Patients rights

Outlined by:

Patiente Vertriedung A.s.b.l.
1b, rue Thomas Edison
L-1445 Strassen
+352 49 14 57
www.patientevertriedung.lu

With the financial support of
The Government of The Grand-Duché of Luxembourg - Health Minisrty
and the Oeuvre Nationale de Secours Grande-Duchesse Charlotte :

LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

ŒUVRE
Nationale de Secours
Grande-Duchesse Charlotte

Layout/Print: Reka, Ehlerange

Content

1	**Guiding principles**	**9**
1.1	The respect of dignity and loyalty	9
1.2	Access to quality healthcare	9
1.3	Freedom of choice of healthcare provider	9
1.4	Support to patients	9
1.5	Safety of patients and visitors	10
1.6	Training and participation in studies in medical research	10
1.7	Duties of nursing and medical staff	10
1.8	Refusal to provide care to a patient	10
1.9	Second opinion	11
1.10.	Psychiatry	11
2	**The relationship between Patient - Healthcare professional - Hospital**	**13**
2.1	Information	14
	2.1.1 The concept	14
	2.1.2 The exceptions	14
2.2	Free and informed consent	16
	2.2.1 The concept	16
	2.2.2 The exceptions	17
	2.2.3 The form of consent	18
	2.2.4 The withdrawal of consent	19
	2.2.5 Proof and challenge	19
2.3	Patient‘s file	19
	2.3.1 Definition	19
	2.3.2 Content of the file	19
	2.3.3 Right of access to the file	20
	2.3.4 The shared medical file	21
	2.3.5 In case the patient passes away	22
	2.3.6 Personal annotations	22
2.4	Professional secrecy	23
2.5	Trusted person	25
2.6	Reffering doctor	26

Content

3	**Cross border healthcare services**	**27**
4	**Specific issues**	**32**
4.1	Generic medicines	32
4.2	Palliative care	33
	4.2.1 Definition	33
	4.2.2 Objectives of palliative care	34
	4.2.3 Advance directive	35
4.3	Life-prolonging treatments	35
4.4	Euthanasia and assistance to suicide	36
	4.4.1 Definition	36
	4.4.2 Arrangements for the end of life	37
4.5	Organs retrieval	38
	4.5.1 Retrieval from a living person	38
	4.5.2 Retrieval from a deceased person	38
4.6	Autopsy	38
5	**Professional misconduct, professional negligence and remedies**	**39**
5.1	Recognition of prejudice	39
	5.1.1 Mistakes	39
	5.1.2 Negligence and professional misconduct	39
	5.1.3 Procedure in case an invoice is disputed	40
5.2	Reconciliation	40
5.3	The national service for information and mediation in the field of healthcare	41
5.4	The procedure for a complaint	41
5.5	Social jurisdictions	42
6	**Miscellaneous**	**45**
6.1	Glossary	45
6.2	Reference works & various law	49

Preface

The patient as a partner!

More and more often and with an ever-louder voice, patients express their wish to be included in the process of a medical consultation as a partner, to be heard and be able to decide together on a treatment. With this new edition of the brochure on the rights and duties of patients, the Patiente Vertriedung asbl gives patients an instrument enabling them to become informed partners on a solid foundation of knowledge-based facts.

With the Patients' Rights Act, which came into force on 24 July 2014, important patients rights were for the first time deliberately anchored in a law. Patients can refer to this text if they want to assert their rights while interacting with a medical service provider.

With the help of this brochure, the patient will be enabled to actively and responsibly participate in the decision-making processes regarding his health and thus becomes an equal partner within the doctor-patient relationship.

Finally, I would like to thank all those who put and will continue to put the patient's well-being at the center. Thanks to your continuous efforts, you help to strengthen the relationship of trust between patient and medical service provider and an enhanced therapy quality and transparency.

Paulette Lenert
Minister of Health

Established on 28 June 1995, Patiente Vertriedung asbl has now been defending patients' rights for 20 years. As far as legislation is concerned, it is the new law which came into force on 24 July 2014 that has allowed for considerable headway. Nevertheless, although our asbl was a contributor to the development of the project, all the point that were important to Patiente Vertriedung were not taken into consideration.

Patients challenged by their sickness, have no choice but try to find their way in uncharted territory. Although they might see their doctor several times a year and undergo medical checks, they are not necessarily aware of their rights and duties, given that they do not quite often know where to get information about their rights. And these are essential rights for the protection of patients.

It is frequent for patients to wonder: "Is my treating doctor experienced?" "How does the operation unfold and what are the risks involved?" "What to do if the operation fails?" "How should I then behave?" "What are my rights?" "If anything happened to me, would my doctor turn to my relatives so that they could let him know my wishes?" "Is there a person one can refer to?"

It is with the aim that patients are enabled to find answers to this kind of questions and get informed about their rights as well as their implementation, that Patiente Vertriedung asbl has drawn up this brochure. It can serve as a reference to be used whenever the need arises. A well-informed patient is more equipped to evaluate a situation and form a point of view. This way patient and doctor are able to act together as equals, which will benefit the relationship between patient and doctor.

The Patiente Vertriedung asbl brochure should contribute to making patients into active partners to the health system by dedicating itself to promoting patients' rights.

I wish you will find this reading most instructive!

René Pizzaferri
President of Patiente Vertriedung asbl

Preliminary observations

This brochure is non-exhaustive, it only addresses the main guidelines in terms of patients' rights based on different laws in force at the time of its publication.

For further information, please refer to related legal bases and contact the different centres which are likely to inform you about your specific questions and how to proceed.

- The 24 July 2014 law on patients 'rights and duties, establishing a national service for information and mediation in the field of healthcare is hereinafter referred to as "the 24 July 2014 law"

- The 1st July 2014 law transposing the European Parliament and Council Directive 2011/24/UE of 9 March 2011 on the implementation of patients' rights in terms of cross-border healthcare services is hereinafter referred to as "the 1st July 2014 law"

As far as patients' rights are concerned, one can also rely on the codes of ethics[1] of the various professions which deal with patients.

[1] See 6.2 Publications & various laws

1 Guiding principles

1.1 The respect of dignity and loyalty

Every patient has the right to the protection of their privacy, to confidentiality, dignity and respect of their religious and philosophical convictions. (Article 3(1) of the 24 July 2014 law)

1.2 Access to quality healthcare

"Without prejudice to priorities due to level of emergency, patients are entitled to equal access to healthcare services required by their health situation. Healthcare services are provided in an efficient manner and are in conformity with scientific knowledge and the legally prescribed norms in relation to quality and safety" (Article 4(1) of the 24 July 2014 law)

1.3 Freedom of choice of healthcare provider

Patients may freely chose their doctor, except in case of emergency. In case of hospitalisation and except for an emergency, patients have the free choice of hospital as well as that of a doctor among those allowed to practice in that very hospital. Patient have always the right to turn to another doctor for an additional opinion on their health status or opt for a joint examination with their referring doctor and a consulting doctor. Nevertheless, health insurance does not cover a medical consultation happening within 24 hours of another one in the same speciality, except for interventions of the medical emergency service.

1.4 Support to patients

A patient may be **assisted** by a third person in his or her procedure/decisions relative to his or her health situation. (Article 7(1) of the 24 July 2014 law). Such third person, also called "Patient companion" is chosen by the patient freely, their identity is recorded in the file. (They may or may not be a healthcare professional)

At the express request of the patient, professional secrecy will be lifted for such companion. (Article 7(2) of the 24 July 2014 law) The person of trust as opposed to "the patient's companion", will take the role of "spokesperson" for the patient, if the latter is no longer able to express his or her will at a later point in time, whereas " the patient's companion" has an assisting role only.

