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*Aneta Schwarzová*

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Ανασκόπηση

# Legal Regulation of the Doctor-Patient Relationship in the Czech Republic: Development and Current State, with a Practical Focus on Gynecology and Obstetrics

**Aneta Schwarzová**[1,2]

[1] Doctoral student at the Faculty of Law, University of West Bohemia, Pilsen, Czech Republic.
[2] Intern, National Commission for Bioethics & Technoethics, Greece.

schwarzova.aneta@seznam.cz

**Abstract**

The article focuses on the development of the relationship between doctor and patient and subsequent legal regulations in the Czech Republic from the beginning of the 20th century to the present. First, it delves into the evolution of the relationship between doctor and patient in the territory of the Czech Republic, providing an overview of important historical events that profoundly influenced the creation of sources and some institutes. Subsequently, it analyzes the current situation in the Czech Republic, subjecting it to a critical evaluation. The author, above all, questions whether the relationship between doctor and patient is truly a partnership and an equal one. The article then addresses persistent inequalities and differences between the rights and obligations of the patient and the doctor. The conclusion acknowledges that, considering the nature of the relationship, it may not be possible to completely eliminate these persistent inequalities. Based on the findings, partial conclusions are formulated, summarizing the individual stages and transformations of this relationship. The analysis of the current state of the relationship between doctor and patient includes a focus on important judicial decisions from practice and how they set limits for the autonomy of the patient's will. In this article, the author primarily concentrates on significant court decisions in the field of gynecology and obstetrics, analyzing how the autonomy of the patient's will is limited in this area in relation to specific situations.

**Keywords:** Health law; doctor-patient relationship; informed consent; autonomy of the will; gynecology-obstetrics.

# Νομική ρύθμιση της σχέσης γιατρού-ασθενούς στην Τσεχική Δημοκρατία: Ανάπτυξη και τρέχουσα κατάσταση, με πρακτική εστίαση στη γυναικολογία και τη μαιευτική

**Aneta Schwarzová**[1,2]

[1] Υπ. Διδάκτωρ στη Νομική Σχολή του Πανεπιστημίου της Δυτικής Βοημίας, Πίλσεν, Τσεχία.
[2] Ασκούμενη, Εθνική Επιτροπή Βιοηθικής και Τεχνοηθικής, Ελλάδα.

**Περίληψη**

Το άρθρο επικεντρώνεται στην ανάπτυξη της σχέσης μεταξύ γιατρού και ασθενή και στις επακόλουθες νομικές ρυθμίσεις στην Τσεχική Δημοκρατία από τις αρχές του 20ού αιώνα μέχρι σήμερα. Αρχικά, εξετάζει την ιστορική εξέλιξη αυτής της σχέσης, σε μια επισκόπηση των σημαντικών γεγονότων που επηρέασαν τη δημιουργία πηγών δικαίου και την ίδρυση ορισμένων ινστιτούτων. Στη συνέχεια, αναλύει την τρέχουσα κατάσταση στην Τσεχική Δημοκρατία, υποβάλλοντας την σε κριτική αξιολόγηση. Το άρθρο περιλαμβάνει αναφορές σε σημαντικές δικαστικές αποφάσεις που θέτουν όρια για την αυτονομία της βούλησης του ασθενούς, κυρίως από τον τομέα της γυναικολογίας και της μαιευτικής. Η συγγραφέας, πάνω απ' όλα, αμφισβητεί εάν η σχέση μεταξύ γιατρού και ασθενούς είναι πραγματικά μια σχέση ισότιμων εταίρων. Στο συμπέρασμα, αναγνωρίζεται ότι, λαμβάνοντας υπόψη τη φύση της σχέσης, είναι δύσκολο να εξαλειφθούν πλήρως αυτές οι ανισότητες.

**Λέξεις κλειδιά:** Δίκαιο υγείας, σχέση γιατρού-ασθενούς, ενημερωμένη συναίνεση, αυτονομία της βούλησης, γυναικολογία-μαιευτική.

## Introduction

The doctor-patient relationship is central to the provision of health care. From the point of view of historical development, this relationship has undergone significant changes. The original unequal position, where the doctor was in a stronger position, turned into a relationship of professional partnership. The reason for the change was, among other things, a change in the primary protected interest. Historically, priority has been given to the protection of the life and health of the individual. It was not expected that the patient would question the doctor's decision and choose a treatment method that would conflict with these interests, or refuse treatment altogether. There were even times when the provision of professional health services was neither common nor available. However, this approach did not respect the will of the patient and his dignity.

The current perception of the doctor-patient relationship is primarily based on communication with the patient and proper instruction. The institute of informed consent is now an integral part of medical procedures. The doctor no longer unilaterally decides on the patient's course of action; instead, they explain the possible procedures in the given case, transferring the choice to the patient. The doctor is no longer the sole authority; they are expected to fully respect the autonomy of the patient's will and the resulting opinion. This expectation holds true in situations where the patient is capable of making decisions about themselves, is conscious, and their mental state allows it, or where their decision does not threaten public health. Is this always fulfilled in practice? Is the doctor-patient relationship truly equal now? Are there still situations where the doctor acts as an authority?

