

Human Rights in Patient Care

A PRACTITIONER GUIDE

MOLDOVA



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PREFACE

The right to health has long been treated as a "second generation right," which implies that it is not enforceable at the national level, resulting in a lack of attention and investment in its realization. However, this perception has significantly changed as countries increasingly incorporate the right to health and its key elements as fundamental and enforceable rights in their constitutions and embody those rights in their domestic laws. Significant decisions by domestic courts, particularly in Asia, Africa, and Latin America, have further contributed to the realization of the right to health domestically and to the establishment of jurisprudence in this area.

Although these and other positive developments toward ensuring the highest attainable standard of physical and mental health represent considerable progress, the right to health for all without discrimination is not fully realized, because, for many of the most marginalized and vulnerable groups, the highest attainable standard of health remains far from reach. In fact, for many, interaction with health care settings and providers involves discrimination, abuse, and violations of their basic rights. As I explored in my report to the UN General Assembly on informed consent and the right to health, violations to the right to privacy and to bodily integrity occur in a wide range of settings. Patients and doctors both require support to prevent, identify, and seek redress for violations of human rights in health care settings, particularly in those cases in which power imbalances—created by reposing trust and by unequal levels of knowledge and experience inherent in the doctor-patient relationship—are further exacerbated by vulnerability due to class, gender, ethnicity, and other socioeconomic factors.

Although there are a large number of publications on the principles of human rights, very little has been available in the area of the application of human rights principles in actual health care settings. In this context, the present guide fills a long-felt void. The specific settings detailed in this guide are Eastern European countries, but the guide is useful beyond this context in the international settings. I hope it will encourage the establishment of protective mechanisms and legislative action relating to violations within health care settings. Not only will it help to support health care providers, legal practitioners, and health activists to translate human rights norms into practice, it will also ultimately help communities to raise awareness, mobilize, and claim the rights they are entitled to.

The authors have done a huge service in furthering the right to health. They deserve full credit for undertaking this arduous task. The Open Society Institute also needs to be thanked for funding and publishing this very important work. I have no doubt that this practitioner's guide will generate a greater appreciation for the role of human rights in the delivery of quality health care in patient care settings and will also prove to be an invaluable resource for those working to realize the right to health.

Anand Grover

United Nations Special Rapporteur on the Right to Health, August 2008-July 2014

ACKNOWLEDGMENTS

Stemming from the genuine concern about the urgent need to further enjoyment of human rights in patient care, this Guide is the joint product of a number of dedicated persons and organizations committed to making a difference. The idea grew out of genuine concern and the sincere belief of many of these individuals that, considering the dependent position of patients in relation to their health care providers, the promotion of human rights norms in the realm of patient care will secure the human dignity of both patients and health care professionals alike.

Special thanks to Ana Ayala, Oscar Cabrera, and Brian Honerman (O'Neill Institute for National and Global Health Law, Georgetown University), who authored the revised international and regional chapters. Additional contributors to these chapters include Tanya Baytor, Marguerite de Causans, Michelle Robert, Luis Enrique Rosas, Ami Shah, Zachary Turk, and Lucy Xi with research support; Eric Friedman, Aliza Glasner, and Susan Kim with review; Susie Talbot (ESCR-Net) for review and comment; and Iain Byrne, who developed the initial version of these chapters (and authored the international glossary with Judith Overall).

Organizations supporting this project include various Open Society Foundation (OSF) entities (the Soros Foundation-Moldova – Public Health Program, the Open Society Foundations' Public Health Program, and Human Rights Initiative). Much appreciation is owed to the individuals from these organizations who were most directly involved: Liliana Gherman (Soros Foundation-Moldova); Tamar Ezer and Jonathan Cohen (Open Society Public Health Program), who, in addition to general oversight and editing responsibilities, contributed to the international and regional procedures, and, with Judith Overall, co-authored the introduction; Mariana Berbec Rostas (Open Society Foundations' Human Rights Initiative) for updating the regional procedures section; Paul Silva (former OSI Communications Officer), for his advice and coordination of work on the Guide's design, and Jeanne Criscola, the designer.

Finally, this guide would not exist if it were not for the enthusiasm and personal dedication paid to this project by Judith Overall, OSF Consultant, JD, MSHA, M.Ed.

Not listed, but still deserving our thanks, are the many others who supported our working group and its work.

Working Group Authors in the Republic of Moldova (in alphabetical order)

Rodica Gramma, MD, MPH, PhD, Associate Professor

Dumitru Sliusarenco, Attorney at Law

Doina Ioana Straisteanu, Lawyer



1.1 INTRODUCTION

1.2 OVERVIEW OF THE GUIDE

1.3 TABLE OF ABBREVIATIONS

1.4 TABLE OF RATIFICATIONS

1

INTRODUCTION

1.1 INTRODUCTION

This Guide is part of a series published in cooperation with the Law and Health Initiative of the Open Society Foundations (OSF) Public Health Program, OSF’s Human Rights and Governance Grants Program, OSF’s Russia Project, and the Soros Foundations of Armenia, Georgia, Kazakhstan, Kyrgyzstan, Macedonia, Moldova, Serbia, and Ukraine. Designed as a practical “how to” manual for lawyers, it aims to provide an understanding of how to use legal tools to protect basic rights in the delivery of health services. The guide systematically reviews the diverse constitutional provisions, statutes, regulations, bylaws, and orders applicable to patients and health care providers and categorizes them by right or responsibility. It additionally highlights examples and actual cases argued by lawyers.

The aim of the guide is to strengthen awareness of existing legal tools that can be used to remedy abuses in patient care. If adequately implemented, current laws have the potential to address pervasive violations of rights to informed consent, confidentiality, privacy, and nondiscrimination. As this effect can be accomplished through both formal and informal mechanisms, this guide covers litigation and alternative forums for resolving claims, such as enlisting ombudspersons and ethics review committees. It is hoped that lawyers and other professionals will find this book a useful reference in a post-Soviet legal landscape, which is often rapidly in flux.

This guide addresses the concept of “human rights in patient care,” which brings together the rights of patients and health care providers. The concept of human rights in patient care refers to the application of general human rights principles to all stakeholders in the delivery of health care. These general human rights principles can be found in international and regional treaties, such as the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the European Convention on the Protection of Human Rights and Fundamental Freedoms; and the European Social Charter. These rights are universal and can be applied in the context of health care delivery just as they can be in any other context.

1.2 OVERVIEW OF THE GUIDE

Chapters 2 and 3 of the Guide respectively cover the international and regional law governing human rights in patient care. They examine relevant “hard” and “soft” law and provide examples of cases and interpretations of treaty provisions. These two chapters are identically organized around established human rights applicable to both patients and providers. These are rights to liberty and security of the person; privacy; information; bodily integrity; life; highest attainable standard of health; freedom from torture, cruel, inhuman, and degrading treatment; participation in public policy; and non-discrimination and equality for patients; and rights to work in decent conditions, freedom of association; and due process for providers. Chapter 4 then provides information on the international and regional procedures for protecting these rights.

Chapters 5, 6, 7, and 8 are country-specific. Chapter 5 clarifies the legal status of international and regional treaties ratified, signed or adopted by the Republic of Moldova, explains the country’s use of precedent, and includes a brief description of the legal and health systems. Chapter 6 deals with patient rights and responsibilities. The patient rights section is organized according to the rights in the European Charter of Patients’ Rights, with the addition of any country-specific rights not specifically covered by the Charter. Drawn up in 2002 by the Active Citizenship Network—a European network of civic consumer, and patient organizations—the European Charter of Patients’ Rights is not legally binding, but is generally regarded as the clearest and most comprehensive statement of patient rights. The Charter attempts to translate regional documents on health and human rights into 14 concrete provisions for patients: rights to preventive measures, access, information, consent, free choice, privacy and confidentiality, respect of patients’ time, observance of quality standards, safety, innovation, avoidance of unnecessary suffering and pain, personalised treatment, the filing of complaints, and compensation. These rights have been

used as a reference point to monitor and evaluate health care systems across Europe and as a model for national laws.¹ Chapter 6 thus uses the rights enumerated in the European Charter of Patients' Rights as an organizing principle, but under each right, the applicable binding provisions under the national laws are presented and analyzed. These rights are then cross-referenced with the more general formulation of rights in the international and regional chapters. Chapter 7 focuses on provider rights and responsibilities, including the rights to work in decent conditions, freedom of association, due process, and other relevant country-specific rights.

Chapter 8 covers the national mechanisms for enforcement of both patient and provider rights and responsibilities. This encompasses administrative, civil, and criminal procedures and alternative mechanisms, including the Office of the Public Prosecutor, ombudspersons, ministries of internal affairs, ethics review committees, and inspectorates of health facilities. It additionally contains an annex of sample forms and documents lawyers would need to file.

The final section is a glossary of terms applicable to the field of human rights in patient care. Some Guides also include a section of the glossary with country-specific terminology. The glossary will enable greater accessibility of law, health, and human rights material.

Uses of the Guide

The Guide has been designed as a resource for both litigation and training. The Guide may be particularly useful in clinical legal education programs. Although designed for lawyers, it may additionally be of interest to medical professionals, public health managers, Ministries of Health and Justice personnel, patient advocacy groups, and patients themselves, who desire a firmer understanding of the legal basis for patient and provider rights and responsibilities and available mechanisms for enforcement.

Accompanying Websites

The field of human rights in patient care is constantly changing and evolving, necessitating the need for regular updates to the Guide. Electronic versions of the Guides will thus be periodically updated at: <http://www.health-rights.org/>. This international homepage links to country websites which also include additional resources gathered by the country working groups that prepared each Guide. These include relevant laws and regulations, case law, tools and sample forms, and practical tips for lawyers. The websites also provide a way to connect lawyers, health providers, and patients concerned about human rights in health care. Each of the websites provides a mechanism for feedback on the Guides.

1. Please see chapter 3 for more information on the European Charter of Patients' Rights.

Note from the Authors

The material in this Guide represents the views of an interdisciplinary working group composed of legal and medical experts. The Guide does not carry judicial or legislative authority, nor does it substitute for legal advice from a qualified lawyer. Rather, it represents the authors' attempt to capture the current state of the law and legal practice in the field of human rights in patient care in Republic of Moldova. The authors welcome any comments about errors, omissions, or suggested additions to the Guide, as well as questions about how the law might apply to a particular factual scenario.

As this Guide illustrates, the field of human rights in patient care is still new and evolving in the Republic of Moldova. Many of the statutory provisions cited in the Guide have not been authoritatively interpreted by courts, and those that have still remain open to additional application and interpretation. There remain huge gaps in understanding of how human rights in patient care apply in practice. This Guide is thus a starting point for legal inquiry, not a final answer. It is hoped that this Guide will attract new professionals to the field of human rights in patient care, and that future editions will be much richer in their elaboration of legal protections.

1.3 TABLE OF ABBREVIATIONS

Abbreviation	Title
AC	Advisory Committee
CAT	Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment
CE	ILO Committee of Experts
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERD	Committee on the Elimination of Racial Discrimination
CESCR	Committee on Economic, Social, and Cultural Rights
CHR	Commission on Human Rights
CMW	International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families
COE	Council of Europe
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
ECOSOC	UN Economic and Social Council
ECSR	European Committee of Social Rights
EPHA	European Public Health Alliance
ESC	European Social Charter
EU	European Union
FCNM	Framework Convention for the Protection of National Minorities
HRC	Human Rights Committee
IAPO	International Alliance of Patients' Organizations
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICN	International Council of Nurses
ILO	International Labour Organization
OHCHR	Office of the High Commissioner for Human Rights
SR	Special Rapporteur on the Right to Health
UDHR	Universal Declaration of Human Rights
UN	United Nations
UPR	Universal Periodic Review
WHO	World Health Organization
WMA	World Medical Association

1.4 TABLE OF RATIFICATIONS

DOCUMENTS	Date of Accession / deposit	Date of Signature	Date of Ratification	Entry into Force	Applicable in country Legislation	Reservation / Declaration Entered
INTERNATIONAL						
International Covenant on Civil and Political Rights (ICCPR)	26.01.1993			26.04.1993	Applicable	-
Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR – OP)	23.01.1908			23.04.2008	Applicable	-
Second Optional Protocol to the International Covenant on Civil and Political Rights aiming to the abolition of the death penalty (CCPR-OP2-DP)	20.09.2006			20.12.2006	Applicable	1
International Covenant on Economic, Social and Cultural Rights (ICESCR)	26.01.1993			26.04.1993	Applicable	-
Optional protocol to the International Covenant on Economic, Social and Cultural Rights (CESCR-OP)	-					-
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	01.07.1994			31.07.1994	Applicable	-
Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW-OP)	28.02.2006			28.02.2006	Applicable	-
Convention for the Elimination of All Forms of Racial Discrimination (CERD)	26.01.1993			25.02.1993	Applicable	1
Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment (CAT)	28.11.1995			28.12.1995	Applicable	2
Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT – OP)	24.07.2006	16.09.2005		23.08.2006	Applicable	-
Convention on the Rights of the Child (CRC)	26.01.1993			25.02.1993	Applicable	-
Optional Protocol to the Convention on the Rights of the Child (CRC-OP-IC)	-					-
Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (CRC-OP-AC)	07.04.2004	08.02.2002		07.04.2004	Applicable	1
Optional Protocol to the Convention on the Rights of the Child on the sale of children child prostitution and child pornography (CRC-OP-SC)	12.04.2007	08.02.2002		12.04.2007	Applicable	1
International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families (CMW)	-	-	-	-	-	-
Convention on the Rights of Persons with Disabilities (DRC)	21.09.2010	30.03.2007	-	21.10.2010	Applicable	-
Optional protocol to the Convention on the Rights of Persons with Disabilities (CRPD-OP)	-					-

SECTION 1.4 TABLE OF RATIFICATIONS

DOCUMENTS	Date of Accession / deposit	Date of Signature	Date of Ratification	Entry into Force	Applicable in country Legislation	Reservation / Declaration Entered
EUROPEAN (REGIONAL)						
Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine 1997		06.05.1997	26.11.2002	01.03.2003	Applicable	1
Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings		12.01.1998	26.11.2002	01.03.2003	Applicable	-
Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin		08.02.2007	05.02.2008	01.06.2008	Applicable	-
Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research		25.01.2005	07.08.2013	01.12.2013	Applicable	-
Additional Protocol to the Convention on Human Rights and Biomedicine concerning Genetic Testing for Health Purposes	-	27.11.2008	29.04.2011	-	-	-
Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights)	-	13.07.1995	12.09.1997	12.09.1997	Applicable	2
Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms		02.05.1996	12.09.1997	12.09.1997	Applicable	1
Protocol No. 2 to the Convention for the Protection of Human Rights and Fundamental Freedoms, conferring upon the European Court of Human Rights competence to give advisory opinions		13.07.1995	12.09.1997	12.09.1997	Applicable	-
Protocol No. 3 to the Convention for the Protection of Human Rights and Fundamental Freedoms, amending Articles 29, 30 and 34 of the Convention		13.07.1995	12.09.1997	12.09.1997	Applicable	-
Protocol No. 4 to the Convention for the Protection of Human Rights and Fundamental Freedoms, securing certain rights and freedoms other than those already included in the Convention and in the first Protocol thereto		02.05.1996	12.09.1997	12.09.1997	Applicable	-
Protocol No. 5 to the Convention for the Protection of Human Rights and Fundamental Freedoms, amending Articles 22 and 40 of the Convention		13.07.1995	12.09.1997	12.09.1997	Applicable	-
Protocol No. 6 to the Convention for the Protection of Human Rights and Fundamental Freedoms concerning the Abolition of the Death Penalty		02.05.1996	12.09.1997	01.10.1997	Applicable	-
Protocol No. 7 to the Convention for the Protection of Human Rights and Fundamental Freedoms		02.05.1996	12.09.1997	01.12.1997	Applicable	-
Protocol No. 8 to the Convention for the Protection of Human Rights and Fundamental Freedoms		13.07.1995	12.09.1997	12.09.1997	Applicable	-

CHAPTER 1. INTRODUCTION

DOCUMENTS	Date of Accession / deposit	Date of Signature	Date of Ratification	Entry into Force	Applicable in country Legislation	Reservation / Declaration Entered
Protocol No. 11 to the Convention for the Protection of Human Rights and Fundamental Freedoms, restructuring the control machinery established thereby		13.07.1995	12.09.1997	01.11.1998	Applicable	-
Protocol No. 14 to the Convention for the Protection of Human Rights and Fundamental Freedoms, amending the control system of the Convention		03.05.2002	18.10.2006	01.02.2007	Applicable	1
Protocol No. 15 amending the Convention for the Protection of Human Rights and Fundamental Freedoms		18.11.2013	14.08.2014	-	-	-
European Social Charter (revised)	-	03.11.1998	08.11.2001	01.01.2002	Applicable	1
European Convention on Nationality	-	03.11.1998	30.11.1999	01.03.2000	Applicable	2
Framework Convention for the Protection of National Minorities (1995)	-	13.07.1995	20.11.1996	01.02.1998	Applicable	-
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment		02.05.1996	02.10.1997	01.02.1998	Applicable	-
European Convention on the Legal Status of Migrant Workers		11.07.2002	20.06.2006	01.10.2006	Applicable	2
Other treaties related to Health Law signed by country						
Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949.				24.11.1993	Applicable	-
Convention for the Amelioration of the Condition of the Wounded and Sick and Shipwrecked Members of Armed Forces at Sea. Geneva, 12 August 1949.				24.11.1993	Applicable	-
Convention relative to the Treatment of Prisoners of War. Geneva, 12 August 1949.				24.11.1993	Applicable	-
Convention relative to the Protection of Civilian Persons in Time of War. Geneva, 12 August 1949.				24.11.1993	Applicable	-
UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances				16.05.1995	Applicable	-
UN Organization's Convention on Psychotropic Substances				17.03.1995	Applicable	-
Convention on Protection of Children and Co-Operation in Respect of Intercountry Adoption				01.08.1998	Applicable	-
UN Convention on Psychotropic Substances, 1971				16.05.1995	Applicable	-
UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988				16.05.1995	Applicable	-
Convention concerning Occupational Safety and Health and the Working Environment				28.04.2001	Applicable	-
Convention concerning Safety and Health in Agriculture, 2001				20.09.2003	Applicable	-
Convention concerning the revision of the Maternity Protection Convention (Revised), 2000				28.08.2007	Applicable	-



2.1 INTRODUCTION

2.2 KEY SOURCES

2.3 PATIENTS' RIGHTS

2.4 PROVIDER' RIGHTS

2

INTERNATIONAL FRAMEWORK FOR HUMAN RIGHTS IN PATIENT CARE

2.1 INTRODUCTION

This chapter presents the main standards that safeguard human rights in patient care internationally and examines how United Nations (UN) treaty-monitoring bodies have interpreted these standards. The chapter is divided into three sections. The first section describes key international sources governing human rights in patient care. The second examines patients' rights and includes subsections that discuss the standards and relevant interpretations connected to a particular right (e.g., right to privacy) within three particularly common health-related contexts: mental health, infectious diseases, and sexual and reproductive rights. These subsections provide examples of potential violations based on UN treaty-monitoring body observations and case law. It is worth underscoring here that these three contexts are used as examples and that human rights violations (and therefore, the application of human rights standards) can occur beyond this limited set of patient care-related contexts. The third section focuses on the rights of health care providers. This last section includes subsections that discuss the standards and relevant interpretations connected to a particular right from UN treaty-monitoring bodies, as well as relevant case law.

The standards addressed in each of these sections include binding treaties, such as the International Covenant on Civil and Political Rights, and non-binding instruments developed by the UN and other entities, such as the World Medical Association’s Declaration of Lisbon on the Rights of the Patient.²

2.2 KEY SOURCES

This section provides an overview of relevant legal instruments, including UN treaties and mechanisms available for monitoring state compliance with each. It also provides examples of non-legally binding instruments issued by the UN and other bodies. It is worth noting that, in this section, the Universal Declaration of Human Rights³ is treated separately from other instruments due to its unique and ambiguous—yet important—legal nature.

UNIVERSAL DECLARATION OF HUMAN RIGHTS

While not a treaty, the Universal Declaration of Human Rights (UDHR)⁴ has been highly influential. It was adopted by the UN General Assembly in 1948 and has served as the foundation for modern human rights law. Many of its provisions have been effectively reproduced in human rights treaties and domestic law, and some argue⁵ that it has achieved the status of customary international law—meaning that its provisions are established state practice and accepted by states as obligations, making them universal standards and legally binding on states.⁶ Unlike the UN treaties discussed below, the UDHR itself is not enforceable through any specific body that monitors state compliance.

UN TREATIES AND TREATY-MONITORING BODIES

There are currently eight core international human rights treaties that contain guarantees related to the protection of human rights in patient care. Many of these treaties have additional optional protocols that are referenced in this guide but are not explored in detail. While these treaties are only binding on those states that have ratified them, their standards have strong moral and political force even for non-ratifying countries. Each of these treaties has a committee in charge of monitoring state compliance with the treaty. These are referred to as “treaty-monitoring bodies” or “treaty bodies.”

UN treaty-monitoring bodies monitor state compliance with their respective treaties using a combination of three types of mechanisms. First, they issue documents that interpret the content of the treaties. While not legally binding, these interpretative documents guide states on how to interpret and implement the content of the rights contained in the relevant treaty. These interpretative documents are known as “General Comments,” with the exception of those issued by the Committee on the Elimination of Discrimination against Women and the Committee on the Elimination of Racial Discrimination, which are referred to as “General Recommendations.” Second, treaty-monitoring bodies evaluate state compliance with the relevant treaty based on reports that member states are required to submit on a regular basis.

2. World Medical Association [WMA]. Declaration on the Rights of the Patient. September/October 1981.

3. United Nations General Assembly. United Nations General Assembly Resolution 217A (III): Universal Declaration of Human Rights (UDHR). UN Doc. A/810 at 71. December 12, 1948.

4. United Nations General Assembly. United Nations General Assembly Resolution 217A (III): Universal Declaration of Human Rights (UDHR). UN Doc. A/810 at 71. December 12, 1948.

5. See Louis Henkin, *The Age of Rights*. New York: Columbia Press, 1990. p. 19; Christina M. Cerna. Universality of human rights and cultural diversity: implementation of human rights in different socio-cultural contexts.” 16 *Hum. Rts. Q.* 740. 1994. p. 745.

6. Hurst Hannum. “The Status of the Universal Declaration of Human Rights in National and International Law.” 25 *Ga. J. Int’l & Comp. L.* 287. 1995-1996. p. 319.

As part of this process, they issue what are known as “Concluding Observations.” Finally, eight⁷ of the ten core treaty-monitoring bodies currently receive and consider individual communications. Through these communications, individuals and groups of individuals can bring allegations of human rights violations by states that have ratified the instrument (e.g., optional protocols to treaties) creating the individual complaint mechanism. Following the examination of the communication, treaty-monitoring bodies issue recommendations to the state being challenged. These recommendations are non-legally binding, but may be influential. Treaty-monitoring bodies also offer different avenues for civil society participation. Each of the bodies’ specific functions, contact information, and ways through which civil society can participate are discussed in Chapter 4.

For the user’s quick reference, below are the abbreviations for treaties and UN treaty-monitoring bodies that will be used throughout this chapter:

Treaties

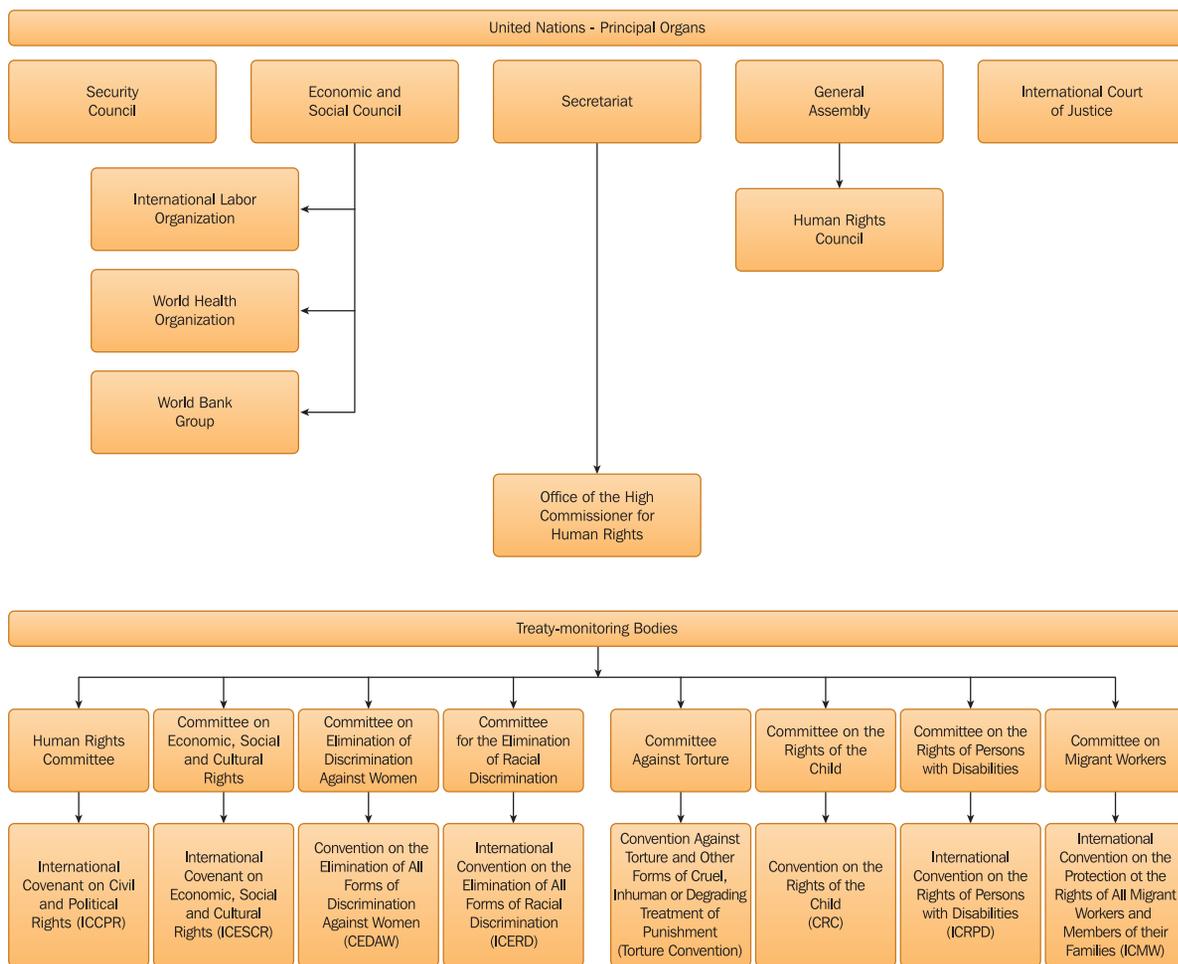
- ▶ **ICCPR - International Covenant on Civil and Political Rights**
- ▶ **ICESCR - International Covenant on Economic, Social, and Cultural Rights**
- ▶ **CAT/Torture Convention - Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment**
- ▶ **CEDAW - Convention on the Elimination of All Forms of Discrimination Against Women**
- ▶ **ICERD – International Convention on the Elimination of All Forms of Racial Discrimination**
- ▶ **CRC - Convention on the Rights of the Child**
- ▶ **ICRPD – International Convention on the Rights of Persons with Disabilities**
- ▶ **ICMW - International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families**

Treaty-Monitoring Bodies

- ▶ **CCPR - Human Rights Committee**
- ▶ **CESCR - Committee on Economic, Social and Cultural Rights**
- ▶ **CAT Committee - Committee Against Torture**
- ▶ **CEDAW Committee- Committee on Elimination of Discrimination against Women**
- ▶ **CERD - Committee on the Elimination of Racial Discrimination**
- ▶ **CRC Committee - Committee on the Rights of the Child**
- ▶ **CRPD - Committee on the Rights of Persons with Disabilities**
- ▶ **CMW - Committee on Migrant Workers**

7. Human Rights Committee [CCPR], Committee on the Elimination of Racial Discrimination [CERD], Committee Against Torture [CAT Committee], Committee on Elimination of Discrimination against Women [CEDAW Committee], Committee on the Rights of the Child [CRC Committee], Committee on the Rights of Persons with Disabilities [CRPD], Committee on Enforced Disappearances [CED], and Committee on Economic, Social and Cultural Rights [CESCR].

UNITED NATIONS SYSTEM AND PATIENT CARE: RELEVANT CORE TREATIES AND TREATY-MONITORING BODIES



RELEVANT UN CORE TREATIES AND TREATY-MONITORING BODIES AND THEIR STATE REPORTING AND INDIVIDUAL COMMUNICATIONS SYSTEMS

TREATY	MONITORING BODY	STATE REPORTING	INDIVIDUAL COMMUNICATIONS
International Covenant on Civil and Political Rights (ICCPR) ⁸	Human Rights Committee (CCPR)	Every 4 years	For states having ratified the First Optional Protocol under the ICCPR
International Covenant on Economic, Social, and Cultural Rights (ICESCR) ⁹	Committee on Economic, Social, and Cultural Rights (CESCR)	Every 5 years	For states having ratified the Optional Protocol
Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment (CAT/Torture Convention) ¹⁰	Committee Against Torture (CAT Committee)	Every 4 years	For states declaring recognition of the competence of the CAT Committee under Article 21 of the CAT
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) ¹¹	Committee on the Elimination of Discrimination Against Women (CEDAW Committee)	As needed, but at least every 4 years	For states having ratified the Optional Protocol
International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) ¹²	Committee on the Elimination of Racial Discrimination (CERD)	Every 2 years	For states declaring recognition of the competence of the CERD Committee under Article 14 of the CERD
Convention on the Rights of the Child (CRC) ¹³	Committee on the Rights of the Child (CRC Committee)	Every 5 years	For states having ratified the Optional Protocol
International Convention on the Rights of Persons with Disabilities (ICRPD) ¹⁴	Committee on the Rights of Persons with Disabilities (CRPD)	Every 4 years	For states having ratified the Optional Protocol
International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICMW) ¹⁵	Committee on Migrant Workers (CMW)	Every 5 years	Article 77 of the CMW will create this mechanism once 10 states have made the necessary declarations.

8. United Nations General Assembly. United Nations General Assembly Resolution 2200A [XXI]: International Covenant on Civil and Political Rights (ICCPR). UN Doc. A/6316. December 16, 1966.
9. United Nations General Assembly. United Nations General Assembly Resolution 2200A[XXI]: International Covenant on Economic, Social and Cultural Rights (ICESCR). UN Doc. A/6316. December 16, 1966.
10. United Nations General Assembly. United Nations General Assembly Resolution 39/46: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). UN Doc. A/39/51. December 10, 1984.
11. United Nations General Assembly. United Nations General Assembly Resolution 34/180: Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). UN Doc. A/34/46. December 18, 1979.
12. United Nations General Assembly. United Nations General Assembly Resolution 2106 [XX]: International Convention for the Elimination of all Forms of Racial Discrimination (ICERD). UN Doc. A/6014. December 21, 1965.
13. United Nations General Assembly. United Nations General Assembly Resolution 44/25: Convention on the Rights of the Child (CRC). UN Doc. A/44/49. November 20, 1989.
14. United Nations General Assembly. United Nations General Assembly Resolution 61/106: International Convention on the Rights of Persons with Disabilities (ICRPD). UN Doc. A/61/49. December 13, 2006.
15. United Nations General Assembly. United Nations General Assembly Resolution 45/158: International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families. UN Doc. A/45/49. December 18, 1990.

In addition to state reporting and individual communications, other monitoring mechanisms have been established:

- ▶ **Inter-State Complaints Procedures.** This allows the treaty body to examine complaints brought by a state alleging human rights violations in another state. To date, this procedure has never been used.
 - Treaty-monitoring bodies with this competence: CCPR, CESC, CERD, CAT Committee, CRC Committee, CMW, CRPD
- ▶ **Inquiries.** This allows the treaty body to initiate inquiries into systemic or grave human rights violations in a country.
 - Treaty-monitoring bodies with this competence: CESC, CEDAW Committee, CAT Committee, CRC Committee, CRPD
- ▶ **Early Warning Procedure.** This allows the treaty body to adopt measures to prevent certain situations from escalating into conflicts or matters requiring urgent attention.
 - Treaty-monitoring body with this competence: CERD

These procedures may require additional declarations and ratifications by countries before entering into force and will not be discussed in detail here. For more information on these procedures, see Chapter 4 (International and Regional Procedures).

NON-LEGALLY BINDING INSTRUMENTS

There are a number of other instruments that, even though do not have the legally binding force of treaties, have received international consensus and assist in interpreting the content of patients' rights. In fact, some of these have been adopted by civil society groups, such as professional associations and non-governmental organizations. Below are a few examples.

United Nations

▶ **Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment¹⁶**

These principles provide guidance on the treatment and rights of all persons who are under any form of detention or imprisonment, including the right to not be subjected to medical or scientific experimentation that is detrimental to his/her the individual's health, even with her/his consent.

▶ **Declaration of Alma-Ata¹⁷**

This declaration "reaffirms that health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity, and is a fundamental human right" (Article 1). It focuses on the importance of primary health care.

▶ **Declaration on the Elimination of Violence against Women¹⁸**

This declaration affirms states' commitment to preventing violence against women and protecting their rights, including their rights to life, to liberty and security of person, to be free from all forms of discrimination, to the highest standard attainable of physical and mental health and freedom from torture, or other cruel, inhuman or degrading treatment or punishment.

16. United Nations General Assembly. United Nations General Assembly Resolution 43/173: Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment. UN Doc. A/RES/43/173. December 9, 1998.

17. International Conference on Primary Health Care. Declaration of Alma-Ata. September 6, 1978.

18. United Nations General Assembly. United Nations General Assembly Resolution 48/104: Declaration on the Elimination of Violence against Women. UN Doc. A/48/49. December 20, 1993.

▶ **Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights¹⁹**

Developed by a group of international law experts, these principles delineate the scope and nature of obligations of states that have ratified the ICESCR. They have been issued as an official UN document and recognized in the work of the CESCR in interpreting state obligations under the Covenant.

▶ **Maastricht Guidelines on Violations of Economic, Social and Cultural Rights²⁰**

Developed by international law experts, these guidelines seek to outline the meaning and scope of economic, social and cultural rights violations. They consider that a state's failure to provide primary care may constitute a violation, and they call on international bodies to adopt new standards on a number of rights, including the right to health. They have been issued as an official UN document.

▶ **Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment²¹**

These principles outline the duties of health care providers to prisoners and detainees, including protecting their mental and physical health in the same way that they would protect the health of a person who is not a prisoner or detained. They must also refrain from inciting or attempting to commit torture or other cruel, inhuman or degrading treatment or punishment.

▶ **Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care²²**

These principles define the rights of persons with mental disabilities within the context of health care. They address issues of informed consent, confidentiality, standard of care, and treatment. They also address the rights of those in mental disability institutions.

▶ **Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights²³**

These principles have played an important role in evaluating measures that restrict human rights guaranteed under the ICCPR. They require that any measure that the government takes that would restrict the human rights under the ICCPR is: 1) provided by and in accordance with the law, (2) in the interest of a legitimate objective, (3) strictly necessary in a democratic society to achieve the objective, (4) the least restrictive and intrusive means available, and (5) not arbitrary, unreasonable, or discriminatory.

▶ **Standard Minimum Rules for the Treatment of Prisoners²⁴**

This instrument outlines a model system of penal institutions in terms of what is generally accepted as good principle and practice in the treatment of prisoners and the management of institutions.

19. United Nations Commission on Human Rights. The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights. UN Doc. E/CN.4/1987/17. January 8, 1987.

20. Maastricht Guidelines on Violations of Economic, Social and Cultural Rights. January 22-26, 1997.

21. United Nations General Assembly. UN General Assembly Resolution 37/194: Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. UN Doc. A/37/51. December 18, 1982.

22. United Nations General Assembly. UN General Assembly Resolution 46/119: Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care. December 17, 1991.

23. United Nations Commission on Human Rights. The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights. UN Doc. E/CN.4/1985/4. September 28, 1984.

24. United Nations. Economic and Social Council Resolution 663 C (XXIV): Standard Minimum Rules for the Treatment of Prisoners. August 30, 1955.

▶ **(UN General Assembly’s) Social, Humanitarian Cultural Committee (Third Committee) Draft Resolutions**

The Third Committee is tasked with advancing the General Assembly’s social, humanitarian, and human rights agenda through a variety of ways, including the discussion and drafting of resolutions to be considered during the General Assembly’s plenary meeting.

▶ **UN Human Rights Council Resolutions**

As the General Assembly’s subsidiary organ responsible for the protection and promotion of all human rights, the Human Rights Council issues recommendations to UN member states in the form of resolutions.

Civil Society

▶ **Declaration of Lisbon on the Rights of the Patients (WMA)²⁵**

This declaration outlines patients’ rights that physicians should recognize and uphold, addressing issues such as the rights to confidentiality, information, and informed consent.

▶ **Declaration on Patient-Centred Healthcare (International Alliance of Patients’ Organizations (IAPO))²⁶**

This declaration promotes the involvement of patients in their care through self-management, adherence to treatment, and behavioral changes to make the system more cost-effective and improve health outcomes for patients.

▶ **Jakarta Declaration on Leading Health Promotion into the 21st Century²⁷**

This declaration is the final outcome document of the Fourth International Conference on Health Promotion. It lays down a series of priorities for health promotion in the twenty-first century, including social responsibility, increased investment and secured infrastructure, and empowerment of the individual.

▶ **Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights²⁸**

These principles focus on states’ extraterritorial obligations to ensure the enjoyment of economic, social and cultural rights, including the right to health.

▶ **Position Statement: Nurses and Human Rights 1998, International Council of Nurses (ICN)²⁹**

The ICN adopted this document recognizing health care as the right of all individuals—including the right to choose or decline care, which encompasses the rights to acceptance or refusal of treatment or nourishment; informed consent; confidentiality; and dignity, including the right to die with dignity. The ICN addresses both patients’ and providers’ rights and outlines nurses’ obligations to protect the patients’ rights.

25. WMA. Declaration on the Rights of the Patient. September/October 1981.

26. International Alliance of Patients’ Organizations [IAPO]. Declaration on Patient-Centred Healthcare. February 2006.

27. WHO. Jakarta Declaration on Leading Health Promotion into the 21st Century. July 21–25, 1997.

28. Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights. September 28, 2011.

29. International Council of Nurses. Position Statement: Nurses and Human Rights. 1998.

2.3 PATIENTS' RIGHTS

This section explores international protection of ten critical patients' rights:

- **Liberty and security of person;**
- **Privacy;**
- **Access to information;**
- **Bodily integrity;**
- **Life;**
- **Highest attainable standard of mental and physical health;**
- **Freedom from torture and other cruel, inhuman or degrading treatment or punishment;**
- **Participation in public policy;**
- **Equality and freedom from discrimination; and**
- **Effective remedy.**

As emphasized by the CCPR, although Article 9 enshrines “the right to liberty and security of person,” the right to liberty is separate from the right to security of person. For this reason, this chapter addresses them separately.³⁰

Treaty-monitoring bodies' interpretative documents have played an important role in the area of patients' rights. The CESCR, specifically, has provided the most significant international legal commentary on the rights of patients. Its interpretation of the right to the highest attainable standard of health (Article 12 of the ICESCR) in General Comment 14³¹ has been particularly influential, despite it not being legally binding. In addition, the CESCR has frequently criticized governments' failure to devote adequate resources to health care and services for patients.

Other UN treaty-monitoring bodies have also provided significant comments on patients' rights. The CCPR has frequently cited Articles 9 (right to liberty and security of the person) and 10 (right of a person deprived of liberty to be treated with humanity and dignity) of the ICCPR to condemn the unlawful detention of mental health patients and the denial of medical treatment to detainees, respectively. It has also upheld the need to protect confidential medical information under Article 17 (right to privacy) of the ICCPR and has used Article 6 (right to life) of the ICCPR to safeguard medical treatment during pretrial detention. In addition, as detailed below, treaty-monitoring bodies concerned with monitoring racial and sex discrimination have examined equal access to health care.

Additionally, other international standards, such as the Standard Minimum Rules for the Treatment of Prisoners, can provide significant reference points regarding patients' rights. Although these standards cannot be directly enforced against states, patients and their advocates can use them to pressure governments and influence judicial and other government interpretation of treaty provisions.

It is worth noting that, as of this writing, the CESCR's individual communications mechanism had just been established. The former lack of a complaint mechanism for the CESCR hampered the treaty body's ability to examine specific violations of the ICESCR beyond the systemic failures identified in country reports. The introduction of this mechanism should provide the CESCR with an opportunity to mirror the work of its sister body, the CCPR, in developing significant case law on human rights in patient care.

30. CCPR. Draft CCPR General Comment No. 35 on Article 9: Liberty and security of person. UN Doc. CCPR/C/107/R.3. January 28, 2013. para. 8.

31. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000.

2.3.1 RIGHT TO LIBERTY AND SECURITY OF PERSON

While guaranteed under the same article as the right to liberty under the ICCPR, the right to security of person is a right in and of itself and is not limited to individuals formally deprived of liberty.³² The right to liberty protects individuals from arbitrary or unjustified physical confinement. The deprivation of liberty must be necessary and proportionate—it must be intended to either protect the individual from harming her/himself or to prevent harm to others, it must take into account less restrictive alternatives, and it must be in line with adequate procedural and substantive legal safeguards.³³ As it relates to patients' rights, the right to liberty protects the individual from arbitrary or unjustified physical confinement on the basis of mental or physical health, such as involuntary hospitalization. The detention of an individual based on health grounds, such as quarantine and isolation, must be done in accordance with established law and must safeguard the individual's rights of due process under the law.³⁴

The right to security of person safeguards the individual's freedom from bodily injury, including protection from fatal injuries and non-intentional injury.³⁵ Under this right, a government must take the necessary measures to protect the individual from threats to her/his bodily integrity, regardless of whether these threats come from the government or private actors.³⁶ Related rights enshrined in international human rights law include the right to freedom from torture, or other cruel, inhuman or degrading treatment; the right to privacy; and the right to the highest attainable standard of health. When it comes to violations of the physical integrity of the person, treaty bodies have opted to address them under other related rights, particularly the right to freedom from torture, cruel, inhuman, or degrading treatment. Therefore, there is little analysis emanating from treaty bodies on these issues under the right to security of person. For this reason, this section contains concluding observations and case law that focus primarily on the right to liberty.

RELEVANT PROVISIONS

▶ UDHR

- **Art. 3:** Everyone has the right to life, liberty and security of person.

▶ ICCPR

- **Art. 9(1):** Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.

▶ ICESCR

- **Art. 12:** The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

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32. CCPR. Draft General Comment No. 35: Article 9: Liberty and security of person. UN Doc. CCPR/C/107/R.3. January 28, 2013. para. 8; CCPR. Communication No. 195/1985: Delgado Páez v. Colombia. UN Doc. CCPR/C/39/D/195/1985. July 12, 1990. paras. 5.4-5.5; CCPR. Communication No. 711/1996: Dias v. Angola. UN Doc. CCPR/C/68/D/711/1996. April 18, 2000. para. 8.3.
33. CCPR. Communication No. 1061/2002: Fijalkowska v. Poland. UN Doc. CCPR/C/84/1061/2002. July 26, 2005; CCPR. Communication No. 1629/2007: Fardon v. Australia. UN Doc. CCPR/C/98/D/1629/2007. March 18, 2010. para. 7.3; CCPR. Concluding Observations: Russian Federation. UN Doc. CCPR/C/RUS/CO/6. November 24, 2009. para. 19.
34. CCPR. Concluding Observations: Bulgaria. UN Doc. CCPR/C/BGR/CO/3. July 25, 2011. para. 17.
35. CCPR. Draft General Comment No. 35: Article 9: Liberty and security of person. UN Doc. CCPR/C/107/R.3. January 28, 2013. para. 8.
36. CCPR. Draft General Comment No. 35: Article 9: Liberty and security of person. UN Doc. CCPR/C/107/R.3. January 28, 2013. para. 8; CCPR. Communication No. 1560/2007: Marcellana and Gumanoy v. Philippines. UN Doc. CCPR/C/94/D/1560/2007. November 17, 2008. para. 7.7; CCPR. Concluding Observations: Uganda. UN Doc. CCPR/CO/80/UGA. May 4, 2004. para. 12.

▶ **CERD**

- **Art. 5(b):** States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right to everyone, without distinction as to race, color or national or ethnic origin, to equality before the law, notably in the enjoyment of. . . (b) the right to security of the person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution.

▶ **CRC**

- **Art. 25:** States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.
- **Art. 39:** States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

▶ **ICRPD**

- **Art. 14:**
 - 1) States Parties shall ensure that persons with disabilities, on an equal basis with others:
 - a) Enjoy the right to liberty and security of person;
 - b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
 - 2) State Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.
- **Art. 17:** Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

▶ **ICMW**

- **Art. 16:**
 - 1) Migrant workers and members of their families shall have the right to liberty and security of person.
 - 4) Migrant workers and members of their families shall not be subjected individually or collectively to arbitrary arrest or detention; they shall not be deprived of their liberty except on such grounds and in accordance with such procedures as are established by law.
 - 8) Migrant workers and members of their families who are deprived of their liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of their detention and order their release if the detention is not lawful. When they attend such proceedings, they shall have the assistance, if necessary without cost to them, of an interpreter, if they cannot understand or speak the language used.

- **Art. 17:**

- 1) Migrant workers and members of their families who are deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person and for their cultural identity.
- 7) Migrant workers and members of their families who are subjected to any form of detention or imprisonment in accordance with the law in force in the State of employment or in the State of transit shall enjoy the same rights as nationals of those States who are in the same situation.

Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment³⁷

- ▶ **Principle 4:** Any form of detention or imprisonment and all measures affecting the human rights of a person under any form of detention or imprisonment shall be ordered by, or be subject to the effective control of, a judicial or other authority.
- ▶ **Principle 11:**
 1. A person shall not be kept in detention without being given an effective opportunity to be heard promptly by a judicial or other authority. A detained person shall have the right to defend himself or to be assisted by counsel as prescribed by law.
 2. A detained person and his counsel, if any, shall receive prompt and full communication of any order of detention, together with the reasons therefor.
 3. A judicial or other authority shall be empowered to review as appropriate the continuance of detention.
- ▶ **Principle 13:** Any person shall, at the moment of arrest and at the commencement of detention or imprisonment, or promptly thereafter, be provided by the authority responsible for his arrest, detention or imprisonment, respectively, with information on and an explanation of his rights and how to avail himself of such rights.
- ▶ **Principle 25:** A detained or imprisoned person or his counsel shall, subject only to reasonable conditions to ensure security and good order in the place of detention or imprisonment, have the right to request or petition a judicial or other authority for a second medical examination or opinion.
- ▶ **Principle 32:**
 1. A detained person or his counsel shall be entitled at any time to take proceedings according to domestic law before a judicial or other authority to challenge the lawfulness of his detention in order to obtain his release without delay, if it is unlawful.
 2. The proceedings referred to in paragraph 1 of the present principle shall be simple and expeditious and at no cost for detained persons without adequate means. The detaining authority shall produce without unreasonable delay the detained person before the reviewing authority.

37. Council for International Organizations of Medical Sciences [CIOMS] in collaboration with the WHO. Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment. 2002.

International Ethical Guidelines for Biomedical Research Involving Human Subjects:³⁸

Respect for persons incorporates at least two fundamental ethical considerations, namely:

- (a) respect for autonomy, which requires that those who are capable of deliberation about their personal choices should be treated with respect for their capacity for self-determination; and
- (b) protection of persons with impaired or diminished autonomy, which requires that those who are dependent or vulnerable be afforded security against harm or abuse.

Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care³⁹

▶ Principle 9:

- 1) Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.
- 2) The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
- 3) Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.
- 4) The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

WMA Declaration of Lisbon on the Rights of the Patients⁴⁰

▶ Principle 2. Right to Freedom of choice

- (a) The patient has the right to choose freely and change his/her physician and hospital or health service institution, regardless of whether they are based in the private or public sector.
- (b) The patient has the right to ask for the opinion of another physician at any stage.

▶ Principle 3. Right to Self-determination

- (a) The patient has the right to self-determination, to make free decisions regarding himself or herself. The physician will inform the patient of the consequences of his/her decisions.
- (b) A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should clearly understand the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.
- (c) The patient has the right to refuse to participate in research or the teaching of medicine.

38. CIOMS. International Ethical Guidelines for Biomedical Research Involving Human Subjects. 2002.

39. United Nations General Assembly. United Nations General Assembly Resolution 46/119: Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. UN Doc. A/RES/46/119. December 17, 1991.

40. WMA. Declaration on the Rights of the Patient. September/October 1981.

Right to Liberty and Security of Person in the Context of Mental Health

Under the right to liberty, a person is protected from arbitrary or unjustifiable detention that is solely based on mental health without judicial review.⁴¹ Governments should ensure that the patient's views are respected in the process and that the interests of the patient are represented and defended.⁴² Any patient involuntarily admitted or detained in a mental health facility also has due process rights, including the right to be informed of the grounds for her/his detention, to be detained for as short a period as is reasonably necessary, and to challenge her/his detention with a judicial body and to have counsel appointed to assist in any such challenge.⁴³ The continuity of detention should be re-evaluated on a regular basis to ensure its necessity.⁴⁴

Under this right, governments have the obligation to refrain from using coercive force or restraint of mental health patients. While relevant to this context, this right has been overshadowed by other related rights (mainly the right to freedom from torture, cruel, inhuman and degrading treatment) in addressing use of coercive force in the mental health context. Refer to sections on the “right to bodily integrity” and the “right to freedom from torture and other cruel, inhuman or degrading treatment or punishment” below.

CONCLUDING OBSERVATIONS ON ESTONIA RELATING TO MENTAL HEALTH AND THE RIGHT TO LIBERTY

[T]he Committee is concerned at some aspects of the administrative procedure related to the detention of a person for mental health reasons, in particular the patient's right to request termination of detention, and, in the light of the significant number of detention measures that had been terminated after 14 days, the legitimate character of some of these detentions. The Committee considers that a period of 14 days of detention for mental health reasons without any review by a court is incompatible with article 9 of the [ICCPR].

The State party should ensure that measures depriving an individual of his or her liberty, including for mental health reasons, comply with article 9 of the Covenant. The Committee recalls the obligation of the State party under article 9, paragraph 4, to enable a person detained for mental health reasons to initiate proceedings in order to review the lawfulness of his/her detention. The State party is invited to furnish additional information on this issue and on the steps taken to bring the relevant legislation into conformity with the Covenant.⁴⁵

CASES RELATING TO MENTAL HEALTH AND THE RIGHT TO LIBERTY

A v. New Zealand (CCPR) (1999). While affirming that treatment in a psychiatric institution against the will of a patient falls within protections of Article 9 (of the ICCPR), the Committee found no violation where the patient was detained for several years in accordance with New Zealand's Mental Health Act as the detention was based upon the evaluation of three psychiatrists and was regularly reviewed by both a panel of psychiatrists and courts.⁴⁶

41. See CCPR. Draft CCPR General Comment No. 35 on Article 9: Liberty and security of person. UN Doc. CCPR/C/107/R.3. January 28, 2013. para. 8; CCPR. Concluding Observations: Belgium. UN Doc. CCPR/CO/81/BEL. August 12, 2004. para. 17.
42. CCPR. Concluding Observations: Czech Republic. UN Doc. CCPR/C/CZE/CO/2. August 9, 2007. para. 14; CCPR. Concluding Observations: Bulgaria. UN Doc. CCPR/C/BGR/CO/3. July 25, 2011. para. 17; see also CRC Committee. General Comment No. 9: The rights of children with disabilities. UN Doc. CRC/C/GC/9. February 2, 2007. para. 48.
43. See United Nations General Assembly. United Nations General Assembly Resolution 46/119: Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. UN Doc. A/RES/46/119. December 17, 1991.
44. CCPR. Communication No. 754/1997: A v. New Zealand. UN Doc. CCPR/C/66/D/754/1997. August 3, 1999. para. 7.2; CCPR. Concluding Observations: Canada. UN Doc. CCPR/C/CAN/CO/5. April 20, 2006. para. 17.
45. CCPR. Concluding Observations: Estonia. UN Doc. CCPR/CO/77/EST. April 15, 2003. para 10.
46. CCPR. Communication No. 754/1997: A v. New Zealand. UN Doc. CCPR/C/66/D/754/1997. August 3, 1999.

Fijalkovska v. Poland (CCPR)(2002). The Committee found no violation where the patient was detained in accordance with Poland's Mental Health Act. However, the Committee did find violations as a result of the complainant not having been provided with adequate counsel to challenge her involuntary admission and for having failed to advise the complainant of her right to challenge her involuntary admission until after she was released.⁴⁷

Right to Liberty and Security of Person in the context of Infectious Diseases

The fear of the spread of infectious diseases has led governments to subject individuals suspected of being infected to forced detention, such as quarantine or forced isolation, including when the individual refuses treatment.⁴⁸ The CCPR has called on governments to ensure that such restrictive measures against individuals with infectious diseases respect the individuals' rights, including guarantees of judicial review.⁴⁹

As explained above, little analysis exists on the right to security of person mainly due to the fact that treaty monitoring bodies have opted to address issues of physical integrity through other related rights. Nevertheless, this right is relevant to cases where the government has applied coercive measures against an individual with infectious diseases, such as forced treatment. Refer to sections on the "right to bodily integrity" and the "right to freedom from torture and other cruel, inhuman or degrading treatment or punishment" below.

CONCLUDING OBSERVATIONS ON MOLDOVA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO LIBERTY

[T]he Committee notes with concern that, under a regulation promulgated in August 2009, persons with tuberculosis may be subjected to forcible detention in circumstances where he or she is deemed to have "avoided treatment". In particular, the regulation is unclear as to what constitutes the avoidance of treatment and fails to provide, inter alia, for patient confidentiality or for the possibility for the judicial review of a decision to forcibly detain a patient. (arts. 2, 9 and 26).

The State party should urgently review this measure to bring it into line with the [ICCPR], ensuring that any coercive measures arising from public health concerns are duly balanced against respect for patients' rights, guaranteeing judicial review and patient confidentiality and otherwise ensuring that persons with tuberculosis are treated humanely.⁵⁰

Right to Liberty and Security of Person in the Context of Sexual and Reproductive Health

The right to liberty protects individuals from interference intended to limit or promote their fertility and hinder their sexual autonomy—either by the state or private individuals. In addition to protecting the life and health of the individual, the right to liberty recognizes the individual's reproductive choice as well as her/his decision on how to conduct her/his sexual life.⁵¹ It requires that the government ensure that individuals have access to legal representation in court proceedings and that women in prison are provided with health care after the termination of a pregnancy.⁵²

47. CCPR. Communication No. 1061/2002: *Fijalkowska v. Poland*. UN Doc. CCPR/C/84/1061/2002. July 26, 2005.

48. OHCHR. International Guidelines on HIV/AIDS and Human Rights. July 2006. para. 105.

49. CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009.

50. CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009.

51. See Rebecca Cook. International Human Rights and Women's Reproductive Health. *Studies in Family Planning*, Vol. 24, No. 2. March - April, 1993. p. 79.

52. CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009. para. 17; see also Inter-American Commission on Human Rights [CIDH]. *Paulina Del Carmen Ramirez Jacinto v. Mexico*. Case 161-02. Report No. 21/07.

As in other contexts, the right to security of person has rarely been used to address issues of sexual and reproductive health. Oftentimes, treaty monitoring bodies have analyzed such issues under the related rights to liberty, privacy, and freedom from torture, cruel, inhuman and degrading treatment. However, the right to security of person has been deemed relevant in cases where the state or private individuals threaten an individual's sexual and/or reproductive health, such as when women are subjected to forced sterilization.

CONCLUDING OBSERVATIONS ON MOLDOVA RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO LIBERTY

The Committee is concerned that, despite the National Strategy for Health (2005-2015), the use of abortion as a contraceptive measure is widespread. It notes, in this respect, that the law on compulsory medical insurance, which provides for the inclusion of contraceptives in the Basic Benefits Package, has not been implemented. Furthermore, the Committee is concerned that, although abortion is not prohibited by law, there have been instances where women have been prosecuted for murder or infanticide after having had an abortion and that no after-abortion healthcare is provided to them in prison. (arts. 3, 9 and 10)

The State party should:

- (a) Take steps to eliminate the use of abortion as a method of contraception by, inter alia, ensuring the provision of affordable contraception and introducing reproductive and sexual health education in school curricula and for the broader public;*
- (b) Consistently apply the law so that women who undergo abortions are not prosecuted for murder or infanticide;*
- (c) Release any women currently serving sentences on such charges; and*
- (d) Provide appropriate health care in prison facilities to women who have undergone abortions.⁵³*

2.3.2 RIGHT TO PRIVACY

The right to privacy protects the individual from unlawful and arbitrary interference with her/his privacy—meaning that any interference must be based on law and be proportionate to the end sought.⁵⁴ In the context of patient care, the right can be applied to prevent undue disclosure of information on a patient's health status, medical condition, diagnosis, prognosis, and treatment and other personal information. The gathering, holding, and sharing of personal information by a private or public actor must be regulated by law.⁵⁵

Moreover, interference by the government—such as administrative hurdles imposed by the judicial system—with matters that should be resolved between the physician and the patient has been considered a violation of the patient's right to privacy.⁵⁶ UN treaty-monitoring bodies have underscored that accessibility to information should not impair the right to have personal health data treated with confidentiality.⁵⁷

March 9, 2007; Inter-Am. C.H.R. OEA/Ser.L/V/II.130 Doc. 22, rev. 1, December 29, 2007.

53. CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009. para. 17.

54. CCPR. CCPR General Comment No. 16: Article 17 (Right to Privacy). The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation. April 8, 1988. paras. 3-4; CCPR. Communication No. 1482/2006: M. G. v. Germany. UN Doc. CCPR/C/93/D/1482/2006. September 2, 2008. para. 10.2.

55. See CCPR. CCPR General Comment No. 16: Article 17 (Right to Privacy). The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation. April 8, 1988. para. 10.

56. CCPR. Communication No. 1482/2006: L.M.R v. Argentina. UN Doc. CCPR/C/101/D/1608/2007. March 29, 2011. para 9.3.

57. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12.

RELEVANT PROVISIONS

▶ UDHR, Art. 12:

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

▶ ICCPR, Art. 17(1):

No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation.

▶ CRC, Art. 16(1):

No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honor and reputation.

▶ CRPD, Art. 22:

- 1) No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence or other types of communication or to unlawful attacks on his or her honor and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.
- 2) State Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

▶ ICMW, Art. 14:

No migrant worker or member of his or her family shall be subjected to arbitrary or unlawful interference with his or her privacy, family, , correspondence or other communications, or to unlawful attacks on his or her honour and reputation. Each migrant worker and member of his or her family shall have the right to the protection of the law against such interference or attacks.

Beijing Declaration and Platform for Action⁵⁸

106. By Governments, in collaboration with non- governmental organizations and employers' and workers' organizations and with the support of international institutions: . . . (f) Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communications skills and the user's right to privacy and confidentiality. These services, information and training should adopt a holistic approach. . .

Declaration of Lisbon on the Rights of the Patients (WMA)⁵⁹

▶ Principle 8. Right to confidentiality

- (a) All identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death. Exceptionally, descendants may have a right of access to information that would inform them of their health risks.
- (b) Confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other health care providers only on a strictly "need to know" basis unless the patient has given explicit consent.

58. Fourth World Conference on Women. Beijing Declaration and Platform for Action. September 1995.

59. WMA. Declaration on the Rights of the Patient. September/October 1981.

- (c) All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of its storage. Human substances from which identifiable data can be derived must be likewise protected.

► **Principle 10. Right to dignity**

The patient's dignity and right to privacy shall be respected at all times in medical care and teaching, as shall his/her culture and values.

Right to Privacy in the Context of Mental Health

In patient care, medical treatment or examination of a patient's mental and physical state could constitute a violation of the patient's right to privacy when it is not performed out of "therapeutic necessity."⁶⁰ Additionally, the government must ensure that any reasons given for the disclosure of medical information on the patient's mental health is balanced with careful consideration of the patients' interests in keeping their information confidential and private.⁶¹

CONCLUDING OBSERVATIONS ON THE REPUBLIC OF KOREA RELATING TO MENTAL HEALTH AND THE RIGHT TO PRIVACY

The Committee welcomes the State party's efforts to improve children's mental health by, inter alia, establishing 32 centres for mental health services nationwide. However, the Committee remains concerned that the overall state of child mental health in the State party has deteriorated and that the rate of depression and suicide among children has increased, especially among girls. The Committee also notes the implementation of a diagnostic tool for facilitating the early detection and prevention of suicide, but is nevertheless concerned that the diagnostic tool could negatively impact the child's right to privacy.

The Committee recommends that the State party undertake measures for the development of a child mental health-care policy based on a thorough study of the root causes of depression and suicide among children, and invest in the development of a comprehensive system of services, including mental health promotion and prevention activities, out-patient and in-patient mental health services, with a view to ensuring the effective prevention of suicidal behaviour, especially among girls ... [I]n applying its diagnostic tool for the detection and prevention of suicide, the Committee recommends that the State party establish adequate safeguards for ensuring that the diagnostic tool is applied in a manner that fully respects the right of the child to privacy and to be adequately consulted.⁶²

Right to Privacy in the Context of Infectious diseases

The right to privacy requires that the government ensure that information regarding individuals' health status, such as HIV status, be kept confidential. The disclosure of this information should be done with the informed consent of the patient. States should clearly define and establish guiding principles and recommendations for handling such information, as well as laws on privacy and confidentiality. They should also raise awareness of those accessing this type of data.⁶³ Laws that interfere with this right in the inter-

60. CCPR. Communication No. 1482/2006: M. G. v. Germany. UN Doc. CCPR/C/93/D/1482/2006. September 2, 2008. para. 10.1.

61. CRPD. Concluding Observations: Hungary. UN Doc. CRPD/C/HUN/CO/1. October 22, 2012. paras. 48-49.

62. CRC Committee. Concluding Observations: Republic of Korea. UN Doc. CRC/C/KOR/CO/3-4. October 6, 2011. paras. 55-56.

63. WHO European Region. Scaling up HIV testing and counselling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support. Policy Framework. WHO/EURO 2010. p. 10.

est of public health must be “in accordance with the provisions, aims and objectives of the [ICCPR] and should be, in any event, reasonable in the particular circumstances.”⁶⁴

CONCLUDING OBSERVATIONS ON MOLDOVA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO PRIVACY

The Committee is concerned that persons infected with HIV/AIDS face discrimination and stigmatization in the State party, including in the fields of education, employment, housing and health care, and that foreigners are arbitrarily subjected to HIV/AIDS tests as part of the immigration rules framework. In particular, the Committee is concerned that patient confidentiality is not always respected by health-care professionals. It is also concerned that legislation prohibits the adoption of children with HIV/AIDS, thereby depriving them of a family environment. (arts. 2, 17 and 26)

*The State party should take measures to address the stigmatization of HIV/AIDS sufferers through, inter alia, awareness-raising campaigns on HIV/AIDS, and should amend its legislation and regulatory framework in order to remove the prohibition on the adoption of children with HIV/AIDS, as well as any other discriminatory laws or rules pertaining to HIV/AIDS.*⁶⁵

CASE RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO PRIVACY

Toonen v. Australia (CCPR) (1994). The Committee found that the laws criminalizing consensual sex between adult males “cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of AIDS/HIV” and, therefore, failed the “reasonableness test,” as the laws arbitrarily interfered with the individual’s right to privacy.⁶⁶

Right to Privacy in the Context of Sexual and Reproductive Health

The need to protect the confidentiality of medical information is particularly vital in relation to sexual and reproductive health. Examinations by UN treaty-monitoring bodies in the context of right to privacy have included: (i) condemnation of a legal duty imposed on health personnel to report cases of abortions as part of a general criminalization of the procedure without exception, thereby inhibiting women from seeking medical treatment and jeopardizing their lives;⁶⁷ (ii) the need to investigate allegations that women seeking employment in foreign enterprises are subjected to pregnancy tests and are required to respond to intrusive personal questioning followed by the administration of antipregnancy drugs;⁶⁸ and (iii) the need to address the concerns and need for confidentiality of adolescents with respect to sexual and reproductive health, including those married at a young age and those in vulnerable situations.⁶⁹

64. See CCPR. CCPR General Comment No. 16: Article 17 (Right to Privacy). The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation. April 8, 1988. para. 4; CCPR. Communication No. 488/1992: Toonen v. Australia. UN Doc. CCPR/C/50/D/488/1992. March 31, 1994. paras. 8.5-8.6.

65. CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009. para. 12.

66. CCPR. Communication No. 488/1992: Toonen v. Australia. UN Doc. CCPR/C/50/D/488/1992. March 31, 1994. paras. 8.5-8.6.

67. CCPR. Concluding Observations: Chile. UN Doc. CCPR/C/79/Add.104. March 30, 1999; CCPR. Concluding Observations: Venezuela. UN Doc. CCPR/CO/71/VEN. April 26, 2001.

68. CCPR. Concluding Observation: Mexico. UN Doc. CCPR/C/79/Add.109. July 27, 1999. Requirement for women to have access to appropriate remedies where their equality and privacy rights had been violated.

69. CRC Committee. Concluding Observations: Djibouti. UN Doc. CRC/C/15/Add.131. June 28, 2000.

CONCLUDING OBSERVATIONS ON AUSTRALIA RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO PRIVACY

The Committee notes as positive that the Office of the Australian Information Commissioner has issued guidelines on the application of the Australian Privacy Act on handling the personal information of children. However, the Committee is concerned that the State party does not have comprehensive legislation protecting the right to privacy of children. Furthermore, while noting that the Office of the Australian Information Commissioner is empowered to hear complaints about breaches of privacy rights under the Privacy Act 1998 (Cth), it is concerned that there are no child-specific and child-friendly mechanisms and that those available are limited to complaints made against government agencies and officers and large private organizations... Furthermore, the Committee is concerned that children receiving health services, particularly sexual and reproductive health services, are not ensured their right to privacy.

The Committee recommends that the State party consider enacting comprehensive national legislation enshrining the right to privacy. It also urges the State party to establish child-specific and child-friendly mechanisms for children complaining against breaches of their privacy and to increase the protection of children involved in penal proceedings...⁷⁰

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO PRIVACY

Karen Noelia Llantoy Huamán v. Peru (CCPR)(2003). The Committee found that the doctor's refusal to terminate the pregnancy as requested by the patient, and forcing her to carry the pregnancy to term despite the existence of laws permitting the service, was not justified and constituted a violation of the patient's right to privacy.⁷¹

L.N.P. v. Argentina (CCPR)(2011). The Committee found the "constant inquiries" by the social worker, medical personnel, and the court "into the author's sexual life and morality" to constitute a violation of her right to privacy as these inquiries were not relevant to her rape. The Committee recalled that interference occurs when the woman's sexual life is considered to define her rights and protections.⁷²

2.3.3 RIGHT OF ACCES TO INFORMATION

The right of access to information guarantees the individual access to personal information concerning her/him, as well as medical information on her/his condition, except when this information could be harmful to her/his life or health. The government should take the necessary measures to guarantee the patient access to information about her health conditions,⁷³ but also ensure that access to this information does not infringe on the patient's right to keep her/his information confidential.⁷⁴ Accordingly, a government's refusal to provide the patient with access to her/his medical records has been treated as a violation of the individual's right of access to information.⁷⁵ However, a patient also has the right not to be informed, unless the disclosure of this information to the patient is needed to protect another person's life.⁷⁶

70. CRC. Concluding Observations: Australia. UN Doc. CRC/C/AUS/CO/4. August 28, 2012. para. 41-42.

71. CCPR. Communication No. 1153/2003: Karen Noelia Llantoy Huamán v. Peru. UN Doc. CCPR/C/85/D/1153/2003. October 24, 2005.

72. CCPR. Communication No. 1610/2007: L.N.P. v. Argentina. UN Doc. CCPR/C/102/D/1610/2007. August 16, 2011. para. 13.7.

73. See UN Special Rapporteur on Freedom of Expression. Report "The Right to Freedom of Opinion and Expression." UN Doc. E/CN.4/2005/64. December 17, 2004. para. 42.

74. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12(b)(iv).

75. CCPR. Communication No. 726/1996: Zheludkov v. Ukraine. UN Doc. CCPR/C/76/D/726/1996. Views adopted October 29, 2002. Individual opinion by Ms. Cecilia Medina Quiroga (concurring).

76. WMA. Declaration on the Rights of the Patient. September/October 1981. principle 7(d).

Additionally, access to information has been interpreted as an essential part of the accessibility component of the right to health.⁷⁷

RELEVANT PROVISIONS

- ▶ **UDHR, Art. 19:** Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.
- ▶ **ICCPR, Art. 19(2):** Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive, and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.
- ▶ **CRC, Art. 17:** States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual, and moral well-being and physical and mental health.
- ▶ **ICRPD, Art. 21:** States Parties shall take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive, and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in article 2 of the present Convention, including by: (a) Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost.
- ▶ **ICMW**
 - **Art. 13(2):** Migrant workers and members of their families shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art or through any other media of their choice.
 - **Art. 33:**
 - 1) Migrant workers and members of their families shall have the right to be informed by the State of origin, the State of employment or the State of transit as the case may be concerning: (a) Their rights arising out of the present Convention;...
 - 3) Such adequate information shall be provided upon request to migrant workers and members of their families, free of charge, and, as far as possible, in a language they are able to understand.

IAPO Declaration on Patient-Centred Healthcare,⁷⁸

- ▶ **Principle 5:** Accurate, relevant, and comprehensive information is essential to enable patients and carers to make informed decisions about health care treatment and living with their condition. Information must be presented in an appropriate format according to health literacy principles considering the individual's condition, language, age, understanding, abilities, and culture.

77. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12(b)(iv).

