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LEGAL PROBLEMS IN ESTONIAN MEDICAL LAW CONCERNING DNR

Bachelor thesis

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I declare that I have prepared the bachelor thesis independently and I have referred to all resources used in compiling the works of other authors, relevant reviews and data, and have not previously submitted the same work for credits.

The length of the work is 9236 words from the introduction to the end of conclusion.

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TABLE OF CONTENTS

ABSTRACT 4
LIST OF ABBREVIATIONS 5
INTRODUCTION 6
1. RIGHT TO LIFE AS A PATIENT'S RIGHT 8
1.1 Right to life as a human right 11
1.2 DNR meaning and application 14
2. DNR REGULATIONS IN ESTONIA AND EU 18
2.1 Regulation of the declaration of intent 20
2.1 Patient's rights in Estonia 22
Conclusion 25
THE LIST OF SOURCES USED 27
APPENDICES 29
Appendix 1. Non-exclusive licence 29

ABSTRACT

The aim of the thesis paper is to present qualitative research to provide an understanding of the lack of legal problems concerning Do Not Resuscitate (DNR) order and in consequence how it implements in the Estonian legal system. The bahelor's thesis question is do Estonian law support the patient's right to life in the case of non-resuscitation (DNR) decision?

The thesis is to achieve a concluded study of the legal basis in the DNR declaration of intent in Estonian medical law for patients to make an autonomous decision concerning DNR and to ensure that it should be a practise that could be legalized in Estonia in near future. Different methods of legal interpretations are used in the interpretation of legal norms and for that legislation and scientific articles.

Medical Law in Estonia has yet to develop strict regulations concerning the implementation of DNR. Patients need to give a declaration of intent beforehand doctors could make one for them. The current lack of regulation can be detrimental to the patient's interests and rights. Everyone has the right to life and dignity and a doctor's instinct to make a DNR decision for the patient based on the diagnosis can lead to major responsibility afterwards the action has been implemented. Formal consent from the patient regarding the DNR simplifies the responsibility for the doctor and from the legal aspect it would be a respecting patient.

Keywords: DNR, Right to life, Patients rights, Declaration of intent

LIST OF ABBREVIATIONS

DNR- Do Not Resuscitate

DNAR- Do Not Attempt to Resuscitate

DNACPR- Do To Attempt Cardiopulmonary Resuscitation

CPR- Cardiopulmonary Resuscitation

AND- Allowing Natural Death

ICU- Intensive Care Unit

ECHR- European Convention of Human Rights

INTRODUCTION

Estonian law does not govern the implementation of DNR usage in the medical field. The key elements missing in the implementation is lawful consent and the declaration of intent of the patient. Patient's rights and right to life are the principles most relevant to the implementation of DNR. Secondly, national level medical law regulation is relevant for the protection of healthcare professionals to set the obligations and responsibilities in the implementation of DNR.

The aim of the thesis is to analyse how no regulation of declaration of intent in the case of non-resuscitation decisions violated the patient's rights, especially the right to life and to achieve a concluded study of the legal bases of the DNR declaration of intent in Estonian medical law for patients to make an autonomous decision concerning DNR and to ensure that it should be a practice that could be legalised in Estonia in a near future. Different methods of legal interpretations are used in the interpretation of legal norms and for that legislation and scientific articles. For the aim of the bachelor's thesis to be achieved the following research question will be answered:

1. Does Estonian law support the patient's right to life in the case of non-resuscitation (DNR) decision?

This thesis paper is conducted in qualitative research to provide an understanding of the lack of legal problems concerning Do Not Resuscitate (DNR) order and in consequence how it implements in the Estonian legal system.

The first part of the thesis is covered by the topics of right to life as a patient and human right and the DNR application and meaning.

The second part of the thesis is covered by the topics of DNR Regulations in Estonia and the declaration of intent and patients rights in Estonia.

The growth of medical and health law is a developing branch in many countries in Europe reflecting the needs and independence among patients who want to feel protected and be involved or even informed of the decision concerning their health. The factors affecting the evolution of medical law is medical science and technology, which is increasingly forced upon the human body and mind moreover affecting mental and physical integrity of the patient. Since patients are dependent on the health system they want to be secure that their rights are being protected.

Moreover, there is a growing sense of human rights in society, which is also reflected in health care. The concept of medical futility presents two major ethical issues that have tremendous legal ramifications: first, whether a physician may ethically and legally determine that a certain therapy or intervention is medically futile, and second, whether the physician may unilaterally or against the wishes of the patient or family decide to withhold, withdraw or not offer that therapy or intervention.[1] Therefore, a declaration of will, or a patient's will can be a time saver and in curtain occasions be an instruction to a medical professional how to behave in a situation where DNR applies. The trend to legislate is discernible both nationally and internationally. On the international level we note two distinct phenomena: The first is that treaties and conventions dealing with human rights and drafted in the early post-war years and in the two decades afterwards are invoked in the health field as a basis to defend patients' rights, thereby sometimes rightfully taking precedence over countries' constitutions that might be less geared to this type of application. The wider scope these treaties have makes them very useful on the one hand, but on the other they sometimes present the doctor and the healthcare field in general with unexpected problems: Which medical experiments cannot be carried out, on what terms is access to medical files granted, transfer of medical data, etc. It is not improbable that these applications were not foreseen when the treaties were drafted. The second phenomenon is the growing trend of international organizations to try to make new declarations, treaties, etc specifically geared to the field of health care. But the field now is beset with moral problems and ethical dilemmas, and endeavours in this direction have not always been crowned with success.[2] On a national level the lack of regulations and laws do not restrict and put liability on doctors who address DNR decisions on patients without their consent.