The text aims to provide insight into the doctor-patient relationship, placing it in a historical context, critically evaluating the current state, and highlighting persistent inequalities. Initially, the development of the doctor-patient relationship and its changes in the Czech Republic will be examined. This will include an overview of significant historical events that have profoundly influenced the creation of sources and certain institutes. Additionally, the text will address the guarantee of patients' rights, their manifestations, and the actual fulfillment of these rights in practice. The analysis of the current state of the doctor-patient relationship will also encompass key judicial decisions and how they set limits on the autonomy of the patient's will. The focus of the article will primarily be on crucial court decisions in the field of gynecology and obstetrics. The aim is to analyze how the autonomy of the patient's will is limited in this area, particularly in specific situations.

Based on the above, conclusions will be formulated, and the basic stages of development will be identified. Subsequently, a critical assessment will be conducted to determine whether the current situation in practice represents an equal relationship that can be described as a professional partnership.

## 1. Historical development of healthcare law in the territory of the Czech Republic

At the beginning of the 20th century in the Czech Republic, the doctor-patient relationship was governed by public law, characterized by inequality. The doctor held an authoritative role, with the main protected interests being life and health. In contrast to the present, where the primary focus is on the autonomy of the patient's will and dignity. During that time, the health status of the population in the Czechoslovak Republic was unsatisfactory due to poor hygienic conditions, lack of food arising from adverse social conditions, and the aftermath of the First World War, especially the high number of post-war invalids.

Although medical care availability improved during the First Republic, legislation in this area remained fragmented, inconsistent, and outdated medical procedures hindered the situation, especially in eastern parts and rural areas.[1] In 1918-1920, the situation came to a dramatic climax during the Spanish flu pandemic.[2] Infectious diseases were on the rise, and the population was also threatened by diseases such as spotted typhus, diphtheria, scarlet fever, whooping cough, tuberculosis, or smallpox. In most cases, these diseases were gradually reduced. Measures, such as compulsory vaccination (e. g. in 1919 against smallpox) or hygiene practices, also contributed to the situation. To address specific issues, specialized institutes were created, such as the Institute for the production of anti-tetanus serum or the Pasteur Institute for the production of rabies vaccine and its treatment.[3]

In the 1930s, the professional public gradually came up with proposals for preventive medicine. Within the framework of Act No. 114/1929 Coll., on the exercise of medical practice (also as „EMP“),[4] the rights and, above all, the duties of a doctor were regulated, such as the obligation to provide first aid (Art. 10 EMP), the right to compensation for the assistance provided (Art. 11 EMP), the obligation of confidentiality (Art. 13 EMP), the procedure for examining and determining a patient's diagnosis (Art. 15 EMP), etc. The law also formulates the way in which medical education can be obtained and the conditions for performing medical practice.

During the period of Nazi occupation from 1939 to 1945, systemic changes occurred and had a significant negative impact on the health sector. The health administration was divided into the Sudetenland part and the protectorate. Public healthcare in the Sudetenland was subject to the locally competent Reich authorities. In the protectorate, the health department was managed by the Ministry of Social and Health Administration. Racial purity supervision and special hereditary health courts (original: *Erbgesundheitsgerichte*) were established.[5] The health conditions of the population worsened during this period. People died due to weakness resulting from hunger and disease, as well as due to physical and psychological torture in concentration camps and inhumane experiments by Nazi doctors. Insufficient medical care also contributed to the mortality, and another portion succumbed to battle injuries. Some Czech doctors were murdered because of their origin, while others went into exile and continued to practice. Increasing obstacles were placed on the education of doctors, and one of the further blows was the closure of universities in 1939.[6] Despite all

[1] Hlaváčková L, Dějiny lékařství v českých zemích, Triton, 2004: 159-161.

[2] Brüssow H, The beginning and ending of a respiratory viral pandemic-lessons from the Spanish flu, Microbial Biotechnology, 2022, 15: 1301-1317.

[3] Hlaváčková L, Dějiny lékařství v českých zemích, Triton, 2004: 162. See also: Lombard M, Pastoret PP, Moulin AM, A brief history of vaccines and vaccination, Revue Scientifique et Technique-Office International des Epizooties, 2007, 26: 29-48. Available at: https://www.researchgate.net/profile/Michel-Lombard/publication/6205699_A_brief_history_of_vaccines_and_vaccination/links/54297ba40cf26120b7b7febe/A-brief-history-of-vaccines-and-vaccination.pdf

[4] Original: *zákon č. 114/1929 Sb., o výkonu lékařské prakse*.

[5] Hlaváčková L, Dějiny lékařství v českých zemích, Triton, 2004: 197-198.

