

ARTICOLE

A BRIEF OVERVIEW ON THE HISTORICAL
BEGINNINGS OF HEALTH LAW IN THE
BROADER CONTEXT OF PRIVATE LAW

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Necessitas non habet legem.

Abstract: Health law and its issues could seem to be just a contemporary problem, with a history going back no more than a century. However, the history of law and especially the history of private law can give us new insights into how traditional institutions such as torts, contracts, liability, consent, the status of persons and property have been drafted in and recomposed in this framework, together with borrowings from public law, to achieve this contemporary eclectic discipline.

Because the contemporary Romanian private law is tributary to the mid-19th century transplant from the French Civil Code of 1804, we will use the historical method to examine how the traces of modern-day health law can be found in much older private law institutions. We will examine this evolution in a Western European context because, ever since the Roman times and up until the 19th century civil codes, this area has been the cradle of private law and its relevance overcomes the

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geographical boundaries and spreads to all the countries that have ever adopted a Western European-inspired civil code.

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Although health law is a contemporary construct, probably owing its existence and development more to the 20th century than to any other previous historical era, its roots can be traced back to the Greek and Roman antiquity, having a lot in common with a series of classical private law institutions, especially relating to persons, consent, liability and contracts, without ignoring property issues. By using the historical method, we will try to uncover the traces of modern-day health law in these durable private law institutions. Our analysis will focus mainly on Western Europe, especially France, because there was the cradle of modern private law, at first through classical and post-classical Roman law, later through the rediscovery and evolution of medieval Roman law and its sibling the Canon law and, finally, in the age of the great Civil Codes of the 19th century, starting with the French Civil Code of 1804, which was quite faithfully transplanted in the Romanian Civil Code of 1864¹.

Because the distinction between private law and public law has been established gradually since the Late Middle Ages and the modern understanding of the term 'civil' law has only been used since the 18th century², for purposes of clarity for the contemporary reader we will use both concepts of 'private law' and 'civil law' in their contemporary meaning, even if these

¹ M. GUȚAN, Building the Romanian Modern Law – Why is It Based on Legal Transplant?, Acta Universitatis Lucian Blaga, 2005, pp. 135-136.

² A. LECA, A. LUNEL, S. SANCHEZ, *Histoire du Droit de la Santé*, Les Études Hospitalières Édition, Bordeaux, 2014, p. 26.

concepts had a different meaning in the historical age that we are analyzing. This paper will only briefly mention the public law aspects of health law, for example those regarding the prior authorization of medical practitioners or the organization of the public health system.

For reasons of brevity, we will sometimes use the colloquial term 'doctor' instead of the broader 'medical professional', making the appropriate distinctions where necessary between the equivalent of a modern-day M. D. and other types of medical professionals.

1 Law and Health in Antiquity

Although Greece is considered nowadays to be the cradle of medical ethics, mainly because the fundamental oath of Hippocrates appeared there for the first time, due to the medical school led by Hippocrates of Cos (460 B. C. - 380 B. C.), the Greeks were much less interested than the Romans in the public regulation of medical practice. The oath of Hippocrates is quite modern in its stating that the goal of medicine is of being useful to the sick and that a medical professional has duties in regard to his or her patients and colleagues, but it understandably leaves out contemporary concerns like the duty to inform the patient, the requirement of consent for medical care, the duty to alleviate pain and to give assistance to the poor. The oath was sworn by both Greek and Roman doctors up until the Christianization of the Roman empire, when it fell into disuse³. Medical ethics was later taken over from its antique

³ Ibidem, pp. 19-23; M. LINDEMANN, *Medicine and Society in Early Modern Europe*, Cambridge University Press, Cambridge, 1999, p. 9; see also V. NUTTON, *Healers in the Medical Marketplace: Towards a Social History of Greco-Roman Medicine*, p. 26 in A. WEAR (editor), *Medicine in Society – Historical Essays*, Cambridge University Press, Cambridge, 1992.

tradition by the Catholic Church, up until the secularization of contemporary times⁴. Roman law had an ambiguous attitude towards liberal professions (*operae liberales*) insofar as to have never really dealt with the problem of monetary payments for services rendered, making tenuous distinctions between the less reputable work of slaves and labourers that received a 'degrading' salary (*merces*), the *stipendium* of the soldier and the *honorarium* of the reputable professions, like doctors and midwives, the latter seen not as compensation but as a token of gratitude⁵.