[1] Mordarski, D. (1993). Medical futility: Has ending life support become the next pro-choice/right to life debate. *Cleveland State Law Review*, 41(4), p. 754.
[2] Wijnberg, B. (1993). Patients' rights and legislative strategies. *Medicine and Law,* 12(1), 137.

1. RIGHT TO LIFE AS A PATIENT'S RIGHT

A right to life is a fundamental right and it can not be limited or deprived from anyone. The right to life Article is set in the European Convention on Human Rights.[3] As it is set in Universal Declaration of Human Rights Article 3. Everyone has the right to life, liberty and security of a person.[4] It could be interpreted that the Convention and the Declaration state that life which has been given must be protected and honoured by anyone and nobody has the right to make a decision to voluntarily take life. Mostly the question of life and death occurs in the hospital, where medical professionals and healthcare providers often have to bounce between what is the right and honourable thing to do. Even though most of the time a patient becomes just another statistic, or a file in an archive, the patient is a human being who has rights and, as vulnerable he might be, they have the right to make their own decisions. Hereby, making own decisions, it is important that the patient has been informed, advised and notified with all the information regarding the patient, treatment and diagnosis. It cannot be denied there is an inherent imbalance between doctors and patients. Doctors have the greater scientific knowledge and practical skills compared with patients - laymen - who seek their help or advice. Patients were, and are, considered the "weaker party" in the medical relationship. Therefore, it comes as no surprise that patients have seen their rights promoted rather than their responsibilities whilst doctors have been lectured only on their duties at the expense of their rights. And for a long time, many articles and reports thought it fair that the burden of liability lies only on doctors.'[5] Thereby, the Convention and the Declaration praise the value of human life but the matter of truth is that sometimes life of a human being is not that important when it is ill, bad condition, or not valuable or even profitable. Over the last 60 years, there has been a unidirectional trend to enhance patients' rights in health care assisted by the different Human Rights Conventions and civil rights movements worldwide over the 20th century. However, even if there is nothing wrong with this tendency as such, patients' responsibilities should not be put aside. There is a need for medical cooperation between patients and doctors who are bound up in a contractual relationship in which each party plays a key role in the medical diagnosis and treatment.[6] It is simple to accuse the doctor of any mishaps or mistreatments of

[3] Council of Europe. (1950). Convention for the Protection of Human Rights and Fundamental Freedoms. In *Council of Europe Treaty Series 005*. Council of Europe., Article 2.
[4] The United Nations. (1948). *Universal Declaration of Human Rights*, Article 3.
[5] Laur, A. (2013). Patients' responsibilities for their health. *Medico-Legal Journal*, 81(3), 119.
[6] *Ibid.*, 120.

the patient but it can not be only the doctor's responsibility. Demanding truth, dignity and respect form the health care provider should work both ways, meaning the patient himself has to be honest, truthful and respectful. Even when doctors do have the upper hand in the process, patients can feel being left out, or even lied to when not getting any straightforward answers to the questions. As easy as it is to understand that a patient is a human and all human rights conventions and declarations apply, there is a A Declaration on the Promotion of Patient's Rights in Europe[7] which constitutes a common European framework for action and includes those principles, as endorsed by the Amsterdam Consultation. This declaration should be interpreted as an enhanced entitlement for citizens and patients in improving partnership in the process of care with health care providers and health services managers.[8]

The Declaration is to be interpreted as an enhanced entitlement for citizens and patients in improving partnership in the process of care with health care providers and health service managers. The Principle of the Patients in Europe is a common framework due to social, economic, cultural, ethical and political developments that have given rise to a movement in Europe towards the fuller elaboration and fulfillment of the rights of patients.[9] The Declaration gives a fuller recognition to patients rights and protection also emphasizing that an active contribution and participation in the diagnosis and treatment is essential as is their subject to informed consent. The Principle of the Right of Patients seeks to "reaffirm fundamental human rights in health care, and in particular to protect the dignity and integrity of the person and to promote respect of the patient as a person."[10] It should also be noted that where exceptional limitations are imposed on the rights of patients, these must be in accordance with human rights instruments and have a legal base in the law of the country.[11]

The Declaration sets out key principles under the human rights and values in health care articles. These principles are in accordance with the basic right of a patient and reflect the autonomy of righteousness. These key principles are combined based on the European Convention on Human Rights and Universal Declaration of Human Rights.

1. Everyone has the right to respect his or her person as a human being.
2. Everyone has the right to self determination

[7] A Declaration on the Promotion of Patient's Rights in Europe 1994.
[8] *Ibid.,* 2.
[9] *Ibid.,* 5.
[10] *Ibid.,* 8.
[11] *Ibid.,* 9.

3. Everyone has the right to physical and mental integrity and to the security of his or her person
4. Everyone has the right to respect for his or her privacy
5. Everyone has the right to have his or her moral and cultural values and religious and philosophical convictions respected.
6. Everyone has the right to such protection of health as in afforded by appropriate measures for disease prevention and health care, and to the opportunity to pursue his or her own highest attainable level of health.[12]

The Charter of Fundamental Rights of the European Union Article 1 states clearly that human dignity is inviolable. It must be respected and protected.[13] Article 1 of the Charter is a declaration that clearly exceeds the regulations of the European Convetion on Human Rights (ECHR). Its importance as a fundamental value provision therefore can not be overrated. By this, it also contains a statement about the relationship of the European Union (EU) to the human being. The EU and its institutions exist for the sake of the human being, not the human being for the sake of the EU. All aims of the EU serve human beings. Further, a relationship exists between human dignity and democracy. ECHR has pointed this out: Tolerance and respect for human dignity for all people are in the same way the basis of a democratic and pluralistic society.[14] As to the second part of the Article, human dignity 'must be respected and protected', meaning that regulation is referred to institutions and bodies of the EU and the Member States. 'Must be respected' means, they are not allowed to impair human dignity. Correspondingly the individual has a fundamental right towards these organs to reject interferences with his dignity. It is a right for everyone, not only an expression of a fundamental conviction. With this, Article 1 is not only a fundamental right in itself, but it constitutes the real basis of fundamental rights. – The competent institutions are further obliged 'to protect' human dignity. Thus, in their sphere of influence they are ordered and obliged to protect people from interference with human dignity by third parties. [15]