[6] Severa D. Co se stalo 17. listopadu 1939 a co tomu předcházelo? SeznamZprávy. Available at:

these negative influences on a global scale, the field of medicine has advanced significantly. Primarily, this progress was attributed to the United States, both in civilian and military medicine. New treatment methods clandestinely reached the Czech Republic, precisely from the USA (discovery of penicillin) or from England (treatment procedure for burns).[7]

After 1945, the population was weakened, and society had to contend with a number of infectious diseases that had not been eradicated until then. In addition, new diseases were on the rise as a reaction to war and traumatic experiences, mainly cardiovascular, oncological, and psychosomatic diseases.[8]

In 1948, healthcare was centralized and nationalized. It had long been one of the priorities of the communist regime. The right to health protection was enshrined in the constitution of May 9, 1948 (also as „May Constitution“ or „MayC“)[9] within the section on social rights. Article 29 of the May Constitution established a system of public health and social care, intending to provide care for the elderly or persons without care or unfit for work (Art. 29, par. 1 MayC). Specifically, special rights to care during pregnancy and maternity were granted (Art. 29, par. 2 MayC). In the course of the following years, several laws nationalizing healthcare institutions were issued.[10] In Art. 29, par. 3 MayC also refers to other laws, including Act No. 99/1948 Coll., on national insurance.[11] Legislation is gradually being unified through centralization, and so are medical procedures. Laws leading to the systematization of healthcare and even prevention are issued.[12] As a result of these laws, new institutions were created, such as hygienic-epidemiological stations.

A step forward in enabling women to make at least some decisions about their bodies was the adoption of Act No. 68/1957 Coll., on the artificial termination of pregnancy (also as “ATP”).[13] In the introductory provision, it is stated that the law was adopted due to the high risks of harm to the health and lives of women who underwent procedures outside medical facilities, often performed by non-specialists and with fatal consequences occurring frequently (Art. 1 ATP). To ensure the healthy development of the family, women were allowed to undergo the procedure in a medical facility. However, one of the conditions for artificial termination of pregnancy was the request of the woman or her legal representative, which had to be approved by a specially established commission (Art. 3 par. 1 ATP). The commission assessed whether it was possible to comply with the request. The reasons for which the request could be granted included the patient's state of health or other reasons worthy of special consideration (Art. 3 par. 2 ATP). In practice, these cases were very exceptional.

https://www.seznamzpravy.cz/clanek/17-listopad-1939-co-se-stalo-78948.

[7] Hlaváčková L, Dějiny lékařství v českých zemích, Triton, 2004: 195 et seq.

[8] Ibidem: 218 et seq.

[9] Original: *Ústavní zákon č. 150/1948 Sb., Ústava Československé republiky.*

[10] E. g. *zákon č. 185 zestátnění léčebných a ošetřovacích ústavů a o organisaci státní ústavní léčebné péče.*

[11] Original: *zákon č. 99/1948 Sb., o národním pojištění.*

[12] E. g. *zákon č. 103/1951 Sb., o jednotné preventivní a léčebné péči, zákon č. 4/1952 Sb., o hygienické a protiepidemické péči*.

[13] Original: *zákon č. 68/1957 Sb., o umělém přerušení těhotenství.*

Constitutional Act No. 100/1960 Coll., the Constitution of the Czechoslovak Socialist Republic,[14] guarantees the right to health protection in Article 23. Nevertheless, the question remains regarding whether and how this guarantee was actually fulfilled. In 1966, in the Czechoslovak Republic, the relationship between doctors and patients was regulated by Act No. 20/1966 Coll., on People's Health Care[15] (also as „People's Health Care Act" or „PHCA"). This regulation remained unchanged in its original form from 1966 to 1990. During this period, the doctor still acted as an authority towards the patient, and the relationship was so-called paternalistic.

In the 1990s, the law underwent several amendments. In 2001, the Convention on Human Rights and Biomedicine[16] entered into force in the Czech Republic, which had a fundamental impact on the relationship between doctors and patients and foreshadowed the necessary changes to this regulation. The People's Health Care Act was replaced in 2012 by Act No. 89/2012 Coll., the Civil Code[17] (also as „Civil Code" or „CC") which enshrines basic provisions regarding the relationship between doctors and patients, and Act No. 372/2011 Coll., on health services and conditions of their provision (Health Services Act)[18] (also as „Health Services Act" or „HSA"), along with other regulations such as Act No. 373/2011 Coll., on specific health services (also as „SHS"),[19] etc. In connection with the regime change, the healthcare sector was privatized.

It is evident from the above facts that it was not a natural, gradual transformation, but rather the adjustment of the doctor-patient relationship developed only in a democratic society, which was associated with a change of regime. Respecting rights in this area is thus inextricably linked to the general respect for rights in the state.[20]

## 2. Current situation on the territory of the Czech Republic

### 2. 1 The relationship between doctor and patient, including its nature and legal regulation

Currently, in the Czech Republic, the patient-doctor relationship is primarily regulated in the private law section, with support found in the Civil Code, specifically in Part Four, Chapter II, Part 9 Health Care (Art. 2636-2651 CC). Now, in most cases, the doctor does not act as an authority, except where it is absolutely necessary, for example, due to the risk of endangering public health.[21] Currently, emphasis is placed on the patient's right to make free decisions about their affairs, body, and the alternatives offered by the treatment. It is the doctor's duty to inform the patient about all alternatives, risks, and potential situations that may arise. The patient's right includes the freedom to decide