1.5 Safety of patients and visitors

Every patient and every visitor must keep to the safety measures stated in the rules of procedure of each hospital as well as to visiting hours and arrangements.

1.6 Training and participation in studies in medical research

Regarding the participation of a patient in the area of training as for example when he or she is presented to medical students, the patient's consent or that of their legal representative is mandatory.

For treatments in the context of medical research, the participation to a study requires the free, informed and written consent of the patient or their legal representative, after having informed the patient in an adequate and exhaustive manner about the goals, methods and expected benefits as well as risks and potential inconveniences. Patients have the right not to take part in studies and to withdraw from them any time they want.

1.7 Duties of nursing and medical staff

Healthcare professionals have the duty to assist patients in exercising their rights.

1.8 Refusal to provide care for a patient

Healthcare professionals are entitled to refuse to provide care for professional or personal reasons (abortion, forced treatment in psychiatry, etc.) (Article 6(1) of the 24 July 2014 law) Refusal can by no means be based on discriminatory considerations. (Article 6(2) of the 24 July 2014 law)

In case of refusal to provide care for a patient, healthcare professionals must direct the patient (at his or her request) towards another professional. (Article 6 (1) of the 24 July 2014 law)

However, (so far as possible) every healthcare professional, whatever their personal convictions may be, is required to provide assistance to a person who is in urgent need of medical care.

1.9 Second opinion

In the context of a complicated intervention or some special cases, it may be useful to ask for a second opinion. A "second opinion" is to be understood as additional advice requested from a doctor other than the one who has already been consulted. Seeking a second opinion is not an act expressing mistrust in the doctor who was first consulted.

It should be noted that the second consultation is only covered by health insurance when it happens later than 24 hours after the first one, except for interventions of the emergency medical service.

Article 36 of the 2011 regulations of Caisse Nationale de Santé provides that:

"Except for prior authorization or justification accepted by medical control, the following are not covered:

- More than one consultation or visit by a general practitioner or specialized doctor of the same branch of medicine in 24 hours, unless there is an intervention of the medical emergency service.
- More than 2 consultation or visit by a general practitioner or specialized doctor of the same branch of medicine in a period of 7 days.
- More than 12 consultation or visit by a general practitioner or specialized doctor of the same branch of medicine in a semester, unless these are consultations or visits provided within the frame of a long geriatric stay or when the patient is staying at a hospital.

1.10 Psychiatry

First of all, it should be emphasised how mental disorders are of a special nature. Indeed, they may seriously alter the patient's judgment, without diminishing his or her degree of consciousness or vigilance, nor make a stay in hospital necessary.

Generally speaking, in the field of psychiatry, just as in all sectors of the healthcare system, consent from patients is required for all measures related to diagnosis or therapy.

So far as possible, people suffering from mental disorders must be treated within the environment where they live. They cannot be placed in a psychiatric institution or closed psychiatric ward unless serious mental disorders make them a hazard for themselves or for others.

During their stay in hospital patients are entitled to a treatment suited to their condition, and unless in an emergency, the attending doctor must as much as possible see to the implementation of the patient's rights in relation to information provided to him or her and to obtaining his or her informed consent.

Treatments must be based on a personalized treatment plan and delivered by qualified medical and nursing staff. To the extent possible treatments must aim at reintegration the patient into society.

Treatments must be delivered with respect for patients' freedom of opinion and for their religious and philosophical convictions. They must also foster patients' physical health as well as their contacts with their family and society and cultural development.

2 The relationship between Patient – Healthcare professional – Hospital

Before one goes to the doctor's or to the hospital, it is advisable to get prepared. Brochures designed to help you prepare for a visit to the doctor or for your stay in hospital are available by Patiente Vertriedung a.s.b.l. and on the Internet site: www.patientevertriedung.lu

2.1 Information

Every patient is **entitled** to adequate information about his or her health condition. There are 3 exceptions to this principle: the express request of the patient not to be informed, emergency and therapeutic exception.

2.1.1 The concept

Every patient has the right to be informed about his or her health condition, the diagnosis, the treatments suggested, therapeutic options, and about the foreseeable benefits and risks. Thus, healthcare professionals must, so far as possible, inform patients about treatments and the effects and consequences of the medical checks they propose.

Healthcare professionals are to provide information to patients. It must be expressed using a language which is clear and understandable to patients, in an adequate environment and taking into consideration his or her possible reactions.

Information related to diagnosis, treatment or results of medical checks is provided under the responsibility of the doctor; other healthcare professionals contribute within the limits of their qualification. Information about possible adverse risks may be made public through written documents. It is "the Scientific Board in the field of healthcare that outlines recommendations for best practices in relation to the provision of information to patients on their health condition" (Article 8(4) of the 24 July 2014 law)

At the request of patients, the information provided will comprise an estimate of the overall cost of the healthcare services which are offered and an estimate of the cost of the planned care. (Article 8(4) of the 24 July 2014 law)

When several healthcare professionals work with a patient, they keep mutually informed, unless the patient objects to it. (Article 8(2) of the 24 July 2014 law)

2.1.2 The exceptions

- **At the express request of a patient:** patients have the right not to be informed about their health condition. Expressed more precisely, it is "the right to be kept in ignorance". Every patient has this right and it must be written in the file of the patient.

This is not an unrestricted right because when the situation is so that the right "to be kept in ignorance" is detrimental to the patient themselves or to a third person, the doctor is under the obligation to inform the patient be it even if the patient has expressed their will not to be informed about their health condition. (For instance: contagious diseases) (Article 9 of the 24 July 2014 law)

- **In case of emergency:** When it proves to be impossible for the doctor to inform the patient appropriately about their health condition.
- **Therapeutic exception:** The doctor may exceptionally decide not to disclose certain information whose disclosure (at that precise moment) he or she believes would cause serious harm to the patient (for example a patient in a fragile situation confronted with a fatal prognosis.

If this is the case the attending doctor will have to consult with a colleague and when applicable with the trusted person. If the doctor decides to refrain from revealing certain information, he or she must make a record of this decision and his or her reasons in the patient's file.

When the doctor believes that the disclosure of such information can now happen without causing harm, they can "lift the therapeutic exception". The decision for the therapeutic exception and the decision to cancel the therapeutic exception must be recorded together with the motivations for them in the patient's file. (Article 10 of the 24 July 2014 law)

Information given to patients is in principle delivered orally and may be completed in written form. (Article 8(7) of the 24 July 2014 law)

Patients may request from doctors information in writing / or documentation in order to be able to give their informed consent.

Any decisions concerning a patient's health condition will be made by the healthcare professional **and** the patient. (Article 8(3) of the 24 July 2014 law)

Healthcare and treatments offered to a patient can only be implemented after the patient has been appropriately informed about them and his or her consent granted. (Article 8(4) of the 24 July 2014 law)

2.2 Free and informed consent

2.2.1 The concept

No measures, be it for diagnosis or therapy, somatic or psychiatric, can be taken without the informed consent of the patient.

Consent is considered "informed" as long as the healthcare professional has provided the patient with all the information needed for him or her to understand his or her situation and understand all the implications of his or her decision. The more these actions entail serious risks, the more the information provided to the patient must be detailed for him or her consent to be informed. (Amended law of 10 August 1992 on youth protection).

Patients are entitled to refuse or accept any intervention for diagnosis or therapy.

When the doctor believes that his or her patient is wrong to oppose an intervention, he or she may request from them to confirm their refusal in writing.