Roman private law was much more advanced in regard to tort liability for medical professionals due to the general provisions of the 3rd century B. C. *Lex Aquilia* and the 1st century B. C. *Lex Cornelia de iniuriis* about cuts and bruises. Although the *Lex Aquilia* initially concerned only damages to things, including slaves, and excluded corporeal damages or the death of a free person, later case law extended its provisions by the creative use of particular procedural tricks such as the *actio utilis*⁶.

The Romans were the first to set up rules for the liability of medical professionals, without concerning themselves with the subtle modern distinctions between contractual liability and tort liability. They defined different writs (*actio*) for different types of liability, like the *actio legis Aquiliae* for death caused by the medicine administered by the doctor himself or the distinctive *actio in factum*, if death was caused by the patient taking the medicine himself, given to him by his doctor⁷. Thus we can say that *Lex*

⁴ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, p. 22.

⁵ *Ibidem*, pp. 23-24.

⁶ *Ibidem*, p. 25; A. LECA, *Un siècle de droit médical en France (1902-2002): de la lutte contre les épidémies aux droits des patients*, Victoria University of Wellington Law Review, 2004, volume 35, issue 2, p. 210.

⁷ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 25-26.

Aquiliae was not only for tort liability in the modern sense, but also for cases where there was a preexisting contract, such as the one between doctor and patient.

The post-classical Roman law was mostly concerned with the tort liability of doctors (*medicus*), especially for negligence. The *Corpus Iuris Civilis* of emperor Justinian had numerous references to cases of medical negligence, like bleeding a slave to death due to the ignorance of the doctor, giving bad medicines, abandoning their patient in the course of treatment and it also mentions that those who sold dangerous medicines or poisons would have been subject to the same law which punished assassins and poisoners (*Lex Cornelia de sicariis et veneficis*) with death or exile⁸.

2 Private Law and Health Issues in Medieval Times

The Early Middle Ages saw the advent of hospitals, or 'homes of hospitality', founded by the local bishops in the cities of Western Europe⁹. The Catholic Church's stated policy was to remind everyone of their duty of hospitality towards the poor, the bishops being bound to encourage the establishment of 'homes of hospitality', to watch over the religious discipline in such places and watch over the duly execution of the wills of the founders. At times, church councils enjoined the bishops to allocate at least a quarter of their resources for the lodging and caring of the sick or the pilgrims, because the embezzlement of funds destined for hospitals was quite frequent. Bishops

⁸ *Ibidem*.

⁹ M. LINDEMANN, *op. cit.*, p. 125.

were often reminded that they were mere administrators and not owners of the estate of the Church¹⁰.

The late 8th century and early 9th Carolingian revival witnessed a flourishing of new hospitals, called 'homes of God' or 'hotels of God', usually near the bishop's palace, the clergy's quarters or at the entrance of towns, in order to accommodate pilgrims and other voyagers. The emperor's decrees made a clear distinction between the estate of the hospital and other Church property, insisting on the due respect for the hospital founders' will, also enjoining the allocation of at least a tenth of the clergy's income for hospitals¹¹.

The High Middle Ages, from the 10th century onward, witnessed the general decline of urban life and the corresponding decline of the bishop-led model of town hospital. Most hospitals were now situated in the rural area, especially around monasteries, and were run by hospitality-driven orders like the Benedictine monks. In theory, they received anyone searching for health, food or shelter, poverty being considered a way towards redemption, but they had different premises for different social classes, resembling hotels for the rich and hospitals for the poor¹².

