CONFLICT OF LAWS IN THE DOCTOR'S CONTRACTUAL RESPONSIBILITY: A COMPARATIVE ANALYTICAL STUDY

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ABSTRACT

A lot of patients travel to receive treatment because of poor or deficient medical care, or because of the emigration of many medical qualifications. Some patients also suffer from poor care provided after returning from treatment abroad, as specialized tourism companies in some countries enable patients to access health care, which is called medical tourism. This is why many countries in the world have taken an interest in it, such as the European Union and the United States of America. We have not found international rules governing the responsibility of the doctor, but we have found only the general rules of complex responsibility in international law. The World Health Organization (WHO) has taken care of the safety of patients to increase the number of medical errors every year in the world, as legal procedures are often inadequate and the patient needs to file a complaint before or after returning home to be subject to the laws of that country, and the countries that apply the insurance system provide sufficient insurance, and insurance companies are sometimes reluctant to pay because of medical negligence. Due to the scarcity of legal studies, I examined the general rules on conflict of laws on the responsibility of doctors, a comparative study between Iraqi civil law, some state laws, international conventions, and the European directive on the safety of patients. It divided it into two research papers: the first on the rules of attribution applicable to the responsibility of the physician and divided it into two; the first on the importance of the responsibility of the physician in international law; the second on the rules of attribution applied; the second on the European Union directive on the application of patients' rights in cross-border health care; and the second on the provisions of patients' rights; and the second on cooperation between the European Union member States. She concluded that the reason for the increase in medical malpractices in the international context is that doctors are working to sign the patient waiver of his right to prosecution, and that many medical and moral damages change and worsen after his return to his homeland. She added that it is necessary to establish medical committees from the Ministry of Health to allow Iraqi patients to travel abroad, monitor their cases, and choose specialized hospitals through Iraqi embassies in those countries.

Keywords: The Contractual Responsibility of the Doctor, The Applicable Law, European Patient Safety Directive 2011, The Law of the Will of the Parties Will of the Parties Law, The Place of Harmful Act

INTRODUCTION

When medical progress in one country is more than others, foreigners come for the purpose of getting treatment, which is today called (medical tourism).

The responsibility of a physician while providing care to patients stems from the responsibility of the physician (Advances in the medical field and the use of modern medical tools and devices in the treatment of the patient help speed the patient's recovery). On the other hand, they increase the risk of the patient being injured or permanently impaired and sometimes dying.

Therefore, legislation of deterrent laws is required to keep pace with this scientific development in the field of human treatment by putting in place the necessary treatments and solutions to determine the responsibility of the doctor and thus protect the patient from harm) (Al, 2018). Medical error is a plan implemented in the wrong interests of the patient that is counterproductive (Now, 2018), since different treatment methods are one of the hidden reasons for medical errors, as patients have many difficulties in proving medical errors (Now, 2018).

The problem of research is that there are no uniform and sufficient international legislative rules to determine the applicable law of physician liability that can be prosecuted.

The importance of the topic lies in the creation of special domestic and international rules governing the liability of the physician for his or her errors, because medical errors increase annually in all the countries of the world at high rates. There are no international rules to deter him or her from medical malpractice with a view to preventing and avoiding medical errors in the future, as the general rules on complex liability are applied in private international law, which leads to the impunity of the doctor.

The World Health Organization (WHO) commemorates on September 17, 2019, the first World Patient Safety Day by the 72nd World Health Assembly, and it has said that millions of patients are affected each year by the lack of health-care safety in various countries of the World Organization 2019.

Thus, an international term has emerged which calls the patient "the consumer" and the need to protect him because of the increase in methods of treatment and the ignorance of the patients in the modern methods used in the countries of treatment and the extent of their success. The competent doctor confirms to the patients the existence of modern treatments and methods that ensure the patient gets satisfactory results and the opposite happens. In India the patient is a "consumer" in need of protection (Signh, 2013), what legal procedures can be provided for under private international law the responsibility of the doctor for medical malpractice?

As for the methodology of the research, it is an analytical study that compares the laws of the countries in force (the subject of the study) and mentions the most important theological opinions and modern trends, in order to reach conclusions and recommendations that serve the field of research. The study will focus on the most important international laws and conventions. We will focus on the study on the rules of support in Iraq, the United States of America and India, with reference to some laws in other countries that have the same similarity in their laws as those mentioned above, and the comparison between the laws of the European Union, the Rome I Regulation of 2008 and the European Directive on the rights of patients to health care across borders 2011.

Based on the foregoing, we will address the problem of research by dividing research into two researchers and concluding with the most important findings and recommendations as follows:

The First One: Determining the physician's responsibility under international law.

First Requirement: The Importance of Medical Responsibility in International Law.
Second Requirement: Applicable Rules of Attribution.

The Second Searcher: EU Directive on the Implementation of Patients' Rights to Cross- Border Health Care 2011/24.

First Requirement: patient rights provisions.
Second Requirement: Cooperation among member states

Conclusion

Determining Physician's Responsibility under International Law

The responsibility of a physician stems from his commitment to practice medicine at the international level, international medical cooperation in the field of health care, increased travel for treatment abroad for various reasons and because medical harm sometimes occurs before and after a patient returns to his country. Therefore, the responsibility of a doctor must be arranged and compensation claimed in the absence of specific legislative rules protecting the patient. We shall therefore consider according to the following:

The Importance of Physician Responsibility in International Law

The importance of the responsibility of the doctor in international law has been demonstrated by international medical cooperation and the increase in medical errors on an annual basis. The World Health Organization has begun to pay attention to medical errors and possible measures to avoid them. We will study this according to the following:

The Special Nature of Medical Work

To illustrate the specific nature of medical work, we will examine two profiles that define medical work and established (medical) scientific origins.

Definition of Medical Work

Jurisprudence differed in the definition of medical work, and some defined it as: “That work is carried out by a person who specializes in the treatment of the patient, so long as this work is based on the prescribed medical principles and rules of medicine.” (Abu Nassir, 2015).

Another aspect of jurisprudence defined him: “Every activity, in its manner and conditions, is consistent with the rules of medicine and is itself oriented according to the normal course of things to the patient's recovery” (Abu Naseer, 2015).

Another aspect of jurisprudence is that the definition of medical work includes any work that is performed on the human body or itself, whether by examination, diagnosis, treatment or prevention, by a physician who is licensed in accordance with established and recognized scientific principles and principles in the science of the physician with the aim of achieving the patient's or his social interest, provided that the patient or his representative is satisfied"(Abu Naseer, 2015).

The origin of medical work is to be for the purpose of providing treatment, but medical work is not to be for the purpose of diagnosing ill health or preventing diseases (Hanna, 2014)

I find that the definition of medical work is: (Any activity emanating from a competent physician and licensed person, which is returned to the patient's body with his or her consent with the intention of providing health care in accordance with the scientific principles of medicine).

