundations.
Keywords: medical law, physician's rights, patient's rights, informed patient's consent, emergency medical care, medical malpractice, *negotiorum gestio*.

Negotiorum gestio: nepaprastosios situacijos elementas informuoto paciento sutikimo doktrinoje

Anatoliy A. Lytvynenko

(Tarptautinė Baltijos akademija (Latvija))

Jevgenij Machovenko

(Vilniaus universitetas (Lietuva))

Tatjana I. Jurkeviča

(Tarptautinė Baltijos akademija (Latvija))

Santrauka. Privalomo paciento sutikimo atlikti medicininę procedūrą taisyklė turi išimčių, viena iš dažniausiai cituojamų išimčių yra nepaprastoji situacija, kuriai esant gydytojas privalo ne prašyti paciento sutikimo, o atlikti gydymą, kuris yra griežtai būtinas gydytojo sprendimu, ir tokiu atveju jis nebus atsakingas už medicininės procedūros atlikimą be paciento sutikimo. Daugelyje teisinių bylų dėl sutikimo atlikti medicinines procedūras teismai išreiškė nuomonę, kad sutikimas gydytis yra būtina jo teisėtumo sąlyga, nebent įvyktų kritinė situacija ir dėl to būtų neįmanoma gauti paciento sutikimo. Kai kuriais XX amžiaus pradžios atvejais skubios būtinosios pagalbos išimtis buvo taikoma ir tada, kai pacientai buvo be sąmonės anestezijos metu, o gydytojai operacijos metu nustatė sunkų sveikatos sutrikdymą, kuris skyrėsi nuo anksčiau sutartos operacijos tikslo. Šiame straipsnyje autoriai išanalizavo skubios būtinosios pagalbos išimtį pagal romėnų teisės sąvoką *negotiorum gestio*, daugiausia dėmesio skirdami teisinių bylų, kuriose buvo įtariama arba įrodyta nepaprastoji situacija, detalėms. Autoriai taip pat išnagrinėjo gydytojų teisės gydyti (įskaitant ir chirurgines operacijas) istoriškai susiklosčiusius teisinius pagrindus ir nustatė, kad nei teisės doktrina, nei paprotinė teisė neturi vienodos pozicijos šiuo klausimu.
Pagrindiniai žodžiai: medicinos teisė, gydytojo teisės, paciento teisės, informuotas paciento sutikimas, skubi medicinos pagalba, medicininis aplaidumas, *negotiorum gestio*.

Introduction

The legal relationships between the doctor and the patient, as any other legal relationships, have a certain legal foundation, whose roots may be found in history. For instance, in the Canadian case, *McInerney v. Macdonald* (1992), the Supreme Court of Canada has described the relationships between the patient and physician as fiduciary (*fiduciario*), upon which certain legal duties arise out of this special kind of relationships, which are characterized by trust and confidence (McInerney v. Macdonald, 1992, p. 138). The French Court of Cassation in a prominent judgment of 1936 found that the relationships of patient and physician should be grounded upon a contract, and thus the civil responsibility of the physician should be understood as *ex contractu* (Cour de Cassation (France), 1936, p. 88–96). Both afore-given examples represent the application of well-known legal theories on the relationships between the patient and physician, from which various disputes may spring out, most commonly, malpractice lawsuits and disputes on remuneration of treatment costs. However, we may go further and try to comprehend, what

is the foundation of the doctor's right to conduct a certain medical procedure, such as surgery, or a certain diagnostic procedure that may be invasive and thus may bring the risks of hazard to the patient? There is no uniform answer to such questions, albeit several legal theories exist. In this article, we will represent several Roman law-based theories to describe the nature of the doctor's right to conduct medical procedures and the physician's right to conduct a certain medical procedure in urgent situations without the consent of the patient as a reflection of the Roman law concept *negotiorum gestio*. To prove the veracity of the theory of *negotiorum gestio* in cases relating to urgent medical treatment, we shall acquaint the reader with the facts *ex post*, that is grounded upon the theoretical and jurisprudential legacy of the past. The article puts the following questions to be answered:

- What are the main theories of the physician's right to conduct his professional activity, that is treat patients and administer different kinds of treatment, including surgery?
- What is the sense of the Roman law concept of *negotiorum gestio* in medical law, and can it be applicable to the doctrine of informed consent?
- Is an emergency (urgent condition of the patient) a proper defense in a medical malpractice lawsuit, where a medical intervention was done without the patient's consent (including the situations, where the surgery was an extension of a previously-agreed operation, or it was a different operation, which was performed according to the physician's judgment that it would be more suitable)?

Thus, the aim of the article is to observe the element of emergency in the law of informed consent, based upon the Roman law theory of *negotiorum gestio*, as well as to discuss the legal roots and foundations of the physician's activity in regard of treating the patients, from which the rule of consent to medical treatment derives, as well as to explore several outstanding judgments dealing with the issue of patient's consent in emergency situations.

1. Theoretical background

The legal foundation of patient-physician relationship and the physician's right to perform medical procedures upon the patient are questionable and arguable between lawyers. In American legal scholarship of the 20th century, there has been a position that the physician (and what is more commonly, a surgeon), while performing a certain medical procedure, usually a surgery, is barred from liability for committing a technical assault and battery by the doctrine of *volenti non fit injuria*, This means the surgeon is immune from liability based on the patient's consent (Kelly, 1959/1960, p. 429–431). A large amount of case law in the United States, dating back to the late 19th century regarding the lack of consent for a medical procedure (mainly surgical operations were involved) established that the principle of consent to surgery allows the physician to conduct the given operation, which exists in two hypostases – express and implied consent (*Rice*, 1953/1954, p. 103–105). At a very early date, the rule of consent to surgery was formulated by the American scholar E. Kinkead (1903), that the patient is the "final arbiter" on what operations and other medical procedures to submit, or not to sumbit (Kinkead, 1903, p. 736). According to W. Rice (1953/1954), there are cases, when the physician is privileged to conduct an operation without the patient's consent – in cases of an emergency, when a delay in providing medical treatment may turn into serious health impairment or demise, and the second one, is when the consent may be probable (presumed), when a patient has been put under an anesthetic, and thus was unconscious, and the physician for some reason found, that an extension of a previously-agreed operation is necessary, or a completely different operation is required (Rice, 1953/1954, p. 104–105). In case the physician is sued, he would have to justify his acts by conducting