In the Early and High Middle Ages, until the 12th century, in a typical Western European country like France, medical practice was divided between an eclectic and undifferentiated group of healers, men and women, lay and religious, with various degrees of medical knowledge, comprising doctors, surgeons and apothecaries¹³. It was a time of quacks and crooks, of little

¹⁰ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, p. 82.

¹¹ *Ibidem*, pp. 82-83.

¹² *Ibidem*, p. 83.

¹³ K. PARK, *Medicine and Society in Medieval Europe, 500-1500*, pp. 59-60 in A. WEAR (editor), *Medicine in Society – Historical Essays*, Cambridge University Press, Cambridge, 1992.

formal medical education, while the first regulations of the medical profession only appeared in the 14th century in Paris and Montpellier. Only in the 15th century an organized monopoly of medical practice began to spread throughout France. A significant medical school was the one organized in the University of Paris, which at first included only religious faculty and was thus naturally affiliated with the papacy¹⁴.

In the Middle Ages, health care in Western Europe was considered to be an activity that concerned mainly the church, with specialized religious orders. Up until the 12th century, numerous members of the clergy, of different ranks, were authorized to practice medicine, but the canon law reforms after 1130 forbade formal medical university studies and regular medical practice to the so-called 'regular' clergy (the monks) outside their convents, because these activities interfered with their religious duties, allowing only certain so-called 'secular' clergy (priests living among lay people) to practice medicine, as long as they could also satisfy their religious obligations¹⁵. The church was the first to try to regulate the medical profession in the 13th century, by demand from the Paris medical school or the medical school from Montpellier, but its orders were never thoroughly enforced. Thus the established medical profession, represented by medical schools like the ones from the Universities of Paris and Montpellier, gradually turned, from the 14th century onward, to the king of France for the enforcement of its professional monopoly¹⁶.

Similarly to doctors (M. D.), surgeons and apothecaries also began slowly to differentiate from barbers and spice shop owners and to be regulated

¹⁴ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 35-37; M. LINDEMANN, *op. cit.*, p. 173.

¹⁵ K. PARK, *op.cit.*, pp. 76-77.

¹⁶ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 29, 37-40.

like medical professionals in the Late Middle Ages, from the 13th century onward¹⁷.

Healthcare and hospitals were considered to be mainly charity work, which from the end of the 13th century began to be supervised by lay authorities, including the king and the cities. This tight relationship between hospitals and charity meant that, during the Middle Ages, healthcare was very much dependent on donations from private individuals who could thus influence the way in which hospitals were run. In France, starting in the Late Middle Ages, the royal power began to get involved in healthcare. Organized religion, science and the state were much less separated at the time than they are today¹⁸.

Hospitals during the Middle Ages were not mainly medical institutions¹⁹ because their primary purpose was to care for the poor and, only as a secondary objective, they also took in the sick poor, who had nobody to care for them. Because hospitals were mainly social care institutions, they had only a marginal connection with doctors, who played only a minor role, were poorly paid and left most of the caring to surgeons and the religious staff. In France, during the Late Middle Ages, from the 12th to the 14th century, there were two types of hospitals: the majority were ecclesiastical institutions under the guise of charitable causes and were under the authority of the local bishop, while the rest, mainly the ones caring for the sufferers of leprosy, were created and run by the lay local authorities²⁰.

¹⁷ *Ibidem*, pp. 40-47.

¹⁸ *Ibidem*, pp. 29-30, 38; M. LINDEMANN, *op. cit.*, p. 126.

¹⁹ M. LINDEMANN, *op. cit.*, pp. 120-121.

²⁰ A. LECA, A. Lunel, S. Sanchez, *op. cit.*, p. 81.

A medieval hospital was typically established and managed by the local bishop, with the purpose of caring for both the corporeal and the spiritual infirmities of their patients. Its finances were very much dependent on charitable donations and legacies, which meant that, while it was not a burden for the public purse, it was also exposed to the irregular nature of this type of private funding. Hospitals were catering for both the spiritual and the earthly needs of the poor, the sick, the infirm and the pilgrims, by offering them care and a home or a temporary shelter²¹. The doctors were only temporary visitors in these institutions, while the chaplains were permanent residents²².