In case of non-urgent surgery, it may be in the interest of the patient to consult with another doctor. (Second opinion)

2.2.2 The exceptions

The patient is not in a condition to give their consent

Article 11 of the 24 July 2014 law provides that if the patient is unable (temporarily or permanently) to express their will, nor give their consent, it is the role and responsibility of the care provider to seek to establish "their assumed will". Before making a decision of such magnitude, the doctor will take into account the opinion of the trusted person or that of any person that may know the patient's will.

In case of emergency

In an emergency situation: when it proves impossible to obtain the free and informed consent of the patient.

In case of minors

This category is for all patients under the age of 18 years old. (Article 388 of the Civil Code)

As a rule, consent must be obtained from the legal representative: for example, from the father and the mother of minor children. The legal representative must then make the decision which is most suited to the interest of the patient. A minor is involved in the process of decision making according to his or her age and degree of maturity.

In case of an adult under protective supervision

Patients under curatorship

Curatorship "applies to persons whose mental faculties are altered to the extent that they need to be assisted by a curator in legal and public proceedings".[1]

---

[1] www.justice.public.lu/fr/famille/tutelle-curatelle/tutelle-curatelle/index.html (Consulted in August 2014)

Under article 14(1) of the 24 July 2014 law, unless a court decision says that the patient who is under curatorship can make decisions in relation to his or her health condition all by themselves, he or she will make them with the assistance of their curator.

Patients under tutorship

Tutorship "applies to persons who are no longer able to express themselves and who therefore need to be represented by a tutor"[2].

In the absence of a trusted person or a person appointed by a guardianship judge, it is the Tutor who personally exercises the interests of the patient placed under his or her supervision. (Article 14(1) of the 24 July 2014 law)

A guardianship judge may appoint a specific representative whose responsibility is to manage the rights of the patient in question. (Article 14(1) of the 24 July 2014 law)

In any case, a patient under a protective regime is to be involved as much as possible according to their level of capability and comprehension.

In case of serious and eminent threat for the life or health of an incapacitated minor or adult, healthcare professionals may, in case of denial of permission by the legal representative or by persons with curator/tutor powers, take any measures of medical nature which the situation calls for according to the provisions of their profession. In such an event, the healthcare provider must send a report justifying every measure of medical nature that has been taken to the Attorney General within three working days. (Articles 13(3) and 14(3) of the 24 July 2014 law)

2.2.3 The form of consent

The patient's consent is in principle given in an express manner. (Article 8(8) of the 24 July 2014 law)

Consent may also be given tacitly, as long as the healthcare professional can reasonably deduct from the patient's behaviour that he or she gives his or her consent to the medical treatments.

[2] www.justice.public.lu/fr/famille/tutelle-curatelle/tutelle-curatelle/index.html (Consulted in August 2014)

2.2.4 The withdrawal of consent

A patient may withdraw their consent at any point in time. (Article 8(5) of the 24 July 2014 law) the doctor will then be under the obligation to warn the patient about the possible consequences of his or her decision. If during the course of providing medical care, the situation requires adapting the treatment and measures initially planned, the treatment already in progress can be finished with the new adaptations without the patient giving their consent. (Article 8(6) of the 24 July 2014 law)

2.2.5 Proof and challenge

The burden of proof lies on the healthcare provider. Proof may be provided by any means, the correct keeping of the file entails simple presumption of its content. (Article 8(9) of the 24 July 2014 law)

2.3 Patient's file

2.3.1 Definition

The patient's file consists of all the documents carrying data and information about the health condition of the patient, its evolution during treatment and hospitalisation. (Article 2(f) of the 24 July 2014 law)

2.3.2 Content of the file

It is mandatory for the file to comprise medical data in the form of anamnesis, medical and nursing reports, results of medical checks, diagnostic work-up reports, prescriptions, X-rays and any document or anything in connection with the health condition of the patient or the treatment.

Every patient is entitled to a patient's file kept up-to-date by the healthcare provider in the frame of a treatment. The minimal content of the patient's file is defined by grand-ducal regulation. (Article 15(1) of the 24 July 2014 law)

The custodian of a patient's file is to keep such file for at least 10 years starting from the taking charge of the patient. (Article 15(4) of the 24 July 2014 law)

No retrieval of any document or any relevant element is allowed for the patient or the provider of healthcare before the deadline for keeping the file has expired. (Article 15(5) of the aforementioned law) In the case of inaccurate or incomplete entry, it is under the responsibility of the healthcare provider (initiating the treatment) that it may be corrected. (Article 15(5) of the aforementioned law)

2.3.3 Right of access to the file

Access to the file generally happens within the frame of the relationship of trust that binds patient and healthcare provider.

Patients are entitled to request a copy of their medical file from any doctor they have consulted (doctor's office). Patients are entitled to obtain a copy of their file at their own expense and against signature. (Article 16(3) of the 24 July 2014 law / Code of ethics of healthcare professionals)

On leaving hospital the attending doctors of the hospital provide a clinical summary to the patient and to his referring doctor. A patient is entitled to access his personal file, which he or she can do themselves or through a doctor of their choice who may be attached to the hospital in question or not. The patient may consult their file on the spot and have the right to obtain a copy of it or part of it free of charge against a signature. (28 August 1998 law on hospitals, chapter IX, article 36)

In addition, patients are entitled to have the content of the file explained to them. (Article 16(1) of the 24 July 2014 law)

If the patient's file is to be consulted or data in relation with his or her health accessed by a third natural person who is not a healthcare professional performing their professional duties without the patient being present, that third person must provide a written document dated and signed by the patient. When a patient is unable to write and sign despite being able to express their will, he or she may request from two witnesses to testify that the document which he or she was unable to draw up themselves expresses his or her free and informed will. These witnesses note their names and titles and their testimony is attached to the mandate. (Article 16(2) of the 24 July 2014 law)

In case the patient is unable to sign a power of attorney, he or she may have 2 witnesses who testify that the document matches the free will of the patient. (Article 16(2) of the 24 July 2014 law)

The healthcare professional in charge of the information in the patient's file may request for a consultation to announce the diagnosis if they think that certain items of information within the file might entail certain risks for the patient. (Article 16(5) of the 24 July 2014 law)

The announcement of these items at a later time is only possible when a healthcare professional is present so to guarantee that the information is

delivered appropriately. If the consultation of these items of information is done through an intermediary, this third person must by all means be a healthcare professional. (Article 16(5) of the 24 July 2014 law)

2.3.4 The shared medical file

The shared medical file "DSP" (for French Dossier Soins Partagé) is an electronic file. The patient, his or her healthcare providers and those to whom the patient grants access to the file, may consult it through a secure Internet portal. This a file that gather all information about the health condition of a patient. With a shared medical file in case of an emergency the emergency doctor would be able to make use of all the information in relation to the health condition of the patient (latest checks, RMI, etc.). This would prevent having to do all those checks once again. Every doctor will keep a file for the patient, just as they have so far. Furthermore, patients are entitled to supress their shared medical file DSP any time they chose. A DSP will be created for each patient unless they oppose that.