the medical intervention beyond the agreed scope, and has to satisfy the court, or the jury, that he acted in strict necessity – usually finding that the case was an urgent one, which required swift action from the side of the physician[1]. We agree with the positions expressed in the scholarship of the mid-20th century, upon which the issue of an unconscious patient is found to be a considerable legal problem, upon which the main legal issue is whether the patient, by submitting himself or herself to a surgical operation, and was put under anesthesia, thereby lodges the authority to the physician to act in a way he or she would decide due to the circumstances discovered during the operation itself? (Straub, 1929, p. 29–33). Such an alteration of the aim of the medical procedure would be, for instance, the extension of the volume of a medical procedure, or conduct a different operation at all. The judgment of the Supreme Court of Minnesota in the case of *Mohr v. Williams* (1905), one of the well-known and one of the earliest cases relating to the rule of consent to a surgical operation, showed that such extension is not legitimate *per se* by the mere fact that: a) the patient has consented to an operation as such; b) the patient was unconscious under anesthesia; c) the physician has found a condition, which itself required an operation (*though not an urgent one*). In this case, the plaintiff applied to an ear surgeon, who, after an examination held that it was necessary to remove a polyp and diseased ossicles in the right ear, but before the operation, the doctor found an even more serious condition in the left ear, and chose to operate the left ear instead of the right one, despite any acts relating to the left ear had not been agreed, the surgeon conducted an ossiculectomy, removing a portion of the drum membrane, casting out the diseased part of the inner ear. There was no implication of medical negligence, but the lawsuit was upheld on the basis of assault and battery at the trial court; despite the physician's claim that the patient's condition was urgent, this was not accepted by the court, which stipulated the following principles regarding exception of emergency: a) the physician should be allowed discretion to act according to the best judgment which is dictated by the necessity to save the patient's life and preserve the patient's health; b) if the patient is injured and unconscious, the physician is justified to provide such treatment as it would be stipulated necessary to save the patient's life or limb; c) in case the doctor, in the course of a certain medical procedure, which was previously agreed by the patient, observes a condition, which was not known before the start of the operation, and which endangers the health of the patient, then the doctor is justified to proceed without the consent of the patient. In this case, the judgment for the plaintiff was affirmed, and there was no evidence that the condition of the left ear was urgent enough to make a justification for a complete "replacement" of the purpose of the operation without the consent of the plaintiff, even in spite that: a) the surgery referred above was performed skillfully (*de lege artis*), the surgeon could not be found negligent; b) the plaintiff's health condition showed good signs of recovery; c) it was not disputed that defendant acted in good faith (*bona fide*) (Mohr v. Williams, 1905, p. 265–271).

Let us discuss other historical approaches to the issue of the doctor's right to perform a certain medical procedure. L. Oppenheim (1892) observed several theories, which could explain its nature. The first theory was *volenti non fit injuria*, which could explain that the physician's right to operate and/or perform certain medical interventions is dictated by the consent of the patient, who submitted to it (Oppenheim, 1892, p. 9–10). However, this theory was not uniform even among the scholars discussing early medical law (Prof. v. Angeger, 1899, p. 351–356). Oppenheim further contended, that in case *volenti non fit injuria* were applicable, then the patient's consent would be overlooked, from

[1] A good historical case depicting this situation is the Canadian case of *Marshall v. Curry* (Marshall v. Curry, 1933, p. 260). See also the discussion of *Mohr v. Williams* (Mohr v. Williams, 1905, p. 265–271), focused upon the point on the justification of the surgeon to use discretion when performing an operation and its limits.

the side of criminal law, as any other consent to injury. What is more, he found that *volenti non fit injuria* was a generalized concept, which did not consider the special right of the physician to carry out medical interventions on a patient; he found, that the precise fact of providing medical assistance, as such, would give a medical procedure its legitimacy. Oppenheim discussed a different point of view, upon which the legal foundation for a medical procedure was the medical profession in itself: such a view could receive its confirmation in a state license to practice medicine and foundation, financing and management of medical universities and hospitals by the state, etc., but at the same time, not all physicians may conduct medical interventions (for instance, such may be surgeons, midwives). At the same time, such a concept could not explain a lot of real-life situations, when non-physicians could undertake to provide instant medical assistance, as well as in situations, where physicians from different states perform operations without having recognition of the country in which the operation took place (Oppenheim, 1892, p. 13–14). Oppenheim also denoted, that from a historical point of view, both the physicians, and occasionally non-physicians conducted medical interventions far before such became punishable, and there was no doubt regarding their legitimacy, and this factor has not changed, apart from the fact that the operations have become more complex than they used to be centuries ago. Hence, he concluded that it was customary law that gave the legal foundation to medical interventions (Oppenheim, 1892, p. 15–18). So, upon such view, the physician's right to perform a medical intervention could be explained as *mos pro lege* – that is, from Latin, a custom, which functions as a law, since the physician's right to treat patients, applying different techniques, including surgical operations, are recognized and were recognized in society even in the times, when the laws did not set out strict requirements for the physician's activity (*lex scripta*). C. J. Riddering (1928) supported the doctrine of *volenti non fit injuria* as a legitimate basis of medical intervention, denoting that as a general rule, the consent of the patient is a prerequisite to medical intervention, and, unless the operation was consented, the physician will be liable for damages. Notably, the question is not put in the way of whether the operation, which was performed without the patient's consent, was done skilfully, or not (Riddering, 1928, p. 59-61). In fact, as we may deduce from the jurisprudence, in such American cases, such as *Mohr v. Williams* (1905) and *Jackovach v. Yocom* (1931), or Canadian cases of *Caron c. Gagnon* (1930) and *Marshall v. Curry* (1933), the plaintiffs even did not allege that the medical intervention, done without the patient's consent, was performed in a somewhat bad and negligent manner – plaintiffs sued for damages because of the lack of consent to medical intervention (Mohr v. Williams, 1905, p. 265–271; Jackovach v. Yocom, 1931, p. 914; Caron c. Gagnon, 1930, p. 155; Marshall v. Curry, 1933, p. 260). The outstanding French judgment on the Antiquaille Hospital Case (1859) also did not contain any allegations that an experimental procedure to treat dermatophytosis by a syphilitic inoculation was performed in a clumsy way (Trib. corr. de Lyon, 1859, p. 88–89). The physicians in all these cases had no *animus nocendi* (intention to harm), Nevertheless, as we can see, neither *bona fide*, nor the fact the operation is conducted *de lege artis*, nor the lack of *animus nocendi* automatically makes an unconsented surgical operation legitimate. As observed by von Angeger (1899), the doctrine of *volenti non fit injuria* was not omnipresently recognized in legal scholarship – he denoted, that it was already established in case law (the article concerned German law) that the concept of battery did not depend on volenti non fit injuria, and what is more, the physician was not likely to be prosecuted on the basis of battery (§ 223 of the 1871 Criminal Code) since he would have no acknowledgment of committing a battery, and the consent was a necessary feature for the physician not to be prosecuted, e.g. for being etherized without the patient's consent. Von Angeger (1899) ascertained, that physicians discarded any unauthorized medical interventions, finding that such medical procedure would be an encroachment on the patient's *personal freedom*, and the patient should be guaranteed the