The powerful people of the Late Middle Ages, be they aristocrats, clergy or rich bourgeoisie, were all participating in the healthcare effort²³ by allocating a part of their fortune for the establishment or maintenance of a hospital, both to signal their Christian virtue and also expecting some reward in the afterlife, charity being viewed as atonement for past sins. Hospitals were depending for their upkeep on the revenues generated by their own real estate, either agricultural land exploited directly or rented out for money or in kind benefits, buildings for their own use or taxes collected from the hospital domain. To establish a new hospital, real estate had to be part of the donation or legacy, but hospitals also organized yearly collects, sometimes in exchange for religious pardons. There was also a custom for hospitals to receive as legacy the furniture or the bed linen of the deceased who died in the establishment²⁴.

²¹ M. LINDEMANN, *op. cit.*, p. 125.

²² A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 81-82.

²³ M. LINDEMANN, *op. cit.*, p. 122.

²⁴ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 83-84, 89-91.

Hospitals were considered church property, like a chapel or a church, a status which encompassed some supervision by the local bishop but also significant legal privileges, including an interdiction to be even partially sold or given away without rigorous formalities and a general exemption for the charitable estate from all kinds of taxes. The hospitals were also endowed, like a parish church, with the right to bury the dead on their premises and the right of asylum, which meant that no troops or police could enter²⁵.

The establishment of a hospital was considered a 'charitable cause' and this had legal significance because the initial purpose of the donation or legacy had to be respected, any change needing special authorization from the local bishop. The will of the founder was decisive in establishing how the place was run, by mentioning those who would nominate and control the administrators, be they the heirs of the founder, the municipality or the local bishop. The administrator either had a life-long appointment with ecclesiastical privileges or he was a simple lay administrator with a three-year appointment that could be renewed. The hospitals established by the local communities all had simple administrators and received only spiritual guidance from the clergy²⁶.

Even in the Late Middle Ages, specialized medical care was only an afterthought in the hospitals of the time. The treatment consisted mainly of potions prepared locally by the monks, baths and blood-letting from visiting barbers. Doctors or barbers/surgeons were called only on a case-by-case basis, and only the 14th century began to witness payed permanent visits from doctors or surgeons, but only in the big hospitals of the time²⁷.

²⁵ *Ibidem*, p. 84.

²⁶ *Ibidem*, pp. 84, 87-88.

²⁷ *Ibidem*, p. 85, M. LINDEMANN, *op. cit.*, p. 127.

However, there was a different status for the hospitals created for leprosy sufferers. They were established well outside the cities²⁸, the sufferers generally had to belong to the local community, they had to pay an 'admission' fee and be accepted by the hospital management. These leprosy hospices were considered to be moral persons and they had to live within their own resources. The leprosy patients were considered dead to the outside world and, when they ventured in the outside villages, they had to signal their presence by sounding a bell²⁹.

Hospitals in the Late Middle Ages were run by religious congregations of brothers and sisters who were subject to a quasi-monastic discipline. They generally had to begin as novices, before being permanently accepted by the religious or lay administrator of the establishment, they had to be a free person, celibate, without debts and not suffering from leprosy or epilepsy. They took a vow of poverty, chastity and obedience, had to dress modestly and to ask for permission from the administrator to travel outside³⁰.

3 Modern View of Health Law in the 16th to the 19th Century

In older Romanian laws, like the 17th century decrees of Vasile Lupu in Moldova and Matei Basarab in Wallachia, sending one's own child to a hospital was a serious reason to lose parental authority, mainly because the

²⁸ M. LINDEMANN, *op. cit.*, p. 123.

²⁹ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 85-86; K. PARK, *op. cit.*, pp. 86-87.

³⁰ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 88-89; M. LINDEMANN, *op. cit.*, p. 133.

hospitals of the era were considered to be terrible places, only for the poor and the sick³¹.