Understandably, in the field of medicine patients are the weaker party and most of the time left out when it comes to truth telling about the severity of the diagnosis and perhaps even the end result of the long prognosis. Even though doctors do not prefer the straight and forward truth telling and instead favor explaining in a simple wording, the patient can always demand a detailed answer because they have the right to do so. For that very important reason the Declaration on the

[12] *Ibid.*, 9.
[13] Charter of Fundamental Rights of the European Union 2012/C 326/02.
[14] Commentary of the Charter of Fundamental Rights of the European Union 2006, 25.
[15] *Ibid.*, 25.

Promotion of Patient's Rights in Europe sets the key principles that support human rights and the right to life. Everyone has the right to life and deserves the right to be treated equally. Because doctors have the advantage over patients with knowledge and skill and with that combination they might, without their knowledge undermine the patient with manipulation into thinking that the patient makes the difficult medical decisions themselves.

1.1 Right to life as a human right

The Constitution of The Republic of Estonia § 16. Everyone has the right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his or her life.[16] Meaning everyone has equal rights to life. A right to life is a human right that can not be limited or deprived from a person. In the context of DNR order, the right to life is not commonly considered. Every person has an inalienable right to life regardless of his mental or physical condition. Similarly, the excessive pain standard is no longer adequate. No physician should undertake the subjective determination of what treatment or diagnostic procedure causes a particular person excessive pain.[17] Even though CPR might not have a positive result, the patient deserves a chance as a sign of respect and dignity and of course from the health care providers point of view, a moral and ethical try. Human rights are the basis of a patient's rights. In health care, patient's rights are liable to be violated. Not because health care providers are more inclined than others to do so, but because the individual in health care is easily reduced to a case and the patient's position is weak because of the illness and the insecurity and fear it produces. In such a situation the individual has to be protected. This has always been the role of law.[18] Patients' rights are essential in health care and many countries have enshrined them in a Code of Ethics, Acts, Conventions, Declarations, Charters of Rights, etc. As any medical treatment affects their well-being, patients undoubtedly have the right to ask for respect of their privacy through protection of their personal data, respect of their choices in decision-making through informed consent and updated information regarding their medical state, and to expect high quality and competent medical care. On the other hand, any right comes with duties,

[16] PS RT I, 15.05.2015, 2, 2, § 16.
[17] Levin, D. L., & Levin, N. R. (1980). Dnr: An objectionable form of euthenasia. University of Cincinnati Law Review, 49(3), 567-579.
[18] Leenen, H. (1994). The rights of patients in europe. European Journal of Health Law, 1(1), 5.

which have equal importance.[19] Patients have the responsibility to provide truthful and honest medical history covering all aspects and from past illnesses and treatments to present. Also, a patient must pay attention to what kind of medical treatment they receive and ask further questions if they are confused or do not understand the reasons behind it. If complications occur, they must accept the consequences (moral and legal) of their refusal to be treated after being given full information by health providers.[20] According to Estonian Code of Medical Ethics a doctor has to explain to the patient their current health status and receive a voluntary given and based on understanding consent for the necessary procedure and treatments to do so. The information provided to the patient must include information about the collection, storage and use of data (including in the health information system) and the need for research and treatment, the possible different treatments, as well as the possible side effects, complications and risks. According to Estonian Law of Obligation Act the provider of health care services shall inform the patient of the results of examination of the patient and the state of his or her health, any possible illnesses and the development thereof, the availability, nature and the purpose of the health care services required, the risks and consequences associated with the provision of such health care services and of other available health care services. At the request of the patient, the provider of health care services shall submit the specified information in a format which can be reproduced in writing.[21] It is the primary duty of the doctor to provide medical care in any situation within their competence, with respecting human dignity, autonomy and well-being of the patient. Meaning the doctors duty is to help the patient without any question to the prognosis to the diagnosis, respecting the patient and their decisions. A patient may be examined and health care services may be provided to him or her only with his or her consent. A patient may withdraw his or her consent within a reasonable period of time after granting consent. At the request of a provider of health care services, such consent or an application to withdraw such consent shall be in a format which can be reproduced in writing.[22] Meaning that when the patient does not give any form of consent any medical examination must not be indicated. At the same time the patient needs self-determination to decline health care services in future in case of incapacity, dementia, or other reasons whereas the patient is not in a condition to express consent. Such a situation is regulated by Estonian Obligation Act if a patient is unconscious or incapable of exercising his or her will for any other reason (a

[19] Laur, A. (2013). Patients' responsibilities for their health. Medico-Legal Journal, 81(3), 119.
[20] *Ibid.*, 120.
[21] VÕS, RT I, 04.01.2021, 19, 41, § 766, para. 1.
[22] VÕS, RT 1, 04.01.2021, 19, 41, § 766, para. 3.