right to decide concerning the medical procedures to undergo (or not), though he admitted that occasionally it is not that easy to persuade the patient to submit to a certain medical procedure, which is urgently necessary (Prof. v. Angeger, 1899, p. 351–356). Hence, interpreting the patient's right to consent to a certain medical procedure deriving from *personal freedom* would refer us to *jus naturale*, of which personal freedom is, against which acts *in invitum* are allowed in the sense of a certain medical procedure. C. Stoofs (1902) still reviewed a medical intervention from the view of battery, but in case of a surgical operation, he drove to a conclusion that it does not cause harm to the patient, even if it is an amputation of the limb, and that's why it is not the surgeon, who has caused the loss of the limb, but the illness, which caused its decay, and even in such case of an amputation it could not be said, upon C. Stoofs, that it causes harm to the patient. Therefore, he came to a conclusion, that a medical intervention performed for the benefit of the patient is not a battery. Hence, C. Stoofs found that a legitimate medical intervention is a rather "watered-down" battery, having no criminal-legal meaning, but in case the damage to the health of the patient is caused by medical treatment, then it is punishable (Dr. Prof. Carl Stoofs, 1902, p. 566–568). Speaking of these concepts in old German and Austrian case law, an unconsented surgery was reviewed as a battery by the German Supreme Court in its judgment of May 31, 1894 (where an unconsented surgery was clearly defined as a battery), whereas in 1908, the same court had already reviewed an unconsented surgery performed on a minor as a breach of contract (Reichsgericht, 1894, p. 375–389; Reichsgericht, 1908, p. 431–438). Our lengthy research in terms of case law in Royal Austria has found a judgment relating to the consent of to a surgical operation performed on a minor patient (K. K. Obersten Gerichts- und Cassationshof, 1906, p. 820–822), as well as one judgment relating to the duty to warn the patient concerning the risks and unfavourable results of the operation (K.K. Obersten Gerichts- und Cassationshof, 1915, p. 844–848), but in both cases, the responsibility of the physicians was viewed in the light of §1299–1300 of the Civil Code of 1811, that is in the view of negligence (*mala praxis*). Upon our view, the doctrine of *volenti non fit injuria* may apply, *sensu stricto*, to describe the legal foundation of a medical intervention to which the patient has given consent. At the same time, there are cases, when the physician acts as a matter of urgency or the patient is hospitalized in an infirmary due to a contagious disease without his or her consent. These cases should be approached with different legal foundations. We also would like to denote that the principle of a patient's consent to surgery existed as a customary rule of the medical profession – we may find similar statements in medical literature. For instance, the Spanish physician Dr. Manuel Jimenez (1845) in "*Diccionario de los diccionarios de medicina*" mentions that the consent of the patient is essential, especially if the operation is a major one, calling the duty of receiving consent a "sacred commitment", and if the patient cannot estimate the gist of the operation himself or herself, then the family should take its responsibility to give assent to the operation, adding that when it is possible, it would be better to let the patient request the operation (Dr. Manuel Jimenez, 1845, p. 177). Hence, the rule of consent to a medical intervention may be also derived from a *mos pro lege*, formed in the practice of physicians, even before legislation and/or jurisprudence made it tortious.

Upon such circumstances, we may denote, that the acts of the physician in two situations that were mentioned above, could be viewed in the context of a Roman law doctrine *negotiorum gestio*, when an act is performed by one party, the actor (*gestor*) in the benefit of another party, the principal (*dominus negotii*) without the latter's consent and/or knowledge. Having its routes in Ancient Roman law, in modern times, the concept of *negotiorum gestio* derives from civil law (Dawson, 1961, p. 819–823), and has no exact analogues in common law jurisdictions (Collings, 1967, p. 818). However, the application of the given doctrine in medical law is discussed relatively seldom. For instance, R. Coll-

ings (1967) provides examples of *negotiorum gestio* in medical law, such as the payment of medical expenses and confinement in psychiatric clinics; in terms of the latter, he also denotes, that the *gestor* would be obliged to prove the usefulness and decent management of the acts, which were done, hence, the *gestor* is somehow under a *duty of care* (Collings, 1967, p. 821–822). This is definitely true for the patient-physician relationships, and emergency care could be even more binding. The concept of *negotiorum gestio* has its application in medical law that related to social welfare and poor law: for instance, in Swedish case law already of the XIX century there were disputes relating to reimbursement of cost for the treatment of a patient, frequently a poor one, by certain institutions (Hogsta Domstolen (Sweden), 1882, p. 23–25). The concept of *negotiorum gestio* also does not mean, that the *gestor* will not be sued or will be completely immune from lawsuits *per se*: the liability, or its absence will strongly depend upon the circumstances of the case, including the ability of the physician to prove that his or her acts were necessary for the patient's health *sensu stricto*, that is, there was a grave necessity for such acts. E. Kinkead (1903) discussed, that in medical practice, it became quite frequent that consent could not be obtained as such, when patients were found injured and unconscious, and thereafter were transported to the hospitals with no relatives present, so physicians had no choice but to administer all necessary (including surgical) treatment they deemed necessary (Kinkead, 1903, p. 737). P. Fenwick and R. G. Beran (1997) called the emergency exception to be the only one in terms of an unconsented surgical operation and did not find an unconscious state of the patient to be a favourable defense for unconsented medical procedures, finding that the state of unconsciousness considerably differs from mental impairments or other disabilities which would prevent the patient to comprehend the gist of a medical procedure (Fenwick and Beran, 1997, p. 217). R. Straub (1929) in his respective article collected a multitude of legal positions and *obiter dicta* by American courts, which faced medical malpractice cases that involved the issue of an unconscious patient, who was under anesthesia, and thus was not able to provide consent to surgeries; in some cases, the courts mentioned that it was up to the jury to decide whether there was an emergency in the case at stake to return a verdict either in favor of plaintiff or the defendant (Straub, 1929, p. 29–33). The *obiter dicta* relating to the exception to the rule of consent before performing a surgery are clear that the courts were uniform to recognize that in a matter of emergency, the physicians have the right to administer treatment, including surgical operations, as they would deem appropriate. In terms of unconscious patients, C. Williams (1977/1978) held that several U.S. state jurisdictions had applied the theory of implied consent, which would mean that in case the patient submits to the operation and is put under anesthesia, hence the patient accepts the *modus operandi* of the hospital, where extensions of surgeries are found to be favourable, however, such view was the minority (Williams, 1977/1978, p. 494–495). Considering the legal position of the Court of Queen's Bench (England) in *Bolam v. Friern Hospital Management Committee* (1957), we may deduce that the English concept of the doctor's standard of care *expressis verbis* derives from *modus operandi*[2]. E. Hope (1929/1930) supported the position of reflecting the physician performing an unconsented operation (an extension of the consented medical intervention, or a different one) through the Roman law doctrine *negotiorum gestio*, discussing if the physician could be officious to conduct the necessary medical interventions in the state of emergency (and according to the legal positions and *obiter dicta* of existing court decisions, it seemed that he could), and E. Hope denoted, that the doctor theoretically could claim the reimbursement of the costs for conducting the operation even in spite the fact the operation was not consented (Hope, 1929/1930, p. 236–237); and speaking about the concept