78. IAPO. Declaration on Patient-Centred Healthcare. February 2006.

WMA Declaration of Lisbon on the Rights of the Patients⁷⁹

▶ Principle 7. Right to information:

- (a) The patient has the right to receive information about himself/herself recorded in any of his/her medical records, and to be fully informed about his/her health status including the medical facts about his/her condition. However, confidential information in the patient's records about a third party should not be given to the patient without the consent of that third party.
- (b) Exceptionally, information may be withheld from the patient when there is good reason to believe that this information would create a serious hazard to his/her life or health.
- (c) Information should be given in a way appropriate to the patient's culture and in such a way that the patient can understand.
- (d) The patient has the right not to be informed on his/her explicit request, unless required for the protection of another person's life.
- (e) The patient has the right to choose who, if anyone, should be informed on his/her behalf.

▶ Principle 9. Right to Health Education:

- (a) Every person has the right to health education that will assist him/her in making informed choices about personal health and about the available health services. The education should include information about healthy lifestyles and about methods of prevention and early detection of illnesses. The personal responsibility of everybody for his/her own health should be stressed. Physicians have an obligation to participate actively in educational efforts.

Right of Access to Information in the Context of Mental Health

Mental health patients are often denied access to information about their mental health condition, including diagnosis and treatment, because of a perceived incapacity to adequately make or participate in decisions concerning their own treatment and care.⁸⁰ Treaty bodies and special procedures have recognized the importance of the right of access to information in the context of mental health and have emphasized that information on the patient's mental health condition be made accessible to the patient and, in the case of children, be made accessible to the parents.⁸¹

CONCLUDING OBSERVATIONS ON ESTONIA RELATING TO MENTAL HEALTH AND THE RIGHT TO ACCESS TO INFORMATION

[T]he Committee is concerned by information that persons with psychosocial disabilities or their legal guardians are not [sic] often denied the right to be sufficiently informed about criminal proceedings and charges against them, the right to a fair hearing and the right to adequate and effective legal assistance (arts. 2, 10, 11, 12, 13 and 16).

The State party should:

- (a) Ensure effective supervision and independent monitoring by judicial organs of any involuntary hospitalization in psychiatric institutions of persons with mental and psychosocial disabilities; and ensure that every patient, whether voluntarily or involuntarily hospitalized, is fully informed about the treatment to be prescribed and given the opportunity to refuse treatment or any other medical intervention ;...*

79. WMA. Declaration on the Rights of the Patient. September/October 1981.

80. UN Special Rapporteur on the Right to Health. Report on "Mental Disability and the Right to Health." UN Doc. E/CN.4/2005/51. February 11, 2005. para. 46(b).

81. UN Special Rapporteur on the Right to Health, Report on "Mental Disability and the Right to Health." UN Doc. E/CN.4/2005/51. February 11, 2005. para. 46(b).

(c) Ensure the right of persons with mental and psychosocial disabilities or their legal guardians to be sufficiently informed about criminal proceedings and charges against them, the right to a fair hearing and the right to adequate and effective legal assistance for their defence.⁸²

Right of Access to Information in the Context of Infectious Diseases

Governments should take measures to control the spread of infectious diseases through the dissemination of information, including through public information campaigns.⁸³ Access to information enables individuals to make informed decisions regarding their health conditions. For example, when an individual needs to decide on whether to take an HIV test, she/he should be provided with information on the voluntary nature of the test; her/his right to decline it; the fact that if the test is declined, it would not affect her/his access to services; the benefits and risks of HIV testing; and available social support.⁸⁴

CONCLUDING OBSERVATIONS LIBYA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO ACCESS TO INFORMATION

The Committee notes the establishment of the National Committee for AIDS Prevention in 1987 and other measures to address the problem of HIV/AIDS, but is concerned at the relatively high number of children afflicted by HIV/AIDS in Benghazi. The Committee is also concerned at insufficient information available in relation to adolescent health, particularly in relation to mental health issues.

The Committee recommends that the State party: ... (c) Ensure that adolescents have access to and are provided with education on adolescent health issues, in particular regarding mental health, in a sensitive manner.⁸⁵

CASE RELATING TO INFECTIOUS DISEASES AND THE RIGHT OF ACCESS TO INFORMATION

Tornel et al. v. Spain (CCPR)(2006). The Committee found that the prison's failure to inform the detained individual's family of his severely deteriorating condition related to his HIV-positive status constituted an arbitrary interference with the family and violated Article 17(1) of the ICCPR.⁸⁶

Right of Access to Information in the Context of Sexual and Reproductive Health

The provision of appropriate and timely information with respect to sexual and reproductive health is particularly crucial as access to this information enables individuals to make informed decisions on the number, spacing, and timing of their children. What is more, the right of access to information includes access to confidential and child-sensitive counseling services⁸⁷ and for adolescents, access to information

82. CAT Committee. Concluding Observations: Estonia. UN Doc. CAT/C/EST/CO/5. June 17, 2013. para. 20.

83. CESCR. Concluding Observations: Lithuania. UN Doc. E/C.12/1/Add.96. June 7, 2004; CEDAW Committee. Report of the Committee on the Elimination of Discrimination against Women: Twenty-eighth session, Twenty-ninth session. UN Doc. A/58/38 (SUPP). 2003. para. 260.

84. WHO European Region. Scaling up HIV testing and counselling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support. Policy Framework. p. 7.

85. CRC Committee. Concluding Observations: Libya (Arab Jamahiriya). UN Doc. CRC/C/15/Add.209. July 4, 2003. paras. 37-38.

86. CCPR. Communication No. 1473/2006: Tornel v. Spain. UN Doc. CCPR/C/95/D/1473/2006. March 20, 2009. para. 7.4.

87. CRC Committee. Concluding Observations: Oman, 2006. UN Doc. CRC/C/OMN/CO/2. September 29, 2006. para. 50(c); CRC Committee. Concluding Observations: Russian Federation. UN Doc. CRC/C/RUS/CO/3. November 23, 2005. para. 56.

without parental consent based on the adolescent's maturity level.⁸⁸ Accordingly, UN treaty-monitoring bodies have urged governments to improve access in light of increasing teenage abortions and sexually transmitted diseases,⁸⁹ including HIV/AIDS,⁹⁰ with this right to access also extending to children.⁹¹

CONCLUDING OBSERVATIONS ON PANAMA RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO ACCESS TO INFORMATION

The Committee is concerned at the State party's insufficient recognition and protection of women's sexual health and reproductive rights, in particular with regard to the delay in the debate over draft law No. 442 on sexual and reproductive health. It regrets the lack of access to information on health-care services provided to adolescent girls, particularly in rural areas, as well as the high number of early pregnancies. Furthermore, the Committee is concerned at the lack of a holistic and life-cycle approach to the health of women in the State party.

The Committee urges the State party to take the necessary steps to overcome the stalemate surrounding draft law No. 442 and to promulgate it as soon as possible. The Committee also urges the State party to improve family planning and reproductive health programmes and policies designed to give women and adolescent girls, in particular in rural areas, effective access to information on health-care services, including reproductive health-care services and contraception, in accordance with the Committee's general recommendation No. 24 on women and health and the Beijing Declaration and Platform for Action. The Committee also recommends that the State party step up its efforts to incorporate age-appropriate sex education in school curricula and organize information campaigns aimed at preventing teenage pregnancies. It further recommends that the State party undertake a holistic and life-cycle approach to women's health that includes an intercultural focus.⁹²

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO ACCESS TO INFORMATION

A.S. v. Hungary (CEDAW Committee) (2006). The Committee found the sterilization of a Roma woman without her informed consent violated her right of access to information and her right to decide freely on the number of children under the CEDAW. The Committee recalled that "informed decision-making about safe and reliable contraceptive measures depends upon a woman having 'information about contraceptive measures and their use, and guaranteed access to sex education and family planning services.'"⁹³

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88. CEDAW Committee. CEDAW General Recommendation No.24: Article 12 of the Convention (Women and Health). UN Doc. A/54/38/Rev. 1, chap. I. 1999. para. 14; CRC Committee. Concluding Observations: Austria. UN Doc. CRC/C/15/Add.98. May 7, 1999. para. 15; CRC Committee. Concluding Observations: Bangladesh. UN Doc. CRC/C/15/Add.221. October 27, 2003. para. 60; CRC Committee. Concluding Observation of the Committee on the Rights of the Child: Barbados. UN Doc. CRC/C/15/Add.103. August 24, 1999. para. 25.
89. CESCR. Concluding Observations: Lithuania. UN Doc. E/C.12/1/Add.96. June 7, 2004; CEDAW Committee. Report of the Committee on the Elimination of Discrimination against Women: Twenty-eighth session, Twenty-ninth session. UN Doc. A/58/38 (SUPP). 2003; see also CESCR. Concluding Observations: People's Republic of China (including Hong Kong and Macao). UN Doc. E/C.12/1/Add.107. May 13, 2005.
90. CESCR. Concluding Observations: Chile. UN Doc. E/C.12/Add.105. November 26, 2004; see also CESCR. Concluding Observations: Cameroon. UN Doc. E/C.12/1/Add.40. December 8, 1999; see also CEDAW Committee. Report of the Committee on the Elimination of Discrimination against Women: Twenty-eighth session, Twenty-ninth session. UN Doc. A/58/38 (SUPP). 2003.
91. CRC Committee. Concluding Observations: Mozambique. UN Doc. CRC/C/15/Add.172. April 3, 2002; see also CRC Committee. Concluding Observations: Indonesia. UN Doc. CRC/C/15/Add.223. February 26, 2004.
92. CEDAW Committee. Concluding Observations: Panama. UN Doc. CEDAW/C/PAN/CO/7. February 5, 2010. para 40-41.
93. CEDAW Committee. Communication No. 4/2004: A.S. v. Hungary. UN Doc. CEDAW/C/36/D/4/2004. July 14, 2006. para. 11.2 (recalling CEDAW Committee's General Comment 21 on equality in marriage and family relations).

2.3.4 RIGHT TO BODILY INTEGRITY

The right to bodily integrity protects the individual from bodily injury.⁹⁴ In the patient care context, this right becomes relevant in cases of involuntary medical treatment and experimentation, among others.⁹⁵ It is not specifically recognized under the ICCPR or the ICESCR, but it has been interpreted to be part of related rights, including the right to freedom from torture, cruel, inhuman, and degrading treatment (ICCPR, Art. 7); the right to security of person (ICCPR, Art. 9); the right to privacy (ICCPR, Art. 17); and the right to the highest attainable standard of health (ICESCR, Art. 12). Under this right, a government must take the necessary measures to protect the individual from threats to her/his bodily integrity, regardless of whether these threats come from the government or private actors.⁹⁶ Please refer to the sections discussing the related rights.

RELEVANT PROVISIONS

- ▶ **UDHR, Art. 3:** Everyone has the right to life, liberty and security of person.
- ▶ **ICCPR, Art. 9(1):** Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.
- ▶ **ICESCR, Art. 12:** The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- ▶ **CERD, Art. 5(b):** States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right to everyone, without distinction as to race, colour or national or ethnic origin, to equality before the law, notably in the enjoyment of. . . (b) the right to security of the person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution.
- ▶ **CRC**
 - **Art. 12(1):** States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
 - **Art. 25:** States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement. States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.
 - **Art. 39:** States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

94. CCPR. Draft General Comment No. 35: Article 9: Liberty and security of person. UN Doc. CCPR/C/107/R.3. January 28, 2013. para. 8.

95. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 8.

96. CCPR. Draft General Comment No. 35: Article 9: Liberty and security of person. UN Doc. CCPR/C/107/R.3. January 28, 2013. para. 8; CCPR. Communication No. 1560/2007: Marcellana and Gumanoy v. Philippines. UN Doc. CCPR/C/94/D/1560/2007. November 17, 2008. para. 7.7; CCPR. Concluding Observations: Uganda. UN Doc. CCPR/CO/80/UGA. May 4, 2004. para. 12.

▶ **ICRPD**

● **Art. 14:**

- 1) States Parties shall ensure that persons with disabilities, on an equal basis with others:
 - (a) Enjoy the right to liberty and security of person; ...

- **Art. 17:** Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

▶ **ICMW, Art. 16:**

- 1) Migrant workers and members of their families shall have the right to liberty and security of person.
- 3) Migrant workers and members of their families shall be entitled to effective protection by the State against violence, physical injury, threats and intimidation, whether by public officials or by private individuals, groups or institutions.

International Ethical Guidelines for Biomedical Research Involving Human Subjects:⁹⁷

Respect for persons incorporates at least two fundamental ethical considerations, namely:

- (a) respect for autonomy, which requires that those who are capable of deliberation about their personal choices should be treated with respect for their capacity for self-determination; and
- (b) protection of persons with impaired or diminished autonomy, which requires that those who are dependent or vulnerable be afforded security against harm or abuse.

Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care⁹⁸

▶ **Principle 9:**

- 1) Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.
- 2) The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
- 3) Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.
- 4) The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

WMA Declaration of Lisbon on the Rights of the Patients⁹⁹

▶ **Principle 2. Right to freedom of choice**

- (a) The patient has the right to choose freely and change his/her physician and hospital or health service institution, regardless of whether they are based in the private or public sector.

97. CIOMS. International Ethical Guidelines for Biomedical Research Involving Human Subjects. 2002.

98. United Nations General Assembly. United Nations General Assembly Resolution 46/119: Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. UN Doc. A/RES/46/119. December 17, 1991.

99. WMA. Declaration on the Rights of the Patient. September/October 1981.

▶ **Principle 3. Right to self-determination**

- (a) The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions.
- (b) A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.
- (c) The patient has the right to refuse to participate in research or the teaching of medicine.

▶ **Principle 4. The unconscious patient**

- (a) If the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained whenever possible, from a legally entitled representative.
- (b) If a legally entitled representative is not available, but a medical intervention is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient's previous firm expression or conviction that he/she would refuse consent to the intervention in that situation.
- (c) However, physicians should always try to save the life of a patient unconscious due to a suicide attempt.

▶ **Principle 5. The legally incompetent patient**

- (a) If a patient is a minor or otherwise legally incompetent, the consent of a legally entitled representative is required in some jurisdictions. Nevertheless the patient must be involved in the decision-making to the fullest extent allowed by his/her capacity.
- (b) If the legally incompetent patient can make rational decisions, his/her decisions must be respected, and he/she has the right to forbid the disclosure of information to his/her legally entitled representative.
- (c) If the patient's legally entitled representative, or a person authorized by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution. In case of emergency, the physician will act in the patient's best interest.

▶ **Principle 6. Procedures against the patient's will**

- (a) Diagnostic procedures or treatment against the patient's will can be carried out only in exceptional cases, if specifically permitted by law and conforming to the principles of medical ethics.

Right to Bodily Integrity in the Context of Mental Health

The right to bodily integrity protects mental health patients from the use of coercive force or restraint. If force or restraint is used, it must be made following a "thorough and professional medical assessment" that calls for this type of intervention.¹⁰⁰ Moreover, the government has the obligation to establish a monitoring and reporting system of mental health-care institutions.¹⁰¹ It requires the monitoring of psychiatric and other institutions to ensure that no person is placed in the institution on the basis of her/his mental disability without her/his free and informed consent.¹⁰²

100. CCPR. Concluding Observations: Norway. UN Doc. CCPR/C/NOR/CO/6. November 18, 2011. para. 10.

101. CCPR. Concluding Observations: Norway. UN Doc. CCPR/C/NOR/CO/6. November 18, 2011. para. 10; CCPR. Concluding Observations: Bulgaria. UN Doc. CCPR/C/BGR/CO/3. July 25, 2011. para. 17.

102. CRPD. Monitoring the Convention on the Rights of Persons with Disabilities Guidance for human Rights Monitors. UN Doc. HR/P/PT/17. April 2010.

As explained above, threats to the bodily integrity of such individuals can be addressed through other related rights, such as the right to security of persons and the right to freedom from torture, cruel, inhuman and degrading treatment. As in the case of the right to security of person, the state is required to monitor of psychiatric and other institutions to ensure that no person is placed in the institution on the basis of her/his mental disability without her/his free and informed consent.¹⁰³ If force or restraint is used, it must be made following a “thorough and professional medical assessment” that calls for this type of intervention.¹⁰⁴ Moreover, the government has the obligation to establish a monitoring and reporting system of mental health-care institutions.¹⁰⁵

CONCLUDING OBSERVATIONS ON CROATIA RELATING TO MENTAL HEALTH AND THE RIGHT TO BODILY INTEGRITY

While noting the State party’s statement concerning its commitment to abolish the use of enclosed restraint beds (cages/net beds) as a means to restrain mental health patients, including children, in institutions, the Committee is concerned about the current use of such beds. The Committee recalls that this practice constitutes inhuman and degrading treatment. (arts. 7, 9, 10 of the Covenant.)

The State party should take immediate measures to abolish the use of enclosed restraint beds in psychiatric and related institutions. The State party should also establish an inspection system, taking into account the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.¹⁰⁶

Right to Bodily Integrity in the Context OF Infectious Diseases

The right to bodily integrity becomes particularly relevant in instances where individuals with infectious diseases are subjected to coercive measures, such as quarantine and forced treatment. In this context, states must ensure that the interests for the protection of the public’s health are balanced with the individual’s right to bodily integrity and that the individual is treated humanely.¹⁰⁷ For example, governments must consider “potential outcomes of HIV testing – including stigma, discrimination, violence and other abuse – in policy and practice.” Moreover, they “must do all they can to prevent such human rights violations, both for the protection of the individual and the effectiveness of the national response to HIV.”¹⁰⁸

CONCLUDING OBSERVATIONS ON MOLDOVA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO BODILY INTEGRITY

[T]he Committee notes with concern that, under a regulation promulgated in August 2009, persons with tuberculosis may be subjected to forcible detention in circumstances where he or she is deemed to have “avoided treatment”. In particular, the regulation is unclear as to what constitutes the avoidance of treatment and fails to provide, inter alia, for patient confidentiality or for the possibility for the judicial review of a decision to forcibly detain a patient. (arts. 2, 9 and 26).

103. CRPD. Monitoring the Convention on the Rights of Persons with Disabilities Guidance for human Rights Monitors. UN Doc. HR/P/PT/17. April 2010.

104. CCPR. Concluding Observations: Norway. UN Doc. CCPR/C/NOR/CO/6. November 18, 2011. para. 10.

105. CCPR. Concluding Observations: Norway. UN Doc. CCPR/C/NOR/CO/6. November 18, 2011. para. 10; CCPR. Concluding Observations: Bulgaria. UN Doc. CCPR/C/BGR/CO/3. July 25, 2011. para. 17.

106. CCPR. Concluding Observations: Croatia. UN Doc. CCPR/C/HRV/CO/2. November 4, 2009. para. 12.

107. CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009. para. 13.

108. WHO European Region. Scaling up HIV testing and counselling in the WHO European Region as an essential component of efforts to achieve universal access to HIV prevention, treatment, care and support. Policy Framework. WHO/EURO 2010. p. 10.

*The State party should urgently review this measure to bring it into line with the [ICCPR], ensuring that any coercive measures arising from public health concerns are duly balanced against respect for patients' rights, guaranteeing judicial review and patient confidentiality and otherwise ensuring that persons with tuberculosis are treated humanely.*¹⁰⁹

Right to Bodily Integrity in the Context of Sexual and Reproductive Health

The right to security of person safeguards the person's right to control her/his health and body. Physical acts on the individual's body done without her/his consent (such as forced sterilization) have been deemed "acts of violence."¹¹⁰ Treaty-monitoring bodies have recognized that practices, such as genital mutilation, can infringe girls' right to personal security and their physical and moral integrity by threatening their lives and health.¹¹¹ In the case of forced sterilization, governments should take the necessary measures to prevent such acts, such as holding health care providers criminally liable for conducting sterilizations without the individual's free, full, and informed consent.¹¹²

CONCLUDING OBSERVATIONS ON THE CZECH REPUBLIC RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO BODILY INTEGRITY

The Committee notes with concern that women, a high proportion of which being Roma women, have been subjected to coerced sterilization. It welcomes the inquiries undertaken by the Public Defender of Rights on this matter, but remains concerned that to date, the State party has not taken sufficient and prompt action to establish responsibilities and provide reparation to the victims...

*The State party should take strong action, without further delay, to acknowledge the harm done to the victims...and recognize the particular situation of Roma women in this regard. It should take all necessary steps to facilitate victims' access to justice and reparation, including through the establishment of criminal responsibilities and the creation of a fund to assist victims in bringing their claims. The Committee urges the State party to establish clear and compulsory criteria for the informed consent of women prior to sterilization and ensure that criteria and procedures to be followed are well known to practitioners and the public.*¹¹³

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO SECURITY OF PERSON

Szjijarto v. Hungary (CEDAW Committee) (2006). The Committee found that the sterilization of a Roma woman without her informed consent amounted to a violation of Article 12 of CEDAW (among others) and underscored that "acceptable services" are those performed with the woman's full and informed consent and reiterated the obligation of States Parties to prevent forms of coercion, such as non-consensual sterilization.¹¹⁴

109. CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009.

110. UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [UN Special Rapporteur on the Right to Health]. UN Doc. E/CN.4/2005/51. February 11, 2005. para. 38; Human Rights Watch [HRW]. Sterilization of Women and Girls with Disabilities: A Briefing Paper. November 10, 2011.

111. CEDAW Committee. Concluding Observations: Burkina Faso. UN Doc. A/55/38 (Supp). August 17, 2000. para. 261.

112. CAT Committee. Concluding Observations: Slovakia. UN Doc. CAT/C/SVK/CO/2. December 31, 2009. para. 10.

113. CERD. Concluding Observations: Czech Republic. UN Doc. CERD/C/CZE/CO/7. April 11, 2007. para 14.

114. CEDAW Committee. Communication No. 4/2004: Szjijarto v. Hungary. UN Doc. A/61/38. August 14, 2006. section 11.3.

2.3.5 RIGHT TO LIFE

The right to life protects the individual from the imposition of the death sentence when the process on which the judgment is based does not meet the requirements under international human rights law (ICCPR, Art. 14).¹¹⁵ In addition, the right to life involves substantive obligations on the part of the state to (1) refrain from the use of actual or potentially lethal force by state officials unless absolutely necessary, and (2) protect the life of individuals at risk of harm by non-state actors. It also includes a procedural obligation on the part of the state to conduct effective investigations into deaths (other than those arising from natural causes).

The right to life is not to be interpreted narrowly and “requires that States adopt positive measures...to increase life expectancy.”¹¹⁶ For example, as it relates to patient care, the right to life requires that the government always fulfill its duty to regulate and monitor private health care institutions in order to protect this right.¹¹⁷

Under the right to life, the government must provide a minimum level of health services and essential medication that ensures a patient’s good health. If health care services are inadequate and lead to the patient’s death, then, depending on the circumstances, the government may be held responsible for the mismanagement of health care resources and the death of the patient.¹¹⁸

RELEVANT PROVISIONS

- ▶ **UDHR, Art. 3: Everyone has the right to life, liberty and security of person.**
- ▶ **ICCPR, Art. 6(1): Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.**
- ▶ **CRC, Art. 6:**
 - 1) States Parties recognize that every child has the inherent right to life.
 - 4) States Parties shall ensure to the maximum extent possible the survival and development of the child.
- ▶ **ICRPD, Art. 10: States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.**
- ▶ **ICMW**
 - **Art. 9:** The right to life of migrant workers and members of their families shall be protected by law.
 - **Art. 28:** Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.

115. CCPR. Communication No. 1520/2006: Mwamba v. Zambia. UN Doc. CCPR/C/98/D/1520/2006. April 30, 2010. para 6.8.

116. CCPR. CCPR General Comment 6: The right to life (Art. 6). April 30, 1982. paras. 1, 5.

117. CEDAW Committee. Communication No. 17/2008: Teixeira v. Brazil. UN Doc. CEDAW/C/49/D/17/2008. September 27, 2011. para 7.4.

118. CCPR. Communication 763/1997: Lantsova v. the Russian Federation. UN Doc. CCPR/C/74/D/763/1997. March 26, 2002. para 9.2; see CCPR. Communication No. 1556/2007: Novaković v. Serbia. UN Doc. CCPR/C/100/D/1556/2007. November 2, 2010.

Right to Life in the Context of Mental Health

In the context of mental health, the right to life acquires even greater importance. The government has a special duty to protect patients with mental disabilities —taking the appropriate health care measures for the protection of patients' lives.¹¹⁹ This right requires the government to ensure the right of life of persons deprived of their liberty even in the absence of a request for protection.¹²⁰

CONCLUDING OBSERVATIONS ON AUSTRALIA RELATING TO MENTAL HEALTH AND THE RIGHT TO LIFE

The Committee is concerned that the State party's level of funding for mental health continues to be substantially below that of other developed countries, with children and young persons seeking mental health services often facing limited access to and substantial delays in receiving such services. In this context, the Committee shares the concerns stated in the health study published by the Australian Institute of Health and Welfare in 2010 indicating that poor mental health is the leading health issue for children and young people and the largest contributor to the burden of disease in children aged 0-14 years (23 per cent) and young people aged 15-24 years (50 per cent). Furthermore, the Committee is concerned about the high rate of suicidal deaths among young people throughout the State party, particularly among the Aboriginal community. The Committee notes as positive that the State party's territory of Western Australia has carried out research investigating the effectiveness of drugs currently used to treat Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD). However, the Committee remains concerned that current diagnosis procedures may not be adequately addressing the underlying mental health issues linked to it resulting in significant increases and/or erroneous prescription of psycho-stimulants to children diagnosed with ADHD and ADD which is of serious concern.

Emphasizing the importance of access to child and youth-friendly mental health support and services, the Committee recommends that the State party:

- (a) Follow-up on the Australian Institute of Health and Welfare health study with measures designed to address the direct and underlying causes of the high rates of mental health problems in children and young people, focusing [sic] especially on suicides and other disorders linked to, inter alia, substance abuse, violence and inadequate quality of care in alternative care settings;*
- (b) Allocate specific resources for improving the availability and quality of early intervention services, training and development of teachers, counsellors, health professionals and others working with children, as well as support to parents;*
- (c) Develop specialized health services and targeted strategies for children at particular risk of mental health problems, and their families, and ensure accessibility for all those requiring such services with due consideration to their age, sex, socio-economic background, geographical and ethnic origin, etc;*
- (d) In planning and implementing the above, consult with children and youth for the development of these measures while undertaking awareness-raising on mental health, with a view to ensuring better family and community support as well as to reducing the associated stigma;*
- (e) Carefully monitor the prescription of psycho-stimulants to children and take initiatives to provide children diagnosed with ADHD and ADD, as well as their parents and teachers, with access to a wider range of psychological, educational and social measures and treatments; and, consider undertaking the collection and analysis of data disaggregated according to the type of substance- and age with a view to monitoring the possible abuse of psycho-stimulant drugs by children.¹²¹*

119. ECtHR. *Dodov v. Bulgaria* (59548/00). April 17, 2008.

120. CCPR. Communication No. 763/1997: *Lantsova v. The Russian Federation*. UN Doc. CCPR/C/74/D/763/1997. March 26, 2002. para 9.2.

121. CRC Committee. *Concluding Observations: Australia*. UN Doc. CRC/C/AUS/CO/4. August 28, 2012. paras. 64-65.

Right to Life in the Context of Infectious diseases

According to the CCPR, under the right to life, governments should “take all possible measures to ... increase life expectancy, especially in adopting measures to eliminate ... epidemics.”¹²² Perceived as the most basic human right, the right to life has been useful in advocating prevention and access to medicines and treatment. The right to life has played a critical role in governments’ response to infectious diseases like HIV/AIDS, and continues to be used by litigants and advocates alike to pressure governments to adopt measures that are necessary for protecting the lives of persons living with HIV/AIDS.¹²³

CONCLUDING OBSERVATIONS ON UGANDA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO LIFE

While the Committee takes note of the measures taken by the State party to deal with the widespread problem of HIV/AIDS, it remains concerned about the effectiveness of these measures and the extent to which they guarantee access to medical services, including antiretroviral treatment, to persons infected with HIV ([ICCPR,] art. 6).

The State party is urged to adopt comprehensive measures to allow a greater number of persons suffering from HIV/AIDS to obtain adequate antiretroviral treatment.¹²⁴

Right to Life in the Context of Sexual and Reproductive Health

In the context of sexual and reproductive health, the right to life has been used to call for measures that safeguard the lives of individuals, particularly women resorting to unsafe abortions—one of the major causes of maternal mortality in the world. Governments have been called to adopt comprehensive abortion laws, especially in cases of rape and incest and for therapeutic reasons.¹²⁵ For example, a state should take measures to help women avoid unsafe abortions,¹²⁶ such as decriminalizing abortion, ensuring access to reproductive health services,¹²⁷ making contraceptives widely available, and establishing health care facilities in rural areas.¹²⁸

CONCLUDING OBSERVATIONS ON CAMEROON RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO LIFE

While noting the efforts by the State party, jointly with international partners, to improve access to reproductive health services, the Committee remains concerned about high maternal mortality and about abortion laws which may incite women to seek unsafe, illegal abortions, with attendant risks to their life and health. It is also concerned about the unavailability of abortion in practice even when the law permits it, for example in cases of pregnancy resulting from rape. ([CCPR,] art. 6)

The State party should step up its efforts to reduce maternal mortality, including by ensuring that women have access to reproductive health services. In this regard, the State party should amend its legislation to effectively help women avoid unwanted pregnancies and protect them from having to resort to illegal abortions that could endanger their lives.¹²⁹

122. CCPR. CCPR General Comment 6: The right to life (Art. 6). April 30, 1982. para. 5.

123. See Open Society Foundations, Ford Foundation, and UNDP. Factsheet: Human Rights & the Three Diseases. October 5, 2011.

124. CCPR. Concluding Observations: Uganda. UN Doc. CCPR/CO/80/UGA. May 4, 2004. CCPR. para. 14.

125. United Nations. Report of the Human Rights Committee. UN Doc. A/67/40 (Vol. I). 2012. p. 46-47, para

126. United Nations. Report of the Human Rights Committee. UN Doc. A/65/40 (Vol. I). 2009. p. 51, para 10.

127. United Nations. Report of the Human Rights Committee. UN Doc. A/65/40 (Vol. I). 2009. p. 94-95, para

128. United Nations. Report of the Human Rights Committee. UN Doc. A/66/40 (Vol. I). 2011. p. 28-29, para

129. CCPR. Concluding Observations: Cameroon. UN Doc. CCPR/C/CMR/CO/4. August 4, 2010. para. 13.

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO LIFE

da Silva Pimentel Teixeira v. Brazil (CEDAW Committee) (2011). The Committee found that the government's failure to ensure appropriate pregnancy-related medical treatment and to provide timely emergency obstetric care to the patient (both of which were found to have led to her death) constituted a violation of the right to life.¹³⁰

2.3.6 RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The right to the highest attainable standard of health (hereinafter "right to health") is the right of everyone to enjoy the highest attainable standard of both mental and physical health. The right to health requires that facilities, goods, and services be available, accessible, acceptable, and of quality. In other words, under this right, states have the obligation to make available health care facilities, goods and services in sufficient quantity and accessible to everyone physically, economically and without discrimination.¹³¹ Health facilities, goods and services must be respectful of medical ethics, culturally acceptable, scientifically and medically appropriate and of good quality.¹³² The right to health extends not only to appropriate and accessible health care but also to the underlying determinants of health, such as access to safe and potable drinking water, and adequate supply of safe food, nutrition and housing.¹³³

The ICESCR allows States Parties to "progressively realize" the right to health, recognizing the limitations that a state's resources may have on the state's ability to achieve the full realization of the right to health. However, it also establishes immediate obligations under which States Parties are to take "deliberate, concrete and targeted" steps towards the right's full realization—these include ensuring that the right is "exercised without discrimination of any kind (art. 2.2)."¹³⁴ The CESCR has been clear in that the "progressive realization" of the right does not strip away the "meaningful content" of States Parties' obligations. Instead, it means that States Parties have "a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of [the right to health]."¹³⁵ Moreover, States Parties are not allowed to take retrogressive measures, and if such measures are taken, the State Party must prove that these measures were taken "after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State Party's maximum available resources."¹³⁶

Violations of the right to health can result from both a deliberate act and a failure to act by the government.¹³⁷ In fact, states have been frequently condemned by the CESCR for failing to devote adequate

130. CEDAW Committee. Communication No. 17/2008: Maria de Lourdes da Silva Pimentel Teixeira v. Brazil. UN Doc. CEDAW/C/49/D/17/2008. September 27, 2011. para. 7.2.

131. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12; See CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Saudi Arabia. UN Doc. CEDAW/C/SAU/CO/2. April 8, 2008. paras. 33-34; CESCR. Concluding observation of the Committee on Economic, Social and Cultural Rights: Algeria. UN Doc. E/C.12/DZA/CO/4. June 7, 2010. para 20.

132. See CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12.

133. See CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 4.

134. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 30.

135. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 31.

136. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 32.

137. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. paras. 46-52.

resources to health care and services because of the obviously detrimental impact of that failure on patients.¹³⁸

Additionally, the right to health is inclusive and covers freedoms in addition to entitlements.¹³⁹ Such freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from non-consensual medical treatment and experimentation.¹⁴⁰

RELEVANT PROVISIONS

▶ UDHR, Art. 25:

- 1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
- 2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection..

▶ ICESCR, Art. 12:

- 1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- 2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: ... (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

▶ CRC

- **Art. 3(3):** States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.
- **Art. 24:**
 - 1) States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
 - 2) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;... (d) To ensure appropriate pre-natal and post-natal health care for mothers.

138. CESCR. Concluding Observations: Uruguay. UN Doc. E/C.12/1/Add.18. December 22, 1997. Alarm expressed at fact that very low wages paid to nurses led to a low ratio of nurses to doctors (lower than 1:5), tending to diminish the quality and accessibility of medical care available to the community; see also CESCR. Concluding Observations: Republic of the Congo. UN Doc. E/C.12/1/Add.45. May 23, 2000. Grave concern expressed at decline of standard of health, due in part to ongoing financial crisis, which resulted in serious shortage of funds for public health services; CESCR. Concluding Observations: Mongolia. UN Doc. E/C.12/1/Add.47. September 1, 2000. Deteriorating health situation for population since 1990 in light of decreasing government expenditure on health from 5.8 percent of GDP in 1991 to 3.6 percent in 1998.

139. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 8; UN Special Rapporteur on the Right to Health. Report on "Mental and the Right to Health." UN Doc. E/CN.4/2005/51. February 11, 2005. para. 38.

140. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 8.

▶ **CEDAW, Art. 12:**

- 1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
- 2) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

▶ **ICRPD, Art. 25:** States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programs as provided to other persons, including in the area of sexual and reproductive health and population-based public health programs;
- (b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- (c) Provide these health services as close as possible to people's own communities, including in rural areas;
- (d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

▶ **ICMW**

- **Art. 28:** Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.
- **Art. 43(1)(e):** Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to:...access to social and health services, provided that the requirements for participation in the respective schemes are met...
- **Art. 45(1)(c):** Members of the families of migrant workers shall, in the State of employment, enjoy equality of treatment with nationals of that State in relation to: access to social and health services, provided that requirements for participation in the respective schemes are met...
- **Art. 70:** States Parties shall take measures not less favorable than those applied to nationals to ensure that working and living conditions of migrant workers and members of their families in a regular situation are in keeping with the standards of fitness, safety, health and principles of human dignity.

Right to Health in the Context of Mental Health

The ICESCR, along with other relevant international legal instruments,¹⁴¹ have established that the right to health is not limited to physical health, but that it also includes the right to the highest attainable standard of mental health.¹⁴² For example, the CRC and the ICRPD have enshrined both aspects of the right and explicitly prohibit discrimination on grounds of disability. States, even those with very limited resources, are expected to adopt measures that protect this right for mental health patients, such as: the recognition, care and treatment of mental disabilities in training curricula of all health personnel; promot[ing] public campaigns against stigma and discrimination of persons with mental disabilities; support[ing] the formation of civil society groups that are representative of mental health-care users and their families; formulat[ing] modern policies and programmes on mental disabilities; downsiz[ing] psychiatric hospitals and, as far as possible, extend community care; in relation to persons with mental disabilities, actively seek[ing] assistance and cooperation from donors and international organizations; and so on.¹⁴³

CONCLUDING OBSERVATIONS ON AUSTRALIA RELATING TO MENTAL HEALTH AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The Committee notes with concern the insufficient support for persons with mental health problems, as well as the difficult access to mental health services, in particular for indigenous peoples, prisoners and asylum-seekers in detention. (arts. 2, para. 2; and 12)

The Committee recommends that the State party take effective measures to ensure the equal enjoyment of the right to the highest attainable standard of mental health, including by (a) allocating adequate resources for mental health services and other support measures for persons with mental -health problems in line with the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care; (b) implementing the recommendations of the Australian Medical Association's 2008 report on indigenous health; (c) reducing the high rate of incarceration of people with mental diseases; (d) ensuring that all prisoners receive an adequate and appropriate mental health treatment when needed.¹⁴⁴

Right to Health in the Context of Infectious Diseases

Under the right to health, persons suffering from infectious diseases have the right to access affordable treatment, such as antiretroviral therapy and appropriate health care services and counseling.¹⁴⁵ In the context of infectious diseases, states also have the obligation to prepare, prevent and respond to the threat of emerging infectious diseases. For example, states are required to implement effective public health surveillance and reporting systems.¹⁴⁶ Governments are also prohibited from discriminating against individuals based on their health status, such as HIV/AIDS and tuberculosis.¹⁴⁷

141. Such instruments are not limited to human rights instruments (see e.g., WHO Constitution).

142. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000; UN Special Rapporteur on the Right to Health. UN Doc. E/CN.4/2005/51. February 11, 2005. para. 32.

143. UN Special Rapporteur on the Right to Health. Report on "Mental Disability and the Right to Health." UN Doc. E/CN.4/2005/51. February 11, 2005. para. 35.

144. CESCR. Concluding Observations: Australia. UN Doc. E/C.12/AUS/CO/4. June 12, 2009. para. 30.

145. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12(b).

146. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 16.

147. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 18.

CONCLUDING OBSERVATIONS ON MAURITANIA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The Committee is concerned that the access to anti-retroviral-treatment (ARV) and prevention of parent to child transmission (PPTCT) services are inadequate; that testing and counselling services are insufficient; and that there is an overall lack of funds for prevention measures.

The Committee recommends, with reference to its general comment No. 3 (2003) on HIV/AIDS and the rights of the child and to the International Guidelines on HIV/AIDS and Human Rights, that the State party:

(a) Ensure the full and effective implementation of a comprehensive policy to prevent HIV/AIDS with adequate targeting of areas and groups that are the most vulnerable;

(b) Strengthen its efforts to combat HIV/AIDS, including through awareness-raising campaigns.¹⁴⁸

Right to Health in the Context of Sexual and Reproductive Health

UN treaty-monitoring bodies have linked maternal mortality to a “lack of comprehensive reproductive health services, restrictive abortion laws, unsafe or illegal abortion, adolescent childbearing, child and forced marriage, and inadequate access to contraceptives.”¹⁴⁹ Moreover, the UN Human Rights Council has declared maternal mortality a human rights violation and has called on states to take the necessary measures to prevent it.¹⁵⁰ For example, in addition to facilitating access to contraceptives and family planning,¹⁵¹ governments are to ensure the establishment of “education and training programmes to

148. CRC Committee. Concluding Observations: Mauritania. UN Doc. CRC/C/MRT/CO/2/Corr.1. July 21, 2009. paras. 57-58.

149. Center for Reproductive Rights. ICPD and Human Rights: 20 years of advancing reproductive rights through UN treaty bodies and legal reform. June 2013. p. 2, citing as examples: CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Malawi. UN Doc. CEDAW/C/MWI/CO/5. February 3, 2006. para. 31; CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Mexico. UN Doc. CEDAW/C/MEX/CO/6. August 25, 2006. para. 32; CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Morocco. UN Doc. CEDAW/C/MAR/CO/4. April 8, 2008. para. 30; CCPR. Concluding Observations: Chile. UN Doc. CCPR/C/CHL/CO/5. May 18, 2007. para. 8; CCPR. Concluding Observations: Madagascar. UN Doc. CCPR/C/MDG/CO/3. May 11, 2007. para. 14; CCPR. Concluding Observations: Panama. UN Doc. CCPR/C/PAN/CO/3. April 17, 2008. para. 9; CRC Committee. Concluding Observations: Democratic People's Republic of Korea. UN Doc. CRC/C/15/Add.239. July 1, 2004. para. 50; CRC Committee. Concluding Observations: Guatemala. UN Doc. CRC/C/15/Add.154. July 9, 2001. para. 40; CRC Committee. Concluding Observations: Haiti. UN Doc. CRC/C/15/Add.202. March 18, 2003. para. 46; CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Eritrea. UN Doc. CEDAW/C/ERI/CO/3. February 3, 2006. para. 22; CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Mozambique. UN Doc. CEDAW/C/MOZ/CO/2. June 11, 2007. para. 36; CRC Committee. Concluding Observations: Sudan. UN Doc. CRC/C/15/Add.10. October 18, 1993. para. 10; CRC Committee. Concluding Observations: Chile. UN Doc. CRC/S/15/Add.173. April 3, 2002. para. 41.

150. Center for Reproductive Rights. ICPD and Human Rights: 20 years of advancing reproductive rights through UN treaty bodies and legal reform. June 2013. p. 2, citing as examples: CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Malawi. UN Doc. CEDAW/C/MWI/CO/5. February 3, 2006; CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Mexico. UN Doc. CEDAW/C/MEX/CO/6. August 25, 2006. para. 32; CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Morocco. UN Doc. CEDAW/C/MAR/CO/4. April 8, 2008. para. 30; CCPR. Concluding Observations: Chile. UN Doc. CCPR/C/CHL/CO/5. May 18, 2007; CCPR. Concluding Observations: Madagascar. UN Doc. CCPR/C/MDG/CO/3. May 11, 2007. para. 14; CCPR. Concluding Observations: Panama. UN Doc. CCPR/C/PAN/CO/3. April 17, 2008. para. 9; CRC Committee. Concluding Observations: Democratic People's Republic of Korea. UN Doc. CRC/C/15/Add.239. July 1, 2004. para. 50; CRC Committee. Concluding Observations: Guatemala. UN Doc. CRC/C/15/Add.154. July 9, 2001. para. 40; CRC Committee. Concluding Observations: Haiti. UN Doc. CRC/C/15/Add.202. March 18, 2003. para. 46; CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Eritrea. UN Doc. CEDAW/C/ERI/CO/3. February 3, 2006. para. 22; CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Mozambique. UN Doc. CEDAW/C/MOZ/CO/2. June 11, 2007. para. 36; CRC Committee. Concluding Observations: Sudan. UN Doc. CRC/C/15/Add.10. October 18, 1993. para. 10; CRC Committee. Concluding Observations: Chile. UN Doc. CRC/S/15/Add.173. April 3, 2002. para. 41.

151. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. paras. 14, 23, 34; CEDAW Committee. General Recommendation No. 21: Equality in marriage and family relations. UN Doc. A/49/38. 1994. para. 22; United Nations General Assembly. Interim report of the UN Special Rapporteur on the Right

encourage health providers to change their attitudes and behaviour in relation to adolescent women seeking reproductive health services and respond to specific health needs related to sexual violence.” Likewise, governments should develop “guidelines or protocols to ensure [reproductive] health services are available and accessible in public facilities.”¹⁵²

CONCLUDING OBSERVATIONS ON BENIN RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

While noting the efforts made by the State party to improve reproductive health care to women, the Committee remains concerned about the lack of access to adequate health care for women and girls, particularly in rural areas. It is concerned about the causes of morbidity and mortality in women, particularly the number of deaths due to illegal abortions, and about inadequate family planning services and the low rates of contraceptive use. The Committee expresses its concern that women require the permission of their husbands to obtain contraceptives and family planning services.

*The Committee recommends that the State party take measures, in accordance with general recommendation 24 on women and health, to improve and increase women’s access to health care and health-related services and information, particularly in rural areas. It calls on the State party to improve the availability of sexual and reproductive health services, including family planning, with the aim also of preventing clandestine abortions, and to make available, without requiring the permission of the husband, contraceptive services to women and girls. It further recommends that sex education be widely promoted and targeted at girls and boys, with special attention to the prevention of early pregnancies and sexually transmitted diseases.*¹⁵³

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

da Silva Pimentel Teixeira v. Brazil (CEDAW Committee) (2011). The Committee found that the government’s failure to ensure that the activities of private institutions providing medical services are appropriate and in line with health policies and practices attributed to the death of the patient and constituted a violation of the right to health.¹⁵⁴

L.C. v. Peru (CEDAW Committee) (2009). The Committee found a violation of Article 12 of CEDAW where the state refused to terminate the woman’s pregnancy that put her life and health at risk. The Committee recalled that states had the obligation of taking “all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.” The Committee also emphasized that a state cannot refuse to provide “certain reproductive health services for women”—a state’s duty to “ensure, on a basis of equality between men and women, access to health-care services, information and education implies an obligation to respect, protect and fulfil women’s rights to health care.”¹⁵⁵

to Health. UN Doc. A/66/254. August 3, 2011. para. 65 (main focus: criminalization of sexual and reproductive health); CRC Committee. Concluding Observations: Australia. UN Doc. CRC/C/15/Add.268. October 20, 2005. para. 46(e); CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: China. UN Doc. CEDAW/C/CHN/CO/6. August 25, 2006. para. 32.

152. CEDAW Committee. Communication No. 22/2009: L.C. v. Peru. UN Doc. CEDAW/C/50/D/22/2009. November 4, 2011. para. 9.2(b).

153. CEDAW Committee. Report of the Committee on the Elimination of Discrimination against Women. UN Doc. A/60/38(SUPP). 2005. para. 157.

154. CEDAW Committee. Communication No. 17/2008: Maria de Lourdes da Silva Pimentel Teixeira v. Brazil. UN Doc. CEDAW/C/49/D/17/2008. September 27, 2011. para. 7.5.

155. CEDAW Committee. Communication No. 22/2009: L.C. v. Peru. UN Doc. CEDAW/C/50/D/22/2009. November 4, 2011. para. 8.11.

2.3.7 RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

The right to freedom from torture and other cruel, inhuman or degrading treatment or punishment (TCIDT) obligates the State to prevent and protect people from, and punish acts of, cruel, inhuman or degrading treatment and torture. In fact, as a *jus cogens* norm, this right is one of the few absolute non-derogable human rights under international law—meaning that the right is “untouchable” even in exceptional circumstances, such as war or threat of war.¹⁵⁶ Most human rights prohibitions against torture cover abuses ranging from torture to cruel and inhuman treatment to degrading treatment. The CCPR has hesitated to sharply distinguish different types of abuse, but has indicated that distinctions are based on the nature, purpose and severity of the treatment.¹⁵⁷ Moreover, while the CAT defines torture under Article 1, none of the international human rights treaties define cruel, inhuman and degrading treatment. However, Manfred Nowak, former UN Special Rapporteur on TCIDT, has made the distinction. According to Nowak, the difference does not stem from the degree of “intensity of the suffering being inflicted” or the “severity of the treatment,” but rather in “the purpose of the conduct, the intention of the perpetrator and the powerlessness of the victim.”¹⁵⁸ Torture consists of four essential elements: an act inflicting severe pain or suffering, whether physical or mental; the element of intent; the specific purpose; and the involvement of a State official, at least by acquiescence.¹⁵⁹ In contrast, CIDT is “the infliction of severe pain or suffering without purpose or intention and outside a situation where a person is under the de facto control of another.”¹⁶⁰ Juan Mendez, the current UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (Special Rapporteur on Torture), has defined CIDT as “acts falling short of [the torture] definition.”¹⁶¹

International human rights law explicitly protects patients against torture in health-care settings and requires the State to prevent, investigate, prosecute and punish violations by non-State actors.¹⁶² Where a violation has occurred, the obligation to provide an effective remedy under Article 2(3)(a) of the ICCPR can include the provision of appropriate medical and psychiatric care;¹⁶³ and where medical personnel participate in acts of torture, they should be held accountable and punished.¹⁶⁴

In his February 2013 report, the Special Rapporteur underscores the applicability of TCIDT in health-care settings, including the State’s obligation to not only prevent torture inflicted by public officials, but also by doctors, health-care professionals and social workers at public or private hospitals, detention centers, and any other institutions where health care is provided.¹⁶⁵ The Special Rapporteur clarifies that “[m]

156. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Addendum: Study on the phenomena of torture, cruel, inhuman or degrading treatment or punishment in the world, including an assessment of conditions of detention. UN Doc. A/HRC/13/39/Add.5. February 5, 2010. paras. 42, 186.

157. CCPR. General Comment 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment. October 3, 1992. para. 4.

158. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Addendum: Study on the phenomena of torture, cruel, inhuman or degrading treatment or punishment in the world, including an assessment of conditions of detention. UN Doc. A/HRC/13/39/Add.5. February 5, 2010. paras. 187-188.

159. CAT, Art. 1. See also UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Addendum: Study on the phenomena of torture, cruel, inhuman or degrading treatment or punishment in the world, including an assessment of conditions of detention. UN Doc. A/HRC/13/39/Add.5. February 5, 2010. para. 30.

160. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Addendum: Study on the phenomena of torture, cruel, inhuman or degrading treatment or punishment in the world, including an assessment of conditions of detention. UN Doc. A/HRC/13/39/Add.5. February 5, 2010. para. 188.

161. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Report on health-care settings. UN Doc. A/HRC/22/53. February 1, 2013.

162. CEDAW Committee. Communication No. 17/2008: Maria de Lourdes da Silva Pimentel Teixeira v. Brazil. UN Doc. CEDAW/C/49/D/17/2008. September 27, 2011. para. 7.5. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Report on health-care settings. UN Doc. A/HRC/22/53. February 1, 2013. para. 24.

163. CCPR. Communication No. 684/1996: Sahadath v. Trinidad and Tobago. UN Doc. CCPR/A/57/40 (Vol. II); CCPR/C/684/1996. April 2, 2002.

164. CAT Committee. Report of the Committee against Torture. UN Doc. A/48/44. 1993.

165. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Report on health-care settings. UN Doc. A/HRC/22/53. February 1, 2013. para. 24. See also CAT Committee. General Comment No.2: Implementation of Article 2 by States Parties. UN Doc. CAT/C/GC/2. January 24, 2008. para. 15.

edical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture.”¹⁶⁶ He explains that involuntary medical treatment, including forced sterilization, involuntary detention and compulsory treatment of people who use drugs, denial of pain treatment and available health services, and solitary confinement or prolonged detention of persons with mental disabilities, among others, constitute violations of the right to freedom from TCIDT. In addition to discussing the special situation of marginalized groups with respect to TCIDT in health-care settings, the Special Rapporteur highlights the obligations of states to prevent, prosecute, and redress violations of the right. Specifically, he recalls that redress shall not require that the abuse in health care settings fit the definition of torture.¹⁶⁷

With respect to detainees, denial to medical treatment and/or access to it when the individual is under custody can be considered cruel, inhuman or degrading treatment or punishment under international law.¹⁶⁸ In relation to Article 10(1), the CCPR has found a violation where a prisoner on death row was denied medical treatment¹⁶⁹ and where severe overcrowding in a pretrial detention center resulted in inhumane and unhealthy conditions, eventually leading to the detainee’s death.¹⁷⁰ Other examples of violations of Articles 7 and 10(1) include a case in which a detainee had been held in solitary confinement in an underground cell, was subjected to torture for three months, and was denied the medical treatment his condition required¹⁷¹ and a case where the combination of the size of the cells, hygienic conditions, poor diet, and lack of dental care resulted in a finding of a breach of Articles 7 and 10(1).¹⁷²

In addition, denying access to pain relief, if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment.¹⁷³ Denying a detainee direct access to her/his medical records, particularly where this may have consequences for her/his treatment, can likewise constitute a breach of Article 10(1).¹⁷⁴ Successive UN Special Rapporteurs on Torture have found numerous abuses of detainees’ health and access to health services that amount to breaches of prohibitions against torture and/or cruel, inhuman or degrading treatment. Special Rapporteurs have noted that conditions and the inadequacy of medical services are often worse for pretrial detainees than for prisoners.¹⁷⁵ Some of the worst abuses include: failure to provide new detainees with access to a medical professional and with sanitary living conditions;¹⁷⁶ failure to segregate those with contagious diseases such

166. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Report on health-care settings. UN Doc. A/HRC/22/53. February 1, 2013. para. 39.

167. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Report on health-care settings. UN Doc. A/HRC/22/53. February 1, 2013. para. 84.

168. United Nations Human Rights Council. Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Doc. A/HRC/10/44. January 14, 2009. para. 71.

169. CCPR. Communication No. 527/1993: Lewis v. Jamaica. UN Doc. CCPR/C/57/D/527/1993. July 18, 1996. Appointments to treat skin condition not kept over period of 2½ years; see also CCPR. Communication No. 232/1987: Pinto v. Trinidad and Tobago. UN Doc. CCPR/A/45/40 (Vol. II SUPP). July 20, 1990. The CCPR reaffirmed that the obligation to treat individuals deprived of their liberty with respect for the inherent dignity of the human person encompasses the provision of adequate medical care during detention and that this obligation, obviously, extends to persons under the sentence of death. However, the facts did not disclose a violation where the allegations of ill treatment and lack of medical care were uncorroborated and made at a late stage in the application; CCPR. Communication No. 571/1994: Henry and Douglas v. Jamaica. UN Doc. CCPR/A/51/40 (Vol. II SUPP); CCPR/C/57/D/571/1994. July 25, 1996. Keeping Henry in a cold cell after he was diagnosed for cancer breached Articles 7 and 10(1); CCPR. Communication No. 613/1995: Leehong v. Jamaica. UN Doc. CCPR/A/54/40 (Vol. II); CCPR/C/66/D/613/1995. July 13, 1999. Prisoner on death row only allowed to see a doctor once, despite sustained beatings by warders and request for medical attention.

170. CCPR. Communication No. 763/1997: Lantsova v. Russian Federation. UN Doc. CCPR/C/74/D/763/1997. March 26, 2002.

171. CCPR. Communication No. R.14/63: Setelich/Sendic v. Uruguay. UN Doc. CCPR/A/37/40. October 28, 1981.

172. CCPR. Communication No. 798/1998: Howell v. Jamaica. UN Doc. CCPR/A/59/40 (Vol. II); C/79/D/798/1998). October 21, 2003.

173. United Nations Human Rights Council. Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Doc. A/HRC/10/44. January 14, 2009. paras. 71-72.

174. CCPR. Communication No. 726/1996: Zheludkov v. Ukraine. UN Doc. CCPR/A/58/40 (Vol. II); CCPR/C/76/D/726/1996. October 29, 2002; see concurring opinion of Quiroga, which states that committee’s interpretation of Article 10(1) relating to access to medical records is unduly narrow and that mere denial of records is sufficient to constitute a breach, regardless of consequences.

175. United Nations Human Rights Council. Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment: Mission to Jordan. UN Doc. A/HRC/33/Add.3. January 5, 2007; United Nations Commission on Human Rights. Report of the UN Special Rapporteur on the question of torture: Mission to Uzbekistan. UN Doc. E/CN.4/2003/68/Add.2. February 3, 2003.

176. United Nations Commission on Human Rights. Report of the UN Special Rapporteur: Russian Federation. UN Doc. E/CN.4/1995/34/Add.1. November 16, 1994.

as tuberculosis;¹⁷⁷ completely unacceptable quarantine procedures;¹⁷⁸ insufficient provision of food, leading in some instances to conditions approaching starvation;¹⁷⁹ and mental suffering that could amount to mental torture.¹⁸⁰

RELEVANT PROVISIONS

- ▶ **UDHR, Art. 5:** No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- ▶ **ICCPR**
 - **Art. 7:** No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.
 - **Art. 10(1):** All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.
- ▶ **CAT**
 - **Art. 1:**
 - 1) For the purposes of this Convention, the term “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.
 - 2) This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application.
 - **Art. 2:**
 - 1) Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.
 - 2) No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.
 - 3) An order from a superior officer or a public authority may not be invoked as a justification of torture.
 - **Art. 4:**
 - 1) Each State Party shall ensure that all acts of torture are offences under its criminal law. The same shall apply to an attempt to commit torture and to an act by any person which constitutes complicity or participation in torture.

177. United Nations Commission on Human Rights. Report of the UN Special Rapporteur: Azerbaijan. UN Doc. E/CN.4/2001/66/Add.1. November 14, 2000.

178. United Nations Commission on Human Rights. Report of the UN Special Rapporteur: Azerbaijan. UN Doc. E/CN.4/2001/66/Add.1. November 14, 2000; United Nations Human Rights Council. Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Doc. A/HRC/10/44/Add.3. February 12, 2009.

179. United Nations Commission on Human Rights. Report of the UN Special Rapporteur: Kenya. UN Doc. E/CN.4/2000/9/Add.4. March 9, 2000.

180. UN Commission on Human Rights. Report on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: China. UN Doc. E/CN.4/2006/6/Add.6. March 10, 2006. para. 64.

2) Each State Party shall make these offences punishable by appropriate penalties which take into account their grave nature.

- **Art. 10:**

1) Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment.

- **Art. 13:** Each State Party shall ensure that any individual who alleges he has been subjected to torture in any territory under its jurisdiction has the right to complain to, and to have his case promptly and impartially examined by, its competent authorities. Steps shall be taken to ensure that the complainant and witnesses are protected against all ill treatment or intimidation as a consequence of his complaint or any evidence given.

- **Art. 14:**

1) Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependents shall be entitled to compensation.

2) Nothing in this article shall affect any right of the victim or other persons to compensation which may exist under national law.

- **Art. 16:**

1) Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

2) The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibits cruel, inhuman or degrading treatment or punishment or which relates to extradition or expulsion.

- ▶ **CRC**

- **Art. 37:** States Parties shall ensure that: (a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

- **Art. 39:** States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

- ▶ **ICRPD, Art. 15:**

1) No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2) States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

▶ ICMW

- **Art. 10:** No migrant worker or member of his or her family shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- **Art. 17(1):** Migrant workers and members of their families who are deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person and for their cultural identity.

Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment¹⁸¹

- ▶ **Principle 1:** All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person.
- ▶ **Principle 6:** No person under any form of detention or imprisonment shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. No circumstance whatever may be invoked as a justification for torture or other cruel, inhuman or degrading treatment or punishment.

Code of Conduct for Law Enforcement Officials¹⁸²

- ▶ **Art. 2:** In the performance of their duty, law enforcement officials shall respect and protect human dignity and maintain and uphold the human rights of all persons.
- ▶ **Art. 5:** No law enforcement official may inflict, instigate or tolerate any act of torture or other cruel, inhuman or degrading treatment or punishment, nor may any law enforcement official invoke superior orders or exceptional circumstances...as a justification of torture or other cruel, inhuman or degrading treatment or punishment.

Standard Minimum Rules for the Treatment of Prisoners¹⁸³

- ▶ **Rule 22:**
 - 1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.
 - 2) Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.
 - 3) The services of a qualified dental officer shall be available to every prisoner.
- ▶ **Rule 23:**
 - 1) In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.

181. United Nations General Assembly. United Nations General Assembly Resolution 43/173: Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment. UN Doc. A/RES/43/173. December 9, 1998.

182. United Nations General Assembly. United Nations General Assembly Resolution 34/169, annex: Code of Conduct for Law Enforcement Officials. UN Doc. A/34/46. February 5, 1980.

183. United Nations. Economic and Social Council Resolution 663 C (XXIV): Standard Minimum Rules for the Treatment of Prisoners. August 30, 1955.

- 2) Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.

▶ **Rule 24:** The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

▶ **Rule 25:**

- 1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.
- 2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

▶ **Rule 26:**

- 1) The medical officer shall regularly inspect and advise the director upon:
 - (a) The quantity, quality, preparation and service of food;
 - (b) The hygiene and cleanliness of the institution and the prisoners;
 - (c) The sanitation, heating, lighting and ventilation of the institution;
 - (d) The suitability and cleanliness of the prisoners' clothing and bedding;
 - (e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.
- 2) The director shall take into consideration the reports and advice that the medical officer submits according to rules 25 (2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

Freedom from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in the Context of Mental Health

The right to freedom from torture and cruel, inhuman and degrading treatment guarantees persons with disabilities the full exercise of their legal capacities and to exercise any procedural safeguard that is at their disposition.¹⁸⁴ In fact, the CCPR has made clear that Article 10(1) of the ICCPR “applies to any person deprived of liberty under the laws and authority of the State, who is held in a prison or hospital— particularly, in a psychiatric hospital—or in a detention camp, correctional institution, or elsewhere, and that States Parties should ensure that the principle stipulated therein is observed in all institutions and establishments within their jurisdiction where persons are being held.”¹⁸⁵ The CCPR has repeatedly reaffirmed that the obligation under Article 10(1) of the ICCPR to treat individuals with respect for the inherent dignity of the human person encompasses the provision of, inter alia, adequate medical care

184. United Nations. Report of the Human Rights Committee. UN Doc. A/65/40 (Vol. I). 2009. p. 40-41, para. 19.

185. CCPR. CCPR General Comment No. 21: Replaces general comment 9 concerning humane treatment of persons deprived of liberty (Art. 10) (Annex VI, B). UN Doc. A/47/40 [SUPP]. March 13, 1993. para. 2.

during detention.¹⁸⁶ Often in conjunction with Article 7, it has gone on to find breaches of this obligation on numerous occasions.¹⁸⁷ Specifically, in relation to persons suffering from mental health disabilities in detention facilities (both in prisons and mental health institutions), the CCPR has required improvements in hygienic conditions and the provision of regular exercise and adequate treatment.¹⁸⁸ Similarly, solitary confinement or deprivation of food is considered torture, and therefore illegal.¹⁸⁹

Additionally, the CAT Committee has identified overcrowding, inadequate living conditions and lengthy confinement in psychiatric hospitals as “tantamount to inhuman or degrading treatment.”¹⁹⁰ It has also condemned, in similar terms, extreme overcrowding in prisons where living and hygiene conditions would appear to endanger the health and lives of prisoners,¹⁹¹ in addition to lack of medical attention.¹⁹²

CONCLUDING OBSERVATIONS RELATING TO CHINA TO MENTAL HEALTH AND THE RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

For those involuntarily committed persons with actual or perceived intellectual and psychosocial impairments, the Committee is concerned that the “correctional therapy” offered at psychiatric institutions represents inhuman and degrading treatment. Further, the Committee is concerned that not all medical experimentation without free and informed consent is prohibited by Chinese law.

*The Committee urges the State party to cease its policy of subjecting persons with actual or perceived impairments to such therapies and abstain from involuntarily committing them to institutions. Further it urges the State party to abolish laws which allow for medical experimentation on persons with disabilities without their free and informed consent.*¹⁹³

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186. CCPR. Communication No. 256/1987: Kelly v. Jamaica. UN Doc. CCPR/C/41/D/253/1987. April 8, 1991. Breach of Article 10(1), where a prisoner contracted health problems as a result of a lack of basic medical care and was only allowed out of his cell for 30 minutes each day; see also CCPR. Communication No. 255/1987: Linton v. Jamaica. UN Doc. CCPR/C/46/D/255/1987. October 22, 1992. Denial of adequate medical treatment for injuries sustained during aborted escape attempt breached Articles 7 and 10(1); CCPR. Communication No. 334/1988: Bailey v. Jamaica. UN Doc. CCPR/C/47/D/334/1988. December 5, 1993; CCPR. Communication No. 321/1988: Thomas v. Jamaica. UN Doc. CCPR/C/49/D/321/1988. October 19, 1993; CCPR. Communication No. 414/1990: Mika Miha v. Equatorial Guinea. UN Doc. CCPR/C/51/D/414/1990. July 8, 1994; CCPR. Communication No. 653/1995: Colin Johnson v. Jamaica. UN Doc. CCPR/C/64/D/653/1995. October 20, 1998; CCPR. Communication No. 326/1988: Kalenga v. Zambia.. UN Doc. CCPR/C/48/D/326/1988. July 27, 1993.
187. CCPR. Communication No. 732/1997: Whyte v. Jamaica. UN Doc. CCPR/C/63/D/732/1997. July 27, 1998. Failure to treat asthma attacks and injuries sustained through beatings; see also CCPR. Communication No. 564/1993: Leslie v. Jamaica. UN Doc. CCPR/C/63/D/564/1993. July 31, 1998. Lack of adequate medical treatment for beatings and stabbing on basis that Leslie was due to be executed imminently; CCPR. Communication No. 610/1995: Henry v. Jamaica. UN Doc. CCPR/C/64/D/610/1995. October 20, 1995. Lack of medical treatment despite a recommendation from a doctor that prisoner be operated on; CCPR. Communication No. 647/1995: Pennant v. Jamaica. UN Doc. CCPR/C/64/D/647/1995. October 20, 1998; CCPR. Communication No. 719/1996: Levy v. Jamaica. UN Doc. CCPR/C/64/D/719/1996. November 3, 1998; CCPR. Communication No. 730/1996: Marshall v. Jamaica. UN Doc. CCPR/C/64/D/730/1996. November 3, 1998; CCPR. Communication No. 720/1996: Morgan and Williams v. Jamaica. UN Doc. CCPR/C/64/D/720/1996. November 3, 1998; CCPR. Communication No. 663/1995: Morrison v. Jamaica. UN Doc. CCPR/C/64/D/663/1995. November 3, 1998; CCPR. Communication No. 775/1997: Brown v. Jamaica. UN Doc. CCPR/C/65/D/775/1997. March 23, 1999; CCPR. Communication No. 590/1994: Bennett v. Jamaica. UN Doc. CCPR/C/65/D/590/1994. March 25, 1999; CCPR. Communication No. 668/1995: Smith and Stewart v. Jamaica. UN Doc. CCPR/C/65/D/668/1995. April 8, 1999; CCPR. Communication No. 962/2001: Mulezi v. Democratic Republic of the Congo. UN Doc. CCPR/C/81/D/962/2001. July 6, 2004; CCPR. Communication No. 964/2001: Saidov v. Tajikistan. UN Doc. CCPR/C/81/D/964/2001. July 8, 2004.
188. CCPR. Concluding Observations: Bosnia and Herzegovina. UN Doc. CCPR/C/BIH/CO/1. November 22, 2006.
189. United Nations. Report of the Human Rights Committee. UN Doc. A/65/40 (Vol. I). 2009. p. 90, para 21.
190. CAT Committee. Concluding and recommendation of the Committee against Torture: Russian Federation. UN Doc. CAT/C/RUS/CO/4. February 6, 2007.
191. CAT Committee. Concluding and recommendation of the Committee against Torture: Cameroon. UN Doc. CAT/C/CR/31/6. February 5, 2004.
192. CAT Committee. Concluding and recommendation of the Committee against Torture: Nepal. UN Doc. CAT/C/NPL/CO/2. April 13, 2007; see also CAT. Summary record of the first part of the 418th meeting: Paraguay. UN Doc. CAT/C/SR.418. January 11, 2001; see also CAT Committee. Summary record of the first part of the 471th meeting: Greece, Brazil. UN Doc. CAT/C/SR.471. May 21, 2001.
193. CRPD. Concluding Observations: China. UN Doc. CRPD/C/CHN/CO/1. October 15, 2012. para 27-28.

CASE RELATING TO MENTAL HEALTH AND THE RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

Williams v. Jamaica (CCPR) (1997). The Committee found that the government's failure to adequately treat the applicant, an inmate with a mental health condition that was exacerbated by being on death row, amounted to a breach of Articles 7 and 10(1) of the ICCPR.¹⁹⁴

Freedom from Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in the Context of Infectious Diseases

Under the right to freedom from torture and other cruel, inhuman or degrading treatment, the intentional transmission of an infectious disease, such as HIV/AIDS, is prohibited.¹⁹⁵ Likewise, this right requires that governments protect persons living with infectious diseases from torture and other cruel, inhuman or degrading treatment. For example, denying persons living with HIV "access to HIV-related information, education and means of prevention, voluntary testing, counselling, confidentiality and HIV-related health care and access to and voluntary participation in treatment trials could constitute cruel, inhuman or degrading treatment."¹⁹⁶ Likewise, forced sterilization of women living with HIV could amount to cruel, inhuman or degrading treatment.¹⁹⁷

Additionally, failing to segregate inmates with infectious diseases (such as tuberculosis) in prisons has been considered a violation of this right.¹⁹⁸ At the same time, persons suffering from infectious diseases may be more vulnerable to ill treatment.¹⁹⁹ They are likely to be denied access to information, prevention, testing, treatment and support.²⁰⁰

CONCLUDING OBSERVATIONS ON CHINA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

While the Committee notes that the Special Rapporteur on the question of torture has found the availability of medical care in the detention facilities he visited to be generally satisfactory (E/CN.4/2006/6/Add.6, para. 77), it also notes with concern new information provided about inter alia the lack of treatment for drug users and people living with HIV/AIDS and regrets the lack of statistical data on the health of detainees (art. 11).

194. CCPR. Communication No. 609/1995: Williams v. Jamaica. UN Doc. CCPR/C/61/D/609/1995. November 4, 1997.

195. United Nations Commission on Human Rights. Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Doc. E/CN.4/2004/56. December 23, 2003. paras. 52-53.

196. United Nations Commission on Human Rights. Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Doc. E/CN.4/2004/56. December 23, 2003. para. 54 (citing HIV/AIDS and Human Rights: International Guidelines, United Nations publication, Sales No. E.98.XIV.1, United Nations, New York and Geneva, 1998, para. 130); see also paras. 56-57 on access to medical care and treatment.

197. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Report on health-care settings. UN Doc. A/HRC/22/53. February 1, 2013. paras. 48, 71; see UN Special Rapporteur on the Right to Health. Report. UN Doc. A/64/272. August 10, 2009. para. 55.

198. See United Nations Commission on Human Rights. Report of the UN Special Rapporteur: Azerbaijan. UN Doc. E/CN.4/2001/66/Add.1. November 14, 2000; United Nations Human Rights Council. Reports of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Doc. A/HRC/10/44/Add.3. February 12, 2009.

199. United Nations Commission on Human Rights. Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Doc. E/CN.4/2004/56. December 23, 2003. para. 61.

200. United Nations Commission on Human Rights. Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Doc. E/CN.4/2004/56. December 23, 2003. para. 61.