For more information:

www.sante.public.lu

www.esante.lu

The 17 December law on the reform of the health system (Article 60 ter, 60 quarter)

2.3.5 In case the patient passes away

Unless the patient (with the required capability) has expressed different in writing while still alive,

- The trusted person (in case of appointment)
- The not separated spouse
- Adult children
- Other rightsholders to the patient
- His or her registered life-patient
- Any person who have been living jointly with the patient at the time of death
- In case of a minor patient – The parents 6 any other person with parental authority

are granted access to the patient's file and to data in relation to the health condition of the patient (after the death of the patient) and are entitled to a copy in order to:

- Know the exact cause of death
- Preserve the patient's memory
- Assert their legitimate rights

(Article 19 of the 24 July 2014 law)

2.3.6 Personal annotations

Patients are not allowed to consult notes by healthcare professionals known as "purely personal", these are notes (not in relation with the health condition of the patient) which belong to the personal thoughts of their author and involve the latter as much as the patient. (Article 17 of the 24 July 2014 law)

2.4 Professional secrecy

Healthcare professionals and their employees as well as students in such fields are bound by professional secrecy under article 458 of the Criminal code. Professional secrecy means that such professionals keep to themselves anything they get to learn in their job and that it is forbidden for them to share such information with anybody outside what is allowed within the frame of the law.

The same article of law is applicable to the trusted person and the companion, which means they are bound by the same "professional" secrecy as the healthcare professionals. (Article 18 of the 24 July 2014 law) In case of non-compliance, they face the same penalties as the professional of the healthcare sector, that is a prison sentence between 8 day and 6 months and a fine between 500€ and 5000€. 3

Patients always have the right to be informed and consult their file. Healthcare professionals may therefore never deny them information on the pretext that they are bound by professional secrecy. In other words, the professional secrecy that binds the healthcare professional is aimed at protecting the patient, not restricting his freedom to know or his self-determination.

Patients are entitled to lift the obligation of professional secrecy on healthcare professionals. For that it is enough for them to orally authorize their doctor to contact the person or organisation in question. It may occur though, especially in sensitive situations or even situations of conflict that the healthcare professional demands a written confirmation of the lifting of professional secrecy.

[3] Article 458 states that: "Doctors, surgeons, health officers, pharmacists, midwives and any other person who by trade or are repository of secrets that have been disclosed to them, who, except when they are summoned to testify in a court or when the law requires from them to reveal such secrets, have revealed them, will be punished by imprisonment between eight days and six months and a fine between 500 euros and 5000 euros"

Unless opposed by the patient, several healthcare professionals may exchange information about this same patient in order to secure continuity of treatment. (Article 18(2) of the 24 July 2014 law)

When a patient is taken care of by a healthcare team in a hospital or by an entity within which care is provided in accordance with the law, all information in relation to the patient is supposed to be disclosed to all members of the medical team. (Article 18(2) of the 24 July 2014 law)

Patient may at any moment refuse the disclosure of certain information items to one or several healthcare professionals, but the professional initiating a treatment will always keep access to information in the file in relation to his service. (Article 18(2) of the 24 July 2014 law)

2.5 Trusted person

Pursuant to article 12(1) of the 24 July 2014 law, "every adult patient having the capacity to consent may, in anticipation of a situation where he or she would not be able to express their will anymore and receive information necessary to making a decision in relation to their health, name a trusted person (…)"

Patients may choose as a trusted person any natural person whether a healthcare professional or not. The appointment of such person must be in writing, dated and signed by the patient in person. In case the patient cannot sign himself or herself the appointment document of the trusted person, they may request from 2 witnesses to testify that the document appointing the trusted person represents the expression of his or her will. "The trusted person has access to the patient's file and professional secrecy is lifted for them." (Article 12(4) of the 24 July 2014 law)

<u>End-of-life situation:</u>

Article 5(3) of the 16 march 2009 law on palliative care, advance directive and assistance to patients at end of life provides that " advance directive may comprise the appointment of a trusted person who must be heard by the doctor if the person at end of life is no longer able to express his or her will".

If the patient is in an end-of-life situation, the healthcare professional always tries to respond to the patient's last will by turning to the trusted person previously appointed by the patient.

Every adult may provide in writing (in anticipation of a situation where he or she can no longer express themselves) for the circumstances under which he or she wishes to undergo **euthanasia**.

In this context, the 16 March 2009 law on Euthanasia and assisted suicide, in particular article 4.1 provides that: "(…) In the arrangement for the end of life, the declarant may appoint an adult trusted person, who let the attending doctor know about the will of the declarant according to his or her latest declarations to them (…)".

2.6 Referring doctor

Starting from January 2012, every patient may choose their referring doctor. He or she is the "trusted" doctor or "favourite" doctor, whose role is to guide his or her patient. It is their mission to record in writing the "patient's summary" "le résumé-patient", which comprises all information/ prescriptions/ examinations of the patient. At the request of the patient, the referring doctor hands it to another doctor. The referring doctor has the duty within the frame of preventive medicine to contribute to upholding his or her patient's health, they suggest consultations deemed "preventive" in order to inform their patient about vaccines/ possible screenings. The referring doctor plays a central role and coordinates all treatments for the patient.

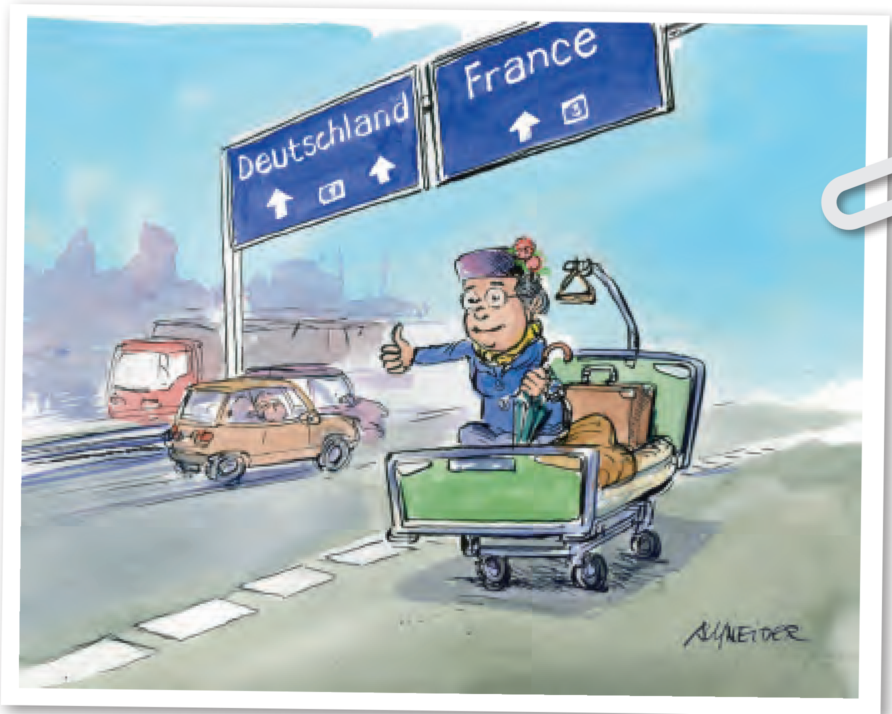
For more information:

www.cns.lu

www.sante.public.lu

3 Cross-border care

This section of the brochure on cross-border care is an extract from the new article 20 of the Social security code made under the 1st July 2014 law.



Healthcare service:

Article 17 of the Social security code introduced a list of the various health-care services:

"The following services are covered to a sufficient and appropriate extent:

1) Medical services;

2) Dental medicine services;

3) Treatments performed by healthcare professionals;
4) Medical biology tests;
5) Orthosis, protheses, epitheses and dental implants;
6) Medicines, human blood and blood components;
7) Medical devices;
8) Treatments performed in hospital;
9) Hospital costs in case of childbirth and in case of hospitalization except in the case of plain accommodation;
10) Therapeutic cures and convalescence programmes;
11) Rehabilitative therapy;
12) Patient transport costs;
13) Palliative care according to arrangement in grand-ducal regulation".