[2] The standard of care, according to this judgment, is based upon accepted medical practice of the time when the disputed clinical episode took place (*Bolam v. Friern Hospital Management Committee*, 1957, p. 582–594).

of *negotiorum gestio*, it would be an *actio contraria*, in a hypothetical case, when the surgeon would sue to recover the costs and expenditures of the performed operation[3], opposite to *actio directa*, in case of which the patient files a lawsuit for *malpractice deriving from the unconsented operation*, though apparently, the patient could file a lawsuit for an unconsented operation as itself[4]). The term "emergency" refers to an urgent condition endangering the life of the patient unless a certain medical procedure or operation takes place. W. Rice (1953/1954), defining the concept of emergency, advised to stick more to certainty of demise or considerable bodily harm if the medical procedure was not performed than rather of any concrete time if the physician had not acted at once (Rice, 1953/1954, p. 104).

2. Examples of *negotiorum gestio* in case law on informed consent and emergencies

Let us review a number of cases, which relate to the doctrine of *negotiorum gestio* and the consent of the patient. The court judgments, commented in the article, are historical; they are from different jurisdictions and all relate to the issue of urgent situations in treating patients.

1. *Mitchell v. Magistrates and Town Council of Aberdeen and Another*
Case: Mitchell v. Magistrates and Town Council of Aberdeen and Another
Court: Court of Session, Inner House, 1st Division, Scotland
Date: 17 January 1893
Case citation: 20 S.C. 253 (Case No. 55)

The pursuer's (*plaintiff* in Scots law) 14-months old son, the only child of the plaintiff and his wife, was seized with measles in July 1892. The child was visited by a local physician, who, after the visit, informed the Local Authority about the case. The doctor told the forbearers of the child that he was going to report the case, as the law prescribed it, and that the child was not fit to be removed to the city hospital. Very soon, a public health officer came to visit the child and told the plaintiff's wife that he came to remove the child to the City Hospital, to which the plaintiff's wife expressed her objection claiming that by the view of the attending physician, the child, suffering from measles, which were complexified by lung congestion, could not be safely removed to the City Hospital, finding she could cope with the situation herself. The public health officer returned on the following day with a conveyance, and took the child to the hospital, regardless of the family's objection. The child's mother chose to stay with the child, attending the child in the hospital, but the child unfortunately died on the following day in the afternoon. The father filed a lawsuit seeking solatium, asserting that the defendants (referred to as the defenders in Scots law) acted unlawfully and held them responsible for the death of the child. It was found that they were not acting in good faith (bona fide) and made false representations claiming authority to act, despite lacking evidence such as a court order legitimizing their actions. The defenders, in their defense, attempted to deny the pursuer's claims but did not discard the statement that the removal of the child to the city hospital was made without a court order. They claimed that under

[3] For instance, in a judgment by the High Land Court of Dresden in 1897, where the physician claimed a honorary for conducting an unconsented operation, the court found he could not claim such payment, having no right to operate on a patient without the patient's consent (OLG Dresden, 1897, p. 728–733).

[4] For instance, in the Michigan case of *Zoterell v. Repp*, (1915), the plaintiff sued the defendant not only for the lack of consent to the operation he performed (ovariectomy), but also for a post-operative hernia. However, in this case, the court found that the plaintiff, in fact, understandingly consented to the operation, so there was no liability of the physician (Zoterell v. Repp, 1915, p. 319).