Following Established (Medical) Scientific Principles

It is also known that medical science includes assets that are established and Muslim in most countries of the world, known to medical personnel, and do not tolerate or override those who are ignorant of them (Hanna, 2014).

Part of the jurisprudence defined established scientific origins in medical science as: (The theoretically and scientifically accepted rules among physicians, which all doctors must be aware of in the practice of medical work, keeping in mind that medicine is in constant progress and that what is today a modern theory and opinion may become an old tomorrow or even be counted as one of its errors) (Abu Naseer, 2015)

The competent physician must abide by the principles and rules of the medical profession applied when performing his medical work and exert the necessary effort in exceptional circumstances in accordance with established scientific principles. He must not tolerate those who do not know, exceed or take it for granted (Abu Nassir, 2015)

The reason that the doctor is obliged to abide by the established scientific principles in the science of medicine is to protect the public interest and the principles of medical work, to protect the human right to life and the safety of his body from manipulation. If the competent doctor violates that obligation, he is exposed to the criminal and civil issue (Abu Naseer, 2015)

Emergence of Medical Tourism

Medical tourism can be traced back to the 1980s, when it first appeared in the United States and Europe. Many of them wanted to travel to many Latin American countries to receive treatment for low costs and ease of travel. They are entering countries as tourists, staying in tourist destinations for more (24) hours and going to hospitals for health care (Mutalib's et al., 2016).

There is no uniform definition of medical tourism, which means that the methods applied between countries are very different. Some countries register foreign patients who go to hospitals for treatment. Some countries register the nationality of patients who enter the country, but not their place of residence, as there may be a problem with people after they return to their country for treatment.

Medical Tourism (Therapeutic)

The means by which an individual moves from his permanent residence to another area for the purpose of prevention or treatment of a disease. These can be environmentally friendly reasons that rely on elements of the natural environment, such as the sun, sea water, lakes, sand, therapeutic clay, metal or sulfur eyes, or other components of healing. They can be medical devices based on modern facilities, equipment, and medical expertise.

According to this definition, medical tourism has three subtypes: preventive, hospitalization and medical tourism in clinics, hospitals and medical centers (Salman, 2009).

The main reason foreigners are intended to access health care abroad is because of technological development, access to better medical care, or cheap costs, speed in providing medical care, access to a physician, ease of procedures and ease of travel to provide fast, convenient and relatively cheap transportation (Tourism, 2013).

Importance of Medical Tourism

International interest in medical tourism has been driven by economic interest, and many Americans are unbelievers and many Western Europeans have long waited to get medical care.

Private companies have started sending many people to be treated abroad for profit-making purposes and are providing comprehensive services to all tourists seeking treatment abroad from the choice of hospital and residence.

Some of them are victims of fraud or mismedical practices, sign a waiver of their rights in case of danger, and are subject to the law of the State providing medical care, which does not provide any guarantees in case of medical error.

The potential benefits of medical tourism are to improve health care, reduce costs, and reduce long waiting times in some countries (concern for health care for foreigners has led citizens to benefit from it. In India, a two-tier system for local citizens and a system for foreign health-care seekers has been established, as in Panama and Thailand, which were aimed at developing health care is to attract foreigners. But this has been in the interest of citizens, and this has led to competition among States in the provision of medical care and is in the interest of the national and foreign patient).

Legal Problems Raised by Medical Tourism

So far, there is no legal system that protects people under the cross-border health care system called medical tourism (MIRRER-SINGER, 2007).

We believe that the problem with travel may be exacerbated by diseases and injuries, and this causes material and moral damage and makes insurance companies unable to pay. Most of the travel is from high-income countries to low- or middle-income countries, with different methods of treatment provided (Kai Ruggeri, 2015) (most of the data on medical travel is very inaccurate, and there is a difference in the definition of medical traveler and the lack of agreed methods for collecting data.)

The problem is that the company providing the medical service and the foreign medical doctor who is trying to protect himself by signing the patient has waived his right to complain and to receive reparation.

The company may be subject to the Companies and Intangible Persons Law, which shall be held accountable according to the location of the branch of the tourist medical activity or the main administrative center. The applicable law shall be the headquarters of the main company or the branch providing the service in application of Article (49) of the Iraqi Civil Code.

We believe that seeking medical care abroad is not a problem. The state that failed to provide medical care to its citizens should protect the sick abroad, because the state is responsible for caring for its citizens wherever they go. And because medical work has started to take the form of a business, so holding the foreign doctor accountable is a duty. Every country that has embassies abroad should follow the situation of citizens abroad, even when seeking medical care.

Evolution of Doctor's Responsibility in the International Context

Millions of patients worldwide are infected each year by poor health care (resulting in nearly 2,6 million deaths worldwide in low- and middle-income countries alone, affecting the socio-economic status of those countries, with losses estimated at billions of dollars, and that every five patients every minute or so die). International laws must be enacted to reduce these.

Healthcare in the EU

The European Union (EU) has adopted two health care and public health treaties and a directive on cross-border patient safety:

The First Item: The Maastricht Treaty of 1992 and the Amsterdam Treaty of 1997: Health and health care were not dealt with by the European Union until the Maastricht Treaty (Treaty,

2007), adopted on 7 February 1992, the first treaty to provide health as part of EU legislation and urges member states Member State (MS) and the European Economic Community (EEC) European Economic Community to act and cooperate with regard to health care in accordance with M(129) of it, with a particular focus on health protection and public health, which states that: (Health protection requirements should form a fundamental part of the policy of the Community and (the Community and the Member States should strengthen cooperation with third countries and international organizations concerning public health).

Subsequently, the Amsterdam Treaty of Amsterdam was promulgated on 2 October 1997. It dealt with health and health care in article 152, M 129, of the Maastricht Convention, which stipulates that public health is "guaranteed a high level of health protection in the definition and implementation of all policies and activities of society", which provides for public health as a subsidiary text but broadens the scope of health legislation within the responsibility of society.

These two treaties strengthened EU public health policies and legislation (in 2000 the European Health Forum published a report and presented health policy recommendations to the EU Commission. Transboundary health services and patient movement are mentioned in this report, which will be discussed in the second paper).

Item 2: Directive on patients' rights to cross-border health care 2011: In 2002, a group of high-level experts began work on inter-State patient travel and health service delivery and arrived at the EU Commission in 2003. In the following years, both interstate and patient travels were on the agenda of the Working Group and the EU Commission. At the same time, funding for the Inter-State Health Services and Patient Travel Program was initiated through the EU Public Health Program 2008. The Directive was proposed and drafted to the European Parliament and Council by the EU Commission. Following discussions, the amended final version of Directive 24/201/EU on the application of patients' rights to cross-border health care was on 28 (February 211), 2017 (MekiMeki, MekiMeki, Meki, MekiMekiMeki)

Health care by WHO

The World Health Organization (WHO) finds medical errors unacceptable, so urgent action must be taken by countries around the world to reduce and avoid medical errors in the future.