*The State party should take effective measures to keep under systematic review all places of detention, including existing and available health services. Furthermore, the State party should take prompt measures to ensure that all instances of deaths in custody are independently investigated and that those responsible for such deaths resulting from torture, ill-treatment or wilful negligence are prosecuted. The Committee would appreciate a report on the outcome of such investigations, where completed, and about what penalties and remedies were provided.*²⁰¹

CASE RELATING TO INFECTIOUS DISEASES AND THE FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

McCallum v. South Africa (CCPR)(2010). The Committee found the government in violation of Article 7 where a prisoner is forced to strip in front of multiple other inmates, is severely beaten (dislocating his jaw and front teeth), is sexually degraded (including anal penetration by a police baton), is exposed to bodily fluids (including urine and fecal matter) and is denied HIV testing, medical treatment, and communication with legal counsel and family after the assault. Despite letters to a number of government officials, the author was unable to obtain HIV testing and, while police promised an investigation of the incident, no official action was taken.²⁰²

Freedom from Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in the Context of Sexual and Reproductive Health

Under the right to freedom from torture and other cruel, inhuman or degrading treatment, a state's failure to provide access to abortion services where the pregnancy would pose a risk on the woman's life or health, results from rape or incest, or where the fetus exhibits severe abnormalities, constitutes a violation of this right.²⁰³ Likewise, forced castration or sterilization has been treated as a breach of this right.²⁰⁴ Harmful traditional practices, such as female genital mutilation, have been considered cruel, inhuman and degrading treatment, and states are required to implement measures that prevent such practices.²⁰⁵

CONCLUDING OBSERVATIONS ON CHAD RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

The Committee expresses its serious concern at the high prevalence of sexual and gender-based violence, including FGM, rape and domestic violence in the State party. It is deeply concerned that violence

201. CAT Committee. Concluding Observations: China. UN Doc. CAT/C/CHN/CO/4. December 12, 2008. para. 12
202. CCPR. Communication No. 1818/2008: McCallum v. South Africa. UN Doc. CCPR/C/100/D/1818/2008. November 2, 2010. paras. 6.2-6.4.
203. CCPR. Communication No. 1153/2003: K.L. v. Peru. UN Doc. CCPR/C/85/D/1153/2003. November 22, 2005. para. 7; CCPR. Communication No: 1608/2007: L.M.R v. Argentina. UN Doc. CCPR/C/101/D/1608/2007. April 28, 2011. para. 9.2; CRC Committee. Concluding Observations: Chad. UN Doc. CRC/C/15/Add.107. August 24, 1999. para. 30; CRC Committee. Concluding Observations: Chile. UN Doc. CRC/C/CHL/CO/3. April 23, 2007. para. 56; CRC Committee. Concluding Observations: Costa Rica. UN Doc. CRC/C/CRI/CO/4. June 17, 2011. para. 64(c); CCPR. Concluding Observations: Guatemala. UN Doc. CCPR/C/GTM/CO/3. April 19, 2012. para. 20; ESCRC. Concluding Observations: Dominican Republic. UN Doc. E/C.12/DOM/CO/3. November 26, 2010. para. 29; ESCRC. Concluding Observations: Chile. UN Doc. E/C.12/1/Add.105. November 26, 2004. para. 53.
204. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Report on health-care settings. UN Doc. A/HRC/22/53. February 1, 2013. paras. 46, 48; United Nations. Report of the Human Rights Committee. UN Doc. A/65/40 (Vol. I). 2009. p. 20, para. 20.
205. United Nations. Report of the Human Rights Committee. UN Doc. A/67/40 (Vol. I). 2012. p. 62, para. 9.

against women is accompanied by a culture of silence and impunity that has impeded the investigation, prosecution and punishment of sexual and gender-based violence perpetrators, regardless of their ethnic group, for acts committed during conflict and post-conflict times. In this context, it also notes with concern that the vast majority of cases of domestic and sexual violence remain under-reported due to cultural taboos and the victims' fear of being stigmatized by their communities. It is further concerned that at least 45% of women in Chad have been subjected to FGM and it deeply regrets the lack of implementation of the Law on Reproductive Health (2002), which prohibits FGM, early marriages, domestic and sexual violence. Likewise, the Committee regrets the lack of information on the impact of the measures and programmes in place to reduce incidences of all forms of violence against women and girls. The Committee is also concerned about the availability of social support services, including shelters, for the victims.²⁰⁶

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

L.M.R v. Argentina (CCPR)(2011). The Committee found an Article 7 violation where a young mentally impaired woman became pregnant after being raped. Despite judicial authorization for an abortion, no hospital was willing to undertake the procedure – due in part to pressure from religious groups, to which Argentinian authorities failed to respond. The woman was forced to resort to an illegal abortion at a later stage in her pregnancy, resulting in psychological harm, including post-traumatic stress disorder.²⁰⁷

2.3.8 RIGHT TO PARTICIPATION IN PUBLIC POLICY

The right to participation in public policy has been treated as an underlying determinant of health,²⁰⁸ and in the context of health services, it is the right and opportunity of every person to participate in political processes and policy decisions affecting their health and wellbeing at the community, national and international levels.²⁰⁹ This opportunity must be meaningful, supported and provided to all citizens without discrimination. The right extends to participation in decisions about the planning and implementation of health care services, appropriate treatments, and public health strategies.

The CESCR has called for countries to adopt “a national public health strategy and plan of action” to be “periodically reviewed, on the basis of a participatory and transparent process.”²¹⁰ In addition, “[p]romoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people’s participation is secured by States.”²¹¹

206. CEDAW Committee. Concluding Observations: Chad. UN Doc. CEDAW/C/TCD/CO/1-4. October 21, 2011. para. 22.

207. CCPR. Communication No. 1608/2007: L.M.R v. Argentina. UN Doc. CCPR/C/101/D/1608/2007. April 28, 2011. para. 9.2.

208. Halabi, Sam. Health and Human Rights Journal. Volume 11, No 1. p. 51

209. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 11.

210. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 43(f).

211. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 54.

RELEVANT PROVISIONS

▶ **UDHR, Art. 21:**

- 1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
- 3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

▶ **ICCPR, Art. 25(a):** Every citizen shall have the right and the opportunity, without ... distinctions ... [t]o take part in the conduct of public affairs, directly or through freely chosen representatives..

▶ **ICESCR, Art. 12:**

- 1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- 2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: ...
 - (i) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (ii) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

▶ **CEDAW**

- **Art. 7(b):** State Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in particular, shall ensure to women, on equal terms with men, the right: ... (b) [t]o participate in the formulation of government policy and the implementation thereof.
- **Art. 14(2)(a):** The right of rural women to participate in development planning.

▶ **ICRPD, Art. 29:** States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake to:

- 1) Ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected, inter alia, by:
 - (i) Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use;
 - (ii) Protecting the right of persons with disabilities to vote by secret ballot in elections and public referendums without intimidation, and to stand for elections, to effectively hold office and perform all public functions at all levels of government, facilitating the use of assistive and new technologies where appropriate;
 - (iii) Guaranteeing the free expression of the will of persons with disabilities as electors and to this end, where necessary, at their request, allowing assistance in voting by a person of their own choice; ...

▶ **Declaration of Alma-Ata,²¹² Art. IV:** The people have the right and the duty to participate individually and collectively in the planning and implementation of their health care.

212. International Conference on Primary Health Care. Declaration of Alma-Ata. September 6, 1978.

▶ **IAPO Declaration on Patient-Centred Healthcare²¹³**

- **Principle 2. Choice and Empowerment:** Patients have a right and responsibility to participate, to their level of ability and preference, as a partner in making health care decisions that affect their lives. This requires a responsive health service which provides suitable choices in treatment and management options that fit in with patients' needs, and encouragement and support for patients and carers that direct and manage care to achieve the best possible quality of life. Patients' organizations must be empowered to play meaningful leadership roles in supporting patients and their families to exercise their right to make informed health care choices.
- **Principle 3. Patient involvement in health policy:** Patients and patients' organizations deserve to share the responsibility of health care policy-making through meaningful and supported engagement in all levels and at all points of decision-making, to ensure that they are designed with the patient at the center. This should not be restricted to health care policy but include, for example, social policy that will ultimately impact on patients' lives.

Right to Participation in Public Policy in the Context of Mental Health

The right to participation in public policy entitles individuals with intellectual disabilities or mental health problems to participate in public life on an equal basis with others, directly or through a chosen representative.²¹⁴ In fact, the participation of persons with mental disabilities “in decision-making processes that affect their health and development, as well as in every aspect of service delivery, is an integral part of the right to health.”²¹⁵ States are to ensure that persons with mental disabilities are involved “at all stages of the development, implementation and monitoring of legislation, policies, programmes and services relating to mental health and social support, as well as broader policies and programmes, including poverty reduction strategies, that affect them.”²¹⁶ Care and support providers, as well as family, should also be involved in the process.²¹⁷

However, while physical disabilities do not justify restrictions on this right, “mental incapacity may be a ground for denying a person the right to vote or to hold office.”²¹⁸ As of this writing, the CRPD has not issued its interpretation of Article 29 of the ICRPD outlining the article's scope of protection of this right.

CONCLUDING OBSERVATIONS ON CHINA RELATING TO MENTAL HEALTH AND THE RIGHT TO PARTICIPATION IN PUBLIC POLICY

The Committee is concerned about the disqualification from voting of all persons who are found to be incapable, by reason of their mental, intellectual or psychosocial disabilities of managing and administering their property and affairs under section 31(1) of the Legislative Council Ordinance and section 30 of the District Councils Ordinance (arts. 2, 25 and 26).

213. International Alliance of Patients' Organizations [IAPO]. Declaration on Patient-Centred Healthcare. February 2006. See also IAPO's Policy Statement on Patient Involvement.

214. FRA. The right to political participation of persons with mental health problems and persons with intellectual disabilities. October 2010.

215. UN Special Rapporteur on the Right to Health. Report on Mental Disability and the Right to Health. UN Doc. E/CN.4/2005/51. February 11, 2005. para. 59; see WHO. Montreal Declaration of Intellectual Disabilities. 2004.

216. UN Special Rapporteur on the Right to Health. Report on Mental Disability and the Right to Health. UN Doc. E/CN.4/2005/51. February 11, 2005. para. 60.

217. UN Special Rapporteur on the Right to Health. Report on Mental Disability and the Right to Health. UN Doc. E/CN.4/2005/51. February 11, 2005. para. 60.

218. CCPR. General Comment No. 25: The right to participate in public affairs, voting rights and the right of equal access to public service (Article 25). UN Doc. CCPR/C/21/Rev.1/Add.7. July 12, 1996. para. 10.

*Hong Kong, China, should revise its legislation to ensure that it does not discriminate against persons with mental, intellectual or psychosocial disabilities by denying them the right to vote on bases that are disproportionate or that have no reasonable and objective relation to their ability to vote, taking account of article 25, of the Covenant and article 29 of the Convention on the Rights of Persons with Disabilities.*²¹⁹

In this instance, the human rights in patient care connection is the right to influence public policy on health care issues, including issues relating to mental, intellectual, or psychosocial disabilities.

Right to Participation in Public Policy in the Context of Infectious Diseases

Persons living with infectious diseases, such as HIV/AIDS have the right to meaningful participation in designing and implementing policies that may impact them.²²⁰ States have been called to engage civil society, including patient groups, in the “formulation and implementation of public policies.”²²¹ As individuals who are most affected by public policies aimed at protecting the public’s health from infectious diseases, their engagement is crucial to creating comprehensive and successful public policy that not only protects the health of the larger community, but also respects the human rights of these individuals.

CONCLUDING OBSERVATIONS ON SURINAME RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO PARTICIPATION IN PUBLIC POLICY

The Committee is concerned about the situation of rural women...who are disadvantaged by poor infrastructure, limited markets, obstacles in availability and accessibility of agricultural land and agricultural credit, low literacy rates, ignorance of existing regulations, lack of services and environmental pollution. It notes with concern the serious absence of specific policies in all these areas, including on family planning and preventing the spread of sexually transmitted diseases, including HIV. The Committee is also concerned that women’s work in rural areas is not considered productive labour and that they are hardly represented at all in local government bodies...

*The Committee urges the State party to give full attention to the needs of rural women...to ensure that they benefit from policies and programmes in all areas, in particular access to health, education, social services and decision-making...*²²²

Right to Participation in Public Policy in the Context of Sexual and Reproductive Health

The right to participation in public policy is essential to protecting the sexual and reproductive health of women. The participation of the populations most affected by policies related to sexual and reproductive health helps to ensure that their needs, such as those related to family planning and access to contraceptives, are met. In addition to granting them a sense of ownership, the involvement of affected individuals can make the policies and implementation efforts more culturally appropriate and thereby increase access to individuals.²²³

219. CCPR. Concluding Observations on the third periodic report of Hong Kong, China. UN Doc. CCPR/C/CHN-HKG/CO/3. April 29, 2013. para. 24.

220. See Declaration of the Paris AIDS Summit. December 1, 1994; UNAIDS. UNAIDS Policy Brief: The Greater Involvement of People Living with HIV (GIPA). March 2007. p. 1.

221. See Declaration of the Paris AIDS Summit. December 1, 1994.

222. CEDAW Committee. Report of the Committee on the Elimination of Discrimination against Women. UN Doc. A/57/38(SUPP). 2002. paras. 65-66.

223. CRF and UNFPA. Briefing Paper: The Right to Contraceptive Information and Services for Women and Adolescents. 2011. p. 24.

CONCLUDING OBSERVATIONS ON MOROCCO RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO PARTICIPATION IN PUBLIC POLICY

The Committee is particularly concerned about the situation of rural women, their lack of participation in decision-making processes and their difficulty in accessing health care, public services, education, justice, clean water and electricity, which impairs seriously the enjoyment of their social, economic and cultural rights. The Committee is also concerned about the lack of data on the *de facto* situation of rural women.

The Committee recommends that the State party take temporary special measures, in accordance with article 4, paragraph 1, of the Convention, to ensure that rural women enjoy their political, social, economic and cultural rights without any discrimination, especially with regard to access to education and health care facilities. It also recommends that they are fully integrated in the formulation and implementation of all sectoral policies and programmes.²²⁴

2.3.9 RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

The right to equality and freedom from discrimination is crucial to the enjoyment of the right to health. Health care services and treatment must be accessible and provided without discrimination (in intent or effect) based on health status, race, ethnicity, age, sex, sexuality, sexual orientation, gender identity, disability, language, religion, national origin, income or social status.²²⁵ The CESCR has stated that health facilities, goods, and services have to be accessible to everyone without discrimination “and especially to the most vulnerable and marginalized sections of the population.”²²⁶ In particular, such health facilities, goods and services “must be affordable for all,” and “poorer households should not be disproportionately burdened with health expenses as compared to richer households.”²²⁷ It is worth highlighting that the protection from racial discrimination has been widely considered an obligation *erga omnes* under international law—meaning that even if a state has not ratified any convention prohibiting racial discrimination, it has a legal obligation to prohibit racial discrimination.²²⁸

Additionally, international discrimination law has distinguished direct discrimination from indirect discrimination, both of which are prohibited. Direct discrimination refers to discriminatory measures that has an intent to discriminate—it is “less favorable or detrimental” to an individual or group of individuals based on a “prohibited characteristic or ground such as race, sex or disability.”²²⁹ Indirect discrimination refers to “a practice, rule, requirement or condition [that] is neutral on its face” but has a negative and disproportionate impact on a group of individuals without justification.²³⁰ This type of discrimination includes stereotyping and acts of stigmatization. Therefore, while direct discrimination is defined by the *purpose*

224. CEDAW Committee. Concluding comments of the Committee on the Elimination of Discrimination against Women: Morocco. UN Doc. CEDAW/C/MAR/CO/4. April 8, 2008. paras. 32-33.
225. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12(b)(i), 18; CESCR. CESCR General Comment No. 20: Non-discrimination in economic, social and cultural rights (Art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights). UN Doc. E/C.12/GC/20. July 2, 2009. para. 32; CRC Committee. CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child. UN Doc. CRC/GC/2003/4. July 1, 2003. para. 6.
226. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12(b).
227. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12(b).
228. Timo Makkonen. *Equal in Law, Unequal in Fact: Racial and Ethnic Discrimination and the Legal Response Thereto in Europe*. Boston: Martinus Nijhoff Publishers, 2012. p. 117.
229. Interights. *Non-Discrimination in International Law: A Handbook for Practitioners*. 2011. 18.
230. Interights. *Non-Discrimination in International Law: A Handbook for Practitioners*. 2011. 18.

of the measure, indirect discrimination is defined the *effect* of the measure. For a more discussion on the issue, refer to Interights' "Non-Discrimination in International Law: A Handbook for Practitioners."²³¹

Under this right, states have an obligation to prohibit and eliminate discrimination on all grounds and ensure equality to all in relation to access to health care and the underlying determinants of health.²³² States should also recognize and provide for differences and specific needs of groups that experience particular health challenges, such as higher mortality rates or vulnerability to specific diseases.²³³ The CESCR has urged particular attention to the needs of "ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS."²³⁴ The CERD has recommended that the states that are party to the convention—as appropriate to their specific circumstances—ensure that they respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services.²³⁵ In fact, according to the CESCR, states are to ensure that health facilities, goods and services are available, accessible, acceptable, of good quality and applicable to all sectors of the population, including migrants.²³⁶ Similarly, the CRC Committee has emphasized that all children be afforded "sustained and equal access to comprehensive treatment and care, including necessary HIV-related drugs, goods and services on a basis of non-discrimination."²³⁷

UN treaty bodies have frequently condemned states for failing to ensure equal access to medical services (often due to a lack of sufficient resources) to marginalized and vulnerable groups. These groups have included indigenous people living in extreme poverty;²³⁸ refugees of a particular nationality;²³⁹ children, older persons, and persons with physical and mental disabilities;²⁴⁰ and those living in rural areas where the geographical distribution of health services and personnel shows a heavy urban bias.²⁴¹ With respect to one country alone, the CESCR noted with regret the differential treatment in providing access to health services between one group of refugees and another,²⁴² the lack of mental health services in the country,²⁴³ and the need to "reinforce reproductive and sexual health programmes, in particular in rural areas."²⁴⁴

231. Interights. *Non-Discrimination in International Law: A Handbook for Practitioners*. 2011.

232. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 18.

233. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 37.

234. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 12(b).

235. CERD. CERD General Comment No. 30: Discrimination Against Non-Citizens. UN Doc. A/59/18. October 1, 2004. para. 36.

236. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para.12.

237. CRC Committee. CRC General Comment No. 3: HIV/AIDS and the rights of the child. UN Doc. CRC/GC2003/3. March 17, 2003. paras. 21, 28.

238. CERD. Concluding Observations: Bolivia. UN Doc. CERD/C/304/Add.10. September 27, 1996; see also CESCR. Concluding Observations: Mexico. UN Doc. E/C.12/1/Add.41. December 8, 1999. State was urged to take more effective measures to ensure access to basic health care services for all children and to combat malnutrition, especially among children belonging to indigenous groups living in rural and remote areas.

239. United Nations. Report of the Committee on the Elimination of Racial Discrimination. UN Doc. A/56/18 (SUPP). 2003. Different standards of treatment are applied to Indochinese refugees compared to those from other nationalities.

240. CESCR. Concluding Observations: Finland. UN Doc. E/C.12/1/ Add.52. December 1, 2000. Failure of certain municipalities to allocate sufficient funds to health care services, resulting in inequality with regard to levels of provision depending on the place of residence.

241. CESCR. Concluding Observations: Mali. UN Doc. E/C.12/1994/17. December 21, 1994; see also CESCR. Concluding Observations: Guatemala. UN Doc. E/1997/22. May 17, 1996; CESCR. Concluding Observations: Paraguay. UN Doc. E/1997/22. May 14, 1996. Noting the very small number of medical and paramedical personnel in the country; also CESCR. Concluding Observations: Mongolia. UN Doc. E/2001/22. August 28, 2000. Noting the long-term deterioration in health situation and need to improve access to health care services for the poor and in rural areas.

242. CESCR. Concluding Observations: Nepal, 2001. UN Doc. E/2002/22. June 6, 2002. para. 545.

243. CESCR. Concluding Observations: Nepal, 2001. UN Doc. E/2002/22. June 6, 2002. para. 550.

244. CESCR. Concluding Observations: Nepal, 2001. UN Doc. E/2002/22. June 6, 2002. para. 571.

RELEVANT PROVISIONS

- ▶ **UDHR, Art. 7:** All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.
- ▶ **ICCPR, Art. 26:** All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
- ▶ **ICESCR, Article 2(2):** The States Parties to the present Covenant undertake to guarantee the rights enunciated in the present Covenant shall be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, birth or other status.
- ▶ **CERD, Art. 5:** In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: ... (e) Economic, social and cultural rights, in particular: ... (iv) The right to public health, medical care, social security and social services.
- ▶ **CEDAW**
 - **Art. 12:**
 - 1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
 - 2) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.
 - **Art. 14(2)(b):** States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right: To have access to adequate health care facilities, including information, counselling and services in family planning.
- ▶ **CRC, Art. 23:**
 - 1) States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
 - (2) States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

- (3) Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.
- (4) States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

▶ ICRPD

- **Art. 1:** The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
- **Art. 12:**
 - 1) States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
 - 2) States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
 - 3) States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
 - 4) States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law.
- **Art. 25:** States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.

▶ ICMW

- **Art. 7:** States Parties undertake, in accordance with the international instruments concerning human rights, to respect and to ensure to all migrant workers and members of their families within their territory or subject to their jurisdiction the rights provided for in the present Convention without distinction of any kind such as to sex, race, colour, language, religion or conviction, political or other opinion, national, ethnic or social origin, nationality, age, economic position, property, marital status, birth or other status.
- **Art. 28:** Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.

- **Art. 43:**
 - 1) Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to: (e) Access to social and health services, provided that the requirements for participation in the respective schemes are met;
 - 2) States Parties shall promote conditions to ensure effective equality of treatment to enable migrant workers to enjoy the rights mentioned in paragraph 1 of the present article whenever the terms of their stay, as authorized by the State of employment, meet the appropriate requirements.

- **Art. 45(1)(c):** Members of the families of migrant workers shall, in the State of employment, enjoy equality of treatment with nationals of that State in relation to: ...access to social and health services, provided that requirements for participation in the respective schemes are met.

Declaration of Lisbon on the Rights of the Patients (WMA),²⁴⁵

- ▶ **Principle 1(a):** Every person is entitled without discrimination to appropriate medical care.

IAP0 Declaration on Patient-Centred Healthcare,²⁴⁶

- ▶ **Principle 4:** Patients must have access to the health care services warranted by their condition. This includes access to safe, quality and appropriate services, treatments, preventive care and health promotion activities. Provision should be made to ensure that all patients can access necessary services, regardless of their condition or socio-economic status. For patients to achieve the best possible quality of life, health care must support patients' emotional requirements, and consider non-health factors such as education, employment and family issues which impact on their approach to health care choices and management.

WMA Resolution on Medical Care for Refugees:²⁴⁷

Physicians have a duty to provide appropriate medical care regardless of the civil or political status of the patient, and governments should not deny patients the right to receive, nor should they interfere with physicians' obligation to administer, adequate treatment; and Physicians cannot be compelled to participate in any punitive or judicial action involving refugees or IDPs or to administer any non-medically justified diagnostic measure or treatment, such as sedatives to facilitate easy deportation from the country or relocation; and Physicians must be allowed adequate time and sufficient resources to assess the physical and psychological condition of refugees who are seeking asylum.

Right to Equality and Freedom from Discrimination in the Context of Mental Health

The right to equality and freedom from discrimination protects individuals with mental disabilities from various forms of stigma and discrimination. For example, those with mental disabilities often face discrimination in accessing general health care services, or stigmatizing attitudes from service providers, which may dissuade them from seeking care in the first place. The right to equality and freedom from discrimination prohibits stigma from leading to the inappropriate institutionalization of persons with men-

245. WMA. Declaration on the Rights of the Patient. September/October 1981.

246. IAP0. Declaration on Patient-Centred Healthcare. February 2006.

247. WMA. Resolution on Medical Care for Refugees. 50th World Medical Assembly. October 1998.

tal disabilities against their will. Under this right, decisions to isolate or segregate persons with mental disabilities, including through unnecessary institutionalization, are inherently discriminatory and contrary to the right of community integration enshrined in international standards. Isolation in itself can also deepen stigma surrounding mental disability.²⁴⁸

Freedom from discrimination on the basis of disability is at the core of the ICRPD—without it, persons with disabilities are not able to enjoy all of their human rights and fundamental freedoms. Under Article 25, States Parties must “take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.” States Parties must also ensure that health professionals “provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.”²⁴⁹

Other international treaties and regional treaties, such as the ICRPD and the CRC, prohibit discrimination on grounds of disability.²⁵⁰ The ICESCR does not explicitly refer to disability as a prohibited ground of discrimination, but interpretative documents adopted by the CESCR have interpreted the ICESCR as prohibiting discrimination on this ground.²⁵¹ In fact, the CESCR has defined disability-based discrimination as “any distinction, exclusion, restriction or preference, or denial of reasonable accommodation based on disability which has the effect of nullifying or impairing the recognition, enjoyment or exercise of economic, social or cultural rights.”²⁵² It has gone on to emphasize the need “to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.”²⁵³ The CESCR has also criticized governments for providing inadequate medical care provided to low-income patients and urged states to subsidize expensive drugs required by chronically ill and mentally ill patients.²⁵⁴

CONCLUDING OBSERVATIONS ON CHINA RELATING TO MENTAL HEALTH AND RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

The Committee is concerned about the reported persistence of discrimination against persons with physical and mental disabilities, especially in terms of employment, social security, education and health.

The Committee recommends that the State party adopt effective measures to ensure equal opportunities for persons with disabilities, especially in the fields of employment, social security, education and health, to provide for more appropriate living conditions for persons with disabilities and to allocate adequate resources for improving the treatment of, and care for, persons with disabilities. The Committee requests the State party to provide detailed information in its second periodic report on the measures undertaken with regard to persons with physical and mental disabilities.²⁵⁵

248. UN Special Rapporteur on the Right to Health. Report on Mental Disability and the Right to Health. UN Doc. E/CN.4/2005/51. February 11, 2005. paras. 52-56.

249. ICRPD. Article 25(f).

250. Convention on the Rights of the Child. Article 2.

251. UN Special Rapporteur on the Right to Health. Report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN Doc. E/CN.4/2005/51. February 11, 2005. para. 31.

252. CESCR. CESCR General Comment No. 5: Persons with disabilities. December 9, 1994. para. 15.

253. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. August 11, 2000. para. 26.

254. CESCR. Concluding Observations: People's Republic of China (including Hong Kong and Macao). UN Doc. E/C.12/1/Add.107. May 13, 2005; see also CESCR. Concluding Observations: Russian Federation. UN Doc. E/C.12/1/ADD.94. December 12, 2003. Committee criticizes Russia for frequent failure of hospitals and clinics in poor regions to stock essential drugs.

255. CESCR. Concluding Observations: People's Republic of China (including Hong Kong and Macao). UN Doc. E/C.12/1/Add.107. May 13, 2005. paras. 16, 47.

Right to Equality and Freedom from Discrimination in the Context of Infectious Diseases

The right to equality and freedom from discrimination protects a person infected with a communicable disease, such as HIV/AIDS or tuberculosis, from discrimination. Treaty-monitoring bodies have emphasized the importance of ensuring that those infected with particular diseases, such as HIV/AIDS, should not be the subject of discrimination and stigmatized as a result of their medical condition.²⁵⁶ States have an obligation to protect persons suffering from an infectious disease from discrimination or stigmatization in fields of education, employment, housing and health care. This may be accomplished, for example, through awareness-raising campaigns on HIV/AIDS or by amending legislation or regulatory frameworks that are discriminatory in intent or effect.²⁵⁷

CONCLUDING OBSERVATIONS ON MOLDOVA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

The Committee is concerned that persons infected with HIV/AIDS face discrimination and stigmatization in the State party, including in the fields of education, employment, housing and health care, and that foreigners are arbitrarily subjected to HIV/AIDS tests as part of the immigration rules framework. In particular, the Committee is concerned that patient confidentiality is not always respected by health-care professionals. It is also concerned that legislation prohibits the adoption of children with HIV/AIDS, thereby depriving them of a family environment. (arts. 2, 17 and 26)

The State party should take measures to address the stigmatization of HIV/AIDS sufferers through, inter alia, awareness-raising campaigns on HIV/AIDS, and should amend its legislation and regulatory framework in order to remove the prohibition on the adoption of children with HIV/AIDS, as well as any other discriminatory laws or rules pertaining to HIV/AIDS.²⁵⁸

CASE RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

Toonen v. Australia (CCPR)(1994). The Committee found that discriminating on the basis of sexual orientation constitutes “sex” discrimination and that criminalization of consensual sex between adult males was not a reasonable measure to prevent spread of HIV/AIDS.²⁵⁹

Right to Equality and Freedom from Discrimination in the Context of Sexual and Reproductive Health

Women and young people continue to suffer from unequal access to health services, a situation that frequently leads to high mortality rates.²⁶⁰ Both groups, particularly women living in rural areas²⁶¹ and

256. CEDAW Committee. Report of the Committee on the Elimination of Discrimination against Women. UN Doc. A/56/38 (SUPP). 2001; see also CESCR. Concluding Observations: Russian Federation. UN Doc. E/2004/22. November 28, 2003.

257. CCPR. Concluding Observations: Zimbabwe. UN Doc. CCPR/C/79/Add.89. April 6, 1998.

258. CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. October 29, 2009.

259. CCPR. Communication No. 488/1992: Toonen v. Australia. UN Doc. CCPR/C/50/D/488/1992. April 4, 1994. para. 8.7.

260. CESCR. Concluding Observations: Peru. UN Doc. E/1998/22. May 16, 1997. para. 145; see also CESCR. Concluding Observations: Ukraine. UN Doc. E/2002/22. August 29, 2001. Noting deterioration in the health of the most vulnerable groups, especially women and children, and in the quality of health services. Committee urges state to ensure that its commitment to primary health care is met by adequate allocation of resources and that all persons, especially from the most vulnerable groups, have access to health care.

261. CEDAW Committee. Report of the Committee on the Elimination of Discrimination against Women. UN Doc. A/55/38. 2000.

especially vulnerable groups of children (such as girls, indigenous children, and children living in poverty), will often experience multiple types of discrimination, requiring specific targeted measures and sufficient budgetary allocations.²⁶² To ensure equality between men and women in accessing health care, the CESCR has stated that the ICESCR requires, at a minimum, the removal of legal and other obstacles that prevent men and women from accessing and benefiting from health care on the basis of gender. This requirement includes, *inter alia*, addressing the ways in which gender roles affect access to determinants of health, such as water and food; the removal of legal restrictions on reproductive health provisions; the prohibition of female genital mutilation; and the provision of adequate training for health care workers to deal with women's health issues.²⁶³

CONCLUDING OBSERVATIONS ON UNITED STATES OF AMERICA RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

The Committee regrets that despite the efforts of the State party, wide racial disparities continue to exist in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African Americans, the high incidence of unintended pregnancies and greater abortion rates affecting African American women, and the growing disparities in HIV infection rates for minority women (art. 5 (e) (iv)).

The Committee recommends that the State party continue its efforts to address persistent racial disparities in sexual and reproductive health, in particular by:

- (i) Improving access to maternal health care, family planning, pre- and post- natal care and emergency obstetric services, inter alia, through the reduction of eligibility barriers for Medicaid coverage;*
- (ii) Facilitating access to adequate contraceptive and family planning methods; and*
- (iii) Providing adequate sexual education aimed at the prevention of unintended pregnancies and sexually-transmitted infections.²⁶⁴*

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

L.N.P. v. Argentina (CCPR)(2011). The Committee found discrimination both on the basis of ethnicity and gender under Article 26 where a 15-year-old member of an ethnic minority was sexually assaulted, was kept waiting for many hours before being seen, was roughly examined and was tested to determine whether she was a virgin, although this was irrelevant to investigating the attack. At trial, she was not informed of her right to appear as a plaintiff, no translation was provided, testimony by other members of her ethnic group was discounted as “nonsensical” and as motivated by ethnic animosity, and her three attackers were ultimately acquitted in an opinion that cited the victim's sexual promiscuity as a key factor.²⁶⁵

L.C. v. Peru (CEDAW Committee)(2009). The Committee found a violation of Article 12 of CEDAW where the state refused to terminate the woman's pregnancy that put her life and health at risk. The Committee recalled that states had the obligation of taking “all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.” The Committee also emphasized that a state cannot refuse to provide “certain reproductive health services for women”—states must

262. CRC Committee. Concluding Observations: Bolivia. UN Doc. CRC/C/16. March 5, 1993.

263. CESCR. CESCR General Comment 16: The equal right of men and women to enjoyment of all economic, social, and cultural rights (Art. 3 of the International Covenant on Economic, Social and Cultural Rights). UN Doc. E/C.12/2005/4. August 11, 2005.

264. CERD. Concluding Observations: United States of America. UN Doc. CERD/C/USA/CO/6. May 8, 2008. para. 33.

265. CCPR. Communication No. 1610/2007: L.N.P. v. Argentina. UN Doc. CCPR/C/102/D/1610/2007. August 16, 2011. para. 13.7.

“ensure, on a basis of equality between men and women, access to health-care services, information and education implies an obligation to respect, protect and fulfil women’s rights to health care.”²⁶⁶

2.3.10 RIGHT TO AN EFFECTIVE REMEDY

The right to an effective remedy requires that remedies for human rights violations be accessible and effective, and they must also adhere to “the special vulnerability of certain categories of person.”²⁶⁷ Accordingly, as explained by the CCPR, this right requires states to establish judicial and administrative mechanisms to ensure that human rights violations are effectively addressed at the domestic level.²⁶⁸ The right also entails at least compensatory relief and preventative measures.²⁶⁹ Although a remedy generally entails appropriate compensation, “reparation can, where appropriate, involve restitution, rehabilitation, and measures of satisfaction, such as public apologies, public memorials, guarantees of non-repetition and changes in relevant laws and practices, and actions to bring to justice the perpetrators of human rights violations.”²⁷⁰ Relevant to the context of patient care, the CESCR has made clear that states have the obligation to ensure that effective remedies are available for violations of economic, social and cultural rights.²⁷¹

The Torture Convention enshrines the right to an effective remedy in its own separate provision (Art. 14). However, the ICCPR has linked the right to an effective remedy to the right to fair trial. Article 14 of the treaty includes both a right to compensation and judicial guarantees, such access to court. It requires that the state ensure determination of the right to a remedy by a competent judicial, administrative, or legislative authority. The state must protect “alleged victims if their claims are sufficiently well-founded to be arguable under the [ICCPR].”²⁷²

RELEVANT PROVISIONS

▶ ICCPR

- **Art. 2(3):** Each State Party to the present Covenant undertakes:
 - (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
 - (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;
 - (c) To ensure that the competent authorities shall enforce such remedies when granted.

266. CEDAW Committee. Communication No. 22/2009: L.C. v. Peru. UN Doc. CEDAW/C/50/D/22/2009. November 4, 2011. para. 8.11.

267. CCPR. CCPR General Comment No. 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant. May 26, 2004. para. 15.

268. CCPR. CCPR General Comment No. 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant. May 26, 2004. para. 15.

269. CCPR. CCPR General Comment No. 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant. May 26, 2004. para. 15.

270. CCPR. General Comment No. 31 [80]: The nature of the general legal obligation imposed on States Parties to the Covenant. UN Doc. CCPR/C/21/Rev.1/Add.13. May 26, 2004. para. 16.

271. CESCR. Concluding Observations: United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories. UN Doc. E/C.12/GBR/CO/5. June 12, 2009. para. 13.

272. CCPR. Communication No. 972/01: George Kazantzis v. Cyprus. UN Doc. CCPR/C/78/D/972/2001. September 13, 2003. para. 6.6.

- **Art. 14:**

1. All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law....
6. When a person has by a final decision been convicted of a criminal offence and when subsequently his conviction has been reversed or he has been pardoned on the ground that a new or newly discovered fact shows conclusively that there has been a miscarriage of justice, the person who has suffered punishment as a result of such conviction shall be compensated according to law, unless it is proved that the non-disclosure of the unknown fact in time is wholly or partly attributable to him.

- ▶ **ICESCR, Art. 2(1):** Each state party to the present covenant undertakes to take steps, individually and through international assistance and cooperation, especially in economic and technical matters, to the maximum extent allowed by its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant by all appropriate means, including, particularly, the adoption of legislative measures...
- ▶ **CAT, Art. 14(1):** Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.

Right to an Effective Remedy in the Context of Mental Health

In highlighting the difficulties that patients of mental health could face in challenging violations of their rights, including in health care settings, treaty bodies have underscored the states' obligation to ensure that the necessary procedural and substantive safeguards are in place to protect these individuals, including the ability to access courts and full exercise their right to an effective remedy.²⁷³

CONCLUDING OBSERVATIONS ON BULGARIA RELATING TO MENTAL HEALTH AND THE RIGHT TO AN EFFECTIVE REMEDY

The Committee remains concerned that persons with mental disabilities do not have access to adequate procedural and substantive safeguards to protect themselves from disproportionate restrictions in their enjoyment of rights guaranteed under the Covenant. In particular, the Committee is concerned that persons deprived of their legal capacity have no recourse to means to challenge violations of their rights, that there is no independent inspection mechanism of mental health institutions and that the system of guardianship often includes the involvement of officials of the same institution as the confined individual (arts. 2, 9, 10, 25 and 26).

The State party should:

(a) Review its policy of depriving persons with mental disabilities of their legal capacity and establish the necessity and proportionality of any measure on an individual basis with effective procedural safeguards, ensuring in any event that all persons deprived of their legal capacity have prompt access to an effective judicial review of the decisions;

273. CCPR. Concluding Observations: Bulgaria. UN Doc. CCPR/C/BGR/CO/3. para. 17; CESCR. Concluding Observations: United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories. UN Doc. E/C.12/GBR/CO/5. June 12, 2009. para. 35.

(b) Ensure that persons with mental disabilities or their legal representatives are able to exercise the right to effective remedy against violations of their rights, and consider providing less restrictive alternatives to forcible confinement and treatment of persons with mental disabilities;...²⁷⁴

CASE RELATING TO MENTAL HEALTH AND THE RIGHT TO AN EFFECTIVE REMEDY

Williams v. Jamaica (CCPR)(1997). The Committee found that the government's failure to adequately treat the applicant, an inmate with a mental health condition that was exacerbated by being on death row, amounted to a breach of Articles 7 and 10(1) of the ICCPR. The Committee concluded that the individual was "entitled to an effective remedy, including in particular to appropriate medical treatment."²⁷⁵

Right to an Effective Remedy in the Context of Infectious Diseases

The right to an effective remedy has been invoked to protect the individuals with infectious diseases as marginalized populations that are stigmatized based on their health status. Treaty monitoring bodies, namely the CESCR, has expressed concern over the obstacles faced by such individuals in accessing the judicial system and have their claims be effectively addressed.²⁷⁶ The CESCR has also called on states to address deleterious prison conditions leading to high rates of infectious diseases, like tuberculosis, among inmates by providing them with medical treatment and improved detention conditions.²⁷⁷

CONCLUDING OBSERVATIONS ON INDIA RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO AN EFFECTIVE REMEDY

The Committee is deeply concerned that in spite of the Constitutional guarantee of non-discrimination as well as the criminal law provisions punishing acts of discrimination, widespread and often socially-accepted discrimination, harassment and/or violence persist against members of certain disadvantaged and marginalized groups, including women, scheduled castes and scheduled tribes, indigenous peoples, the urban poor, informal sector workers, internally-displaced persons, religious minorities such as the Muslim population, persons with disabilities and persons living with HIV/AIDS. The Committee is also concerned about the obstacles faced by the victims in accessing justice, including the high costs of litigation, the long delays in court proceedings and the non-implementation of court decisions by government authorities....

*The Committee ... urges the State party to step up efforts to remove obstacles faced by victims of discrimination when seeking redress through the courts.*²⁷⁸

CASE RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO AN EFFECTIVE REMEDY

Tornel et al. v. Spain (CCPR)(2006). The Committee concluded that the prison's failure to inform the detained individual's family of his severely-deteriorating condition related to his HIV-positive status constituted an arbitrary interference with the family and violated Article 17(1) of the ICCPR. The Committee found that the state had the obligation to provide the victims with effective remedy, including compensation.²⁷⁹

274. CCPR. Concluding Observations: Bulgaria. UN Doc. CCPR/C/BGR/CO/3. para. 17.

275. CCPR. Communication No. 609/1995: Williams v. Jamaica. UN Doc. CCPR/C/61/D/609/1995. November 4, 1997.

276. CESCR. Concluding Observations: India. UN Doc. E/C.12/IND/CO/5. August 8, 2008. para. 13.

277. CESCR. Concluding Observations: Ukraine. UN Doc. E/C.12/UKR/CO/5. January 4, 2008. paras. 49, 52.

278. CESCR. Concluding Observations: India. UN Doc. E/C.12/IND/CO/5. August 8, 2008. para. 13.

279. CCPR. Communication No. 1473/2006: Tornel v. Spain. UN Doc. CCPR/C/95/D/1473/2006. March 20, 2009. para. 7.4.

Right to an Effective Remedy in the Context of Sexual and Reproductive Health

The right to an effective remedy and its corresponding state obligations have been invoked in a number of sexual and reproductive health contexts. Treaty monitoring bodies have established that cases of involuntary sterilization require that states investigate, prosecute, and provide redress to the victims, including compensation.²⁸⁰ Concerned with the inability of involuntary sterilization victims to obtain redress, the CAT Committee has called on states to take the necessary measures to “investigate promptly, impartially and effectively” any instance of an alleged involuntary sterilization of Roma women, to extend the period of time allowed for victims to file complaints, and to hold those involved accountable in order to provide effective remedy to the victims.²⁸¹ Likewise, the CCPR has been clear on the importance of the state obligation to provide redress to victims of sexual violence.²⁸²

CONCLUDING OBSERVATIONS ON CZECH REPUBLIC RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO AN EFFECTIVE REMEDY

The Committee is concerned about the absence of statistical data concerning compensation to victims of torture and ill-treatment, including victims of involuntary sterilization and surgical castration as well as ill-treatment in medical and psychiatric settings, violent attacks against ethnic minorities, trafficking and domestic and sexual violence. It is also concerned about the time limits set for filing complaints (arts. 14 and 16).

The Committee recommends that the State party ensure that victims of torture and ill-treatment are entitled to and provided with redress and adequate compensation, including rehabilitation, in conformity with article 14 of the Convention. It recommends that the State party provide it with statistical data on the number of victims, including victims of involuntary sterilization and surgical castration as well as ill-treatment in medical and psychiatric settings, violent attacks against ethnic minorities, trafficking and domestic and sexual violence, who have received compensation and other forms of assistance. It also recommends the extension of the time limit for filing claims.²⁸³

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO AN EFFECTIVE REMEDY

da Silva Pimentel Teixeira v. Brazil (CEDAW Committee)(2011). The Committee found that the government’s failure to ensure appropriate pregnancy-related medical treatment and to provide timely emergency obstetric care to the patient (both of which were found to have led to her death) constituted a violation of the right to life. The Committee concluded that the state violated Articles 12 and 2(c) by failing to provide a system that could adequately ensure judicial protection and remedies for the victim.²⁸⁴

280. CRC Committee. Concluding Observations: Mozambique. UN Doc. CRC/C/15/Add.172. April 2, 2002. paras. 38-39.

281. CAT Committee. Concluding Observations: Czech Republic. UN Doc. CAT/C/CZE/CO/4-5. May 14-15, 2012. para. 12.

282. CAT Committee. Concluding Observations: Costa Rica. UN Doc. CAT/C/CRI/CO/2. July 7, 2008. para. 19; CEDAW Committee. Concluding Observations: Tanzania. UN Doc. CEDAW/C/TZA/CO/6. July 16, 2008. para. 120; CRC Committee. Concluding Observations: Lebanon. UN Doc. CRC/C/LBN/CO/3. June 8, 2006. paras. 47-48.

283. CAT Committee. Concluding Observations: Czech Republic. UN Doc. CAT/C/CZE/CO/4-5. May 14-15, 2012. para. 13.

284. CEDAW Committee. Communication No. 17/2008: Maria de Lourdes da Silva Pimentel Teixeira v. Brazil. UN Doc. CEDAW/C/49/D/17/2008. September 27, 2011. para. 7.2.

2.4 PROVIDER' RIGHTS

Health care providers play a critical role in addressing the abuses that take place in health care settings. As such, the application of the human rights framework to patient care implies that the interests of both patients and health care providers are to be protected. If providers are unable to fully exercise their rights, they may be deterred or made powerless to effectively prevent abuses of patients.

Numerous international treaties and conventions include rights that are designed to protect workers and ensure safe and healthy work environments. The UN and its agencies, including the International Labor Organization, have developed some of these international labor standards and monitor their implementation. This section presents several standards and how they have been interpreted in relation to three key rights for health care providers. These include the right to (i) work in decent conditions; (ii) freedom of association and assembly, including association with trade unions and the right to strike; and (iii) due process and related rights to receive a fair hearing and an effective remedy, protection of privacy and reputation, and freedom of expression and information.

Part I of this section covers the right to work in decent conditions, including the right to work and the right to fair pay and safe working conditions. Part II discusses the right to freedom of association. Part III explores the right to due process and related rights. Each section begins with a discussion of the significance of that particular right for health providers and is followed by relevant standards from various UN legal instruments and UN treaty-monitoring bodies' concluding observations and case law to exemplify potential violations.

Finally, it is worth noting that relevant standards from the 1998 UN Human Rights Defenders Declaration underscore the fact that health care providers, in addition to enjoying the same core rights as patients, are defenders of rights in their daily work.

2.4.1 RIGHT TO WORK IN DECENT CONDITIONS

Article 7 of the ICESCR guarantees the individual's right to the enjoyment of just and favorable conditions of work, in particular the right to safe working conditions. The right to work, a component of the right to work in decent conditions, is enshrined under Article 6 and protects every individual's right to be able to work, allowing her/him to live in dignity.²⁸⁵ Article 8 of the ICESCR enshrines the collective right to work, which includes the right to form trade unions, join the trade union of her/his choice, and "the right of trade unions to function freely" (see section "Trade Unions and the Right to Strike" below).²⁸⁶ The CESCR has underscored that these three articles are interdependent.

Right to Work

The right to work guarantees that, in law and in practice, men and women are given equal access to jobs at all levels and all occupations and that includes vocational training and guidance programs.²⁸⁷ This right requires the State to ensure that neither itself nor others (such as private companies or other non-state actors) unreasonably or in a discriminatory way prevent a person from earning a living or practicing her/his profession.²⁸⁸ The individual must not be deprived from work unfairly.²⁸⁹ Also, this right protects foreign workers who are employed in a State with valid work permits from being unlawfully deported.²⁹⁰

285. CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 1

286. CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 2.

287. CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 23

288. CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. paras. 6, 23, and 25

289. CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 4

290. CERD. Communication No. 8/1996: B. M. S. v. Australia. UN Doc. CERD/C/54/D/8/1996. May 10, 1999.

Importantly, UN treaty-monitoring bodies have clarified that there is no “absolute and unconditional right” that requires an individual be provided with work or the occupation of one’s choice. States must, however, refrain from unduly hindering the ability of individuals to freely pursue their chosen careers.²⁹¹ Furthermore, states are required to ensure the fair treatment of migrant workers, a requirement that is particularly relevant for medical professionals, who are often recruited from other countries to staff hospitals and clinics.²⁹² The ICMW emphasizes states’ obligations to foreign-born employees.²⁹³ The concern over the migration of medical professionals is driven in part by the poor remuneration that they receive in some countries.

Right to Fair Pay and Safe Working Conditions

The right to “the enjoyment of just and favourable conditions of work,” as enshrined under Article 7(a) of the ICESCR, requires that the government guarantee fair wages and equal pay for work of equal value, among other requirements.²⁹⁴ Under this right, workers who are not covered by collective bargaining are protected.²⁹⁵ It also applies to all workers with disabilities, whether they work in sheltered facilities or in the open labor market. Workers with disabilities may not be discriminated against with respect to wages or other conditions if their work is equal to that of nondisabled workers. States Parties have a responsibility to ensure that disability is not used as an excuse for creating low standards of labor protection or for paying below-minimum wages.²⁹⁶ Article 3 of the ICESCR provides for the equal right of men and women to the enjoyment of the rights enshrined in the treaty. Therefore, when read with Article 7, this right requires that the State identify and eliminate the underlying causes of pay differentials, such as gender-based job evaluation.²⁹⁷ The State must take measures to eliminate discrimination against non-citizen workers in relation to working conditions and work requirements.²⁹⁸ Workers should not face discrimination in employment on the grounds of political opinion.²⁹⁹ The State must also develop regulations to penalize and remedy sexual harassment in the workplace.³⁰⁰

This right also protects the individual from working conditions that are harmful to the individual’s health and wellbeing. It establishes limits on the duration of the working day and sets a minimum level of weekly rest,³⁰¹ as well as prohibits failure to pay medical staff for extended periods of work.³⁰² Medical staff cannot be subjected to low wages and substandard working conditions in hospitals.³⁰³ With respect to women, this right establishes special protection against harmful types of work during pregnancy and requires the provision of paid maternity leave.³⁰⁴ Finally, this right requires that the State reduce the constraints faced by men and women in reconciling professional and family responsibilities by promoting adequate policies for childcare and care of dependent family members.³⁰⁵

291. CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 6.

292. CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 18.

293. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Article 7.

294. CESCR. CESCR General Comment 16: The equal right of men and women to enjoyment of all economic, social, and cultural rights (Art. 3 of the International Covenant on Economic, Social and Cultural Rights). UN Doc. E/C.12/2005/4. August 11, 2005. para. 24.

295. CESCR. Concluding Observations: Suriname. UN Doc. E/1996/22. December 12, 1996.

296. See ICRPD, specifically arts. 8, 9, 27. See also CESCR. CESCR General Comment No. 5: Persons with disabilities. December 9, 1994. para. 25.

297. CESCR. CESCR General Comment 16: The equal right of men and women to enjoyment of all economic, social, and cultural rights (Art. 3 of the International Covenant on Economic, Social and Cultural Rights). UN Doc. E/C.12/2005/4. August 11, 2005. para. 24.

298. CERD. CERD General Comment No. 30: Discrimination Against Non Citizens. October 1, 2004. paras. 33–35.

299. CESCR. Concluding Observations: Germany. UN Doc. E/C.12/1993/17. January 5, 1994.

300. CEDAW Committee. Report of the Committee: Argentina. UN Doc. A/52/38/Rev.1. 1997. part. II; see also CEDAW Committee. Report of the Committee: Cuba. UN Doc. A/55/38. June 19, 2000. part. II; CEDAW Committee. CEDAW General Recommendation No.24: Article 12 of the Convention (Women and Health). UN Doc. A/54/38/Rev. 1. 1999. part. I.

301. CESCR. Concluding Observations: Suriname. UN Doc. E/1996/22. December 12, 1996.

302. CRC Committee. Concluding Observations: Solomon Islands. UN Doc. CRC/C/132. October 23, 2003.

303. CESCR. Concluding Observations: Georgia. UN Doc. E/2003/22. November 29, 2000.

304. CEDAW Committee. CEDAW General Recommendation No.24: Article 12 of the Convention (Women and Health). UN Doc. A/54/38/Rev. 1. 1999. para. 28.

305. CESCR. CESCR General Comment 16: The equal right of men and women to enjoyment of all economic, social, and cultural rights (Art. 3 of the International Covenant on Economic, Social and Cultural Rights). UN Doc. E/C.12/2005/4. August 11, 2005. para. 24.

RELEVANT PROVISIONS

- ▶ **UDHR, Art. 23(1): Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.**

- ▶ **ICESCR**

- **Art. 6(1):** The States Parties to the present Covenant recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.
- **Art. 7:** The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:
 - (a) Remuneration which provides all workers, as a minimum, with:
 - i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;
 - ii) A decent living for themselves and their families in accordance with the provisions of the present Covenant;
 - (b) Safe and healthy working conditions;
 - (c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence;
 - (d) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays.
- **Art. 12:**
 - (1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
 - (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for ... 1. [t]he improvement of all aspects of environmental and industrial hygiene....

- ▶ **ICERD, Art. 5(e)(i):** In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: ...

- (e) Economic, social and cultural rights, in particular: ...
 - (i) The rights to work, to free choice of employment, to just and favourable conditions of work, to protection against unemployment, to equal pay for equal work, to just and favourable remuneration...

- ▶ **ICRPD**

- **Article 8 - Awareness-raising:**
 1. States Parties undertake to adopt immediate, effective and appropriate measures:
 - a. To raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities;
 - b. To combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
 - c. To promote awareness of the capabilities and contributions of persons with disabilities.

Measures to this end include:

- a. Initiating and maintaining effective public awareness campaigns designed:...
 - i. To promote recognition of the skills, merits and abilities of persons with disabilities, and of their contributions to the workplace and the labour market...

- **Article 9 – Accessibility:**

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia: (a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces...

- **Article 27 - Work and employment**

1. States Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, inter alia:
 - a. Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions;
 - b. Protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances;
 - c. Ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others;
 - d. Enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training;
 - e. Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment;
 - f. Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business;
 - g. Employ persons with disabilities in the public sector;
 - h. Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;
 - i. Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;
 - j. Promote the acquisition by persons with disabilities of work experience in the open labour market;

- k. Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.
 - 2. States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour.
- ▶ **ILO Occupational Safety and Health Convention, 1981 (No. 155),³⁰⁶ Art. 4:**
 - (1) Each Member shall, in the light of national conditions and practice, and in consultation with the most representative organisations of employers and workers, formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment.
 - (2) The aim of the policy shall be to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, by minimising, so far as is reasonably practicable, the causes of hazards inherent in the working environment.
- ▶ **ILO Occupational Health Services Convention, 1985 (No. 161),³⁰⁷ Art. 3:** Each Member undertakes to develop progressively occupational health services for all workers, including those in the public sector and the members of production co-operatives, in all branches of economic activity and all undertakings. The provision made should be adequate and appropriate to the specific risks of the undertakings. ...
- ▶ **ILO Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187),³⁰⁸ Art. 2(1):** Each Member which ratifies this Convention shall promote continuous improvement of occupational safety and health to prevent occupational injuries, diseases and deaths, by the development, in consultation with the most representative organizations of employers and workers, of a national policy, national system and national programme.

PROVISIONS RELATED TO NURSING STAFF

- ▶ **ILO Nursing Personnel Convention, 1977 (No. 149)³⁰⁹**
 - **Art. 2**
 - 1) Each Member which ratifies this Convention shall adopt and apply, in a manner appropriate to national conditions, a policy concerning nursing services and nursing personnel designed, within the framework of a general health programme, where such a programme exists, and within the resources available for health care as a whole, to provide the quantity and quality of nursing care necessary for attaining the highest possible level of health for the population.
 - 2) In particular, it shall take the necessary measures to provide nursing personnel with—
 - (a) education and training appropriate to the exercise of their functions; and (b) employment and working conditions, including career prospects and remuneration, which are likely to attract persons to the profession and retain them in it. (3) The policy mentioned in paragraph 1 of this Article shall be formulated in consultation with the employers' and workers' organisations concerned, where such organisations exist. (4) This policy shall be co-ordinated with policies relating to other aspects of health care and to other workers in the field of health, in consultation with the employers' and workers' organisations concerned.

306. International Labor Organization [ILO]. Occupational Safety and Health Convention, 1981 (No. 155). August 11, 1983.

307. ILO. Occupational Health Services Convention, 1985 (No. 161). February 17, 1985.

308. ILO. Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187). February 20, 2009.

309. ILO. Nursing Personnel Convention, 1977 (No. 149). July 11, 1979.

- **Art. 6:**

Nursing personnel shall enjoy conditions at least equivalent to those of other workers in the country concerned in the following fields: (a) hours of work, including regulation and compensation of overtime, inconvenient hours and shift work; (b) weekly rest; (c) paid annual holidays; (d) educational leave; (e) maternity leave; (f) sick leave; (g) social security.

- **Art. 7:** Each Member shall, if necessary, endeavour to improve existing laws and regulations on occupational health and safety by adapting them to the special nature of nursing work and of the environment in which it is carried out.

PROVISIONS RELATED TO WOMEN

▶ ICESCR

- **Art 10(2):** Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.
- **Art. 7:** The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:
 - (a) Remuneration which provides all workers, as a minimum, with:
 - (i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;
 - (ii) A decent living for themselves and their families in accordance with the provisions of the present Covenant;
 - (b) Safe and healthy working conditions;
 - (c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence;
 - (d) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays.

▶ CEDAW

- **Art .11:**
 - 1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:
 - (a) the right to work as an inalienable right of all human beings; ...
 - (c) the right to free choice of profession and employment, the right to promotion, job security and all benefits and conditions of service and the right to receive vocational training and retraining, including apprenticeships, advanced vocational training and recurrent training;...
 - (f): [t]he right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.
 - 2) In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:
 - (a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in marital status;

- (b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;
 - (c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;
 - (d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.
- **Art. 12:**
 - 1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
 - 2) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

PROVISIONS RELATED TO MIGRANT WORKERS

- ▶ **CERD, Art. 5(e)(i): In compliance with the fundamental obligations laid down in Article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the rights to work, to free choice of employment, to just and favourable conditions of work, to protection against unemployment, to equal pay for equal work, to just and favourable remuneration.**
- ▶ **ICMW**
 - **Art. 25:**
 - (1) Migrant workers shall enjoy treatment not less favourable than that which applies to nationals of the State of employment in respect of remuneration and:
 - (a) Other conditions of work, that is to say, overtime, hours of work, weekly rest, holidays with pay, safety, health, termination of the employment relationship and any other conditions of work which, according to national law and practice, are covered by these terms;
 - (b) Other terms of employment, that is to say, minimum age of employment, restriction on home work and any other matters which, according to national law and practice, are considered a term of employment.
 - (2) It shall not be lawful to derogate in private contracts of employment from the principle of equality of treatment referred to in paragraph 1 of the present article.
 - (3) States Parties shall take all appropriate measures to ensure that migrant workers are not deprived of any rights derived from this principle by reason of any irregularity in their stay or employment. In particular, employers shall not be relieved of any legal or contractual obligations, nor shall their obligations be limited in any manner by reason of such irregularity.

- **Art. 51:** Migrant workers who in the State of employment are not permitted freely to choose their remunerated activity shall neither be regarded as in an irregular situation nor shall they lose their authorization of residence by the mere fact of the termination of their remunerated activity prior to the expiration of their work permit, except where the authorization of residence is expressly dependent upon the specific remunerated activity for which they were admitted. Such migrant workers shall have the right to seek alternative employment, participation in public work schemes and retraining during the remaining period of their authorization to work, subject to such conditions and limitations as are specified in the authorization to work.
- **Art. 70:** States Parties shall take measures not less favourable than those applied to nationals to ensure that working and living conditions of migrant workers and members of their families in a regular situation are in keeping with the standards of fitness, safety, health and principles of human dignity.

CONCLUDING OBSERVATIONS ON SURINAME RELATING TO THE RIGHT TO WORK IN DECENT CONDITIONS

*The Committee recommends that legislation be enacted to protect workers who are not covered by collective bargaining agreements, in order to ensure them a minimum wage, health and maternal benefits, safe working conditions, and other guarantees that meet international standards for conditions of work. In this connection, the Committee recommends that assistance from ILO be sought. Furthermore, the Committee encourages the Government to extend such protection also to immigrant workers.*³¹⁰

CASE RELATING TO THE RIGHT TO WORK IN DECENT CONDITIONS

B.M.S. v. Australia (CERD)(1999). An Indian doctor failed to pass several exams in order to obtain permanent medical registration in Australia. The Committee did not find the examination and quota system to be discriminatory, given that all overseas-trained doctors were subjected to it, irrespective of their race. The Committee found no violation of Article 5 of the ICERD.³¹¹

2.4.2 RIGHT TO FREEDOM OF ASSOCIATION AND ASSEMBLY

The right to freedom of association and assembly protects the association from the government's unjustifiable refusal to register it.³¹² This right works to ensure that the procedural formalities that associations of workers must undergo in order to be formally recognized are not too burdensome.³¹³ For example, the CCPR has called on governments to refrain from restricting the right to freedom of association through processes that could deny registration to an individual for purposes of joining or forming an association.³¹⁴ This right also requires allowing men and women to organize and join workers' associations that address their specific concerns.³¹⁵ As it relates to providers, such as hospital

310. CESCR. Concluding Observations: Suriname. UN Doc. E/1996/22. December 12, 1996.

311. CERD. Communication No. 8/1996: B. M. S. v. Australia. UN Doc. CERD/C/54/D/8/1996. May 10, 1999.

312. International Labour Organization [ILO]. Freedom of Association - Digest of decisions and principles of the Freedom of Association Committee of the Governing Body of the ILO. 2005; ILO. Freedom of Association - Digest of decisions and principles of the Freedom of Association Committee of the Governing Body of the ILO. 1996; ILO. 332nd Report of the Committee on Freedom of Association. November 2003; ILO. Case No. 2225 (Bosnia and Herzegovina). Complaint date: October 18, 2002.

313. CCPR. Concluding Observations: Belarus. UN Doc. CCPR/C/79/Add.86. November 19, 1997; CCPR. Concluding Observations: Lithuania. UN Doc. CCPR/C/79/Add.87. November 19, 1997.

314. CCPR. Concluding Observations: Lebanon. UN Doc. A/52/40 (Vol. II). September 21, 1997.

315. CESCR. CESCR General Comment 16: The equal right of men and women to enjoyment of all economic, social, and cultural rights (Art. 3 of the International Covenant on Economic, Social and Cultural Rights). UN Doc. E/C.12/2005/4. August 11, 2005. para. 25.

personnel, they are entitled to join organizations for the promotion and defense of workers' interests without previous authorization.³¹⁶

Workers' right to form, join and run associations without undue interference is critical to their ability to effectively defend their rights. Health care professionals enjoy the same collective action rights as other employees, and even though the health sector provides an essential service, this fact only precludes its members from work stoppage under certain exceptional circumstances. Additionally, certain provisions of the UN Human Rights Defenders Declaration emphasize the role of health care providers as human rights defenders who implement and protect social rights and fundamental civil rights, such as life and freedom from torture and inhuman or degrading treatment.³¹⁷

Although UN jurisprudence on freedom of association has focused on the treatment of NGOs and political parties, the interpretation of the core aspects of the right can also be applied to professional associations and trade unions, which are also the subject of relevant ILO standards.

RELEVANT PROVISIONS

▶ UDHR, Art. 20:

- (1) Everyone has the right to freedom of peaceful assembly and association.
- (2) No one may be compelled to belong to an association.

▶ ICCPR

- **Art. 21:** The right of peaceful assembly shall be recognized. No restrictions may be placed on the exercise of this right other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (*ordre public*), the protection of public health or morals or the protection of the rights and freedoms of others.
- **Art. 22:**
 - 1) Everyone shall have the right to freedom of association with others, including the right to form and join trade unions for the protection of his interests.
 - 2) No restrictions may be placed on the exercise of this right other than those which are prescribed by law and which are necessary in a democratic society in the interests of national security or public safety, public order (*ordre public*), the protection of public health or morals or the protection of the rights and freedoms of others. This article shall not prevent the imposition of lawful restrictions on members of the armed forces and of the police in their exercise of this right.
 - 3) Nothing in this article shall authorize States Parties to the International Labour Organisation Convention of 1948 concerning Freedom of Association and Protection of the Right to Organize to take legislative measures which would prejudice, or to apply the law in such a manner as to prejudice, the guarantees provided for in that Convention.

▶ ILO Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87),³¹⁸

- **Art. 2:** Workers and employers, without distinction whatsoever, shall have the right to establish and, subject only to the rules of the organization concerned, to join organisations of their own choosing without previous authorisation.

316. ILO. Freedom of Association: Digest of Decisions and Principles of the Freedom of Association Committee. 2005.

317. United Nations General Assembly. General Assembly Resolution 53/144: Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms. UN Doc. A/RES/53/144. March 8, 1999.

318. ILO. Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87). July 4, 1950.

▶ **UN Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms (the Human Rights Defenders Declaration) 1998³¹⁹**

- **Art. 1:** Everyone has the right, individually and in association with others, to promote and to strive for the protection and realization of human rights and fundamental freedoms at the national and international levels.
- **Art. 5:** For the purpose of promoting and protecting human rights and fundamental freedoms, everyone has the right, individually and in association with others, at the national and international levels:
 - (a) To meet or assemble peacefully;
 - (b) To form, join and participate in nongovernmental organizations, associations or groups;
 - (c) To communicate with non-governmental or intergovernmental organizations.

PROVISIONS RELATED TO WOMEN

▶ **CEDAW**

- **Art. 7(c):** States Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in particular, shall ensure to women, on equal terms with men, the right to participate in non-governmental organizations and associations concerned with the public and political life of the country.
- **Art. 3:** States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

PROVISIONS RELATED TO RACE

- ▶ **CERD, Art. 5(d)(ix):** In compliance with the fundamental obligations laid down in Article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of [t]he right to freedom of peaceful assembly and association.

CONCLUDING OBSERVATIONS ON BELARUS RELATING TO THE RIGHT TO FREEDOM OF ASSOCIATION AND ASSEMBLY

With respect to article 22 of the Covenant, the Committee is also concerned about the difficulties arising from the registration procedures to which non-governmental organizations and trade unions are subjected. The Committee also expresses concern about reports of cases of intimidation and harassment of human rights activists by the authorities, including their arrest and the closure of the offices of certain non-governmental organizations. In this regard:

319. United Nations General Assembly. General Assembly Resolution 53/144: Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms. UN Doc. A/RES/53/144. March 8, 1999.

The Committee, reiterating that the free functioning of non-governmental organizations is essential for protection of human rights and dissemination of information in regard to human rights among the people, recommends that laws, regulations and administrative practices relating to their registration and activities be reviewed without delay in order that their establishment and free operation may be facilitated in accordance with article 22 of the Covenant.³²⁰

Trade Unions and the Right to Strike

The right to freedom of association protects the individual from policies or conditions that would impact her/his ability to form associations and to bargain collectively.³²¹ It also protects the individual from reprisals for exercising free association rights and unnecessary interference in trade union activities.³²² Accordingly, under international human rights law, the existence of multiple trade unions should be lawfully guaranteed,³²³ and the absence of enabling legislation on trade unions must be condemned.³²⁴ The CESCR has condemned the refusal of some employers to recognize or negotiate with new “alternative” unions and some employers’ adverse actions against them, including dismissal of union activists.³²⁵ Trade union protection includes ensuring that foreign workers are not barred from holding official positions and that unions are not dissolved by the executive.³²⁶

Consultation and co-operation are no substitute for the “right to strike.”³²⁷ Individuals are guaranteed participation in discussions concerning the determination of minimum wages.³²⁸ With respect to health care workers, this right guarantees those employed in public hospitals the right to enjoy the right to collective bargaining.³²⁹ Moreover, while the “right to strike” is not explicitly mentioned under Article 22 of the ICCPR, the right to freedom of association establishes that an absolute ban on strikes by public servants who are not exercising authority in the name of the state and are not engaged in “essential services” may violate this right.³³⁰ Nevertheless, given this “absolute ban,” complex and serious implications for the health and lives of patients can arise if medical personnel were to exercise this right.

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320. CCPR. Concluding Observations: Belarus. UN Doc. CCPR/C/79/Add.86. November 19, 1997. para. 19.
321. CCPR. Concluding Observations: Lebanon. UN Doc. A/52/40 (Vol. I). September 21, 1997; CCPR. Concluding Observations: Chile. UN Doc. A/54/40 (Vol. I). October 21, 1999.
322. CCPR. Concluding Observations: Costa Rica. UN Doc. A/54/40 (Vol. I). October 21, 1999. “Freedom of association, including the right to collective bargaining, should be guaranteed to all individuals. Labour legislation should be reviewed and, where necessary, reformed to introduce measures of protection against reprisals for attempts to form associations and trade unions and to ensure that workers have access to speedy and effective remedies”; see also CCPR. Concluding Observations: Dominican Republic. UN Doc. A/56/40 (Vol. I). October 26, 2001; CCPR. Concluding Observations: Argentina. UN Doc. A/50/40 (Vol. I). October 3, 1995; CCPR. Concluding Observations: Guatemala. UN Doc. A/51/40 (Vol. I). April 3, 1996; CCPR. Concluding Observations: Nigeria. UN Doc. A/51/40 (Vol. I). April 3, 1996; CCPR. Concluding Observations: Bolivia. UN Doc. A/51/40 (Vol. I). April 9, 1997; CCPR. Concluding Observations: Venezuela. UN Doc. A/56/40 (Vol. I). April 2, 2001; CESCR. Concluding Observations: Jamaica. UN Doc. E/1990/23. January 22-24, 1990.
323. CCPR. Concluding Observations: Brazil. UN Doc. A/51/40 (Vol. I). April 13, 1997. CCPR. Concluding Observations: Rwanda. UN Doc. E/1989/22. February 13-14, 1989.
324. CCPR. Concluding Observations: Georgia. UN Doc. A/52/40 (Vol. I). September 21, 1997.
325. CESCR. Concluding Observations: Russian Federation. UN Doc. E/1998/22. June 20, 1998.
326. CCPR. Concluding Observations: Senegal. UN Doc. CCPR/C/79/Add.82. November 19, 1997.
327. CESCR. Concluding Observations: Luxembourg, 1990. UN Doc. E/1991/23. It is questioned whether the covenant, virtually alone among applicable international human rights treaties, is considered a non-self-executing in its totality. It was observed that, by contrast, the covenant contained a number of provisions that the great majority of observers would consider to be self-executing. These included, for example, provisions dealing with nondiscrimination, the right to strike, and the right to free primary education.
328. CESCR. Concluding Observations: Uruguay. UN Doc. E/1995/22. January 1, 1995.
329. ILO. 306th Report of the Committee on the Freedom of Association. 2009; ILO. Case No. 1882 (Denmark). Complaint date: May 10, 1996; see ILO. Right to Organise and Collective Bargaining Convention (No. 98). July 1, 1949.
330. CCPR. Concluding Observations: Germany. UN Doc. A/52/40 (Vol. I). September 21, 1997.