patient without the capacity to exercise his or her will) and if he or she does not have a legal representative or his or her legal representative cannot be reached, the provision of health care services is permitted without the consent of the patient if this is in the interests of the patient and corresponds to the intentions expressed by him or her earlier or to his or her presumed intentions and if failure to provide health care services promptly would put the life of the patient at risk or significantly damage his or her health. The intentions expressed earlier by a patient or his or her presumed intentions shall, if possible, be ascertained using the help of his or her immediate family. The immediate family of the patient shall be informed of his or her state of health, the provision of health care services and the associated risks if this is possible in the circumstances.[23] In a situation where the patient is capable of decision making there is no issue finding out if they consent to the medical procedures or examination. Questioning patients' decisions, it could be considered that when a patient has willingly and understably expressed the wish not to be resuscitated, should the doctor honor the decision or provide help by CPR to prolong life. Over the last three decades, health professionals and ethicists have become aware of the need to deal with the end-of-life relating to the patients' right to request to end their lives with dignity.[24] Although it seems a bit ridiculous to ask the doctor to request dignity when it comes to end-of-life situations, it is a process that involves the patient and their wishes. Of course the capacity of the patient plays a huge role in the decision. If the patient is mentaly capable, he must be consulted and his autonomy, integrity, ginity and decision must be respected.[25] It is up to the doctor and the Consilium of Doctors to decide whether to put a note of DNR to a patient's clinical record or not. Of course it is reasonable to assume that before such a decision has been made, the patient, if possible, has been informed and his family or relatives as well. However, what if this is not the case and the decision is made by only one party without consulting the wishes of the patient or relatives. The respect and dignity towards the patient is left in the background because he might not recover from the disease or from the assumed fatal condition. Indeed, miracles happen and when they do, will the patient be informed of the decision that a Consilium of Doctors has made a decision for him, that when it is time, he will not be resuscitated or even given a chance to be resuscitated for dignity. This is where legal aspects of declaration of intent come to action. For the protection of both parties, patient and the doctor, there should be a legal document announcing whether the patient wants to be resuscitated or allows DNR action. The will to treat and the practice of DNR are yet to

[23] VÕS, RT I, 04.01.2021, 19, 41, § 767.
[24] Rubinstein, D. (2015). End-of-life decisions: Dnr vs. and. *Medicine and Law*, 34(1), 136
[25] Samuels, A. (2016). Do not resuscitate: Lawful or unlawful. *Medico-Legal Journal*, 84(4), 191.

be legally regulated and even the medical professionals often do not have a common understanding and guidelines regarding DNR. The long ongoing practise has to be challenged and it requires a compelling and convincing justification in law.

It is the primary duty of the doctor to provide care to the patient and in that matter remain respectful, honest and do their job with dignity. Understandably, it can work in such a way if the patient contributes as much as possible and shows active interest in the medical process. Because the patient in this contractual relationship is the weaker party, the patient is more likely to be violated in sense of capacity, intent and consent. In such a manner the patient's rights are very easliy violated and mostly without the knowledge of the patient. Even though doctors might lack the skills or teaching how to approach the topic of end of life decision, it is crucial that the doctor who once took the oath to do no harm continues when the patient's diagnosis shows no improvement or considered is terminally ill. Since there are no specific laws in Estonia that regulates DNR decision, does not mean the doctor has the right to make a decision for the patient, for example in the case of DNR. Understandably, it is irreversible action and can only be implemented with the consent of the patient.

1.2 DNR meaning and application

The term Do Not Resuscitate (DNR) order, is defined as a legal order, written either in the hospital or on a legal form, to respect the patient's wishes to refrain from Cardiopulmonary Resuscitation (CPR). Cardiopulmonary Resuscitation, or as known CPR, came into hospital practise in the United States of America around the 1960's. As a response to universal revitalization inefficiency of practise non resuscitation decision practise was formed in 1970's. The DNR request, usually made by the patient or health-care power of attorney, allows the medical team to respect these wishes.[26] DNR, a command to the hospital staff, prohibits initiating CPR after cessation of cardiac or respiratory function. By denying application of contemporary medical technology and treatment, this order leads to an imminent death.[27] While DNR orders explicitly apply only to an individual patient, the hospital culture and milieu in which DNR orders are implemented could potentially have an overall impact on

[26] Rubinstein, D. (2015). End-of-life decisions: Dnr vs. and. *Medicine and Law*, 34(1), 137.
[27] Levin, D. L., & Levin, N. R. (1980). Dnr: An objectionable form of euthenasia. *University of Cincinnati Law Review*, 49(3), 567-579.

aggressiveness of care across patients.[28] By definition, DNR is a decision made now for a future eventuality. Forward preparation is sensible in principle and helpful for all the medical staff should an emergency such as a cardiac arrest arise. But circumstances may change, the condition of the patient may improve, so it may be better to keep all the medical options open. The anticipatory decision as of now is essentially a medical decision, though it will be for the judge if challenged. Judges tend to be cautious and depending upon the circumstances inclined to the view that DNR may be premature.[29] Understandably, DNR is applicable to patient cases where the medical condition is irreversible and to avoid suffering from terminal illness and other serious conditions. DNR orders only affect a small group of patients and are designed to avoid suffering in medically irreversible terminal illnesses and other serious conditions. The order actually authorizes withholding medical treatment. Requesting DNR does not mean stopping the care, but rather changing the goal of the treatment. As specified in the chart of medical orders, DNR restricts the use of CPR techniques and other measures to revive the patient by hospital and pre-hospital personnel. Thus, the DNR order is not really suited to dying or terminal cases and, insofar as all kinds of active, aggressive, life-sustaining treatments are inappropriate, it does not answer the patient's and/or the family's needs. While a DNR patient hospitalized in Intensive Care might be put on a ventilator, given artificial hydration, or have a feeding tube inserted, such procedures, being painful and burdensome for the terminally ill, would not be initiated, or would be withdrawn or discontinued in a Allowing Natural Death (AND) patient.[30] Curtanly, a decision that has such radical and irreversible action needs to be considered with care and consent. Hospitals across the country routinely give incoming patients the option to sign a "do not resuscitate," or DNR order, requesting that heroic measures, such as cardiopulmonary resuscitation, not be taken should such measures be required to keep the person alive. Yet, the same doctors who are willing to respect their dying patients' wishes not to be resuscitated, due to fear of prosecution, are unwilling to take more active steps to relieve their terminally ill patients' suffering when asked.[31] The doctor or the Consilium of Doctors put or give the instructions in the hospital clinical records to DNR. A Do Not Attempt Resuscitation (DNAR) order is given by a licensed physician or alternative authority as per local regulation, and it must be signed and dated to be valid. In many settings, AND, is becoming a preferred term to replace DNAR, to emphasize that the order is to allow