Section 118 of the Public Health Act of 1867, the Local Authority and the Board should not be made responsible for any irregularities committed by the officers acting in compliance with the said Public Health Act of 1867. The pursuer, nevertheless, held that the defenders acted without his sanction, and without court approval, and should be held liable. He blamed the defenders for the death of the child, which, upon his averments, was caused by the child's removal to the hospital. The sheriff-substitute, in a judgment of November 23, 1892, repelled the first plea in law for the defenders, while the pursuer appealed for a jury trial. The arguments of the parties to the proceedings were pretty much the same – he assumed, that the defenders acted not within the execution of the provision of the statute (that is the Public Health Act of 1867) and did not act in *bona fide* The defenders claimed that the Public Health Act of 1867, Section 118 bars any action against the public officials, who are performing their public duty, and they acted in *bona fide*. Lord President denoted, that in case the public health officers had the patient's consent, they would be justified to remove the person to the hospital, but upon the defenders' averments that they discarded the statements as to their acts being *in invitum* and that they had authority to do so even without a court order, are not proper. The public health officers were not empowered to enter the domiciles of other people and to remove anybody to the hospitals unless they had a warrant, that is a court order, based upon a medical practitioner's certificate. No evidence showed there was such a one, but defenders still claimed they acted under the statute, in bona fide, and were immune from lawsuits based on Section 118. The said provision, seen throughout the Poor Law Statute, as of the view of the Lord President, did not bar any lawsuits but to send them to a particular Court. Hence, Lord President found that the sheriff-substitute correctly repelled the first plea in law for defenders relating to relevancy and in terms of the present case, Lord President held that this case may be heard before the jury. Upon the opinion of Lord M'Laren, the limitation of a certain action within a statute exists only in two cases: when there is a certain time for bringing a lawsuit, after which the action, unless brought before, is time-barred, and in case the matter has to be heard before the court of special jurisdiction. At the same time, there was no dispute of jurisdiction between the parties of the proceedings. Instead, the defenders ascertained that their acts were justified within the meaning of the statute (namely, Section 118 of the Public Health Act of 1867), so the question tried should be viewed within the issue of whether the acts of the defenders were legitimate. Lord M'Laren found that the question of *solatium* and damages for the loss of a relative should be heard before a jury court. Lord Kinnear agreed with Lord M'Laren, and held that the statute authorized to removing patients to the hospital in case they were homeless or dwelled in places where the room they stayed was occupied by other people, but even in these cases, they could remove such a person to the hospital upon a court order, issued upon a certificate of an appropriate medical practitioner. From the circumstances of the case, it was clear to deduce, that such provisions did not coincide with the afore-mentioned statement, especially, taking into account that there was no accommodation problem at all, and the mother expressed firm confidence that she could take care of the child herself, and the fact that even the attending physician told the mother that the child was not in a fit condition to be brought to the City Hospital. Hence, Lord Kinnear concluded that the defenders were not acting within the statute and thus could be entitled to protection from liability upon the provisions of the statute, finding that the case could be heard before a jury. Upon the new hearing, the court repelled the first plea in law for defendants, allowing an issue (Mitchell v. Magistrates of Aberdeen and Another, 1893, p. 253–257).

Comment. The case raises the problem of a legitimate removal of a patient, who suffers from a contagious disease to a public hospital. When the court orders the removal of the patient to the hospital, the court exercises the *parens patriae* jurisdiction, upon which, the state, acting through the powers of the court, may order administering medical treatment to save the life and health of the patient, regardless

of the existence of the consent of the patient, or the patient's family. Since the removal of a patient suffering from a contagious disease to a public hospital is done for the patient's benefit, and without the patient's consent, the situation is clearly a *negotiorum gestio*. In the case at stake, however, the public health officers removed the child without a court order, and this fact was not disputed; the defenders put up a defense claiming they acted in bona fide, and hence could not be held liable, but the Court of Session did not agree with such contention. By far, this seems to be the earliest case of informed consent in Scotland, the other ones are considerably later (Goorkani v. Tayside Health Board, 1990, p. 94). Notably, Section 166 of the Public Health Act of 1897 set out a two-month limitation period for medical malpractice actions (Duncan v. Magistrates and Town Council of Hamilton, 1902, p. 140–142).

2. *Yackovach v. Yocom*
Case: Jackovach v. Yocom
Court: Supreme Court of Iowa, USA
Date: 20 January 1931
Case citation: 212 Iowa 914, 237 N.W. 244 (Iowa 1931)

The plaintiff, a young man aged 17, at the time when the accident and the operation took place, and another young man, boarded a freight train to travel to a town nearby. When the freight train approached the town, the young men noticed that it was not going to stop, so they decided to jump. As the plaintiff jumped, he hit the iron step of the car with his head, injuring it, he fell on the ground on his arm and was dragged a distance from fifty to eighty feet. A witness described the young man as having torn clothes, having a scratched face, and his arm was mangled. Later, the plaintiff was taken to Yocom Hospital, where it was found that he had a profusely bleeding scalp wound and his elbow joint had a compound fracture. He was taken to the operating room, where his scalp wound was sewn and his arm was amputated. The plaintiff brought a lawsuit, contending that the surgeon was employed to reduce the fracture of the arm and that the amputation was conducted without his consent and the consent of his parents. At the trial court, the jury returned a verdict for defendant, and this judgment was appealed. The key point in the case we are discussing here was the contention from the side of the plaintiff that the question of whether the plaintiff's arm should have been removed should have been presented to the jury, and the plaintiff's objection to the instruction to the jury regarding the question whether the operation was performed without the plaintiff's consent and whether the doctor was justified to do so. The court of appeals established that no necessity of submitting the question to the jury relating to whether the arm should have been amputated existed, pointing out, that the surgeons believed that the urgency of the operation, which would presuppose the amputation of the arm, was dictated by the necessity to save the patient's life. None of the expert witnesses testified that the amputation of the arm was unnecessary or should have not been done. To wit, regardless of the above-written, the plaintiff contended that this operation should have not been performed, and as the reader may remember from the statements above, the plaintiff believed that the surgeon had only to reduce the fracture. The findings of the court relating to consent were that the physician had made an effort to call the young man's parents, but unsuccessfully, and faced a difficult situation when the plaintiff was put under anesthesia, and his scalp was treated and sewn, and the doctor was to affirm himself of whether the plaintiff or his parents would assent to the amputation, or to perform the operation under one anesthetic, or instead, to awake the plaintiff and use a second general anesthesia. The other findings of the court were, that the plaintiff indeed did not expect amputation and did not know what the physicians would undertake; the arm was mangled and presented menace to the life of the patient; the surgeon faced an emergency

situation, and upon his judgment, he decided to conduct the amputation. The court held, that in case the physician is faced with an emergency, then it is his duty to administer medical treatment of what the case requires, quoting the court: "… *it is his duty to do that which the occasion demands within the usual and customary practice among physicians and surgeons in the same or similar localities, without the consent of the patient*", adding that there was no bad faith from the side of the physician. Besides, the question of emergency was submitted to the jury: the court instructed the jury that in the absence of an emergency, which would necessitate immediate action from the side of the physician to save the life and health of the patient, an operation on a patient performed without his consent, constituted an assault. As the reader remembers from the text above, the jury returned a verdict for the defendant; moreover, all the expert witnesses were uniform in the conclusion that the plaintiff's condition of the arm was an emergency and thus required amputation. Upon such conclusions, the Supreme Court of Iowa affirmed the judgment of the lower court (Jackovach v. Yocom, 1931, p. 914).

Comment. The case represents the concept of *negotiorum gestio* in an emergency operation featuring an amputation of the limb. No evidence showed that the operation was conducted negligently (*mala praxis*), or in bad faith (*mala fide*), and it was even not contended to be such by the plaintiff. The physician, at the same time, did not talk to the plaintiff concerning the necessity of amputation and seemed to have chosen not to warn him of this (though the doctor attempted to find his parents) which could be easily explained from the side of the urgency of the condition. Moreover, the 1920–30s cases relating to consent to surgery paid more attention to the issue of consent itself and the legitimacy of a certain medical intervention than to the physician's duties to provide explanations of the forthcoming surgery.