Investing in patient safety reduces the cost of physical and social loss worldwide, as prevention costs less than treatment (Organization, 2019) (In the United States alone, improved health service safety has saved $28 billion in the years 2010-2015, and the patient can be engaged to provide better health services to reduce the damage by 15% and save billions of dollars each year.)

The First Item: Global Patient Safety Alliance: The World Health Organization (WHO) endorsed the differences in standards for health-care providers in October 2004 and launched the Global Alliance for Patient Safety. The Alliance was established in response to resolution WHA 55-18 of the 55th World Health Assembly of the World Health Organization (WHO) in May 2002, which urged member states to pay the utmost attention to the problem of patient safety and to establish and strengthen evidence-based systems to improve patient safety and improve the quality of health care.

Patients seeking treatment abroad may be exposed to risks due to unforeseen surgical actions and may face significant complications after returning to their home country, and may find it difficult to obtain health insurance to cover health costs that could occur because of future complications (Organization, 2019).

Item 2: World Patient Safety Day 2019: The 194 members of the World Health Organization (WHO) decided on 24 May 2019 to count 17 September 2019 as the first World Patient Safety Day (WPSD) adopted by the 72nd World Health Assembly and officially included on the WHO list of health dates. WHO gives global importance to patient safety and urges patients, health workers, and health-care policy makers and industry to raise awareness through "Patient Safety Advocacy" (Organization, 2019).

Goals for World Patient Safety Day

Aims to: Raising awareness of patient safety issues at the global level, promoting cooperation and understanding on the central role of patient safety in achieving universal health coverage and sustainable development goals globally, working to develop and encourage court systems and procedures on all avoidable health-care damages, risk and crisis management in health care, encouraging Governments to commit and support the implementation of plans to ensure patient safety and risk management and promote supportive learning cultures, encouraging cooperation and participation at all global, regional, national and local levels to implement patient safety plans and improve health-care safety, and highlighting issues of patient health and safety, medical safety training, patient safety education, reporting systems (2019), and the Assembly.

Medical Tourism in the United States

The United States of America has gained a worldwide reputation for providing high-quality, advanced medical care. Tourists from all over the world come to receive treatment in complicated medical conditions (Garman, 2015).

The health services trade in the United States of America, often called "medical tourism", has increased steadily in recent years because of the increase in the number of foreign travelers seeking health care within the United States, despite the high cost of treatment due to the availability of high-quality medical services and the large availability of hospitals, treatment centers and clinics (Assembly, 2019), and abortion to criminalize abortion in some countries' laws.

Many sick Americans who travel outside the United States seek treatment and more affordable health care because of the high cost of treatment in the United States (Chambers, 2015).

Many health-care providers in the United States of America are also seeking to improve health services and obtain an international certification in health-care delivery in order to attract many foreign patients as tourists for profit.

Disputes between health-care providers and foreign patients are governed by the "State of Destination" law, that is, the law of the United States of America in which the "tourist patient" intended to be treated.

We note from the above that the different methods of diagnosis and treatment, the development of medical and laboratory equipment, the increase in medical errors at home, the different laws in doctor accountability, the ease and speed of transport, and the extent of interest of countries in providing health care to their citizens, are what has led to the emergence and development of health care abroad for the fear of the patient being exploited, fraudulent or harmed by health care at home. Likewise, it is the announcements of medical services in the countries and companies promoting and helping to obtain medical care abroad that have helped the flourishing of travel for the purpose of treatment.

Applicable Rules of Support

There are no legal rules relating to the law applicable to the responsibility of the physician. International trends differ in determining the law applicable to the responsibility of the physician. We therefore refer to the general rules on contractual responsibility under private international law, including doctrinal and other legal trends at the domestic and international levels.

The obligations arising out of the contract in accordance with the rules of attribution in private international law are governed by the law of will, the law of the common home of the contractors or the place of conclusion of the contract (Sadiq, 1995). We shall also examine the contract of absence to determine the responsibility of the doctor according to the following:

Internal Laws

The theory of the contract is one of the most important manifestations of the principle of the sovereignty of will. It has affected the mechanism of private international law, which considers the agreement sufficient to arrange the obligation, and it is part of the terms of the contract (Egypt, 2011), in addition to other regulations approved by the legislator.

We will examine the issue of Iraqi civil law and the law in the United States of America to conflict laws with reference to some other laws as follows:

Iraqi Civil Code

We note that the Iraqi legislator has taken a Basic Support Officer and a Reserve Officer in Article (25/1) of the amended Iraqi Civil Code (No. (40) 1951), which reads as follows: (The law of the State in which the contractors have a common home shall apply to contractual obligations if a national is united, and if the law of the State in which the contract is concluded differs, this shall be unless the contractors agree or it appears from the circumstances that another law is to be applied) (by the same text, Jordanian civil law is taken in article 20/1, and Egyptian civil law article 19/1, and this principle is taken in French practice by the majority of Western laws) (Egyptian, 2011).

First item: basic support officer: The definition of an international contract is the affirmative action and acceptance of the parties to the contract that goes beyond the effects of the contract in the sphere of a single State, agreement on the applicable law: It is the freedom of the parties to the relationship to choose the law applicable to the resolution of their international disputes and is divided into an express and implicit choice.

This article emphasized that the applicable law is the law of will as the basic support officer, and could be an explicit will to determine the applicable law as the title of the law of a particular State or legal system, or to provide for specific articles in the law of a State to be added at the origin of the contract, and could establish terms or clauses in the contract by the parties that are not taken from a particular legal system in implementation of the principle of "contract", which may be model or standard contracts (Hafez, 1998) or by subsequent agreement: It is an agreement to which the debtor is bound in breach of its obligation whether to agree to release or to tighten liability.

Or it is an implicit will that a judge can derive from the contract and the circumstances of the contract, because it is the agreed law. When there is no express will to specify the law applicable in the contract, the judge must draw the implied will, by means of a set of controls and evidence that indicates the intention of the parties to apply a law relating to the contract, the most important of which is the place of execution of the contract, the presentation of the dispute to a particular State, the nationality of the individuals, the nature of the contract, the process of performance, the contract formula, the language of the contract, the editing of the contract by official notary.... etc (Mujahid, 2011).

However, this principle has been criticized because the choice of law by individuals will establish rules of conflict of laws on an equal footing with the state and will remove its authority and control. Proponents of this principle have replied that there is prior tacit consent of the states concerned to the applicability of the law of will (Egypt, 2011).