RELEVANT PROVISIONS

- ▶ **UDHR, Art. 23(4):** Everyone has the right to form and to join trade unions for the protection of his interests.
- ▶ **ICCPR, Art. 22:**
 - (1) Everyone shall have the right to freedom of association with others, including the right to form and join trade unions for the protection of his interests.
 - (2) No restrictions may be placed on the exercise of this right other than those which are prescribed by law and which are necessary in a democratic society in the interests of national security or public safety, public order (*ordre public*), the protection of public health or morals or the protection of the rights and freedoms of others. This article shall not prevent the imposition of lawful restrictions on members of the armed forces and of the police in their exercise of this right.
 - (3) Nothing in this article shall authorize States Parties to the International Labour Organisation Convention of 1948 concerning Freedom of Association and Protection of the Right to Organize to take legislative measures which would prejudice, or to apply the law in such a manner as to prejudice, the guarantees provided for in that Convention.
- ▶ **ICESCR, Art. 8:**
 1. The States Parties to the present Covenant undertake to ensure:
 - (a) The right of everyone to form trade unions and join the trade union of his choice, subject only to the rules of the organization concerned, for the promotion and protection of his economic and social interests. No restrictions may be placed on the exercise of this right other than those prescribed by law and which are necessary in a democratic society in the interests of national security or public order or for the protection of the rights and freedoms of others;
 - (b) The right of trade unions to establish national federations or confederations and the right of the latter to form or join international trade-union organizations;
 - (c) The right of trade unions to function freely subject to no limitations other than those prescribed by law and which are necessary in a democratic society in the interests of national security or public order or for the protection of the rights and freedoms of others;
 - (d) The right to strike, provided that it is exercised in conformity with the laws of the particular country.
 2. This article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces or of the police or of the administration of the State.
 3. Nothing in this article shall authorize States Parties to the International Labour Organisation Convention of 1948 concerning Freedom of Association and Protection of the Right to Organize to take legislative measures which would prejudice, or apply the law in such a manner as would prejudice, the guarantees provided for in that Convention.
- ▶ **ILO Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)³³¹**
 - **Art. 2:** Workers and employers, without distinction whatsoever, shall have the right to establish and, subject only to the rules of the organisation concerned, to join organisations of their own choosing without previous authorisation.

331. ILO. Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87). July 4, 1950.

- **Art. 3:**
 - (1) Workers' and employers' organisations shall have the right to draw up their constitutions and rules, to elect their representatives in full freedom, to organise their administration and activities and to formulate their programmes.
 - (2) The public authorities shall refrain from any interference which would restrict this right or impede the lawful exercise thereof.
- **Art. 4:** Workers' and employers' organisations shall not be liable to be dissolved or suspended by administrative authority.
- **Art. 5:** Workers' and employers' organisations shall have the right to establish and join federations and confederations and any such organisation, federation or confederation shall have the right to affiliate with international organisations of workers and employers.

▶ **ILO Right to Organise and Collective Bargaining Convention, 1949 (No. 98)³³²**

- **Art. 1:**
 - (1) Workers shall enjoy adequate protection against acts of anti-union discrimination in respect of their employment.
 - (2) Such protection shall apply more particularly in respect of acts calculated to:
 - (a) Make the employment of a worker subject to the condition that he shall not join a union or shall relinquish trade union membership;
 - (b) Cause the dismissal of or otherwise prejudice a worker by reason of union membership or because of participation in union activities outside working hours or, with the consent of the employer, within working hours.
- **Art. 2(1):** Workers' and employers' organisations shall enjoy adequate protection against any acts of interference by each other or each other's agents or members in their establishment, functioning or administration.
- **Art. 6:** This Convention does not deal with the position of public servants engaged in the administration of the State, nor shall it be construed as prejudicing their rights or status in any way.

CONCLUDING OBSERVATIONS ON LEBANON RELATING TO TRADE UNIONS AND THE RIGHT TO STRIKE

The Committee has noted that while legislation governing the incorporation and status of associations is on its face compatible with article 22 of the Covenant, de facto State party practice has restricted the right to freedom of association through a process of prior licensing and control. The delegation itself conceded that the practice of denying that registration took place is unlawful. The Committee also regrets that civil servants continue to be denied the right to form associations and to bargain collectively, in violation of article 22 of the Covenant.³³³

332. ILO. Right to Organise and Collective Bargaining Convention, 1949 (No. 98). July 1, 1949.

333. CCPR. Concluding Observations: Lebanon. UN Doc. A/52/40 (Vol. I). September 21, 1997.

2.4.3 RIGHT TO DUE PROCESS AND RELATED RIGHTS

This section outlines the relevant due process standards that health care providers enjoy when commencing or responding to civil proceedings, including disciplinary matters. It does not deal with the rights of the accused in criminal proceedings. As in previous sections, this section highlights material that interprets standards related to health sector personnel. The first part of this section examines the right to a fair hearing. The second part focuses on the related right to an effective remedy.

This section also details those standards that protect the privacy rights of health care providers—in and outside the workplace—and their honor and reputation. In addition, there is a brief discussion of standards that address the right to free expression and the right to impart information. These liberties are particularly significant, as they might offer protection to whistle blowers who seek to place certain information in the public domain. This protection is important because public sector employees are often reluctant to disseminate information for fear of facing adverse consequences.

Right to a Fair Hearing

The right to a fair hearing in a civil suit encompasses: 1) equality before the courts³³⁴ (this distinction is narrower than the right of equality before the law as the latter applies to all organs involved in the administration of justice and not just to judicial power)³³⁵ and 2) access to courts³³⁶ (access includes the provision of legal aid).³³⁷ This right requires that states provide for particular causes of action “in certain circumstances” and for competent courts to determine those causes of action.³³⁸ The meaning of “suit at law” under Article 14(1) of the ICCPR continues to evolve, although regulation of the activities of a professional body and scrutiny of such regulations by the courts may fall within its scope.

Elements of a fair hearing in a civil suit include equality of arms (both parties have equal procedural access to the court),³³⁹ respect for the principle of adversarial proceedings, preventing the passing of a judgment that makes the interested party worse off (*ex officio reformatio in pejus*), and an expeditious procedure.³⁴⁰ Violations of the right to a fair hearing include: refusing to allow the complainant to attend the proceedings and to have the opportunity to brief legal representatives properly,³⁴¹ failing to inform the litigant of her/his appeal date until after it has taken place,³⁴² refusal of an administrative tribunal to admit crucial evidence³⁴³ and failure to permit one litigant to submit comments on the other side’s submissions.³⁴⁴

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334. CCPR. General Comment No. 32: Article 14, Right to equality before courts and tribunals and to fair trial. UN Doc. CCPR/C/GC/32. August 23, 2007. paras. 3, 7.
335. CCPR. General Comment No. 32: Article 14, Right to equality before courts and tribunals and to fair trial. UN Doc. CCPR/C/GC/32. August 23, 2007. para. 65.
336. CCPR. General Comment No. 32: Article 14, Right to equality before courts and tribunals and to fair trial. UN Doc. CCPR/C/GC/32. August 23, 2007. paras. 8, 9, and 12.
337. CCPR. Communication No. 468/1991: Bahamonde v. Equatorial Guinea. UN Doc. CCPR/C/49/D/468/1991. November 10, 1993; CCPR. Communication No. 202/86: Avellanal v. Peru. UN Doc. CCPR/C/34/D/202/1986. October 31, 1989; CCPR. General Comment No. 32: Article 14, Right to equality before courts and tribunals and to fair trial. UN Doc. CCPR/C/GC/32. August 23, 2007. para. 10.
338. CCPR. Communication No. 547/1993: Mahuika v New Zealand. UN Doc. CCPR/C/70/D/547/1993. November 15, 2000.
339. CCPR. General Comment No. 32: Article 14, Right to equality before courts and tribunals and to fair trial. UN Doc. CCPR/C/GC/32. August 23, 2007. para. 13; see CCPR. Communication No. 757/1997: Pezoldova v. The Czech Republic. UN Doc. CCPR/C/75/D/757/1997. October 25, 2002. Concurring individual opinion of Prafullachandra Natwarlal Bhagwati “[a]s a prerequisite to have a fair and meaningful hearing of a claim, a person should be afforded full and equal access to public sources of information....”
340. CCPR. Communication No. 207/1986: Morael v. France. UN Doc. CCPR/C/36/D/207/1986. July 28, 1989; see also CCPR. Communication No. 514/1992: Fei v. Colombia. UN Doc. CCPR/C/53/D/514/1992. April 26, 1995; CCPR. General Comment No. 32: Article 14, Right to equality before courts and tribunals and to fair trial. UN Doc. CCPR/C/GC/32. August 23, 2007. para. 27.
341. CCPR. Communication No. 289/1988: Wolf v. Panama. UN Doc. CCPR/C/44/D/289/1988. March 26, 1992.
342. CCPR. Communication No. 532/1993: Thomas v. Jamaica. UN Doc. CCPR/C/61/D/532/1993. December 4, 1997.
343. CCPR. Communication No. 846/1999: Jansen-Gielen v. The Netherlands. UN Doc. CCPR/C/71/D/846/1999. May 14, 2001. Proceedings to determine psychiatric ability to perform job.
344. CCPR. Communication No. 779/1997: Aarela and Anor v. Finland. UN Doc. CCPR/C/73/D/779/1997. February 4, 1997.

RELEVANT PROVISIONS

▶ ICCPR

- **Art. 14(1):** All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.
- **Art. 26:** All persons are equal before the law and are entitled without any discrimination to the equal protection of the law.

▶ **CERD, Art. 5(a):** In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: The right to equal treatment before the tribunals and all other organs administering justice.

▶ **CEDAW, Art. 15(1):** States Parties shall accord to women equality with men before the law.

CONCLUDING OBSERVATIONS ON AUSTRIA RELATING TO THE RIGHT TO A FAIR HEARING

The Committee notes that the State party's new Law on Equal Treatment improves the avenues of redress. However, the Committee is concerned that due to the complexity of the complaints mechanisms and of the legal framework, it may be difficult for the victims of racial discrimination to have access to the relevant procedure (art. 6). The Committee recommends that the State party take steps to simplify the procedures in such cases, to extend the national provisions on the regulation of the burden of proof in civil matters in accordance with the Convention, to ensure that the complaints against racial discrimination are processed free of charge, and to offer legal assistance to persons who need it.³⁴⁵

CASE RELATING TO THE RIGHT TO A FAIR HEARING

Nenova v. Libya (CCPR)(2012). A team of doctors was arrested for allegedly injecting almost 400 children with HIV at the hospital. They were held in a police station incommunicado, allegedly drugged and tortured, and tried after one year of detention. The Committee considered these acts on the part of the government to constitute a violation of both Article 7 (freedom from torture) and Article 14 (right to a fair process).³⁴⁶

2.4.4 RIGHT TO AN EFFECTIVE REMEDY

The right to an effective remedy requires that remedies for human rights violations be accessible, affordable, timely and effective. Relevant to the context of patient care, the CESCR has made clear that states have the obligation to ensure that effective remedies are available for violations of economic, social and cultural rights.³⁴⁷ Although a remedy generally entails appropriate compensation, “reparation can, where appropriate, involve restitution, rehabilitation, and measures of satisfaction, such as public apologies,

345. CERD. Concluding Observations: Austria. UN Doc. CERD/C/AUT/CO/17. August 21, 2008.

346. CCPR. Communication No. 1755/2008: Nenova v. Libya. UN Doc. CCPR/C/104/D/1755/2008/Rev.1. July 10, 2012.

347. CESCR. Concluding Observations: United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories. UN Doc. E/C.12/GBR/CO/5. June 12, 2009. para. 13.

public memorials, guarantees of non-repetition and changes in relevant laws and practices, and actions to bring to justice the perpetrators of human rights violations.”³⁴⁸

The Torture Convention enshrines the right to an effective remedy in its own separate provision (Art. 14). However, the ICCPR has linked the right to an effective remedy to the right to fair trial. Article 14 of the treaty includes both a right to compensation and judicial guarantees, such access to court. It requires that the state ensure determination of the right to a remedy by a competent judicial, administrative, or legislative authority. The state must protect “alleged victims if their claims are sufficiently well-founded to be arguable under the [ICCPR].”³⁴⁹

RELEVANT PROVISIONS

▶ ICCPR

- **Art. 2(3):** Each State Party to the present Covenant undertakes:
 - (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
 - (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;
 - (c) To ensure that the competent authorities shall enforce such remedies when granted.
- **Art. 14:**
 1. All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law....
 6. When a person has by a final decision been convicted of a criminal offence and when subsequently his conviction has been reversed or he has been pardoned on the ground that a new or newly discovered fact shows conclusively that there has been a miscarriage of justice, the person who has suffered punishment as a result of such conviction shall be compensated according to law, unless it is proved that the non-disclosure of the unknown fact in time is wholly or partly attributable to him.

▶ **ICESCR, Art. 2(1):** Each state party to the present covenant undertakes to take steps, individually and through international assistance and cooperation, especially in economic and technical matters, to the maximum extent allowed by its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant by all appropriate means, including, particularly, the adoption of legislative measures...

▶ **CAT, Art. 14(1):** Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.

348. CCPR. General Comment No. 31 [80]: The nature of the general legal obligation imposed on States Parties to the Covenant. UN Doc. CCPR/C/21/Rev.1/Add.13. May 26, 2004. para. 16.

349. CCPR. Communication No. 972/01: George Kazantzis v. Cyprus. UN Doc. CCPR/C/78/D/972/2001. September 13, 2003. para. 6.6.

CONCLUDING OBSERVATIONS ON AFGHANISTAN RELATING TO THE RIGHT TO AN EFFECTIVE REMEDY

The Committee expresses grave concern that limited action has been taken by the State party to combat widespread sexual abuse and exploitation of children, and that perpetrators of such abuse enjoy impunity. The Committee also expresses deep concern that while there is a systematic failure on the part of the authorities to prosecute perpetrators of sexual abuse, child victims are very often considered and treated as offenders, and charged with offences such as debauchery, homosexuality, running away from home or zina.

The Committee calls on the State party to:

- (a) Urgently develop awareness-raising programmes and campaigns, with the involvement of children, to curb sociocultural norms that lead to sexual abuse of children, condone abusers and stigmatize child victims;
- (b) Revise legislation in order to adequately protect all girls and boys from all forms of sexual abuse and violence, and ensure that the crime of rape is clearly defined;
- (c) Ensure that child victims of any form of sexual abuse or exploitation are considered and treated as victims and no longer charged and detained as offenders;
- (d) Strengthen Family Response Units and establish, as a matter of urgency, effective and child-friendly procedures and mechanisms to receive, monitor and investigate complaints;
- (e) Ensure that perpetrators of sexual abuse and exploitation of children are brought to justice and punished with sanctions proportionate to their crimes; and
- (f) Develop a national strategy to respond to the housing, health, legal and psychosocial needs of child victims of sexual exploitation and violence.³⁵⁰

2.4.5 RIGHT TO PROTECTION OF PRIVACY AND REPUTATION

Under the right to protection of privacy and reputation, the integrity and confidentiality of correspondence should be guaranteed by the law and in practice. This right protects the individual from the interceptions of electronic, telephonic, telegraphic, and other forms of communication; and wiretapping and recording of conversations. Searches of a person's home should be restricted to a search for necessary evidence and should not be allowed to amount to harassment. Even with regard to interferences that conform to the ICCPR, relevant legislation must specify in detail the precise circumstances in which such interferences may be permitted.³⁵¹

The right requires that gathering and holding of personal information on computers, data banks, and other devices—whether by public authorities or by private individuals or bodies—must be regulated by law.³⁵² The state must provide protection under the law against any unauthorized interferences with correspondence³⁵³ and ensure strict and independent (ideally, judicial) regulation of any such practices, including wiretapping.³⁵⁴ An interference with this right can only be justified if it is lawful and not arbitrary—if

350. CRC. Concluding Observations: Afghanistan. UN Doc. CRC/C/AFG/CO/1. April 8, 2011.

351. CCPR. CCPR General Comment No. 16: Article 17 (Right to Privacy). The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation. April 8, 1988. para. 8.

352. CCPR. CCPR General Comment No. 16: Article 17 (Right to Privacy). The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation. April 8, 1988. para. 10.

353. CCPR. CCPR General Comment No. 16: Article 17 (Right to Privacy). The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation. April 8, 1988. para. 8; CCPR. Concluding Observations: Zimbabwe. UN Doc. CCPR/C/79/Add.89. April 6, 1998.

354. CCPR. Concluding Observations: Poland. UN Doc. CCPR/C/79/Add.110. July 29, 1999; see also CCPR. Concluding Observations: Lesotho. UN Doc. CCPR/C/79/Add.106. April 8, 1999.

it complies with an established legal procedure.³⁵⁵

As it relates to providers, professional duties of confidence, such as those undertaken by the medical profession, are an important aspect of the right to privacy, and any legislation that requires a medical professional to disclose her/his patients' information that should otherwise be kept confidential must specify in detail the circumstances when this requirement would take effect.³⁵⁶

RELEVANT PROVISIONS

- ▶ **ICCPR, Art. 2(3):** Each State Party to the present Covenant undertakes:
 - (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
 - (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;
 - (c) To ensure that the competent authorities shall enforce such remedies when granted.
- ▶ **ICESCR, Art. 2(1):** Each state party to the present covenant undertakes to take steps, individually and through international assistance and cooperation, especially in economic and technical matters, to the maximum extent allowed by its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant by all appropriate means, including, particularly, the adoption of legislative measures...

2.4.6 RIGHT TO FREEDOM OF EXPRESSION AND INFORMATION

The right to freedom of expression includes the freedom to impart information and establishes that any restrictions on the right that do not accord with acceptable limitations, such as public order or public health, could result in a breach.³⁵⁷ Freedom of expression (including that of the media) can be lawfully restricted to protect the rights and reputation of others through, for example, the use of reasonable civil defamation laws.³⁵⁸ While it is not clear what public health-based restrictions would be permitted, it has been suggested that prohibiting misleading information on health-threatening activities could be justified.³⁵⁹

RELEVANT PROVISIONS

- ▶ **ICCPR, Art. 19(2):** Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.

355. CCPR. Communication No. 450/1991: I.P. v. Finland. UN Doc. CCPR/C/48/D/450/1991. July 26, 1993; Joseph, Schultz, and Castan. *The ICCPR-Cases, Materials and Commentary*. 2004. p. 494.

356. CCPR. Concluding Observations: Portugal. UN Doc. CCPR/CO/78/PRT. July 5, 2003.

357. CCPR. Communication No. 780/1997: Laptsevich v. Belarus. UN Doc. CCPR/C/68/D/780/1997. April 13, 2000.

358. Joseph, Schultz, and Castan. *The ICCPR-Cases, Materials and Commentary*. 2004. p. 541.

359. Joseph, Schultz, and Castan. *The ICCPR-Cases, Materials and Commentary*. 2004. p.525.

- ▶ **CERD, Art. 5(d)(viii):** In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: The right to freedom of opinion and expression...
- ▶ **Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms (Human Rights Defenders Declaration),³⁶⁰**
- ▶ **Art. 6:** Everyone has the right, individually and in association with others:
 - (a) To know, seek, obtain, receive and hold information about all human rights and fundamental freedoms, including having access to information as to how those rights and freedoms are given effect in domestic legislative, judicial or administrative systems;
 - (b) As provided for in human rights and other applicable international instruments, freely to publish, impart or disseminate to others views, information and knowledge on all human rights and fundamental freedoms;
 - (c) To study, discuss, form and hold opinions on the observance, both in law and in practice, of all human rights and fundamental freedoms and, through these and other appropriate means, to draw public attention to those matters.

360. United Nations General Assembly. General Assembly Resolution 53/144: Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms. UN Doc. A/RES/53/144. December 9, 1998.



3.1 INTRODUCTION

3.2 KEY SOURCES

3.3 PATIENTS` RIGHTS

3.4 PROVIDERS` RIGHTS

3

REGIONAL FRAMEWORK FOR HUMAN RIGHTS IN PATIENT CARE

3.1 INTRODUCTION

This chapter elaborates on the main standards that safeguard human rights in patient care within Europe, which include those established and interpreted by the European Union (EU), the Council of Europe (COE), the European Court of Human Rights (ECtHR), and the European Committee of Social Rights (ECSR). As in the preceding chapter on the international framework, this chapter is divided into three sections. The first section describes key sources within the region governing human rights in patient care. The second section examines patients' rights and includes subsections that discuss the standards and relevant interpretations connected to a particular right within three particularly common health-related contexts: mental health, infectious diseases, and sexual and reproductive rights. These subsections provide examples of potential violations based on case law. It is worth underscoring here that these three contexts are merely used as examples and that human rights violations (and therefore, the application of human rights standards) can occur beyond this limited set of patient care-related contexts. The third section focuses on the rights of health care providers and discusses the standards and relevant interpretations of each particular provider right that stem from relevant case law.

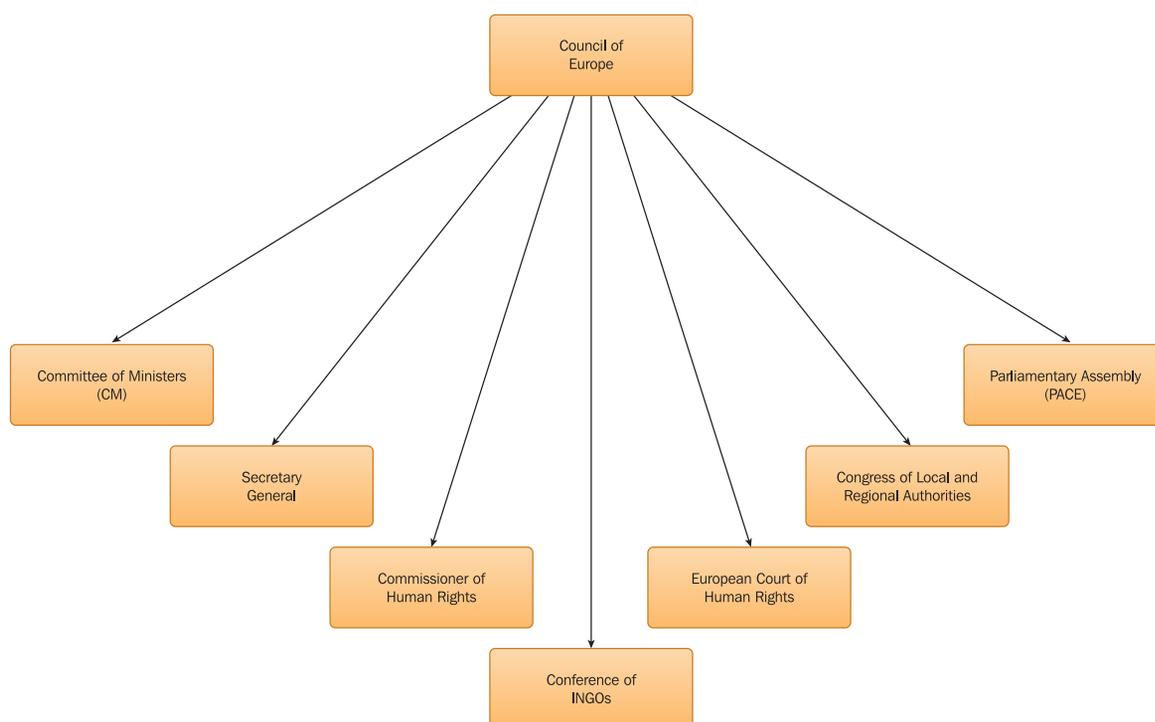
3.2 KEY SOURCES

The standards included in this chapter include those from binding treaties, such as the Convention for the Protection of Human Rights and Fundamental Freedoms (otherwise known as the “European Convention on Human Rights”) (ECHR) and the original and revised European Social Charter (ESC), as well as those included in non-binding instruments. The treaties referenced below have come from either the European Union (EU) or the COE. Some non-binding instruments have also been developed by these organizations, but there are others that have emanated from other actors, including civil society groups.

The EU is an economic and political partnership of 28 European member states, created following World War II for the purposes of fostering economic cooperation among its members. Despite its economic nature, the EU considers human rights and equality to be core values and has developed instruments that are relevant to patient care and human rights. EU law has the same level of legal authority as national law for all its member states and must be transposed into national law. As seen below, some EU directives address matters that are relevant to patient care. A “directive” is a type of EU legislative act that sets out goals for member states to achieve, and member states are free to determine how they will devise their laws and implement these goals.

The COE is a non-EU body that focuses on protection of human rights, democracy, and the rule of law in the European region and is located in Strasbourg, France. It consists of seven bodies, known as “institutions,” that help the COE carry out its functions. All those states that have ratified the ECHR are members of the COE, and as of this writing, there are 47 of them.³⁶¹ Importantly, the COE must not be confused with the European Council (an EU non-legislative body made up of EU leaders that meets regularly to define EU political direction and priorities) or the Council of the European Union (informally known as the “EU Council,” a legislative body of the EU).

STRUCTURE OF THE COUNCIL OF EUROPE



361. Council of Europe [COE]. “The Council of Europe in Brief.” Accessed October 29, 2013.

LEGALLY BINDING INSTRUMENTS

European Union

▶ Charter of Fundamental Rights of the European Union³⁶²

This treaty incorporates into EU law a wide range of civil, political, economic, and social rights belonging to all European citizens and residents. It was signed in Nice, France, on November 7, 2000, and became legally binding on December 12, 2007. It is binding on all EU institutions and on EU governments whenever they apply EU law. The charter also acts as an important reference point on human rights obligations for countries outside of the EU, especially those in the process of accession. Refer to Chapter 4 (International and Regional Procedures) for descriptions of procedures available at the European regional level, including detailed information on monitoring and adjudicatory bodies (e.g., the European Court of Human Rights) and the complaint procedure established by the European Convention on Human Rights.

The Charter differentiates among ‘legal rights’ (individual rights) and so-called principles (‘social rights’). Most scholars, however, find it unlikely that the Charter social right - or principle - to health-care can be held justiciable.³⁶³ This ‘aspirational’ norm leaves Member States a wide margin of appreciation how to organise and to define the nature and scope of the health benefit scheme.³⁶⁴ However, there are cases and opinion juris that claim otherwise.³⁶⁵

Patient/professional mobility

▶ Directive 2011/24/EU on the Application of Patients’ Rights in Cross-Border Healthcare³⁶⁶

This directive was adopted on March 9, 2011, and entered into force on April 4, 2011. It clarifies the rules on access to healthcare in another EU country, including reimbursement for health care services. The directive is binding on all member states and creates legal certainty on patients’ rights, including the right to seek health care abroad and to be reimbursed the same amount that patients would have received if they had sought care in their home country. It also outlines member states’ responsibility to provide access to health care in their territory and for ensuring that treatment in other member states meets quality and safety standards and takes into account international medical advances and sound medical practices.

362. Official Journal of the European Communities. Charter of Fundamental Rights of the European Union. OJ C 364/01. December 7, 2000.

363. E.g., Hervey and McHale, Article 35, although the potential for a right to healthcare claim is there, particularly in case of vulnerable groups, in: S. Peers and others (eds), *The EU charter of fundamental rights: a commentary* (Hart 2014), p. 957; and linked with more individual rights, see Hervey and McHale p. 160, 176-7; the same line of reasoning, see N. Koffeman, *Morally Sensitive Issues and Cross-border Movement in the EU. The cases of reproductive matters and legal recognition of same-sex relationships* (Diss.) (Intersentia 2015), p. 70-80; D. Anderson and C. Murphy, ‘The Charter of Fundamental Rights’, in A. Biondi, P. Eeckhout, S. Ripley (eds), *EU Law after Lisbon* (OUP 2012), p. 161-2. in the absence of any case law, it is unknown how the CJEU will interpret such a combined individual-social rights claim.

364. More extensively on general principles of EU law, read: P. Craig and G. de Búrca, *EU Law. Texts, Cases and Materials* (6th ed., OUP, 2015).

365. See e.g. Kedzia, Z.: Reinforcement of Economic, Social and Cultural Rights, in: W. Benedek, F. Benoit-Rohmer, W. Karl, M. C. Kettermann & M. Nowak (ed.), *European Yearbook on Human Rights 2014*. Antwerp, Intersentia, (2014) pp. 23-37. See e.g. European Court of Human Rights, CLR on behalf of Valentin Campeanu v. Romania Grand Chamber judgment, Appl. No. 47848/08, 17.07.2014. As underlined in the Court’s Factsheet on Health, from June 2017 (p.2): “Valentin Câmpeanu had been placed in medical institutions which were not equipped to provide adequate care for his condition; that he had been transferred from one unit to another without proper diagnosis; and, that the authorities had failed to ensure his appropriate treatment with antiretroviral medication. The authorities, aware of the difficult situation – lack of personnel, insufficient food and lack of heating – in the psychiatric hospital where he had been placed, had unreasonably put his life in danger.” (as cited in Roksandić Vidlička, *Filling the void: the case for international economic criminal law*, *Zstw* 2017; 129(3):1-34.

366. Official Journal of the European Union. Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients’ rights in cross-border healthcare. OJ L 88/45. April 4, 2011.

- ▶ **Regulation 883/2004/EC of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems.**³⁶⁷

This Regulation replaces Regulation 1408/71 of 14 June 1971, while modernizing and simplifying the rules essential for the free movement of persons, including patients receiving healthcare abroad. Next to the Directive on cross-border care, the Regulation set additional reimbursement rules for receiving, inter alia, health care abroad (Ch.1). To certain extent, the Regulation's regime sets more favorable rules, i.e. full compensation, no upfront payments, for certain categories of patients.

- ▶ **Directive 2005/36/EC of 7 September 2005 on the recognition of professional qualifications.**³⁶⁸

The Directive allows member states' nationals the right to pursue a profession in another member state. Therefore, the Directive introduces a system of mutual recognition of diplomas, and other qualifications. Freedom of movement and the mutual recognition for qualifications of doctors, nurses, dentist, pharmacists and midwives ('regulated professions) is based on the principle of automatic recognition of the evidence of formal qualifications, as it meets the system of minimum requirements. (Professional mobility)

Privacy

- ▶ **General Data Protection Regulation 2016/679/EU of 27 April 2016 on the processing of personal data and the free movement of such data, and repealing Directive 95/46/EC.**³⁶⁹

The Regulation will adapt European data protection to the requirements of today's information technology, to establish a high standard of protection in particular on the internet and to harmonise highly divergent rules on data protection applying in the member states. As far as data protection in health care is concerned, the basic provisions follow the previous Data Protection Directive (95/46/EC).

- ▶ **Regulation 536/2014 of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC.**³⁷⁰

The Regulation will simplify and further harmonise the administrative provisions governing clinical trials in the Union. At the same time upholding the rules for the protection of the rights, safety, dignity and well-being of subjects participating in such trials (including incapacitated persons and minors).

Infectious/communicable diseases

- ▶ **Directive 2002/98/EC of 27 January 2003 setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components.**³⁷¹

The quality and safety framework is based on common values, such as voluntary donor services, anonymity of both donor and recipient, benevolence of the donor, and absence of profit of the establishments involved in blood transfusion services. The Directive introduces additional safeguards to prevent unauthorised disclosure of health-information. Therefore, member states take all necessary measures to guarantee the donor's confidentiality of any health-related information provided to the authorised personnel, the results of the tests of their donations as well as any future traceability of their donation.

367. Official Journal of the European Union OJ L166, 30.4.2004, of April 29, 2004.

368. Official Journal of the European Union OJ L 255/22, 30.9.2005, of September 7, 2005, as amended.

369. Official Journal of the European Union OJ L 119/1 of 4.5.2016, May 4, 2016, entering into force May 4, 2018.

370. Official Journal of the European Union OJ L 158/1 of 27.5.2014, May 27, 2014,

371. Official Journal of the European Union OJ L 33 of 8 February 2003 and amending Directive 2001/83/EC.

- ▶ **Directive 2004/23/EC of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells.**³⁷²

The main aim of this Directive is to prevent the transmission of infectious diseases by tissues and cells. The Directive echoes the human rights principles as mentioned under the Blood Directive, and reflected in the EU Charter Fundamental Rights, and the Biomedicine Convention, i.e. voluntary and unpaid donation, anonymity of both donor and recipient, altruism of the donor and solidarity between donor and recipient, freely and informed consent, confidentiality and protection of health data, including genetic information.

Equal treatment

- ▶ **Directive 2004/113/EC of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services**³⁷³

This directive was adopted on December 13, 2004, and entered into force on December 21, 2004. It is legally binding on member states and requires them to prohibit discrimination based on sex in the supply of public goods and services.

- ▶ **Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation**³⁷⁴

This directive was adopted on November 27, 2000, and entered into force on December 2, 2000. It establishes a “guideline framework” for member states to address employment discrimination. It prohibits discrimination based on religion or belief, disability, age, or sexual orientation.

- ▶ **Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin**³⁷⁵

This directive was adopted on June 29, 2000, and entered into force on July 19, 2000. It requires member states to ensure that discrimination based on race or ethnic origin is prohibited in both public and private sectors. The directive lists access to health care as one of the contexts where this type of discrimination must be prohibited.

Organ donation and transplantation Directive 2010/53/EU of 7 July 2010.³⁷⁶ The ‘Organ Directive’ establishes a quality and safety framework encompassing the entire chain from donation to transplantation. Human rights obligations under the Directive include: the prohibition on commodifying human organs; consent as the underlying principle of organ donation; protecting the confidentiality of medical data of organ donors and recipients; providing access to transplantation services of sound quality; and respecting the non-discrimination principle, meaning the allocation of organs based on medical and medically-related criteria only.

The Directive is neutral with respect to the donor consent system (‘opting-out’ or ‘opting in’). It is up to individual member states what kind of consent is required (explicit or presumed, or even something in between). This approach also applies to another issue: deceased or living donation.

372. Official Journal of the European Union OJ L 102 of 7.4.2004, March 31, 2004.

373. Official Journal of the European Union. Council Directive 2004/113/EC of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services. OJ L 373 of 21.12.2004. June 25, 2009.

374. Official Journal of the European Union. Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation. OJ L 303 of 2.12.2000. December 2, 2000.

375. Official Journal of the European Union. Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin. OJ L 180 of 19.7.2000. July 19, 2000.

376. Directive 2010/53/EU of the European Parliament and of the Council of 7 July 2010 on the standards of quality and safety of human organs intended for transplantation [2010] OJ L207/14; Corrigendum to Directive 2010/45/EU of the European Parliament and of the Council of 7 July 2010 [2010] OJ L243/68.

Both modalities are left open, following the Council of Europe approach in the Council of Europe's Biomedicine Convention.³⁷⁷

Of further relevance is the consensus on principles governing organ donation: voluntary and unpaid donation; leaving room for a modest compensation of certain expenses in the case of living donation; a ban on organ-advertising and organ trafficking; the non-profit nature of organ procurement; and the protection of personal data in all organ donation and transplantation activities (Ch. III).

Council of Europe

► **Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine 1997 (European Convention on Human Rights and Biomedicine)**³⁷⁸

This COE convention sets out certain basic patient rights principles based on the premise that there is a “need to respect the human being both as an individual and as a member of the human species and recognizing the importance of ensuring the dignity of the human being.”³⁷⁹ It is binding on ratifying states. It is binding on ratifying states. It is a framework Convention allowing the formulation of additional Protocols (also legally binding) on specific subjects, elaborating and complementing the Convention. It is enforced by national courts in COE member states.

Additional Protocols: the Prohibition of Cloning Human Beings (CETS 168); on Transplantation of Organs and Tissues (CETS 186); Biomedical Research (CETS 195); Genetic Testing for Health Purposes (CETS 203).

► **European Convention on Human Rights (ECHR)**³⁸⁰

The ECHR is the leading regional human rights treaty, and it has been ratified by all COE member states. It is enforced by the ECtHR, which hands down binding decisions that frequently involve monetary compensation for victims. It should be considered with the European Social Charter as forming the key, complementary instruments protecting human rights across Europe.

► **European Social Charter of 1961 and 1996 (ESC)**³⁸¹

A COE treaty, the ESC is the leading, regional economic and social rights instrument. It is monitored by the ECSR through a system of periodic state reporting and collective complaints. Originally drafted in 1961, the ESC was significantly revised in 1996, although some states have not ratified the later version and can select which provisions to accept. Given the generality of many of the clauses and given the progressive/liberal approach of the ECSR, patients' rights can be advocated under a number of provisions even in the absence of acceptance of the specific health care guarantees.

► **Framework Convention for the Protection of National Minorities**³⁸²

This COE treaty guarantees equal treatment for all ethnic and other minorities. It requires that states take the necessary measures “to promote, in all areas of economic, social, political and cultural life, full and effective equality between persons belonging to a national minority and those belonging to the majority,” and such measures are not to be considered acts of discrimination.

377. Officially known as the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. ETS No. 164.

378. COE. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention of Human Rights and Biomedicine. ETS No. 164. April 4, 1997.

379. Subsequent additional protocols have been produced on prohibition of cloning (ETS No. 168. December 1, 1998), transplantation of organs and tissues (Treaty ETS No. 186. January 24, 2002), and biomedical research (ETS No. 195. January 25, 2005).

380. COE. European Convention on Human Rights. ETS No. 5. November 4, 1950.

381. COE. European Social Charter. ETS No. 35. November 4, 1950.

382. COE. Framework Convention for the Protection of National Minorities. ETS No. 35. February 1, 1995.

States are to consider “the specific conditions of the persons belonging to national minorities.”³⁸³

NON-LEGALLY BINDING INSTRUMENTS

There are a number of instruments that do not have the legally binding force of treaties but have acquired regional consensus and assist in developing the content of patients' rights. In fact, some of these have been adopted by civil society groups, such as professional associations and non-governmental organizations. Below are a few examples.

► **Declaration on the Promotion of Patients' Rights in Europe: European Consultation on the Rights of Patients, Amsterdam**³⁸⁴

This declaration was issued by the WHO Regional Office for Europe in 1994 and has been influential. It sets the International Bill of Rights,³⁸⁵ the ECHR, and the ESC as its foundation and focuses on rights to information, consent, confidentiality and privacy, as well as care and treatment. It emphasizes the complementary nature between rights and responsibilities and takes into account the perspectives of health care providers and patients. According to this declaration, patients have “responsibilities both to themselves for their own self-care and to health care providers, and health care providers enjoy the same protection of their human rights as all other people.” By outlining patients' rights, this declaration hopes to raise awareness among patients about “their responsibilities when seeking and receiving or providing health care,” and thereby create patient/provider relationships based on “mutual support and respect.”³⁸⁶

► **The European Charter of Patients' Rights**³⁸⁷

Drawn up in 2002 by the Active Citizenship Network, a European network of civic, consumer, and patient organizations, this instrument provides a clear, comprehensive statement of patients' rights. It states:

*As European citizens, we do not accept that rights can be affirmed in theory, but then denied in practice, because of financial limits. Financial constraints, however justified, cannot legitimize denying or compromising patients' rights. We do not accept that these rights can be established by law, but then left not respected, asserted in electoral programmes, but then forgotten after the arrival of a new government.*³⁸⁸

This statement was part of a grassroots movement across Europe that encouraged patients to play a more active role in shaping the delivery of health services and was also an attempt to convert regional documents concerning the right to health care into specific provisions.³⁸⁹ This instrument identifies 14 concrete patients' rights that are currently at risk: the right to preventive measures, access, information, consent, free choice, privacy and confidentiality, respect of patients' time, observance of quality standards, safety, innovation, avoidance of unnecessary suffering and pain, personalized treatment, the filing of complaints, and compensation. Although this instrument is not legally binding, a strong network of patients' rights groups across Europe has successfully lobbied their national governments for recognition and adoption of the rights it addresses.³⁹⁰ It has also been used as a reference point to monitor and evaluate health care systems across Europe.

383. COE. Framework Convention for the Protection of National Minorities. Article 4(2). ETS No. 35. February 1, 1995.

384. WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

385. The Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

386. WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

387. Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.

388. ACN. European Charter of Patients' Rights. November 2002. Preamble.

389. The pharmaceutical company Merck & Co., Inc., also provided funding for this movement.

390. One of the activities of new EU member states during the process of preparation for accession in the EU was adjustment of health care legislation toward European legislation and standards. Many countries, such as Bulgaria, adopted new health law, whose structure and contents are strictly in line with the European Charter of Patients' Rights.

▶ **Ljubljana Charter on Reforming Health Care**³⁹¹

This instrument was developed by WHO to improve health systems in the European region. It contains a number of fundamental principles to ensure that “health care should first and foremost lead to better health and quality of life for people.”³⁹² Specifically, it recommends that health care systems be people-centric and calls for patient participation in shaping improvements.

▶ **Recommendation No. R (2000) 5 of the Committee of Ministers to member states on the development of structures for citizen and patient participation in the decision-making process affecting health care.**³⁹³

Issued by the COE’s Committee of Ministers, this recommendation contains strong political and moral authority even though it is not legally binding on COE member states. It focuses on the need to ensure effective participation for all in increasingly diverse and multicultural societies where groups such as ethnic minorities are frequently marginalized.

▶ **Recommendation Rec (2001) 12 of the Committee of Ministers to member states on the adaptation of health care services to the demand for health care and health care services of people in marginal situations.**³⁹⁴

It proposes a multi-sectoral approach to preventive action, to create supportive environments for the social re-integration, to avoid stigmatization and to increase knowledge base.

▶ **Recommendation No R (2004) 10 of the Council of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder.**³⁹⁵

This Recommendations aims to enhance the protection of the dignity, human rights, and fundamental freedoms of persons with mental disorder, in particularly those who are subject to involuntary placement or involuntary treatment.

▶ **Recommendation Rec (2006) 18 of the Committee of Ministers to member states on health services in a multicultural society.**³⁹⁶

Ethnic groups face inequalities with regard to health care access, the lack of cultural competence in health care providers, lack of essential provisions (such as of interpreter services, or translated health education material), all of which may be structural barriers to quality care. The Recommendation recommends governments to prioritise health care access and quality issues in multicultural societies, in health care policy.

▶ **Resolution 1763 (2010)**³⁹⁷

“The right to conscientious objection in lawful medical care”: the Parliamentary Assembly emphasises the need to affirm the right of conscientious objection together with the responsibility of the state to ensure that patients are able to access lawful medical care in a timely manner. The Assembly is concerned that the unregulated use of conscientious objection may disproportionately affect women, notably those having low incomes or living in rural areas. <https://assembly.coe.int/nw/xml/News/FeaturesManager-View-EN.asp?ID=950>

391. World Health Organization [WHO]. Ljubljana Charter on Reforming Health Care. June 19, 1996.

392. WHO. Ljubljana Charter on Reforming Health Care.

393. COE. Recommendation Rec No. R (2000) 5. April 30, 2002.

394. CoE Recommendation Rec (2001) 12. 10 October 2001

395. CoE Recommendation Rec (2004) 10. 22 September 2004.

396. CoE Recommendation Rec (2006) 18. 8 November 2006.

397. CoE Recommendation Rec (2010) 7 October 2010

► **Resolution 1928 (2013)**³⁹⁸

“Safeguarding human rights in relation to religion and belief, and protecting religious communities from violence”: The Parliamentary Assembly ensures the right to well-defined conscientious objection in relation to morally sensitive matters, such as military service or other services related to health care and education, in line also with various recommendations already adopted by the Assembly, provided that the rights of others to be free from discrimination are respected and that the access to lawful services is guaranteed’

3.3 PATIENTS' RIGHTS

This section is structured around ten critical patient rights:

- **Liberty and security of person;**
- **Privacy;**
- **Access to information;**
- **Bodily integrity;**
- **Life;**
- **Highest attainable standard of mental and physical health;**
- **Freedom from torture and other cruel, inhuman or degrading treatment or punishment;**
- **Participation in public policy;**
- **Equality and freedom from discrimination; and**
- **Effective remedy.**

The ECHR and the ESC constitute the two main complementary instruments covering the range of human rights in the European region, with the ECtHR and the ESCR taking a cross-fertilization approach in terms of developing human rights protection and understanding of the substantive content of rights. On rare occasions, the European Union Court of Justice (EUCJ) has dealt with some (aspects) of the human rights mentioned above (e.g. access to cross-border health care, life and human dignity).

The lack of an explicit provision guaranteeing the right to health in the ECHR has not prevented the ECtHR, the ECHR's supervisory and enforcement body, from addressing many patients' rights issues through other articles in the ECHR (the most common ones being Articles 2, 3, 5, 8, 13 and 14). Article 5, which guarantees the right to liberty and security of person, has been used by the ECtHR to protect the rights of those detained on mental health grounds. Article 3 provides an absolute prohibition on the use of torture and/or cruel, inhuman, or degrading treatment against detainees, including those detained on mental health grounds. Article 8, safeguarding the right to privacy, has been successfully argued in relation to unlawful disclosure of personal medical data. Beyond these examples, however, the ECtHR has been reluctant to indirectly recognize a positive right to health, although the door has been left open in relation to the right to life under Articles 2 and 3 in cases in which preexisting obligations have not been fulfilled (e.g. incapacitated persons, prisoners and aliens).³⁹⁹ This reluctance is in line with the ECtHR's general desire not to make decisions that could have a significant economic and/or social impact on policy or resources.

398. CoE Recommendation Rec (2013) 24 April 2013

399. E.g. Valentin Campeanu v. Romania, 17 July 2014 (Grand Chamber); Oval v. Turkey, 23 May 2010; Kudla v Poland, judgment (Grand Chamber) of 26 October 2000, para 94; Mouïsel v. France, 14 November 2002; Holomiov v. Moldova, 7 November 2006; VD v. Romania (no. 7078/02), 16 February 2010; Nogin v. Russia, 15 January 2015; Yunusova v. Azerbaijan, 2 June 2016; D. v United Kingdom (no. 30240/96), 2 May 1997.

On the other hand, in Article 11 of the ESC, the ESCR has specifically defined the right to protection of health, together with a number of related guarantees, such as the right to social and medical assistance under Article 13. Because the ESC cannot be used by individual victims, however, all of the ECSR's analysis relates to country reports or to the collective complaints mechanism and, therefore, tends to be general in nature (stating, for example, that health care systems must be accessible to everyone or that there must be adequate staff and facilities). To date, under the collective complaints mechanism, the ECSR has considered eight right-to-health cases, concerning issues ranging from detrimental effects on health from environmental pollution to denial of medical assistance to poor illegal immigrants.⁴⁰⁰ Therefore, there is great potential for further development of the ECSR's case law in this area.

Other significant sets of standards discussed in this chapter, such as the European Charter of Patients' Rights, also contain a number of specific relevant guarantees, but these standards lack any form of supervisory body. They, therefore, cannot be directly enforced by victims to gain redress. Nonetheless, that does not mean that they cannot be referenced when arguing claims under binding treaties, such as the ECHR and the ESC, in order to better interpret the treaties' own provisions. In turn, increased references to nonbinding documents such as the European Charter of Patients' Rights will help them gain further credibility and strength so that, over time, some of their provisions might attain customary international law status.⁴⁰¹

3.3.1 RIGHT TO LIBERTY AND SECURITY OF PERSON

As it relates to patients' rights, the right to liberty of the person protects the individual from arbitrary or unjustified physical confinement on the basis of mental or physical health, such as involuntary hospitalization. The detention of an individual based on health grounds, such as quarantine and isolation, must be done in accordance to established law and must safeguard the individual's rights to due process under the law. The detention is considered "lawful" only if it occurs in a hospital, clinic, or other appropriate authorized setting.⁴⁰² However, the fact that detention may be in a suitable institution has no bearing on the appropriateness of the patient's treatment or conditions under which she/he may be detained.⁴⁰³

The ECtHR has established procedural guarantees in relation to the application of Article 5(1)(e), which guarantees this right under the ECHR:

- ▶ Committing an individual to confinement must only occur according to a properly prescribed legal procedure and cannot be arbitrary. In relation to the condition of "unsound mind," this guarantee means that the person must have a recognized mental illness and require confinement for the purposes of treatment;⁴⁰⁴

400. COE. International Federation of Human Rights Leagues (FIDH) v. Belgium. Collective Complaint No. 75/2011. January 23, 2013; COE. International Federation of Human Rights Leagues (FIDH) v. Greece. Collective Complaint No. 72/2011. January 23, 2013; COE. Defence for Children International (DCI) v. Belgium. Collective Complaint No. 69/2011. October 23, 2012; COE. Médecins du Monde - International v. France. Collective Complaint No. 67/2011. September 11, 2012; COE. Decision on the merits: International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia. Collective Complaint No. 45/2007. March 30, 2009; COE. European Roma Rights Centre (ERRC) v. Bulgaria. Collective Complaint No. 46/2007. December 3, 2008; COE. Marangopoulos Foundation for Human Rights (MFHR) v. Greece. Collective Complaint No. 30/2005. December 6, 2006; COE. Confédération Générale du Travail (CGT) v. France. Collective Complaint No. 22/2003. December 8, 2004.

401. Article 38(1)(b) of the Statute of the International Court of Justice refers to "international custom" as a source of international law, specifically emphasizing the two requirements of state practice and acceptance of the practice as obligatory.

402. ECtHR. De Donder and de Clippel v. Belgium. App. No. 8595/06. December 6, 2011.

403. ECtHR. Ashingdane v. The United Kingdom. App. No. 8225/78. May 28, 1995.

404. ECtHR. Winterwerp v. The Netherlands. App. No. 6301/73. October 24, 1979; see also ECtHR. H.L. v. The United Kingdom. App. No. 45508/99. January 1, 2004. (system of detaining "informal patients" in psychiatric institutions did not incorporate sufficient procedural safeguards in order to prevent arbitrary deprivations of liberty).

- ▶ Any commitment must be subject to a speedy periodic legal review that incorporates the essential elements of due process;⁴⁰⁵ and
- ▶ Where such guarantees have not been adhered to, the ECtHR has been prepared to award damages for breaches of a person's liberty under Article 5(1)(e).⁴⁰⁶

With respect to the right to security of person, it is often enshrined under the same provision as the right to liberty, such as Article 5 of the ECHR. The right to liberty protects the individual from arbitrary or unjustified physical confinement. The right to security of person safeguards the individual's freedom from bodily injury or interference. As shown in this section, the facts present in relevant case law have led the ECtHR to address issues concerning physical or bodily integrity (right to security of person) under Article 5 without making a distinction between the two rights. Moreover, most cases concerning violations of physical or bodily integrity in health care settings have been analyzed under related rights that include the right to freedom from torture and cruel, inhuman and degrading treatment (ECHR, Art. 3), the right to privacy (ECHR, Art. 8), and the right to the highest attainable standard of health (ESC, Art. 11). For example, the Court has examined cases involving the administration of forced medication (including injections), forced feeding and nonconsensual sterilizations under the right to privacy (ECHR, Art. 8)⁴⁰⁷ and the right to freedom from torture, cruel, inhuman or degrading treatment (ECHR, Art. 3).⁴⁰⁸ Therefore, there is little analysis emanating from the ECtHR solely on the right to security of person. For this reason, this section contains case law that focuses primarily on the right to liberty.

RELEVANT PROVISIONS

- ▶ **ECHR, Art. 5(1):** Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: ... (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants. ...

Right to Liberty and Security of Person in the Context of Mental Health

In order to detain an individual on the basis of mental health, three conditions must be satisfied:

- It must be reliably established through objective medical expertise that the person has a mental disorder;
- The mental disorder must be of a kind to warrant compulsory confinement and the deprivation of liberty must be shown to be necessary in the circumstances;
- The mental disorder must persist throughout the period of detention or confinement; and
- The period of confinement must also be under periodic review.⁴⁰⁹

Any detention must be "lawful"—it must be conducted according to a law with adequate substantive and procedural safeguards.⁴¹⁰ Moreover, although the intent of 5(1)(e) is not, in principle, concerned with suitable treatment or conditions of detention, the ECtHR has repeatedly stated that the detention of a person

405. ECtHR. *X v. The United Kingdom*. App. No. 7215/75. July 7, 1977.

406. ECtHR. *Gajcsi v. Hungary*. App. No. 34503/03. October 3, 2006. (patient unlawfully detained for three years in a Hungarian psychiatric hospital, where the commitment procedure was superficial and insufficient to show dangerous conduct).

407. ECtHR. *Storck v. Germany*. App. No. 61603/00. June 16, 2005; see also ECtHR. *X v. Finland*. App. No. 34806/04. November 19, 2012; *V.C. v. Slovakia*. App. No. 18968/07. November 8, 2011.

408. ECtHR. *Ciorap v. Moldova*. App. No. 12066/02. June 19, 2007; *V.C. v. Slovakia*. App. No. 18968/07. November 8, 2011; *Gorobet v. Moldova*. App. No. 30951/10. October 11, 2011.

409. ECtHR. *Winterwerp v. Netherlands*. App. No. 6301/73. October 24, 1979; ECtHR. *Stanev v. Bulgaria*. App. No. 23419/07. November 22, 2012.

410. See ECtHR. *Stanev v. Bulgaria* (36760/06). January 17, 2012.

in terms of 5(1)(e) will only be considered lawful if the detention is carried out in a hospital, clinic, or other appropriate institution authorized to detain and treat individuals with the relevant mental disorder.⁴¹¹

Additionally, the ECtHR has recognized the need to protect the physical and mental integrity of mental health patients. It has considered forced treatment of mental health patients to be in violation of Article 5 when it fails to satisfy the arbitrariness safeguards.⁴¹² For further discussion on physical integrity violations, refer to the section on the “right to bodily integrity” below for more discussion on the issue.

CASES RELATING TO MENTAL HEALTH AND THE RIGHT TO LIBERTY AND SECURITY OF PERSON

De Donder and De Clippel v. Belgium (ECtHR)(2012). The Court held that the placement of the mental health patient in an ordinary section of the prison rather than a specialized institution or the psychiatric wing of the prison constituted a breach of Article 5 of the ECHR. The Court reiterated that the “detention” of a mental health patient is legally justified under Article 5(1)(e) only if it is done “in a hospital, clinic or other appropriate institution.”⁴¹³

Herz v. Germany (ECtHR)(2003). A person was detained in a psychiatric hospital because a judge ordered the person’s emergency confinement on the basis of a diagnosis given over the telephone by a doctor who had not personally examined this person. The Court held that the judge’s order was in conformity with the Convention because of the urgent nature of the situation.⁴¹⁴

H.L. v. United Kingdom (ECtHR)(2005). The Court found that the involuntary confinement of an autistic person who had shown signs of agitated behavior lacked procedural safeguards and was therefore arbitrary and in violation of Article 5 of the ECHR.⁴¹⁵

Shopov v. Bulgaria (ECtHR)(2010). The Court found the government in violation of Article 5(1) where an applicant was forced to undergo psychiatric treatment for more than five years as a result of the public prosecutor and the police overstepping the limits of a domestic court’s judgment ordering treatment in an outpatient clinic and not in a psychiatric hospital.⁴¹⁶

Storck v. Germany (ECtHR)(2005). The Court found the mental health patient’s confinement in a psychiatric hospital and forced treatment to be in violation of Article 5(1) as the confinement had not been ordered by a court. The Court stressed the responsibility of the State to protect vulnerable populations (such as mental health patients) and concluded that retrospective measures to protect such individuals from the unlawful deprivation of liberty were insufficient.⁴¹⁷

X. v. Finland (ECtHR)(2012). The Court found that the confinement and forced treatment of a pediatrician in a mental health hospital lacked the proper safeguards against arbitrariness and, therefore, constituted a violation of Article 5.⁴¹⁸

411. ECtHR. *De Donder and De Clippel v. Belgium*. App. No. 8595/06. June 12, 2011. para. 106.

412. ECtHR. *X. v. Finland*. App. No. 34806/04. November 19, 2012; ECtHR. *Shopov v. Bulgaria*. App. No. 11373/04. December 2, 2010; ECtHR. *Storck v. Germany*. App. No. 61603/00. September 16, 2005.

413. ECtHR. *De Donder and De Clippel v. Belgium*. App. No. 8595/06. June 12, 2011; see ECtHR. *Aerts v. Belgium*. App. No. 25357/94. July 30, 1998. (psychiatric wing could not be regarded as an institution appropriate for the detention of persons of unsound mind).

414. ECtHR. *Herz v. Germany*. App. No. 44672/98. December 3, 2003.

415. ECtHR. *H.L. v. The United Kingdom*. App. No. 45508/99. January 5, 2005.

416. ECtHR. *Shopov v. Bulgaria*. App. No. 11373/04. December 2, 2010.

417. ECtHR. *Storck v. Germany*. App. No. 61603/00. September 16, 2005.

418. ECtHR. *X. v. Finland*. App. No. 34806/04. November 19, 2012.

Right to Liberty and Security of Person in the Context of Infectious Diseases

Article 5(1)(e) of the ECHR may permit detention based on the threat posed by the spread of infectious diseases. The ECtHR has allowed detention under this provision in the interests of both the individual and public safety.⁴¹⁹ According to the ECtHR, the essential criteria for lawfully detaining an individual “for the prevention of the spreading of infectious diseases” are:

- The spread of the infectious disease poses a danger to public health or safety;
- It is the least restrictive way of preventing the spread of the disease to safeguard the public interest; and
- Both the danger of spreading the infectious disease and detention being the least restrictive means of safeguarding the public interest must persist throughout the period of detention.⁴²⁰

Moreover, the right to security of person becomes particularly relevant in instances where individuals with infectious diseases are subjected to coercive measures, such as quarantine and forced treatment. Refer to the section on “right to bodily integrity” for more discussion on violations concerning physical and bodily integrity.

CASE RELATING TO INFECTIOUS DISEASES AND RIGHT TO LIBERTY AND SECURITY OF PERSON

Enhorn v. Sweden (ECtHR) (2005). The Court found a violation of Article 5 of the ECHR where an individual living with HIV was placed involuntarily in a hospital for almost one and a half years after having transmitted the virus to another man as a result of sexual activity. The Court concluded that the compulsory isolation was not the least restrictive means available to prevent him from spreading HIV, and therefore, the authorities failed to strike a fair balance between the need to ensure that the HIV virus did not spread and the applicant’s right to liberty.⁴²¹

Right to Liberty and Security of Person in the Context of Sexual and Reproductive Health

The right to liberty protects individuals from interference intended to limit or promote their fertility and hinder their sexual autonomy—either by the state or private individuals. In addition to protecting the life and health of the individual, the right to liberty recognizes the individual’s reproductive choice as well as her/his decision on how to conduct her/his sexual life.⁴²² For example, women can use this right to challenge legal actions involving deprivation of liberty that are taken against them for terminating their own pregnancy.⁴²³

With respect to the right to security of person, it safeguards the person’s right to control her/his health and body and is pertinent to issues relating to sexual and reproductive health, such as forced sterilization, genital mutilation, and abortion. The European Commission of the EU has committed to ending violence against women and ending female genital mutilation (FGM), recognizing it as a violation of women’s human rights and the international Convention on the Rights of the Child (CRC).⁴²⁴ The EU Council has

419. ECtHR. *Enhorn v. Sweden*. App. No. 56529/00. January 25, 2005. para. 43; ECtHR. *Litwa v. Poland*. App. No. 26629/95. April 4, 2000; see ECtHR. *Hutchison Reid v. The United Kingdom*. App. No. 50272/99. February 20, 2003. (detention under Article 5(1)(e) of a person with psychopathic personality disorder justified both in the interests of the individual and on public safety grounds, even where her/his condition was not susceptible to medical treatment).

420. ECtHR. *Enhorn v. Sweden*. App. No. 56529/00. January 25, 2005. para. 43.

421. ECtHR. *Enhorn v. Sweden*. App. No. 56529/00. January 25, 2005.

422. See Rebecca Cook. *International Human Rights and Women’s Reproductive Health*. *Studies in Family Planning*, Vol. 24, No. 2 (March-April, 1993). p. 79.

423. ECtHR. *P. and S. v. Poland*. App. No. 57375/08. January 30, 2013.

424. European Commission. *Communication from the Commission to the European Parliament and the Council: Towards the elimination of female genital mutilation*. November 25, 2013.

stated: “[FGM] constitutes a breach of the fundamental right to life, liberty, security, dignity, equality between women and men, non-discrimination and *physical* and mental *integrity*” (emphasis added).⁴²⁵

However, as in other contexts, ECtHR case law involving these sexual and reproductive health issues have been typically addressed under either the right to privacy (ECHR, Art. 8) or the right to freedom from torture and cruel, inhuman, and degrading treatment (ECHR, Art. 3).⁴²⁶

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO LIBERTY AND SECURITY OF PERSON

P. and S. v. Poland (ECtHR)(2013). The Court found that the essential purpose of placing a 14-year-old girl, who had become pregnant as a result of rape, in a juvenile shelter was to separate her from her parents and prevent an abortion—not for educational supervision, which would have been in accordance with Article 5(1)(d). Therefore, the applicant’s confinement was in violation of Article 5.⁴²⁷

3.3.2 RIGHT TO PRIVACY

The right to privacy protects the individual from unlawful and arbitrary interference with her/his privacy. As it relates to patients’ rights, the right to privacy has been used to protect the bodily integrity of the individual, the confidentiality of the patient’s medical information, and to prevent the government from unlawfully interfering in matters that should be resolved between the patient and her/his physician (e.g., to terminate pregnancy). The ECtHR has held that a person’s body concerns the most intimate aspect of one’s private life⁴²⁸ and has used the right to privacy to protect the individual from medical treatment or examination without her/his informed consent.⁴²⁹ The ECtHR recognizes that the administration of medication against the will of a patient constitutes an interference with an individual’s right to respect for their private life.⁴³⁰

With regards to the patient’s medical information, the ECtHR has held that “the protection of personal data, not least medical data, is of fundamental importance to a person’s enjoyment of his or her right to respect for private and family life.” Moreover, it is “crucial ... to preserving his or her confidence in the medical profession and in the health services in general.”⁴³¹ Failure to protect the confidentiality of the patient’s medical information can deter those in need of medical assistance from revealing personal and intimate information that may be necessary to receive appropriate treatment and even from seeking such assistance, thereby endangering their own health and/or those of others.⁴³²

Generally, any interference with an individual’s right to respect for her/his private life will not constitute a breach if such interference is:

- In accordance with the law;
- Pursued a legitimate aim or aims under 8(2) of the ECHR (national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others); and

425. EU Council. Council Conclusion on Combating Violence Against Women, and the Provision of Support Services for Victims of Domestic Violence. December 6, 2012. para. 1.

426. *Tysiac v Poland*, 20 May 2007; *RR v. Poland* (no. 27617/04), 26 May 2011; *Dickson v. United Kingdom*, 4 December 2007 (Grand Chamber); *V.C. v. Slovakia* (no. 18968/07), 8 November 2111; *Costa and Pavan v. Italy*, 28 August 2012; *A.K. v. Latvia* (no. 33011/08), 24 June 2014

427. ECtHR. *P. and S. v. Poland*. App. No. 57375/08. January 30, 2013.

428. ECtHR. *Y.F. v. Turkey*. App. No. 24209/94. October 22, 3003.

429. ECtHR. *Glass v. The United Kingdom*. App. No. 61827/00. March 9, 2004. (the Court found a violation of the right to privacy in the administration of dimorphine a son against his mother’s wishes and a DNR (Do Not Resuscitate) order placed in his records without his mother’s knowledge).

430. ECtHR. *Storck v. Germany*. App. No. 61603/00. September 16, 2005; ECtHR. *X. v. Finland*. App. No. 34806/04. November 19, 2012; see also ECtHR. *Glass v. The United Kingdom*. App. No. 61827/00. March 9, 2004.

431. ECtHR. *M.S. v. Sweden*. App. No. 20837/92. August 27, 1997; ECtHR. *Z v. Finland*. App. No. 22009/93. February 25, 1997.

432. ECtHR. *Z v. Finland*. App. No. 22009/93. February 25, 1997.

- Is necessary in a democratic society and proportionate to the legitimate aim pursued.⁴³³

With regard to “necessary in a democratic society” the ECtHR has stated that the interference would be assessed in a case-by-case basis, taking into account the “case as a whole and having regard to the margin of appreciation enjoyed by the State in such matters.”⁴³⁴

RELEVANT PROVISIONS

▶ ECHR, Art. 8:

- (1) Everyone has the right to respect for his private and family life, his home and his correspondence.
- (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

▶ COE Recommendation No. R (2004) 10,⁴³⁵

- **Art. 13(1):** All personal data relating to a person with a mental disorder should be considered to be confidential. Such data may only be collected, processed and communicated according to the rules relating to professional confidentiality and personal data collection.

▶ Convention for the Protection of Individuals with Regard to Automatic Processing of Personal Data⁴³⁶

- **Article 5 – Quality of data:** Personal data undergoing automatic processing shall be: obtained and processed fairly and lawfully; stored for specified and legitimate purposes and not used in a way incompatible with those purposes; adequate, relevant and not excessive in relation to the purposes for which they are stored; accurate and, where necessary, kept up to date; preserved in a form which permits identification of the data subjects for no longer than is required for the purpose for which those data are stored.
- **Article 6 – Special categories of data:** Personal data revealing racial origin, political opinions or religious or other beliefs, as well as personal data concerning health or sexual life, may not be processed automatically unless domestic law provides appropriate safeguards. The same shall apply to personal data relating to criminal convictions.
- **Article 8 – Additional safeguards for the data subject:** Any person shall be enabled: (a) to establish the existence of an automated personal data file, its main purposes, as well as the identity and habitual residence or principal place of business of the controller of the file; (b) to obtain at reasonable intervals and without excessive delay or expense confirmation of whether personal data relating to him are stored in the automated data file as well as communication to him of such data in an intelligible form; (c) to obtain, as the case may be, rectification or erasure of such data if these have been processed contrary to the provisions of domestic law giving effect to the basic principles set out in Articles 5 and 6 of this convention; (d) to have a remedy if a request for confirmation or, as the case may be, communication, rectification or erasure as referred to in paragraphs b and c of this article is not complied with.

433. ECtHR. L.L. v France. App. No. 7508/02. October 10, 2006; ECtHR. X. v. Finland. App. No. 34806/04. November 19, 2012.

434. ECtHR. L.L. v France. App. No. 7508/02. October 10, 2006.

435. COE. Recommendation Rec No. R (2004) 10. September 22, 2002.

436. COE. Convention for the Protection of Individuals with Regard to Automatic Processing of Personal Data. January 28, 1981.

▶ **Declaration on the Promotion of Patients' Rights in Europe**⁴³⁷

1.4 Everyone has the right to respect for his or her privacy.

4.1 All information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death.

4.6 There can be no intrusion into a patient's private and family life unless and only if, in addition to the patient consenting to it, it can be justified as necessary to the patient's diagnosis, treatment and care.

4.8 Patients admitted to health care establishments have the right to expect physical facilities which ensure privacy.

▶ **European Charter of Patients' Rights**,⁴³⁸

- **Art. 6 (Right to Privacy and Confidentiality):** Every individual has the right to the confidentiality of personal information, including information regarding his or her state of health and potential diagnostic or therapeutic procedures, as well as the protection of his or her privacy during the performance of diagnostic exams, specialist visits, and medical/surgical treatments in general.

▶ **Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine**,⁴³⁹

- **Art. 10(1):** Everyone has the right to respect for private life in relation to information about his or her health.

Right to Privacy in the Context of Mental Health

The ECtHR does not automatically condemn the interference in a mental health patient's private life, but it does condemn any breach of privacy that is not in accordance with the law. The placement of a mental health patient in guardianship must be "in accordance with the law and based on a legitimate aim."⁴⁴⁰ In cases where an individual has been deprived of her/his legal capacity, such an individual is entitled to a periodic review of her/his condition.⁴⁴¹ Moreover, with respect to persons in need of psychiatric treatment, the State must secure the right to physical integrity to its citizens in accordance to Article 8 of the ECHR.

In deciding to interfere with the mental health patient's right to privacy, authorities must "strike a fair balance between the interests of a person of unsound mind and the other legitimate interests concerned."⁴⁴² However, when determining someone's mental health status, authorities enjoy a wide margin of appreciation,⁴⁴³ which will be evaluated based on "the degree of interference" in the patient's life and the "quality of the decision-making process."⁴⁴⁴ Should the interference with the individual's private life be disproportionate to the legitimate aims of the government,⁴⁴⁵ or

437. WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

438. Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.

439. COE. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. April 4, 1997.

440. ECtHR. A.G. v. Switzerland. App. No. 28605/95. April 9, 1997.

441. ECtHR. Lashin v. Russia. App. No. 33117/02. April 22, 2013; see also ECtHR. Salontaji-Drobnjak v. Serbia. App. No. 36500/05. January 13, 2010.

442. ECtHR. Shtukaturv v. Russia. App. No. 44009/05. June 27, 2008. para. 87

443. ECtHR. Shtukaturv v. Russia. App. No. 44009/05. June 27, 2008.

444. ECtHR. Shtukaturv v. Russia. App. No. 44009/05. June 27, 2008.

445. ECtHR. Shtukaturv v. Russia. App. No. 44009/05. June 27, 2008.

should the decision-making process employed by the State be flawed⁴⁴⁶ (including failure by the State to periodically re-access the individual's condition⁴⁴⁷), the Court is likely to find a breach of Article 8.

CASES RELATING TO MENTAL HEALTH AND THE RIGHT TO PRIVACY

Lashin v. Russia (ECtHR)(2013). The Court found a violation of the right to privacy where the applicant, a person with schizophrenia, was committed by the domestic courts to a psychiatric hospital against his will and without possibility of review, which prevented him from getting married.⁴⁴⁸

Salontaji-Drobnjak v. Serbia (ECtHR)(2010). The applicant was diagnosed with litigious paranoia and was placed under guardianship. The Court found a violation of the right to privacy on account of the serious limitation of the applicant's legal capacity (he was unable to independently take part in legal actions, file for a disability pension, or decide about his own medical treatment) and because the procedure that the domestic courts had applied in depriving the applicant of his legal capacity had been "fundamentally flawed," and further, the domestic courts had failed to appropriately reassess the applicant's legal capacity.⁴⁴⁹

Shtukurov v. Russia (ECtHR)(2008). The Court found the domestic court's decision to hospitalize the applicant based on a medical report that had not sufficiently analyzed the degree of the applicant's incapacity to constitute a violation of the right to privacy. The Court determined that the interference with the applicant's private life was disproportionate to the legitimate aim of the State.⁴⁵⁰

Right to Privacy in the Context of Infectious Diseases

The ECtHR considers that the unauthorized disclosure of confidential health data could be detrimental to the individual's private and family life, as well as his/her social and work life, and could put him/her at risk of being ostracized.⁴⁵¹ Disclosure of medical information can be particularly damaging to persons living with HIV or other infectious diseases. Therefore, sufficient safeguards in domestic law are necessary. In cases concerning individuals living with HIV, the ECtHR has also established that States have positive obligations to enforce the right to privacy against others.⁴⁵²

CASES RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO PRIVACY

Biriuk v. Lithuania (ECtHR)(2009) and Armoniene v. Lithuania (ECtHR)(2009). The Court held that the State's failure to enforce the applicants' right to privacy against the newspaper that published the applicants' HIV status on its front page amounted to a violation of the right to privacy.⁴⁵³

Colak and Tsakiridis v. Germany (ECtHR)(2009). The Court affirmed the domestic court's finding that the physician's failure to disclose the HIV status of a patient to the patient's sexual partner (the applicant) did not amount to "gross error in treatment"—which was required to find the physician liable for malpractice—

446. ECtHR. *Salontaji-Drobnjak v. Serbia*. App. No. 36500/05. January 13, 2010.

447. ECtHR. *Lashin v. Russia*. App. No. 33117/02. April 22, 2013; see ECtHR. *Salontaji-Drobnjak v. Serbia*. App. No. 36500/05. January 13, 2010.