ATTENTION:

Unlike in Luxembourg, patients may benefit from supplementary services, which are not covered by a health insurance, by entering into a specific contract/agreement (for example in Germany "Wahlleistungen").

These supplementary services may entail hefty invoices not covered by a health insurance that will be charged to the patient.

The question of whether a differential amount should be reimbursed by a health insurance, in the instance that among the services charged under such agreement there are also services covered by "CNS" had the treatment been performed in Luxembourg, is still not setteled.[1]

[1] For more information : Brochure de la Chambre des salariés Luxembourg et de l'Union Luxembourgeoise Des Consommateurs (ULC) sur la „ consultation d'un médecin et hospitalisation à l'étranger : Que va rembourser la caisse de maladie et comment ?", August 2010

A. Healthcare services laid down in article 17 al 1 of the Social security code, which are prescribed or performed in an EU member state, Switzerland, Liechtenstein, Norway or in Iceland:

Pursuant the new article 20 of the Social security code, "If these cross-border healthcare services entail:

- For the ensured person a stay in hospital, specialized medical facility or a facility for persons at end of life for at least one night

OR

- Resorting to highly specialized and costly facilities (national expertise centres, national services, rehabilitation and convalescence centres, thermal spas), or to highly specialized an costly medical equipment.

A condition to having these covered is the obtention of a prior authorisation from the "CNS" (S2 form to be submitted by the healthcare professional), with a reasoned opinion by the Medical control of the social security. The "CNS" decide first on the admissibility of the application and it is only after that the Medical control gives its opinion.

A reason must always be given for any rejection of the prior authorisation application for cross-border healthcare services.

- Cases when "CNS" may not refuse to grant a prior authorisation:

The "CNS" may not refuse to grant a prior authorisation in the different following cases:

  - If the cross-border healthcare services belong to article 17 al. 1 of the Social security code, but such healthcare services cannot be provided on Luxembourg soil within a medically acceptable timeframe, according to the assessment of Medical control of the social security (…)

OR

- If the cross-border healthcare services are necessary according to the Medical control of the social security but not provided for in the Luxembourg legislation.

Cross-border healthcare services for hospitals:

For hospital cross-border healthcare services pursuant to article 60 al. 2,[2] reimbursement will be up to the average cost of hospitalisation in Luxembourg fixed by the "CNS", without exceeding the actual costs charged to the insured patient.

Healthcare services not covered under the Luxembourg legislation:

The cross-border healthcare services referred to here are those deemed necessary according to the Medical control of the social security. Their reimbursement will be fixed by the Medical control of the social security by equating the healthcare service in question with one of equivalent scope.

B. Healthcare services covered in article 17 al. 1 of the Social security code, performed or prescribed in a country other than a member state of the European Union, other than Switzerland, Liechtenstein, Norway, Iceland, and not bound to Luxembourg by a bilateral agreement on health insurance:

This specific case is provided for in the new article 20 bis incorporated in the Social security code through the 1st July 2014 law.

[2] Article 60 al. 2 of the Social security code provides that: "Are considered hospital healthcare services, any benefits in kind provided to an insured person being treated in a hospital, a specialized medical facility or a facility for persons at the end of life as defined in the amended law of 28 August 1998 on medical facilities".

Reimbursement is linked:

- To exclusively emergency care in case of sickness/ accidents happening abroad subject to reasoned opinion of the Medical control of social security.

OR

- To obtaining a prior authorization from the "CNS" based on the reasoned opinion of the Medical control of the social security. The "CNS" decides first on the admissibility of the application and only then is the Medical control of social security turned to for its opinion.

Reimbursement is made based upon price list applicable in the Grand-Duché without exceeding the costs actually charged to the patient.

Healthcare services in the hospital sector:

For cross-border healthcare services in the hospital sector as defined by article 60 al.2,[3] reimbursement will be up to the average cost of hospitalisation in Luxembourg fixed by the "CNS", without exceeding the actual costs charged to the insured patient.

Absence from luxembourgish price list:

If there are no Luxembourgish tariffs or rates, reimbursement will be fixed by the Medical control of the social security by equating the healthcare service in question with one of equivalent scope. (Article 1 of the law of 1st July 2014 transposing the European Parliament and Council 2011/24/ UE of 9 march 2011 on the implementation of patients' rights in relation to cross-border healthcare services)

[3] Article 60 al. 2 of the social security code provides that: „Are considered healthcare services of the hospital sector, any benefits in kind provided to an insured person treated in a hospital, a specialized medical facility or a facility hosting persons at the end of life as defined in the 28 August 1998 amended law on medical facilities".

4 Specific issues

4.1 Generic medicines

A generic medicine is "the copy" of an originator medicine. Its active substance (active ingredient of the medicine) is identical to that of the branded product; the only possible differences being the pharmaceutical form and excipients.

The medicine containing the active substance is called "reference medicinal product or originator medicine". Exclusive rights on this medicine are valid for several years, afterwards all pharmaceutical companies are allowed to make a replication of this medicine which then will be called "generic medicine".

Before any medicine is made available to the public, an authorisation is needed from the Ministry for health or from the European Medicines Agency, this way generic medicines are subjected to the same safety,

quality and efficacy conditions as the originator medicine.[1] Pharmacist are required to inform patients at the time they deliver a medicine that it is a medicine whose reimbursement is made relative to a certain reference and they must offer to substitute it with the cheapest medicine of the same group.

Patients remain free though to choose to be handed "the originator medicine" or "the generic medicine". Note that reimbursement by the "CNS" will be made on the basis of a" reference price" (based on the lowest price), which implies that the difference in price is charged to the patient. In other words, if the patient wishes to have the "originator medicine", the difference in price is to be paid by the insured person, that is the contribution of the insured person will be higher. [2]

4.2 Palliative care

4.2.1 Definition

The law on palliative care, advance directive and end-of-life care was voted and published on 16 March 2009.

Every patient is entitled to palliative care required by his health condition, in line with the information available from science and professional ethics at the time of diagnosis and/or treatment. According to the definition by the World Health Organisation in 2002, "palliative care aims at improving the quality of life for patients and their families, facing the consequences of a potentially lethal disease, by prevention and the easing of suffering, detected at an early stage and evaluated with precision, as well as treatment of the pain and the other physical, psychological and spiritual problems connected to it".

[1] Ministry for Social security, Ministry for health, Union des caisses de maladie (Union of health funds), "Information campaign for generic medicines", Press release of 13.02.2006

[2] www.sante.public.lu/fr/dossiers/2010/reforme-sante/060-substitution-medicaments/index.html (consulted in August 2014)

4.2.2 Objectives of palliative care

Palliative care:

- Brings relief from pain and from other irritating symptoms,
- Considers death as a normal process,
- Does not aim at accelerating nor postponing death,
- Integrate psychological and spiritual aspects of care to patients,
- Offers a support system to help patients live as actively as possible until death,
- Supports the family through the disease of the patient and their own mourning,
- Uses a team approach to meet the needs of patients and their families adding to it bereavement counselling when necessary,
- Can improve quality of life and maybe also influence positively the evolution of the disease,
- Can be implemented at an early stage of the disease, combined with other treatments capable of prolonging life, such as chemotherapy, radiotherapy and comprise the necessary investigations to better understand the irritating clinical complications and in a way that allows for their treatment.

In case of incurable and terminal condition, the healthcare professional must soothe the patient's physical and mental pain by providing him or her with the appropriate treatments, avoiding any hopeless aggressive life-prolonging treatments and maintaining quality of life as much as possible. Patients have also the right to refuse palliative care.