[28] Hemphill J. C., 3rd (2007). Do-not-resuscitate orders, unintended consequences, and the ripple effect. *Critical care*, *11*(2), 121.
[29] Samuels, A. (2016). Do not resuscitate: Lawful or unlawful. *Medico-Legal Journal*, 84(4), 192
[30] Rubinstein, D. (2015). End-of-life decisions: Dnr vs. and. *Medicine and Law*, 34(1), 140.
[31] Bussey R. (1997). Physician-assisted suicide: the Hippocratic dilemma. *Thurgood Marshall law review*, *22*(2), 254.

natural consequences of a disease or injury, and to emphasize ongoing end-of-life care. The DNAR order should explicitly describe the resuscitation interventions to be performed in the event of a life-threatening emergency. In most cases, a DNAR order is preceded by a documented discussion with the patient, family, or surrogate decision maker addressing the patient's wishes about resuscitation interventions. In addition, some jurisdictions may require confirmation by a witness or a second treating physician.[32] The patient must sign the directive in front of two witnesses, neither of whom to their own knowledge may be named in the patient's will, appointed as a health care agent in the directive, or financially responsible for patient care.[33] Life threatening illnesses often limit the patient's autonomy and capacity for decision making, making the doctrine of informed consent difficult, if not impossible, to apply. Resuscitation requires the physician to "do everything possible" to save the patient-mechanical ventilation, cardiac massage, administration of powerful drugs to stimulate the heart-despite the fact that further treatment may be of little benefit. The physician often confronts a moral and legal dilemma. After 25 yrs of DNR orders, it remains reasonable to presume consent and attempt resuscitation for people who suffer an unexpected cardiopulmonary arrest or for whom resuscitation may have physiologic effect and for whom no information is available at the time as to their wishes (or those of their surrogate). However, it is not reasonable to continue to rely on such a presumption without promptly and actively seeking to clarify the patient's (or surrogate's) wishes. The DNR order, then, remains an inducement to seek the informed patient's directive.[34] At some point, the desirability of further treatment becomes a question of medical judgment. Recognizing this decision as one of medical judgment allows the physician to rightfully discard the "do everything" order. [35]

Before a doctor can implement the DNR decision, it is reasonable to assume that the DNR order has been consented by the patient with a legal order. In the sense of a binding notary document or a declaration of intent expressed or signed by the patient. If the patient has requested to be refrained from the CPR, or any kind of other helping measures, the duty of the healthcare professional or the doctor is to respect it and leave it be. But in the case where the patient has not requested the DNR order, the doctor or the CPR team has to do whatever they

[32] Breault J. L. (2011). DNR, DNAR, or AND? Is Language Important?. *The Ochsner journal*, *11*(4), 302–306.
[33]Legislation & regulations. *Mental & Physical Disability Law Reporter (30)*1, 155. (2006). American Bar Association.
[34] Burns, J. P., Edwards, J., Johnson, J., Cassem, N. H., & Truog, R. D. (2003). Do-not-resuscitate order after 25 years. *Critical care medicine*, *31*(5), 1543–1550.
[35] Beatty, C. (1987). Case of no consent: The dnr order as medical decision. *Saint Louis University Law Journal*, 31(3), 701

can to help the patient as it is their primary obligation. The simple consept of the DNR lies in the legal aspect. The action has to be authorized and correctly implemented within the respect of the patient. Otherwise it can be seen from the doctors point of view as an act of crime punishable with penalties.

Preferable term for DNR in some contexts is AND, but there is no difference in what the action is called or what kind of an abbreviation is used to shorten the term. The end result is the same no matter what, the patient is allowed to die naturally without any interfering of medicine. Explaining the opportunity of AND might sound better and seem more of a natural setting rather than DNR, which can be off putting and even frightening to imagine for a patient who is in between decisions. More or less, the focus must be placed on the consent of the patient, no matter what the name of the action is.

Even though the rate of patients who request the DNR is not very notable, it is still important that those who do wish to die without medical interference, they are fully aware of the cause and action. And vice versa, patients who deny the DNR action are aware of the availability of the chance to apply for it.

2. DNR REGULATIONS IN ESTONIA AND EU

The obligation of the state with respect to the right to health protection can be divided into the obligation to respect, to protect and to fulfil. The obligation to respect prevents the state from damaging one's health; the pbligation to protect demands action from the state to prevent interference from third parties. The obligation to fulfil forces the state to adopt various measures to protect the health of the individuals.[36] In Estonia, the will to treat and the practitioner of non-resuscitation are not legally regulated as well the medical profession does not have common understandings and guidelines. The Consilium of Doctors make the decision based upon the prognosis and diagnosis. The patient's consent plays a little role in the decision making because either the patient is in a condition where they are unable to respond, in a vegetative state, and therefore doctors take the decision making in their hand. As mentioned before Estonian Law of Obligation Act clearly states that the provider of the health care services shall inform the patient of the results of the examination of the patient and the state of his or her health, any possible illnesses and the development thereof, the availability, nature and purpose of the health care services required, the risks and consequences associated with the provision of such health care services and of other available health care services. At the request of the patient, the provider of health care services shall submit the specified information in a format which can be reproduced in writing.[37] Meaning the law obligates the health care providers to inform the patient regarding any circumstances, including DNR decisions related to the patient. Both civil and criminal law constraints are prescribed upon the arising of issues during the provision of a health care service. With civil liability, one must distinguish between the liability of the health care professional themselves and the liability of the health care institution that employs the health care professional. One must also distinguish between tortious and contractual liability. With criminal liability, one must examine liability for both misdemeanours as well as crimes.[38]