[14] Original: *zákon č. 100/1960 Sb., Ústava Československé socialistické republiky*.
[15] Original: *zákonem č. 20/1966 Sb., o péči o zdraví lidu*.
[16] Full name: *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine*.
[17] Original: *zákon č. 89/2012 Sb., občanský zákoník*.
[18] Original: *zákon č. 372/2011 Sb., o zdravotních službách a podmínkách jejich poskytování (zákon o zdravotních službách).*
[19] Original: *zákon č. 373/2011 Sb., o specifických zdravotních službách.*
[20] Schwarzová A, Vývoj vztahu mezi lékařem a pacientem a navazující právní úpravy od počátku 20. století po současnost, Iurium Scriptum, 2023, 7: 81-94.
[21] Šustek P, Holčapek T, et al, Zdravotnické právo, Wolters Kluwer, 2017.

on the choice of procedure. On the other hand, the doctor also has the right to refuse to perform a chosen procedure (e. g. conscientious objection), and the patient has the obligation to tolerate a certain procedure (e. g. due to the already mentioned risk of endangering public health).

From the perspective of respecting the autonomy of the patient's will, it is generally stated that the relationship between the patient and the doctor is one of partnership and equality. This statement is theoretically valid considering the development and transformation of the doctor-patient relationship. However, this does not imply the absence of inequalities in the doctor-patient relationship.

A contractual relationship, the subject of which is healthcare, represents a service provided to the patient (layman) by the service provider (professional). Therefore, the basic inequality observed is professional inequality. Another inequality is informational. The doctor is always in the role of an expert, and the patient depends on and trusts the information provided by the doctor. In general, the doctor is obligated to familiarize the patient with all information related to the patient's state of health. In specific cases, when all the information would clearly and seriously endanger the patient's health, the doctor may decide not to disclose the information to the patient (the so-called therapeutic privilege). The doctor can provide additional information to the patient, tell only the necessary part, or disclose it to a confidant (Art. 2640 CC).

Other factors that can create inequality and influence the patient's final opinion include pain, fear, or fatigue. Under the burden of the experience of the situation, the patient may make a hasty decision to, for example, alleviate pain quickly. Considering these circumstances, the patient may be more easily influenced. Although the relationship between the doctor and the patient is considered equal in theory, there are significant differences in terms of social psychology, specifically in terms of power and authority, which can impact the autonomy of the patient's will and the final decision.[22] Of course, the health care contract is governed by general principles of obligations or consumer law, such as the principle of protecting the weaker party. Therefore, the patient is considered the weaker party and is accordingly protected. In cases of uncertainty in the relationship between the doctor and the patient, the decision is made in favor of the patient.[23]

**2. 2 Informed consent**

One of the essential parts of the health care contract is the patient's informed consent (Art. 2642, par. 1 CC). When the doctor becomes familiar with the patient's condition, a decision is made on the next course of action. The doctor cannot proceed with this procedure without the patient's consent, unless the law provides otherwise (Art. 2642, par. 1 CC). Informed consent is required for each procedure. Specific exceptions, allowing the provision of health services without the patient's consent, are listed in the Health Services Act. These include situations, for example, where the patient's state of health necessitates urgent care and simultaneously prevents the expression of consent (Art. 38,

[22] Kipnis D, Does power corrupt? Journal of Personality and Social Psychology, 1972, 24: 33-41.
[23] Šustek P, Holčapek T, Informovaný souhlas: Teorie a praxe informovaného souhlasu ve zdravotnictví, Aspi, 2007: 50-51.

par. 1, lett. c) HSA). Furthermore, in situations such as an immediate and serious threat posed by the patient to himself or his surroundings (Art. 38, par. 1, lett. b) HSA), or if the patient has been ordered to be isolated or quarantined (Art. 38, par. 1, lett. a), point 2. HSA), or protective treatment in the form of inpatient care imposed by a final court decision (Art. 38, par. 1, lett. a), point 1. HSA), etc.

If the patient consents, the consent must be informed and freely given. The doctor is obliged to instruct the patient in a proper and comprehensible manner. As part of the instruction, the doctor must clearly explain to the patient the intended procedure, possible risks, and consequences (Art. 2638, par. 1 CC). The doctor must ensure that the patient has understood the information communicated to him (Art. 2639, par. 1 CC). Only subsequently can the patient give consent to the act, unless the law stipulates that consent is not required in the given case (Art. 2642, par. 1 CC). The above conditions can be conveyed verbally or in writing, as required. The extent of instruction will also depend on the circumstances. As stated above, if the doctor assesses that the instruction is redundant under the given circumstances or could endanger or worsen the patient's health, he can modify the scope and provide adequate instruction or perform it additionally (Art. 2640 CC).

In the event that the patient refuses to give consent, the provider of health services may require written confirmation (Art. 2642, par. 1 CC). However, the health care contract does not expire by refusing an individual act within the framework of care. The obligation as a whole is canceled only if the patient expressly refuses health care (Art. 2651 CC).

## 2. 3 Limits of autonomy of the patient's will in healthcare law (with a focus on the field of gynecology and obstetrics)

Respecting the autonomy of the patient's will and their decisions is also related to the principle of protecting the inviolability of the patient. However, concerning the monitored protected interest, the rights of the patient may be limited in some situations. In such cases, the doctor performs the act against the patient's will. The Constitutional Court, in its judgment of May 18, 2001, no. IV. ÚS 639/2000, states that in cases where it is necessary to perform certain medical procedures or examinations without the express consent of the patient, it is always necessary to proceed with maximum restraint. A doctor should act in accordance with the principle of free decision-making in matters of personal health care, which arises from the constitutional principle of the inviolability of a person's integrity. And he adds that a diagnosis cannot be more than a right.