448. ECtHR. *Lashin v. Russia*. App. No. 33117/02. April 22, 2013.

449. ECtHR. *Salontaji-Drobnjak v. Serbia*. App. No. 36500/05. January 13, 2010.

450. ECtHR. *Shtukurov v. Russia*. App. No. 44009/05. June 27, 2008.

451. ECtHR. *Z v. Finland*. App. No. 22009/93. February 25, 1997.

452. ECtHR. *Biriuk v. Lithuania*. App. No. 23373/03. February 25, 2009. para. 35; ECtHR. *Armoniene v. Lithuania*. App. No. 36919/02. February 25, 2009. para. 36.

453. ECtHR. *Biriuk v. Lithuania*. App. No. 23373/03. February 25, 2009; ECtHR. *Armoniene v. Lithuania*. App. No. 36919/02. February 25, 2009.

and that the physician did not disregard medical standards but overestimated his duty of confidence to the patient. The Court held that there was no breach of the right to privacy.⁴⁵⁴

Mitkus v. Latvia (ECtHR)(2013). The Court found the disclosure of the inmate applicant's HIV status in a prison newspaper to constitute a violation of the right to privacy—it led other inmates to ostracize the applicant.⁴⁵⁵

Right to Privacy in the Context of Sexual and Reproductive Health

The right to privacy has served an important role in the promotion of sexual and reproductive health in ECtHR case law. While the right to privacy is often seen as implicating negative State obligations, the ECtHR has been clear in emphasizing the positive obligations that arise in enforcing respect for an individual's private and family life—particularly where individuals seek access to information regarding risks to their health (such as genetic testing⁴⁵⁶ and the health of their fetus⁴⁵⁷) or seek access to their medical records.⁴⁵⁸ In fact, States have a positive obligation under Article 8 to ensure that individuals have meaningful access to their own medical records.⁴⁵⁹ The ECtHR has held in a State-specific context that organizations may not be restrained from providing information about domestic abortion rights, and abortion related services available internationally.⁴⁶⁰

Furthermore, the Court has interpreted the right to include the right to personal autonomy and personal development, encompassing matters concerning gender identification, sexual orientation, sexual life, the physical and mental integrity of the person, and decisions on whether to become a parent.⁴⁶¹

In the context of abortion, the ECtHR has not interpreted Article 8 as conferring a right to abortion;⁴⁶² however, it has recognized that States that permit abortion are responsible for providing the legal framework to determine entitlements to lawful abortion and procedures to resolve disputes between women seeking abortion services and medical practitioners.⁴⁶³ The ECtHR has also addressed the possible 'chilling effects' that domestic criminal law may have regarding an individual's ability to access reproductive health care services,⁴⁶⁴ finding that criminal laws that deter medical providers from providing lawful abortion services, or deter patients from seeking such services for fear of criminal responsibility, may contravene Article 8.

The ECtHR has also held that the choice of whether or not to become a parent is encompassed by Article 8 (for both men and women).⁴⁶⁵ Medical procedures that limit a person's ability to conceive and bear children may be contrary to the right to privacy, including forced sterilization⁴⁶⁶ and serious medical errors that deprive individuals of their reproductive capacity.⁴⁶⁷ The Court found a breach of Article 8 where a detainee was denied access to artificial insemination services, considering that his wife would experience difficulties conceiving after his release due to her age and the time frame her husband was anticipated to remain in detention.⁴⁶⁸

454. ECtHR. Colak and Tsakiridis v. Germany. App. No. 77144/01 and 35493/05. June 5, 2009.

455. ECtHR. Mitkus v. Latvia. App. No. 7259/03. January 2, 2013.

456. ECtHR. Tysiąc v. Poland. App. No. 5410/03. March 20, 2007.

457. ECtHR. Costa and Pavan v. Italy. App. No. 54270/10. August 28, 2012; see ECtHR. R.R. v. Poland. App. No. 27617/04. May 26, 2011.

458. ECtHR. K.H. and Others v. Slovakia. App. No. 32881/04. April 28, 2009.

459. ECtHR. K.H. and Others v. Slovakia. App. No. 32881/04. April 28, 2009.

460. ECtHR. Open Door and Dublin Well Woman v. Ireland. App. No. 14234/88; 14235/88. October 29, 1992.

461. ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010. para. 212.

462. ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010; see ECtHR. P. and S. v. Poland. App. No. 57375/08. January 30, 2013.

463. ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010; see P. and S. v. Poland. App. No. 57375/08. January 30, 2013.

464. ECtHR. Ternovsky v. Hungary. App. No. 67545/09. December 14, 2010; see ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010.

465. ECtHR. Evans v. The United Kingdom. App. No. 6339/05. April 10, 2007.

466. ECtHR. K.H. and Others v. Slovakia. App. No. 32881/04. April 28, 2009; ECtHR. V.C. v. Slovakia. App. No. 18968/07. February 8, 2012; ECtHR. N.B. v. Slovakia. App. No. 29518/10. June 12, 2012; ECtHR. I.G., M.K. and R.H. v. Slovakia. App. No. 15966/04. November 13, 2012.

467. ECtHR. Csoma v. Romania. App. No. 8759/05. January 15, 2013.

468. ECtHR. Dickson v. The United Kingdom. App. No. 44362/04. December 4, 2007.

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO PRIVACY

A, B and C v. Ireland (ECtHR)(2010). Interpreting Article 8 to include the state's positive obligation of providing the necessary procedures to determine entitlement to lawful abortion, the Court found that Ireland's failure to provide such safeguards constituted a violation of the right to privacy. The Court also noted the uncertainty surrounding the process of establishing whether a woman's pregnancy posed a risk to her life and that the threat of criminal prosecution had "significant chilling" effects both on doctors and the women concerned.⁴⁶⁹

Costa and Pavan v. Italy (ECtHR)(2012). A couple, who were healthy carriers of cystic fibrosis, wanted to avoid transmitting the disease to their offspring with the help of medically-assisted procreation and genetic screening. The Court found the inconsistency in Italian law that denied the couple access to embryo screening but authorized medically-assisted termination of pregnancy if the fetus showed symptoms of the same disease to constitute a violation of the right to privacy.⁴⁷⁰

Ternovsky v. Hungary (ECtHR)(2011). The Court found the lack of specific and comprehensive legislation on when health professionals would be penalized for assisting in a home birth constituted a violation of the right to privacy, considering that the applicant was not free to choose to give birth at home because of the permanent threat of prosecution deterring health professionals from providing this service.⁴⁷¹

Tysic v. Poland (ECtHR)(2007). The applicant was refused a therapeutic abortion, after being warned that her already severe myopia could worsen if she carried her pregnancy to term. Following the birth of her child, she had a retinal hemorrhage, which resulted in a disability. The Court found that denying her access to an effective mechanism that would determine her eligibility for a legal abortion was a violation of her right to privacy.⁴⁷²

V.C. v. Slovakia (ECtHR)(2012). Where a Roma woman was sterilized at a public hospital without her informed consent, the Court found the lack of legal safeguards to protect her reproductive health to constitute a violation of the right to private and family life.⁴⁷³

3.3.3 RIGHT OF ACCES TO INFORMATION

The right of access to information guarantees the individual access to personal information concerning her/him, as well as the medical information on the individual's condition, except when this information could be harmful to the individual's life or health. As in international law, the right of access to information is contained within the right to freedom of expression. With respect to patients, the right of access to information requires the government to take the necessary measures to guarantee access to information about the patient's health conditions.⁴⁷⁴ The ECtHR has interpreted this right as only prohibiting authorities from restricting a person from receiving information from others and not imposing a positive obligation on the government to provide the information.⁴⁷⁵ However, it is worth noting that the ECtHR has interpreted a positive state obligation to provide information under Article 8 (right to respect for family and private life).⁴⁷⁶

469. ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010.

470. ECtHR. Costa and Pavan v. Italy. App. No. 54270/10. August 28, 2012.

471. ECtHR. Ternovsky v. Hungary. App. No. 67545/09. March 14, 2011.

472. ECtHR. Tysic v. Poland. App. No. 5410/03. September 24, 2007.

473. ECtHR. V.C. v. Slovakia. App. No. 18968/07. February 8, 2012.

474. ECtHR. Herczegfalvy v. Austria. App. No. 10533/83. September 24, 1992.

475. ECtHR. Guerra v. Italy. App. No. 14967/89. February 19, 1998.

476. ECtHR. Tysic v. Poland. App. No. 5410/03. March 20, 2007.

RELEVANT PROVISIONS

▶ ECHR

- **Art. 8(1):** Everyone has the right to respect for his private and family life, his home and his correspondence.
- **Art. 10(1):** Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers....

▶ Declaration on the Promotion of Patients' Rights in Europe⁴⁷⁷

- 2.2 Patients have the right to be fully informed about their health status, including the medical facts about their conditions; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment.
- 2.5 Patients have the right not to be informed, at their explicit request.
- 2.6 Patients have the right to choose who, if any one, should be informed on their behalf.

▶ European Charter of Patients' Rights,⁴⁷⁸

- **Art. 3 (Right to Information):** Every individual has the right to access to all kind of information regarding their state of health, the health services and how to use them, and all that scientific research and technological innovation makes available.

▶ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine,⁴⁷⁹

- **Art. 10:**
 1. Everyone has the right to respect for private life in relation to information about his or her health.
 2. Everyone is entitled to know any information collected about his or her health. However, the wishes of individuals not to be so informed shall be observed.
 3. In exceptional cases, restrictions may be placed by law on the exercise of the rights contained in paragraph 2 in the interests of the patient. Everyone has the right to know any information collected about his or her health.

▶ Recommendation No. R (2000) 5 of the Committee of Ministers to member states on the development of structures for citizen and patient participation in the decision-making process affecting health care⁴⁸⁰

6. Information on health care and on the mechanisms of the decision-making process should be widely disseminated in order to facilitate participation. It should be easily accessible, timely, easy to understand and relevant.
7. Governments should improve and strengthen their communication and information strategies should be adapted to the population group they address.
8. Regular information campaigns and other methods such as information through telephone hotlines should be used to heighten the public's awareness of patients' rights. Adequate referral systems should be put in place for patients who would like additional information (with regard to their rights and existing enforcement mechanisms).

477. WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

478. Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.

479. COE. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. April 4, 1997.

480. COE. Recommendation Rec No. R (2000) 5. April 30, 2002.

Right of Access to Information in the Context of Mental Health

Under this right, health care providers have an obligation to provide mental health patients with accurate information about their medical data and/or the treatment they are receiving. Therefore, continuous treatment lacking regular evaluation would undermine the right of access to information, as the patient would not have access to accurate information on her/his mental health status, making it difficult for her/him to challenge the treatment.⁴⁸¹ Indeed, the ECtHR has found that the denial of access to information may violate Article 10 of the ECHR, even if the denial of access to information is defended by the government on therapeutic grounds.⁴⁸²

It is worth noting that the right of access to information is closely linked to the concept of consent, and the ECtHR has held that even if a person is diagnosed with a mental illness, a patient always has the right of access to her/his medical records.⁴⁸³

CASE RELATING TO MENTAL HEALTH AND THE RIGHT OF ACCESS TO INFORMATION

Herczegfalvy v. Austria (ECtHR)(1992). The applicant who had been diagnosed with a mental illness was detained in a psychiatric hospital. The hospital limited the applicant's access to "reading matter, radio and television," which the ECtHR concluded was a violation of Article 10 of the ECHR.⁴⁸⁴

Right of Access to Information in the Context of Sexual and Reproductive Health

Under the right of access to information, States have a positive obligation to provide accurate information regarding reproductive health laws and the availability of abortion services.⁴⁸⁵ The ECtHR has interpreted Article 8 (right to respect for private and family life) of the ECHR to include the government's obligation to enable access to information regarding risks to pregnant women's health⁴⁸⁶ and the health of their unborn fetuses,⁴⁸⁷ as well as the obligation to provide minors with access to information regarding abortion services.⁴⁸⁸ This right includes information that is necessary to determine the legality of a woman's access to therapeutic abortion services.⁴⁸⁹ Additionally, the right of access to information requires consent of the individual, which is important in the area of sexual and reproductive health. For example, the ECtHR has held that sterilization without consent is impermissible and that full and informed consent is mandatory under Article 8.⁴⁹⁰

Furthermore, a government's efforts to prevent organizations from distributing information regarding the procurement of abortion services constitute a violation of this right.⁴⁹¹ The Court found that such restrictions infringed both on the organization's right to impart information and on the right of individuals to receive such information, both of which are protected under Article 10.⁴⁹²

481. ECtHR. *Shopov v. Bulgaria*. App. No. 11373/04. September 2, 2010.

482. ECtHR. *Herczegfalvy v. Austria*. App. No. 10533/83. September 24, 1992.

483. ECtHR. *Lashin v. Russia*. App. No. 33117/02. April 22, 2013.

484. ECtHR. *Herczegfalvy v. Austria*. App. No. 10533/83. September 24, 1992.

485. ECtHR. *P. and S. v. Poland*. App. No. 57375/08. January 30, 2013.

486. ECtHR. *Tysic v. Poland*. App. No. 5410/03. March 20, 2007.

487. ECtHR. *Costa and Pavan v. Italy*. App. No. 54270/10. August 28, 2012; see ECtHR. *R.R. v. Poland*. App. No. 27617/04. May 26, 2011.

488. ECtHR. *P. and S. v. Poland*. App. No. 57375/08. January 30, 2013.

489. ECtHR. *Tysic v. Poland*. App. No. 5410/03. March 20, 2007.

490. ECtHR. *V.C. v. Slovakia* (, no. 18968/07).. February 8, 2012.

491. ECtHR. *Open Door and Dublin Well Woman v. Ireland* (, no. 14234/88; 14235/88).. October 29, 1992.

492. ECtHR. *Open Door and Dublin Well Woman v. Ireland* (, no. 14234/88; 14235/88).. October 29, 1992.

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT OF ACCESS TO INFORMATION

K.H. and Others v. Slovakia (ECtHR)(2009). Eight women of Roma origin could no longer conceive after being treated at gynecological departments in two different public hospitals and suspected that they had been sterilized during their stay in those hospitals. They complained that they could not obtain photocopies of their medical records. The Court concluded that merely providing access to review the records but not providing the applicants with a photocopy of their medical records constituted a violation of Article 8.⁴⁹³

Open Door and Dublin Well Woman v. Ireland (ECtHR)(1992). The applicants were two Irish companies that complained about being prevented, by means of a court injunction, from providing pregnant women with information concerning abortion services available abroad. The Court found that the restriction imposed on the applicant companies had created a risk to the health of women who did not have the resources or education to seek and use alternative means of obtaining information about abortion. In addition, given that such information was available elsewhere, and that women in Ireland could, in principle, travel to Great Britain to have abortions, the restriction had been largely ineffective. The Court found a violation of Article 10.⁴⁹⁴

R.R. v. Poland (ECtHR)(2011). A mother of two was pregnant with a child thought to be suffering from a severe genetic abnormality and was deliberately denied timely access to the genetic tests to which she was entitled by doctors who were opposed to abortion. The Court found a violation of Article 8 because Polish law did not include any effective mechanisms which would have enabled the applicant to have access to the available diagnostic services and to make, in the light of their results, an informed decision as to whether or not to seek an abortion.⁴⁹⁵

3.3.4 RIGHT TO BODILY INTEGRITY

The right to bodily integrity safeguards the individual's freedom from bodily injury or interference. Most cases concerning violations of physical or bodily integrity in health care settings have been analyzed under related rights that include the right to freedom from torture and cruel, inhuman and degrading treatment (ECHR, Art. 3), the right to privacy (ECHR, Art. 8), and the right to the highest attainable standard of health (ESC, Art. 11). The Court has examined cases involving the administration of forced medication (including injections), forced feeding and nonconsensual sterilizations under the right to privacy (ECHR, Art. 8)⁴⁹⁶ and the right to freedom from torture, cruel, inhuman or degrading treatment (ECHR, Art. 3).⁴⁹⁷

RELEVANT PROVISIONS

▶ ECHR

- **Art. 3:** No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

493. ECtHR. *K.H. and Others v. Slovakia* (, no. 32881/04). 6. November 6, 2009.

494. ECtHR. *Open Door and Dublin Well Woman v. Ireland* (, no. 14234/88; 14235/88). 29. October 29, 1992.

495. ECtHR. *R.R. v. Poland* (, no. 27617/04). 28. November 28, 2011.

496. ECtHR. *Storck v. Germany*. App. No. 61603/00. June 16, 2005; ECtHR. *X. v. Finland*. App. No. 34806/04. November 19, 2012; *V.C. v. Slovakia*. App. No. 18968/07. November 8, 2011.

497. ECtHR. *Ciorap v. Moldova*. App. No. 12066/02. June 19, 2007; *V.C. v. Slovakia*. App. No. 18968/07. November 8, 2011; *Gorobet v. Moldova*. App. No. 30951/10. October 11, 2011.

- **Art. 5(1):** Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: ... (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants. ...
- **Art. 8:**
 - (1) Everyone has the right to respect for his private and family life, his home and his correspondence.
 - (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.
- ▶ **Charter of Fundamental Rights of the European Union,⁴⁹⁸**
 - **Art. 3(1) (Right to the integrity of the person):** Everyone has the right to respect for his or her physical and mental integrity.
- ▶ **COE Recommendation No. R (2004) 10,⁴⁹⁹**
 - **Art. 18 (Criteria for Involuntary Treatment):** A person may be subject to involuntary treatment only if the following conditions are met:
 - i. the person has a mental disorder;
 - ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;
 - iii. no less intrusive means of providing appropriate care are available;
 - iv. the opinion of the person concerned has been taken into consideration.
- ▶ **Declaration on the Promotion of Patients' Rights in Europe⁵⁰⁰**
 - 1.1 Everyone has the right to respect of his or her person as a human being.
 - 1.3 Everyone has the right to physical and mental integrity and to the security of his or her person.
 - 3.1 The informed consent of the patient is a prerequisite for any medical intervention.
 - 3.2 A patient has the right to refuse or to halt a medical intervention....
 - 3.5 When the consent of a legal representative is required, patients (whether minor or adult) must nevertheless be involved in the decision-making process to the fullest extent which their capacity allows.
 - 3.9 The informed consent of the patient is needed for participation in clinical teaching.
 - 3.10 The informed consent of the patient is a prerequisite for participation in scientific research.
 - 5.10 Patients have the right to relief of their suffering according to the current state of knowledge.
 - 5.11 Patients have the right to humane terminal care and to die in dignity.
- ▶ **European Charter of Patients' Rights⁵⁰¹**
 - **Art. 4 (Right to Consent):** Every individual has the right of access to all information that might enable him or her to actively participate in the decisions regarding his or her health; this information is a prerequisite for any procedure and treatment, including the participation in scientific research.

498. Official Journal of the European Communities. Charter of Fundamental Rights of the European Union. OJ C 364/01. December 7, 2000.

499. COE. Recommendation Rec No. R (2004) 10. September 22, 2002.

500. WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

501. Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.

- **Art. 5 (Right to Free Choice):** Each individual has the right to freely choose from among different treatment procedures and providers on the basis of adequate information.
- **Art. 11 (Right to Avoid Unnecessary Suffering and Pain):** Each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness.
- ▶ **Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine,⁵⁰²**
 - **Art. 5:** An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

Right to Bodily Integrity in the Context of Mental Health

The ECtHR has recognized the need to protect the physical and mental integrity of mental health patients. Issues concerning a mental health patient's right to bodily integrity are often raised and treated in conjunction with right to liberty and security of person and freedom from torture concerns. For example, in *Storck v. Germany*, the Court analyzed forced treatment of the psychiatric patient under the rubric of the right to liberty and security of person, while recognizing the State's obligation to protect the physical integrity of the individual and underscoring the need for psychiatric institutions to regularly assess the justification of treatment administered to their patients.⁵⁰³

CASES RELATING TO MENTAL HEALTH AND THE RIGHT TO BODILY INTEGRITY

M.S. v. United Kingdom (ECtHR)(2012). This case involved the detention of a man suffering from mental illness held in police custody for more than three days. The Court found a violation of Article 3, holding that, although there had been no intentional neglect on the part of the police, the applicant's prolonged detention without appropriate psychiatric treatment had diminished his human dignity.⁵⁰⁴

Shopov v. Bulgaria (ECtHR)(2010). The Court found the government in violation of Article 5(1) where an applicant was forced to undergo psychiatric treatment for more than five years as a result of the public prosecutor and the police overstepping the limits of a domestic court's judgment ordering treatment in an outpatient clinic and not in a psychiatric hospital.⁵⁰⁵

Storck v. Germany (ECtHR)(2005). The Court found the mental health patient's confinement in a psychiatric hospital and forced treatment to be in violation of Article 5(1) as the confinement had not been ordered by a court. The Court stressed the responsibility of the State to protect vulnerable populations (such as mental health patients) and concluded that retrospective measures to protect such individuals from the unlawful deprivation of liberty were insufficient.⁵⁰⁶

X. v. Finland (ECtHR)(2012). The Court found that the confinement and forced treatment of a pediatrician in a mental health hospital lacked the proper safeguards against arbitrariness and, therefore, constituted a violation of Article 5.⁵⁰⁷

502. COE. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. April 4, 1997.

503. ECtHR. *Storck v. Germany*. App. No. 61603/00. September 16, 2005.

504. ECtHR. *M.S. v. The United Kingdom*. App. No. 24527/08. August 3, 2012.

505. ECtHR. *Shopov v. Bulgaria*. App. No. 11373/04. December 2, 2010.

506. ECtHR. *Storck v. Germany*. App. No. 61603/00. September 16, 2005.

507. ECtHR. *X. v. Finland*. App. No. 34806/04. November 19, 2012.

Right to Bodily Integrity in the Context of Infectious Diseases

The right to bodily integrity becomes particularly relevant in instances where individuals with infectious diseases are subjected to coercive measures, such as quarantine and forced treatment. The ECtHR has established that, under Article 5 of the ECHR, the essential criteria for determining whether the detention of a person “for the prevention of the spreading of infectious diseases” is lawful are:

- The spread of the infectious disease poses a danger to public health or safety;
- It is the least restrictive way of preventing the spread of the disease to safeguard the public interest; and
- Both the danger of spreading the infectious disease and detention being the least restrictive means of safeguarding the public interest must persist throughout the period of detention.

CASE RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO BODILY INTEGRITY

Enhorn v. Sweden (ECtHR)(2005). The Court found a violation of Article 5(1)(e) where an individual living with HIV was placed involuntarily in a hospital for almost one and a half years after having transmitted the virus to another man as a result of sexual activity. The Court concluded that the compulsory isolation was not the least restrictive means available to prevent him from spreading HIV, and therefore, the authorities failed to strike a fair balance between the need to ensure that the HIV virus did not spread and the applicant’s right to liberty.⁵⁰⁸

Right to Bodily Integrity in the Context of Sexual and Reproductive Health

The right to bodily integrity safeguards the person’s right to control her/his health and body and is pertinent to issues relating to sexual and reproductive health, such as forced sterilization, genital mutilation, and abortion. The European Commission of the EU has committed to ending violence against women and ending female genital mutilation (FGM), recognizing it as a violation of women’s human rights and the international Convention on the Rights of the Child (CRC).⁵⁰⁹ The EU Council has stated: “[FGM] constitutes a breach of the fundamental right to life, liberty, security, dignity, equality between women and men, non-discrimination and *physical and mental integrity*” (emphasis added).⁵¹⁰

While these sexual and reproductive health issues directly involve the right to bodily integrity, they have been typically addressed by the ECtHR under either the right to privacy (ECHR, Art. 8) or the right to freedom from torture and cruel, inhuman, and degrading treatment (ECHR, Art. 3).

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO BODILY INTEGRITY

I.G., M.K. and R.H. v. Slovakia (ECtHR)(2013). The Court found that the sterilization of two Roma women without their full and informed consent amounted to a violation of Article 3. The Court also considered the government’s failure to conduct an effective official investigation into the sterilizations was a procedural violation of Article 3.⁵¹¹

508. ECtHR. *Enhorn v. Sweden*. App. No. 56529/00. January 25, 2005.

509. European Commission. Communication from the Commission to the European Parliament and the Council: Towards the elimination of female genital mutilation. November 25, 2013.

510. EU Council. Council Conclusion on Combating Violence Against Women, and the Provision of Support Services for Victims of Domestic Violence. December 6, 2012. para. 1.

511. ECtHR. *I.G., M.K. and R.H. v. Slovakia*. App. No. 5966/04. April 29, 2013; see ECtHR. *V.C. v. Slovakia*. App. No. 18968/07. February 8, 2012; ECtHR. *N.B. v. Slovakia*. App. No. 29518/10. June 12, 2012.

V.C. v. Slovakia (ECtHR)(2012). The Court found that the sterilization of a woman at a public hospital without her informed consent amounted to a violation of Article 3. The Court found that the applicant experienced fear, anguish and feelings of inferiority as a result of her sterilization. Although there was no proof that the medical staff concerned had intended to ill-treat her, they had acted with gross disregard to her right to autonomy and choice as a patient.⁵¹²

3.3.5 RIGHT TO LIFE

As the right to life relates to patients' rights, the ECtHR has recognized positive obligations, beyond the State's obligation to refrain from intentionally and unlawfully taking the life of an individual.⁵¹³ The ECtHR has clarified that Article 2 of the ECHR requires that the State undertake the necessary measures to protect the lives of those living in its jurisdiction, which include the obligations to establish an effective judicial system and to investigate deaths other than those resulting from natural causes.⁵¹⁴ Specifically, in cases of deaths occurring during medical care, it is required to create regulations compelling public and private hospitals: 1) to adopt measures for the protection of patients' lives, and 2) to ensure that the cause of death, if in the case of the medical profession, can be determined by an "effective, independent judicial system" so that anyone responsible can be made accountable. Civil law proceedings may be sufficient in cases of medical negligence provided they are capable of both establishing liability and providing appropriate redress, such as damages.⁵¹⁵ Additionally, the State is required to regulate and monitor private health-care institutions.

In terms of medical negligence claims, the ECtHR has held that where a State has "made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients [the Court] cannot accept that matters such as error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient by themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life."⁵¹⁶ Further, given the recognizable problems that arise in determining the allocation of limited resources for health care and the general reluctance of the ECtHR to sanction States for the impact of their economic decisions, a breach of the right to life for denial of health care will likely be found only in exceptional cases.⁵¹⁷ However, the ECtHR has held that an issue may arise under this right "where it is shown that the authorities ... put an individual's life at risk through the denial of health care which they had undertaken to make available to the population generally"⁵¹⁸—in other words, where there are preexisting obligations, these must not be applied in a discriminatory manner.

It is worth noting that the ECtHR has also left open the possibility that the right to life could be implicated in a situation in which sending a terminally ill person back to their country of origin could seriously shorten her/his life span or could amount to cruel and inhuman treatment due to inadequate medical facilities.⁵¹⁹ Moreover, to date, there have been only a few substantive decisions on euthanasia.⁵²⁰

512. ECtHR. *V.C. v. Slovakia*. App. No. 18968/07. February 8, 2012.

513. ECtHR. *Powell v. The United Kingdom*. App. No. 45305/99. May 4, 2000. (claim by parents that circumstances surrounding the alleged falsification of their son's medical records and the authorities' failure to investigate this matter properly gave rise to a breach of Article 2 (1) was declared inadmissible).

514. See ECtHR. *Nitecki v. Poland*. App. No. 65653/01. March 21, 2002; ECtHR. *Erikson v. Italy*. App. No. 37900/97. October 26, 1999.

515. ECtHR. *Calvelli and Ciglio v. Italy*. App. No. 32967/96. January 17, 2002. (The dissenting judgments favored the use of criminal proceedings. On the facts, by accepting compensation through the settling of civil proceedings with respect to the death of their baby, plaintiffs denied themselves access to the best means of determining the extent of responsibility of the doctor concerned).

516. ECtHR. *Wiater v. Poland*. App. No. 42990/08. May 15, 2012. para 34.

517. ECtHR. *Nitecki v. Poland*. App. No. 65653/01. March 21, 2002 (considering that the state had provided the applicant medical treatment and facilities, including covering a large part of the cost of the required medications, the Court found no breach of Article 2—the authorities paid 70 percent of the cost of the lifesaving drugs prescribed to applicant, with the latter expected to pay the remainder); see ECtHR. *Pentiacova v. Moldova*. App. No. 14462/03. January 4, 2005. (haemodialysis); ECtHR. *Wiater v. Poland*. App. No. 42990/08. May 15, 2012. (medication to treat narcolepsy); ECtHR. *Sentges v. Netherlands*. App. No. 27677/02. July 8, 2003 (robotic arm).

518. ECtHR. *Cyprus v. Turkey*. App. No. 25781/94. May 10, 2001.

519. ECtHR. *D v. The United Kingdom*. App. No. 30240/96. May 2, 1997. (issues under Article 2 were indistinguishable from those raised under Article 3).

520. See ECtHR. *Koch v. Germany*. App. No. July 19, 2012; ECtHR. *Haas v. Switzerland*. App. No. 31322/07. January 20, 2011; ECtHR. *Pretty v. The United Kingdom*. App. No. 2346/02. April 29, 2002.

RELEVANT PROVISIONS

▶ ECHR,

- **Art. 2(1):** Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Right to Life in the Context of Mental Health

The ECtHR has held that the right to life can impose a duty to protect those in custody, including cases in which the risk derives from self-harm.⁵²¹ The ECtHR will consider whether the authorities knew or ought to have known that the person “posed a real and immediate risk of suicide and, if so, whether they did all that could have been reasonably expected of them to prevent that risk.”⁵²²

CASES RELATING TO MENTAL HEALTH AND THE RIGHT TO LIFE

Çoşelav v. Turkey (ECtHR)(2013). A juvenile detained in an adult prison committed suicide. The Court concluded that there was a violation of the right to life, finding that authorities had not only been indifferent to his grave psychological problems but had been responsible for a deterioration of his state of mind by detaining him in a prison with adult inmates without providing any medical or specialist care, all of which led to his suicide.⁵²³

Reynolds v. United Kingdom (ECtHR)(2012). Upon admission, a voluntary psychiatric patient suffering from schizophrenia was determined to be a low risk of suicide by the psychiatric institution. The patient spoke of hearing voices telling him to kill himself and subsequently jumped from a window and died. The Court determined that the right to life was violated because appropriate measures had not been taken to protect the patient and because the applicant (the patient's mother) lacked recourse to domestic remedies to seek non-pecuniary damages for her son's death.⁵²⁴

Right to Life in the Context of Infectious Diseases

The ECtHR has addressed the right to life in relation to infectious diseases in the context of detention. The Court has recognized the State's responsibility to provide appropriate medical treatment to those in detention; failure to do so in cases involving the death of a detainee could result in the violation of the right to life.⁵²⁵ However, in order for the positive obligations of the State regarding the provision of medical treatment to be triggered under this right, the State must have knowledge of the detainee's medical need. However, this does not entitle the State to turn a “blind-eye” to the detainee's condition. An obligation may arise on the part of the detainee to inform the State of his condition in order to procure adequate medical treatment.⁵²⁶

521. ECtHR. Keenan v. The United Kingdom. App. No. 27229/95. April 3, 2001.

522. ECtHR. Keenan v. The United Kingdom. App. No. 27229/95. April 3, 2001.

523. ECtHR. Çoşelav v. Turkey. App. No. 1413/07. March 18, 2013.

524. ECtHR. Reynolds v. The United Kingdom. App. No. 2694/08. June 13, 2012.

525. ECtHR. Salakhov and Islyamova v. Ukraine. App. No. 28005/08. March 14, 2013.

526. ECtHR. Salakhov and Islyamova v. Ukraine. App. No. 28005/08. March 14, 2013.

CASES RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO LIFE

Oyal v. Turkey (ECtHR)(2010). An infant was infected with HIV during a blood transfusion at a public hospital. The Court found a violation of the right to life from the inadequate remedies provided by domestic law for the negligence of hospital staff, who had failed to test the blood properly and screen donors effectively.⁵²⁷

Salakhov and Islyamova v. Ukraine (ECtHR)(2013). The Court found a violation of the right to life where a detainee living with HIV was not provided with adequate medical treatment, which resulted in the death of the detainee.⁵²⁸

Right to Life in the Context of Sexual and Reproductive Health

The ECtHR has left the determination of when life begins, in the context of embryos, to the law of the States.⁵²⁹ Additionally, because the ECtHR does not apply Article 2 of the ECHR to the unborn, the issue of abortion is typically addressed under the right to respect for private and family life under Article 8 of the ECHR. The Court has not interpreted Article 8 as conferring a right to abortion.⁵³⁰ However, the Court has recognized that the government is responsible for providing a legal framework (including “accessible and effective procedure[s]”) to determine access to lawful abortion, including procedures to resolve disputes between women seeking abortion services and medical practitioners.⁵³¹

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO LIFE

Byrzykowski v. Poland (ECtHR)(2006). The Court found that the prolonged investigation into the death of a woman following a cesarean was found to be a violation of the right to life, holding that a “prompt examination of cases concerning death in a hospital setting” is required under the procedural limb of this right, as such information can be disseminated to medical staff of the institution “to prevent the repetition of similar errors and thereby contribute to the safety of users of all health services.”⁵³²

Evans v. United Kingdom (ECtHR)(2007). The applicant was suffering from ovarian cancer and underwent in-vitro fertilization before her ovaries were removed. The applicant and her husband divorced, and her former husband withdrew his consent for the use of the embryos and requested that they be destroyed according to the contract with the clinic. The ECtHR found no violation of right to life, holding that the embryos created did not have a right to life.⁵³³

Vo v. France (ECtHR)(2004). Due to a mix-up with another patient with the same surname, the applicant’s amniotic sack was punctured, making a therapeutic abortion necessary. She maintained that the unintentional killing of her child should have been classified as manslaughter. The Court found no violation of the right to life, concluding that it was not desirable or possible at the moment to rule on whether an unborn child was a person under Article 2 of the ECHR.⁵³⁴

527. ECtHR. *Oyal v. Turkey*. App. No. 4864/05. June 23, 2010.

528. ECtHR. *Salakhov and Islyamova v. Ukraine*. App. No. 28005/08. March 14, 2013.

529. ECtHR. *Evans v. The United Kingdom*. App. No. 6339/05. April 10, 2007.

530. ECtHR. *A, B and C v. Ireland*. App. No. 25579/05. December 16, 2010.

531. ECtHR. *A, B and C v. Ireland*. App. No. 25579/05. December 16, 2010.

532. ECtHR. *Byrzykowski v. Poland*. App. No. 11562/05. September 27, 2006.

533. ECtHR. *Evans v. The United Kingdom*. App. No. 6339/05. April 10, 2007.

534. ECtHR. *Vo v. France*. App. No. 53924/00. July 8, 2004.

3.3.6 RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The ECHR does not contain an express right to health, but the ECtHR has interpreted this entitlement under various rights protected by the ECHR, most notably the right to freedom from torture and other cruel, inhuman or degrading treatment, freedom from discrimination, and the right to private and family life. States have a duty to protect the health of detainees and lack of treatment may amount to a violation of Article 3, which prohibits torture and cruel, inhuman, and degrading treatment or punishment.⁵³⁵ Nevertheless, a right to health is expressly recognized under Article 11 of the ESC, and as stated above, the ESCR has issued seven judgments based on Article 11 to date⁵³⁶—only one of which falls into one of the contexts examined throughout this guide, namely sexual and reproductive health.⁵³⁷ For this reason, the case law provided in this section is limited to this ESCR case.

According to the ESCR, Article 11 includes physical and mental well-being in accordance with the definition of health in the WHO Constitution.⁵³⁸ Under this right, States must ensure the best possible state of health for the population according to existing knowledge, and health systems must respond appropriately to avoidable health risks, i.e., those controlled by human action.⁵³⁹ The health care system must be accessible to everyone, and arrangements for access must not lead to unnecessary delays in provision. Access to treatment must be based on transparent criteria, agreed upon at the national level, taking into account the risk of deterioration in either clinical condition or quality of life.⁵⁴⁰ Additionally, there must be adequate staffing and facilities - with a very low density of hospital beds, combined with waiting lists, amounting to potential obstacles to access for the largest number of people.⁵⁴¹ Accordingly, the conditions of stay in hospitals, including psychiatric hospitals, must be satisfactory and compatible with human dignity.⁵⁴²

In relation to advisory and educational facilities, the ESCR has identified two key obligations: 1) developing a sense of individual responsibility through awareness campaigns and 2) providing free and regular health screening, especially for serious diseases.⁵⁴³

The EU cross-border care Directive (2011/24/EU) allows EU citizens to seek healthcare in other Member States. The Directive is the result of a number of rulings by the Court of Justice of the EU on reimbursement claims for medical treatment abroad based on the free movement principles.⁵⁴⁴ In essence, Member States remain responsible for providing safe, high-quality, efficient and quantitatively adequate healthcare to citizens on their territory (Art. 4). Simultaneously, they have to respect basic legal principles. In the case of cross-border care this means applying objective, non-discriminatory criteria—which should be known in advance—as well as providing access to a judicial review procedure if granting cross-border health care is refused, while taking into account all relevant circumstances. It follows that, when there is a delay, it is not

535. ECtHR. *Hurtado v. Switzerland*. App. No. 17549/90. January 28, 1994; ECtHR. *Ilhan v. Turkey*. App. No. 22277/93. June 27, 2000.

536. ESCR. *International Federation of Human Rights Leagues (FIDH) v. Greece*. Collective Complaint No. 72/2011. January 23, 2013; ESCR. *Defence for Children International (DCI) v. Belgium*. Collective Complaint No. 69/2011. October 23, 2012; ESCR. *Médecins du Monde - International v. France*. Collective Complaint No. 67/2011. September 11/, 2012; ESCR. *Decision on the merits: International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia*. Collective Complaint No. 45/2007. March 30, 2009; ESCR. *European Roma Rights Centre (ERRC) v. Bulgaria*. Collective Complaint No. 46/2007. December 3, 2008; ESCR. *Marangopoulos Foundation for Human Rights (MFHR) v. Greece*. Collective Complaint No. 30/2005. December 6, 2006; ESCR. *Confédération Générale du Travail (CGT) v. France*. Collective Complaint No. 22/2003. December 8, 2004.

537. ESCR. *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia*, Collective Complaint No. 45/2007. March 30/, 2009.

538. COE. *Conclusions of the European Committee of Social Rights*. (XVII -2); *Conclusions 2005*. Statement of interpretation of Article 11.

539. COE. *Conclusions: Denmark*. (XV-2).

540. COE. *Conclusions: United Kingdom*. (XV-2).

541. COE. *Conclusions: Denmark*. (XV-2).

542. COE. *Conclusions of the European Committee of Social Rights*. (XVII -2); *Conclusions 2005*. Statement of interpretation of Article 11; *Conclusions 2005: Romania*.

543. COE. *The Right to Health and the European Social Charter*.

544. E.g. Case C-120/95, *Decker v. Caisse de maladie des employés privés*, ECLI:EU:C:1998:167; Case C-158/96, *Kohll v. Union des caisses de maladie*, ECLI:EU:C:1998:171; Case C-368/98 *Vanbraekel* [2001] ECR I-5363; Case C-385/99 *Müller-Fauré and Van Riet* [2003] ECR I-4509; Case C-372/04 *Yvonne Watts* [2006] ECR I-4325; Case C-444/05 *Stamatelaki* [2007] ECR I-3185; Case C-512/08 *European Commission v French Republic* [2011] ECR I-8833; Case C-173/09 *Elchinov* [2010] ECR I-8889, and Case C-268/13 *Petru* ECLI:EU:C:2014:2271.

allowed to use waiting lists merely as a necessary planning argument to refuse authorisation, without taking into account the patient's medical history, needs and degree of pain. Secondly, though prior authorisation violates the free movement principles, it can be justified for reasons of public interest, but only if the patient needs hospital and high technology care (Art. 8).⁵⁴⁵ No prior authorisation is required for out-patient health-care services abroad. This restriction to in-patient healthcare is the direct result of previous Court of Justice rulings since it is assumed that consuming out-patient healthcare abroad will not disrupt the financial balance of national healthcare systems. Thirdly, the obligation to reimburse cross-border healthcare is limited to services the insured person is entitled to. As such, the Directive respects the fundamental ethical choices of Member States. If controversial medical interventions (e.g. abortion, stem cell therapy) are excluded from the benefit package at home, one cannot claim reimbursement when such an intervention is performed abroad (Art. 7(1)). Furthermore, the reimbursement level of health care costs abroad is limited to the assumed costs in the home Member State/state of affiliation. Fourthly, the recognition of prescriptions from another Member State should not affect the professional or ethical duty that would require pharmacists to dispense the prescription (Art. 11). Fifthly, a new element includes the establishment of national contact points for cross-border healthcare (Art. 6), tasked with providing information on healthcare providers, safety and quality standards that would enable informed choices on where to receive healthcare in the EU.

For achieving patient mobility, Art. 7 stipulates the key principles of the reimbursement of cross-border care. In the Netherlands, the *Smits/Peerbooms* and *Muller/Fauré* cases made clear that the prior authorization mechanism as applied in the former Dutch Health Insurance Act was not in line with European law.⁵⁴⁶ The financial sustainability argument justified a restrictive contracting mechanism for in-patient care as prescribed in Dutch law. However, national law applied an overly restrictive condition for prior authorization (i.e. "normal according to national professional circles"), which was replaced by a more objective criterion to the effect that the requested treatment should be evidence-based according to international standards. The new Health Insurance Act 2006 incorporated the Court ruling by granting prioritisation of services following "international standards of science and practice".⁵⁴⁷

RELEVANT PROVISIONS

▶ ECHR

- **Art. 3:** No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

▶ Charter of Fundamental Rights of the European Union,⁵⁴⁸

- **Art. 35:** Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.

545. Other reasons that justify prior authorisation are: treatments presenting a particular risk for the patient or the population (art.8(2)(b); and health care provided by a provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care (art.8(2)(b)-(c)).

546. *Geraets-Smits v Stichting Ziekenfonds VGZ* (C-157/99) [2001] E.C.R. I-5473; [2002] 2 C.M.L.R. 21; *Muller-Fauré v Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA* (C-385/99) [2003] E.C.R. I-4509; [2004] 2 C.M.L.R.

547. *Besluit Zvw art.2.1(2)*.

548. Official Journal of the European Communities. Charter of Fundamental Rights of the European Union. OJ C 364/01. December 7, 2000.

▶ **Declaration on the Promotion of Patients' Rights in** ⁵⁴⁹

1.6 Everyone has the right to such protection of health as is 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.

5.3 Patients have the right to a quality of care which is marked both by high technical standards and by a humane relationship between the patient and health care providers.

▶ **ESC**

- **Art. 11 – The right to protection of health:** With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organizations, to take appropriate measures designed inter alia:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

- **Art. 13 – The right to social and medical assistance:** With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953.

▶ **European Charter of Patients' Rights**⁵⁵⁰

- **Art. 8 (Right to the Observance of Quality Standards):** Each individual has the right of access to high quality health services on the basis of the specification and observance of precise standards.

- **Art. 9 (Right to Safety):** Each individual has the right to be free from harm caused by the poor functioning of health services, medical malpractice and errors, and the right of access to health services and treatments that meet high safety standards.

- **Art. 10 (Right to Innovation):** Each individual has the right of access to innovative procedures, including diagnostic procedures, according to international standards and independently of economic or financial considerations.

549. WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

550. Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.

▶ **EU Directive on Cross-Border Care (2011/24/EU)**

CHAPTER III: REIMBURSEMENT OF COSTS OF CROSS-BORDER HEALTHCARE

● **Article 7. General principles for reimbursement of costs**

1. ... the Member State of affiliation shall ensure the costs incurred by an insured person who receives cross-border healthcare are reimbursed, if the healthcare in question is among the benefits to which the insured person is entitled in the Member State of affiliation.
2. By way of derogation from paragraph 1:
 - (a) if a Member State is listed in Annex IV to Regulation (EC) No 883/2004 and in compliance with that Regulation has recognised the rights to sickness benefits for pensioners and the members of their families, being resident in a different Member State, it shall provide them healthcare under this Directive at its own expense when they stay on its territory, in accordance with its legislation, as though the persons concerned were residents in the Member State listed in that Annex;
 - (b) if the healthcare provided in accordance with this Directive is not subject to prior authorisation, is not provided in accordance with Chapter 1 of Title III of the Regulation (EC) No 883/2004, and is provided in the territory of the Member State that according to that Regulation and Regulation (EC) No 987/2009 is, in the end, responsible for reimbursement of the costs, the costs shall be assumed by that Member State. That Member State may assume the costs of the healthcare in accordance with the terms, conditions, criteria for eligibility and regulatory and administrative formalities that it has established, provided that these are compatible with the TFEU.
3. It is for the Member State of affiliation to determine, whether at a local, regional or national level, the healthcare for which an insured person is entitled to assumption of costs and the level of assumption of those costs, regardless of where the healthcare is provided.
4. The costs of cross-border healthcare shall be reimbursed or paid directly by the Member State of affiliation up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory without exceeding the actual costs of healthcare received. Where the full cost of cross-border healthcare exceeds the level of costs that would have been assumed had the healthcare been provided in its territory the Member State of affiliation may nevertheless decide to reimburse the full cost. The Member State of affiliation may decide to reimburse other related costs, such as accommodation and travel costs, or extra costs which persons with disabilities might incur due to one or more disabilities when receiving cross-border healthcare, in accordance with national legislation and on the condition that there be sufficient documentation setting out these costs.
5. Member States may adopt provisions in accordance with the TFEU aimed at ensuring that patients enjoy the same rights when receiving cross-border healthcare as they would have enjoyed if they had received healthcare in a comparable situation in the Member State of affiliation.
6. For the purposes of paragraph 4, Member States shall have a transparent mechanism for calculation of costs of cross-border healthcare that are to be reimbursed to the insured person by the Member State of affiliation. This mechanism shall be based on objective, non-discriminatory criteria known in advance and applied at the relevant (local, regional or national) administrative level.

7. The Member State of affiliation may impose on an insured person seeking reimbursement of the costs of cross-border healthcare, including healthcare received through means of telemedicine, the same conditions, criteria of eligibility and regulatory and administrative formalities, whether set at a local, regional or national level, as it would impose if this healthcare were provided in its territory. This may include an assessment by a health professional or healthcare administrator providing services for the statutory social security system or national health system of the Member State of affiliation, such as the general practitioner or primary care practitioner with whom the patient is registered, if this is necessary for determining the individual patient's entitlement to healthcare. However, no conditions, criteria of eligibility and regulatory and administrative formalities imposed according to this paragraph may be discriminatory or constitute an obstacle to the free movement of patients, services or goods, unless it is objectively justified by planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources.
 8. The Member State of affiliation shall not make the reimbursement of costs of cross-border healthcare subject to prior authorisation except in the cases set out in Article 8.
 9. The Member State of affiliation may limit the application of the rules on reimbursement for cross-border healthcare based on overriding reasons of general interest, such as planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources.
 10. Notwithstanding paragraph 9, Member States shall ensure that the cross-border healthcare for which a prior authorisation has been granted is reimbursed in accordance with the authorisation.
 11. The decision to limit the application of this Article pursuant to paragraph 9 shall be restricted to what is necessary and proportionate, and may not constitute a means of arbitrary discrimination or an unjustified obstacle to the free movement of goods, persons or services. Member States shall notify the Commission of any decisions to limit reimbursement on the grounds stated in paragraph 9. EN L 88/58 Official Journal of the European Union 4.4.2011
- **Article 8 Healthcare that may be subject to prior authorisation**
 1. The Member State of affiliation may provide for a system of prior authorisation for reimbursement of costs of cross-border healthcare, in accordance with this Article and Article 9. The system of prior authorisation, including the criteria and the application of those criteria, and individual decisions of refusal to grant prior authorisation, shall be restricted to what is necessary and proportionate to the objective to be achieved, and may not constitute a means of arbitrary discrimination or an unjustified obstacle to the free movement of patients.
 2. Healthcare that may be subject to prior authorisation shall be limited to healthcare which:
 - (a) is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources and:

- (i) involves overnight hospital accommodation of the patient in question for at least one night; or
- (ii) requires use of highly specialised and cost-intensive medical infrastructure or medical equipment;
- (b) involves treatments presenting a particular risk for the patient or the population; or
- (c) is provided by a healthcare provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of healthcare which is subject to Union legislation ensuring a minimum level of safety and quality throughout the Union.

Member States shall notify the categories of healthcare referred to in point (a) to the Commission.

3. With regard to requests for prior authorisation made by an insured person with a view to receiving cross-border healthcare, the Member State of affiliation shall ascertain whether the conditions laid down in Regulation (EC) No 883/2004 have been met. Where those conditions are met, the prior authorisation shall be granted pursuant to that Regulation unless the patient requests otherwise.
4. When a patient affected, or suspected of being affected, by a rare disease applies for prior authorisation, a clinical evaluation may be carried out by experts in that field. If no experts can be found within the Member State of affiliation or if the expert's opinion is inconclusive, the Member State of affiliation may request scientific advice.
5. Without prejudice to points (a) to (c) of paragraph 6, the Member State of affiliation may not refuse to grant prior authorisation when the patient is entitled to the healthcare in question in accordance with Article 7, and when this healthcare cannot be provided on its territory within a time limit which is medically justifiable, based on an objective medical assessment of the patient's medical condition, the history and probable course of the patient's illness, the degree of the patient's pain and/or the nature of the patient's disability at the time when the request for authorisation was made or renewed.
6. The Member State of affiliation may refuse to grant prior authorisation for the following reasons:
 - (a) the patient will, according to a clinical evaluation, be exposed with reasonable certainty to a patient-safety risk that cannot be regarded as acceptable, taking into account the potential benefit for the patient of the sought cross-border healthcare;
 - (b) the general public will be exposed with reasonable certainty to a substantial safety hazard as a result of the cross-border healthcare in question;
 - (c) this healthcare is to be provided by a healthcare provider that raises serious and specific concerns relating to the respect of standards and guidelines on quality of care and patient safety, including provisions on supervision, whether these standards and guidelines are laid down by laws and regulations or through accreditation systems established by the Member State of treatment;
 - (d) this healthcare can be provided on its territory within a time limit which is medically justifiable, taking into account the current state of health and the probable course of the illness of each patient concerned.
7. The Member State of affiliation shall make publicly available which healthcare is subject to prior authorisation for the purposes of this Directive, as well as all relevant information on the system of prior authorisation.

Right to Highest Attainable Standard of Health in the Context of Sexual and Reproductive Health

According to the ESCR, the right to health under Article 11 of the ESC requires that the State “provide education and aim to raise public awareness in respect of health-related matters,” including sexual and reproductive health.⁵⁵¹ This education should be available in schools throughout the school year.⁵⁵² The ESCR considers sexual and reproductive health education to constitute “a process aimed at developing the capacity of children and young people to understand their sexuality in its biological, psychological, socio-cultural and reproductive dimensions which will enable them to make responsible decisions with regard to sexual and reproductive health behaviour.”⁵⁵³

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO HIGHEST ATTAINABLE STANDARD OF HEALTH

International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia (ESCR)(2009). The ESCR found a violation of the right to health where the State failed to provide adequate, sufficient, and non-discriminatory sexual and reproductive health education to students in public schools.⁵⁵⁴

3.3.7 RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT

The right to freedom from torture and other cruel, inhuman or degrading treatment requires the State to prevent and protect people from and punish acts of inhuman or degrading treatment and torture. This right has been interpreted under Article 3 (prohibition of torture) of the ECHR. The ECtHR considers this right to be “one of the most fundamental values of a democratic society.”⁵⁵⁵ It cannot be interpreted in absolute terms and the “ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3.”⁵⁵⁶ According to the Court, “the assessment of this minimum is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim.”⁵⁵⁷ Examples of breaches of Article 3 in the context of patient care include: the continued detention of a cancer sufferer, causing “particularly acute hardship;”⁵⁵⁸ significant defects in the medical care provided to a mentally ill prisoner known to be a suicide risk;⁵⁵⁹ and systematic failings in relation to the death of a heroin addict in prison.⁵⁶⁰

551. ESCR. Decision on the merits: *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia*. Collective Complaint No. 45/2007. March 30, 2009). para. 43.

552. ESCR. Decision on the merits: *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia*. Collective Complaint No. 45/2007. March 30, 2009). para. 45.

553. ESCR. Decision on the merits: *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia*. Collective Complaint No. 45/2007. March 30, 2009). para. 46.

554. ESCR. Decision on the merits: *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia*. Collective Complaint No. 45/2007. March 30, 2009).

555. ECtHR. *Hagyó V. Hungary*. App. No. 52624/10. April 23, 2013. para. 39.

556. ECtHR. *Hagyó V. Hungary*. App. No. 52624/10. April 23, 2013. para. 40.

557. ECtHR. *Hagyó V. Hungary*. App. No. 52624/10. April 23, 2013. para. 40.

558. ESCR. *Mouisel v. France*. Application No. 67263/01. November 14, 2002. (finding the detention amounted to inhuman and degrading treatment).

559. ECtHR. *Keenan v. The United Kingdom*. App. No. 27229/95. March 4, 2001. (finding failure to refer to psychiatrist and lack of medical notes).

560. ECtHR. *McGlinchey and Ors v. The United Kingdom*. App. No. 50390/99. July 29, 2003. (finding inadequate facilities to record weight loss, gaps in monitoring, failure to take further steps including admission to hospital).

Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture. The former European Commission on Human Rights stated that it “did not exclude that the lack of medical care in a case where someone is suffering from a serious illness could in certain circumstances amount to treatment contrary to Article 3.”⁵⁶¹ In fact, the ECtHR has held that the need for adequate medical assistance and treatment beyond that available in prison could, in exceptional cases, justify the inmate’s release subject to appropriate restrictions in the public interest.⁵⁶² Moreover, the mere fact that a doctor saw the detainee and prescribed a certain form of treatment cannot automatically lead to the conclusion that the medical assistance was adequate.⁵⁶³ Additionally, the combined and cumulative impact on a detainee of both the conditions of detention and a lack of adequate medical assistance may also result in a breach of Article 3.⁵⁶⁴

However, the medical cases that the ECtHR has examined in relation to Article 3 have tended to involve those who are confined either (a) under the criminal law or (b) on mental health grounds.⁵⁶⁵ With respect to both forms of detention, failure to provide adequate medical treatment to persons deprived of their liberty may violate Article 3 in certain circumstances.⁵⁶⁶ Breaches will tend to amount to inhuman and degrading treatment rather than torture. If an individual suffers from multiple illnesses, the risks associated with any illness she/he suffers during her/his detention may increase and her/his fear of those risks may also intensify. In these circumstances, the absence of qualified and timely medical assistance, coupled with the authorities’ refusal to allow an independent medical examination of the applicant’s state of health, leads to the person’s strong feeling of insecurity, which, combined with physical suffering, can amount to degrading treatment.⁵⁶⁷

Nevertheless, Article 3 cannot be construed as laying down a general obligation to release detainees on health grounds. Instead, the ECtHR has reiterated the “right of all prisoners to conditions of detention which are compatible with human dignity, so as to ensure that the manner and method of execution of the measures imposed do not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention.”⁵⁶⁸

Where detainees have preexisting conditions, it may not be possible to ascertain to what extent symptoms at the relevant time resulted from the conditions of the imposed detention. However, this uncertainty is not determinative as to whether the authorities have failed to fulfil their obligations under Article 3. Therefore, proof of the actual effects of the conditions of detention may not be a major factor.⁵⁶⁹

Experimental medical treatment may amount to inhuman treatment in the absence of consent,⁵⁷⁰ and generally, compulsory medical intervention in the interests of the person’s health, where it is of “therapeutic necessity from the point of view of established principles of medicine,” will not breach Article 3.⁵⁷¹ In such cases, however, the necessity must be “convincingly shown,” and appropriate procedural

561. ECtHR. *Tanko v. Finland*. App. No. 23634/94. May 19, 1994.

562. ECtHR. *Wedler v. Poland*. App. No. 44115/98. April 16, 2007; see ESCR. *Mouisel v. France*. App. No. 67263/01. November 14, 2002.

563. ECtHR. *Hummatov v. Azerbaijan*. App. No. 9852/03; 13413/04. November 29, 2007; ECtHR. *Malenko v. Ukraine*. App. No. 18660/03. February 19, 2009.

564. ECtHR. *Popov v. Russia*. App. No. 26853/04. July 13, 2006; ECtHR. *Lind v. Russia*. App. No. 25664/05. December 6, 2007; ECtHR. *Kalashnikov v. Russia*. App. No. 47095/99. July 15, 2002.

565. Some of these interpretations may also be relevant to the context of those in compulsory military service, as such persons are effectively under the control of the State.

566. ECtHR. *Hurtado v. Switzerland*. App. No. 17549/90. January 28, 1994; ECtHR. *Ilhan v. Turkey*. App. No. 22277/93. June 27, 2000.

567. ECtHR. *Khudobin v. Russia*. App. No. 59696/00. January 26, 2007.

568. ESCR. *Mouisel v. France*. App. No. 67263/01. November 14, 2002.

569. ECtHR. *Keenan v. The United Kingdom*. App. No. 27229/95. April 3, 2001. (the treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 with regard to the protection of fundamental human dignity, even though the person may not be able to point to any specific ill effects).

570. ECtHR. *X v. Denmark*. App. No. 9974/82. March 2, 1983.

571. ECtHR. *Jalloh v. Germany*. App. No. 54810/00. July 11, 2006.

guarantees must be in place. Furthermore, the level of force used must not exceed the minimum level of suffering/humiliation that would amount to a breach of Article 3, including torture.⁵⁷²

This right also requires that authorities ensure that there is a comprehensive record concerning the detainee's state of health and the treatment she/he underwent while in detention⁵⁷³ and that the diagnoses and care are prompt and accurate.⁵⁷⁴ The medical record should contain sufficient information, specifying the kind of treatment the patient was prescribed, the treatment she/he actually received, who administered the treatment and when, and how the applicant's state of health was monitored, etc. In the absence of such information, the court may draw appropriate inferences.⁵⁷⁵ Contradictions in medical records have been held to amount to a breach of Article 3.⁵⁷⁶

It is worth noting here the European Committee for the Prevention of Torture (CPT), established by the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and tasked with monitoring compliance with Article 3 of the ECHR through regular visits to places of detention and institutions. Its mandate includes prisons, juvenile detention centers, psychiatric hospitals, police holding centers, and immigration detention centers. The CPT has established detailed standards for implementing human rights-based policies in prisons and has also set monitoring benchmarks.⁵⁷⁷ The CPT has emphasized the impact of overcrowding on prisoners' health.⁵⁷⁸ It has also highlighted the frequent absence of sufficient natural light and fresh air in pretrial detention facilities and the impact of these conditions on detainees' health.⁵⁷⁹

RELEVANT PROVISIONS

▶ ECHR,

- **Art. 3:** No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

▶ **Declaration on the Promotion of Patients' Rights in Europe**⁵⁸⁰

- 1.3 Everyone has the right to physical and mental integrity and to the security of his or her person.
- 5.10 Patients have the right to relief of their suffering according to the current state of knowledge.
- 5.11 Patients have the right to humane terminal care and to die in dignity.

▶ **European Charter of Patients' Rights**,⁵⁸¹

- **Art. 11 (Right to Avoid Unnecessary Suffering and Pain):** Each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness.

572. ECtHR. *Nevmerzhitsky v. Ukraine*. App. No. 54825/00. April 5, 2005. (finding that force feeding of prisoner on hunger strike was unacceptable and amounted to torture; see ECtHR. *Herczegfalvy v. Austria*. App. No. 10533/83. September 24, 1992. (finding that forcible administration of drugs and food to violent prisoner on hunger strike complied with established medical practice).

573. ECtHR. *Khudobin v. Russia*. App. No. 59696/00. January 26, 2007.

574. ECtHR. *Aleksanyan v. Russia*. App. No. 46468/06. June 5, 2009.

575. ECtHR. *Hummatov v. Azerbaijan*. App. No. 9852/03; 13413/04. November 29, 2007; ECtHR. *Melnik v. Ukraine*. App. No. 72286/01. June 28, 2006; see ECtHR. *Holomiov v. Moldova*. App. No. 30649/05. November 7, 2006.

576. ECtHR. *Radu v. Romania*. App. No. 34022/05. October 3, 2012.

577. COE. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. [CPT]. The CPT Standards.: "Substantive" sections of the CPT's General Reports. (CPT/Inf/E [2002, rev. 2006]). October, 2006.

578. COE. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. CPT. The CPT Standards.: "Substantive" sections of the CPT's General Reports. (CPT/Inf/E [2002, rev. 2006]). October, 2006.

579. COE. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. CPT. The CPT Standards.: "Substantive" sections of the CPT's General Reports. (CPT/Inf/E [2002, rev. 2006]). October, 2006.

580. WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

581. Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.

Freedom from Torture and Other Cruel, Inhuman or Degrading Treatment in the Context of Mental Health

The ECtHR recognizes the special position of mental health patients in relation to Article 3, particularly when those suffering from mental illness are subject to detention: “the mentally ill are in a position of particular vulnerability, and clear issues of respect for their fundamental human dignity arise whenever such persons are detained by the authorities.”⁵⁸² The Court has found that failure to provide psychiatric treatment to a person in need while subject to detention may constitute degrading treatment, thus amounting to a breach of Article 3.⁵⁸³ The Court also recognizes that in addition to positive obligations that may arise in the context of those who are detained and suffer from mental illness (such as specialized psychiatric services), there are also negative obligations, where the State should avoid procedures that may aggravate the conditions of persons suffering from mental illness.⁵⁸⁴ For example, the State should avoid placing detainees with mental illness in solitary confinement, which may aggravate the detainee’s illness and/or present an increased risk of suicide.⁵⁸⁵

The State is also responsible for providing humane conditions in relation to detention, including adequate temperature control, food, and sanitary conditions.⁵⁸⁶ The Court has found degrading treatment in violation of Article 3 in cases where living conditions in institutions housing mental health patients are insufficient.⁵⁸⁷ Insufficient living conditions may include the failure on the part of the State to provide adequate food, heat, clothing, sanitary conditions and health services.⁵⁸⁸ Insufficient financial resources on the part of the State to provide adequate living conditions will not serve as a justification for failure to do so.⁵⁸⁹

CASES RELATING TO MENTAL HEALTH AND THE RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT

Claes v. Belgium (ECtHR)(2013). The Court found the national authorities’ failure to provide the applicant with adequate care during his detention for over 15 years in a prison psychiatric wing to constitute degrading treatment, and thus a violation of Article 3. The Court stressed that a structural problem existed on account of the inability to afford appropriate care for persons with mental disorders who were held in prison owing to the shortage of places in psychiatric facilities elsewhere.⁵⁹⁰

Keenan v. United Kingdom (ECtHR)(2001). The applicant, who was suffering from paranoia, committed suicide in prison after being placed in the segregation unit as a punishment. The Court found that the lack of effective monitoring, lack of informed psychiatric input into his assessment, and significant defects in the medical care provided amounted to a violation of Article 3. Moreover, the imposition on him of a serious disciplinary punishment, which might well have threatened his physical and moral resistance, had not been compatible with the standard of treatment required in respect to a person suffering from mental illness.⁵⁹¹

M.S. v. United Kingdom (ECtHR)(2012). This case involved the detention of a man suffering from mental illness, held in police custody for more than three days. The Court found a violation of Article 3, holding that, although there had been no intentional neglect on the part of the police, the applicant’s prolonged detention without appropriate psychiatric treatment had diminished his human dignity.⁵⁹²

582. ECtHR. *M.S. v. The United Kingdom*. App. No. 24527/08. August 3, 2012.

583. ECtHR. *M.S. v. The United Kingdom*. App. No. 24527/08. August 3, 2012.

584. ECtHR. *Renolde v. France*. App. No. 5608/05. January 16, 2009.

585. ECtHR. *Renolde v. France*. App. No. 5608/05. January 16, 2009.

586. ECtHR. *Stanev v. Bulgaria*. App. No. 36760/06. January 17, 2012.

587. ECtHR. *Stanev v. Bulgaria*. App. No. 36760/06. January 17, 2012.

588. ECtHR. *Stanev v. Bulgaria*. App. No. 36760/06. January 17, 2012.

589. ECtHR. *Stanev v. Bulgaria*. App. No. 36760/06. January 17, 2012.

590. ECtHR. *Claes v. Belgium*. App. No. 43418/09. April 10, 2013.

591. ECtHR. *Keenan v. The United Kingdom*. App. No. 27229/95. April 3, 2001.

592. ECtHR. *M.S. v. The United Kingdom*. App. No. 24527/08. August 3, 2012.

Freedom from Torture and Other Cruel, Inhuman or Degrading Treatment in the Context of Infectious Diseases

Persons suffering from infectious diseases may be more vulnerable to ill treatment. Under Article 3 of the ECHR, the government has an obligation to ensure the health and wellbeing of the individual in detention, which includes providing the necessary medical assistance.⁵⁹³ This right can be implicated when people living with HIV in prisons or detention centers are denied treatment.⁵⁹⁴ Where the lack of such assistance gives rise to a medical emergency or otherwise exposes the victim to “severe or prolonged pain,” the breach of Article 3 may amount to inhuman treatment.⁵⁹⁵ However, even when these results do not occur, a finding of degrading treatment may still be made if humiliation was caused to the victim by the stress and anxiety that she/he suffers from a lack of medical assistance.⁵⁹⁶ For example, the ECtHR has found that lack of medical treatment for a person’s various illnesses (including TB) that were contracted in prison resulted in the individual’s considerable mental suffering, thereby diminishing his human dignity.⁵⁹⁷

CASES RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO FREEDOM FROM TORTURE AND CRUEL, INHUMAN AND DEGRADING TREATMENT

A.B. v. Russia (ECtHR)(2011). The applicant, a person living with HIV and in prison, never received anti-viral treatment for HIV; neither was he admitted to a hospital, due to a lack of beds. Medical staff rarely visited and provided no medication when they did. The Court found the lack of medical assistance to constitute a violation of Article 3.⁵⁹⁸

Khudobin v. Russia (ECtHR)(2007). Being HIV positive and suffering from several chronic diseases, including epilepsy, viral hepatitis and various mental illnesses, the applicant contracted a number of serious diseases during his detention on remand of more than one year, including measles, bronchitis and acute pneumonia. A request by his father for a thorough medical examination was refused. The Court found that the applicant had not been given the medical assistance he needed, in violation of Article 3. While the Court accepted that the medical assistance available in prison hospitals might not always be at the same level as in the best medical institutions for the general public, it underlined that the State had to ensure that the health and well-being of detainees were adequately secured by providing them with the requisite medical assistance.⁵⁹⁹

Logvinenko v. Ukraine (ECtHR)(2011). The Court concluded that the applicant, who was a person living with HIV and serving a life prison sentence, had suffered inhuman or degrading treatment as a result of the absence of comprehensive medical supervision and treatment for tuberculosis and HIV, as well as unsuitable prison conditions. The Court therefore found a breach of Article 3.⁶⁰⁰

Vasyukov v. Russia (ECtHR)(2011). The Court found the authorities’ failure to duly diagnose the applicant with tuberculosis contracted during his detention and to provide adequate medical care to constitute a violation of Article 3.⁶⁰¹

593. ECtHR. Salakhov and Islyamova v. Ukraine. App. No. 28005/08. March 14, 2013. para. 126; see ECtHR. Kudla v. Poland. App. No. 30210/96. October 26, 2000.

594. ECtHR. E.A. v. Russia. App. No. 44187/04. August 23, 2013. (violation of Article 3 due to lack to medical attention/treatment of applicant’s HIV infection while in detention).

595. ECtHR. McGlinchey and Ors v. The United Kingdom. App. No. 50390/99. July 29, 2003.

596. ECtHR. Sarban v. Moldova. App. No. 3456/05. January 4, 2006.

597. ECtHR. Hummatov v. Azerbaijan. App. No. 9852/03; 13413/04. November 29, 2007.

598. ECtHR. A.B. v. Russia. App. No. 1439/06. January 14, 2011; see also ECtHR. E.A. v. Russia. App. No. 44187/04. August 23, 2013; ECtHR. Yakovenko v. Ukraine. App. No. 15825/06. January 25, 2008.