However, agreement on the choice of law is not binding for the court if the contract does not relate to this law agreed upon due to fraud towards the law, or has some defect from satisfaction such as mistake, coercion and fraud, or is contrary to public order and the higher interests of the state of the judge, or if the law cannot be established by the parties, and if the judge is unable to extract the implicit will of the contractors (Egypt, 2011).

We find that the application of the law of open or implied will can lead to the implementation of judgments in the state, which avoided the beginning of choosing its own law. The state that did not consider the dispute will bear the consequences of the contract, and this is contrary to logic and justice, such as when an Iraqi doctor and a patient from Iraq agree to conclude a medical contract in Iraq for the purpose of treatment in Jordan, and in the event of a conflict that applies Iraqi law, a medical error occurred in Jordan. If Iraqi law is applied, Jordan will bear the results of the contract, which is contrary to justice.

Agreement can lead to a doctor's escape from responsibility, as a law that is not accountable for his wrongdoing, omission, or wrongful act may be chosen as the applicable law.

Item 2: reserve support officers: It is the common home of the contractors and the place of conclusion of the contract as referred to in article (25-1):

First: Home Union: If the contracting parties do not agree to specify the law applicable explicitly or implicitly, the law of the common home of the contractors shall be applied as a reserve support officer in the absence of the express or implied will, because it is more responsive to the needs of the contracting parties, and is considered the legal status and place in which they conduct their dealings (Al-Aboudi, 2015), since the Iraqi legislator found that the common domicile is a sufficient criterion for the contract to be subject to the law of this State (Ibrahim, 1982), and because the parties to therelationship have prior knowledge of the applicable law (Al, 1997).

Dr. Mamdouh Abdel Karim said: (The criterion of the common domicile of contractors is no longer considered at present because it governs the international contract, and may be considered as falling within the internal or national contract because there is no difference in place for the parties involved, because the domicile is more important than the nationality bond for the parties.)

The difference of the nationals of the parties to the international contract enumerated by the Vienna Convention on the International Contract for the Sale of Goods on 11 April 1980 is the basis of the standard of the international contract.

The Iraqi Civil Law (Home Union for the Seller and the Buyer) in the international sale contract is subject to the provisions of that law governing the common home of the contractors, whereas such a contract must be considered internally and not internationally for lack of a foreign element (Hafiz, 1998).

I find this opinion right on the one hand that the Homeland Union allows the law to be applied easily to contractors for the above reasons, but on the other hand, I find that it is not right. It might be the common home of contractors that has nothing to do with the subject of the contract. If an Iraqi agrees with an Iraqi doctor to perform an operation in Jordan or Turkey, and they sign the contract at the hospital outside Iraq, and a medical error occurs, what is the relationship of Iraqi law to the contract? The doctor's fault that caused the damage was in Turkey or in Jordan, not Iraq.

Second: Application of the law of place of contract: If the parties are not united in the home and there is no explicit or implicit will, the law of the place where the contract was concluded (Al Abudi, 2015) is applied, and perhaps the most important arguments in support of this officer:

a. Leads to the unity of the law governing the contract.
b. Has the logical priority in determining the applicable law because it is the place where the contract was created and the point of convergence between the will of the contracting parties.
c. The law of the place of conclusion of a contract is also known to the parties in advance (Abdullah, 1969).

However, the most important criticism was leveled against the officer:

a. Sometimes choosing where to conclude a contract can be a coincidence, as traders may meet at a certain place for final negotiation and finalization and signing of their contracts.
b. Most international contracts are concluded by telephone or Internet, which makes it difficult to know where the contract is concluded, as State legislation varies in determining where the contract is concluded in such contracts (Sadek, 1995).

Likewise, it is possible for an Iraqi doctor to agree with an Iraqi patient to have an operation outside of Iraq. Final negotiations, a contract, and an operation outside of Iraq will take place in Jordan, for example. Negotiations and agreements can be made *via* mobile phones and the internet, as we find many ads with phone numbers of doctors and private hospitals on the internet, in order to attract patients for the purpose of contracting for treatment.

In order to focus the law spatially in case of disagreement, the judge shall have a role in this by relying on several elements such as the place of conclusion of the contract, the place of execution of the contract, the joint nationality of the contractors and their location, the voluntary determination of the competent court, the language of the contract... etc (Masry, 2011).

I find that the place to conclude the contract is not sufficient to determine the applicable law, so the matter may be left to the judge in the absence of agreement.

Item 3: Rules of attribution applicable to variable medical damage: The health condition of the affected person plays an important role in changing the amount of damage, particularly physical damage, since physical injury can worsen, and even extend to moral damage, and exacerbating the disease may result in the disadvantage of the affected person from full reparation (Sari, 2019)

Variable Damage: The definition of jurisprudence as "the frequency between exacerbation and imperfection in a particular direction, which may occur in accordance with emergency circumstances between the time the error is committed and the damage is caused" (Al-Safi, 2019).

The importance of this topic is that many patients after treatment and full recovery show other signs of illness, whether they are related to the disease itself or to an injury or another disease as a result of treatment and after returning from treatment abroad. For example: An Iraqi may go to therapy for blindness in one eye and for treatment lose another eye and turn from curable blindness to irreversible total blindness. The question is how can a judge determine the amount of damage? What is the verdict in case the disease gets worse after the court verdict? What law is applicable?

The time of damage estimation is especially important in reparation, because of the change in value of objects and the monetary purchasing currency upward and downward (Sari, 2019).

The Iraqi judiciary took into consideration the time when damages were incurred in assessing compensation, not the time of sentencing, as the decision of the Court of Cassation came:

(Compensation for damage in tort liability is estimated at the date of the injury and not at the date of the action). Decision (5177/Dec. 1, transferred/998, in 7/4/1999, and decision 3/Dec. 3/2001, in 14.1/2001) (in effect, 2019).

The French Court of Cassation has another opinion. It took the time of the judgment, ruling on 5 November 1936: (The right of the injured to compensation arises only from the date of the judgment.) A further judgment was rendered on 2 December 1947: (The right to compensation for damage within the scope of contractual liability is born out of judgment.) Miqdad Al-Said, Compensation for moral damage in civil liability "Comparative study", Dar Al-Haddatha Printing and Publishing, T.1, 1985, Lebanon, p.260 Referred to by the judge (Sari, 2019).

We believe that the most likely opinion is that estimating the compensation for the variable damages at the time of sentencing, with giving the affected person the right to review the courts after acquiring the final degree of control in the case of worsening the disease, if the increase in the disease due to the injury in question, especially with regard to the psychological damages that the patient suffers and that worsen with time, and have no treatment for the most part, or the patient's interruption from work, which makes him or her impoverished with time, needs compensation.