In this chapter, I will present some interesting cases that have occurred in practice. These represent significant decisions made by Czech courts, establishing limitations on the autonomy of the patient's will, particularly in the field of gynecology and obstetrics. The discussion will also highlight situations in which granting the patient's informed consent is excluded.

### 2. 3. 1 Conflict between the rights of the mother and those of the unborn child

In jurisprudence, the conflict between the rights of the mother and those of the unborn child is typically mentioned in relation to the limitation of the patient's rights. It is applicable in cases where the life and health of the unborn child are immediately threatened, allowing for the limitation of the mother's rights if actions are taken that are adequate to the purpose and protection of the life and health of the unborn child.[24]

In a situation where the patient is, for example, a child unable to give consent on their own, their legal representative can give

[24] E. g. Decision of the Constitutional Court, March 16, 2021, no. III. ÚS 2480/20.

what is known as proxy consent. Substitute consent can only be granted for a procedure that will directly benefit the patient.[25] In practice, on the contrary, it may also happen that legal representatives do not agree with the procedure proposed by the doctor. In its judgment of August 20, 2004, the Constitutional Court, no. III. ÚS 459/03, dealt with the admissibility of interference with parental rights for the purpose of protecting the health and life of a minor child. This was a situation where the child was diagnosed with a highly malignant cancer. The proposed treatment included chemotherapy and a blood transfusion. Due to their religious beliefs (Jehovah's Witnesses), the parents rejected the proposed *lege artis* treatment and demanded alternative treatment, mainly consisting of pain relief. It should be noted that none of the alternative options in this case were able to eliminate the causes of the disease other than the treatment suggested by the doctor. In this case, the Constitutional Court expressed the opinion that parents cannot be allowed to take measures harmful to the health or development of the child.[26]

### 2. 3. 2 The mother's right to release the placenta

Another issue concerning rights in the relationship between doctor and patient is the patient's right to decide about their body, its parts, and how they should be disposed of. The Constitutional Court of the Czech Republic, in its judgment of March 16, 2021, no. III. ÚS 2480/20, dealt with a complaint in which the complainant stated, among other things, her right to the inviolability of the person and privacy according to Art. 7, par. 1 Charter of Fundamental Rights and Freedoms[27] (also as „ChFRF“), as well as the right to protection against unauthorized interference in private and family life according to Art. 10, par. 2 ChFRF. The complainant received medical care in the field of obstetrics and gynecology at a medical facility. Following the care, the applicant requested the release of the placenta. The complainant believes that she has the right to have the placenta released, unless demonstrable reasons aimed at protecting public health prevent it. As the medical facility refused to release the placenta, she asserted that her personal rights were violated and demanded compensation for the non-pecuniary damage caused during the provision of medical services. The general courts unanimously concluded that the medical facility acted *de lege artis* in pursuing the goal of protecting the health of the child and the mother. The complainant was at risk of infection after the amniotic fluid was drained, and a blood test confirmed the presence of infection. Consequently, she was administered antibiotics. Due to the possibility of pathological changes in the placenta and its potential defectiveness, the decision was made not to release it. Objectively, no non-property damage occurred.

The Constitutional Court did not conclude that the applicant's fundamental rights were affected, as it was not possible to rule out the possibility that the placenta was already in a

[25] Povolná M. Komentář k ustanovení § 2642. In: Petrov J. et al. Občanský zákoník. Komentář. 2nd updated edition. C. H. Beck, Praha, 2023.

[26] Decision of the Constitutional Court, August 20, 2004, no. III. ÚS 459/03.

[27] Original: *Usnesení č. 2/1993 Sb., usnesení předsednictva České národní rady o vyhlášení LISTINY ZÁKLADNÍCH PRÁV A SVOBOD jako součástí ústavního pořádku České republiky*.

pathological state. Thus, it arrived at the same result as the general courts and concurred with the denial of the delivery of the placenta. However, it states that the denial of the right to release the placenta in general, without further ado, cannot be considered constitutionally compliant. In the event that there is no known reason indicating that a person's health should be at risk, health service providers are obliged to release the placenta to the mother upon request. The Constitutional Court further justifies this by emphasizing that the placenta is a separate part from the patient's body, and the decision of how such a body part should be disposed of falls within the scope of a person's freedom to decide how to live according to their own way. It is not up to medical facilities or courts to evaluate the motivation of women giving birth.

In its justification of the decision, the Constitutional Court states that the autonomy of the individual's will, both mentally and physically, must be respected. It emphasizes that the state has only limited possibilities to interfere in an individual's decision-making or limit their rights. The reasons for such restrictions may include the protection of the rights of other persons or other constitutionally protected assets. The recognition of the legal subjectivity of the individual and their will is manifested through free and informed consent. Consequently, the patient can express their will by disapproving and refusing a procedure, even though the consequences could be negative. This underscores the current concept of the relationship between doctor and patient, which respects and protects human dignity and freedom (Art. 3, par. 1 CC) and acknowledges the right of everyone to live according to their own wishes (Art. 81, par. 1 CC).