Unfortunately, most of the time the patients themselves are unaware of the decision and the reason behind it is that doctor's do not know how to approach the topic and since there are no regulations or law that could protect doctors, it is understandable why doctor's keep the decision inside the circle. Another reason why the topic of consented DNR could be considered as a taboo, is that the society is simply just not ready for it. Because of the lack of regulations, preparation and

[36] Nõmper, A. & Annus, T. (2002). From Transition to Accession: A New Era of Estonian Constitutional Thinking. *Juridica* issue 2002/7, 121.
[37] VÕS, RT I, 04.01.2021, 19, 41, § 766.
[38] Nõmper, A., Kiivet, R.A., & Tammepuu, K. (2019). Proposal: Reduce the Liability of Healthcare Professionals to Establish Patient Insurance. *Juridica* issue 2019/1, 56-68.

knowledge of how to approach the patient or relatives with the consideration of DNR action, health care providers are left to keep it a secret. The reason behind the secret is that often the medical team, doctors and health care providers do not see any effective results of the CPR. Once the diagnosis and the illness has reached the peak, it could be said that, it is just easier to let the patient die in peace in terms of saving resources. Estonian Penal Code states that, knowing refusal to provide assistance to a person who is in a life-threatening situation due to an accident or general danger, although such assistance could be provided without endangering the person providing assistance, is punishable by a pecuniary punishment or up to three years' imprisonment.[39] Therefore everyday the health care providers are faced with a contradiction because the Obligation Act gives the patient the right to make their own decision concerning the practise of medicine and Penal Code leaves responsibility if assistance is not provided by the healthcare professionals. In practice, there has been some confusion in situations in which it needs to be assessed whether or not a doctor's activity can be qualified as an act of an official. There are regulations in Estonian law that enable a doctor to be qualified as an official, but at the same time, the entire professional activity of a doctor cannot be viewed as exercising public duties as an official. Doctors are usually persons governed by private law. At the same time, there are operations in a doctor's profession that seem inherent to an official, but are not according to legal provisions, or the norms are so narrow or general that it cannot be concluded that a doctor holds an official position for the performance of public duties.[40] Obligation Act states that if a patient is unconscious or incapable of exercising his or her will for any other reason (a patient without the capacity to exercise his or her will) and if he or she does not have a legal representative or his or her legal representative cannot be reached, the provision of health care services is permitted without the consent of the patient if this is in the interests of the patient and corresponds to the intentions expressed by him or her earlier or to his or her presumed intentions and if failure to provide health care services promptly would put the life of the patient at risk or significantly damage his or her health. The intentions expressed earlier by a patient or his or her presumed intentions shall, if possible, be ascertained using the help of his or her immediate family. The immediate family of the patient shall be informed of his or her state of health, the provision of health care services and the associated risks if this is possible in the circumstances.[41] Immediate family specification is determined in the same paragraph section (2) immediate family means the spouse, parents,

[39] KarS RT I, 03.03.2021, 3, 3 § 124.
[40] Schneider, V. (2016). The Possibilities of Viewing a Doctor as an Official in the Penal Law. *Juridica* issue 2016/5 330-340.
[41] VÕS, RT I, 04.01.2021, 19, 41 § 767.

children, sisters and brothers of the patient. Other persons who are close to the patient may also be deemed to be immediate family if this can be concluded from the way of life of the patient. Understandably, there can be confrontation between family members regarding the decision and the process of unraveling the truth of what the patient wishes can be long. Therefore it is right to suggest that doctors and medical care providers should have the access to documents or a declaration of will of the patient that would be in accordance with Estonian Penal Code and Estonian Obligation Act. A code of conduct where a set of principles and rules are written to firstly to protect both sides of the contract and secondly, to help resolve questionable situations relying on laws.

Therefore, because of the lack of regulations, doctors are juggling daily between obligation to provide urgent care and be responsible if urgent care is not given. Balancing the two on its own is nearly impossible and not for the doctors to do. Both sides, the patient and the doctor, are left in the grey area, where the only regulations are Law of Obligation Act and Penal Code. For that same reason there is a need for a separate branch of medical law which delegates specifically and in detail the legal acts of a DNR decision. Understandably, it is a hard topic to unravel, because once the process of DNR decision is being legalized, questions start to arise whether how many doctors have used it before in their field of medicine and was it done legally, meaning with the consent of the patient. Most likely the half of the doctors in Estonia would be held liable for the unlawful action of DNR decision. Perhaps it is reasonable to assume that evidence supporting the DNR decisions made so far, are held on to and archived. But there is a small chance it is done so and the matter of the fact is that DNR actions are given out by doctors too freely, not understanding the consequences.