As for the law applicable in the case of a dispute between parties because of the variable harm that affects the patient, I did not find any law or one of the jurists to speak about, and I believe that the law of time of judicial claim should be applied, that is, the law of the judge to the variable damage. The judge is the one who determines when and how the harm increased and changed, and how to make it greater.

We notice that Iraqi legislators have settled on applying the general rules of conflict of laws to the responsibility of doctors, and have not updated their legislation.

Conflict of Laws in the United States of America

There is a difference between the laws of two or more states in determining the law applicable to a particular case. The result depends on the applicable law to be applied to each disputed case. The legal rules may be different and inconsistent between the States and the laws of other States. In the United States, the second Conflict of Laws Act (Restatement (Second) of Conflict of Law) 1971 in Article (187/1) State law chosen by the parties provides: 187. Law of the State Chosen by the Parties:

(1) The law of the state chosen by the parties to govern their contractual rights and duties will be applied if the particular issue is one which the parties could have resolved by an explicit provision in their agreement directed to that issue.

2) The law of the state chosen by the parties to govern their contractual rights and duties will be applied, even if the particular issue is one which the parties could not have resolved by an explicit provision in their agreement directed to that issue, unless either

(a) The chosen state has no substantial relationship to the parties or the transaction and there is no other reasonable basis for the parties' choice, or
(b) application of the law of the chosen state would be contrary to a fundamental policy of a state which has a materially greater interest than the chosen state in the determination of the particular issue and which, under the rule of § 188, would be the state of the applicable law in the absence of an effective choice of law by the parties.

3 In the absence of a contrary indication of intention, the reference is to the local law of the state of the chosen law.

From the above, it can be shown that the law in the United States of America requires that the law be explicit, not implied, and that it has a substantive connection with the parties to the relationship or the contract, and that such a choice does not result in a violation of the rules of the State whose law is applicable, or that greater benefits may be achieved in the absence of the application of the agreed law. If the above conditions are not met, the agreement is not valid and the judge is not required to apply it.

Part of American jurisprudence has gone to the tacit will by taking the context of the language of the contract (Shaaban & Khudayr, 2016).

I believe that the direction taken by American legislation is right because the will can only be inferred from it if it is explicit and expresses the true will of the parties if it does not conflict with the public order and the constitution of the United States of America, and the tacit will is not sufficient to know the direction or intention of the contracting parties.

The Iraqi legislator has taken the explicit and implicit will in the contracts, which is the same direction as American legalization.

Rome Statute, 2008

"The system" is a binding legislative act. It should be fully implemented throughout the EU. For example, when the EU wanted to ascertain the existence of common guarantees for goods imported from outside the EU, the Council adopted the Regulation, the EU (European Union), and the Rome Statute 2008 on the law applicable to civil and commercial complex matters issued by the EU, the European Parliament and the Council of the EU issued a new Regulation called the Rome Statute I 593/2008 on 17 June 2008, called "Regulation applicable to contractual obligations", "Rome I"." Published in the Official Journal of the EU on 4/7/2008, which came into force on 17 December 2009 (26), July 17, 2009 29 the implementation of the Convention, aiming at the fulfillment of the legal obligations of the European Community, with the exception of the European Convention of the Community of the European Convention, in respect of the Convention of the Community of the Convention of the 1980 replaced it with the law applicable to complex matters and has universal application also to non-member States with respect to civil and commercial matters (it is purely European international law), which includes:

Freedom of Choice

Chapter II (Uniform rules) Article (3) (Freedom of choice) contains a text that contains the freedom to agree on a particular law governing conflict of laws

Chapter II (Uniform Rules) Art 3 (Freedom of choice).

1. A contract shall be governed by the law chosen by the parties. The choice shall be made expressly or clearly demonstrated by the terms of the contract or the circumstances of the case. By their choice the parties can select the law applicable to the whole or to part only of the contract.
2. The parties may at any time agree to subject the contract to a law other than that which previously governed it, whether as a result of an earlier choice made under this Article or of other provisions of this Regulation. Any change in the law to be applied that is made after the conclusion of the contract shall not prejudice its formal validity under Art 11 or adversely affect the rights of third parties.
3. Where all other elements relevant to the situation at the time of the choice are located in a country other than the country whose law has been chosen, the choice of the parties shall not prejudice the application of provisions of the law of that other country which cannot be derogated from by agreement.
4. Where all other elements relevant to the situation at the time of the choice are located in one or more Member States, the parties' choice of applicable law other than that of a Member State shall not prejudice the application of provisions of Community law, where appropriate as implemented in the Member State of the forum, which cannot be derogated from by agreement.

5. The existence and validity of the consent of the parties as to the choice of the applicable law shall be determined in accordance with the provisions of Articles 10, 11 and 13.

The parties have the freedom to choose the applicable law without a fixed time limit. Paragraph (13) of the Grounds for Proxil Regulation (I) of 2008 states that "the parties shall be given the freedom to choose the applicable law which is one of the fundamental pillars of the conflict-of-laws regime in matters of conflict of law relating to contractual obligations. The parties shall have the utmost freedom of any law to be applied" (Behr, 2011).

This article is the fundamental substance of the Rome Statute, which enhances the legal certainty of international trade. The provisions of this Regulation are the same as those of the Rome Convention 1980, which is repealed in Article (3). However, the Rome Statute, I. Article (3), contains two clarifications:

a. The article does not require that the agreement be in express terms, as the parties may implicitly agree on the choice of law and may derive that agreement from the terms of the contract or the circumstances of the case in the service of international trade.

b. Paragraph (14) of the grounds for the Statute clarifies when the parties agree on the jurisdiction of one or more courts to hear the dispute in the event that it occurs, the judge may make use of that choice in the determination of the applicable law that is implicitly agreed upon. (This is the trend of English law and is also reflected in the improvement of the texts of the repealed 1980 Rome Convention) (Ministry of Justice, 2010).

We note from the text that this system is consistent with the right of the Iraqi civilian to take the express and implicit will and affirm it. However, it disagrees with the law of conflict in the United States of America, which does not take the tacit will but emphasizes the express will in the contract.

Where the parties have chosen the law of a State which is not connected with the contract in question to derogate from the law of another State, this agreement is void and the law of the other State which is relevant to the contract in dispute is applied in paragraph (3).

However, if the law of one or more Member States is applicable to the contract in question and the parties have chosen the law of another State which is not a member of the Community, this agreement shall not derogate from the law of the Member State which is involved in the subject of the dispute, paragraph (4) (Behr, 2011).

The parties may agree on a law governing the dispute over part of the contract, sometimes this agreement is not valid if there are multiple laws governing the contract, making the contract provisions incompatible, and the choice of law can be agreed at any time either when the contract is concluded as a condition in the contract or during the contract's execution. This text did not change the provisions of the repealed Rome Convention of 1980.