The healthcare professional must assist the dying patient to the end and take action in order to allow the patient to remain dignified. Likewise, he or she will offer the patient's relatives appropriate assistance to ease their pain in connection with this situation.

With death approaching, the patient is entitled to be continuously accompanied by at least a person of his or her choice in dignified conditions for him or her (end-of-life support leave). Such a leave may be applied for by any employee who is the mother/father, a sister/brother, a daughter/son or

the spouse (the wife/husband or registered life partner) of a patient suffering from a serious disease in terminal stage. (Chapter III – On leave for the accompaniment of persons at end of life in the law of 16 march 2009)

4.2.3 Anticipated directive

Anticipated directive is not the same as arrangements for the end of life which is defined in the law on euthanasia and assistance to suicide also voted and published on 16 March 2009.

An anticipated directive is a written document, carrying the date and signature of the patient in which they have recorded their will in relation to their end of life.

Pursuant to article 5(2) of the 16 March 2009 law on palliative care, anticipated directive and assistance at end of life, if the patient cannot sign himself or herself anticipated directives, they may request from 2 witnesses to testify that the document is genuine and that the directives therein represent the expression of his or her will.

Such a document helps lead the doctors, nurses and others around the patient in the right direction in relation to the decisions to be made about his or her end of life, if the patient is no longer able to express their will.

Through such directive, the patient defines the conditions for his or her **"natural" end of life"**, that is without any influence on the moment of their death. In contemporary society, it is important for every patient to clarify the circumstances and the way they wish to arrange their end of life in case of a serious or incurable disease or serious accident.

The anticipated directive must be taken into account by the attending doctor, it will serve as lead for the decisions to be made for the situation.

4.3 Life-prolonging treatments

The doctor must do his or her utmost to keep the patient alive, it is though absolutely forbidden for doctors to engage in inadequate, disproportionate treatments or tests.

Article 2 of the 16 March 2009 law on palliative care, anticipated directive and assistance at end of life provides that. " It is not a criminal offence and it cannot give ground for a civil lawsuit for indemnification if a doctor refuses or refrains from implementing, at an advanced or terminal stage

of a serious and incurable condition, whatever its origin may be, tests or treatments which are inadequate given the condition of the person at end of life and which according to the medical knowledge at the moment would not bring to the person at end of life any relief nor improvement of their condition, nor any hope for recovery. (…)".

4.4 Euthanasia and assistance to suicide

4.4.1 Definition

The law on euthanasia and assistance to suicide was also voted and published on 16 march 2009.

The wording of this law defines euthanasia as "a procedure implemented by a doctor who intentionally puts an end to a person's life at his or her request." and "assistance to suicide as the fact that a doctor intentionally helps another person to commit suicide or provides him or her with the means to do it, this being at that person's request". (Article 1 of the 16 March 2009 law on euthanasia and assistance to suicide)

Since that law was voted, a doctor who performs euthanasia or provides assistance to suicide does not break the law as long as "fundamental conditions" and procedures in the law are fulfilled. These being:

- "The patient requesting euthanasia must be an adult in possession of legal capacity and in a conscious state at the time of his or her request.
- The request must be expressed in a wilful, thoughtful and if necessary repeated manner, and must not stem out of external pressure.
- The patient must be in a dead-end medical situation and be going through constant and unbearable physical or mental suffering without any perspective for improvement.
- The patient's request must be drawn up in writing" (Article 2.1 of the 16 March 2009 law on euthanasia and assistance to suicide)

It is the doctor's duty to inform the patient about his or her condition and medical options according to the present state of medicine. The doctor must consult with an unbiased colleague about the serious and incurable character of the disease and must check to make sure that the physical or mental suffering is persistent. No doctor can be forced to perform euthanasia and the patient can cancel his or her request at any moment.

4.4.2 Arrangements for the end of life

A considerable part of this law provides for arrangement for the end of life. "Every adult person in possession of legal capacity may, in the event he or she were not able to express their will, put in writing in arrangement for the end of life, the circumstances and conditions under which he or she wishes to undergo euthanasia if the doctor concludes:

- That he or she suffers from an accidental or pathological condition which is serious and incurable,
- That he or she is unconscious,
- And that this situation is irreversible according to the present state of science". (Article 4.1 of the 16 March 2009 law on euthanasia and assistance to suicide)

Such a request must be made anticipatorily in a thoughtful, wilful manner and repeatedly, and must not emerge from external pressure. It will be draw up in writing, dated and signed by the declarant and officially registered with the National Control and Assessment Committee. The request may be revoked at any moment. The National Control and Assessment Committee requests confirmation of the person's will every 5 years. (Article 4.1.2 of the 16 March law on euthanasia and assistance to suicide)

If the patient is not in a condition to sign / write his or her arrangements for the end of life, he or she may turn to an adult natural person of their choice (in the presence of 2 witnesses) who will write or sign the arrangements for the end of life. The document must be signed by the witnesses, by the person who signed / wrote it and by the trusted person if one has been appointed. 8Article 4.2 of the 16 march 2009 law on euthanasia and assistance to suicide)

4.5 Organs retrieval

4.5.1 Retrieval form a living person

Retrieval of any organs may only take place if the living person (in full possession of their mental faculties) has given their free and informed consent in writing. Furthermore, retrievals may only be performed for therapeutical purposes. Prior to such an intervention, the organ donor is informed about all possible risks and side effects. Retrievals on a minor person is strictly regulated and are subject to cumulative conditions. (See article 3 of the 25 November 1982 law regulating retrieval of material of human origin).

4.5.2 Retrieval from a deceased person

Retrieval of organs and tissue may be performed after death on any adult person whose last legal place of residence was in Luxembourg and who did not oppose such a retrieval in their lifetime. When the deceased is a minor or legally incapacitated adult, authorisation by their legal representative is necessary (25 November 1982 law regulating retrieval of material of human origin).

The doctor remains free though to consult with the relatives of the deceased.

An organ donor card or card for refusal to donate organs can be requested from the Ministry for health or from Luxembourg-transplant.

4.6 Autopsy

Luxembourg law does not address the issue of persons who may request an autopsy. In practice, the family may request an autopsy on the deceased person for scientific purposes.

In the context of a suspicious death, the family as well as the doctor may request an autopsy, the prosecuting authorities must be informed about it beforehand though.

5 Professional misconduct, professional negligence and remedies

5.1 Recognition of prejudice

When a patient sustains harm in the wake of a treatment, they may initiate proceedings

Of legal nature

- As a civil action seeking compensation for the harm suffered
- As a criminal prosecution in order to get punishment for those at fault (fine or prison sentence)

Of disciplinary nature

- Allowing to warn the person in charge and to prevent future harm through blaming, suspension or withdrawal of licence to practise

5.1.1 Mistakes

Jurisprudence take into account the imperfections of medical science and human reliability. Healthcare professionals do not bear liability for simple mistakes, which are to a certain extent inherent to the practise of a profession where views may be just as diverse as divergent. Indeed, as long as the diagnosis has been conscientiously established in line with professional standards, an adequate treatment has been prescribed and applied in accordance with the principles generally approved by the medical profession, the doctor is protected from accusations of neglect or professional negligence.

5.1.2 Negligence and professional misconduct

We speak of negligence or professional misconduct when there is an evident mistake, a treatment which is clearly inappropriate, definite violation of professional standards, or ignoring of facts generally known to medical science. It is worth noting though that negligence is not assessed solely in terms of blameable conduct but also in terms of the circumstances surrounding it.

5.1.3 Procedure in case an invoice is disputed

When an invoice is disputed, the first procedure is a discussion with the doctor or a representative of the medical facility in question.