2.1 Regulation of the declaration of intent

As a result of the extremely rapid development of medicine, the possibilities for postponing death have significantly expanded. Earlier times to prolong or not to prolong life with the patient's consent was not really taken into consideration since the level of medicine just could not afford it. In the case where the patient has made the decision to refuse medical care and prefers to die the health care provider has to respect the autonomy of the patient. In such cases the patient’s will

must be considered and honoured even when the patient is unable to to respond. In the situations where the patient is unable to express their will on their own, many countries have introduced the use of living wills that are also often called advance directives. A living will is a declaration, usually in writing, on what kind of treatment a person wishes or does not wish to receive in a situation in which they are unable to make decisions on their own, for instance, in the case of unconsciousness or dementia. In addition to preparing a living will, people can also provide future health care directives by assigning a substitute decision maker who can express the person's presumed will in case of the person being unable to express their decision.[42] Most strongly, patient autonomy ensures a patient's will, considering that a patient draws up the will himself. Although patient's will is not commonly used, Estonian law and regulations allow it. There is a possibility to draw a patient's will in a notary office, where the patient's will is recorded with all the wishes regarding medical decisions when in future the person is unable to do so. Countries in Europe such as Germany or Netherlands have already regualted the patient's will with law as a separate institute, but not in Estonia. Since there is no law that specifically regulates a patient's will institution, provision can be deduced from Estonina Obligation Act on the provision of healthcare services. The biggest concern among Estonian medicine is the will to treat and the formulation of the DNR decision in the absence of rules and lack of counseling know-how. Everyone who comes into contact with patients may come up with the need for these complex issues to discuss with the patient. Before mentioned Estonian Obligation Act § 766 (3) and § 767 (1) regulate in Estonian law patient's will. If § 767 (1) allows in certain cases the provision of health care services to a patient also in a situation where he or she cannot express his or her will, then a patient's will can prohibit the provision of health care services in these situations. In the medical context, this right of bodily integrity is closely associated with the doctrine of informed consent. "The common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment."[43] Lack of consent for treatment, especially when the treatment involves risks, is a violation of the autonomy of patients and a failure to respect them as human beings. To respect autonomous agents is to recognize with appreciation their own value judgments and outlooks. Even if a physician believed that the "desire for the truth" was really a mistake and therefore unnecessary, he should none the less respect the patients' autonomy.[44] Involment of the law in health care is also caused by the bureaucratization of medicine. Medicine

[42] Nõmper, A., Int, R., & Kruus, M. (2017). Living Will: for What and for Whom? Forms, Formalising, and the Issue in Implementation. *Juridica* issue 2017/5 329-339.
[43] Bussey R. (1997). Physician-assisted suicide: the Hippocratic dilemma. *Thurgood Marshall law review*, *22*(2), 258.
[44] Moutsopoulos, L. (1984). Truth-Telling to Patients. *Medicine and Law*, 3, 246.

has become a large-scale and bureaucrtic institution in which personal relations tend to deteriorate. But alsi individual rights are likely to be aggected in such institutions. Defending the patient in the complex healt care system has become a task for health law. The combination of the deep intruding, sophisticated and bureaucratic health care system on one hand and the dependent patient who often feels lost and regarded as an object, on the other, has caused what could be called a paradox of health system. The patient has to be defended against the healthuacare system of which the only justification is the interest of the patient. Health law contributes to the softening of this paradox.[45]

Patient's autonomy in a healthcare system is the foundation to a secure system in medicine where the patient is given more open hands and an opportunity to be more involved with the process and diagnosis. In that case both parties, the patient and the doctor, have a better chance to connect and bond, and form a relationship which helps, from a doctors point of view to invest more time and sources and from the patient's point of view a sense of security and a secure environment. Indeed, that would be a perfect scenario but the reality is that most of the doctors simply just do not have the time to be so involved with one patient. Careless mistakes and faults do happen but surely not purposely.

2.1 Patient's rights in Estonia

The general rights of patients are set out in the Law of Obligations Act. According to the law, healthcare is provided on the basis of a contract concluded between the healthcare provider and the patient. The healthcare provided must be at least equivalent to the general level of medical science at the time the service is provided and must be provided with the care normally expected of a healthcare provider. The patient must disclose to the healthcare provider, to the best of his or her knowledge, all the circumstances necessary for the provision of the healthcare and provide the assistance that the healthcare provider needs. The patient may be examined and provided with healthcare only with his or her consent. The patient may withdraw the consent within a reasonable time after it has been given. At the request of the healthcare provider, the consent or application for its revocation must be in a form that can be reproduced in writing. In the medical context, this

[45] Leenen, H. (1994). The rights of patients in europe. *European Journal of Health Law*, 1(1), 6.

right of bodily integrity is closely associated with the doctrine of informed consent.[46] While the word 'consent' has always been both a noun and an intransitive verb ('my consent', 'I consent'), in the medical context it is now sometimes used as a transitive verb ('have you consented the patient?')-as if 'consent' is something that is done to patients rather than something that patients do.[47] However, decisions to limit care are often predicated on the assumption that treating physicians are able to accurately predict outcome in the specific case at hand.[48] According to the Health Services Organization Act, every person staying in the territory of the Republic of Estonia has the right to receive emergency care, which a health care worker is required to provide within the limits of his or her competence and the possibilities available to him or her. [49] According to the Health Insurance Act, a patient also has the right to a second opinion if he or she doubts a doctor's decision. The secondary opinion concerns the assessment of the accuracy of the diagnosis, the need for the prescribed medicinal product or healthcare, the alternatives and expected effects explained, and the risks associated with the provision of the healthcare.[50]

Since the relationship between the healthcare provider and the patient is contractual and based on free will and consent, the access to medical records could turn out to be a tricky obstacle. In Estonia there is a patient's portal where information about outpatient or inpatient visits are recorded with minimum wording and explanation about what the visitation was about. Outpatient visit is when a patient visits the doctor upon a scheduled meeting for concerns, check ups or other reasons and the visit is recorded simply stating whether the patient was described as medication or any medical procedures were done during the visit. The same simple constructive overview is done when the patient is in an inpatient visit. Meaning the patient needs to stay in the hospital for a certain period of time under the doctors and nurses monitoring. After the hospital stay is over or the 'contract' has been fulfilled, the patient can see the stay and diagnosis in the patient portal but not the information about administration medication during the stay, medical procedures and the result of them, or any other information that was written in the hospital documents. For that information to reach the patient, he/she must submit a request of information to the hospital to get the copies of medical records. Although, the person submitting the request of information on behalf of another person, for example a deceased parent, must have a document proving their right to access the medical records. Either a birth certificate, court order, certificate of succession or a written consent