599. ECtHR. Khudobin v. Russia. App. No. 59696/00. January 26, 2007.

600. ECtHR. Logvinenko v. Ukraine. App. No. 13448/07. January 14, 2011.

601. ECtHR. Vasyukov v. Russia. App. No. 2974/05. September 15, 2011.

Freedom from Torture and Other Cruel, Inhuman or Degrading Treatment in the Context of Sexual and Reproductive Health

The ECtHR has recognized that pregnant women occupy a position of particular vulnerability⁶⁰² and that delayed access to medical treatment such as genetic testing (of a fetus) or abortion services may constitute degrading treatment in violation of Article 3 of the ECHR.⁶⁰³ Additionally, the Court has repeatedly recognized that forced sterilization constitutes humiliating and degrading treatment.⁶⁰⁴ In the case of women refugees, the ECtHR has emphasized that States have an obligation under international law, including Article 3 of the ECHR, to protect them by guaranteeing them the authorization to remain in the State if returning to their home country could subject them to a real risk of being subjected to treatment contrary to Article 3 in the receiving country, including female genital mutilation.⁶⁰⁵

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO FREEDOM FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT

Aden Ahmed v. Malta (ECtHR)(2013). An asylum seeker was detained and suffered from episodes of depression, recurrent physical pain, a miscarriage, and an infection during detention. The Court found that the conditions of her detention, when coupled with her fragile health, amounted to a violation of Article 3.⁶⁰⁶

I.G., M.K. and R.H. v. Slovakia (ECtHR)(2013). The Court found that the sterilization of two Roma women without their full and informed consent amounted to a violation of Article 3. The Court also considered the government's failure to conduct an effective official investigation into the sterilizations was a procedural violation of Article 3.⁶⁰⁷

V.C. v. Slovakia (ECtHR)(2012). The Court found that the sterilization of a woman at a public hospital without her informed consent amounted to a violation of Article 3. The Court found that the applicant experienced fear, anguish and feelings of inferiority as a result of her sterilization. Although there was no proof that the medical staff concerned had intended to ill-treat her, they had acted with gross disregard to her right to autonomy and choice as a patient.⁶⁰⁸

3.3.8 RIGHT TO PARTICIPATION IN PUBLIC POLICY

The right to participation in public policy has been treated as an underlying determinant of health,⁶⁰⁹ and in the context of health services, it is the right and opportunity of every person to participate in political processes and policy decisions affecting her/his health and wellbeing at the community, national and international levels.⁶¹⁰ This opportunity must be meaningful, supported and provided to all citizens without

602. ECtHR. *R.R. v. Poland*. App. No. 27617/04. May 26, 2011.

603. ECtHR. *P. and S. v. Poland*. App. No. 57375/08. January 30, 2013; see also ECtHR. *R.R. v. Poland*. App. No. 27617/04. May 26, 2011.

604. ECtHR. *V.C. v. Slovakia*. App. No. 18968/07. February 8, 2012; ECtHR. *N.B. v. Slovakia*. App. No. 29518/10. June 12, 2012; ECtHR. *I.G., M.K. and R.H. v. Slovakia*. App. No. 15966/04. November 13, 2012.

605. ECtHR. *Collins and Akaziebie v. Sweden*. App. No. 23944/05. March 8, 2007.

606. ECtHR. *Aden Ahmed v. Malta*. App. No. 55352/12. July 23, 2013. paras. 97-100.

607. ECtHR. *I.G., M.K. and R.H. v. Slovakia*. App. No. 5966/04. April 29, 2013; see ECtHR. *V.C. v. Slovakia*. App. No. 18968/07. February 8, 2012; ECtHR. *N.B. v. Slovakia*. App. No. 29518/10. June 12, 2012.

608. ECtHR. *V.C. v. Slovakia*. App. No. 18968/07. February 8, 2012.

609. Halabi, Sam. Participation and the right to health: lessons from Indonesia. *Health and Human Rights Journal*, Vol. 11, No. 1. P. 2009, p. 51.

610. CESCR, GC 14, para. 11. CESCR. CESCR General Comment No. 14: The right to the highest attainable standard of health. U.N. Doc. E/C.12/2000/4. August 11, 2000. para. 11.

discrimination. The right extends to participation in decisions about the planning and implementation of health care services, appropriate treatments, and public health strategies.

There is no explicit provision guaranteeing the right to participation in public policy in the ECHR; however, the European Charter of Patients' Rights contains a "right to participate in policy-making in the area of health" that fosters citizens' "rights to participate in the definition, implementation and evaluation of public policies relating to the protection of health care rights." In addition, the ECtHR has addressed the restriction of voting rights of discrete populations under the right to freedom from torture and cruel, inhuman and degrading treatment (ECHR 3).⁶¹¹

RELEVANT PROVISIONS

COE Recommendation No. R (2000) 5 of the Committee of Ministers to member states on the development of structures for citizen and patient participation in the decision-making process affecting health care⁶¹²

Recommends that the governments of member states:

- ensure that citizens' participation should apply to all aspects of health care systems, at national, regional and local levels and should be observed by all health care system operators, including professionals, insurers and the authorities;
- take steps to reflect in their law the guidelines contained in the appendix to this recommendation;
- create legal structures and policies that support the promotion of citizens' participation and patients' rights, if these do not already exist;
- adopt policies that create a supportive environment for the growth, in membership, orientation and tasks, of civic organizations of health care "users," if these do not already exist;
- support the widest possible dissemination of the recommendation and its explanatory memorandum, paying special attention to all individuals and organizations aiming at involvement in decision-making in health care.

The guidelines in this recommendation cover: citizen and patient participation as a democratic process; information; supportive policies for active participation; and appropriate mechanisms.

Committee of Ministers Recommendation No. R (2006) 18 to member states on health services in a multicultural society⁶¹³

- 5.1. Patient training programmes should be developed and implemented to increase their participation in the decision-making process regarding treatment and to improve outcomes of care in multicultural populations.
- 5.2. Culturally appropriate health promotion and disease prevention programmes have to be developed and implemented as they are indispensable to improve health literacy in ethnic minority groups in terms of health care.
- 5.3. Ethnic minority groups should be encouraged to participate actively in the planning of health care services (assessment of ethnic minorities' health needs, programme development), their implementation and evaluation.

611. See ECtHR. *Hirst v. The United Kingdom* (No. 2) App. No. 74025/01. October 6, 2005; see also ECtHR. *Alajos Kiss v. Hungary*. App. No. 38832/06. August 20, 2010.

612. COE. Recommendation No. R (2000) 5. February 24, 2000. On the development of structures for citizen and patient participation in the decision-making process affecting health care.

613. COE. Committee of Ministers Recommendation No. R (2006) 18. November 8, 2006.

Ljubljana Charter on Reforming Health Care,⁶¹⁴

- **Art. 5.3:** Health care reforms must address citizens' needs, taking into account their expectations about health and health care. They should ensure that the citizen's voice and choice decisively influence the way in which health services are designed and operate. Citizens must also share responsibility for their own health.

Right to Participation in Public Policy in the Context of Mental Health

Under the right to participation in public policy, people with mental disabilities have the right to participate in public life as long as the law allows them to do so, or through a representative.⁶¹⁵ The law can still prevent some with mental illness from participating in public life if their mental capacities are too low, but restrictions can be accepted only if legally justified, proportionate, and decided by the Courts.⁶¹⁶ The legal capacity of the patient is based upon official decisions.⁶¹⁷

Under the right to freedom from torture and cruel, inhuman and degrading treatment (ECHR 3) the Court has found that the complete removal of the voting rights of the mentally ill (those placed under partial or full guardianship) may breach Article 3, even if the guardianship status of such individuals is periodically subject to judicial review.⁶¹⁸ The Court has considered that "if a restriction on fundamental rights applies to a particularly vulnerable group in society, who has suffered considerable discrimination in the past, such as the mentally disabled, then the State's margin of appreciation is substantially narrower and it must have very weighty reasons for the restrictions in question."⁶¹⁹

CASE RELATING TO MENTAL HEALTH AND THE RIGHT TO PARTICIPATION IN PUBLIC POLICY

Alajos Kiss v. Hungary (ECtHR)(2010). Where the applicant was an individual with manic depression placed under partial guardianship, the Court found the domestic law prohibiting individuals under partial or full guardianship from participating in elections to be in violation of Article 3 (prohibition of degrading treatment) of the ECHR.⁶²⁰

Right to Participation in Public Policy in the Context of Infectious Diseases

Persons living with infectious diseases, such as HIV/AIDS have the right to meaningful participation in designing and implementing policies that may impact them.⁶²¹ As individuals who are most affected by public policies aimed at protecting the public's health from infectious diseases, their engagement is cru-

614. World Health Organization [WHO]. Ljubljana Charter on Reforming Health Care. June 19, 1996.

615. European Union Agency for Fundamental Rights [FRA]. The right to political participation of persons with mental health problems and persons with intellectual disabilities. October 2010.

616. European Commission for Democracy through Law (the Venice Commission), Code of Good Practice in Electoral Matters – Guidelines and Explanatory Report, adopted by the Venice Commission at 52nd session (18-19 October 2002). Opinion No. 190/2002, doc. CDL-AD (2002) 23 rev.

617. ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.

618. ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.

619. ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.

620. ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.

621. See Declaration of the Paris AIDS Summit, December 1, 1994; UNAIDS. UNAIDS Policy Brief: The Greater Involvement of People Living with HIV (GIPA). March 2007. p. 1.

cial to creating comprehensive and successful public policy that not only protects the health of the larger community, but also respects the human rights of these individuals.

Right to Participation in Public Policy in the Context of Sexual and Reproductive Health

The right to participation in public policy is essential to protecting the sexual and reproductive health of women. The participation of the populations most affected by policies related to sexual and reproductive health helps to ensure that their needs are met, such as those related to family planning and access to contraceptives. In addition to granting them a sense of ownership, the involvement of affected individuals can make the policies and implementation efforts more culturally appropriate and thereby increasing access to individuals.⁶²²

3.3.9 RIGHT TO NONDISCRIMINATION AND EQUALITY

The rights to equality and to freedom from discrimination are important to patient care and are essential components of the right to health. The COE has recognized and emphasized “effective access to health care for all without discrimination” as a “basic human right.”⁶²³ Article 14 of the ECHR prohibits discrimination based on “sex, race, color, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

Importantly, unless states have ratified Protocol No. 12 to the ECHR (which prohibits discrimination and does not require that other rights be implicated),⁶²⁴ Article 14 is not a stand-alone provision—it must be argued in conjunction with one of the substantive provisions of the ECHR.⁶²⁵ For this reason, the Court has not always examined Article 14 claims in cases in which it has already found a violation of the main provision.

International discrimination law has distinguished direct discrimination from indirect discrimination. “Direct discrimination” refers to discriminatory measures that have intent to discriminate. “Indirect discrimination” refers to “a practice, rule, requirement or condition [that] is neutral on its face” but has a negative and disproportionate impact on a group of individuals without justification.⁶²⁶ Under EU law, Directive 2000/43/EC of 29 June 2000 (which is applicable to the context of access to health care) establishes that “any direct or indirect discrimination based on racial or ethnic origin as regards the areas covered by this Directive should be prohibited throughout the Community.”⁶²⁷ In this directive, Article 2(2) defines “direct discrimination” as “occur[ing] where one person is treated less favourably than another is, has been or would be treated in a comparable situation on grounds of racial or ethnic origin.” It defines “indirect discrimination” as “occur[ing] where an apparently neutral provision, criterion or practice would put persons of a racial or ethnic origin at a particular disadvantage compared with other persons, unless that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary.” Further, the directive understands both harassment and instruction to discriminate to constitute discrimination.

In contrast, the ECtHR has not made such a distinction. Rather, the Court has established a test for determining whether to analyze the claim under Article 14 of the ECHR. Because a violation of Article 14

622. CRF and UNFPA. Briefing Paper: The Right to Contraceptive Information and Services for Women and Adolescents. December 2010. p. 24.

623. COE. Conclusions: Portugal. (XVII -2).

624. Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No. 177). Entered into force on April 1, 2005.

625. Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No. 177). Entered into force on April 1, 2005.

626. Interights. Non-Discrimination in International Law: A Handbook for Practitioners. 2011. 18.

627. Official Journal of the European Union. Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin. OJ L 180 of 19.7.2000. July 19, 2000. (13).

requires the violation of another right protected under the ECHR (again, unless the state has ratified Protocol No. 12), the Court must first establish whether the alleged discrimination indeed constitutes a violation of another right under the Convention. Second, the Court must determine whether there has been a violation of a “substantive provision.” If so, the Court’s analysis of the discrimination is subsumed within the discussion of that provision. Third, the Court will determine whether the applicant demonstrated a difference in treatment from similarly-situated individuals, a step that requires that the applicant identify with a group of persons in “analogous situations” and show the differential treatment. In response, the State may demonstrate that the differential treatment is justified.

Although the Court has hesitated to draw distinctions between direct and indirect discrimination, as well as to rely on statistical evidence that supports arguments of indirect discrimination, the Court for the first time recognized indirect discrimination in 2001 in *Hugh Jordan v. the United Kingdom*, where it established that even when a measure does not have a discriminatory purpose, it could still be considered discriminatory.⁶²⁸ For a more discussion on the issue, refer to Interights’ “Non-Discrimination in International Law: A Handbook for Practitioners.”⁶²⁹

With respect to Article 11 (right to protection of health) of the ESC, the ECSR has stated that the health care system must be accessible to everyone and that restrictions on the application of Article 11 must not be interpreted in such a way as to impede disadvantaged groups’ exercise of their rights to health.⁶³⁰ With regard to Article 13 (right to social and medical assistance), the ESCR did find, based on a purposive interpretation of the ESC consistent with the principle of individual human dignity, that medical assistance protection should extend to illegal and to lawful foreign migrants (although this condition did not apply to all ESC rights). This finding is highly significant in relation to the protection afforded to such marginalized groups within Europe.

RELEVANT PROVISIONS

▶ ECHR,

- **Art. 14:** The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, color, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

▶ ESC

- **Art. 11 – The right to protection of health:** With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organizations, to take appropriate measures designed inter alia:
 1. to remove as far as possible the causes of ill-health;
 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.
- **Art. 13 – The right to social and medical assistance:** With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:
 1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

628. ECtHR. *Hugh Jordan v. The United Kingdom* App. No. 24726/94. May 4, 2001. para. 154.

629. Interights. *Non-Discrimination in International Law: A Handbook for Practitioners*. 2011.

630. ESCR. *Defence for Children International (DCI) v. Belgium*. Collective Complaint No. 69/2011. October 23, 2012.; COE. *Conclusions of the European Committee of Social Rights*. (XVII -2); *Conclusions 2005*. Statement of interpretation of Article 11.

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
 3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
 4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953.
- **Art. 15 – The right of persons with disabilities to independence, social integration and participation in the life of the community:** With a view to ensuring to persons with disabilities, irrespective of age and the nature and origin of their disabilities, the effective exercise of the right to independence, social integration and participation in the life of the community, the Parties undertake, in particular:
 1. to take the necessary measures to provide persons with disabilities with guidance, education and vocational training in the framework of general schemes wherever possible or, where this is not possible, through specialized bodies, public or private;
 2. to promote their access to employment through all measures tending to encourage employers to hire and keep in employment persons with disabilities in the ordinary working environment and to adjust the working conditions to the needs of the disabled or, where this is not possible by reason of the disability, by arranging for or creating sheltered employment according to the level of disability. In certain cases, such measures may require recourse to specialized placement and support services;
 3. to promote their full social integration and participation in the life of the community in particular through measures, including technical aids, aiming to overcome barriers to communication and mobility and enabling access to transport, housing, cultural activities and leisure.
- ▶ **Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine,⁶³¹**
- **Art. 3:** Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.

Right to Equality and Freedom from Discrimination in the Context of Mental Health

The ECtHR has recognized that persons with mental illness constitute a discreet population that suffers from particular vulnerabilities and that has been subject to discrimination.⁶³² As such, the State enjoys a lower margin of appreciation when restricting the rights of vulnerable populations that have been subject to discrimination, such as mental health patients.⁶³³

631. COE. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. April 4, 1997.

632. ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.

633. ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.

CASE RELATING TO MENTAL HEALTH AND THE RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

X. and Y. v. Netherlands (ECtHR)(1985). A 16 year-old girl suffering from mental disabilities was sexually assaulted while living in an institutional home for children with mental disabilities. Based on her age, the victim was considered competent to bring a complaint under domestic law; but because of her mental disability, the victim's father lodged a complaint on her behalf. The domestic courts provided no legal recourse for the sexual assault, stating that the victim should have brought the complaint herself. The ECtHR declined to examine the issue under Article 14 of the ECHR, even though the applicant argued that the lack of special protections for those with mental disabilities amounted to discriminatory treatment under the law.⁶³⁴

Right to Equality and Freedom from Discrimination in the Context of Infectious Diseases

The right to equality and freedom from discrimination protects a person with an infectious disease, such as HIV/AIDS or tuberculosis, from discrimination. Citing Recommendation 1116 (1989) by the Parliamentary Assembly of the Council of Europe, the Court has held that health status falls under the "other status" category provided in Article 14 for the purposes of protecting individuals from discrimination.⁶³⁵ Where States afford differential treatment based on health status, the state has the obligation to provide a "particularly compelling justification."⁶³⁶

CASE RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

Kiyutin v. Russia (ECtHR)(2011). In this case a man applied for residency status; however his application was denied because of his HIV positive status. The man lived in Russia, was married to a Russian woman and had fathered a child with her; however Russia had a policy of denying residency status to those living with HIV. The Court found that this policy constituted discrimination in violation of Article 14 and noted, for the first time, that persons living with HIV are protected as a distinct group against discrimination in relation to their fundamental rights, and that they are a "vulnerable group" and any restriction of their rights attracts a higher degree of scrutiny on the part of the ECtHR.⁶³⁷

Right to Equality and Freedom from Discrimination in the Context of Sexual and Reproductive Health

Victims of forced sterilization have brought cases under Article 14, but the ECtHR has opted to analyze the issue under a different article, such as Article 3 (prohibition of torture)⁶³⁸ and Article 8 (right to respect for private and family life).⁶³⁹

634. ECtHR. X. and Y. v. The Netherlands. App. No. 8978/80. 26 . March 26, 1985.

635. ECtHR. Kiyutin v. Russia. App. No. 2700/10. September 15, 2011. para. 57.

636. ECtHR. Kiyutin v. Russia. App. No. 2700/10. September 15, 2011. para. 65.

637. ECtHR. Kiyutin v. Russia. App. No. 2700/10. September 15, 2011.

638. ECtHR. I.G., M.K. and R.H. v. Slovakia. App. No. 5966/04. April 29, 2013; see also ECtHR. V.C. v. Slovakia. App. No. 18968/07. February 8, 2012; ECtHR. N.B. v. Slovakia. App. No. 29518/10. June 12, 2012.

639. ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010.

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

E.B. v. France (ECtHR)(2008). The Court found that discriminatory treatment suffered by a homosexual woman who applied to adopt a child amounted to a violation of Article 8 (right to respect for private and family life) in conjunction with Article 14 (prohibition of discrimination). Although Article 8 does not guarantee a right to adoption, the Court held that discrimination on the basis of sexual orientation runs afoul of both Article 8 and Article 14.⁶⁴⁰

3.3.10 RIGHT TO AN EFFECTIVE REMEDY

The right to an effective remedy guarantees individuals the ability to have human rights violations addressed at the domestic level and have appropriate relief.⁶⁴¹ The ECHR enshrines the right to an effective remedy under both Articles 13 (right to an effective remedy) and 41 (just satisfaction). States are granted discretion on how they fulfill their obligations under this right, and the scope of their obligations depends on the nature of the case.⁶⁴² Nevertheless, the Court has stated that the right to an effective remedy consists of “a thorough and effective investigation” in order to identify and hold accountable those responsible for the violation, as well as granting “effective access for the complainant to the investigatory procedure”—in addition to payment of compensation where appropriate.⁶⁴³ The right to an effective remedy also requires that the availability of the remedy include the determination of the claim and the possibility of redress.⁶⁴⁴

Additionally, the ECtHR clarified that the right to an effective remedy is not absolute and that Article 13 must be read as requiring only that which is “as effective as can be” considering the limitations in scope that are set by the nature of the case.⁶⁴⁵ The remedy must be effective both in practice and in law, meaning that there must not be undue interference by State authorities.⁶⁴⁶ The Court has explained, however, that the effectiveness of the remedy cannot depend on “the certainty of a favourable outcome” for the victim.⁶⁴⁷

Victims’ ability to access courts is of critical importance to effectively exercise this right.⁶⁴⁸ The ECtHR has clarified that Article 13 is intended to provide States with an opportunity to remedy victims of human rights violations within their own national courts before the victim can seek recourse at the Court, which according to the Court grants an additional guarantee to individuals to ensure the full enjoyment of her/his rights.⁶⁴⁹

640. ECtHR. *E.B. v. France*. App. No. 43546/02. January 22, 2008.

641. ECtHR. *Hagyó V. Hungary*. App. No. 52624/10. April 23, 2013. para. 96.

642. ECtHR. *Hagyó V. Hungary*. App. No. 52624/10. April 23, 2013. para. 96; ECtHR. *Garayev v. Azerbaijan*. App. No. 53688/08. September 10, 2010. para. 82.

643. ECtHR. *Aksoy v. Turkey*. App. No. 26211/06. January 12, 2011. para. 98.

644. ECtHR. *Klass v. Germany*. App. No. 5029/71. September 6, 1978.

645. ECtHR. *Kudla v. Poland*. App. No. 30210/96. para. 151.

646. ECtHR. *Hagyó v. Hungary*. App. No. 52624/10. April 23, 2013. para. 96; ECtHR. *Kudla v. Poland*. App. No. 30210/96. October 26, 2000. para. 151; ECtHR. *Aksoy v. Turkey*. App. No. 21987/93. December 18, 1996. para. 95.

647. ECtHR. *Hagyó v. Hungary*. 52624/10. April 23, 2013. para. 96; ECtHR. *Garayev v. Azerbaijan*. 53688/08. September 10, 2010. December 18, 1996. para. 82.

648. ECtHR. *Kudla v. Poland*. App. No. 30210/96. October 26, 2000. paras. 147-148, 157.

649. ECtHR. *Kudla v. Poland*. App. No. 30210/96. October 26, 2000. paras. 147-148, 152.

RELEVANT PROVISIONS

▶ ECHR

- **Art. 6(1):** In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interests of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.
- **Art. 13:** Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.
- **Art. 41:** If the Court finds that there has been a violation of the Convention or the protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party.

▶ ESC

- **Art. 11 – The right to protection of health:** With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organizations, to take appropriate measures designed inter alia:
 1. to remove as far as possible the causes of ill-health;
 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.
- **Art. 13 – The right to social and medical assistance:** With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:
 1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
 2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
 3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
 4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953.
- **Art. 15 – The right of persons with disabilities to independence, social integration and participation in the life of the community:** With a view to ensuring to persons with disabilities, irrespective of age and the nature and origin of their disabilities, the effective exercise of the right to independence, social integration and participation in the life of the community, the Parties undertake, in particular:
 1. to take the necessary measures to provide persons with disabilities with guidance, education and vocational training in the framework of general schemes wherever possible or, where this is not possible, through specialized bodies, public or private;

2. to promote their access to employment through all measures tending to encourage employers to hire and keep in employment persons with disabilities in the ordinary working environment and to adjust the working conditions to the needs of the disabled or, where this is not possible by reason of the disability, by arranging for or creating sheltered employment according to the level of disability. In certain cases, such measures may require recourse to specialized placement and support services;
3. to promote their full social integration and participation in the life of the community in particular through measures, including technical aids, aiming to overcome barriers to communication and mobility and enabling access to transport, housing, cultural activities and leisure.

► **Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine,⁶⁵⁰**

- **Art. 3:** Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.

Right to an Effective Remedy in the Context of Mental Health

In highlighting the difficulties that mental health patients could face in challenging violations of their rights, the ECtHR has underscored that an assessment of whether an individual with mental disabilities has exhausted domestic remedies requires taking into consideration her/his “vulnerability, and in particular [her/his] inability in some cases to plead her/his case coherently.”⁶⁵¹

CASES RELATING TO MENTAL HEALTH AND THE RIGHT TO AN EFFECTIVE REMEDY

B. v. Romania (No. 2)(ECtHR)(2013). The applicant diagnosed with paranoid schizophrenia was subjected to psychiatric confinement and lost guardianship of her three children. The Court found that the State had violated Article 8 of the ECHR when failing to ensure “adequate legal protection for the applicant during her successive admissions to psychiatric institutions and during the proceedings that resulted in her children remaining in care.” It ordered the State to provide the applicant with the necessary legal protection as required by ECHR.⁶⁵²

Lashin v. Russia (ECtHR)(2013). The Court found a violation of the right to privacy where the applicant, a person with schizophrenia, was committed by the domestic courts to a psychiatric hospital against his will and without possibility of review, which prevented him from getting married.⁶⁵³

Kudla v. Poland (ECtHR)(2000). The applicant suffered from chronic depression and was held in detention for fraud charges. He attempted to commit suicide twice while in prison. The applicant repeatedly requested his release and appealed decisions to hold him in detention. The Court held that the State failed to provide the applicant with the necessary means for challenging the length of the proceedings for determining the charges held against him, and therefore, the State was in violation of Article 13 of the ECHR.⁶⁵⁴

650. COE. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. April 4, 1997.

651. ECtHR. *B. v. Romania* (No. 2). App. No. 1285/03. February 19, 2013. para. 79.

652. ECtHR. *B. v. Romania* (No. 2). App. No. 1285/03. February 19, 2013.

653. ECtHR. *Lashin v. Russia*. App. No. 33117/02. April 22, 2013.

654. ECtHR. *Kudla v. Poland*. App. No. 30210/96. October 26, 2000. paras. 147-148, 157.

Right to an Effective Remedy in the Context of Infectious Diseases

The right to effective remedy has been invoked to protect individuals with infectious diseases as marginalized populations that are stigmatized based on their health status. The Court has analyzed the importance of this right with respect to the lack of medical treatment provided to detainees who suffer from infectious diseases and the failure to provide detention conditions sensitive to the detainees' state of health.⁶⁵⁵

CASES RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO AN EFFECTIVE REMEDY

Kozhokar V. Russia (ECtHR)(2010). The applicant was a detainee living with HIV and Hepatitis C. The Court joined the applicants' allegations under Article 3 with Article 13 and found that the State had violated Article 13 by not providing the applicant "effective and accessible" means through which he could challenge the prison conditions, including inadequate medical assistance.⁶⁵⁶

Logvinenko v. Ukraine (ECtHR)(2010). The applicant was a detainee who suffered from HIV and tuberculosis. The Court found the State in violation of Article 3 when failing to provide adequate medical treatment and to ensure that the "physical arrangements" of his detention were compatible with his state of health. Because the State did not provide appropriate redress or effective remedies through which the applicant could bring complaints, the Court held that the State had violated Article 13.⁶⁵⁷

Right to an Effective Remedy in the Context of Sexual and Reproductive Health

In the context of sexual and reproductive health, the ECtHR has treated issues of effective remedy within its analysis of other rights, such as the right to privacy, to avoid overlap. This is not to say that the right to an effective remedy, as protected under Article 13 of the ECHR, is not imperative to issues of sexual and reproductive health. On the contrary, as shown in the cases provided in this sub-section, the ECtHR considers this right essential. For example, with respect to abortion, the Court has read Article 8 to require States that permit abortion to provide the legal framework to determine entitlements to lawful abortion and procedures to resolve disputes between women seeking abortion services and medical practitioners.⁶⁵⁸

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO AN EFFECTIVE REMEDY

R.R. v. Poland (ECtHR)(2011). A mother of two was pregnant with a child thought to be suffering from a severe genetic abnormality and was deliberately denied timely access to the genetic tests to which she was entitled by doctors who were opposed to abortion. The Court found a violation of Article 8 because Polish law did not include any effective mechanisms which would have enabled the applicant to have access to the available diagnostic services and to make, in the light of their results, an informed decision as to whether or not to seek an abortion.⁶⁵⁹

655. See ECtHR. *Logvinenko v. Ukraine*. App. No. 13448/07. October 14, 2010; ECtHR. *Kozhokar V. Russia*. App. No. 33099/08. December 16, 2010.

656. ECtHR. *Kozhokar v. Russia*. App. No. 33099/08. December 16, 2010.

657. ECtHR. *Logvinenko v. Ukraine*. App. No. 13448/07. October 14, 2010.

658. ECtHR. *A, B and C v. Ireland*. App. No. 25579/05. December 16, 2010; see also ECtHR. *P. and S. v. Poland*. App. No. 57375/08. January 30, 2013.

659. ECtHR. *R.R. v. Poland*. App. No. 27617/04. November 28, 2011.

Tysi c v. Poland (ECtHR)(2007). The applicant was refused a therapeutic abortion, after being warned that her already severe myopia could worsen if she carried her pregnancy to term. Following the birth of her child, she had a retinal hemorrhage, which resulted in a disability. The Court found that denying her access to an effective mechanism that would determine her eligibility for a legal abortion was a violation of her right to privacy.⁶⁶⁰

3.4 PROVIDERS' RIGHTS

Health care providers play a critical role in addressing the abuses that take place in health care settings. Accordingly, the application of the human rights framework to patient care implies that the interests of patients and health care providers are interrelated and the interests of both are to be protected. If providers are unable to fully exercise their rights, they may be deterred or made powerless to effectively prevent abuses of patients. This section highlights several relevant European regional standards as they appear in the European Convention on Human Rights (ECHR) and the European Social Charter (ESC) and how they have been interpreted in relation to three key rights for health care providers. These include the right to (i) work in decent conditions; (ii) freedom of association and assembly, including association with trade unions and the right to strike; and (iii) due process and related rights to receive a fair hearing and an effective remedy, protection of privacy and reputation, and freedom of expression and information.

The chapter is divided into three major sections. Part I of this section covers the right to work in decent conditions, including the right to work and the right to fair pay and safe working conditions. Part II discusses the right to freedom of association. Part III explores the right to due process and related rights. Each section begins with a discussion of the significance of that particular right for health care providers and is followed by relevant standards from European legal instruments and case law to exemplify potential violations. Even if there is little or sometimes no direct reference to the standards provided in this chapter, health sector personnel enjoy the same level of protection as other workers.

3.4.1 RIGHT TO WORK IN DECENT CONDITIONS

The European Committee of Social Rights (ECSR) has provided extensive interpretation of the right to work in decent conditions, which is governed by the European Social Charter (ESC). The ESC enshrines the right to work (ESC, Art. 1), the right to just conditions of work (ESC, Art. 2), the right to equal opportunities and equal treatment in matters of employment and occupation without discrimination on the grounds of sex (ESC, Art. 20), and the right to safe and healthy working conditions (ESC, Art. 3). Although not the focus of this section, relevant ECHR standards include Article 2 (the right to life) and Article 3 (the prohibition of torture and subjection to inhuman or degrading treatment or punishment), insofar as they provide safeguards against ill treatment in the workplace.

Right to work

The right to work requires that States “legally prohibit any discrimination, direct or indirect, in employment” and provide special protection with regard to gender, race or ethnic group.⁶⁶¹ This right also protects the individual from the dismissal or other retaliatory action by the employer against an employee who has lodged a complaint or taken legal action.⁶⁶² While not analyzed under the right to work, the ECtHR found a

660. ECtHR. *Tysi c v. Poland*. App. No. 5410/03. September 24, 2007.

661. Conclusions are drawn from the Digest of September 2008, by the COE; ECSR. Conclusions XVI-1, Austria, p. 25.

662. COE. Conclusions: Iceland. (XVI-1).

violation under Article 8 (right to privacy) and Article 14 (freedom from discrimination) where an employee was dismissed based on his HIV status.⁶⁶³ The right to equal opportunities and equal treatment in matters of employment and occupation without discrimination on the grounds of sex, as enshrined under Article 20 of the ESC, protects the individual from a) discrimination in employment; b) any practice that might interfere with a worker's right to earn a living in an occupation freely entered,⁶⁶⁴ or cause her/him to be a subject of forced or compulsory labor. Legislation should prohibit any indirect discrimination, which arises when a measure or practice that is identical for everyone, without a legitimate aim, disproportionately affects persons having a particular religion or belief, disability, age, sexual orientation, political opinion, ethnic origin, etc.⁶⁶⁵ Furthermore, domestic law must at least provide for the power to abrogate or amend any provision contrary to the principle of equal treatment, which appears in collective labor agreements, in employment contracts, or in firms' own regulations.⁶⁶⁶ Domestic law must also provide appropriate and effective remedies that are adequate and proportionate and available to victims in the event of an allegation of discrimination. In the same way, this right establishes that impositions of predefined upper limits to compensation (derived from the violation of this right) that may be awarded to the workers are not in conformity with this right.⁶⁶⁷

Under EU law, Directive 2000/78/EC of 27 November 2000⁶⁶⁸ provides member states with a “guideline framework” in order to address employment discrimination. Recognizing that “[e]mployment and occupation are key elements in guaranteeing equal opportunities for all and contribute strongly to the full participation of citizens in economic, cultural and social life and to realising their potential,” the directive prohibits “any direct or indirect discrimination based on religion or belief, disability, age or sexual orientation.” The directive is clear in that the requirements set out constitute “minimum requirements” and that member states can adopt higher standards but that the requirements under the directive should not be used to “justify any regression.”

Right to fair pay and safe working conditions

the right to just conditions of work (ESC, Art. 2) establishes limits on daily and weekly working hours, including overtime. The provisions of this right must be guaranteed through legislation, regulations, collective agreements, or any other binding means.⁶⁶⁹ Also, periods of “on call” duty during which the employee has not been required to perform work for the employer constitute effective working time and cannot be regarded as rest periods (within the meaning of Article 2, except in the framework of certain occupations or particular circumstances and pursuant to appropriate procedures). This right holds that the absence of effective work cannot constitute an adequate criterion for regarding such a period as a period of rest.⁶⁷⁰ Overtime work must not simply be left to the discretion of the employer or the employee—the reasons for overtime work and its duration must be subject to regulation.⁶⁷¹

The right to just conditions of work likewise requires that wages be above the poverty line in a given country to be considered fair remuneration. A wage must not fall too far short of the national average wage. In fact, the ESCR has emphasized that minimum wage must be “sufficient to give the worker a decent standard of living.”⁶⁷² In the same way, this right also establishes that employees who work overtime must be paid at a higher rate than the normal wage rate.⁶⁷³ Also, this right ensures that women and men

663. ECtHR. *I.B. v. Greece*. App. No. 552/10. October 3, 2013.

664. COE. Conclusions of the European Committee of Social Rights. Conclusions (II and XVI-1). Statements of interpretation of Article 1§2.

665. David Harris et al. *Law of the European Convention on Human Rights*. Oxford: Oxford University Press, 2009. p. 607.

666. COE. Conclusions: Iceland. (XVI-1).

667. COE. Conclusions 2006: Albania.

668. Official Journal of the European Union. Council Directive 2004/113/EC of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services. OJ L 373 of 21.12.2004. June 25, 2009.

669. COE. Conclusions I. Statement of Interpretation on Article 2§1.

670. ECSR. *Confédération Française de l'Encadrement CFE-CGC v. France*. Collective Complaint No. 16/2003. October 12, 2004.

671. COE. Conclusions. (XIV-2). Statement of Interpretation on Article 2(1).

672. Conclusions 2003, France, p. 120

673. COE. Conclusions I. Statement of Interpretation on Article 4§2.

are entitled to have “equal pay for work of equal value.”⁶⁷⁴ Accordingly, domestic law must provide for appropriate and effective remedies in the event of alleged wage discrimination.⁶⁷⁵ Anyone who suffers wage discrimination on grounds of sex must be entitled to adequate compensation, sufficient to make good the damage suffered by the victim and to act as a deterrent to the offender.⁶⁷⁶

The right to safe and healthy working conditions (ESC, Art. 3) requires that occupational risk prevention be a priority and that it be incorporated into the public authorities' activities at all levels and form part of other public policies (on employment, persons with disabilities, equal opportunities, etc.).⁶⁷⁷ Under this right, workers, all workplaces, and all sectors of activity must be covered by occupational health and safety regulations.⁶⁷⁸ In the same way, this right requires that States ensure that the policy and strategies adopted are assessed and reviewed regularly, particularly in light of changing risks. At the employer level, in addition to compliance with protective rules, there must be regular assessment of work-related risks and the adoption of preventive measures geared to the nature of risks in addition to information and training for workers. Employers are also required to provide appropriate information, training, and medical supervision for temporary workers and employees on fixed-term contracts (for example, taking account of employees' accumulated periods of exposure to dangerous substances while working for different employers).⁶⁷⁹ The right applies to both the public and private sectors.⁶⁸⁰

RELEVANT PROVISIONS

► ESC

- **Art.1(2) – The right to work:** With a view to ensuring the effective exercise of the right to work, the Parties undertake:...to protect effectively the right of the worker to earn his living in an occupation freely entered upon...
- **Art.2(1) – The right to just conditions of work:** With a view to ensuring the effective exercise of the right to just conditions of work, the Parties undertake: ...to provide for reasonable daily and weekly working hours, the working week to be progressively reduced to the extent that the increase of productivity and other relevant factors permit...
- **Art. 3 – The right to safe and healthy working conditions:** With a view to ensuring the effective exercise of the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and workers' organisations:
 1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;
 2. to issue safety and health regulations;
 3. to provide for the enforcement of such regulations by measures of supervision;
 4. to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions.

674. COE. Conclusions: Slovak Republic. (XV-2, addendum).

675. COE. Conclusions I. Statement of Interpretation on Article 4§3.

676. COE. Conclusions. (XIII -5). Statement of Interpretation on Article 1 of the Additional Protocol.

677. COE. Conclusions 2005: Lithuania.

678. COE. Conclusions 2005: Estonia.

679. COE. Conclusions 2003: Bulgaria. p. 31.

680. COE. Conclusions II. Statement of Interpretation on Article 3.

- **Art. 4 – The right to a fair remuneration:** With a view to ensuring the effective exercise of the right to a fair remuneration, the Parties undertake:
 1. to recognise the right of workers to a remuneration such as will give them and their families a decent standard of living;
 2. to recognise the right of workers to an increased rate of remuneration for overtime work, subject to exceptions in particular cases;
 3. to recognise the right of men and women workers to equal pay for work of equal value;
 4. to recognise the right of all workers to a reasonable period of notice for termination of employment;
 5. to permit deductions from wages only under conditions and to the extent prescribed by national laws or regulations or fixed by collective agreements or arbitration awards. The exercise of these rights shall be achieved by freely concluded collective agreements, by statutory wage-fixing machinery, or by other means appropriate to national conditions.
- **Art. 22 – The right to take part in the determination and improvement of the working conditions and working environment:** With a view to ensuring the effective exercise of the right of workers to take part in the determination and improvement of the working conditions and working environment in the undertaking, the Parties undertake to adopt or encourage measures enabling workers or their representatives, in accordance with national legislation and practice, to contribute:
 - a. to the determination and the improvement of the working conditions, work organization and working environment;
 - b. to the protection of health and safety within the undertaking;
 - c. to the organization of social and socio-cultural services and facilities within the undertaking;
 - d. to the supervision of the observance of regulations on these matters.

PROVISIONS RELATED TO WOMEN

▶ ESC,

- **Art. 20 – The right to equal opportunities and equal treatment in matters of employment and occupation without discrimination on the grounds of sex:** With a view to ensuring the effective exercise of the right to equal opportunities and equal treatment in matters of employment and occupation without discrimination on the grounds of sex, the Parties undertake to recognise that right and to take appropriate measures to ensure or promote its application in the following fields:
 - a) access to employment, protection against dismissal and occupational reintegration;
 - b) vocational guidance, training, retraining and rehabilitation;
 - c) terms of employment and working conditions, including remuneration;
 - d) career development, including promotion.

PROVISIONS RELATED TO PERSONS WITH DISABILITIES

▶ ESC,

- **Art. 15(2) – The right of persons with disabilities to independence, social integration and participation in the life of the community:** With a view to ensuring to persons with disabilities, irrespective of age and the nature and origin of their disabilities, the effective exercise of the right to independence, social integration and participation in the life of the community, the Parties undertake, in particular...to promote their access to employment through all measures tending to encourage employers to hire and keep in employment persons with disabilities in the ordinary working environment and to adjust the working conditions to the needs of the disabled or, where this is not possible by reason of the disability, by arranging for or creating sheltered employment according to the level of disability. In certain cases, such measures may require recourse to specialised placement and support services...

CASES RELATING TO THE RIGHT TO WORK IN DECENT CONDITIONS

Confédération Française de l'Encadrement CFE-CGC v. France (ESCR)(2004). The petitioners claimed that the Act of 17 January 2003 passed by the government allowed “on-call time” (*périodes d’astreinte*) to be considered rest time under the law. The Committee found that “on-call time” during which the employee has not been required to perform work for the employer, although they do not constitute effective working time, cannot be regarded as a rest period. The Committee therefore held that equating “on-call time” to rest periods constitutes a violation of the right to reasonable working time.⁶⁸¹

Marangopoulos Foundation for Human Rights (MFHR) v. Greece (ESCR)(2006). The ESCR found that the lack of legislation to ensure the security and safety of persons working in lignite mines as well as reduced working hours or additional holidays constituted a violation of Article 3 of the ESC, which works to ensure the right to safe and healthy working standards of the highest possible level. The ESCR emphasized that this article requires the government “to issue health and safety regulations providing for preventive and protective measures against most of the risks recognised by the scientific community and laid down in Community and international regulations and standards.”⁶⁸²

Syndicat national des Professions du Tourisme v. France. (ESCR)(2000). The ESCR found a violation of the right to non-discrimination in employment where entities offering guided tours (within the remit of the government) afforded differential treatment between lecturer guides hired by them and interpreter guides and national lecturers holding a state diploma. The ESCR concluded that that difference in treatment had no reasonable and objective justification and constituted *de facto* discrimination in employment to the detriment of interpreter guides and national lecturers with a state diploma.⁶⁸³

681. ESCR. *Confédération Française de l'Encadrement CFE-CGC v. France*. Collective Complaint No. 16/2003. October 12, 2004.

682. ESCR. *Marangopoulos Foundation for Human Rights (MFHR) v. Greece*. Collective Complaint No. 30/2005. December 6, 2006. §224.

683. ESCR. *Syndicat national des Professions du Tourisme v. France*. Collective Complaint No. 6/1999. October 10, 2000. para. 32.

3.4.2 RIGHT TO FREEDOM OF ASSOCIATION AND ASSEMBLY

The right to freedom of association and assembly is enshrined under Article 5 (right to organize) of the ESC and Article 11 (freedom of assembly and association) of the ECHR. The right to freedom of association and assembly establishes that “association” is an autonomous concept that is not dependent on the classification adopted under domestic law. This factor is relevant but not decisive.⁶⁸⁴ It also includes the freedom not to join an association or trade union.⁶⁸⁵

Additionally, it applies to private law bodies only, as public law bodies (i.e., those established under legislation) are not considered to be “associations.” However, this right allows for “lawful restrictions” to be placed on certain public officials (for example, the armed forces and the police) and on members of the “administration of the state.”⁶⁸⁶

The ECtHR has confirmed that the right includes the freedom to abstain from joining an association. In addition, the ECtHR has determined that official regulatory body members do not fall within the scope of the guarantee. This finding is particularly important for medical professionals as these bodies are established by law and have the authority to discipline their members.⁶⁸⁷

This section covers two aspects of freedom of association: the freedom of association and assembly (ECHR, Art. 11) and the right to form trade unions and to strike (ESC, Arts. 5, 6, 21, and 22).

RELEVANT PROVISIONS

▶ ECHR,

- **Art. 11** :(1) Everyone has the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of his interests. (2) No restrictions shall be placed on the exercise of these rights other than such as are prescribed by law and are necessary in a democratic society in the interests of national security or public safety, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others. This article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces, of the police or of the administration of the State.

CASE RELATING TO THE RIGHT TO FREEDOM OF ASSOCIATION AND ASSEMBLY

Albert and Le Compte v. Belgium (ECtHR)(1983). The applicant claimed that the obligation to join in a specific organ (the Ordre des médecins) had the effect of eliminating freedom of association. The Court held that Ordre des médecins cannot be regarded as an association within the meaning of Article 11; that the existence of the Ordre des médecins and the resultant obligation on practitioners to be entered on its register and to be subject to the authority of its organs clearly have neither the object nor the effect of limiting, even less suppressing, the freedom of association.⁶⁸⁸

684. ECtHR. Chassagnou and Ors v. France. App. No. 25088/94; 28331/95; and 28443/95. April 29, 1999. (hunters' associations in France are held to be “associations” for purposes of Article 11 even though government argued that they were public law institutions).

685. ECtHR. Young and Ors v. The United Kingdom. App. No. 3455/05. February 19, 2009. (“closed shop,” compulsory membership of the rail trade union breached Article 11); see also ECtHR. Sigurjonsson v. Iceland. App. No. 16130/90. June 30, 1993.

686. This approach has been endorsed by ESCR experts but not by the ILO Freedom of Association Committee, although Article 9(1) of ILO Convention No. 87 limiting public servants' rights does not refer to “administration of the state”.

687. See also International Centre for the Protection of Legal Rights. INTERIGHTS Manual for Lawyers. Article 11 of the European Convention of Human Rights: Freedom of Assembly and Association. Provides information on how the ECtHR has interpreted Article 11 of the ECHR.

688. ECtHR. Albert and Le Compte v. Belgium. App. No. 7299/75; 7496/76. February 10, 1983.

Trade unions and the right to strike

The right to form trade unions and the right to strike establish that workers must be free to join and free not to join a trade union.⁶⁸⁹ Under this right, any form of compulsory trade union membership imposed by law is incompatible with the provisions of this right.⁶⁹⁰ The right to form trade unions and the right to strike also establish that domestic law must clearly prohibit all pre-entry or post-entry “closed shop” clauses and all union security clauses (automatic deductions from wages).⁶⁹¹ Consequently, clauses in collective agreements or legally-authorized arrangements whereby jobs are reserved in practice for members of a specific trade union are a breach to the cited right.⁶⁹²

The right to form trade unions and the right to strike protect trade union members from any harmful consequence that their trade union membership or activities may have on their employment, particularly any form of reprisal or discrimination in the areas of recruitment, dismissal, or promotion. Where such discrimination occurs, domestic law must make provision for compensation that is adequate and proportionate to the harm suffered by the victim.⁶⁹³ Under this right, trade unions and employers' organizations must be independent from excessive State interference in relation to their infrastructure or effective functioning.⁶⁹⁴

This right also establishes that trade unions and employer organizations must be free to organize without prior authorization, and initial formalities, such as declaration and registration, must be simple and easy to apply. If fees are charged for the registration or establishment of an organization, they must be reasonable and designed only to cover strictly necessary administrative costs.⁶⁹⁵ However, the “right to strike” may be restricted; prohibiting strikes in sectors that are essential to the community is deemed to serve a legitimate purpose, as strikes in these sectors could pose a threat to public interest, national security, and/or public health. Simply banning strikes, however, even in essential sectors—particularly when they are extensively defined, for example, as “energy” or “health”—is not deemed proportionate to the specific requirements of each sector. At most, the introduction of a minimum service requirement in these sectors might be considered in conformity with the ESC.⁶⁹⁶ The most comprehensive analysis of the right to strike has been made under the ESC. The ECtHR has engaged in a more limited exploration of trade unions, which includes upholding workers' right to strike.

RELEVANT PROVISIONS

► ESC

- **Art. 5 – The right to organize:** With a view to ensuring or promoting the freedom of workers and employers to form local, national or international organizations for the protection of their economic and social interests and to join those organizations, the Parties undertake that national law shall not be such as to impair, nor shall it be so applied as to impair, this freedom. The extent to which the guarantees provided for in this article shall apply to the police shall be determined by national laws or regulations. The principle governing the application to the members of the armed forces of these guarantees and the extent to which they shall apply to persons in this category shall equally be determined by national laws or regulations.

689. COE. Conclusions I. Statement of Interpretation on Article 5.

690. COE. Conclusions III . Statement of Interpretation on Article 5.

691. COE. Conclusions VIII . Statement of Interpretation on Article 5.

692. COE. Conclusions: Denmark. (XV-1).

693. COE. Conclusions 2004: Bulgaria.

694. COE. Conclusions: Germany. (XII -2).

695. COE. Conclusions: United Kingdom. (XV-1).

696. COE. Conclusions I. Statement of Interpretation on Article 6§4; ECSR. Confederation of Independent Trade Unions in Bulgaria, Confederation of Labour “Podkrepa” and European Trade Union Confederation v. Bulgaria. Collective Complaint No. 32/2005. October 16, 2006.

- **Art. 6 – The right to bargain collectively:** With a view to ensuring the effective exercise of the right to bargain collectively, the Parties undertake:
 1. to promote joint consultation between workers and employers;
 2. to promote, where necessary and appropriate, machinery for voluntary negotiations between employers or employers' organizations and workers' organizations, with a view to the regulation of terms and conditions of employment by means of collective agreements;
 3. to promote the establishment and use of appropriate machinery for conciliation and voluntary arbitration for the settlement of labor disputes; and recognise:
 4. the right of workers and employers to collective action in cases of conflicts of interest, including the right to strike, subject to obligations that might arise out of collective agreements previously entered into.
 - **Art. 19(4)(b) – The right of migrant workers and their families to protection and assistance:** With a view to ensuring the effective exercise of the right of migrant workers and their families to protection and assistance in the territory of any other Party, the Parties undertake: ... 4. to secure for such workers lawfully within their territories, insofar as such matters are regulated by law or regulations or are subject to the control of administrative authorities, treatment not less favourable than that of their own nationals in respect of the following matters:
 - a. remuneration and other employment and working conditions;
 - b. membership of trade unions and enjoyment of the benefits of collective bargaining...
 - **Art. 22 – The right to take part in the determination and improvement of the working conditions and working environment:** With a view to ensuring the effective exercise of the right of workers to take part in the determination and improvement of the working conditions and working environment in the undertaking, the Parties undertake to adopt or encourage measures enabling workers or their representatives, in accordance with national legislation and practice, to contribute:
 - a. to the determination and the improvement of the working conditions, work organization and working environment; ...
 - c. to the organization of social and socio-cultural services and facilities within the undertaking;
 - d. to the supervision of the observance of regulations on these matters.
- ▶ **Charter of Fundamental Rights of the European Union,⁶⁹⁷**
- **Art. 28:** Workers and employers, or their respective organisations, have, in accordance with Union law and national laws and practices, the right to negotiate and conclude collective agreements at the appropriate levels and, in cases of conflicts of interest, to take collective action to defend their interests, including strike action.

CASES RELATING TO TRADE UNIONS AND THE RIGHT TO STRIKE

European Trade Union Confederation (ETUC)/Centrale Générale des Syndicats Libéraux de Belgique (CGSLB)/Confédération des Syndicats Chrétiens de Belgique (CSC)/Fédération Générale du Travail de Belgique (FGTB) v. Belgium (ESCR)(2011). The ESCR held in favour of the complainant trade unions, finding that although Belgium's Constitution and statutes did not enshrine a right to strike, this right (as understood under Article 6(4) of the ESC) was guaranteed in "established and undisputed" domestic case law. The Court also concluded that the restrictions on activities of strike pickets, under Belgian law, were incompatible with Article G of the ESC and constituted a violation of the right to strike under Article 6(4).⁶⁹⁸

697. Official Journal of the European Communities. Charter of Fundamental Rights of the European Union. OJ C 364/01. December 7, 2000.

698. ESCR. European Trade Union Confederation (ETUC)/Centrale Générale des Syndicats Libéraux de Belgique (CGSLB)/Confédération des Syndicats Chrétiens de Belgique (CSC)/Fédération Générale du Travail de Belgique (FGTB) v. Belgium Collective Complaint 59/2009. September 13, 2011.

Enerji Yapi-Yol Sen v. Turkey (ECtHR)(2008). Where a circular was issued by the government banning all civil servants from taking strike action, the Court held that the right to strike was not absolute and subject to restrictions. Moreover, the Court concluded that a ban on strike action could be imposed on civil servants, but it could not deprive all civil servants of the right to strike.⁶⁹⁹

Unison v. The United Kingdom (ECtHR)(2002). A trade union for public service employees, including healthcare providers in hospitals, challenged a decision preventing it from organizing strikes. The Committee held that the right to form trade union does not implicitly create a right to strike and declared the application inadmissible.⁷⁰⁰

3.4.3 RIGHT TO DUE PROCESS AND RELATED RIGHTS

This section discusses four aspects of the right to due process and related rights: the interpretation of the right to a fair hearing; the guarantee of effective remedy; the protection of privacy and reputation; and the protection of freedom of expression and information. With respect to health care providers, these rights come into play when legal challenges concerning their conduct are lodged against them. The ECtHR has provided extensive interpretation of the right to a fair hearing, which is protected in Article 6 of the ECHR. This right encompasses matters such as licensing and medical negligence.

Right to a fair hearing

The right to a fair hearing, as protected by Article 6 of the ECHR, entitles every individual to “a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law.” This right applies to the process of determining the individual’s civil rights or criminal charges brought against her/him. It also applies to all related proceedings between the State and the individual or between private parties—the result of which is “decisive” for civil rights and obligations.⁷⁰¹ Administrative proceedings do not necessarily need to comply with Article 6, provided that, at some point, there is an opportunity to appeal to a judicial process that does adhere to Article 6 standards. Similarly, legal proceedings do not need to meet fair trial standards at each stage of the process. Rather, courts will assess whether the proceedings, taken together as a whole, constitute a fair trial.

In civil proceedings, a litigant has the rights to real and effective access to a court, notice of the time and place of the proceedings, a real opportunity to present her/his case, and a reasoned decision. There is no express requirement for legal aid in civil cases. In order to give effect to the right of access and the need for fairness, however, some assistance may be required in certain cases.⁷⁰²

Additionally, under this right, the principle of the “equality of arms” (both parties have equal procedural access to the court) does apply and can be violated by mere procedural inequality.⁷⁰³ This right establishes that both parties have a right to be informed of the other’s submissions and other written material and have a right to reply.⁷⁰⁴

699. ECtHR. *Enerji Yapi-Yol Sen v. Turkey*. App. No. 68959/01. April 21, 2009.

700. ECtHR. *Unison v. The United Kingdom*. App. No. 53574/99. January 10, 2002.

701. ECtHR. *Ringeisen v. Austria*. App. No. 2614/65. July 16, 1971.

702. ECtHR. *Airey v. Ireland*. App. No. 6289/73. October 9, 1979; ECtHR. *P and Ors v. The United Kingdom*, App. No. 11209/84; 1234/84; 11266/84; 11386/85. November 29, 1988.

703. ECtHR. *Fischer v. Austria*. App. No. 33382/96. January 17, 2002.

704. ECtHR. *Dombo Beheer BV v. The Netherlands*. App. No. 14448/88. October 27, 1993.

RELEVANT PROVISIONS

▶ ECHR,

- **Art. 6:** In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interests of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

CASE RELATING TO THE RIGHT TO A FAIR HEARING

Konig v. Germany (ECtHR)(1978). As the result of disciplinary proceedings, a doctor was found to be unfit for practice. He then complained about the length of the proceedings. The Court found the right to practice medicine to be a civil right and that the length of the proceedings exceeded the ‘reasonable time’ required under Article 6 (more than 10 years of appeals process).⁷⁰⁵

3.4.4 RIGHT TO AN EFFECTIVE REMEDY

The right to an effective remedy establishes that the availability of a remedy must include the determination of the claim and the possibility of redress.⁷⁰⁶ Under this right, all procedures, including judicial and nonjudicial, will be examined.⁷⁰⁷ This right also establishes that the nature of the remedy required to satisfy the obligation under the cited right depends upon the nature of the alleged violation. In most cases, compensation will suffice. In all cases, the remedy must be “effective” in both practice and law, meaning that there must not be undue interference by State authorities.⁷⁰⁸ This right requires that the authority with the ability to provide the remedy must be independent of the body alleged to have committed the breach.⁷⁰⁹

RELEVANT PROVISIONS

▶ ECHR,

- **Art. 13** Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.

705. ECtHR. *Konig v. Germany*. App. No. 6232/73. June 28, 1978.

706. ECtHR. *Klass v. Germany*. App. No. 5029/71. September 6, 1978.

707. ECtHR. *Silver v. The United Kingdom*, App. No. 5947/72; 6205/73; 7052/75; 7061/75; 7107/75; 7113/75; 7136/75. March 25, 1983.

708. ECtHR. *Aksoy v. Turkey*. App. No. 219987/93. December 18, 1996.

709. ECtHR. *Khan v. The United Kingdom*, App. No. 35394/97. October 4, 2000; ECtHR. *Taylor-Sabori v. The United Kingdom*, App. No. 47114/99. January 22, 2003.

CASE RELATING TO THE RIGHT TO AN EFFECTIVE REMEDY

Aksoy v. Turkey (ECtHR)(2011). Where an individual claimed that he has been tortured by agents of the State, the Court held that the right to an effective remedy consists of “a thorough and effective investigation capable of leading to the identification and punishment of those responsible and including effective access for the complainant to the investigatory procedure”—in addition to payment of compensation where appropriate.⁷¹⁰

3.4.5 RIGHT TO AN EFFECTIVE REMEDY RIGHT TO PROTECTION OF PRIVACY AND REPUTATION

The right to protection of privacy and reputation protects the private life of the individual. For example, it provides protection against the unlawful bugging of telephone calls.⁷¹¹ Under this right, protection can extend to certain behavior and activity that takes place in public, depending on whether the individual had a “reasonable expectation of privacy” and whether that expectation was voluntarily waived.⁷¹² This right also requires that, in addition to refraining from arbitrarily interfering, the State take measures necessary for ensuring the respect of this right, such as protecting it from third party abuse.⁷¹³

RELEVANT PROVISIONS

▶ ECHR

- **Art. 8:**

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

- **Art. 10:**

1. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.
2. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.

- **Art. 13:** Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.

710. ECtHR. *Aksoy v. Turkey*. App. No. 26211/06. January 12, 2011. para. 98.

711. ECtHR. *Halford v. The United Kingdom*. App. No. 20605/92. June 25, 1997. (concluding that bugging of private telephone calls made to an office telephone could constitute a breach of Article 8).

712. ECtHR. *Von Hannover v. Germany*. App. No. 40660/08; 60641/08. February 7, 2012.

713. ECtHR. *Von Hannover v. Germany*. App. No. 40660/08; 60641/08. February 7, 2012. paras. 98-99.

3.4.6 RIGHT TO FREEDOM OF EXPRESSION AND INFORMATION

The right to freedom of expression and information protects the individual from the restriction by the government to receive information that others may wish to impart. However, under this right, the State has no positive obligation to collect and disseminate information on its own motion.⁷¹⁴ This right establishes that civil servants, insofar as they should enjoy public confidence, can be protected from “offensive and abusive verbal attacks.” Even in such cases, however, civil servants have a duty to exercise their powers by reference to professional considerations only, without being unduly influenced by personal feelings.⁷¹⁵

While rights to impart and receive information are not each enshrined under an article, they have been interpreted as part of the right to freedom of expression, which is protected by Article 10 of the ECHR. Moreover, freedom of expression can be restricted legitimately, through application of Article 8, to protect the rights and reputation of others. For example, the media does not have an absolute right to publish unwarranted attacks on public officials.

RELEVANT PROVISIONS

▶ ECHR,

- **Art. 10 (1):** Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.

CASE RELATING TO THE RIGHT TO FREEDOM OF EXPRESSION AND INFORMATION

Sosinowska v. Poland (ECtHR)(2011). A physician was sanctioned by the medical board for criticizing another physician’s decisions on diagnosis and treatment of the ward’s patients. The Court found that the medical board’s interference constituted a violation of Article 10, holding that the sanction “was not proportionate to the legitimate aim pursued and, accordingly, was not ‘necessary in a democratic society.’”⁷¹⁶

714. ECtHR. *Guerra and Ors v. Italy*. App. No. 14967/89. February 19, 1998.

715. ECtHR. *Yankov v. Bulgaria*. App. No. 39084/97. March 11, 2004.

716. ECtHR. *Sosinowska v. Poland*. App. No. 10247/09. October 18, 2011.



4.1 INTRODUCTION

4.2 THE INTERNATIONAL SYSTEM

4.3 THE EUROPEAN SYSTEM

4.4 COMPLAINT PROCEDURE OF THE EUROPEAN COURT OF HUMAN RIGHTS

4

INTERNATIONAL AND REGIONAL PROCEDURES

4.1 INTRODUCTION

International and regional human rights monitoring mechanisms play an important role in implementing human rights. These mechanisms have been established to increase states' compliance with international and regional human rights treaties that they have ratified. While treaties are legally binding international law, treaty interpretations issued by these human rights monitoring mechanisms are not directly binding on states, although several bodies have the mandate to issue legally binding rulings. Moreover, treaty interpretations by these bodies have been influential even at the domestic level.⁷¹⁷

In general, human rights monitoring mechanisms take the form of either:

- an adjudicative body that acts in a judicial capacity and issues rulings that are binding on States parties that have ratified the respective treaty; or
- a body that examines reports submitted by States parties on their compliance with the respective human rights treaties and, in some cases, examine individual or group complaints of human rights violations under those treaties.

This chapter is intended to serve as a quick reference for the user on how to navigate both the international and regional (European) systems, providing basic information on these human rights monitoring mechanisms, including contact information.

717. See *Mini Numa Comty. v. Sec'y of Health & Ors.*, Juzgado del Distrito de Guerrero [JD] [District Court of Guerrero], J.A.IA. 1157/2007-II (Mex.); see also Christof Heyns and Frans Viljoen, *The Impact of the United Nations Human Rights Treaties on the Domestic Level* (The Hague: Kluwer Law International, 2002). (includes discussion for 20 countries of their record in complying with decisions of several major international HR committees).

4.2 THE INTERNATIONAL SYSTEM

As discussed in Chapter 2, there are currently eight core international human rights treaties that contain guarantees related to the protection of human rights in patient care. While these treaties are only binding on those states that have ratified them,⁷¹⁸ their standards have strong moral and political force even for non-ratifying countries. Each of these treaties has a committee in charge of monitoring state compliance with the treaty. These are referred to as “treaty-monitoring bodies” or “treaty bodies.”

U.N. TREATY-MONITORING BODIES

In general, UN treaty-monitoring bodies monitor state compliance with their respective treaty using a combination of three types of mechanisms: 1) interpretative documents on the content of the relevant treaty; 2) evaluating state compliance with the relevant treaty based on reports that member states are required to submit on a regular basis; and 3) receiving and considering individual communications alleging state violations of one or more of the human rights protected by the relevant treaty, and issuing recommendations to the respondent state. Each of the bodies’ specific functions, contact information, and ways through which civil society can participate are detailed below.

A NOTE ON THE USE OF ALTERNATIVE REPORTS IN U.N. TREATY-MONITORING BODIES

Treaty-monitoring bodies offer different avenues for civil society participation, a key option being the submission of alternative reports (also known as “parallel” or “shadow” reports or “written information”). These reports can serve an important role within the periodic reporting process of UN treaty-monitoring bodies. They allow civil society to provide supporting or alternative information on the human rights situation of the country being reviewed. For this reason, this section of the chapter highlights shadow reports as one of the tools available to civil society used to influence treaty-monitoring bodies’ work.

Past shadow reports, as well as information for civil society regarding the submission of such reports, are accessible on the UN Office of the High Commissioner for Human Rights’ website.

Human Rights Committee

MANDATE

The Human Rights Committee (CCPR) oversees compliance with the International Covenant on Civil and Political Rights (ICCPR) by those states that have ratified the treaty. The CCPR issues interpretative documents on the ICCPR called “general comments.”

The CCPR monitors progress in implementing the ICCPR based on review of periodic reports submitted by the States parties, considers inter-state complaints of human rights violations, and examines “individual communications,” which are complaints submitted by individuals or groups of individuals alleging violations of the rights set forth in the ICCPR by States parties that have ratified the First Optional Protocol to the ICCPR.

As part of the periodic reporting procedure, States parties must report to the CCPR after one year of ratifying the ICCPR and upon request thereafter—approximately every four years. Once a state submits its report, the CCPR examines the report and issues “concluding observations,” providing its concerns and recommendations to the state on how to better implement the treaty.

The CCPR meets three times per year.

718. Office of the UN High Commissioner for Human Rights (OHCHR). Ratifications, Reservations and Declarations. <http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en>. Accessed August 14, 2013.

CIVIL SOCIETY PARTICIPATION

As part of the periodic reporting procedure, NGOs can submit alternative reports to the CCPR on any aspect of a State party's compliance with the ICCPR. These reports should be submitted, by the relevant deadline, through the CCPR Secretariat based at the Office of the High Commissioner for Human Rights in Geneva, which also maintains a calendar of when States parties come before the CCPR. See "Participation in the work of the Committee" on the CCPR's website.

Organizations may attend the CCPR sessions as observers, but are not permitted to speak during the review of states. To do so, they must complete and file an "accreditation request form" in advance. Those that have submitted reports to the CCPR may make a brief oral presentation on the first day of the session. Organizations may also organize informal lunchtime briefings with the Committee.

Additionally, under the CCPR's individual complaints mechanism, NGOs are allowed to submit reports on behalf of individuals with the individual's consent. See 'Complaints procedure' on the CCPR's website.

CONTACT INFORMATION

Secretariat

Human Rights Committee (CCPR)
Human Rights Treaties Division (HRTD)
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Mailing Address:

UNOG-OHCHR
CH-1211 Geneva 10, Switzerland
Tel.: +41 (0) 22 917 92 61
Fax: +41 (0) 22 917 90 08
E-mail: ccpr@ohchr.org
Website: <http://www.ohchr.org/EN/HRBodies/CCPR/Pages/CCPRIndex.aspx>

Individual Communications

Petitions Team
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
1211 Geneva 10, Switzerland
Fax: + 41 (0) 22 917 9022 (particularly for urgent matters)
E-mail: petitions@ohchr.org

Committee on Economic, Social and Cultural Rights

MANDATE

The Committee on Economic, Social and Cultural Rights (CESCR) oversees State party compliance with the International Covenant on Economic, Social and Cultural Rights (ICESCR). The CESCR issues interpretative documents on the ICESCR called "general comments."

The CESCR monitors progress in the implementation of the ICESCR based on periodic reports submitted by states that have ratified the treaty, considers inter-state complaints of human rights violations, and examines “individual communications,” which are complaints submitted by individuals or groups of individuals alleging violations of the rights set forth in the ICESCR by States parties that have ratified the Optional Protocol to the ICESCR.

As part of the periodic reporting procedure, States parties must report within two years of ratifying the ICESCR and every five years thereafter. Once a State party submits its report, the CESCR examines the report and issues “concluding observations,” providing positive observations, concerns, and recommendations on how the State party can better implement the treaty.

The CESCR meets twice per year.

CIVIL SOCIETY PARTICIPATION

As part of the periodic reporting procedure, organizations can submit “parallel reports” to the CESCR on any aspect of a State party’s compliance with the ICESCR. Parallel reports should be submitted through the CESCR Secretariat based at the Office of the High Commissioner for Human Rights in Geneva, which also maintains a calendar of when States parties come before the CESCR. See “Participation in the work of the Committee” on the CESCR’s website.

Organizations may attend a CESCR session or a pre-session working group meeting. To do so, they must complete and file an “accreditation request form” in advance. Those that have submitted reports to the CESCR may make a brief oral presentation on the afternoon of the first Monday of the session and/or organize informal lunchtime briefings with the Committee.

Within the CESCR’s individual complaints mechanism, NGOs are allowed to submit reports on behalf of individuals with the individual’s consent. See ‘Complaints procedure’ on the CESCR’s website.

CONTACT INFORMATION

Secretariat

Committee on Economic, Social and Cultural Rights (CESCR)
Human Rights Treaties Division (HRTD)
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Mailing Address:

UNOG-OHCHR
CH-1211 Geneva 10, Switzerland
Tel.: +41 (0) 22 917 90 00
Fax: +41 (0) 22 917 90 08
E-mail: cescr@ohchr.org
Website: <http://www.ohchr.org/en/hrbodies/cescr/pages/cescrindex.aspx>

Individual Communications

Petitions Team
 Office of the High Commissioner for Human Rights
 United Nations Office at Geneva
 1211 Geneva 10, Switzerland

Fax: + 41 (0) 22 917 9022 (particularly for urgent matters)

E-mail: petitions@ohchr.org

Committee Against Torture**MANDATE**

The Committee Against Torture (CAT Committee) oversees State compliance with the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT or “Torture Convention”). The CAT Committee issues interpretative documents on the Torture Convention called “general comments.”

The CAT Committee monitors progress in the implementation of the Torture Convention based on periodic reports submitted by states that have ratified the treaty, considers inter-state complaints of human rights violations, and examines individual complaints of human rights violations allegedly committed by states that have expressly recognized the CAT Committee’s competence to receive individual complaints (under article 22 of the Convention).

As part of the periodic reporting procedure, States parties must report within one year of ratifying the Torture Convention and every four years thereafter. Once a state submits its report, the CAT Committee examines the report and issues “concluding observations,” which includes the Committee’s conclusions on the state’s compliance with the Torture Convention and can address previous recommendations.

The CAT Committee meets twice per year.

CIVIL SOCIETY PARTICIPATION

As part of the periodic reporting procedure, NGOs can submit “written information” to the CAT Committee on any aspect of a State party’s compliance with Torture Convention. Written information should be submitted through the CAT Secretariat at the Office of the High Commissioner for Human Rights in Geneva, which also maintains a calendar of when States parties come before the CAT Committee. See “Participation in the work of the Committee” on the CAT Committee’s website.

Organizations that have submitted written information may meet privately with the CAT Committee, prior to the Committee’s meeting with the delegation of the state being reviewed. National Human Rights Institutions (NHRIs) may likewise meet in private with relevant CAT Committee members and country rapporteurs, prior to the CAT Committee’s meeting with the state. To participate in this manner, organizations must complete and file an “accreditation request form” in advance.

The CAT Committee may also consider individual complaints of human rights violations allegedly committed by states that have made the necessary declaration under article 22 of the Torture Convention. See ‘Complaints procedure’ on the CAT Committee’s website.

CONTACT INFORMATION

Secretariat

Committee against Torture (CAT)
Human Rights Treaties Division (HRTD)
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Mailing Address:

UNOG-OHCHR
CH-1211 Geneva 10, Switzerland
Tel.: +41 (0) 22 917 97 06
Fax: +41 (0) 22 917 90 08
E-mail: cat@ohchr.org
Website: www.ohchr.org/EN/HRBodies/CAT/Pages/CATIndex.aspx

Individual Communications

Petitions Team
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
1211 Geneva 10, Switzerland
Fax: + 41 (0) 22 917 9022 (particularly for urgent matters)
E-mail: petitions@ohchr.org

Committee on the Elimination of All Forms of Discrimination Against Women

MANDATE

The Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee) oversees State compliance with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The CEDAW Committee issues interpretative documents on the CEDAW called “general recommendations.”