The transition from the Middle Ages to the modern era saw a dense network of hospitals in France who were in a bad state due to the ravages of the Hundred Years' war and a decrease in charitable impetus of the people. There was also a decline in the discipline of these establishments, coupled with a decrease in the Catholic Church's authority in regard to the lay local and later royal authorities³².

The post-medieval France of the *Ancien Régime* witnessed a conflict between the royal authority and the Catholic Church in regard to the management of hospitals, starting in the 16th century, but this conflict was later resolved by appointing joint councils, made up of both lay people and members of the clergy, who ran these charitable institutions up until the late 18th century and the French Revolution of 1789. The 17th century also saw the advent of a new type of hospital, the so-called 'general hospital', established by the king with the purpose of locking away and disciplining the urban paupers³³, while the traditional religiously-inspired hospitals slowly drifted towards a more pronounced role in medical care³⁴.

The 16th century in France witnessed the attempted taking over of hospital administration by the royal authority, firstly by establishing a local

³¹ D. ALEXANDRESCO, *Principiile dreptului civil român*, vol. I, Atelierele grafice SOCEC & Co., București, 1926, pp. 240-241.

³² A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, p. 91; M. LINDEMANN, *op. cit.*, p. 130.

³³ M. LINDEMANN, *op. cit.*, p. 131.

³⁴ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 81, 93.

tax called 'the poor men's due' to finance hospitals and also by merging smaller hospitals into larger establishments for the better management of resources. The King of France also tried to take over directly hospital management, in order to curtail widespread embezzlement and the misuse of the founders' donations and legacies, by appointing commissions made up of members of the bourgeoisie to run the hospitals and answer to royal officers. These attempts were not very successful due to the lack of enthusiasm of the royal officers to take on new assignments and due to the resistance of the local clergy. This struggle between Church, local authorities and the central royal power for preeminence in regard to hospital administration would continue for the following two centuries, one of the tenets for the resistance to centralization being the private law principle of respecting the initial will of the founder who had established the hospital³⁵.

The modern age in France was similar to the Middle Ages in regard to the all-powerful respect and obedience to the will of a hospital's founder. These hospitals were plagued by a near total disregard to sanitary principles. They were destined to alleviate all kinds of misfortune, including poverty, and the health element was a mere secondary concern. Hospital resources remained generally insufficient, in spite of royal intervention, and hospital administration was disputed by the Catholic Church, the King of France, the local and regional authorities³⁶.

The French Revolution of 1789 was a time of great reforms for the entire healthcare system. Before the Revolution, doctors were the only medical professionals with a university degree, while the surgeons and the

³⁵ *Ibidem*, pp. 94-100; M. LINDEMANN, *op. cit.*, p. 131.

³⁶ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, p. 108.

apothecaries were mere practitioners. The laws at the beginning of the 19th century established for France the compulsory nature of formal studies and exams for doctors, surgeons and apothecaries and gave them a monopoly on medical practice. Laws at the end of the 19th century also regulated the dentists and the midwives as medical professionals³⁷.

The more than two thousand hospitals which existed in France at the end of the 18th century were more social establishments than medical ones and their personnel was almost entirely religious³⁸. They were run by the local authorities, with the exception of hospitals in Paris, even if they needed a prior authorization from the central authorities. Although laws at the beginning of the 19th century saw the creation of a daily price for hospital care, fees paid by patients were only a small part of any hospital's budget during the 19th century, while France was also lacking a generalized compulsory social insurance scheme, that could have taken charge of medical costs, unlike Germany and Austria³⁹.

The 19th century France defined hospitals as places of public health assistance for everybody, including the paupers, endowed them with legal personality, a budget, an estate and standing in litigation. The medical focus of these institutions was progressively increased in the late 19th century, medicine finally becoming a scientific discipline after 1880. At the same time, the dominant voluntary religious personnel was slowly supplemented by lay nurses, especially after the first civil nurses' schools were opened in 1899.