The existence and validity of the choice of law is governed by the law governed by this Rome Statute if the contract is in force, as is the case in the repealed Rome Convention. However, there is a reservation in order to prove non-consent; the parties can rely on the usual State of residence with regard to the legal effects of its conduct. This opinion is important if the choice of a particular law is not respected.

As for the validity of the formal agreement clause, article (3/5) refers to article (11), which provides a set of solutions in favor of formal validity based on the location of the parties at the time of conclusion of the contract, when the contract is concluded between the parties located in the same country, the required formalities must be met in accordance with the law of that State in which the contract was concluded, article (11/1), but if the parties are present at the time of conclusion of the contract in two States, article (11/2) provides a set of solutions that the model

must be consistent with the law governing the contract, the law of any State in which the parties are present, or the law of any State in which the parties have their habitual residence(Behr, 2011).

The Law Applicable in the Event of Disagreement

We also know that the medical contract is of a private nature and is not a sales contract, a lease, a service contract or a concession contract. It is a private type contract and therefore the provisions of article (4/4), which provides for the application of the law of the State which is closely linked, are applied.

Art 4 Applicable law in the absence of choice: (4. Where the law applicable cannot be determined pursuant to paragraphs 1 or 2, the contract shall be governed by the law of the country with which it is most closely connected).

The Rome Statute contained a provision that was more relevant, the application of the law, which was complex and uncertain in nature, allowing national courts in member States to interpret it in different ways according to their rules and legal procedures, which in turn led to uncertainty, particularly with regard to the interpretation of the text by the European Court of Justice, the Court of Justice of the European Union (CJU) and its status in Luxembourg 1952, the highest court of the European Union and its function under Clause 19, Clause 1, the text of the EU Constitution and the EU Supreme Court of Human Rights and the Court of the European Union (EU). The EU Supreme Court and the EC Court of the Court of Justice is the European Supreme Council (EC). Court is the Court of Court of Court of Justice and the EC is the Court of the Court of Court of Court of Justice (CJEU, N.D.) Since this paragraph (4) is applied if the three paragraphs cannot be applied, for the purpose of creating a degree of flexibility and in order to achieve an appropriate and reasonably foreseeable balance, it has made this paragraph a means to escape the application of the text of the article and to resort to the European Court of Justice (Behr, 2011), a trend neither Iraqi nor US law have taken.

DIRECTIVE 2011/24/EC/EC ON THE APPLICATION OF PATIENTS' RIGHTS TO CROSS-BORDER HEALTH CARE

Directive (is a legislative act that sets out a goal to be achieved by all EU States. However, it is up to each individual State to establish its own laws on how to achieve these objectives) (EU EC) which are internal rules for the protection of patients' rights (EU Directive 2011/24/EC of the European Parliament and the Council of 9 March 2011 on the application of patients' rights to health care across borders, published in the Official Gazette in 4/4/2011, for 88/ 45 and made effective 20 days after it was published in the Official Journal) between Member States. It is applied within the EU to Member States on EU nationals and on foreign nationals in special cases, the most recent EU initiative on the free medical care (t1100, 1the Hrelocation of patients, the Member States of 25 October 2013 and of the European Economic Area (Iceland, Liechtenstein and Norway) since 1 أب 2015. However, it does not apply to Switzerland) The Directive consists of five chapters, which we shall examine in the following order:

Patient Rights Provisions

The EU directive sets out a set of basic rules to ensure that member states cooperate to protect patients' rights to seek treatment and to provide cross-border aid and money:

General Provisions

This Directive lays down rules for access to safe, high-quality health care across borders and for the promotion of cooperation among Member States within the European Union through the organization and delivery of health services. These rules ensure coordination among European Union Member States on the right of a insured person to receive treatment within European Union States, as he will be able to receive the same care as nationals of a European Union Member State (Union, n.d.) as residents and stateless persons who have traveled to a European Union Member State to obtain health care:

Article (3) defines health care as: (The provision to patients of health services (a physician or a nurse responsible for general care, a dentist, a midwife or a pharmacist under Directive 36/2005/EC) to assess their state of health, to repair or restore the organs of the body, including a medical prescription, and to provide medical products and devices. This definition is wide-ranging in that it provides not only for physicians to have a duty to provide health care but also for health-care personnel and for all types of treatment, including curative, preventive and rehabilitative treatment.)

The definition of an insured person includes all persons and their family members, with reference to the Regulation 884/2004 (on social security within the European Union, taking into account the customs and traditions of each State) Regulation No. 859/ 2003 (of 14 May 2003), which provides for the rights of nationals of a third State (not a member of the European Union) for nationals of a third State (not a member of the European Union), Regulation 1231/2010 of the European Parliament and of the Council of 24 November 2010 (EU Regulation 1231/2010 of the European Parliament and of the Council of 24 November 2010 on the extension of the Regulation (EC987/2009) Regulation883/2004 (EC) to citizens). third countries who are not already covered by the regulations solely on the basis of their nationality) Health care in the EU therefore includes citizens of the EU as well as persons outside the EU who have the right to pre-authorized or non-EU health care depending on the type of treatment.

However, Article (1/3) does not apply to persons in need of assistance, transplants, transplants of human organs and vaccinations against infectious diseases (Hert, 2011).

Patients are also allowed to receive treatment in any public or private sector, and the State shall pay the costs of a citizen who has sought health care in a Member State, as long as treatment is covered by the health-care system in that State (Union, n.d.).

Responsibilities of Member States with Regard to Cross-Border Health Care

Speaks of the responsibilities of MSI, MEST and the National Contact Points (NCP) in three terms:

a. (**STE**) Mission **Support Team** is responsible for providing clear and specific information about healthcare providers, developing transparent mechanisms and procedures for filing complaints for treatment if patients suffer harm because of the healthcare they receive, and protecting personal data and medical records for treatment, provided these services are provided to domestic patients without any discrimination.

b. **Most Seriously Affected**; **The Mutual Security Agency (Economic Assistance)** is responsible for the reimbursement of the health care provided by **MSTT**(Ekmekci, 2017), providing clear and adequate information regarding patients' rights and entitlements to payment, treatment (Hert, 2011) and medical records.

c. **National Contact Points (NCP)**: These are the cross-border health-care institutions that provide information to patients for access and claim their rights with regard to cross-border health care.

Cross-Border Reimbursement for Health Care

These costs shall be paid by the EU Member States providing health care in accordance with their internal procedures according to this Directive after it has been established that the physician is undertreated by the bodies specified in the Directive.