The CEDAW Committee monitors country progress in the implementation of the CEDAW based on periodic reports submitted by States parties that have ratified the treaty. The Committee is also empowered to initiate inquiries into systemic violations of women’s rights, as well as examine and consider individual complaints relating to violations of rights allegedly committed by states that have ratified the Optional Protocol to CEDAW.

Under the periodic reporting procedure, States parties must report within one year of ratifying the CEDAW and at least every four years thereafter. Once the State party submits its report, the committee examines the report and provides conclusions on the state’s implementation of the CEDAW, highlighting both positive aspects and areas of concern, as well as providing suggestions and recommendations on how the state can better implement the treaty.

The CEDAW Committee meets as many times as needed to carry out its functions.

CIVIL SOCIETY PARTICIPATION

As part of the periodic reporting procedure, NGOs can submit alternative or shadow reports to the CEDAW Committee on any aspect of a State party's compliance with CEDAW. These reports should be submitted through the Division for the Advancement of Women in New York, which also maintains a calendar of when States parties come before the committee. (See "Participation in the work of the Committee" on the CEDAW Committee's website and "Producing Shadow Reports to the CEDAW Committee: A Procedural Guide" by International Women's Rights Action Watch). NGOs can also request the CEDAW Committee to initiate inquiries into systemic violations of women's rights by states that have ratified the Optional Protocol under CEDAW.

Organizations may attend a CEDAW Committee's session as observers or present at pre-session meetings, which are limited to UN representatives and NGOs whose country reports are being reviewed. To do so, they must complete and file an "accreditation request form" in advance. Those that have submitted alternative or shadow reports to the CEDAW Committee may make an oral presentation during the informal consultation meeting, which is usually scheduled on the first day of the week. Organizations must also seek accreditation from the Committee to participate in this meeting.

Within the CEDAW Committee's individual communications mechanism, NGOs are allowed to submit reports on behalf of individuals with the individual's consent. See 'Complaints procedure' on the CEDAW Committee's website.

For more information, see "NGO Participation" on United Nations Entity for Gender Equality and the Empowerment of Women's (UN Women) website.

CONTACT INFORMATION

Secretariat

Committee on the Elimination of Discrimination against Women (CEDAW)
Human Rights Treaties Division (HRTD)
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Mailing address:

UNOG-OHCHR
CH-1211 Geneva 10, Switzerland
Tel.: +41 (0) 22 917 94 43
Fax: +41 (0) 22 917 90 08
E-mail: cedaw@ohchr.org
Website: <http://www.ohchr.org/en/hrbodies/cedaw/pages/cedawindex.aspx>

Individual Communications

Petitions Team
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
1211 Geneva 10, Switzerland

Fax: + 41 (0) 22 917 9022 (particularly for urgent matters)
E-mail: petitions@ohchr.org

Committee on the Elimination of Racial Discrimination

MANDATE

The Committee on the Elimination of Racial Discrimination (CERD) oversees State party compliance with the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). The CERD issues interpretative documents on the ICERD called “general recommendations.”

The CERD monitors country progress in the implementation of the ICERD based on periodic reports submitted by states that have ratified the treaty, as well as through an early warning procedure, where the CERD undertakes measures to prevent certain situations from escalating into conflicts or matters requiring urgent attention. The CERD is also tasked with receiving and examining inter-state complaints of human rights violations, as well as individual complaints against states that have expressly recognized the CERD’s competence to examine individual complaints (under article 14 of the ICERD).

Under the periodic reporting procedure, States parties must report to the CERD one year after ratifying the ICERD and every two years thereafter. Once a State party submits its report, the CERD examines the report and issues “concluding observations,” providing its concerns and recommendations to the state on the implementation of the treaty.

The CERD meets twice per year.

CIVIL SOCIETY PARTICIPATION

As part of the periodic reporting procedure, NGOs can submit “alternative reports” to CERD on any aspect of a State party’s compliance with ICERD. Shadow reports should be submitted through the CERD Secretariat based at the Office of the High Commissioner for Human Rights in Geneva, which also maintains a calendar of when States parties come before the CERD. See “Participation in the work of the Committee” on the CERD’s website.

Organizations may attend a CERD session as observers. Organizations may participate in the informal pre-session meetings with NGOs held at the beginning of each week during the CERD’s session. Here, NGOs can provide information on the countries being reviewed that week. NGOs may also organize informal lunchtime briefings with the Committee. To engage in any of these activities, they must complete and file an “accreditation request form” in advance.

CERD may also consider individual complaints of human rights violations allegedly committed by states that have made the necessary declaration under article 14 of the ICERD. See ‘Complaints procedure’ on the CERD’s website.

CONTACT INFORMATION

Secretariat

Committee on the Elimination of Racial Discrimination (CERD)
 Human Rights Treaties Division (HRTD)
 Office of the United Nations High Commissioner for Human Rights (OHCHR)
 Palais Wilson - 52, rue des Pâquis
 CH-1201 Geneva, Switzerland

Mailing address:

UNOG-OHCHR
 CH-1211 Geneva 10, Switzerland
 Tel.: +41 (0) 22 917 94 40
 Fax: +41 (0) 22 917 90 08
 E-mail: cerd@ohchr.org
 Website: <http://www.ohchr.org/EN/HRBodies/CERD/Pages/CERDIndex.aspx>

Individual Communications

Petitions Team
 Office of the High Commissioner for Human Rights
 United Nations Office at Geneva
 1211 Geneva 10, Switzerland

Fax: + 41 (0) 22 917 9022 (particularly for urgent matters)
 E-mail: petitions@ohchr.org

Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families

MANDATE

The Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW) monitors the implementation of the International Convention of the Protection of the Rights of All Migrant Workers and their Families (ICMW). The CMW issues interpretative documents on the ICMW called “general comments.”

The CMW monitors progress in the implementation of the ICMW based on periodic reports submitted by states that have ratified the treaty. As part of the periodic reporting procedure, States parties must report to the CMW one year after ratifying the ICMW, and then every five years. Once the State party submits its report, the CMW examines it and issues “concluding observations,” providing its concerns and recommendations to the state on the implementation of the treaty.

The CMW currently does not have competence to consider individual complaints. The optional protocol to the ICMW granting the Committee this power opened for signature in 2012, but as of this writing had not yet acquired the 10 ratifications needed for the individual complaint mechanism to enter into force.

The CMW Committee meets twice per year.

CIVIL SOCIETY PARTICIPATION

As part of the periodic reporting procedure, NGOs can submit “written submissions” (i.e., alternative reports) to the CMW Committee on any aspect of a State party’s compliance with the ICMW. Written submissions should be submitted through the CMW Secretariat at the Office of the High Commissioner for Human Rights in Geneva, which also maintains a calendar of when States parties come before the CMW Committee.

Organizations may attend a CMW session as observers. They may also present oral briefings before the Committee at public and/or informal meetings held during the session. To engage in any of these activities, they must complete and file an “accreditation request form” in advance.

The individual complaint mechanism for the CMW has not yet entered into force.

CONTACT INFORMATION

Secretariat

Committee on Migrant Workers (CMW)
Human Rights Treaties Division (HRTD)
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Mailing Address:

UNOG-OHCHR
CH-1211 Geneva 10, Switzerland
Tel.: +41 (0) 22 917 96 41
Fax: +41 (0) 22 917 90 08
E-mail: cmw@ohchr.org
Website: <http://www.ohchr.org/EN/HRBodies/CMW/Pages/CMWIndex.aspx>

Individual Communications

Petitions Team
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
1211 Geneva 10, Switzerland
Fax: + 41 (0) 22 917 9022 (particularly for urgent matters)
E-mail: tb-petitions@ohchr.org

Committee on the Rights of Persons with Disabilities

MANDATE

The Committee on the Rights of Persons with Disabilities (CRPD Committee) oversees state compliance with the Convention on the Rights of Persons with Disabilities (CRPD). Issuing interpretative documents on the treaty's content is part of the CRPD Committee's mandate, but as of this writing, has only issued draft general comments.

The CRPD Committee monitors progress in the implementation of the CRPD based on periodic reports submitted by states that have ratified the treaty, considers inter-state complaints of human rights violations, and examines individual complaints of human rights violations allegedly committed by states that have ratified the Optional Protocol to the CRPD.

As part of the periodic reporting procedure, States parties must report within two years of ratifying the CRPD and every four years thereafter. Once a State party submits its report, the CRPD Committee examines the report and issues "concluding observations," expressing general recommendations and suggestions on how the state can better implement the treaty.

The CRC Committee meets twice per year.

CIVIL SOCIETY PARTICIPATION

As part of the periodic reporting procedure, NGOs can submit “shadow reports” to the CRPD Committee on any aspect of a State party’s compliance with the CRPD. Shadow reports should be submitted through the CRPD Secretariat at the Office of the High Commissioner for Human Rights (OHCHR) in Geneva, which also maintains a calendar of when States parties come before the CRPD Committee.

CONTACT INFORMATION

Secretariat

Committee on the Rights of Persons with Disabilities (CRPD)
Human Rights Treaties Division (HRTD)
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Mailing address:

UNOG-OHCHR
CH-1211 Geneva 10, Switzerland
Tel.: +41 (0) 22 917 97 03
Fax: +41 (0) 22 917 90 08
E-mail: crpd@ohchr.org
Website: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDIndex.aspx>

Individual Communications

Petitions Team
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
1211 Geneva 10, Switzerland
Fax: + 41 (0) 22 917 9022 (particularly for urgent matters)
E-mail: petitions@ohchr.org

Committee on the Rights of the Child

MANDATE

The Committee on the Rights of the Child (CRC Committee) oversees State party compliance with the Convention on the Rights of the Child (CRC). The CRC Committee issues interpretative documents on the CRC called “general comments.”

The CRC Committee monitors progress in the implementation of the CRC based on periodic reports submitted by states that have ratified the treaty. It also examines individual complaints of human rights violations allegedly committed by states that have ratified the Optional Protocol to the CRC.

The CRC Committee meets three times per year.

CIVIL SOCIETY PARTICIPATION

As part of the periodic reporting procedure, NGOs can submit “shadow reports” to the CRC Committee on any aspect of a State party’s compliance with the CRC. Shadow reports should be submitted through the CRC Secretariat based at the Office of the High Commissioner for Human Rights in Geneva, which also maintains a calendar of when States parties come before the CRC Committee.

CONTACT INFORMATION

Committee on the Rights of the Child (CRC)
Human Rights Treaties Division (HRTD)
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

Mailing address:

UNOG-OHCHR
CH-1211 Geneva 10, Switzerland
Tel.: +41 (0) 22 917 91 41
Fax: +41 (0) 22 917 90 08
E-mail: crc@ohchr.org
Website: <http://www2.ohchr.org/english/bodies/crc/index.htm>

Individual Communications

Petitions Team
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
1211 Geneva 10, Switzerland
Fax: + 41 (0) 22 917 9022 (particularly for urgent matters)
E-mail: petitions@ohchr.org

International Labour Organization

MANDATE

The International Labour Organization (ILO) promotes the advancement of proper working conditions, decent employment opportunities, and the enhancement of social protection on work-related issues. The ILO is unique in its tripartite governing structure—representing governments, employers, and workers alike.

The ILO hosts biannual conferences that serve as a forum for labor dialogue, establishing and adopting international labor standards, and electing the ILO Governing Body. States that have ratified an ILO convention have a legal obligation to apply its provisions. To date, the ILO has adopted 189 international labor conventions.

There exist two kinds of mechanisms to monitor member state compliance with ILO conventions: a regular system of supervision and special procedures. Under the “regular system of supervision,” ILO Member States are required to submit reports every two years on the implementation of the eight fundamental

and four priority conventions ratified and every five years for all other conventions. However, a State party may be asked to submit reports at shorter intervals. The Committee of Experts on the Application of Conventions and Recommendations (CEACR) examines the report and communicates with the State party on the implementation of the conventions. Once adopted, the CEACR annual report is submitted to the International Labour Conference and examined by the Conference Committee on the Application of Standards (Conference Committee), which selects specific observations for discussion and invites States parties to respond and provide information on the matter(s) at issue. The Conference Committee usually issues conclusions and recommendations for improved implementation of the ILO convention(s).

The CEACR meets in November and December of each year, and the International Labour Conference is held in June.

The other mechanism is the ILO's "special procedures," where an industrial association of employers or workers can bring a complaint against member states. They may bring complaints before the ILO Governing Body against any member state for failing to comply with the ratified convention. A committee of the Governing Body examines the case and submits to the Governing Body its conclusions and recommendations. If the Governing Body is not satisfied with the state's response, it may publish the representation and the response. Employers' and workers' organizations can also bring a claim before the Committee on Freedom of Association—another special procedure. If the Committee finds a violation of freedom of association, it issues recommendations in the Governing Body's report and requests that the States parties later report on the implementation of its recommendations.

CIVIL SOCIETY PARTICIPATION

Civil society organizations can participate in a number of ways within the ILO. Employers' and workers' organizations elect representatives to form part of the Governing Body and various ILO consultative bodies, where they enjoy the same level of decision-making authority as governments. The ILO conventions and recommendations provide member states with procedures for consulting with workers' and employers' organizations and their representatives on all ILO matters. As outlined above, workers' and employers' associations are invited to submit information on the State party's implementation of a ratified convention in preparation of the CEACR's review of a state's report. The ILO also provides training and advisory services to these organizations.

Using the complaints mechanisms under "special procedures" (outlined above), employer and workers' organizations may file complaints with the International Labour Office against a member state for alleged violations of the ratified convention(s).

The ILO also works with local, national and regional organizations, such as professional associations, co-operatives, village development committees, water users' committees, rural or urban credit groups, NGOs concerned with local and national development or human rights, indigenous community organizations, and networks of homeworkers, especially women. They participate in the ILO's technical cooperation activities. With respect to indigenous peoples, the convention encourages states to consult with them in preparing reports. Indigenous peoples may also affiliate themselves with workers' associations or form their own workers' association in order to more directly communicate with the ILO.

In addition to integrating NGOs in its tripartite structure, international non-governmental organizations recognized by the ILO enjoy consultative status, which allows them to express their views on issues discussed at ILO meetings even though they do not have the right to vote. Also, NGOs that are part of the "Special List" have working relations with the ILO as they are understood to share the ILO's principles and objectives. Finally, International non-governmental organizations can also limit their level of engagement and only attend ILO meetings based on their specific interests.

For more information on civil society participation opportunities, visit: www.ilo.org/pardev/civil-society/lang-en/index.htm.

CONTACT INFORMATION

4 route des Morillons
 CH-1211 Genève 22, Switzerland
 Tel.: +41 (0) 22 799 6111
 Fax: +41 (0) 22 798 8685
 E-mail: ilo@ilo.org
 Website: www.ilo.org

U.N. CHARTER BODIES

In addition to the treaty bodies above, there are a number of bodies created for the protection and promotion of human rights under the Charter of the United Nations.

Human Rights Council

The Human Rights Council (HRC) is the principal charter body of the UN system, which replaced the Commission on Human Rights in 2006 and is not to be confused with the Human Rights Committee (CCPR) created by the ICCPR. The HRC is a subsidiary organ of the United Nations General Assembly that addresses situations of human rights violations, including gross and systematic violations.

The HRC has four mechanisms for monitoring human rights:

- Universal Periodic Review (UPR);
- Special Procedures;
- Human Rights Council Advisory Committee; and
- Human Rights Council Complaints Procedure.

For more information, visit: www.ohchr.org/EN/HRBodies/HRC/Pages/HRCIndex.aspx.

Universal Periodic Review

Established as part of the Human Rights Council's mandate, the Universal Periodic Review (UPR) consists of a regular review of the human rights records of all UN Member States. It was established in 2008 and completed the first review of all 193 Member States in 2011. The UPR – much as with the above-mentioned committees – requires States parties to submit reports on the actions that they have taken to improve human rights in their country and fulfill human rights obligations.

The UPR is not limited to specific treaty obligations, so it is able to consider a broader range of human rights issues than any of the individual committees. The UPR complements the committees; it does not replace them.

CIVIL SOCIETY PARTICIPATION

NGOs can submit “shadow reports” to the HRC on any aspect of a state’s compliance with human rights standards. Additionally, civil society organizations with consultative status with the United Nations Economic and Social Council (ECOSOC) are allowed to participate in the working group session and the adoption of the UPR for the relevant country. A schedule of countries coming up for UPR is maintained on the HRC’s website: <http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx>.

The HRC has published a practical guide on civil society participation in the UPR process, which is accessible at: <http://www.ohchr.org/EN/HRBodies/UPR/Documents/PracticalGuideCivilSociety.pdf>

Special Procedures

“Special Procedures” is the general term given to individuals (known as “Special Rapporteurs,” “Special Representatives,” or “Independent Experts”) or to groups (known as “working groups”) that are mandated by the Human Rights Council (HRC) to investigate and address specific country situations or thematic issues throughout the world. At the time of this writing, the OHCHR web page (see link below) notes that as of October 1, 2013, there are 37 thematic and 14 country-specific Special Procedures.

The thematic Special Procedures that are most relevant to human rights in patient care include:

- Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;
- Working Group on arbitrary detention;
- Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment;
- Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression;
- Special Rapporteur on the rights to freedom of peaceful assembly and of association;
- Special Rapporteur on violence against women, its causes and consequences; and
- Working Group on the issue of discrimination against women in law and in practice.

For more information, visit the HRC website: www.ohchr.org/EN/HRBodies/SP/Pages/Welcomepage.aspx

CIVIL SOCIETY PARTICIPATION

In addition to meeting with civil society during their country visits, Special Rapporteurs are able to receive individual complaints requesting assistance or investigation into human rights violations by States parties within their thematic areas. If warranted, the Special Rapporteur requests responses from States parties to the allegations and reports on the Special Rapporteur’s findings to the Human Rights Council.

For more information on the process of submitting individual complaints to Special Rapporteurs, visit: www.ohchr.org/EN/HRBodies/SP/Pages/Communications.aspx.

Advisory Committee

The Human Rights Council Advisory Committee (Advisory Committee) functions as a think-tank for the HRC and engages in substantive research and work at the direction of the HRC. The Advisory Committee is implementation-oriented, and the scope of its research and advice is confined to thematic issues pertaining to the mandate of the HRC. It is composed of 18 experts serving in their personal capacity for appointments of up to three years.

The Advisory Committee meets twice a year.

CIVIL SOCIETY PARTICIPATION

NGOs in consultative status with United Nations Economic and Social Council (ECOSOC) may submit written statements relevant to the work of the Advisory Meeting prior to the Advisory Committee's meetings. Additionally, oral submissions can be made during the course of the meetings on the work of the Advisory Committee.

For more information on civil society participation, visit: www.ohchr.org/EN/HRBodies/HRC/Advisory-Committee/Pages/NGOParticipation.aspx.

Complaints Procedure

The Complaints Procedure functions as a confidential forum for bringing complaints on “consistent patterns of gross and reliably attested violations of all human rights and all fundamental freedoms occurring in any part of the world and under any circumstances”⁷¹⁹ to the attention of the Human Rights Council (HRC). The procedure promotes a victim-oriented and timely approach to alleged violations. The complaints may be filed by individuals, groups, or NGOs as victims of human rights violations or based on having direct and reliable knowledge of the violations.

The Complaints Procedure is composed of two distinct working groups: the Working Group on Communications (WGC) and the Working Group on Situations (WGS). The WGC meets twice a year to assess the admissibility and the merits of a violation. The WGS meets twice a year in order to examine communication deemed admissible by the WGC and to present the HRC with a report on state violations and recommendations for a course of action.

CIVIL SOCIETY PARTICIPATION

As outlined above, NGOs may file a complaint with the Complaints Procedure as victims of human rights violations or based on direct and reliable knowledge of the violations. A complaint must be filed using the form available at: <http://www.ohchr.org/Documents/HRBodies/ComplaintProcedure/HRCComplaintProcedureForm.doc>.

Complaints

Treaties and Human Rights Council Branch

OHCHR-UNOG

1211 Geneva 10, Switzerland

Fax: +41 (0) 22 9 17 90 11

E-mail: CP@ohchr.org

Website: www.ohchr.org/EN/HRBodies/HRC/ComplaintProcedure/Pages/HRCComplaintProcedureIndex.aspx

Economic and Social Council

The UN Economic and Social Council (ECOSOC) coordinates the work of 14 specialized UN agencies, functional commissions, and regional commissions working on various international economic, social, cultural, educational, and health matters. The ECOSOC holds several short sessions per year and an annual substantive session for four weeks every July.

719. Human Rights Complaint Procedure (www.ohchr.org/EN/HRBodies/HRC/ComplaintProcedure/Pages/HRCComplaintProcedureIndex.aspx).

CIVIL SOCIETY PARTICIPATION

ECOSOC consults regularly with civil society, and nearly 3,000 NGOs enjoy consultative status. ECOSOC-accredited NGOs are permitted to participate, present written contributions, and make statements to the council and its subsidiary bodies.

For more information on NGOs with consultative status, visit: <http://csonet.org/>.

ECOSOC agencies and commissions that may be relevant to patient care include:

- Commission on the Status of Women;
- Commission on Narcotic Drugs;
- Committee on Economic, Social and Cultural Rights; and
- International Narcotics Control Board.

4.3 THE EUROPEAN SYSTEM

As detailed in Chapter 3, the European system includes a number of avenues through which both patients' and providers' rights can be vindicated. This section provides basic information to help the user navigate through the European system.

European Court of Human Rights

MANDATE

The European Court of Human Rights (ECtHR) is a body of the Council of Europe (COE) that enforces the provisions of the European Convention on Human Rights (ECHR). The ECtHR adjudicates both disputes between states and complaints (known as "applications") submitted by individuals and groups alleging violations of human rights protected under the ECHR against a state or states, provided that they have exhausted all other options available to them domestically, and issues decisions which are binding on the respondents states. The ECtHR's procedural process is further elaborated below.

The COE's Committee of Ministers is responsible for monitoring the implementation of judgments made by the ECtHR.

CIVIL SOCIETY PARTICIPATION

Civil society may submit applications on behalf of individuals or groups of individuals before the ECtHR. NGOs can also file briefs on particular cases either at the invitation of the president of the court or, with permission of the ECtHR, as *amici curiae* ("friends of the court") if they can show that they have an interest in the case or have special knowledge of the subject matter and can also show that their intervention would serve the administration of justice. The hearings of the ECtHR are generally public.

An application form and more information on lodging applications before the ECtHR may be obtained from the ECtHR website

(<http://www.echr.coe.int/Pages/home.aspx?p=applicants&c=>).

CONTACT INFORMATION

European Court of Human Rights Council of Europe
F-67075 Strasbourg-Cedex, France

Tel: +33 (0) 3 88 41 20 18
Fax: + 33 (0) 3 88 41 27 30
Website: www.echr.coe.int

European Committee of Social Rights

MANDATE

The European Committee of Social Rights (ECSR) is a body of the Council of Europe (COE) that conducts regular legal assessments of state compliance with provisions of the European Social Charter (ESC) (adopted in 1961 and revised in 1996). These assessments are based on reports submitted by States parties at regular two- to four-year intervals, known as “supervision cycles.” The governmental committee and the COE’s Committee of Ministers also evaluate state reports under the ESC.

The ECSR publishes its conclusions every year and also receives collective complaints alleging widespread failures of compliance with the ESC, against states which have accepted the procedure under the Additional Protocol to the ESC.

CIVIL SOCIETY PARTICIPATION

Reports submitted by States parties under the ESC are public and may be commented upon by individuals or NGOs. International NGOs with COE consultative status and national NGOs recognized by their state may also submit collective complaints to the COE alleging violations of the ESC.

Instructions for NGOs seeking to obtain or renew entitlement for lodging collective complaints with the ECSR are available at:

www.coe.int/t/dghl/monitoring/socialcharter/OrganisationsEntitled/Instructions_en.asp.

CONTACT INFORMATION

Department of the European Social Charter and the European Code of Social Security
Conseil de l'Europe
Directorate General of Human Rights and Rule of Law
Agora
Council of Europe
1, quai Jacoutot
F – 67075 Strasbourg Cedex, France

Tel: +33 (0) 3 88 41 32 58
Fax: +33 (0) 3 88 41 37 00
E-mail: social.charter@coe.int
Website: www.coe.int/t/dghl/monitoring/socialcharter/ECSR/ECSRdefault_en.asp

Committee of Ministers

MANDATE

The Committee of Ministers (CM) is the decision-making body of the Council of Europe (COE) composed of foreign ministers of all COE Member States (or their permanent representatives). The CM provides a forum for discussion on problems facing the region and their solutions.

The CM monitors the implementation of judgments of the ECtHR and evaluates reports produced by the European Committee of Social Rights (ECSR). The CM also makes separate recommendations to Member States on matters for which the CM has agreed to a “common policy”—including matters related to health and human rights.

Some of these recommendations are provided by the Parliamentary Assembly of the Council of Europe, a consultative body composed of representatives of Member States’ parliaments.

CIVIL SOCIETY PARTICIPATION

International non-governmental organizations may be granted participatory status by the COE. Similarly, NGOs may enter into concluding partnership agreements with the COE. In this manner, organizations are able to support the work of the COE, including the CM, through their work.

With respect to the implementation of ECtHR judgments, NGOs may participate in the proceedings before the CM. They are allowed to submit communications to the CM at any time while the case is pending before the CM. Such communications may regard the respondent state’s level of compliance, demand that a state present an action plan/report, submit suggestions on how action plans/reports should be executed, call for a public debate on the judgment during a human rights meeting (reserved for certain cases), call for a change in the standard of review by the CM, and the like.

CONTACT INFORMATION

Tel: +33 (0) 3 88 41 28 49

E-mail: cm@coe.int

Website: www.coe.int/cm

Advisory Committee

MANDATE

The Advisory Committee (AC) is the independent expert committee responsible for evaluating the implementation of the Framework Convention for the Protection of National Minorities (FCNM) in States parties and advising the Committee of Ministers (CM). It monitors country progress on implementing the FCNM by examining periodic reports submitted by States parties.

In addition to examining country reports, the AC may hold meetings with states and request additional information from other sources. The AC then prepares an opinion, which is submitted to the CM. Based on this opinion, the CM issues conclusions concerning the adequacy of measures taken by each State party. The CM may involve the AC in monitoring the follow-up to these conclusions and recommendations.

CIVIL SOCIETY PARTICIPATION

NGOs can submit “shadow reports” to the AC on any aspect of a State party’s compliance with the FCNM. Shadow reports should be submitted through the FCNM’s Secretariat. NGOs may also submit written information outside the monitoring status of a state that regards the implementation of the FCNM, encourage states to ratify the FCNM, liaise with state officials during the preparation of the state report, participate in follow-up meetings after the AC publishes monitoring results, and contribute to the AC’s preparation of commentaries on specific issues.

For more information on civil society participation, visit: www.coe.int/t/dghl/monitoring/minorities/2_monitoring/ngO_intro_en.asp

CONTACT INFORMATION

Directorate General of Human Rights
Secretariat of the Framework Convention for the Protection of National Minorities
F-67075 Strasbourg-Cedex, France
Tel: +33 (0) 3 90 21 44 33
Fax: +33 (0) 3 90 21 49 18
E-mail: minorities.fcnm@coe.int
Website: www.coe.int/minorities

4.4 COMPLAINT PROCEDURE OF THE EUROPEAN COURT OF HUMAN RIGHTS

BASIC FACTS ON THE EUROPEAN COURT OF HUMAN RIGHTS⁷²⁰

ORIGIN

▶ **When and how was the European Court of Human Rights created?**

The ECtHR was created in 1959 pursuant to the European Convention on Human Rights (ECHR).

▶ **When did it become operational?**

The ECtHR opened in 1959 as part of a two-tier structure comprising the ECtHR and the Commission on Human Rights, with the latter acting as a filtering mechanism to the ECtHR. This two-tier structure was replaced in 1998 by a single court, pursuant to revisions introduced by Protocol 11 to the ECHR.

PURPOSE

▶ **What is the European Court of Human Rights’ general objective?**

To examine complaints of violation of the ECHR

▶ **What are the European Court of Human Rights’ functions?**

- Interstate complaints (Article 33, ECHR)

720. Based on Reported Killing as Human Rights Violations by Kate Thompson and Camille Giffard (published by the Human Rights Centre, University of Essex).

- Individual complaints (Article 34, ECHR)
- Fact-finding (in the context of individual complaints only and an optional step in the procedure)

COMPOSITION

▶ How many persons compose the European Court of Human Rights?

As many judges as there are States parties to the European Convention on Human Rights

▶ Are these persons independent experts or state representatives?

Independent experts

WHAT ARE THE ADMISSIBILITY REQUIREMENTS?

▶ A communication will be declared inadmissible if:

- The communication is anonymous;
- The communication has not been submitted within six months of the date of the domestic authorities' final decision in the case;
- The communication is “manifestly ill-founded or an abuse of the right of petition” (a preliminary examination of the petition does not point to any appearance of a violation of rights protected under the ECHR—where the petition can be immediately declared inadmissible without having to proceed to the formal examination on the merits);
- The communication is incompatible with the provisions of the Convention
- The application is substantially the same as one that has already been considered by the court or as another procedure of international investigation and contains no new and relevant information;
- Domestic remedies have not been exhausted, except where the remedies are unavailable, ineffective or unreasonably prolonged (and an explanation as to such issues has been provided to the Court).

As of June 1, 2010, in accordance with Protocol 14 to the ECHR, a new admissibility requirement allows the Court to declare inadmissible applications where the applicant has not suffered a significant disadvantage, unless “respect for human rights” requires an examination on the merits, and no domestic judicial remedy is available.⁷²¹ These are known as “minor complaints.”

WHAT SHOULD YOUR APPLICATION CONTAIN?

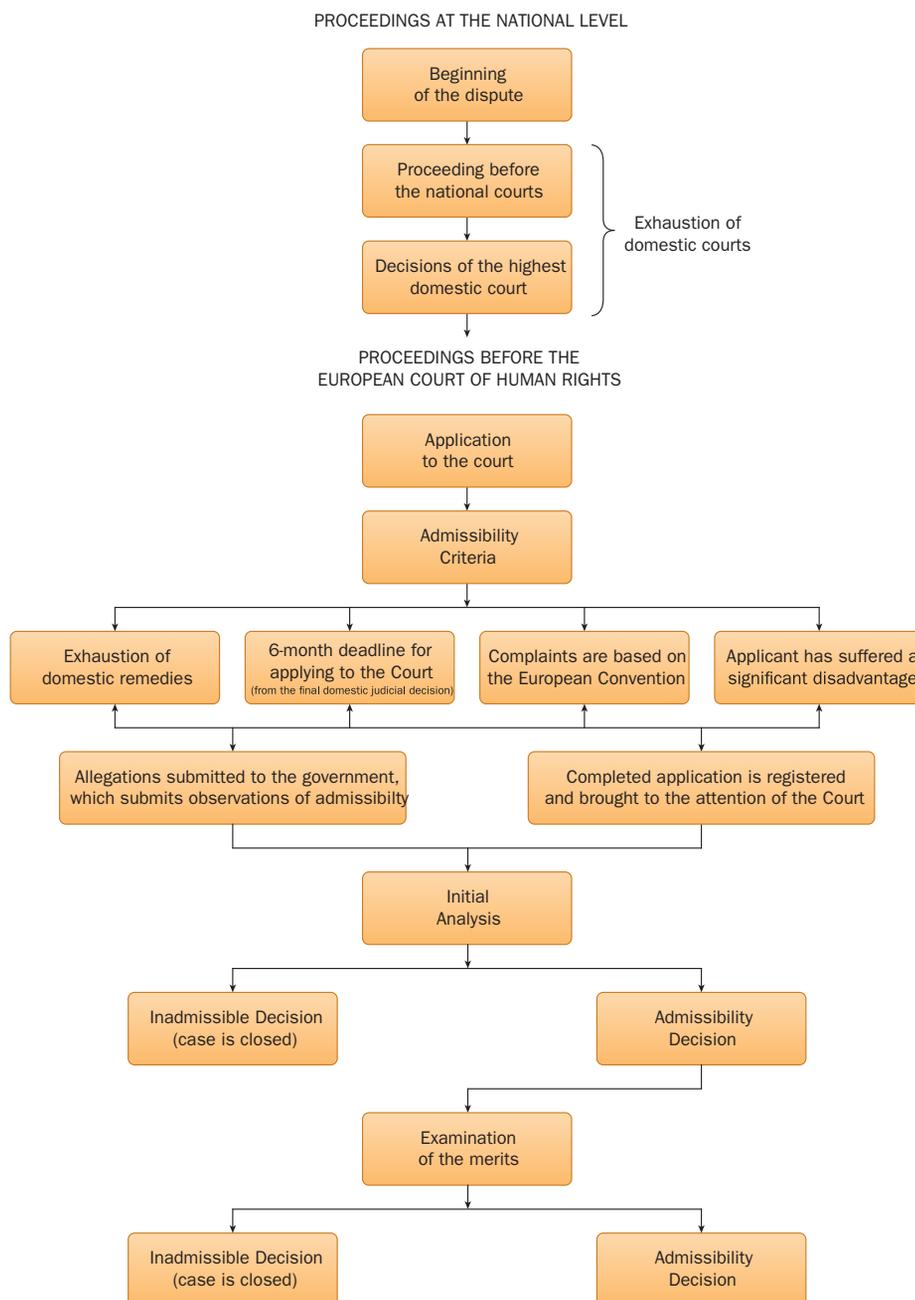
▶ Your initial letter should contain:

- A brief summary of your complaints;
- An indication of which rights in the ECHR you think have been violated;
- An indication of the domestic remedies you have used or attempted to use; and
- A list of the official decisions in your case, including the date of each decision, by whom it was made, and an indication of what it said (attach a copy of each of these decisions).

An application form and more information on lodging applications before the ECtHR may be obtained from the ECtHR website (<http://www.echr.coe.int/Pages/home.aspx?p=applicants&c=>).

721. Article 12 of Protocol 14 of the ECHR, amending article 35 of the ECHR.

Table: Basic Chronology of the Individual Complaint Procedure of the European Court of Human Rights⁷²²



Practicalities of the Use of the Individual Complaint Procedure in the European Court of Human Rights

► **Who can bring a case under this procedure?**

Individuals, NGOs, and groups of individuals claiming to be victim of a human rights violation; a case can be brought by a close relative of the victim where the victim cannot do so in person, for example, if he or she has disappeared or died.

722. Based on Reported Killing as Human Rights Violations by Kate Thompson and Camille Giffard (published by the Human Rights Centre, University of Essex) and “Life of an Application” by the European Court of Human Rights, (http://www.echr.coe.int/Documents/Case_processing_ENG.pdf).

▶ **Is there a time limit for bringing an application?**

Six months from the date of the final decision taken in the case by the state authorities

▶ **Can you bring a case under this procedure if you have already brought one under another procedure concerning the same set of facts?**

No

▶ **Do you need legal representation?**

Legal representation is not necessary at the time of the application, but is required for proceedings after the case has been declared admissible, unless the president of the court gives exceptional permission for the applicant to present his or her own case.

▶ **Is financial assistance available?**

Yes, but only if the application is communicated to the State; the applicant will need to fill out a statement of means, signed by a domestic legal aid board, as legal aid is only granted where there is a financial need.

▶ **Are amicus curia briefs accepted?**

Yes, with permission (Rule 61 of the Rules of Court)

▶ **Who will know about the communication?**

In principle, the proceedings are public unless the President of the Chamber decides otherwise. In exceptional cases, where an applicant does not wish his or her identity to be made public and submits a statement explaining the reasons for this, anonymity may be authorized by the president.

▶ **How long does the procedure take?**

Several years

▶ **What measures, if any, can the mechanisms take to assist the court in reaching a decision?**

Fact-finding hearings, expert evidence, written pleadings, oral hearings

▶ **Are provisional or urgent measures available?**

Yes, but they are practices that have been developed by the Court and have no basis in the convention and are applied only in very specific cases, mainly immigration/ deportation cases, where there is a “real risk” to a person (Rule 39 of the Rules of Court).

A Note on Researching European Convention of Human Rights Case Law

The original structure of the Court and mechanism for handling cases provided for a two-tier system of rights protection – the European Commission of Human Rights (now obsolete) as well as the European Court of Human Rights. In 1998, Protocol 11 of the European Convention on Human Rights came into force, eliminating the Commission of Human Rights and allowing for the emergence of a new European Court of Human Rights. If researching a particular topic under the Convention case law, research both Commission and Court decisions.



5.1 STATUS OF INTERNATIONAL AND EUROPEAN LAW

5.2 STATUS OF PRECEDENT

5.3 LEGAL SYSTEM AND HEALTH SYSTEM: AN OVERVIEW

5

COUNTRY-SPECIFIC CONTEXT

5.1 STATUS OF INTERNATIONAL AND EUROPEAN LAW

In the enforcement of international treaties to which Moldova is a party (European Convention and its Additional Protocols (nos. 1, 2, 3, 4, 5, 6, 7, 8 and 11; UN conventions and the other), courts take into account the provisions of art. 4, para. (2) of the Constitution of the Republic of Moldova, the provisions of the Constitutional Court Decision no. 55 of October 14th, 1999 "On the interpretation of certain provisions of the Article 4 of the Constitution of the Republic of Moldova", which reveals that international treaties are an integral part of the national legal system and, respectively, their provisions directly applicable, as any other law of the Republic of Moldova, the latter having priority over the rest of national laws which are in conflict with it. This also results from the content of Article 53 of the European Convention on Human Rights, for example, according to which no provision in this Convention shall be interpreted as limiting or affecting human rights and fundamental freedoms, which may be recognised under the laws of either Contracting Party or any other convention to which the Contracting Party is a party. At the same time, Articles 2 and 12 of the Civil Procedure Code and Articles 2 and 7 of the Criminal Procedure Code provide that international treaties take precedence over national laws and require judges to directly apply the provisions of international treaties. In this regard, national courts are primarily responsible for the application of international treaties. Thus, while reviewing cases, courts should verify whether a law or an instrument, which is to be applied and which provides for the rights and freedoms proclaimed in international treaties, is compatible with its provisions. If it is not compatible, courts shall directly apply the provisions of the international treaty, which is mentioned in decisions issued by the court.

5.2 STATUS OF PRECEDENT

Upon its accession to the European Convention on Human Rights and Fundamental Freedoms (hereinafter, the European Convention), the Republic of Moldova undertook to ensure the observance and protection of the fundamental rights and freedoms proclaimed in the Convention for all persons under its jurisdiction. The State has the primary responsibility to ensure the observance of the fundamental rights and freedoms provided for in the European Convention, according to the principle of subsidiarity. This principle presumes that, before resorting to Convention institutions, any applicant should have addressed his complaint to all those national institutions that could provide an effective and appropriate remedy under the circumstances of the case, as the respondent State "must have first the opportunity to remedy the given situation by its own means and within the national legal system".

However, this principle reflects not only the existence of remedies, but also the primary obligation of all authorities, especially the courts, to prevent violations through direct application of the European Convention in their decisions.

The only court that is entitled to give official interpretations on the application of the European Convention, through its decisions, is the European Court of Human Rights (hereinafter ECtHR). Following the provisions of Article 4, para. (2) of the Constitution of the Republic of Moldova, explanations provided in the decision of the Constitutional Court no. 55 of October 14th, 1999 "On the interpretation of certain provisions of the Article 4 of the Constitution of the Republic of Moldova" and pursuant to the text of the Article 46 of the European Convention, ECtHR judgments are binding for the Republic of Moldova.

Pursuant to the provisions of the Article 46 of the Convention, the Republic of Moldova is committed to comply with the final judgments of the Court in any cases to which it is party. This means that ECtHR's interpretations contained in its judgments relating to the Republic of Moldova are binding for the courts. At the same time, in order to observe the human rights and fundamental freedoms, the courts are bound to consider the ECtHR case law established in its judgments in relation to other States - parties to the European Convention.

In this context, the courts shall apply the ECtHR case law if the circumstances of the case under review are similar to the circumstances that were reviewed by the ECtHR and in relation to which ECtHR issued its judgment. This is also obvious from the provisions of the Article 7, paras. (8) and (9) of the Criminal Procedure Code, stating that the final judgments of the European Court of Human Rights are binding for the criminal investigation bodies, prosecutors and courts. Similarly, the judgments of the Criminal Division of the Supreme Court of Justice issued as a result of reviewing the appeal on points of law are binding on courts to the extent that the de facto and de jure circumstances of the case remain the same as those existing upon the hearing of the appeal.

5.3 LEGAL SYSTEM AND HEALTH SYSTEM: AN OVERVIEW

5.3.1 LEGAL SYSTEM OF THE REPUBLIC OF MOLDOVA

The act of justice in the Republic of Moldova is administered by courts. The judiciary is independent, separated from the legislative power and the executive power, and has its own powers, exercised by the courts that administer justice. The courts are established based on the principle of appointment of judges and examine all cases, including civil cases, administrative cases, criminal cases, and any other case, for which the law does not establish a different jurisdiction. Courts are legal entities, have their stamp with the State emblem and their name, and are structured by hierarchy as follows:

a) Supreme Court of Justice of the Republic of Moldova;

- b) 4 Courts of Appeal (Chişinău, Bălţi, Cahul and Comrat);
- c) Courts of Law (district courts and constituency courts of the Chişinău municipality).

Authors' Note: *The Constitutional Court of the Republic of Moldova is not part of the judicial system. It is an independent entity of the state power, empowered to oversee compliance with the Constitution of laws and regulations issued by the Parliament, the Government and the President of the Republic of Moldova. (See below for discussion of the Constitutional Court.)*

Everyone has the right to obtain effective protection from competent courts against acts that violate their legitimate rights, freedoms and interests. The hearing of cases is conducted in compliance with the principle of random distribution of case files through the electronic case management system. If the judge to whom a case was assigned is unable to continue the trial, the responsible person, based on a substantiated decision of the president of the court, through the electronic case management system, ensures the random redistribution of the case to another judge. The random distribution data sheet should necessarily be attached to every case. Panels of judges are established and their presidents are appointed at the beginning of the year by the order of the court president. Panel members are only changed in exceptional cases, based on a substantiated decision of the court president and according to objective criteria established by the regulation approved by the Superior Council of Magistracy. The substantiated decision on changing the panel members is attached to the case file.

Article 117 of the Constitution of the Republic of Moldova enshrines the public nature of court hearings: "Hearings in all courts of law are public. Cases may be heard behind closed doors only as stipulated by law and in compliance with all the rules of procedure". The detailed regulation of the information on the activity of courts is provided in the Criminal Procedure Code, Civil Procedure Code and the Law of the Republic of Moldova on Access to Information. Article 10 of the Law on Judicial Organization concerning the "Public nature of court hearings and the principle of adversarial system" establishes the public nature of hearings. Closed hearings are held only in cases provided by law, with due observance of the judicial proceedings. Article 23 of the Civil Procedure Code on the "Public nature of court hearings" provides that "hearings in all courts of law are public. Minors under the age of 16 years shall not be admitted to a hearing unless summoned as participants or witnesses in the trial. Closed hearings may be held only in order to protect information that represents State secret, commercial secret or other information the disclosure of which is prohibited by law". Article 18 of the Criminal Procedure Code regarding the "Public nature of court hearings" stipulates that hearings in all courts are public, unless otherwise provided by the law. Access to the courtroom may be denied to the press or the public by a substantiated decision, throughout the whole trial or part of the trial in order to observe morality, public order or national security, when required to protect the interests of minors or the privacy of the parties in the trial, or to the extent strictly required by the court when, due to special circumstances, a public hearing would prejudice the interests of justice. If a minor is a victim or witness in a trial, the court will hear the minor's statements in a closed hearing. Trial in a closed court hearing should be substantiated and carried out in compliance with all the rules of judicial proceedings. In all cases, court judgments are pronounced in public hearing.

Article 14 of the Law on Judicial Organization provides for the right to use technical means. Court hearings are recorded using video or audio means or taken down in shorthand. Records and shorthand copies are transcribed immediately. Audio and/or video recording of hearings is conducted in the manner established by the Superior Council of Magistracy. The registrar or shorthand specialist puts down all statements, questions and allegations made by trial participants and other persons participating in the proceedings and those made by judges. Audio and video recording, photography and the use of other technical means by trial participants and other persons are only allowed under the procedural law. Article 18 of the Civil Procedure Code provides that in order to document the proceedings and preserve evidence, the court may use any technical means under this Code and other laws. Participants in the trial can perform the audio recording of the hearing. The video recording, photography, and use of other technical means than those provided under para. (11) Article 18 of the Civil Procedure Code may be al-

lowed only by the presiding judge and only at the opening of the court hearing and upon pronouncement of the judgment. Violation of the provisions of para. (2) is punishable by a fine of up to 20 conventional units and seizure of records (film, photos, tapes, etc.).

Constitutional Court

As a body that exercises the constitutional jurisdiction, the Court is independent of the legislative, executive and judiciary powers, and is an independent constitutional body of the state. It is subject only to the Constitution. The major function of the Constitutional Court is the constitutional control of laws and regulations and the cancellation of legal rules that are in conflict with the Constitution, as well as the interpretation of the Constitution. The Court operates according to its own jurisdiction, based on the principles of independence, immovability, collegiality, legality and publicity. In its work, the Court has financial autonomy and its own budget, which is a distinct part of the State budget.

The Constitutional Court performs an organizational, oversight activity, which is aimed at notifying public authorities whose activity is under the Court's control to remove the regulations that are in conflict with the Constitution and suspend the action of a regulation. However, only the authority that adopted the regulation has the right to amend or cancel it. Decisions relating to constitutional control are binding and final, leading to the invalidity of a regulation or its declaration as unconstitutional. As the sole authority of constitutional jurisdiction, the Court exercises its powers under the Article 135 of the Constitution, Article 4 of the Law on the Constitutional Court and Article 4 of the Code of Constitutional Jurisdiction:

- performs, upon notification, the constitutional control of laws, regulations and decisions of the Parliament, Presidential decrees, decisions and orders of the Government and international treaties to which the Republic of Moldova is a party;
- interprets the Constitution;
- rules on initiatives to amend the Constitution;
- confirms the results of national referenda;
- confirms the results of elections of the Parliament and the President of the Republic of Moldova, validates the commissions of the members of the Parliament and that of the President of the Republic of Moldova;
- ascertains the circumstances justifying the dissolution of the Parliament, the dismissal of the President, the interim of the position of President, the inability of the President to exercise his powers for more than 60 days;
- addresses exceptions of unconstitutionality of legal acts, notified by the Supreme Court of Justice;
- decides on issues relating to the constitutionality of a party.

Supreme Court of Justice

The Supreme Court of Justice is the highest court that ensures the correct and uniform enforcement of law by all courts, settlement of disputes arising during law enforcement, and guarantees the State's responsibility before the citizen and the citizen's responsibility before the State. Through its work, the Supreme Court of Justice ensures observances of the principle of presumption of innocence and the principle of rule of law and contributes to the establishment of rule of law. The Supreme Court of Justice is based in the city of Chişinău.

Powers of the Supreme Court of Justice:

- examines, as a court of appeal, civil, administrative, criminal or other matters under the procedural law;
- notifies, ex officio or at the proposal of the courts, the Constitutional Court to examine the constitutionality of legal acts; the Constitutional Court can either examine the merits of the case or declare the claim (petition) inadmissible;

- generalises the case law and analyses its own judicial statistics;
- provides ex officio explanations in matters of case law not related to the interpretation of laws and not binding on judges;
- exercises, within its competence, duties arising from international treaties to which the Republic of Moldova is a party.

Composition of Supreme Court of Justice:

- The Supreme Court of Justice is composed of the President, two Vice-Presidents, who are also chairing 2 divisions: 1) the Civil, Commercial and Administrative Division and, respectively, 2) the Criminal Division, and 30 judges (of which two judges hold simultaneously the positions of deputy chairs) who work both in the divisions and in the Court Plenum. Judges of the Supreme Court of Justice are appointed by the Parliament at the proposal of the Superior Council of Magistracy, until they reach the mandatory retirement age, i.e. 65 years. To be appointed as a judge of the Supreme Court of Justice, a judge must comply with the provisions of the Law on the Status of Judges and have at least 10 years of working experience as a judge. Every judge of the Supreme Court of Justice is assisted by three judicial assistants.
- A Scientific Advisory Board, composed of scientists and practitioners in the field of jurisprudence, operates under the Supreme Court of Justice.
- The Plenum of the Supreme Court of Justice operates with all the judges of the Court, is chaired by the President of the Court, and, in his/her absence, by one of the chairs of divisions.
- The sessions of the Supreme Court of Justice may be attended, depending on the subject discussed, by the Minister of Justice and the Prosecutor General.

The Plenum of the Supreme Court of Justice:

- notifies, ex officio or at the proposal of other courts, the Constitutional Court to rule on the constitutionality of legal acts;
- examines the results of generalised case law and adopts explanatory decisions;
- in order to ensure a uniform case law, issues, at the request of the courts, advisory opinions in case of issues related to law enforcement. However, this cannot be considered a form of legal precedent due to the fact that advisory opinions of the Plenum have only a recommendation nature and are mostly based on the interpretation of national and international laws rather than on the interpretation of the practices;
- establishes, as appropriate, divisions for various matters, and determines the duration of their activity;
- confirms the composition of divisions;
- confirms the composition of the Scientific Advisory Board;
- approves the Regulation on the organization and functioning of the Supreme Court of Justice.

Courts of Appeal

There are four Courts of Appeal in the Republic of Moldova: one in Chișinău, one in Bălți, one in Comrat and one in Cahul. Every Court of Appeal exercises its jurisdiction in a geographic area covering several courts. Courts of appeal may consist of several divisions, by the type of cases, or as a single joint division. Divisions consist of judges working for courts of appeal. The composition of divisions is approved by the order of the President of the Court, at the beginning of each year. The President of the Court of Appeal is entitled to order, where appropriate, the involvement of judges from one division in the trial of cases in another division.

The courts of appeal consider requests for appeal against decisions and sentences issued by courts of first instance. Disputes concerning the protection of the rights of healthcare providers and patients are

always in the jurisdiction of first instance courts; they are subject to review by the Court of Appeal upon the lodging of an appeal. In exceptional cases, however, such as disputes initiated at the request of the Central Election Commission, the Court of Appeal will review the case as a first instance court.

Ordinary courts

Ordinary courts are also called first instance courts. They operate in precincts established by law. The courts function in districts and municipalities (their sectors). The ordinary courts consider all cases and requests, with the exception of those that are, in accordance with the law, under the jurisdiction of other courts of law.

The judicial system is also composed of specialized courts: the Military Court and Commercial Precinct Court which review the cases within their jurisdiction under the law and operate under the general rules of judicial organization, with exceptions provided by law. The structure and staffing of the secretariat of courts are established by the Ministry of Justice, in cooperation with the Superior Council of Magistracy.

The judges in the courts of law are appointed by the President of the Republic of Moldova following a proposal submitted to him by the Superior Council of Magistracy.

Prosecutor's Office

The Prosecutor's Office represents the general interests of the society and protects the rule of law and the citizens' rights and freedoms, supervises and performs the criminal investigation, and represents the prosecution in courts under the law (Article 124, para. (1) of the Constitution). It is the public authority with the leading role in combating crime and supervising criminal investigation. According to Article 270 of the Criminal Procedure Code of the Republic of Moldova, the prosecutor is solely responsible to perform the criminal investigation. For this reason, all complaints about an offense that was committed or is under preparation should be addressed exclusively to the prosecutor for investigation.

- The official nature of criminal proceedings, as defined in Article 28 of the Criminal Procedure Code, requires the prosecutor to initiate the criminal investigation, if he/she is notified in the manner prescribed by the Code, about a crime that was committed and to take the necessary actions in order to identify the crime and the perpetrator.
- The criminal investigation is aimed at collecting the necessary evidence related to the existence of a crime, and identification of the perpetrator, to ascertain whether or not to refer the criminal case to a court under the law and to determine the perpetrator's liability (Article 252 of the Criminal Procedure Code).
- The prosecutor is obliged to play an active role in the interests of the crime victims, to take all measures provided by the law to perform a comprehensive, complete and objective investigation of circumstances of the case in order to establish the truth (Articles 9 and 254 of the Criminal Procedure Code).
- Upon notification about a crime that was committed or about founded suspicions that a crime is about to be committed, the prosecutor is obliged to order, within 15 days, the initiation of a criminal investigation, if the content of the notification or the findings generate a reasonable suspicion that a crime was committed and there is no circumstance that precludes criminal investigation, and to inform the person who submitted the notification or the relevant authority. If the prosecutor refuses to initiate a criminal investigation, he shall confirm this fact by a substantiated motion and shall notify about that, in the shortest time possible, but not exceeding 15 days, the person who submitted the notification (Article 274 of the Criminal Procedure Code).
- According to the Article 262 of the Criminal Procedure Code, the prosecutor is notified not only upon submission of a complaint by the victim, but also upon:
 - denunciation (when a third person informs the prosecutor about the crime);
 - self-denunciation (when the offender voluntarily notifies about the commission of the crime);

- self-notification (direct identification by the prosecutor of a reasonable suspicion about the commission of a crime).
- Irrespective of the method of notification, the prosecutor is obliged to actively and equally react to effectively investigate the alleged crime.

5.3.2 HEALTH SYSTEM

The health system of the Republic of Moldova is organized according to the principles of universal access to basic health services and equity and solidarity in healthcare financing; it is funded from both the State budget and by individuals through the Mandatory Health Insurance. The health system includes a mix of public and private medical facilities, as well as public agencies and authorities involved in the provision, financing, regulation and administration of health services.

Public medical facilities at primary and secondary levels provide services to the community and belong to the local public authorities. In every district, there are also providers of emergency care (ambulance services) belonging to the Ministry of Health. Medical facilities at the tertiary level provide specialized and highly specialized medical care for the whole population; almost all of these tertiary facilities are located in Chișinău and belong to the Ministry of Health.

Since 2004, health financing in the Republic of Moldova has been organized as Mandatory Health Insurance (MIH). Contributions from the working population come predominantly through fixed percentage of salary (7% in 2012 and 9% in 2015: 4.5% to be paid by the employee and 4.5% to be paid by the employer); self-employed persons are expected to purchase their own coverage for the year at a fixed price. The non-working population (14 categories including pensioners, students, children, registered unemployed persons, etc.) is covered through transfers of funds from the State budget to the National Health Insurance Company (NHIC), which is the agency to collect the funds in the health sector. The NHIC is also the sole purchaser of health services which has enabled the development of a purchaser-provider relationship, and payments for services are made on the basis of contracts, most of which are prospective.

Access to emergency and primary care services is universal, regardless of the insurance status; so are the services connected to key public health issues such as HIV infection and AIDS disease, tuberculosis and immunization. The package of benefits available under MHI covers specialized outpatient and hospital care and a very limited range of pharmaceuticals. For those without insurance coverage (most often are self-employed agricultural workers or those in informal employment (employment without contract) in urban areas), these services are paid in full as out-of-pocket payments.

Public medical facilities are autonomous self-financing, non-profit organizations that are directly contracted by the NHIC for the provision of medical services under the Mandatory Health Insurance. Public medical facilities at primary and secondary levels provide services to the community and belong to the local public authorities.

Some health services are provided by the private sector (mainly specialized outpatient care providers, diagnostic laboratories, pharmacies and, less frequently, hospitals and primary healthcare providers). Private healthcare providers can be contracted by the NHIC.

Institutions with regulatory functions, such as licensing, offering support in the development of health policies or conducting public health monitoring, are financed from the State budget through the Ministry of Health to which they are subordinated. The regulatory functions are thus centralized within the Ministry of Health. Through these institutions, the Ministry of Health collects and analyses data and generates relevant information to contribute to the development of evidence-based policies.

The Ministry of Health addresses the major challenges in the health sector and promotes the principle of health in all policies through multi- and inter-sectorial collaboration, including the coordination of public health activities within the sector and beyond it. This means greater transparency in health policy deci-

sion-making and a more tolerant influence in policy-making through the involvement of non-governmental organizations (NGOs) representing patient rights and interests in the development process.

To improve equity in the system, amendments to the Law on Mandatory Health Insurance sought to expand access to services by making universal the access to primary care services and to increase the financial protection of vulnerable households by extending automatic MHI coverage to families registered as living below the poverty line even if they are formally "self-employed".

Major changes to pharmaceutical pricing and procurement policies have sought to improve access to pharmaceuticals by introducing reference pricing to ensure that pharmaceuticals are not more expensive in the Republic of Moldova than in the neighbouring countries and by centralizing the procurement of medicines essential for public health facilities.

Most reforms of the Moldovan health system have sought to reorganize the inherent Semashko system and adapt it to the new conditions and social, economic and health demands it faces. The key task has been to improve the efficiency of facilities and the way they are financed. However, changing the mentality of those working in the system and of service users (who are often resistant to change) is a much greater task. This has an impact on the development of new regulatory mechanisms as the Soviet way of working with regulations does not fit with the current socioeconomic reality and many of the regulations still in use are dated before the independence period. Some reform initiatives have faced various levels of political support or resistance – particularly in terms of optimization of the health system as this involves rationalization of the hospital network, which is a very challenging political view, irrespective of the party in power.

KEY ACTORS IN THE MOLDOVAN HEALTH SYSTEM

The **Parliament** – according to the Constitution of the Republic of Moldova (1994), the Parliament establishes the structure of the national health system and the means for protecting the physical and mental health of individuals. Through legal acts, the Parliament has the power to reorganize the national health system and the pharmaceutical activity according to the Law on Healthcare (no. 411-XIII, 28.03.1995). The Parliament approves the annual Law on the State Budget (which includes the budget of the Ministry of Health) and the annual Law on Mandatory Health Insurance Funds. The Parliamentary Commission for Social Protection, Health and Family examines draft laws and proposals relating to the health sector, develops reports or commentaries, conducts parliamentary investigations and debates, and takes decisions on inter-sectorial health issues.

The **Government** – manages, coordinates and approves regulations and regulates the activities of the Ministry of Health, the NHIC and any other government structures that have their own parallel health networks, as per the Law on Government (no. 64-XII, 31.06.1990).

The **Ministry of Health (MoH)** – is responsible for the health policy and the development of the legislation regulating the organization and provision of health services. It is also responsible for the quality assurance and the establishment of the minimum quality criteria, the definition of the benefit package, resource planning and surveillance of population health, the setting of public health priorities, the management of national health programs (including health education), as well as the promotion of health in all policies.

The **Regional/Local Administrative Units (Local Health Authorities)** – are responsible for the local regulatory issues, but they do not finance health services and the service providers are not directly subordinated to them. The legal framework regarding the competencies of local authorities in health is quite confusing and contradictory, so the efficacy of local/regional health authorities is not optimal.

The **National Health Insurance Company (NHIC)** - is a state non-profit body with financial autonomy that was created by the Government in 2001. Its responsibilities include: MHI for the population; contracting health service providers for the provision of services to insured people; verifying that the provisions of the

contracts correspond in terms of volume, terms, quality and costs of the healthcare services provided; managing MHI resources within the limits of the contracted services; protecting the interests of the insured individuals; case validation; and concluding re-insurance contracts. The NHIC manages five funds: the Fund for Reimbursement of Health Services, the Reserve Fund, the Fund for Prophylactic Measures, the Fund for the Development and Modernization of Public Health Service Providers, and the Administrative Fund for the MHI system.

The **National Centre of Health Management** – is financed and subordinated to the Ministry of Health. Its basic functions include: the collection, standardization and analysis of statistical information in the public health sector; the provision of scientific strategies underpinning the development of the public health system; the development of standards, norms and regulations for healthcare; the monitoring of health service markets and the technical and material basis necessary for the provision of health services, and others.

The **National Centre of Public Health (NCPH)** – together with other 36 territorial centres of public health, which are located in all districts across the country, is supervised by the Chief Sanitary Doctor, who is a deputy minister of health. NCPH coordinates the technical and methodological activities in the health sector directed towards the development and implementation of strategies for the health protection and promotion, the prevention and control of transmissible and non-transmissible diseases.

The **Drug Agency** – is subordinated to the MoH and financed from the State budget. It is responsible for the authorization of medicines, the quality control of medicines and the regulation of the pharmaceutical activity, the monitoring and coordinating of drugs supply and pharmaceutical service provision at the national level.

The **Transplant Agency** - is subordinated to the MoH and financed from the State budget. The basic functions of the Agency include the organization and coordination of activities related to the collection, transportation and allocation of organs and the organization and coordination of activities related to the sampling, processing, conservation, validation, storage and transportation for the transplantation of human tissues and cells for therapeutic purposes over the territory of the Republic of Moldova.

The **National Scientific and Practical Centre of Emergency Medicine** – coordinates the activity of the Emergency Healthcare Service and Disaster Medicine at the national level.

The **National Healthcare Evaluation and Accreditation Council** – was created by the Government in 2002 and is a self-financing institution; it is not directly subordinated to the MoH. The basic functions of the Council include the assessment of the compliance of health and pharmaceutical institutions and the activity of enterprises with the relevant standards and, based on this evaluation, the provision of the official recognition that a health and/or pharmaceutical unit and its personnel are competent to conduct activities specific to its profile, in accordance with standards and legal provisions in the field of medicine and pharmacy.

Organizations representing patients/consumers – there are some organizations representing patients' interests. Most of them are active in the field of chronic and rare diseases, such as diabetes, arthritis, haemophilia, phenylketonuria and others. There are also organizations promoting the access to information and the protection of the rights of patients and disabled people, but these are mostly oriented towards services for people living with HIV, TB or mental health disorders.

Professional and providers' associations – are specialized associations for family medicine, surgery, oncology, rheumatology, and other specialties. The ability of such organizations to promote their members' "interests" and the participation of these bodies in decision-making processes depends heavily on how active the leadership of the association is. One of the most active professional associations is the Association of Nursing from the Republic of Moldova. The health trade union ("Sănătatea") is a well-organized structure at national and local level. It plays an important role in protecting the rights of its members as well as promoting their labour, professional, economic and social interests.

NGOs – a wide network of NGOs is active in HIV/AIDS and tuberculosis control and in supporting children's health, particularly for those with disabilities. NGOs are active participants in the development of health policy and their contribution to the development of partnership with the civil society and in monitoring the health reform is increasing.

Private sector – very few health services are provided by the private sector, which are mainly providers of outpatient healthcare services, diagnostic laboratories and pharmacies. Accredited healthcare providers and pharmacies can sign contracts with the NHIC for the provision of services.

The Legislation of the Republic of Moldova Related to Health and Human Rights and Human Rights in Patient Care

The legislation comprises texts which regulate various aspects of medicine/healthcare services: rights of patients and research subjects (including vulnerable groups, such as minors, persons with mental disorders, patients with HIV/AIDS, and others), duties and responsibilities of healthcare professionals and institutions, human organ transplantation, assisted reproductive technologies, public health issues. Legislation of the Republic of Moldova in the field of Health and Human Rights and Human Rights in Patient Care comprises the Constitution, international agreements and treaties to which the Republic of Moldova is a party, the national laws and other legislative and regulatory texts.

► National Laws Related to Health and Human Rights and Human Rights in Patient Care:

- Law on Healthcare no. 411-XIII of 28.03.1995
- Law no. 263-XVI of 27.10.2005 on the Patient's Rights and Responsibilities
- Law no. 264-XVI of 27.10.2005 on Practicing the Medical Profession
- Law no. 552 of 11.10.2001 on the Assessment and Accreditation in Health
- Law no.10 of 03.02.2009 on State Supervision of Public Health
- Law no. 1402 of 16.12.1997 on Mental Health
- Law no. 23-XVI of 16.02.2007 on HIV/AIDS Prevention and Control
- Law no. 1585 of 27.02.1998 on Mandatory Medical Insurance
- Law no. 153 of 04.07.2008 on the Control and Prevention of Tuberculosis
- Law no. 138 of 15.06.2012 on Reproductive Health
- Law no. 93 of 05.04.2007 on Civil Protection and Exceptional Circumstances
- Law no. 42 of 06.03.2008 on Transplantation of Human Organs, Tissues and Cells
- Law no. 1409 of 17.12.1997 on Pharmaceutical Activity
- Law no. 382 of 06.05.1999 on Circulation of Narcotics, Psychotropic Drugs and their Precursors
- The Law no. 278 of 14.12.2007 on Tobacco and Tabaco products
- The Law no. 241 of 20.11.2008 on Blood Donation and Transfusion

Among these laws, the "**Law on Healthcare**" is considered to be the general framework law, which determines the priorities and sets out fundamental principles of healthcare legislation of the Republic of Moldova.

The "**Law on the Patient's Rights and Responsibilities**" is the specific law that defines all major principles of patients' rights protection.

The "**Law on the Practice of the Medical Profession**" defines the responsibilities of doctors towards patients and also regulates all major aspects of doctors' training, professional development and activity. The definition of legal duties of doctors in relation to patients' rights creates the possibility to introduce disciplinary sanctions in case a doctor fails to fulfil their professional duties.

The "**Law on Public Health**" is related to the rights of patients, as far as it defines rules of interrelation between individuals and the public health system; and in a few, very specific cases, it restricts the rights of individuals for the sake of public interest.

Other laws regulate patients' rights in the context of various specific medical fields, such as psychiatry, human organ transplants, HIV/AIDS and others.

Professional Codes of Ethics and Medical Institution Decision

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** is an important, though not legally-binding instrument aimed at implementing the highest ethical standards in the everyday practice of physicians in the Republic of Moldova. The Code was approved at the Board of the Ministry of Health in 2007.

- The Code includes a preamble, general provisions and specific chapters on the doctor's relationship with patients, co-workers and towards the society. The text is quite general on the whole; it mostly defines general principles and attitudes rather than detailed instructions for each specific case.
- No sanctions may be applied in the case of an eventual breach of the provisions of the Code. However, most of the provisions of the Code are based on principles already laid down in health related laws (such as the Law on Healthcare, the Law on the Practice of the Medical Profession, the Law on the Rights of Patients, and others). Therefore, there is good reason to follow the provisions of the Code, as they are mostly based on the existing legislation.
- The Code is the first national code of ethics in the field of biomedicine.

Decisions of medical institutions are other instruments regulating the conduct of medical personnel, their rights and responsibilities, as well as the rights and responsibilities of the patients. These bylaws shall correspond to the existing legislation. However, if certain internal provisions contravene the law, such provisions shall be deemed void, according to the existing hierarchy of established legislation.



6.1 PATIENTS'S RIGHTS

6.2 PATIENTS' RESPONSIBILITIES

6

PATIENT'S RIGHTS AND RESPONSABILITIES AT NATIONAL LEVEL

6.1 PATIENTS'S RIGHTS

The patient's rights and responsibilities in the Republic of Moldova are guaranteed by the *Constitution*, by the *Article 23*, which states the *Right to Know One's Rights and Duties*.

One of the basic rights of every individual is **the right to health**, which, at any level and in any form, is composed of the following indissoluble elements:

- a) *Availability*. Any state shall have a sufficient number of institutions, goods, services and programs in the healthcare system.
- b) *Accessibility*. Goods and services in healthcare, which the State owns, should be accessible to every individual. The accessibility can have 4 aspects:
 - *non-discriminatory access*: any person has the right to use the healthcare goods and services without any discrimination; in particular, this right must be provided to vulnerable groups of the population;
 - *physical access*: the healthcare goods and services shall be physically accessible (distance, access conditions for people with disabilities, etc.);
 - *economic access*: the terms and conditions of payment for healthcare goods and services are to be based on the principle of social equity, so that they are accessible for the entire population;
 - *access to information*: the right to seek, receive and communicate information concerning the healthcare system, without violating the principle of individual confidentiality of the patient.
- c) *Acceptability*. All healthcare goods and services shall comply with the principles of medical ethics and the cultural criteria, so that the particularities of all categories of people (minority groups, women, children, people living in rural areas, etc.) are taken into consideration.

- d) *Quality*. The healthcare goods and services shall be acceptable from both the scientific and medical point of view and shall be of high quality.

The European Charter of Patient's Rights, approved in 2002, in Rome, contains 14 rights of the patient, used as the construct for this section of the Guide, as described in this chapter.

6.1.1 RIGHT TO PREVENTIVE MEASURES

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right to proper services in order to prevent illness.

The legislation of the Republic of Moldova does not specifically mention the "right to preventive measures". However, several provisions could be interpreted as being indirectly applicable to the right to prevention, particularly the provisions concerning the right to healthy conditions/environment and to healthcare/medical services. In the first case, measures which are essential to achieve and maintain a "healthy environment" should be considered as preventive measures; and in the second case, "medical services" in general include various types of preventive measures as well. The explanations below are based on the above interpretation of the healthy environment and medical/healthcare services.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ ***Constitution of the Republic of Moldova, in Article 36***, guarantees the right to health protection and states that the structure of the national healthcare system and the means necessary to protect individual physical and mental health shall be established by organic laws.

Ensuring adequate living conditions and a healthy environment that is ecologically safe for life and health is a mandatory requirement to prevent illness. The right to a healthy environment is stipulated in the Constitution (**Article 37**), and the State shall guarantee to every individual the right to free access and to dissemination of accurate information regarding the condition of the natural environment, the living and working conditions, the quality of food products and household appliances and other factors which may be detrimental to health.

- ▶ ***Law on Healthcare no. 411-XIII of 28.03.1995*** states that one of the fundamental principles of the healthcare system is that of prophylactic orientation to ensure the population's health in all spheres of vital activity. (**Article 2, (f)**)

Prophylaxis is the fundamental principle to ensure the population's health. Thus, the public administration authorities and economic units are obliged to undertake social and medical measures focused on the primary prevention of diseases, especially focused on the environmental sanitation, the development and maintenance of hygienic conditions favourable for life and work, the maintenance and preservation of people's health and some of its categories (women, children, elderly), for the propagation of active rest and physical mass culture, for rational nutrition and health education of the population. (**Article 3**)

Article 18 of the Law describes the right of the population to possess the knowledge necessary to ensure one's health and to prevent diseases.