3. *Caron c. Gagnon*
Case: Caron c. Gagnon
Court: Superior Court of Quebec, Canada
Date: 1930
Case citation: 68 C.S. 155

The plaintiff, a railroad constable, was the husband of a 20-year-old woman, who was treated by the defendant on various occasions. The defendant was a surgeon, who practiced surgery since 1922 and repeatedly conducted research in Europe, specializing in gynecology and obstetrics, and at the time of the proceedings, the defendant was working at various hospitals in Quebec. Since July 1928, the defendant treated the woman for different diseases of the reproductive system. In May 1929, the plaintiff's wife suffered from an attack of appendicitis, and the defendant advised immediate surgery. During this operation, the defendant noticed an inflammation of the right ovary, so he decided to act immediately. According to the defendant, the woman's husband appreciated his acts and even paid him for performing this operation, but soon the defendant was sued by the husband of the female patient claiming that because of the operation she became sterile, and so he and his wife could never have children, and that the claimed damages the couple had allegedly suffered could be attributed to the defendant's acts. The defendant, in his turn, claimed that the woman's ovaries were in a polycystic degeneration, which would naturally develop into an acute condition that would require a major and (potentially) hazardous operation, which would in any case soon require an ovariectomy, He added that he had acted prudently and skillfully, and in the interest of the woman. The court denoted that the case did not pose a question concerning a medical error by the defendant and he was not blamed for conducting the operation negligently, the point was in the issue of consent – namely, whether the plaintiff and his wife gave their consent to the operation, and whether the circumstances of the case

justified the physician or even obliged him to operate. According to the findings of the court, the defendant surgeon had treated the woman since 1928, and when the appendicitis condition occurred in May 1929, he talked to the plaintiff before the operation, who said, that in case it was necessary to do the operation, then he wished his wife to be operated immediately, so that this situation would be terminated for good. The plaintiff also told the doctor that he wished him to try to treat his wife in such a way that the operations, which were always expensive and hazardous, would be unnecessary thereafter. Hence, the court asked, whether, by these words, the plaintiff did not give the defendant the authority to use all the methods a surgeon could apply to treat his wife. If the plaintiff said so, would it be justified for the surgeon to remove the woman's ovaries? The surgeon did not conceal the fact he had removed the ovaries from the plaintiff wife's body, and informed him about this, and the plaintiff agreed that he did right, but advised not to tell the woman not to depress her. Within a month, the plaintiff saw the surgeon and asked him to tell the woman that she had undergone the afore-mentioned surgery since she did not know it. When the woman came to the surgeon, he told her that she underwent an operation on the ovaries. The defendant also denoted that neither the plaintiff nor his wife complained about the operation until the action was instituted. The court held that the plaintiff's claims could be enough to find the physician's acts justified, but was it the physician's obligation to act so? Within the operation, which was apparently a consented one (that is the removal of appendicitis), the defendant noticed the condition of the ovaries, which could become acute in 90 out of 100 cases, and every time he found the ovaries in such condition, he decided to remove the ovaries. Next, the court found, that there was no claim in terms of the negligent performance of the operation, from which the court arrived to a conclusion that the operation was performed well, that is *de lege artis*. After the operation, the ovaries were maintained in a laboratory, and after their examination, they were full of cysts as well as multiple tumors. The court held, that it would be reckless to express a view different from the view of the physician in terms of the operation, its urgency, and its necessity. The court stated that in terms of difficult medical interventions, only the honour, which stays between the conscience of the physician and the patient, and only God is the sole judge between the two. Therefore, the court held that the physician, who acted with his knowledge and his honour, acted correctly. Similar questions are of medical nature, and the courts do not give conclusions concerning such scientific issues. Next, the defendant's averments that the ovaries were seriously diseased, and the operation was urgent, were upheld by the conclusions of experts, who found the physician's acts to be fully justified. The court also paid attention to the plaintiff's complaint that the woman became sterile because of this operation, and the court did not dispute it, but added, that it was doubtful whether someone with such diseased ovaries could be able to have children. The court also outlined, that in Canada, only one similar judgment was handed down (in fact, by the same court) in 1899 (Parnell v. Springle, 1899, p. 74), where the physician was held to be justified to conduct an ovariectomy despite the patient and the physician had agreed to a different procedure, and upon this principle, the physician was justified to conduct the necessary procedure for saving the life of the patient. So, the court held to dismiss the lawsuit (Caron c. Gagnon, 1930, p. 155).

Comment. This case, as *Parnell v. Springle* (1899) represented a complicated legal issue of the performance of a completely different operation (unconsented) within the course of performing the operation, which had been consented. In both *Parnell v. Springle* and *Caron c. Gagnon*, the surgeon faced a condition requiring an operation (Parnell v. Springle, 1899, p. 74; Caron c. Gagnon, 1930, p. 155). While not being as urgent as appendicitis itself in the case of *Caron c. Gagnon*, the delay of the operation would require conducting it in any case shortly. The court trusted the physician concerning the doctor's judgment to perform the operation and added that the question of urgency and necessity

belonged to the medical (scientific) category, on which the courts cannot present conclusions. A very similar situation occurred in *Marshall v. Curry* (1933), where a physician, operating on the plaintiff's left groin hernia, decided to remove the testicle, which was in a severely diseased condition; in this case, the physician was also justified to do this operation (Marshall v. Curry, 1933, p. 260).