Whereas Article (7) provides for the costs of cross-border health care; whereas the general rule is that the Ministry of Social Welfare is responsible for compensation for health care received by an insured person from the other Member State; whereas, however, the health care received by the insured person must be among the benefits to which the insured person is entitled (**MSA**).

SA has the right to determine the health care to which the insured person is entitled and the amount of compensation to be covered by the National Tariff for SA.

Travel, subsistence and other costs are not subject to the obligation to be met, so MSA has the authority to meet or not pay these related costs.

MSA may establish a health care list requiring prior approval, which shall be restricted to health care requests that are subject to the planning requirements relating to ensuring permanent and adequate access to a balanced set of high quality treatment in the Member State providing care, or the desire to protect and avoid waste of funds and technical and human resources.

Includes the provision on a case-by-case basis of treatments that pose a risk to patients, residents or health-care providers, which can cause serious and specific concerns about the quality or safety of care, with the exception of health care, which applies EU legislation guaranteeing a minimum level of safety and quality within the EU, provided that the national state guarantees the provision of treatment to the patient after his or her return (European Union, 2011).

However, where a **MSF** position to be granted under the Directive is also to be determined by Article (8), a Member State shall not refuse to grant a prior authorization where health care cannot be provided on its territory within a specified period of time which can be medically justified (based on a medical report issued on the patient's condition, the date and probable course of illness, the degree of pain of the patient and/or the nature of the patient's disability at the time the authorization application is made or renewed).

Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community law relating to medicinal products for human use.

EC (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down the procedures for the Community to obtain a license and supervise medicinal products for human and veterinary use and for the establishment of the European Medicines Agency (text with EEA relevance) (OJ L 136, 30.4.2004, p. 1).

Advance authorization shall be made available to all and shall be carried out within a certain time period taking into account the specific medical condition, urgency and individual circumstances.

Executive Regulation (EC) No 884/ 2004 is relevant to the payment of costs, which concerns the social security institutions of **MS** and regulates the social security provisions for insured persons in the European Union. The system is intended to achieve and ensure, in practice, the free movement of workers and self-employed persons applicable to a person who travels for treatment to another Member State (not for the reason of seeking health care, but for work). He needs health care. There is no need to obtain the consent of the (worker) but in other States, other health systems provide care within public sector institutions while Directive 2011/24/EC applies to public and private health care systems.

Cooperation among Member States

Because of the many health problems and the desire for cooperation among Member States in the field of health care delivery, the European Directive on Cross-Border Health Care has been issued. The primary aim or objective of the Directive is to increase cooperation in the field of health care among Member States of the European Union and to develop solutions to common problems among Member States through the International Court of Justice. It also contains rules for the coordination of social security which work in tandem with those laid down in Regulations (EEC) No 883 and (EEC) No 987:

Healthcare Collaboration

This Directive focuses on mutual aid for the implementation of the provisions of the Directive in accordance with established standards of quality, safety and information exchange. This Chapter examines recipes from MSTTS and relevant European networks (European Reference Networks=ERN) for rare diseases and electronic health (E- Health= Electronic Health and common cooperation in health technology assessment.

The recognition of prescriptions is necessary to ensure continuity of treatment and therefore requires MS to enable the necessary measures to facilitate this task in line with the provisions of Directive 2001/83/EC (of the European Parliament and of the Council of 6 November 2001 on the Community Act on Medicinal Products for Human Use) or of EC Regulation 726/ 2004 (of the European Parliament and of the Council of 31 March 2004 laying down community procedures for the licensing and supervision of medicinal products for human and veterinary use, the establishment of the European Medicines Agency (text with the importance of EEA) (OJ L 136, 30.4.2004, p 1)) and the preservation of pharmacist's rights under national ethical provisions.

Whereas this Directive requires publication guidance to develop the possibilities of working together on electronic recipes; whereas measures should be taken to address the correct identification and discharge from one Member State of prescribed medical products or medical devices adopted in another; and concerns relating to the safety of patients and the preference for cross-border health care; whereas legislation should allow for the replacement of one Member State by another.

Relevant European networks between health-care providers and centers of expertise, especially on rare diseases, will be established on the basis of voluntary partnership. The aim of the relevant European networks is to raise the potential of the Member State and the European Union with regard to health-care services and specialized health-care systems to a significant degree, to contribute to the gathering of knowledge with regard to the prevention of diseases, to increase the quality of experience with rare diseases, and to promote the effective use of the cost of materials.

Rare diseases are being treated within the scope of expanding the capacity to diagnose and treat them, because experience in such cases is very limited. Relevant European networks are a useful tool for increasing the capacity to manage rare diseases. E-health assessment and technology assessment are being promoted as areas where the Directive encourages greater cooperation and coordination at the level of the European Union.

Patient's rights under EU legislation and the position of the European Court of Justice (Union, 2012)

In the Treaty on the Functioning of the European Union (TFEU), public health is among the political areas in which the European Union and the United States of America share competence (pharmacy, mutual recognition of diplomas, special health areas such as blood, blood products, tissue and cells).

On the other hand, health care services are a political aspect that concerns the member states in full and does not concern the European Union Treaty on the Functioning of the European Union (TFEU).

However, people seeking health care across borders are either a factor that allows free movement like workers, or as an individual subject to free movement of individuals. People have challenged this concept (Ekmekci, 2017).

The directive referred to the refusal to provide health care across borders if the disease poses a risk to the public from serious infectious diseases that can be transmitted by travel (Hert, 2011).

Several cases have been brought before the European Court of Justice (the European Court of Justice (ECJ) since 1998 to uphold the principle of freedom to choose the type of health care (Kohl, Decker, Smits, Peer Booms and Watts) which are the most famous of the Kohl and Decker cases with a significant impact on patients' rights to cross-border health care, the decision of the European Court of Justice in such cases as the current concept of cross-border health care, etc. to a policy area subject to internal market rules governing the free movement of goods and services.

The case of **Kohl** 1994 is summarized by Mr. Kohl, a Luxembourg citizen who wanted his daughter to receive treatment from the orthodontics in Germany and who requested the approval of the Luxembourg Health Insurance Fund. The Fund rejected the application on the grounds that the treatment was not urgent and that the treatment could be completed in Luxembourg on the basis of the freedom to provide services (and not under Regulation No. 1408/71). Mr. Kohl considered that he had the right to seek treatment for his daughter in Germany without prior permission and was entitled to reimburse the costs from his insurance fund, not in accordance with the German payment rules but with the insurance rules in Luxembourg.

The European Court of Justice has decided that the treatment provided by a specialist should be considered a service, in such cases, prompting the application for treatment abroad in accordance with the rules of payment in the patient's country and that subjecting her to prior authorization would be an impediment to access to medical services in another Member State.

The Court further noted that these rules were not justified by the undermining of the Social Security Financial System or for reasons of public health care in accordance with the Treaty (28 April 1998, Kohll, C158/96).