Patients may in various cases turn to Commission de Surveillance des Assurances Sociales:

- In case invoiced services are disputed
- Or in case partial reimbursement is disputed
- Or in case reimbursement of an invoiced amount is not made

And regardless of any personal convenience or statutory participation. Patients may turn first to Patiente Vertiedung a.s.b.l. for advice before escalating the issue.

La commission de surveillance (supervisory committee) is competent to for disputes referred to it by an insured person or by a healthcare provider.

If the Commission de Surveillance comes to the conclusion that the care provider did not follow the tariffs set in the catalogue of services, agreements or provisions relating to exceeding fixed prices, it orders repayment to the insured person of the unduly charged amount. Otherwise, the health insurance reimburses the insured person in accordance with the law, regulations and statutory provisions.

5.2 Reconciliation

It is advisable for every patient who believes that their right have been violated, to try a last reconciliation procedure with the healthcare professional in question or with the management when at a medical facility, before filing a complaint. Indeed, it is not uncommon that a dispute is induced by failed communication between the patient and the healthcare professional.

5.3 The national service for information and mediation in the field of healthcare

By virtue of the 24 July 2014 law on the rights and duties of patients (article 20 and what follows), a new national service for information and mediation in the field of healthcare has been established.

This service has multiple roles among which for instance information

- "on the rights and duties of patients / healthcare providers,
- On procedural rules for mediation in the field of healthcare,
- On possibilities for settlement of claims when mediation fails (…)". (Article 21 (2) of the 24 July 2014 law)

If the two conflicting parties come to an agreement (which states specific commitments for each party), such agreement will be made in writing and the document dated and signed by the parties. (Article 22 (5) of the 24 July 2014 law)

5.4 The procedure of a complaint

If the conflict remains despite efforts for reconciliation, the patient may file a complaint to the *Directeur de la Santé,* at the *College Médical* and/or to the *Commission de Surveillance aupres de la Caisse Nationale de Santé.*

5.5 Social jurisdictions

Patients may take legal action before social jurisdictions against any decision by a social security entity.

The arbitration board of social security – *Conseil arbitral de la sécurité sociale*

- has jurisdiction on the whole territory of the Grand-Duché
- has jurisdiction of first instance in the following areas:
  - "disputes concerning affiliation,
  - obligation of affiliation,
  - contributions
  - administrative fines,
  - services
- Adjudicates as first and last resort up to a value of 1 250 EUR and subject to appeal when the object of litigation exceeds this amount"[1]
- Initiating such proceeding must absolutely happen within 40 days[2] following notification of the decision (under penalty of laps of rights). The complaint must be made by simple petition to be submitted at the office of the Conseil arbitral.[3]

Patiente Vertriedung a.s.b.l. supports patients and provides them with advice, to the extent possible, in all these procedures.

---

[1] www.justice.public.lu/fr/organisation-justice/juridictions-sociales/index.html(consulted in September 2014)

[2] Given the lack of precision, it is advisable to assume that these are calendar days rather than working days

[3] www.justice.public.lu/fr/organisation-justice/juridictions-sociales/index.html(consulted in September 2014)

- High Council of social security – *Conseil supérieur de la sécurité sociale*

  It has jurisdiction in the whole territory of the Grand-Duché and is an appeal body for:

  - “disputes concerning affiliation,
  - obligation of affiliation,
  - contributions
  - administrative fines
  - services,

involving a value in excess of 1 250 EUR.

The appeal must be lodged within 40 days following notification of the decision of the arbitration board of social security (under penalty of laps of rights). The petition must be submitted at the office of the High Council of social security.

Patiente Vertriedung a.s.b.l. supports patients and provides them with advice, to the extent possible, in all these procedures.

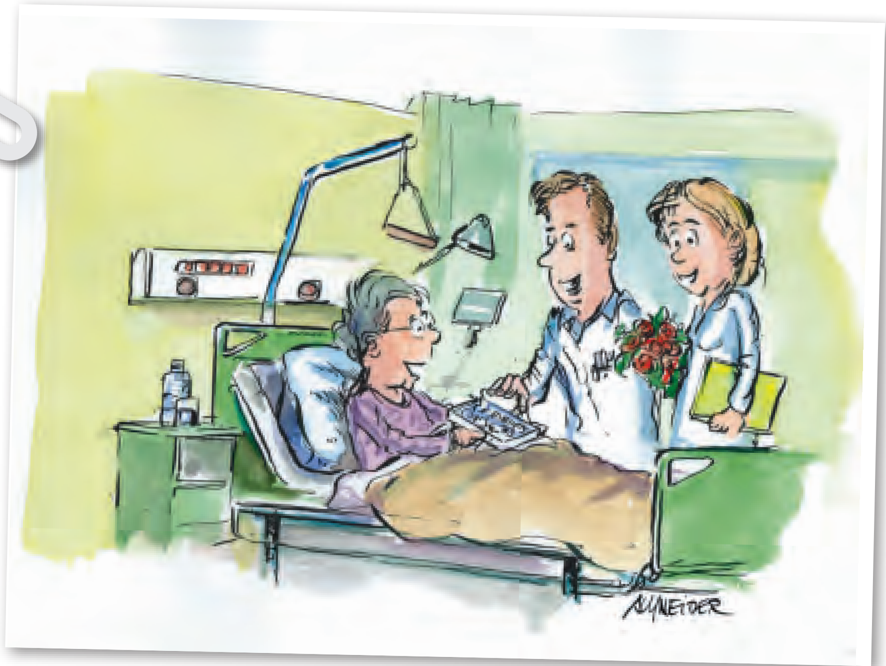
- Cour of cassation – *Cour de cassation*

Last resort decisions by the board of arbitration and judgement by the High Council of social security may be appealed in the Cour de cassation, such appeals are receivable only “on grounds of violation of the law or failure to comply with formal procedural requirements”.

Before initiating legal proceedings against a healthcare provider, it is advisable for patients to first seek information about their rights and duties as well as about their chances of success in such a trial.

Given the complexity of the matter, it is recommended to appoint a lawyer for all these procedures.

Patiente Vertriedung a.s.b.l. supports patients and provides them with advice, to the extent possible, in all these procedures.



6 Miscellaneaous

6.1 Glossary

Medical hazard: "is the risk generated by medical activity, that is an accident that happens during surgery or during a treatment with no connection with the initial condition of the patient, with no connection with the normal evolution of that condition and independent of any mistake by the doctor (…)".[1]

Anamnesis: All the information provided to the doctor by the patient or their close circle on the history of the illness or circumstances before it.

Assistance to suicide: "an instance where a doctor intentionally helps another person to commit suicide or provides them with the means to do it, at the express and wilful request of the person in question."[2]

Supplementary insurance: the health fund/la caisse de maladie reimburses healthcare expenses up to a certain threshold. In order to profit from a supplementary reimbursement, subscribing to a supplementary insurance is needed (for example: CMCM – Caisse Médico-Chirurgicale)

Nursing-care insurance: "(…) Nursing-care insurance is a compulsory branch of social insurances. It covers the costs of necessary assistance and care to a dependant person (e.g. daily personal care). Nursing-care insurance does not replace health insurance. It covers assistance and care not covered by health insurance (…)". (www.sante.public.lu)

Advance directive : A document stating the will of a patient at the end of life if their health condition is such that they cannot possibly express their will. Through an advance directive the patient may determine the conditions for his or her so called "natural" end of life.