In relation to the handling of the placenta (and parts of the body), it addresses the obligations of the medical facility according to Art. 26 HSA, including the options for preservation and use, as well as the obligation to cremate the placenta. Regarding the cremation of the placenta, it argues that a purely grammatical interpretation of this provision is incorrect. The obligation to incinerate the placenta comes into consideration only when the patient does not request the delivery of the placenta, and at the same time, when delivery is not prevented by other serious reasons. Cremation of the placenta is a solution for a situation in which the patient is not interested in the placenta, and the hospital has to dispose of it. It emphasizes that proportionate interference with the patient's right is possible if there are serious reasons for which the release of the placenta by the medical facility is inadmissible, as such a procedure is contrary to the public interest in health protection.

### 2. 3. 3 Artificial insemination with the germ cells of the deceased husband

In this case, the Supreme Court of the Czech Republic ruled in its judgment of February 21, 2018, no. 21 Cdo 4020/2017, regarding the appeal of a female reproductive clinic patient. The Supreme Court investigated the question of whether the failure to fulfill the obligation to complete the process of artificial insemination with the germ cells of the deceased husband is capable of interfering with the patient's right to family life.

The patient sought to be legally and artificially inseminated using her germ cells and the cryopreserved sperm of her late husband. The husband died on June 16, 2015. On June 26, 2014, he signed an informed consent for sperm cryopreservation before infertility treatment and assisted reproduction methods. He never revoked this consent. On December 15, 2014, the patient and her husband signed an informed consent for infertility treatment using the in vitro fertilization method, consented to the thawing and use of sperm before infertility treatment using assisted reproduction methods, and on the same day, they also signed an informed consent for intracytoplasmic sperm injection. Subsequently, the patient was no longer given hormonal injections because her husband died, and her mental state after her husband's death did not allow the artificial insemination process to continue. After some time, she again demanded to continue the process of artificial insemination. However, the clinic refused to accommodate the patient due to the

absence of the husband's valid consent. The clinic stated that Art. 6 SHS prevents the completion of the artificial insemination process. According to this provision, artificial insemination can only be carried out if the request of the infertile couple requesting artificial insemination is not older than 6 months. In addition, this provision emphasizes the informed consent of the future parental couple, as it aims to treat the infertility of a man and a woman, not an individual. In this case, informed consent does not replace the previously expressed consent of the deceased spouse, and artificial insemination cannot be performed on its basis. The patient disagrees with this and believes that the clinic acts in violation of the principle of pacta sunt servanda but also denies the plaintiff her right to private and family life.

The Supreme Court also determined that the deceased's parents, who were heirs in addition to the patient, would have consented to the artificial insemination procedure. Furthermore, it is important to note that part of the informed consent included the instruction that sperm storage concludes in the event of the man's death, unless otherwise specified. Details about proposed methods, procedures, embryo storage, information on parentage determination, expected financial costs, and the storage period are integral components of the education provided to the infertile couple (Art. 8, par. 1 SHS). Subsequently, the infertile couple provides written consent for assisted reproduction, and this written consent must be obtained before each artificial insemination (Art. 8, par. 2 SHS).

The Supreme Court maintains the position that the failure to complete the process of artificial insemination with the reproductive cells of the deceased husband is not capable of interfering with the patient's right to family life, as it objectively does not exist. Nevertheless, it may represent an interference with the right to private life, given the close connection between the patient's desire and her husband's to start a family, with their actions being aimed at this goal. Artificial insemination can be pursued if it is unlikely or improbable for a woman to become pregnant naturally, and other treatment methods for her or her partner would not, or with a high degree of probability, lead to pregnancy. The court further notes that the husband's consent was limited to joint artificial insemination, not a blanket consent to the creation of embryos.

The Supreme Court further asserts that the rationale behind establishing the 6 month period is rooted in the child's right to know his parents, as outlined in Art. 7 of the Convention on the Rights of the Child.[28] Consequently, in cases of artificial insemination, it is stipulated that the child should be born into a complete family. The crucial moment determining the status of a child born from artificial insemination is the re-consent of the father. Artificial insemination cannot proceed without the consent of the man, and after his withdrawal, against the will of the husband, mother, or partner, or after his death.

The Supreme Court further asserts that, according to the explanatory report to the law, it can be inferred that artificial insemination is possible only *inter vivos* (between the living). Simultaneously, the condition of treating the couple's infertility must be fulfilled. This inference is supported by the allowance of artificial insemination for a woman in her fertile age. It is evident from the above that after the death of the man who forms the infertile couple, it is no longer possible to refer to them as an infertile couple or to provide treatment. In this case, even doubts arise as to whether the man would have still consented to artificial insemination after his death, given that the informed consent for the preservation of biological material also included a provision

[28] Original: *Sdělení č. 104/1991 Sb., sdělení federálního ministerstva zahraničních věcí o sjednání Úmluvy o právech dítěte*.

for destruction in the event of death. The Supreme Court concludes that, in this case, the assisted reproduction clinic did not make a mistake. A reproductive health care provider is not obliged to complete artificial insemination by combining a patient's germ cell with her deceased husband's cryopreserved sperm.