³⁷ *Ibidem*, pp. 184, 205-210, 216.

³⁸ M. LINDEMANN, *op. cit.*, p. 122.

³⁹ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 217-219.

Better built hospitals were attracting even the well-off for medical care, gradually shifting their focus away from caring for free only for the paupers⁴⁰.

The French civil code of 1804, although very broad in its definition of civil tort liability, had no specific provisions about the medical 'art', unlike its Austrian counterpart from 1811, which had very specific provisions for these cases. Only after 1830 did the French courts agree that medical damages fell under the provisions of civil tort liability and thus, they could not be insured up until 1945. Tort liability for the medical professional was based on negligence or bad faith, a common fault encompassing the failure of his professional duty⁴¹.

French civil law was reluctant to see the doctor-patient relationship as a contractual one, although there were 16th century authors like Cujas, who translated the rules of the common services contract in this context. 19th century French civil law doctrine considered all liberal professional acts, including medicine, to be invaluable and thus they could not be the object of a 'vulgar' services contract⁴².

4 Contemporary Integration of Private Law Rules in Health Law

The 20th century saw the generalization of social medicine, the interwar period seeing France develop its own system of social insurance and a gradual opening up of the hospital system to the general population. The first coherent healthcare systems emerged at the end of the 19th century in Germany and were now spreading in the United Kingdom (1910), Japan

⁴⁰ *Ibidem*, pp. 221-222.

⁴¹ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 228-230.

⁴² *Ibidem*, p. 230; Ch. AUBRY, C. F. RAU, *Droit civil français*, 5th edition, Volume 4, p. 533.

(1922), Australia and New Zealand (1938), thus decoupling healthcare from charity and the wealth of the local communities⁴³.

In regard to medical liability, it was only in the 1930s that the French courts accepted that there could be contractual liability between a free-practicing doctor and his patient, the doctor having only a 'best efforts' duty, according to current science, to heal the patient and not necessarily to achieve a certain result⁴⁴.

The interwar period saw the statutory provisions that cemented the right of the patient to choose his medical professional. After the Second World War, the French Constitution stipulated the right to the protection of health as a constitutional right⁴⁵.

In France, medical law was considered in the 19th century to be a part of public law due to the strong administrative and criminal element, but it slowly reemerged as a close relative of civil law, using its concepts in relation to persons, property, liability and ingeniously integrating the duty of public service. The 20th century witnessed the novelty of informing the patients about their health and asking for their informed consent for any medical procedure, rendering obsolete the 19th century justification of the therapeutic value of the medical lie, medical law being at the forefront of this duty to inform, which later spread to other areas of civil law. This evolution preceded in France by some decades the acceptance of the contractual nature of the doctor-patient relationship and it was based on the respect for the dignity of the human being⁴⁶.

⁴³ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 222-223, 239.

⁴⁴ *Ibidem*, pp. 230-231.

⁴⁵ *Ibidem*, pp. 237-238; A. LECA, *op. cit.*, p. 215.

⁴⁶ A. LECA, A. LUNEL, S. SANCHEZ, *op. cit.*, pp. 266-269; A. LECA, *op. cit.*, p. 219.

5 Conclusions

Healthcare has been considered an equivalent of charity for a very long historical time. It has often been bundled up with social care and the Christian duty to care for the poor and the needy. Receiving payment for health services was often viewed as shameful and the training of medical professionals had frequently been neglected or reduced to a mere vocational experience. Hospitals were at first asylums for the poor and later even concentration camps or prisons for the paupers. Financing healthcare was often reliant on private donations and legacies, given out of Christian piety and an unexpressed desire for atonement for past sins and the hope of rewards in the afterlife.

Out of all this chaos, the modern healthcare system and its accompanying legal system emerged in the 19th and 20th century, frequently paid for by the state or by social insurance schemes. Private law norms regarding persons, liability, contracts, property and torts were seamlessly blended with public law institutions from administrative and criminal law in order to create the contemporary health law.