End of life arrangements: "Every adult person in possession of legal capacity may, in the event he or she were not able to express their will, put in writing in arrangement for the end of life, the circumstances and conditions under which he or she wishes to undergo euthanasia (…)"[3]

---

[1] G. vogel, E. Rudloff, Lexique de Droit Médical & Hospitalier, publisher: Promoculture 2nd edition, p.39

[2] Article 1 of the 16 March 2009 law on euthanasia and assistance to suicide

[3] Article 4.1 of the 16 March 2009 law on euthanasia and assistance to suicide

Patient's file: "all the documents carrying data and information about the health condition of the patient, its evolution during treatment, regardless of the nature of their format.[4]

CAAS: Committee of arbitration of social insurances

College medical: Includes as an order/college all doctors, dentists and pharmacists (www.collegemedical.lu)

CMFEP: Health fund for civil servants and state employees - Caisse de Maladie des fonctionnaires et Employés Publics

CNS: National health fund – Caisse Nationale de Santé

CSCPS: High Council for certain healthcare professions – Conseil Supérieur de certaines professions de Santé (www.sante.public.lu)

COPAS: Union of entities providing assistance and care – Confédération des Organismes Prestataires d'Aides et Soins (www.copas.lu)

FHL: Luxembourg hospitals federation – Fédération des Hopitaux Luxembourgeois (www.fhlux.lu)

Incapacitated – *Incapable*: Person unfit to bebefit from a right or exercise it by themselves.

Active euthanasia: Is the fact that a doctor intentionally induces the death of a person at their request, if all substantive conditions are fulfilled.

Passive euthanasia: Is synonymous with "allow the patient to die"

Private doctor – *Médecin liberal:* In Luxembourg there are doctors who practise medicine "privately", that is they practice their profession in a doctors' surgery / in certain hospitals.

Employed doctor – *Médecin salarié:* alongside doctors practising privately, there are employed doctors subject to all rights and duties of an employment relationship. Such doctors are not self-employed, they are rather employees of a government service / an institution / a hospital.

Capable adult: Any individual aged 18 and over and who can express their will / protect their belongings.

[4] Article 2(f) of the 24 July 2014 law on the rightd and duties of patients, providing for the establishment of a national information and mediation service in the field of healthcare

Incapacitated adult: Any individual aged 18 and above but who is not in a position to express their will / protect their belongings and who must be either assisted or represented.

Minor: a minor is an individual of either gender who has not completed the age of eighteen years.

Obligation of means: "Obligation of means is that under which the debtor commits to do their utmost i.e. exercise all due care to fulfil the task. The debtor only commits to use all possible means, without committing to reach the targeted result".[5] In principle the obligation incumbent on a doctor is an obligation of means.[6]

Obligation of result: "Is the case when the debtor commits to achieve a result".7 Since a judgement of the Cour de Cassation on 31 january 2013 (Nr 3099 of the register) establishes the principle that "the incidental obligation of safety incumbent on the medical facility in relation to nosocomial infections is an obligation of result".[8]

General practitioner – *Omnipraticien*: Family doctor

Patient: "Any natural person seeking to receive or receiving medical care"[9]

Healthcare provider: Doctors, dentists, healthcare professions, medical facilities, medical and clinical biology laboratories, therapeutic cure facilities, functional re-education and rehabilitation facilities, suppliers of orthopaedic protheses, orthoses and epithesis, pharmacists, opticians, suppliers of blood products and persons involved in the transportation of patients.

---

[5] Monthly publication published by CSL, "infos juridiques-Flash sur le droit du travail", Issue 02/13, p.11

[6] G. vogel, E. Rudloff, Lexique de Droit Médical & Hospitalier, publisher: Promoculture 2nd edition, p.141

[7] Monthly publication published by CSL, "infos juridiques-Flash sur le droit du travail", Issue 02/13, p.11

[8] JurisNews – Droit médical, „Les infection nosocomiales: aspects pratiques et juridiques", Vol.1, Nr 2/2013

[9] Article 2(b) of the 24 July 2014 law

Healthcare professional: Doctors, dentists, assistant-nurses, assistants to the elderly, technical medical assistants, nurses, anaesthetics and intensive care nurses, paediatrics nurses, psychiatric nurses, masseurs/masseuses, midwives, social hygiene assistants, social workers, dieticians, occupational therapists, infirmiers gradués (nurses of higher qualification and rank), laboratory technicians, physiotherapists, speech-language therapists, orthoptists, curative teachers, psychomotor therapists.

Healthcare: "healthcare services provided to patients by a healthcare professional in order to evaluate, maintain or restore their health condition, including prescription, supply and delivery of medicines and medical devices".[10]

Palliative care: "Palliative care is acute care which is continuous and co-ordinated, performed by a multidisciplinary team with due regard to the dignity of the person receiving care. It aims at fulfilling all the physical, psychological and spiritual needs of the person receiving care and at providing support for the people involved with him or her. It includes treatment of pain both physical and psychological".[11]

[10] Article 2(b) of the 24 July 2014 law

[11] Article 1 al. 2 of the 16 March 2009 law on palliative care, advance directive and assistance at end of life

6.2 Reference works & various laws

- G. Vogel, E. Rudloff, Lexique de Droit Médical & Hospitalier, Publisher : Promoculture, 2nd edition
- 28 August 1998 law on medical facilities (Mémorial A, 1998 page 1563)
- 10 August 1992 law on youth protection (Mémorial A, 1995 page 1913)
- 26 March 1992 law on the pursuit of certain healthcare profession and the improvement of their status (Mémorial A, 1992 page 806 and 1995 page 27)
- 25 November 1982 law regulation retrieval of material of human origin (Mémorial A, 1982 page 2020)
- 26 May 1988 law on admission in a psychiatry ward or facility for persons suffering from mental disorders (Mémorail A, 1988 pages 560 and 638)
- 16 march 2009 law on palliative care, advance directive andassistance at end of life (Mémorial A, 2009 Nr 46, pages 609-614)
- 16 March 2009 law on euthanasia and assistance to suicide (Mémorial A,2009, Nr 46, page 615)
- 16 July 2014 law transposing the 2011/24/UE Directive of the European Parliament and council on 9 march 2011 on the implementation of patients' rights in relation to cross-border healthcare services (Mémorial A, 2014, Nr 115, page 1737)
- 24 July 2014 law on the rights and duties of patients, a new national service for information and mediation in the field of healthcare (Mémorial A, 2014, Nr 140, page 2193)
- Civil Code
- Criminal Code and Code of Criminal Investigation
- Code of Social Security, Articles of incorporation of Caisse Nationale de Santé
- Codes of Ethics:
  - Ministerial Decree of 1st march 2013 approving the Code of Ethics enacted by the College Médical for the professions of doctor and dentist.
  - Grand-ducal Regulation of 7 October 2010 establishing the code of ethics for certain healthcare professions.
  - Ministerial Decree of 11 July 2010 approving the Code of Ethics enacted by the College Médical for pharmacists.

Membership form

Last name/First name ________________________________

Matricule

Marital status ________________________________

Nationality ________________________________

Spouse

Last name/First name ________________________________

Matricule

Nationality ________________________________

Children

Last name/First name ________________________________

Matricule

Last name/First name ________________________________

Matricule

Last name/First name ________________________________

Matricule

Last name/First name ________________________________

Matricule

Adresse

Nr, street ________________________________

Postal code/Town ________________________________

Mobile phone ________________ Landline ________________

Office phone ________________________________

Email adress ________________________________

(**ATTENTION**: We would like to draw our new members' attention to the fact that for organisational reasons, **all affiliations expire on 31 December of any current year** regardless of the date membership was gained)