**2. 3. 4 Situations in which the granting of informed consent is excluded**

As part of the introductory provisions of the Civil Code, it is formulated that everyone has the right to the protection of life and health, as well as freedom, honor, dignity, and privacy (Art. 3, par. 2, lett. a) CC). In connection with this provision, it is necessary to recall Art. 19, par. 2 CC, which states that the natural rights associated with a person's personality cannot be alienated and cannot be waived. If this happens, it is not taken into account (Art. 19, par. 2 CC). This is a very important rule for the field of health law and research. In general, you cannot give consent to another to injure or kill another. In the field of healthcare, however, interference with bodily integrity protects protected interests, health, and life, and this is a procedure in accordance with the law. The Civil Code, for these cases, enshrines a rule that confirms this and says that, apart from the cases established by law, no one may intervene in the integrity of another person without his consent given with knowledge of the nature of the intervention and its possible consequences. If one consents to be seriously harmed, it is disregarded; this does not apply if the intervention is necessary under all circumstances in the interest of the life or health of the person concerned (Art. 93, par. 1 CC).

**2. 4 Public law limits within the doctor-patient relationship**

The legislator emphasizes the change that the relationship between doctor and patient has undergone (as early as the 1990s) and its private law nature.[29] The explanatory memorandum to this, clarifies that this private law anchoring does not negate the impact of public law regulations on this relationship.[30] One example is the adjustment of health insurance, for instance.[31] In addition, physicians may face criminal liability in cases of malpractice. Currently, there exists an expert consensus on the correct or appropriate treatment procedure for doctors, known as the *lege artis* procedure. This obligation is generally regulated in Art. 2643 par. 1 CC and in Art. 45, par. 1 HSA. The term *lege artis* is not explicitly defined by law. Essentially, it represents the most optimal solution, considering crucial circumstances and respecting the autonomy of the patient's will. Non-compliance with the *lege artis* procedure or potential misconduct can be addressed not only through disciplinary proceedings and at the civil level but also within the realm of criminal prosecution. Thus, even though it involves a private law relationship, the intertwined public law aspects cannot be overlooked.

In connection with public law, it is essential to highlight the obligations that a doctor has, irrespective of the patient's will, especially concerning the handling of information obtained from and about the patient. Besides the selection of a treatment procedure, patients

[29] Explanatory note to the Civil Code.
[30] Ibidem.
[31] Ministerstvo zdravotnictví ČR, Veřejné zdravotní pojištění, Available at: https://www.mzcr.cz/verejne-zdravotni-pojisteni-2/.

have the right to decide whether and to whom information about their person and health condition will be disclosed. In this context, doctors are bound by a duty of confidentiality, and any violation of this duty can result in criminal liability. The doctor committing the criminal act of unauthorized handling of personal data pursuant to Art. 180, par. 2 of the Act No. 40/2009 Coll., Criminal Code.

Conversely, doctors are obligated to report facts they learn in the course of their work, as required by HSA or other legal regulations (Art. 51, par. 2, lett. c) HSA). Additionally, they must provide information for the needs of criminal proceedings either voluntarily or upon request (Art. 51, par. 2, lett. d) HSA). When obstructing the notification of a criminal offense or disclosure of patient information, or when releasing a patient's medical documentation for criminal proceedings, doctors function as authorities and must act in accordance with their imposed duties. Failure to do so may result in criminal sanctions.

The field of health law is highly specific, as it amalgamates various legal and scientific branches. This specificity is evident in the extensive framework of standard-setting within the realm of health care, encompassing over a thousand statutory and by-law sources, including ethical codes.

## Discussion

It is evident that in the Czech Republic, there hasn't been a gradual development in healthcare law, but rather a systemic change has taken place. The development in the territory of the Czech Republic from the beginning of the 20th century to the present day can be divided into several basic stages. The first stage involves the separation of the department of public health, leading to the creation of a separate ministry. During this time, legislation became fragmented, reacting to problems that had already arisen and addressing the poor hygienic conditions of the population and epidemic situations. Another significant issue during this period was the availability of health care. Although efforts were made for systemic changes, the period of Nazi occupation fundamentally affected the planned changes.

The second stage involves the centralization and nationalization of healthcare. During this period, the relationship between doctor and patient still maintains a public law nature, with the doctor acting as an authority. The right to health protection is formally enshrined in the constitution, and care becomes more accessible through the creation of a system of public and social care. However, the autonomy of the patient's will is limited by the (dis)respect of rights in society. For instance, patients are legally allowed to undergo an artificial termination of pregnancy upon request, but the reasonability of the request is decided by a commission established for this purpose. A unified specialized legal regulation is created - the Act on People's Health Care. Although there are already international-level documents guaranteeing patients the right to decide for themselves based on informed consent, these procedures are not consistently followed.

The third stage involves the transformation of the legal nature of the relationship between the doctor and the patient, anchoring it within the private law framework. In the first two stages, the focus was on addressing the availability and systematization of healthcare provision. Only in the third stage can we truly talk about the relationship between the doctor and patient. The doctor-patient relationship is now perceived as equal, with an emphasis on communication with the patient. The patient is free to decide, and their will is respected. In general, prior informed consent of the patient is always required for the provision of health services.