[46] Bussey R. (1997). Physician-assisted suicide: the Hippocratic dilemma. *Thurgood Marshall law review*, *22*(2), 258.
[47] Jackson, E. (2010). Autonomy, informed consent and medical law: relational challenge. *Medical Law International*, 10(3), 239.
[48] Hemphill, J. C., 3rd, Newman, J., Zhao, S., & Johnston, S. C. (2004). Hospital usage of early do-not-resuscitate orders and outcome after intracerebral hemorrhage. *Stroke*, *35*(5), 1130–1134.
[49] TTKS RT I, 21.04.2021, 16, 2 §6.
[50] RaKS RT I, 29.12.2020, 19, 3 §40.

of the deceased parent to prove the legitimate right to the information. Of course there is a 30 day period for the hospital to reply to the request but the chance of refusal remains high since the information is delicate and the person in request must have a proof of legitimate interest.

The general principle of patients rights is provided in Estonian Constitution under § 28. Everyone has the right to health protection.[51] Although, it is important to remember that the paragraph does not mean the state has an obligation to provide all known health-promoting services such as cosmetic surgery. The state establishes a specific list of public health services that are provided to its citizens. The national list of healthcare services must contain the scientifically proven method of treatment and diagnosis that is necessary for people to maintain and improve their quality of life and correspond to the health status of each patient. In a case of medical malfunction, violation or a complaint the patient has the right to turn to the health care provider, or the health care quality expert committee to file a complaint.

Before any medical procedure, the doctor is obligated to explain the method, solution and an outcome of the procedure so that the patient can think about whether to accept or refuse from the procedure. Naturally, the healthcare professionals are encouraging patients to accept, and simply because the chances of getting helpful information providers the doctors a wider scope of the diagnosis and the patient some sort of piece of mind. But the main factor that can lead to the piece of mind is consent. Consent is given freely and willingly and should not be manipulated into. If the patient understands the procedure and what the risks are, it is up to the patient to decide whether to do it or not. Same idea of consent is regarded to DNR, to refuse the action it must be consented and explained to the patient. The doctors can not decide to implement DNR on the basis of diagnosis or irreversible conditions, meaning the treatment would not work or there is nothing left for them to do. The explanation behind it should not be expenses or the lack of medical assistance available. Every human life has value no matter the conditions and deserves a chance of respect even when it relates to death.

[51] PS RT I, 15.05.2015, 2, 2 § 28.

Conclusion

The aim of the thesis was to analyse how no regulation of declaration of intent in the case of non-resuscitation decisions violated the patient's rights, especially the right to life and the lack of regulations in Estonia regarding DNR. The thesis seeks to address the question:

1. does Estonian law support the patient's right to life in the case of non-resuscitation (DNR) decision?

In the first chapter of the thesis, the author explains human rights as a patient's rights. Analysing the relationship between the patient and the doctor and how it can be unbalanced if the contractual relationship is not divided between the parties. The patient has the responsibility to provide the healthcare professional with information as much as possible. Yet, the patient is often seen as the weaker party whose rights can be violated. The author discusses the binding between the right to life as a human right and how the implementation of DNR order does not respect human rights. The declaration of intent and consent are the key elements missing in the implementation of DNR order in Estonia.

DNR in an offical use, term and practise is faerly new in the field of medicine comparing to, for example euthanasia, which has been a topic of argumentation for years. The simplicity of the DNR is allowing the patient to take control and consent to no help. Instead of doctors relying on the instinct and making the decision for the patient. DNR is an irreversible action where the end result is death. When being a patient, there is A Declaration on the Promotion of Patient's Rights in Europe which lays down the key principles of patients rights and are connected to Universal Declarations of Human Rights and the Convention on Human Rights.

The medical regulations are delegated by the Estonian Law of Obligation which gives the patient the right to make their own decisions concerning the practise of medicine and Penal Code leaves responsibility if assistance is not provided by the healthcare professionals. Obligation Act and Penal Code covers medical law in a very broad sense and does not focus on the taboo topic of DNR. The DNR order must only be implemented with the consent of the patient, a legal document providing the declaration of intent or a patient's will. Estonian laws do not regulate the DNR implementation, usage, responsibilities nor obligation. DNR implementation can be considered as a grey area in Estonian medical field, where the Consilium of Doctors have taken the power to decide over the patient's life or death decision.

In terms of regulations and laws regarding DNR in Estonia, there is a long way to go. The main factor stopping the unlawful DNR usage is fear of liability and consequences. Even if there is a consent, or a patient's will that regulates the action it could be full of legal loopholes that create more legal responsibility to health care professionals. Even though creating regulations and laws regarding DNR would take perhaps a full decade, it is still a start and some sort of an accomplishment. The Consilium of Doctors are not above the law and cannot keep making decisions instead of patients and the Obligation Act and Penal Code are not enough to cover the technicality of the action by law. Since the lack of knowledge or understanding of the legal consequences of DNR application among doctors is pushed aside, there is a need of patient's autonomy and a declaration of intent in Estonian medical system. A patient deserves a say in a decision regarding whether to resuscitate or not. Praising patient's autonomy and rights have no meaning when ultimately the end decision come from the doctor's who think they know better.

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