4. Judgment of the Paris Court of Appeals (1923)
Court: Cour d'Appel Paris, France
Date: 28 June 1923
Case citation: Dall. Per. 1924 II 116

The plaintiff was a woman, who entered the Tenon Hospital in Paris in March 1914, where the defendant surgeon was the heading physician and an Associate Professor of the Medical faculty. The patient was complaining of pains in the lesser pelvis following fatigue or after sudden movements. The medical examination showed cystocele and retroversion of the uterus, which apparently required to perform an operation, which was consented to by the plaintiff. During the operation, the surgeon noticed that both ovaries of the plaintiff were affected by cystic degeneration, the right ovary had a multitude of cysts, and the left ovary had a large cyst, described as a "pear-size" one. Hence, the physician found that instead of the fixation of the uterus through hysteropexy, he needed to perform a different operation – a hysterectomy, which is the removal of the uterus. The plaintiff left the hospital sixteen days after the operation and was feeling well after the operation. Even the medical records that were produced by the plaintiff showed that her health condition was good and that she had no complaints of pains in her lower pelvis. Nevertheless, she decided to litigate: in 1916, the plaintiff lodged a lawsuit against the Administration of Public Assistance in Paris, claiming 35,000 Francs in damages, and in 1919 she sued the surgeon, who performed the operation, claiming that the surgeon told her that only a slight medical intervention was necessitated, and she firmly expressed her will not to undergo any serious operation, especially if the operation is connected to the prospect of being unable of becoming pregnant. Despite her will, the surgeon nevertheless conducted this operation, without warning the plaintiff or her husband about it. In her view, the operation was useless, and because of the said operation, the plaintiff would be unable to have children in the future. The experts' conclusions in the case showed, that the surgeon acted very diligently and in accordance with all the rules of surgery, and could not be blamed for negligence, and the court, finding the plaintiff's position unfounded also denoted, that the operation was not a kind of a some medical experiment, but was an everyday practice of the surgeons. The court also wondered why the plaintiff deferred or did not lodge this lawsuit earlier, but had waited for five years. Concerning the operation itself, the court said, that the plaintiff had voluntarily undergone an operation in the area of the uterus, and was anesthetized by chloroform. After the operation, which was a laparotomy, was completed, the surgeon noticed the cysts, and acting upon his honour, he decided to conduct a hysterectomy, which he found necessary for the health of the patient. Because of the circumstances of this situation, the physician could not terminate the operation, the deferral of which could cause complications of a hazardous nature to the patient. The court found that the physician's act (that is, not to terminate the operation instead of terminating it and asking for the patient's consent when the patient would be awake) did not encroach on the principle that every medical intervention should be conducted with the patient's consent. The court also said, that the court should not estimate the efficiency of some kind of medical treatment, and hallmarked, that the acts of the surgeon corresponded to the doctrine of Professor J. L. Faure who found that the cyst of the ovary contains a mortal hazard, and has to be operated immediately, adding

that the technique applied during the operation was not criticized. Based on these conclusions, the Paris Court of Appeals ruled to affirm the judgment of the trial court and dismissed the plaintiff's appeal (Cour d'Appel Paris, 1923, p. 116–117).

Comment. At a very early date, it was adopted in French jurisprudence that the court should not inquire into the means and methods of treatment administered by a certain physician and should not estimate whether these are correct from a medical point of view, since it is a question of the medical art (Cour de Metz, 1867, p. 107–108). Apparently, the court may determine of whether there was negligence in the acts of the physician, which could be, for instance, by appointing an expertise, which could determine it. The rule of patient's consent to a medical intervention was established in the Antiquaille Hospital Case in 1859 (Trib. corr. de Lyon, 1859, p. 88–89), and later discussed in the judgment of the Court of Aix in 1906 (Cour de Aix, 1906, p. 41–44). Both of these judgments dealt with unconsented treatment by experimental means, and in both cases, the doctors were held liable. The judgment discussed above dealt with the legitimacy of conducting a different operation than initially planned; it was conducted in accordance with the physician's conscious judgment that it would be better for the health of the patient. Although the surgery was technically unconsented (the plaintiff agreed to a different surgery), the physician was justified to make a different operation, finding that not operating in the urgent condition of the plaintiff would cause a hazard to her health, unless operated at once. So, the principle of *negotiorum gestio* by conducting a different operation without the patient's consent for the patient's benefit is well-illustrated in this case as well.

Conclusions

Having arrived at the concluding part of the article, the authors summarize it as follows:

1. There are several aged theories of the legitimacy of medical procedures, and especially, surgeries conducted by the physicians. Upon the doctrine of *volenti non fit injuria*, the consent of the patient makes the medical procedure legitimate. However, not all scholars support this approach. Some other views claim that the legitimacy of medical treatment could be either in the physician's kind of profession, or in customary law. Upon the last approach, the physician's activity in a historical sense is *mos pro lege*, that is recognized by society throughout the ages of its existence (though at present time, the regulation of the physician's profession apparently lies in *lex scripta*).
2. The concept of *negotiorum gestio*, which means performing actions for the benefit of *actor* by *gestor* without the former's consent, in which the *dominius negoti* is the patient, and the *gestor* is the physician, applies to certain situations in medical law. There are occurrences when during an operation, which was previously consented to, a physician finds a certain diseased condition of the patient, which would, upon the physician's view, require swift actions; a physician may perform an extension of the consented operation, or a different operation. The physician apparently believes to be acting in good faith (*bona fide*) and in the interest of the patient. However, such acts are not always found to be legitimate *de jure*.
3. The exception of emergency is recognized by courts as legitimate. In this case, the physician is entitled to act by his or her own discretion, administering treatment and performing the necessary medical procedures according to his or her best judgment, and he/she will be not held liable for an unconsented medical procedure (however, if no emergency is proved, the physician may be held liable for damages). This occurrence is exceptionally covered by the concept of *negotiorum gestio*, since in most urgent cases, the consent is either impossible or impracticable to be obtained from the patient or the patient's family.

References

Academic literature

von Angerer, O. (1899). Strafrechtlicher Verantwortlichkeit des Arztes. *Münchener Medicinische Wochenschrift*, 14 März 1899.

Collings, R. W. (1967). Application of the Institution of Negotiorum Gestio to the Confinement of the Mentally Ill. 27 *La. L. Rev*. 815.

Dawson, J. P. (1961). Negotiorum Gestio: The Altruistic Intermeddler. 74 *Harv. L. Rev*. 817.

Fenwick, P., Beran, R. G. (1997). Informed Consent – Should Bolam be rejected. 16 *Med. & L.* 215.

Hope, E. W. (1929–1930). Officiousness. 15 *Cornell L. Q.* 205.

Jimenez, M. (1845). *Diccionario de los diccionarios de medicina*, Tomo VII.

Kelly, W. A. (1959–1960). The Physician, the Patient and the Consent. 8 *U. Kan. L. Rev.* 405.

Kinkead, E. B. (1903). *Commentaries on the law of torts; a philosophic discussion of the general principles underlying civil wrongs ex delicto*, Vol. I. San Francisco, Bancroft-Whitney Company.

Oppenheim, L. (1892). *Das ärztliche Recht zu körperlichen Eingriffen an Kranken und Gesunden*. Basel. Benno Schwabe, Verlagsbuchhandlung.