The theory describes the current relationship between the doctor and the patient as an equal partnership, often referred to as a professional partnership. While this statement is generally valid, emphasizing the respect for the autonomy of the patient's will in contrast to earlier times, the specificity of this relationship introduces complexities. Despite the notion of equality in the doctor-patient relationship, various inequalities can emerge in specific situations, primarily in terms of professional and informational aspects. In most cases, the

patient is a layman making decisions based on information provided by the doctor. The doctor is obligated to share all crucial information transparently, ensuring that the patient understands the message without feeling overwhelmed. However, the doctor retains significant influence over the communication's extent, deciding, in justified cases, to withhold certain information. Conversely, the patient is also obliged to truthfully communicate all relevant facts that could impact proposed procedures. Mutual trust stands as a crucial component in the doctor-patient relationship.

Another inequality arises from the fact that the patient actively seeks out a doctor and visits the doctor in their environment. Typically, patients consult doctors when they already have a health issue. Given that the patient is not an expert and relies on the information provided by the doctor, decisions are often made under the influence of their current condition. Factors such as pain, fear, shame, anxiety, fatigue, may affect the decision-making process. Due to these considerations, the patient is regarded as the weaker party and is therefore entitled to protection.

Significant differences are evident in the rights and obligations of the parties involved in this relationship. The doctor is bound by a comprehensive set of legal regulations that impose various obligations. Consequently, there are situations where the doctor is obligated to act, irrespective of the patient's wishes. Examples include instances where a doctor may act against the mother's will to protect the rights of an unborn child whose life and health are at risk. In cases involving child patients, the doctor is obliged to intervene if the legal representatives take actions that may be harmful to the child's health or development, among other scenarios.

In the field of obstetrics and gynecology, the mother's right to handling the placenta may be further restricted. Generally, the patient has the right to decide how the severed body part should be disposed of, unless otherwise specified. However, if there is a known reason that the separated part of the body could endanger the health of a person, it cannot be issued. Medical facilities in the Czech Republic are obliged to respect the autonomy of the patient's will and release the placenta. Mothers can only be restricted in their rights if the delivery of the placenta would be contrary to the public interest in health protection.

Another case that may arise in practice is the patient's request to complete artificial insemination with the germ cells of her deceased partner. This is a very specific and borderline situation that was resolved in the Czech Republic in 2018. Czech law allows assisted reproduction only as a means of treating an infertile couple (a man and a woman). Artificial insemination cannot be carried out without the consent of the man, and after the withdrawal of consent, against the will of the husband, mother, or partner, or after his death. Although the patient felt that her rights had been violated, the court expressed a clear opinion that such a procedure is not possible in the Czech Republic. In this case, limiting the autonomy of the patient's will, who was requesting artificial insemination with the germ cells of her deceased husband, protects the rights of other persons, namely the rights of the deceased spouse and the unborn child.

Although the nature of the relationship between the doctor is private law, it is still limited by public law norms that may interfere with it. In a situation where a patient is suffering from a highly contagious disease, it is the doctor's duty not only to treat the patient but also to prevent the spread of the disease. The patient may be placed in quarantine despite disagreement. From the viewpoint of communicating information, a situation may arise in practice where the doctor is obliged to communicate the discovered information to the relevant institutions and authorities regardless of the patient's consent. In addition to the reporting obligation, the doctor may, in justified cases, release the patient's entire medical records to law enforcement authorities for the purposes of criminal proceedings. The rights and obligations of a doctor may also result from professional regulations and ethical standards. In the event of a doctor's misconduct, which may result from a wrongly

chosen procedure, disregarding the patient's will, breach of confidentiality, failure to report information to the competent authority, violation of hygiene standards and preventive measures, etc., the doctor is responsible for his actions and may face different types of sanctions (private law, labor law, disciplinary, criminal). In contrast, the patient does not have these obligations and is protected. In cases of doubt, the decision is made in favor of the patient. I believe that the mentioned inequalities regarding responsibility in the relationship between doctor and patient may partly contribute to establishing the position of the doctor as an authority.

In addition to the reasons mentioned above, inequalities can also be observed resulting from research in the field of social psychology. The research results highlight significant differences in power and authority within the doctor-patient relationship. Among other things, this asymmetry can consciously and unconsciously influence the individual decisions of the patient.

Personally, I believe that the above-mentioned inequalities are very difficult to eliminate. Considering the nature of the relationship, the protected interests, and the potential consequences that may arise in the event of a mistake, it is logical that doctors often prefer to proceed cautiously. This cautious approach, however, in some situations, may result in a lack of respect for the patient's will. Structured education for doctors in this area could improve the situation, addressing both the rights and obligations in relation to their person and the performance of their profession, as well as the rights and obligations of patients. Similarly, positive benefits would arise from educating patients, with a focus on understanding the differences and positions of individual subjects.

Patients would become more active participants in their own care and could play an increasingly involved role in the decision-making process about their body and health. In the future, the relationship between doctor and patient could evolve into more of a professional partnership, with the doctor serving as a guide to health care. However, this transition may not be without exceptions, as the doctor's statements from a position of authority could still persist in certain situations.