As for the other verdict in Decker's call: There is no need to obtain prior authorization for the purchase of prescription medical devices or products in another Member State.

The fact is that medicines or medical devices for a patient can be prescribed by a physician working in another Member State and drugs have been bought in another Member State (either by personal travel to that Member State or by mail). This was true in the case of Mr. Decker, who in his 1992 years bought himself a pair of glasses from Belgium by an ophthalmologist working in Luxembourg. The Luxembourg Health Insurance Fund refused to pay compensation for the purchase of glasses on the grounds that the purchase was made abroad without prior permission.

The European Court of Justice has decided that the refusal to pay medical products purchased without prior authorization from another Member State constitutes an unjustified impediment to the free movement of goods, since the requirement of health care at home is not justified on public health grounds in order to ensure the quality of medical products provided by other Member States, since then, patients have been able to purchase their medical devices and medical products from another Member State without prior permission and claim compensation from their health insurance fund in accordance with the methods and rates of payment adopted in their country (28 April 1998, Decker, C-120/95)..

We note from the previous two decisions that the Court of Justice considered the patient a consumer, that the treatment and the medical devices used are goods and services, and that the Member States have the duty to help the citizen obtain the best health care within the European Community under a general health insurance that the Member State of the citizen guarantees to pay

its costs, and that the General Insurance Fund cannot refuse to pay, even if they do not obtain prior permission from it.

The European Court of Justice has interpreted access to health services as applying Article (1/56) of the Treaty on the Functioning of the European Union (TFEU) as: (Restrictions on the freedom to provide services within the European Union are prohibited as regards nationals of member states who are discussed in another member state other than the person to whom they are intended for services.)

This interpretation means that all systems that restrict access to cross-border health care, which impede the establishment of an internal market for the free provision of goods and services, cannot be applied. These provisions have extended the patient's rights and challenged the implementation of such a pre-authorization and security measure in the EU's main law - Directive or Directive 2011/24/EC - strengthen the case law with regard to cross-border health care under the EU Treaty on the Functioning of the European Union (TFEU) by regulating patients' rights in this context.

Patients have the right to receive, from Directive 2011/24/EC within the European Union:

1- Health-care services not available in their countries.
2- High quality and safe treatment in another Member State.
3- Information on a transparent mechanism for calculating the costs of cross-border health care.
4- Reimbursement of the costs of cross-border health care provided to another Member State (as defined in Directive 2011/24/EC and in application of Executive Regulation (883/2004).
5- Information on their rights and entitlements and the providers of services in the other Member State having cross-border health care.
6- Medical follow-up by MSF after treatment.
7- Copy of their medical records.
8- Recognition of their medical qualities in their home country.
9- Methods of filing and receiving complaints for cross-border health care (Ekmekci, 2017)

From the foregoing, we find that this directive is aimed at laying down general foundations for cooperation within the European Union in the provision of health care to protect individuals and their rights. States should follow the example of the European Union in providing health care, protection against errors and the provision of the necessary health insurance.

This Directive is a major development in the provision of Trans boundary health services, *i.e.,* between Member States within the European Union and all residents within the Union, to ensure the safety of patients. It is different in its rules from the rules applicable between States, as it facilitates the patient's access to care and facilitates the legal sanction against the wrongdoer by providing them with social security. Neither Iraqi law nor the laws of any other State provide a system that protects patients across borders.

CONCLUSION

From the foregoing, we have reached a number of conclusions and proposals according to the following:

First: Results:

1. We conclude that the implicit will of the parties to the medical contract can lead to the application of more than one law or the conflict over one law, which is unfair.
2. Public hospitals may enter into contracts with patients before initiating treatment or prior to performing surgery with the patient, his or her parents or the person legally responsible for them.

3. Travel for treatment is a contractual liability.
4. The adoption of the law on the place of the injurious act results in the physician's escape from international responsibility for his or her errors, because many of the symptoms are caused after the patient's return to his or her home country and he is ignorant of the laws of the State providing health care.

Second: Proposals:

1. Amend the text of Article (25) of the Civil Code and add the place of performance of the contract as a support officer because it is the place agreed by the parties to implement the terms of the contract.
2. The legislator must make any agreement that the patient or his family waive their rights to the doctor that is considered invalid.
3. A physician is not allowed to practice medicine until the approval of a competent medical board under the Ministry of Health and the Board of Medical Specializations has been obtained. The identity of the medical association is not granted annually until it has passed the most modern and best methods of medical treatment that are universally recognized. Penalties for the work of a physician are increased. The work of doctors must be characterized by professionalism and integrity.
4. We need to legislate deterrent domestic laws to protect the patient, since the doctor deals with the human life, which is the most sacred thing, and to legislate an international law of responsibility and work to unify the laws of health care in Iraq with the laws of the States, the European Union and the World Health Organization.
5. To appoint a family doctor in Iraqi embassies to follow up on cases of illness of Iraqi residents and tourists abroad and to provide guidance to those seeking treatment in those countries, and to follow up on incurable medical cases that are treated inside Iraq that are sent by the Ministry of Health for the purpose of treatment abroad, that no person shall be allowed to travel for the purpose of treatment, even if he is at his own expense, except with the approval of a specialized medical committee from the Ministry of Health. He shall submit his medical reports to a committee from the Ministry to verify medical reports and examinations and determine the need for treatment abroad. He shall be identified by the countries and hospitals that can review them for the purpose of treatment. He shall be issued a medical visa. He shall be entitled to travel to travel to travel to travel for the purpose of the purpose of a medical degree in order and to receive medical treatment in the Iraqi Embassy. He shall not be allowed to return after he is in the State hospital and he is not to receive his medical treatment. All health papers will be sealed from the hospital providing treatment and with the seal of the embassy, in order to guarantee the safety and health of Iraqis after their return and to prevent them from being fraudulent. He will be able to file complaints against the hospital and the doctor for treatment abroad in the event of symptoms arising after their return to Iraq.
6. The rule of the place of injury adopted by the European Union can be taken and applied to the liability of the contract and not only to the place of the injurious act, because the medical act has become a profit-making business that varies according to the country providing the treatment and the patient has become a consumer in need of protection. A patient affected by the treatment cannot return to the country causing the damage to bring proceedings against the physician. The rules of consumer protection can be applied in private international law and the case can be brought in his country after his return if it is proved through medical reports, and the consumer support rules can be applied within the framework of the framework of private international law and the place of residence or the home of the consumer.
7. The provisions on defects of will or consent stipulated in the Civil Code may be applied in the event of errors in the medical contract or malfeasance and of inducement to the patient due to the medical contract, thereby nullifying the medical contract by nullifying the agreement on the choice of applicable law and applying the other attribution controls established by law.

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