Rice, W. A. (1953–1954). Torts-Battery-Consent and Privilege in Surgical Operations – Tabor v. Scobee (Notes and Comments). 42 *Ky. L. J.* 98.

Riddering, C. J. (1928). Surgeon's liability for operation without the patient's consent. 45 (2) *Medico-Legal Journal* 59.

Stoofs, C. (1902). Aerztliche Behandlung und Körperverletzung. *Deutsche Juristen-Zeitung*, Jg. 7.

Straub, R. (1929). The Surgeon and the Unconscious Patient. 33 *Law Notes* (Edward Thompson Co.), 29.

Williams, C. B. T. (1977–1978). Consent to Surgical Procedure. 31 *Ark. L. Rev*. 493.

Case law

McInerney v. MacDonald, [1992] 2 S.C.R. 138 (Supreme Court of Canada), 5 February and 11 June 1992).

Cour de Cassation (France), Cham. Civ., 20 mai 1936, Dall. Per. 1936 I 88, 88–96.

Marshall v. Curry [1933] D.L.R. 260 (Nova Scotia Supreme Court, 15 May 1933).

Mohr v. Williams, 95 Minn. 261, at p. 265–271 (1905) (23 June 1905); also reported in North-Western Reporter (USA), Vol. 104: 104 N.W. 12, at p. 12–16, as well as other sources: 1 L.R.A.N.S. 439, 111 Am.St.Rep. 462, 5 Am.Ann.Cas. 303.

Caron c. Gagnon, 68 C.S. 155 (1930) (Superior Court of Quebec, 1930).

Jackovach v. Yocom, 237 N.W. 444 (Iowa 1931), 20 June 1931.

Trib. corr. de Lyon, 15 decembre 1859, Dall. Per. 1859 III 87, 87–88.

Reichsgericht, III. Strafsenat, Urteil vom 31. Mai 1894, g. W. Rep. 1406/94, Entsch. RG Strafsachen Bd. 25, S. 375–389 (Entsch. Nr. 127).

Reichsgericht, VI. Zivilsenat, Urteil vom 27. Mai. 1908, Rep. VI. 484/07, Entsch. RG Zivilsachen Bd. 68, S. 431–438 (Entsch. Nr. 106).

K.K. Obersten Gerichtshof, Entsch. vom 4. Januara 1906, Ziffer 18553 ex 1905, Glaser/Unger (begründet), Pfaff, Schey & Krupský (fortgeseβt), Bd. 45, Nr. 4449, S. 820–822, Zentralblatt für juridische Praxis, Bd. 26, S. 816–817, Entsch. Nr. 276.

K.K. Obersten Gerichtshof, Entsch. vom 7. September 1915, Rv I 448/15, Glaser/Unger (begründet), Schey/Štěpán (fortgeseβt). Bd. 52, Nr. 7557, S. 844–848.

Hogsta Domstolen (Sweden), utslag d. 20 Jan. 1882, Nytt juridisk arkiv, 9 Ångången, Mål Nr. 8, s. 23–25.

King v. Carney, 85 Okla. 62, 204 P. 270 (1922), 17 January 1922.

Bolam v. Friern Hospital Management Committee, [1957] 1 W.L.R 582 (pp. 582–594) [1956 B. 507], adjudicated 20.02, 21.02, 22.02, 25.02, 26.02.1957.

OLG Dresden, Entsch. vom 7. Oktober 1897. O. I. 65/97, Sächsisches Archiv für bürgerliches Recht und Prozeß (Bd. 7 (1897)), S. 728-733., Deutsche Juristen-Zeitung, Jg. 4 (1899), S. 215–216.

Zoterell v. Repp, 187 Mich. 319, 153 N.W. 682 (1915), 23 July 1915.

Mitchell v. Magistrates of Aberdeen and Another, Court of Sessions, Inner House, 1st Div., 17 Jan. 1893 (Case No. 55), 20 S.C. 253, pp. 253–257.

Goorkani v. Tayside Health Board, Court of Session (Outer House), 18 January 1990, 1991 S.L.T. 94.

Duncan v. Magistrates and Town Council of Hamilton, Court of Session (Inner House), 1st Div., 29 November 1902, [1902] ScotLR 140 (Vol. 40), p. 140–142.
Parnell v. Springle, 5 Rev. de. Jur. 74 (1899) (Superior Court of Quebec, 20 January 1899).
Cour d'Appel Paris, 28 juin 1923, Dall. Per. 1924 II 116, p. 116–117.
Cour de Metz, 21 mai 1867, Recueil Sirey 1868 I 107, p. 107–108.
Cour de Aix, 22 Oct. 1906, Dall. Per. 1907 II 41, p. 41–44.

Anatoliy Lytvynenko is a Doctor of Legal Sciences and a Lecturer at the Baltic International Academy (Riga, Latvia). His areas of scientific interest include Civil Law, Theory of Law, Medical Law, History of Law, Ecclesiastical Law, and Human Rights Law.

Anatoliy Lytvynenko yra teisės mokslų daktaras ir Tarptautinės Baltijos akademijos (Ryga, Latvija) lektorius. Jo mokslinių interesų sritys – civilinė teisė, teisės teorija, medicinos teisė, teisės istorija, bažnytinė teisė ir žmogaus teisių teisė.

Prof. Dr. (HP) Jevgenij Machovenko is a Professor at the Department of Public Law, Faculty of Law, Vilnius University, and the head of the Legal History Research Center. Areas of scientific interest: History of Law, Theory of Law, Constitutional Law.

Prof. dr. (HP) Jevgenij Machovenko yra Vilniaus universiteto Teisės fakulteto Viešosios teisės katedros profesorius, Teisės istorijos mokslo centro vadovas. Jo mokslinių interesų sritys – teisės istorija, teisės teorija, konstitucinė teisė.

Tatjana Jurkeviča is a Doctor of Legal Sciences and Associate Professor at the Faculty of Law of the International Baltic Academy (Riga, Latvia). Her scientific interests cover the legal regulation of the protection of patients' rights and the evaluation of evidence in civil proceedings.

Tatjana Jurkeviča yra teisės mokslų daktarė, Tarptautinės Baltijos akademijos (Ryga, Latvija) Teisės fakulteto docentė. Svarbiausios jos mokslinių interesų sritys: pacientų teisių apsaugos teisinio reguliavimo problematika, įrodymų vertinimas civiliniame procese.