The prophylactic anti-epidemic measures are guaranteed to the citizens of the Republic of Moldova by the State from the free minimum health insurance. (**Article 20, paragraph 2, (a)**)

- ▶ ***Law on the Free Minimum Medical Assistance Guaranteed by the State no. 267 of 03.02.1999*** stipulates the right of the population of the Republic of Moldova to immune-prophylaxis, provided free of

charge, against the entire spectrum of contagious diseases. Therewith, the minimum guaranteed also includes the primary medical assistance provided to the population by the family doctor, whose duties also include the implementation of preventive and health education measures and screening of some diseases. **(Article 4, (a), (g))**

- ▶ **Law on State Supervision of Public Health no. 10 of 03.02.2009** describes the organization of the State system of public health surveillance. **Article 27** stipulates the right of natural persons to:

- 1) a favourable living environment, which is ensured through the implementation of a complex of measures to prevent the action of unfavourable environmental factors on the human being, through the fulfilment of the provisions of the healthcare legislation by individuals and legal entities, and through the observance of the provisions of normative documents on the security and safety of products and services;
- 2) to obtain complete and accurate information on:
 - a) aspects of activity with a potential impact on public health;
 - b) public health measures undertaken and their results;
 - c) products and services safety;
- 3) to participate directly or through a representative or through public organizations, in the development, revision and adoption of public health measures by the public authorities.

- ▶ **Law on the Patient's Rights and Responsibilities no. 263 of 27.10.2005** states the right to know the information on the environmental factors which are harmful to health. Since the information of patients on potential risks and hazards for the development of morbid states is part of the preventive measures, the patient has the right to know the information on his/her own health, diagnosis, treatment and recovery, and prevention, as well as on their potential risk and therapeutic efficiency **(Article 5, (i), (j))**.

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates the right of every person to adequate sex education, to use or to refuse to use contraceptive methods, to diagnostic and treatment of sexually transmitted infections and the HIV/AIDS infection, to regulation of fertility and to safe abortion, to qualified perinatal assistance, to early diagnostic and treatment of genital and breast cancer, to treatment of infertility and medically assisted human reproduction, to nursing during menopause/andropause. **(Article 4, paragraph 3)**.

The state shall ensure continuous information of the population through messages preventing the problems of reproductive health. People are entitled to medical consultation for purposes of choosing a contraceptive method. Every woman is entitled to an annual consultation, free of charge, for early detection of genital and breast cancer, to screening of the genital and breast cancer, to treatment and care after treatment. Every man is entitled to the screening of the reproductive system pathology, including genital cancer, to treatment and rehabilitation. Every person is entitled to consultations and investigations, free of charge, aimed at preventing and treating the sexually transmitted infections and the HIV/AIDS infection; and to measures of sexual violence prevention, nursing and rehabilitation of victims of violence. **(Article 5)**

- ▶ **Law on Tuberculosis Control and Prevention no. 153 of 04.07.2008** states the right of the population to measures of tuberculosis control and prevention. The tuberculosis prevention measures are implemented especially in the vulnerable groups: children, immigrants, asylum seekers, refugees, beneficiaries of humanitarian protection, prisoners, and other disadvantaged categories. **(Article 8)**

People having been or being in contact with persons suffering from tuberculosis will be mandatorily subject to medical examination and surveillance, free of charge, with the purpose to detect the tuberculosis and will be subject to anti-tuberculosis chemo-prophylactic treatment as established by the Ministry of Health. The prophylactic vaccination against tuberculosis is mandatory for all persons who do not have medical contraindications and is performed according to the national vaccination calendar, approved by the Ministry of Health. **(Article 13)**

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

The **Decision of the Government of the Republic of Moldova no. 1192 of 23.12.2010 on the approval of the National Immunization Program for the period 2011-2015** was issued to prevent the spread of infectious diseases over the population. (Minister Order No. 259-263, Art. No. 1319). The goal of the National Immunization Program (NIP) is to decrease the morbidity and mortality in the population related to vaccine-preventable infectious diseases. The main objective of the NIP is to ensure vaccination coverage of over 95% of the population of target age at the national level, in every district and municipality, to ensure the vaccination with vaccines that meet the international quality and safety requirements and are stored and administered under appropriate conditions.

In Moldova, all children are entitled to vaccination, free of charge, with vaccines included in the NIP. The vaccination of the population of the Republic of Moldova with vaccines included in NIP is mandatory. These provisions are derived from a number of normative acts:

- ▶ *Government Decision no. 886 of 06.08.2007, on the "Approval of the National Health Policy";*
- ▶ *Government Decision no. 1171 of 21.12.2010 on the "Approval of the National Tuberculosis Control and Prevention Program for the period 2011-2015";*
- ▶ *The Order of the MoH no. 37 of 23.01.2006 on the "Strategies to Eliminate Measles and Rubella and Surveillance Measures for These Infections";*
- ▶ *The Order of the MoH no. 148 of 21.11.2005 on the "Provision of Additional Immunization Services for the Population of the Republic of Moldova".*

D) PROVISIONS IN THE CODE OF ETHICS

The right of the patient to health and preventive measures is followed through the obligation of medical and pharmaceutical workers to protect the patient's physical and mental health, which is described in the **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Worker (Chapter I)**.

E) OTHER RELEVANT SOURCES

There are no relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance.

- ▶ According to the National Immunization Program, which is properly funded, the State shall ensure the vaccination of the population with a wide range of vaccines starting with the first days of life and throughout life. The vaccination coverage of the population of target age, at the national level, is over 95%. All people, who do not have medical contraindications, and risk contingents are subject to vaccination with vaccines, which meet the international quality and safety requirements and are stored and administered under proper conditions. (**Case reported by the Ministry of Health**)
- ▶ Iodine deficiency is a problem of public health in the Republic of Moldova. The development of national programs on fortification of food salt, flour and water with iodine are measures to prevent the diseases resulting from the lack of iodine in the body. (**Case reported by the Ministry of Health**)

2. Examples of Breach

- ▶ The lack of public information programs on the ways of getting infected with the hepatitis B virus and the non-vaccination of the population against this disease may cause the high number of patients suffering from hepatitis.

3. Actual Case

- ▶ Mumps infections are common in children, but in cases when adults get infected there is an increased risk of complications. Therefore, the vaccination against this infection is recommended at the global level and is performed in two stages: at the age of 1 year old and at the age of 6-7 years old. In the 1990s, the healthcare system of the Republic of Moldova faced severe financial difficulties. The resources were not even sufficient for ensuring the procurement of vaccines. Children born during 1990-91 were to receive the second stage of vaccine in 1996-1997. In this period, the required doses were not purchased because of the lack of funds. Subsequently, when the financial situation improved, the National Immunization Program began to be implemented with adequate coverage of all groups of the population. However, the re-vaccination in children who were not vaccinated against Mumps in the period 1996-97 was neglected. As a result, in the period 2007-2008 a Mumps pestilence broke out throughout the country, which affected especially the young generation (16-18 years old) that was not revaccinated according to the schedule. There was a massive admission to all municipal, republican and district hospitals. It is worth mentioning that besides the complications caused by the Mumps, in adults this infection may cause partial sterility (about 13% of complications), which may be observed in time, across the lifespan of those young people who have/had the disease. There were not initiated any legal actions or complaints regarding the failure to vaccinate. **(Case reported by the Ministry of Health)**

G) PRACTICE NOTES FOR LAWYERS

The lawyers are advised to consult the recommendations and guidelines on the methods of prevention and prophylaxis of certain diseases and the Orders of the Ministry of Health. Usually, these orders contain concrete instructions concerning the actions to be undertaken by the healthcare workers (for example, the family doctor) to ensure prevention of occurrence of certain diseases. It shall be carefully analysed whether these instructions were strictly followed by the healthcare workers to prevent diseases in the patient. The arguments of the opposing party, such as the lack of financial resources to purchase the vaccines or the impossibility to separate the infectious patients from those with non-transmissible diseases cannot serve as an excuse for the healthcare workers and the healthcare facilities that violated the prescribed rules, because the State has the obligation to prevent illnesses among the population and to ensure people's security, including against illness.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to Preventive Measures under the Right to the Highest Attainable Standard of Health in Chapter 2 on International Standards of Human Rights in Patient Care and Chapter 3 on Regional Standards of Human Rights in Patient Care.

6.1.2 RIGHT OF ACCESS

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right to healthcare services according to needs. The healthcare services must guarantee equal access to everyone, without discrimination by financial resources, place of residence, type of illness or time of accessing the services.

The right of access has many dimensions. The most important constituent of this right is the financial accessibility. However, geographical accessibility, elimination of discrimination, and ensuring adequate quality of services are of great importance as well, as their existence contributes to making the access effective.

Ensuring the adequate quality of services needs particular attention because ensuring access to services without ensuring adequate quality of those services does not help patients. Therefore, the right to access and the right to adequate quality are closely interrelated.

For instance, there is no real benefit from hypothetically having free access to ambulance services when the cars are not adequately equipped, and the staff is not appropriately trained to offer effective emergency services to the population.

The right of access to health services is supported by the Moldovan legislation. Financial accessibility to health services is determined by the provision of State health programs, which in turn are defined by the Law on State Budget, subject to annual approval by Parliament for the given year.

At the same time, the legislation of the Republic of Moldova includes concrete provisions against discrimination, also referring to the right to healthcare services.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The **Constitution of the Republic of Moldova**, by the **Article 36** guarantees the right to healthcare and the right to minimum health insurances provided free of charge by the State.

At the same time, equal access to healthcare services for all people, without discrimination, is guaranteed by **Article 16** of the Constitution, which stipulates the principle of equality of all citizens of the Republic of Moldova without any discrimination as to race, nationality, ethnic origin, language, religion, gender, political affiliation, personal property or social origin.

- ▶ **Law on Ensuring Equality no. 121 of 25.05.2012** also stipulates the principle of non-discrimination in medical healthcare. Equal rights are ensured to all people being on the territory of the Republic of Moldova, in political, economic, social, cultural areas and other spheres of life irrespective of race, skin colour, nationality, ethnic origin, language, religion or belief, gender, age, disability, views, political affiliation, and also on the basis of any other similar criterion. (**Article 1**)
- ▶ **Law on Healthcare of the Republic of Moldova no. 411-XIII of 28.03.1995** stipulates the principles of provision of healthcare services to the population.
 - *The right to health insurance without discrimination.* This is stated in **Article 17, paragraph 1**, which stipulates the right of the inhabitants of the country to health insurance, irrespective of nationality, race, social affiliation and religion.
 - Citizens of the Republic of Moldova, irrespective of their own income, are provided equal possibilities to benefit from opportune and qualitative healthcare services within the mandatory health insurance scheme.

- *Right to free choice.* The Law guarantees the right to free choice of the doctor, the healthcare facility and the form of medical care (**Article 25**).
- *Emergency medical care.* **Article 24** of the Law stipulates that persons are insured with emergency medical care in cases of danger for life (accidents, severe acute illness, etc.). Medical care is guaranteed to persons in extreme cases (calamities, disasters, accidents, illness and mass intoxications, ionizing and non-ionizing radiation, heavy pollution of the environment).
- *Marriage and family planning.* With the purpose to protect the health of people who get married and their descendants, the healthcare facilities provide prenuptial consultation on marriage and family planning, medical examination, free of charge, based on the informed consent of the person. Persons who get married, as well as their spouses, benefit from medical examinations and medical-genetic consultations, in relevant healthcare facilities, to detect genetic alterations in their genome, which lead to malformations in their future child. (**Article 46**)
- *Pregnant women and new-borns.* The healthcare facilities ensure qualified healthcare services to the woman during pregnancy, at birth, after birth and curative-prophylactic support to the mother and the new-born. (**Article 49**)
- *Children and teenagers.* The curative-prophylactic facilities (polyclinics, hospitals, dispensaries, sanatoriums, etc.) provide medical care to children and teenagers. They are periodically provided active medical surveillance. Early-age children are ensured special food products, including free of charge, as established. (**Article 50**)
- *Unemployed persons.* People having lost their jobs and income have the right to minimum health insurance ensured by the State free of charge to protect their health and the health of their dependents. (**Article 37**)
- *Elderly medical-social care.* The State shall ensure that elderly persons benefit from medical-social care according to certain medical-social rehabilitation programs, which are focused on the support of physical and psychological needs, the extension of the active life period, including in domestic conditions, the improvement of the capacity of social-psychological adaptation to the old age, the prevention of chronic affections and disabilities. (**Article 38**)
- *People with HIV/AIDS.* Medical and social care is ensured to people contaminated with the human immunodeficiency virus (HIV) and those suffering from AIDS. (**Article 41**)
- *Tuberculosis.* People suffering from tuberculosis are ensured with anti-tuberculosis preparations and undergo treatment in hospitals, sanatoriums and preventoriums, free of charge. (**Article 44**)
- *Arrest or detention.* People under arrest or detention are guaranteed medico-sanitary care according to the legislation in force. (**Article 39**)

It is worth mentioning that the **Article 169, paragraph (1), (e)** of the **Enforcement Code of the Republic of Moldova no. 443 from 24.12.2004** stipulates that the convicted is guaranteed the right to healthcare services.

- ▶ **Law on Mandatory Health Insurance no. 1585 of 27.02.1998**, in **Article 4** stipulates that the Government has the role of insurer, being obliged to insure the risk of illness for the following categories of people, residents of the Republic of Moldova and registered with the competent institutions in the country:
 - a) children of preschool age;
 - b) pupils in primary and secondary education;
 - c) pupils in secondary vocational education;
 - d) students in secondary specialized education (colleges) attending full-time studies;
 - e) students in higher education attending full-time studies;
 - f) residents in postgraduate education and doctoral students attending full-time studies;
 - g) children not enrolled in education till the age of 18;
 - h) disabled people;
 - i) pregnant, parturient and postpartum women;

- j) pensioners;
- k) unemployed people receiving unemployment allowance;
- l) people who take care of a child with disabilities of severity I or of a person with disabilities of severity I since childhood bedridden at home;
- m) mothers of four and more children;
- n) persons living in disadvantaged families who benefit of welfare support according to the Law no. 133-XVI of 13.06.2008 on the welfare support.

Insured people can be citizens of the Republic of Moldova or foreign citizens and stateless people having residence in the Republic of Moldova, employed based on an individual labour agreement in the Republic of Moldova, or foreign citizens and stateless people having the residence in the Republic of Moldova for whom there was paid the mandatory health insurance in the amount and within the term set by the legislation (**Article 9**).

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005**, in **Article 5** explicitly stipulates the right of the patient to healthcare services. Thus, the patient is entitled: to benefit free of charge from nursing in the volume set by the law; to relief of suffering and to alleviation of pain caused by an illness and/or medical intervention; to appeal to alternative medical opinions and to consulting several specialists; to health insurance (mandatory or voluntary); to examination, treatment and proper conditions of sanitary-hygienic norms. The right of the patient to a respectful and human attitude from the part of healthcare providers, irrespective of age, sex, ethnic affiliation, social-economic status, political and religious beliefs is also stipulated.

The fulfilment of patient's social rights to healthcare is determined by ensuring equitable access to healthcare services of the highest attainable quality that the society is able to guarantee with the human, financial and material resources available, according to the legislation in force (**Article 8**). Thus, the legislation in force describes the means of access of the population to various healthcare services. The unlimited access and registration with the family doctor services and, when possible, the right to choose the family doctor is guaranteed to every patient (for example, the lack of doctors in a village may limit the exercise of this right).

The free of charge access to emergency services is ensured by the family doctor or in outpatient or inpatient healthcare facilities within the limits of the patient's location.

- ▶ **Law on the Practice of the Medical Profession no. 264 of 27.10.2005**, in **Article 18**, stipulates that the doctor-patient relationship is founded on respect and mutual confidence, on the right of the patient to an option, exercised according to the legislation in force.

The obligation of healthcare workers to provide access to healthcare services is stipulated in Chapter 7 of this Guidebook.

- ▶ **Law on Prevention and Control of HIV/AIDS no. 23-XVI of 16.02.2007**, in **Article 25**, stipulates the right of every individual to equal access to medical services, regardless of perceived or actual HIV status. The refusal of hospitalization, admission, or access to healthcare services of HIV positive persons is not allowed in public, departmental or private healthcare and balneal facilities; neither is charging of higher fees to provide this kind of services.

The citizens of the Republic of Moldova, foreign citizens and stateless persons who live or temporarily reside on the territory of the Republic of Moldova are ensured the access to medical examination free of charge (including anonymously) with the aim to early detect the HIV virus and AIDS pestilence. (**Article 11**)

All pregnant women shall have access to free counselling and testing of HIV markers. Pregnant HIV positive women and their new-born children are guaranteed the access to ARV prophylactic therapy provided free of charge. (**Article 21**)

HIV positive persons are entitled to ARV treatment, provided free of charge, and treatment of opportunistic infections, according to the clinical-immunological indications. Persons infected with HIV and suffering

from AIDS are entitled to medical care based on the Unique Program of Mandatory Health Insurance, according to the legislation in force. **(Article 19)**

Children and youth affected by HIV/AIDS shall have equal rights as their peers to access to educational and HIV/AIDS Prevention programs, social and legal protection, as well as care and treatment, which they require as a result of their status. HIV positive women have the benefit of free contraception methods, including voluntary sterilization subsequent to thorough counselling. **(Article 6)**

Prisoners are entitled to free of charge ARV treatment and treatment for opportunistic infections. **(Article 9, (c))**

- ▶ **Law on Tuberculosis Prevention and Control no. 153 of 04.07.2008**, in **Article 17**, stipulates that when providing anti-tuberculosis medical care, the persons registered in relation to tuberculosis and consumptives are entitled to:

- diagnostic and treatment in anti-tuberculosis specialized healthcare facilities or in outpatient conditions, depending on the manifestation of the disease and the sanitary-hygienic conditions available;
- admission in an anti-tuberculosis specialized healthcare facility for a period necessary for investigations and/or treatment;
- anti-tuberculosis medical care in conditions which meet the sanitary-hygienic requirements and the anti-epidemic regime;
- benefit of medical examination, investigations of diagnosis and chemotherapy, prophylactic vaccination against tuberculosis, medicinal preparations necessary for the treatment, all provided free of charge, in the anti-tuberculosis specialized healthcare facility or in outpatient conditions.

- ▶ According to the **Law on Reproductive Health no. 138 of 15.06.2012**, men and women have equal access to all medical services for the protection of reproductive health which are described in the law's articles.

Teenagers have the right to information and access to medical services for the protection of the reproductive health adjusted to their needs. **(Article 6)**

Women and men of the third age (elderly population) are entitled to benefit from high quality services for the protection of sexual health. **(Article 7)**

Persons are entitled to infertility treatment, including with the use of technologies of medically-assisted human reproduction. **Articles 9-13** of this Law describe the conditions of using the medically-assisted human reproduction technologies.

Every person has the right to use contraception methods and to advisory support on choosing a contraception method, taking into consideration the health condition, the age and the individual particularities. **(Article 5, (d))**

Every couple, and every single woman, shall benefit from free of charge access, in safe conditions, to prenatal, delivery and new-born, and postnatal care, irrespective of the payment or non-payment of mandatory health insurance and regardless of whether the respective service has or has not an emergency character. **(Article 5, (j))**

- ▶ **Law on Child Rights no. 338 of 15.12.1994** guarantees the right of the child to life and to physical and psychological inviolability. The State recognizes the right of the child to the use of best technologies in the treatment, recovery and prophylaxis of diseases. **(Article 4)**

- ▶ **Law on Social Inclusion of People with Disabilities no. 60 of 30.03.2012** guarantees the right of persons with disabilities to a respectful and human attitude from healthcare providers, without any discrimination by disabilities criteria. **Article 42** describes the right of disabled persons, which includes the access to:

- a) pertinent and qualitative medical care within the system of mandatory health insurance;

- b) the provider of primary healthcare services and the family doctor at patient's choice;
- c) individual treatment and medical care;
- d) healthcare services provided throughout the country, in the community (at the place of residence) and in specialized healthcare facilities, provided that, according to medical indications, the outpatient medical care is inefficient or unavailable;
- e) healthcare services in the quantity and quality stipulated in the Unique Program of Mandatory Health Insurance;
- f) healthcare services, provided that they are citizens of the Republic of Moldova living abroad, according to international treaties and agreements to which the Republic of Moldova is party.

Central and local public authorities organize and contribute to the establishment and development of the system of medical and social rehabilitation of persons with disabilities to help them achieve and maintain an optimal level of physical, intellectual, psychological and/or social activity, while providing them with the means to change their lifestyles and achieve greater independence. The persons with disabilities are entitled to free or partially paid sanatorium and spa recovery, if this is provided in the individual programme for social rehabilitation and inclusion and is done in line with the regulations approved by the Government. **(Article 43, paragraph 1, 3)**

► **Law on Mental Health no. 1402 of 16.12.1997**, in **Article 5** stipulates that when providing psychiatric care, the person suffering from mental disorders is entitled to:

- all types of treatment (including balneal-therapeutic) according to therapeutic indications;
- psychiatric care in conditions which meet the hygienic and sanitary standards;
- require the invitation of any specialist, with the consent of the patient, to participate in providing psychiatric care or to be part of the medical commission for the issues regulated by the present law.

Minor persons suffering from mental disorders enjoy all rights and freedoms of the citizens stipulated in the legislation **(Article 5¹)**.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

The Directive of the Ministry of Health on the organization of the access to healthcare services no. 611-d/2010

D) PROVISIONS IN THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers, Chapter I** stipulates the obligation of the medical and pharmaceutical worker to observe the right of the human being to life and dignity, without any discrimination as to age, sex, race, ethnicity, religion, nationality, social condition, ideology, politics or for any other reasons, both during peace and war periods.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The Family Doctor Centre from the locality D. has a specified number of physicians according to needs and the number of the population. The Centre is equipped with diagnostic equipment and

has a laboratory equipped with up-to-date equipment. The patients are pre-emptively scheduled for consultation with the doctors. The Centre provides diagnostic and treatment services in outpatient clinics and implements information and education programs in the health field, programs on immunization, and regular measures on prevention and screening. If necessary, in cases of complicated diseases, specialized physicians from specialized centres are invited for consultation. The access to primary healthcare services is insured to all persons from that locality, irrespective of age, social or economic status.

2. Examples of Breach

- ▶ The Romani patient R. asked for emergency medical care from the healthcare facility. The patient had a leg broken in a conflict with the neighbours. The doctors on duty were providing care to other persons who were asking for nursing, ignoring patient R., who had to wait without being consulted for 3 hours in the corridor of the institution. When the patient asked for consultation, one of the medical workers answered: "You gypsies, first of all don't be so aggressive and pugnacious... and you won't need us. But now, wait here, that's what you deserve, so that you calm down a little". Finally, the patient received medical care but with a significant delay (**from author's practice**).
- ▶ Mrs. D. suffers severe food poisoning intoxication. She requires the assistance of emergency medical service. The doctor arrives at Mrs. D's home and initiates the procedure of gastric lavage. Mrs. D. informs the doctor that she has HIV. When finding out this information, the doctor takes the instruments and leaves, refusing to continue providing medical care and arguing that patients with HIV shall be provided medical care in specialized facilities. At the request of the patient to be taken to one of these facilities where she could benefit assistance, the doctor brutally answers that he was not the taxi service. The patient did not make complaint to any authority (**from author's practice**).

3. Actual Case

- ▶ ***The Council on the Prevention and Elimination of Discrimination and Ensuring Equality reviewed the case 021/13 (Decision of December 27th, 2013), initiated based on the complaint of Ms. R. T., addressed to "Z" District Hospital and the Ministry of Health of the Republic of Moldova, regarding discrimination on HIV criteria in having access to healthcare services.***

The Council reviewed the steps taken by the doctor, as well as the contents of the Order no. 100 of the Ministry of Health. The Council ruled that there had been no discrimination on the doctor's part; however, Order no.100 of the Ministry of Health violates the principle of equality, unduly limiting the access of HIV positive pregnant women to healthcare services related to delivery, forcing them – regardless of their place of residence – to request medical care only in Chişinău and Bălţi. In its conclusions, the Council stated that *'[...] the Order no. 100 of the Ministry of Health comes into conflict with the standards developed by the UNO Committee on Economic, Social and Cultural Rights, which explained in its General Comment no. 14 that any person has the right to the highest attainable standard of health that includes mandatory elements of ensuring this right, such as availability, accessibility, non-discrimination, acceptability and quality. Accessibility refers to physical access, i.e. there must be easy safe access to healthcare institutions, goods and services for all population groups, particularly the vulnerable or marginalized ones, such as ethnic minorities, women, children, teenagers, elderly, disabled people and people living with HIV and AIDS. As for accessibility in economic terms, the prices of healthcare services should not impede the person to request the necessary medical care and discrimination should be prohibited, i.e. healthcare institutions, goods and services must be accessible to all, de jure and de facto, especially to the most vulnerable or marginalized groups of population, without discrimination based on any of the prohibited grounds. The Council is not aware of any other order of the same nature and for the same purpose, which would limit the access of pregnant women with hepatitis or other infectious*

diseases to medical care at the time of delivering only in the cities of Chişinău and Bălţi; hence, the Council admits as legitimate the petitioner's argument that the Order no. 100 of the Ministry of Health is discriminatory, namely treats less favourably the HIV positive pregnant women if compared to pregnant women with hepatitis or other infectious diseases when it comes to equal access to healthcare services at delivery. The Council also notes that the Ministry of Health indirectly acknowledges this by declaring that 'the order in question has not undergone legal review and was not published in the Official Gazette, which confirms the absence of legal provisions regulating any rights, obligations or restrictions of citizens. Moreover, once the Law on HIV/AIDS Prevention no. 23 of 16.02.2007 was adopted, all conflicting legal provisions have become obsolete [...].'

G) PRACTICAL NOTES FOR LAWYERS

To claim the violation of some of the rights guaranteed by the Constitution and the National Law (the right to live in a healthy environment, the right to health insurance, for example), lawyers should seek expert medical opinions proving that the medical treatment a person received did not comply with the medical standards established by the State.

Evidence (records, witnesses) shall be provided which confirms the refusal of the doctor to provide medical care and the reason of the refusal, to invoke in the court a determination of the restriction of access to healthcare services. In a case when the doctor orally refused to treat the patient, a written request shall be addressed to the respective institution to issue in writing the reasons for not providing the requested medical care.

Additionally, the lawyers representing patients should require from the criminal investigative body or from the court, as appropriate, that a forensic expertise be carried out by a commission with the invitation of an independent expert to establish a causal relation between the non-provision of medical services and the subsequent consequences.

It should be taken into account that the discrimination can be manifested in many forms:

Article 2 of the **Law on Equality no. 121 of 25.05.2012** stipulates that:

- *direct discrimination* is a person's treatment based on any prohibitive criteria in a manner less favourable than the treatment of another person in a comparable situation;
- *indirect discrimination* involves any apparently neutral provision, action, criterion or practice, as a result of which one person becomes disadvantaged over another person based on the criteria stipulated in this Law, except where that provision, action, criterion or practice is objectively justified by a legitimate purpose and if the means for achieving that purpose are proportionate, appropriate and necessary;
- *discrimination by association* is any act of discrimination committed against a person who, although not part of a group of people identified according to the criteria stipulated in this law, is associated with one or more persons belonging to such group of people;
- *racial segregation* is any act or omission leading directly or indirectly to separation or differentiation of individuals on the grounds of race, colour, national or ethnic origin;
- *harassment* is any unwanted behaviour that leads to the creation of an intimidating, hostile, degrading, humiliating or offensive environment, with the purpose or effect of violating the dignity of a person based on the criteria stipulated in this law;
- *incitement to discrimination* is any behaviour whereby a person applies pressure or displays intentional conduct in order to discriminate against a third party based on the criteria stipulated in this law;

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please see a discussion on international and regional standards relevant to the Right to Access under the Right to Non-Discrimination and Equity in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

6.1.3 RIGHT TO INFORMATION

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right to access to all kind of information regarding their state of health, the health services and how to use them, and all that scientific research and technological innovation makes available.

This right is enforced through the "general legislation" in the Law on Healthcare and the Law on Patients' Rights. Moreover, provisions ensuring citizens' right to information relevant to their health are included in specific laws on Mental Health, on HIV/AIDS Prevention, on Transplantation of Human Organs, Tissues and Cells, and others. Finally, the Law on the Professional Activity of Doctors defines the duties to provide patients and/or their relatives with information about the health condition, and the treatment proposed to the patient.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ **Article 34** of the **Constitution of the Republic of Moldova** expressly refers to a person's right to information and access to information, both public and personal or private, that cannot be restricted. The media agencies, State or private, are obliged to provide correct information to the public.
- ▶ **Law no. 982-XV of 11.05.2000 on Access to Information** describes the general principle of access to information of public interest and to personal information. Any person has the right to access to personal information. He/she may take note of this information personally or in the presence of another person to clarify this information in order to ensure completeness and accuracy of it; if necessary, to rectify or remove it when it is used improperly; to find the purpose of use of this information; to make copies of the documents containing information about himself/herself. **(Article 8, paragraph 5)**
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** provides the patient's right to request and to receive information on his/her health condition. Besides the fact that patients have the right to know the objective information regarding their condition, during a medical examination and treatment they have the right to information on the medical procedures to be performed, their potential risk and therapeutic efficacy, on alternative methods, the same as on diagnosis, prognosis and course of treatment, and on preventive recommendations. Patients have the right to consult their objective data recorded in medical records or other documents concerning them. In cases when it could cause serious damage to the physical or mental condition of the patient or compromise the treatment outcomes, the above information will be given to a person close to the patient. **(Article 27)**

The patient has the right to request information from doctors or the medical institution in writing. The procedure for the issue of information in written by healthcare workers is described in Chapter VII of this Guidebook.

However, regarding the rights of children/teenager patients to receive information on all medical proce-

dures, the beneficiaries of this law are, by law, the parents, guardians or curators. **(Article 50)**

- ▶ **Law on the Patient's Rights and Responsibilities no. 263 of 27.10.2005** stipulates that patients have the right to exhaustive information on their health, the methods of diagnosis, treatment and rehabilitation, prevention, and on the potential risks and their therapeutic effectiveness. **(Article 5, (i))**

It is important, given the express provisions of the law, for the patient to receive the information regarding all medical procedures in a more accessible language; depending on the patient's level of understanding, the physician informing the patient should not use medical terminology which is not understood by the patient; and if the patient does not know the State language, the physician will seek another form of communication. **(Article 11, paragraph 5)**

The patient has the right to information, education and services necessary for a normal sexual life and reproductive health, without any discrimination **(Article 9, paragraph 3)**.

- ▶ **Law on Mental Health no. 1402 of 16.12.1997** guarantees that in case of psychiatric care, a person suffering from a mental disorder has the right to information on his/her rights, the nature of the mental disorder and treatment methods in an accessible way, taking into consideration his/her mental condition **(Article 5, (b))**.

The law describes the conditions in which patients suffering from mental disorders will be informed. To exercise their legitimate rights and interests, persons suffering from mental disorders or their legal representative may obtain any information on the delivered mental health and the psychiatric care **(Article 9)**.

- ▶ **Law on Social Inclusion of People with Disabilities no. 60 of 30.03.2012** stipulates that during the medical examination and treatment, the disabled person is entitled to request information about the medical procedures applied, the potential risk posed by such medical procedures and their therapeutic effectiveness, and alternative methods as well as the diagnosis, prognosis and progress of treatment and prophylactic recommendations in an accessible format. **(Article 42, paragraph 11)**

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates that every person has the right to truthful information concerning the rights and obligations in the field of reproductive health and reproductive health condition, including the results of medical investigations, prognosis, treatment methods, related risks, possible medical interventions, consequences and results of the treatment performed. **(Article 4, paragraph 1, (e))**

Article 6, paragraph 1 of the Law stipulates that teenagers have the right to information and access to reproductive healthcare services that meet their needs.

- ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** states that in receiving care for TB, patients have the right to information on their rights and obligations, in an accessible way, on the nature of the disease they are suffering from, the methods of investigation and the treatment administered **(Article 17)**.

- ▶ **Law on HIV/AIDS Prevention no. 23-XVI of 16.02.2007** states that where a person will require an HIV test, counselling must be ensured before and after the test, during which the tested person will be informed on the HIV infection in general and on test results.

- ▶ **Law on Medicines no. 1409 of 17.12.1997**, in **Article 12**, describes the protection of patients and volunteers involved in clinical trials. Patients, volunteers or their legal representatives will be informed about the content of the tests, the drug properties, the expected effect, the possible consequences and the degree of risk for the patient or volunteer.

- ▶ **Law on Transplantation of Organs, Tissues and Cells no. 42 of 06.03.2008** states the right of living donors to be informed on the necessary tests to determine the compatibility of the donor, on the purpose

and nature of sampling, and on the possible consequences and risks. The recipient has the right to be fully informed about the nature of the procedure and the possible risks and consequences. Close relatives of the deceased donor will be informed about the need for compatibility testing of the donor and the consequences of testing. Written, verbal or otherwise expressed refusal of the minor prevents any sampling. **(Article 24)**

Sampling of tissues or regenerative cells from minors can be done only with the consent of the supervisory authority or each of the legal representatives of the minor. Written, verbal or otherwise expressed refusal of the minor prevents any sampling **(Article 19)**.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

Order of the Ministry of Health of the Republic of Moldova no. 303 of 06.05.2010 on access to information concerning one's own medical data and the list of medical interventions that require Informed Consent (MoH no. 108-109/382 of 29.06.2010). Through an Ordinance, the *Instruction on the way of issuing information on the patient's personal medical data* was approved. The instruction regulates the release of information from medical records by healthcare providers, regardless of the legal form of organization, in order to ensure patients' access to their medical data and to ensure the confidentiality of information relating to medical secrecy. Responsibility for carrying out this instruction refers to healthcare providers, as described in Chapter VII of this Guidebook.

D) PROVISIONS OF THE CODE OF ETHICS

The obligation of the medical and pharmaceutical personnel to observe the patient's right to information on his/her health condition, treatment and preventive and diagnostic measures is stipulated in **Chapter V** of the **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers**.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- After applying for healthcare services, patient X. was informed by the doctor about the need for the medical investigation to be performed for establishing the diagnosis. Later, the test results were described in a language that could be understood by the patient and the established diagnosis was explained. The patient's disease can be treated surgically, but there are good results in therapeutic treatment without surgery. The physician explains to patient X. the options, their risks and benefits. The patient is given time to think and to make a decision. Along the way, the patient asks the doctor questions and receives answers that he understands.
- In a medical institution, in public spaces, information is available with regard to health risk factors, the need for prevention, and prophylaxis measures, there are described the means to avoid certain diseases. The information is provided in all languages spoken in the locality, in a way accessible for the population. Additional sources of information are provided that can be taken by people (brochures, leaflets). In the institution there is an office for information, where people can come if they have further questions regarding the risks for their health and the means for the disease prevention. Contact information of this office (phone, location) is displayed in places visible to the public.

2. Examples of Breach

- The doctors refuse to provide details to the patient about his/her health condition, claiming that s/he does not have enough medical knowledge to understand what his/her diagnosis means, and also claiming that not knowing how advanced his/her disease is would protect him/her from stress. **(Hypothetical)**
- The oncologist discusses a possible intervention for radical resection to be performed on the patient with a colon tumour only with the patient's son, notwithstanding the patient being a fully conscious man aged 56. After the surgery the patient was surprised and revolted that they had opted for a stoma exteriorization (the intestine was brought out through a hole in the abdominal wall) without having discussed the decision with him in advance. **(Hypothetical)**
- Teaching staff is forbidden to discuss with high-school students about reproductive health issues, as it would promote immoral behaviour among young people. **(Hypothetical)**

3. Actual Case

- The Council on the Prevention and Elimination of Discrimination and Ensuring Equality reviewed the case no. 087/14 (*Decision of July 4th, 2014*), initiated by self-intimation to the Psychiatric and Neurological Residential Facility in Bălți, the Perinatology Centre in Bălți and the Ministry of Labour, Social Protection and Family, addressing the alleged gender and disability discrimination in ensuring the right to protection of private life and family, the right to physical integrity and access to medical information and reproductive health services of the beneficiaries of the psychiatric and neurological residential facility in Bălți. The Council reviewed the biases of medical staff regarding women with disabilities when it comes to their right to privacy through access to information about reproductive health. The case was started pursuant to the publication of a journalistic investigation regarding the Psychiatric and Neurological Residential Facility in Bălți in the newspaper Ziarul de Gardă.

In its conclusion the Council stressed that *'[...] any woman with disabilities, regardless of the type of disability and personality, has the right to respect for her dignity and to enjoyment of the right to healthcare services, including with regard to sexual and reproductive health. [...] The definition of reproductive health is also found in the Law no. 185 on Reproductive Healthcare and Family Planning, which lays down the legal foundation for free enjoyment by every person of his/her reproductive rights and of family planning services. Sexual health is defined as the physical, emotional, mental and social well-being in terms of sexuality; it is not about the absence of diseases, dysfunctions or infirmity only. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having satisfactory and safe sexual experiences, without coercion, discrimination and violence. [...] The Council has not received a clear answer why the beneficiaries of the services of the Psychiatric and Neurological Residential Facility in Bălți do not have access to information about their reproductive health and why they do not have access to contraceptives. The story of plaintiff M. G. clearly shows that abortion is used by the facility as a method of contraception. [...] The Psychiatric and Neurological Residential Facility and the Perinatology Centre are reluctant to provide services to the women with disabilities who want to start a family and have children. They are treated solely as a patient having the stigma of disability, which leads to a stereotyped image of women with disabilities. [...] Besides, the prevailing approach is to deny women with disabilities the enjoyment of their right to make decisions concerning their own health. The Council was informed that a relative or the facility staff used to decide instead of the woman whether the pregnancy should be terminated, the pregnant women being excluded from the decision-making process as such. [...]*'.

G) PRACTICAL NOTES FOR LAWYERS

It should be kept in mind whether the patient had access to information about his/her health condition. This point is very important to determine if the patient has a real possibility to take an informed decision

on the treatment and interventions proposed. However, we must consider the extent and modality of the patient's information and how it was adjusted to the degree of understanding of the patient. The mandatory written informed consent should be collected by the doctors, which necessarily has the informational part and the approval (signature) of the patient. (More information on the informed consent is contained in the next patient right discussion below.)

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to Information in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

6.1.4 RIGHT TO CONSENT

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right of access to all information that might enable him or her to actively participate in the decisions regarding his or her health; this information is a prerequisite for any procedure and treatment, including the participation in scientific research.

The right to consent is the core of patients' rights, and is based on or is derived from the principle of observance of the autonomy of the patient, and, in a broader sense, from the principle of respect for persons and the dignity of individuals. The right to consent (informed consent) in general terms is explicitly outlined in the Law on Healthcare, and is further specified in the Law on the Patient's Rights and Responsibilities and a number of specific laws regulating different branches of medicine (transplantation, HIV/AIDS, and mental health, for example).

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The ***Constitution of the Republic of Moldova*** stipulates the right of every person to physical and mental integrity. This right is manifested by the patient's freedom to express voluntary consent for his/her healthcare provider performing a medical act. However, in **paragraph (2) of Article 51**, which refers to rights of persons with disabilities, it is stated that nobody can be subjected to forced medical treatment except in cases approved by the law.
- ▶ ***Law on Healthcare no. 411-XIII of 28.03.1995*** sets out the right of the patient to express his/her consent for using methods of preventing a disease, diagnostic and treatment, as well as for using new medication. **Article 23** of the Law requires a patient's consent for any proposed medical procedure for prevention, diagnostic, treatment and recovery. The consent of a patient with temporary or permanent lapses of judgment shall be expressed by the legal representative or a close relative of the patient.

The consent or refusal of the patient or his/her legal representative shall be certified in writing by the signature of the physician or the panel of the doctors on duty; in exceptional circumstances the signature of the management of the facility shall be required. (**Article 23 paragraph 7**)

To express consent, the patient must be able to think clearly and have preserved discernment. For the patients younger than 16 or who are mentally ill, parents, a guardian or a curator shall provide consent in writing. (**Article 28, paragraph 2**)

Every person shall express in writing his/her consent for performing surgical sterilization, which should only be voluntary, at the person's request or at the doctor's recommendation. **(Article 31)**

Coercive treatment

The Law provides situations in which patients can be treated without their consent, coercively. This category includes patients with active tuberculosis who evade voluntary treatment, patients who violate the prescribed diet or are abusing alcohol or using illicit drugs **(Article 42)**, mentally disordered patients without discernment who can endanger their own or another person's life or physical integrity **(Article 44)**, and patients with venereal diseases who avoid examination and medical treatment **(Article 45)**.

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005**, in **Article 13** describes in detail how to obtain the patient's informed consent or voluntary refusal for the medical intervention. For high-risk medical interventions (invasive or surgical) the consent shall be compulsory, provided in writing by filling in a special form called an informed consent form. The patient's written consent is required for the sampling, storage and use of all biological products taken from his/her body, including organs and tissues for transplantation. Patient's consent is required where these biological products are used for diagnostic or treatment with which the patient agrees.

Patients cannot be photographed, filmed or exhibited in any other form as study objects in a healthcare institution without their own or their legal representative's (close relatives) written consent. **(Article 13, paragraph 10)**

Patient's consent is required in case of participation in a clinical medical training. **(Article 14)**

- ▶ **Law on HIV/AIDS Prevention no. 23-XVI of 16.02.2007** stipulates that HIV testing is done upon written, voluntary and informed consent of the person.

There is a difference concerning the agreement of minors. The law stipulates that HIV testing of minors is done both based on the written consent of the minor and his/her legal representative and, if it is impossible to obtain the consent of the representative, the written voluntary consent of the minor person is sufficient. **(Article 13)**

- ▶ **Law on Mental Health no. 1402 of 16.12.1997** stipulates that psychiatric care is provided upon the voluntary request of the patient, except in the cases provided by law. For persons aged less than 18 and persons declared incompetent as provided by law, psychiatric care is provided at the request or with the consent of their legal representatives in accordance with the present law. **(Article 4)**

Treatment, psychiatric examination, and hospitalization of persons suffering from mental disorders are provided only with their consent. **(Articles 4, 5, 11, 22, 27)**

In exceptional cases established by legislation, medical actions towards people with mental disorders will apply even without their consent.

Exceptional situations:

- Treatment can be carried out without the free consent of the person suffering from mental disorders or his/her legal representative only if applying coercive medical measures, in accordance with the **Criminal Code** and in case of hospitalization without free consent in accordance with **Article 28** of the Law on Mental Health. In such cases, except emergencies, treatment is done in accordance with the decision of the commission of psychiatrists. **(Article 11, paragraph 4)**
- Psychiatric examination can be performed without the consent of the person or his/her legal representative in the case where the person performs actions that serve as the basis for the assumption of a serious mental disorder that causes immediate danger to himself/herself or others and/or serious damage to his/her health if psychiatric care is not provided. **(Article 22, paragraph 4)**

- ▶ **Article 42** of the **Law on the Social Inclusion of People with Disabilities no. 60 of 30.03.2012** provides that the participation of disabled people in decision-making about their personal health condition shall be ensured in all cases, except for the cases when there is a serious threat to their health or life. The people with disabilities shall express consent with medical interventions themselves, certifying their informed consent or voluntary refusal, in line with actual the law in force.

- ▶ **Law on Tuberculosis Control and Prevention no. 153 of 04.07.2008** provides that for anti-tuberculosis medical care it is necessary to have the consent of the patient, except for cases provided by legislation and regulations in force. **(Article 13, paragraph 1)**

Thus, the patient with a contagious form of tuberculosis who breaches a sanitary and epidemiological regime or evades the anti-tuberculosis treatment is admitted, pursuant to a court judgment for coercive treatment, in a specialized phthisiopneumologic establishment. **(Article 15)**

Consent for anti-tuberculosis care for children up to 18 years old and persons declared unable to provide consent is given by their legal representative **(Article 13, paragraph 2)**

- ▶ **Law on Transplantation of Human Organs, Tissues and Cells no. 42 of 06.03.2008** requires compulsory consent of persons for organ donation. **Article 13** describes the conditions of removal from cadavers, which is possible only if there is consent of the person before death, expressed in accordance with the law. If consent is absent, the donation is possible if there was no written refusal for donation by at least one adult family member, another 1st degree relative or the legal representative of the deceased.

In **Article 15**, the conditions of sampling organs, tissues and cells from living persons are described. This is possible only when people have full legal capacity and only if there is a written, free, prior and express consent on those conditions. The consent is signed only after the donor was informed by the physician about the potential risks and the physical, psychological, familial and professional consequences of the act of sampling.

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** provides that every adult woman and every adult man are free to decide on the number of their children and the time of their birth, as well as the issues related to reproductive health, without coercion and without external influence. **(Article 4, paragraph 2)**

Surgical contraception methods. Voluntary surgical contraception methods can be applied only upon request and based on the informed consent of the person **(Article 5, (e))**.

Minors aged less than 16 years. In the case of minors aged less than 16 years, the voluntary consent for reproductive healthcare services is expressed both by the minor and his/her legal representative. In case it is impossible to obtain the consent of the legal representative of the minor and medical services are necessary for minor's life and health, the minor's voluntary consent is sufficient. In this case, the decision is taken after the healthcare providers' advice in the best interests of the child, in accordance with the regulations of the Ministry of Health. **(Article 6, paragraph 6)**

Consent for use of medical assistive technologies. The use of medical assistive technologies of human reproduction is possible only based on the written informed consent of patients, which will include complete and accurate information about the essence of the medical assistive technologies of human reproduction to be used, the medical and legal aspects of the procedures to be performed, the associated risks, the side effects and possible complications, the expected results of the administered treatment and the factors on which the outcome depends. In the field of medically-assisted human reproduction, the application of medical assistive technologies of human reproduction without consent of the person is prohibited. **(Article 9, paragraph 4, 10)**

Legally married spouses and medical assistive technologies. A man and woman in a legally-registered marriage have the right to use medical assistive technologies of human reproduction with the mutual agreement of the spouses. The written informed consent of infertile couples is a prerequisite for achieving an in vitro fertilization program. If married or cohabiting couples, the written consent of both partners is mandatory. For solitary women, only their written consent is enough. **(Article 11, paragraph 6, 7, 8)**

Sexual cells and embryo donation. In sexual cells and embryo donation a voluntary informed consent, signed by the donor (donors) is mandatory, including: a description of the peculiarities of the medical procedure to be performed, information about the potential risks of side effects and possible complications, and the legal consequences of the donation. **(Article 12, paragraph 6)**

Cryopreservation of sexual cells and embryos. A written informed consent of patients is mandatory in cryopreservation of sexual cells and embryos, and this consent document will include information about the cryopreservation method, storage conditions and terms for preserved sexual cells and / or embryos. **(Article 13, paragraph 6)**

- ▶ **Law on Medicines no. 1409 of 17.12.1997**, in **Article 12** provides that clinical testing is performed only with the written consent of the patient or volunteer, and if the patient is a minor or legally incompetent person - with the written consent of his/her legal representative.

Children's Right to Consent

According to the **Civil Code of Moldova (Law no. 1107 of 06.06 2002)**, full legal capacity commences on the date when the individual reaches the age of majority, i.e. when (s)he turns 18.

Underage persons who are 16 years old can be recognized as having full legal capacity if they work under an employment agreement or run their own business, with the consent of their parents, adoptive parents or guardians. A minor is assigned emancipation by the decision of the guardianship authority, with the consent of both parents, adoptive parents or guardians, or, in the absence of such consent, by court order. **(Article 20, paragraph 3)**

An underage person above the age of 14 may conclude legal acts with the consent of his/her parents, adoptive parents or guardians, and also, in cases provided by law, with the consent of the guardianship authority. **(Article 21)**

All legal acts for and on behalf of the child under the age of 14 can only be concluded by his/her parents, adoptive parents, or guardians **(Article 22)**.

Guardianship and curatorship

- **Guardianship** is assigned over persons who do not have legal capacity and over children under the age of 14, as the case might be. The guardian is the legal representative of the person under guardianship and is entitled to conclude all necessary legal documents as proxy, on behalf of the person and in his/her interest. **(Article 33)**
- **Curatorship** is assigned over persons aged between 14 and 18 and over individuals with legal capacity limited by the court due to abuse of alcohol, drugs and other psychotropic substances. The curators consent to the conclusion of legal documents by the individuals who are under guardianship and are not entitled to conclude legal acts on their own. The curators help the persons under guardianship in enjoying their rights and meeting their obligations, and protect them against abuse of third parties. **(Article 34)**

The patient may express his/her consent **at the moment of reaching the age of 16**. If the patient is under 16, the consent is given by his/her legal representative. In case of imminent danger of death or serious threat to health, medical care may be provided without the consent of the legal representative. To give consent, the patient must be capable of lucid reasoning and have clear judgment; in the case of children under the age of 16 or mentally ill persons, their parents, guardians or curators shall provide consent in writing. **(Law on Healthcare no. 411-XIII, Article 28)**

For reproductive healthcare services to **minors under 16**, consent must be expressed both by the minor and his/her legal representative. If there is no possibility to get the consent of the minor's legal representative, and when healthcare is needed to preserve the patient's life and health, the consent of the underage patient suffices. **(Law on Reproductive Health no. 138, Article 6, paragraph 6)**

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

Order of the Ministry of Health of the Republic of Moldova no. 303 of 06.05.2010 on Ensuring Access to Information Regarding Personal Medical Data and the List of Medical Interventions that Require Informed Consent. Obligation to observe the provisions of this Order is described in Chapter 7 of this Guidebook.

D) PROVISIONS OF THE CODE OF ETHICS

The obligation of a medical worker to obtain the patient's informed consent for each planned medical intervention is described in **Chapter VII** of the **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers of the Republic of Moldova**. These provisions are described in Chapter 7 of this Guidebook, which refers to the rights and responsibilities of healthcare providers.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The patient D. needs a surgical operation due to acute appendicitis. His doctor, Dr. M., concluded that the patient is in a condition to understand all relevant information, has a clear mind, and is able to make an informed decision. He asks if the patient wishes to discuss his situation in the presence of his wife. Mr. D. answers positively, so his wife is invited to join them. Then Dr. M. discusses with the couple Mr. D' health situation, and gives them all the information about the diagnosis, the treatment needed, the risks and benefits associated with the proposed surgery, as well as the financial aspects, and the expected results of non-treatment. After asking some questions to Dr. M. and clarifying issues related to the anaesthesia and the post-surgery care, Mr. D. gives his consent in written form (**Example collected by the authors**).

2. Examples of Breach

- A young couple, Mr. N. and Mrs. A. visited a gynaecologist for family planning consultation. The young couple would like to have children later and seek medical advice in choosing the most efficient and reliable method of contraception. The doctor knew that both partners were HIV-positive and personally was categorically against this couple's having children. The gynaecologist recommended tubal ligation as one of the most effective and safe methods without negative impact on the woman's health, as, for example, pills. Both partners accepted this method and soon Mrs. A was sterilized. The doctor avoided saying that this form of sterilization is irreversible and that the couple would not be able to have children in future. (**Case collected by the authors**)
- The patient F. needs a surgical operation due to a benign tumour. Dr. K. concludes that the patient has a clear mind and is in condition to understand all relevant information. However, he decides not to bother the patient, and discusses the situation separately with the patient's wife. He gives her all information about her husband's health condition, the treatment needed, its associated risks and benefits, the financial aspects, as well as the expected results of non-treatment. The wife of the patient agrees to the surgery and signs the informed consent form (**Hypothetical example**).

3. Actual Case

- Physician R. was accused of recklessly causing the death of citizen L., 18 years of age. Patient L. requested emergency care because of a broken right collarbone. After providing first aid (a plaster dressing), the patient was directed to the Trauma Unit for surgery on consolidation of collarbone fragments. The surgery was scheduled. On the established day, at 9 o'clock, the patient L. came with his parents to the Trauma Unit, where doctor R., after examination, decided to perform the surgery. Doctor R. did not inform the patient prior to administration about the medication to be used for anaesthesia, did not require the patient's consent and did not ask the patient or his parents whether he had any allergies to medications. Doctor R. did not perform the sensitivity test which is required to be sure that the patient can take this drug. Because of a severe allergic reaction after administration of the preparation, the patient died. According to forensic experts' conclusion, death occurred after anaphylactic shock caused by the allergic reaction to the medication used. A criminal case against the doctor charged under the Article 115¹ of the Penal Code of the Republic of Moldova, was sent to the District Court. According to the Court decision, doctor R. was found guilty of the offense provided for in the Article 115¹ of the Penal Code of the Republic of Moldova was fined 200 minimal salaries, and was suspended from the practice of medicine for 3 years. **(Real case)**

NB. According to the Government Decision no. 165 of 09.03.2010, the minimum wage is established to the amount of MDL 1,900.

- **The violation of the right to give consent on treatment has often been reviewed by the European Court of Human Rights (ECtHR) in terms of the Article 5 of the Convention, namely the right to freedom and personal security.**

Thus, in the case **David v. Moldova, Judgment of November 27th, 2014**, the plaintiff George DAVID was found guilty in 1987 for criticizing the Soviet authorities and for expressing the opinion that Moldova had been occupied by the Soviet Union and that it should have united with Romania. Based on a medical report ordered by the court, he was declared mentally unsound and sent for forced treatment to a psychiatric hospital in eastern Ukraine. He was held there for 1 year and then released and ordered to continue treatment in Chişinău. In 1990, the sentence was cancelled and he was acquitted. In September 2004, the plaintiff filed a case to court against the Ministry of Finance, claiming compensation. He claimed, among other things, that after the forced treatment he was administered during the period from 1987 to 1988, he ended up having health problems, namely loss of memory, emotional instability, and inhibited behaviour, and therefore he had no other choice than to live from a very small disability living allowance. During the proceedings, the Health Ministry questioned the fact that the applicant was able to plead before the court, given his medical history. The applicant disagreed with the Ministry of Health, but fearing that his case would be rejected, agreed to a medical examination to prove the contrary. On an unspecified date, the applicant passed a medical examination carried out by a specialized commission. The Commission could not reach a conclusion, and in an official document dated February 25th, 2004 concluded that, in order to reach a conclusion, it was necessary to examine the plaintiff as an inpatient. Since he agreed, the court ordered the same day the inpatient medical examination of the plaintiff at the Central Psychiatry Hospital. On April 4th, 2004 he went to the hospital, where, to his surprise, his belongings were taken away and he was placed in the same ward with the mentally ill, who had limited freedom of movement. According to the plaintiff, the hospital was not heated in April and he fell ill with acute bronchitis, because he was wearing light clothes. Two days after admission, he asked to be released to go home to change clothes and buy medication. The doctors prohibited him to leave the ward to which he had been admitted. According to the plaintiff, he was given no opportunity to complain to anyone about his detention, or to call someone or get in touch with people outside the hospital in other ways to complain about his detention. On October 12th, 2005 the prosecutor refused to initiate the criminal proceedings, without specifying the reasons. The prosecutor only said that the instruction of the Court of Justice of the Central District of Chişinău had been followed through and the repeated review had led to keeping the initial decision not to start a criminal case. On October 19th, 2005, the same judge at the Court of Justice of the Central District of Chişinău

rejected the plaintiff's appeal, concluding that the plaintiff's detention was in line with the conclusion of March 14th, 2005.

The ECtHR ruled, unanimously, that Article 5, paragraph 1 of the Convention was violated. The Court noted that, although the plaintiff initially agreed to inpatient medical examination, once the plaintiff expressed his will to leave the hospital, his detention was a 'deprivation of liberty'. Article 5, paragraph 1 of the Convention specifies a comprehensive list of exceptional circumstances when a person may be deprived of liberty. The detention of a person with mental problems under Article 5, paragraph 1 (e) of the ECHR is admissible only if it is proved that the person is mentally ill, his/her mental illness is of a nature or degree that would justify forced detention and if continued detention is justified by the presence of illness. The circumstances of the case show that none of these conditions was met in the plaintiff's case. The purpose of the conclusion of March 14th, 2004 was only to determine the plaintiff's ability to advocate in court, rather than protect him from other people. Therefore, forced detention after the applicant expressed his will to leave the hospital went contrary to the very essence of Article 5, paragraph 1, e) of the Convention.

- The European Court of Human Rights, in the **case of Evans v. the United Kingdom, Judgment of April 10th, 2007**, reviewed the right to consent to in vitro treatment under Article 8 of the Convention. On July 12th, 2000, Natallie Evans, the plaintiff, a British citizen aged 34, went to a clinic in Bath with her boyfriend for artificial insemination. On October 10th, 2000, it was found that the plaintiff had a pre-cancerous tumour on the ovaries and was proposed to undergo ovariectomy, the agreement being that once the tumour was dealt with, the in vitro fertilization treatment would start. Both partners consented to the creation, preservation of embryos and their implantation after administration of the treatment needed to cure the plaintiff. They were informed that they could withdraw their consent at any time prior to embryo implantation into the uterus of the plaintiff. On November 12th, 2001, eleven embryos were collected and fertilized, of which six embryos were preserved. In May 2002, the plaintiff and her boyfriend broke up and the latter withdrew his consent for the implantation of embryos. The plaintiff's appeal filed with the High Court, by which she requested that her former partner be ordered by law to give consent, was rejected. The plaintiff appealed to the Court of Appeal which in turn rejected the request to authorize the appeal. On November 29th, 2004, the House of Lords dismissed the appeal of the ruling of the Court of Appeal. On February 27th, 2005, the European Court of Human Rights, to which the plaintiff had appealed, requested the British Government to take measures to prevent the destruction of the embryos until final settlement of the case by the Court.

The Grand Chamber ruled that Article 8 of the Convention was not violated in the plaintiff's case. The Court noted that there is no international consensus regarding the regulation of treatment by artificial insemination and use of embryos for that purpose. The United Kingdom is not the only member country of the Council of Europe that allows those who have initially given their consent for embryo implantation to withdraw it later. Judgment of such a delicate case raises moral and ethical issues. The Court noted that four years after the birth of the first child conceived through such a method, an expert investigation commission headed by Ms. Mary Warnock was established. The conclusions and recommendations of the Commission were published as a Green Paper and were subject to public debate. After analysing the observations made, these recommendations were incorporated in a White Paper and finally integrated into a bill passed by the Parliament in 1990. Under the Annex 3 of the Law adopted in 1990, all clinics that offer in vitro treatment are required to inform those who give their consent that it can always be withdrawn prior to performing the implantation. In this case, the partners were informed. The Court held that the Law adopted in 1990 regulated the issue of in vitro insemination in a form that does not violate Article 8 of the Convention, not exceeding the limits set for the signatory States for discretion of decision-making.

G) PRACTICAL NOTES FOR LAWYERS

- When a physician administered treatment to a patient without consulting the patient's opinion, lawyers representing the patient must be sure that there is proof showing there was no patient's informed consent (extract this proof from the medical records).

It is important to assess whether before the medical intervention the patient was informed in an accessible language about possible risks, side effects, or influence on other organs of the body. Consent may be considered conscious only when the patient receives the appropriate volume of information, is warned of potential consequences and assumes the risks of medical interventions. It is necessary to ask health workers for evidence demonstrating that the patient was fully informed and that consent was not collected under superficial and insufficient information.

- In case of a conflict between surrogate decision-makers, i.e. heirs-at-law of the same line that would take different decisions on behalf of the same patient, the legislation does not provide direct guidance. If time allows, the most appropriate action would be to apply to court; yet if there is an emergency, healthcare providers are entitled by law to do whatever is in the patient's best interest. This approach is related also to the situation when healthcare providers think that the decision of the proxies is against the interest of the patient, or when the proxies could not be contacted in time.
- The right to consent in the context of blood transfusion necessary for the treatment administered to Jehovah's Witnesses **according to the Moldovan legislation**

The doctrine of the informed consent and the right to refuse any treatment can be clearly described using the example of blood transfusion for treatment purposes, administered to members of the Jehovah's Witnesses. It is well known that Jehovah's Witnesses (a religious denomination) reject blood transfusion even when this type of medical care procedure is vital for saving the patient's life.

In such instances, medical staff faces a dilemma: on one hand, their duty is to assist the patient; on the other hand, the patient, his/her family member, or legal representative does not allow medical personnel to perform their duty.

From the perspective of legal and medical ethics, this dilemma is based on the conflict between the principle of the patient's autonomy (duty of the doctor to observe patient's choices) recognized universally, including in the Moldovan legislation, and the principle of beneficence (duty of the doctor to assist the patient).

The Republic of Moldova's healthcare legislation (laws on healthcare, on the patient's rights and responsibilities, and on medical professional activity) straightforwardly stipulates that a patient who is legally capable and able to make a conscious decision enjoys the right to decide on allowing or rejecting medical intervention. In that case, the patient's decision is final. Medical personnel do not have the right to carry out medical intervention for which the patient is against, except in cases established by law.

This means that medical personnel do not have the right to transfuse blood to competent Jehovah's Witnesses having conscious decision-making capacity, if the patient is against blood transfusion.

Different rules are established in case the patient is incompetent (a minor or the person is recognized by the court as incompetent due to mental disease or imbecility) and requires urgent medical care, or is in a dangerous life condition. In such cases, the decision must be made according only to the patient's health interests. This also applies to the situations when legal representatives (e.g. parents of the minor) are against the lifesaving intervention.

Hence, if the Jehovah's Witness is a minor and his/her life is in a dangerous condition or requires urgent medical care, without which death is imminent, medical personnel are authorized to transfuse blood to them, even if the medical personnel cannot contact the patient's relative or legal representative or even if the relative or the legal representative is against this medical intervention.

Rejection by the Jehovah's Witnesses of the blood transfusion procedure gives rise to yet another problem: rejection of blood transfusion by a delivering woman. There are instances when blood transfusion to a delivering mother is the only way to save both the life of a woman and the foetus. In such cases, there is a conflict between the mother's autonomy and the life of a foetus⁷²³.

Thus, by recognizing, on the one hand, the supremacy of the principle of patient's autonomy, the Moldovan legislation allows competent persons having conscious decision-making capacity to decide whether or not to undergo medical intervention, including blood transfusion. On the other hand, the law protects incompetent persons, including minors, from the decisions of their relatives, legal representative, or the woman in labour carrying the foetus, from situations which expose their lives to danger (e.g. through refusal of blood transfusion).

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

- Please find a discussion of international and regional standards relevant to the Right to Consent under:
- Right to Liberty and Security of the Person in Chapter 2 and Chapter 3
- Right to Privacy in Chapter 2 and Chapter 3
- Right to Freedom from Torture and Cruel, Inhuman, and Degrading Treatment in Chapter 2 and Chapter 3
- Right to Bodily Integrity in Chapter 2 and Chapter 3
- Right to the Highest Attainable Standard of Health in Chapter 2 and Chapter 3

6.1.5 RIGHT TO FREE CHOICE

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right to freely choose from among different treatment procedures and providers on the basis of adequate information.

The right to free choice could be interpreted in two ways: (1) the right to freely choose from among different treatment procedures is linked to the broader rights to receive information and give informed consent to one of the treatments offered; and (2) the right to choose or change healthcare institution or healthcare professional (e.g. attending family doctor).

B) THE RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ The ***Constitution of the Republic of Moldova*** does not expressly regulate the person's right to free choice. The free choice can be made only when the correct information is provided to the patient, and the right to information is stipulated in **Articles 34 and 37, paragraph 2**.
- ▶ In accordance with the ***Law on Healthcare no. 411-XIII of 28.03.1995***, one of the fundamental principles of the healthcare system is the patient's freedom to choose the family physician and the primary health institution (**Article 2**).

723. Human Rights and Patient Care: A Practical Guidebook. Georgia. P.167. <http://www.opensocietyfoundations.org/sites/default/files/Practitioner-Guide-Georgia-English-20130516.pdf>

Citizens of the Republic of Moldova, foreign citizens and stateless persons have the right to freely choose the physician and the type of medical care. They also have the right to require medical care in healthcare units with any type of ownership and legal form, both in the country and abroad, in accordance with the international treaties and agreements to which the Republic of Moldova has adhered. **(Article 25)**

Pregnant women have the right to free choice of doctor and the medical institution providing medical care at delivery and after delivery, except the cases when according to medical indications it is necessary to observe the principles of regionalism and screening of pregnant women in providing perinatal medical care. **(Article 33¹)**

- ▶ **Law on the Patient's Rights and Responsibilities no. 263 of 27.10.2005**, in **Article 2** recognizes the patient and, where required by law, his/her legal representative, as the main participant in the decisions regarding a medical intervention.

In accordance with **Article 5 (e)**, the patient is entitled to the possibility of an alternative medical opinion and to receive recommendations from other professionals.

If it is possible, the patient has the right to choose or change his/her family physician. For the achievement of this right, each medical institution should display lists of family doctors and the modality to opt for them. **(Article 8, paragraph 2 (i))**

- ▶ **Law on the Practice of the Medical Profession no. 264 of 27.10.2005** contains a provision that supports and confirms the patient's right to free choice. **Article 18, paragraph 1** stipulates that the relationship between doctor and the patient must be based on the patient's right of choice exercised under the current legislation.

- ▶ **Law on Mental Health no. 1402 of 16.12.1997** stipulates the right of persons suffering from mental disorders to require any specialist, with their consent, to participate in providing psychiatric care or to collaborate in a medical commission on mental health disorders regulated by this law. **(Article 5, paragraph 2 (g))**

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates the freedom of individuals to choose the physician and the institution/organization homologated to provide reproductive healthcare services. **(Article 4, paragraph 1 (d))**

Every adult woman and every adult man are free to decide on the number of their children and the time of their birth and on issues related to reproductive health, without coercion and without external influence. **(Article 4, paragraph 2)**

Reproductive rights are met according to the will and interests of the person without prejudice to the rights, freedoms and legitimate interests of other people. The State is not involved in the achievement of the right to make free decisions about childbirth. **(Article 8 (a), (b))**

Patients undergoing in vitro fertilization can be embryo donors, when with free and informed consent they agree to donate their extra embryos to another couple. **(Article 12 paragraph 7)**

It should be noted that in the context of medically-assisted human reproduction it is prohibited to choose a future child's sex, except in cases when there is a risk of severe gender-related genetic diseases. **(Article 9, paragraph 10)**

- ▶ **Law on Medicines no. 1409 of 17.12.1997**, in **Article 12**, provides the protection of the rights of patients and volunteers in clinical trials. People have the right to decide on the participation or the refusal to participate/continue to participate in clinical trials. Clinical testing is performed only with the written consent of the patient or volunteer - and if the patient is a minor or incapable person, with the written consent of his/her legal representative.

- ▶ **Law on Transplantation of Human Organs, Tissues and Cells no. 42 of 06.03.2008** stipulates that the information about the donor may be shared with the recipient, and information about the recipient may be shared with the donor, if both parties agree. **(Article 26)**

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no additional provisions that refer specifically to this right.

D) PROVISIONS OF THE OF ETHICS

Paragraph 18 of the *Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers* stipulates the obligation of healthcare professionals to observe the patient's right to free choice of the persons involved in the medical act.

Especially, it is stipulated the obligation to observe the right of subjects involved in the research to withdraw from the research at any time without suffering any damage for their refusal. **(Paragraph 79)**

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- In accordance with the legislation in force, each year, in August-September, primary healthcare institutions collect applications from insured persons regarding the inclusion of the insured in the family doctors' lists. The institution places lists of family doctors employed there, and patients submit their applications to the institution's administration. Thus, for the next year, patients can be monitored and treated by the family doctor, according to their preference. There is a limit for the number of patients referred to one family doctor - 1,500-2,000 persons. **(Actual situation)**.
- Patient Mrs. P. is recommended to have a tonsillectomy by her attending doctor, Dr. S., who provides her with comprehensive and understandable information about the need to carry out the surgery. Dr. S. also describes the possibility to proceed without the surgery; but in this case, the patient may need long-term treatment with various medications and procedures having different success rates and side reactions. The patient decides to have the surgery. **(Example collected by the authors)**

2. Examples of Breach

- Patient Mrs. X. visited a public clinic for investigating some health problems. After analysing the test results, the doctor informed the patient that she had a tumour in the mammary gland and needed a large surgery with resection of breast tissue, ribs and adjoining muscles, which implies a serious mutilation of the body. The patient knew details about such intervention because her aunt suffered from a similar disease and was operated on exactly the same way. Mrs. X did not want to have the same experience as her deceased aunt, but knew that there are therapeutic methods of treatment for the disease and that many positive results have been recorded after using it. The patient expressed her willingness to start treatment using a non-surgical method, but the doctor insisted with the surgery because he was convinced that the best way was surgery, with more chances of healing. The patient refused surgery and assumed all risks in case the non-surgical method would not be effective for her illness. The doctor refused to treat the patient using the requested method and informed her that if she did not agree with his professional decision, he would refuse to treat her in general and asked her to look for another doctor. The patient did not complain about the doctor's refusal but decided to change the doctor with a specialist which would observe her decision. **(Example collected by the authors)**

3. Actual Case

There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

It should be determined whether there were ample conditions to achieve the patient's right to free choice of healthcare providers, whether information was available regarding the qualification of the doctor who provided medical care, and whether the patient had the opportunity to choose the type of medical intervention.

Parents as legal representatives of minor children exercise this right on behalf of children and in their interests. However, parents are liable under the law in force in cases when they take away the child's medical card from a family doctor and do not submit it to another, so that the child is not monitored by any family doctor.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The Right to choose is directly connected with the Right to Information and the Right to the Integrity of the Patient. Please find a discussion of international and regional standards relevant to the Right to Free Choice under:

- Right to Liberty and Security of the Person in Chapter 2 and Chapter 3.
- Right to Privacy in Chapter 2 and Chapter 3.
- Right to Freedom from Torture and Cruel, Inhuman, and Degrading Treatment in Chapter 2 and Chapter 3.
- Right to Bodily Integrity in Chapter 2 and Chapter 3.
- Right to the Highest Attainable Standard of Health in Chapter 2 and Chapter 3.

6.1.6 RIGHT TO PRIVACY AND CONFIDENTIALITY

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right to the confidentiality of personal information, including information regarding his or her health condition and potential diagnostic or therapeutic procedures, as well as the protection of his or her privacy during the performance of diagnostic examinations, specialist visits, and medical/surgical treatments in general.

The right of patients to privacy and confidentiality is regulated by various laws in the field of healthcare. As in the case of other patients' rights, the Law on Healthcare is more general, while the Law on the Patients' Rights and Responsibilities is more specific in defining rights. The Law on the Practice of the Medical Profession defines the duties of doctors to observe privacy and maintain confidentiality; and other specific laws regulate issues of privacy and confidentiality in specific circumstances (laws on HIV Infection/AIDS Prevention; on Transplantation of Human Organs, Tissue and Cells; on Mental Health, etc.).

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ In the **Constitution of the Republic of Moldova**, the right to observe privacy is described in **Article 28**, being regulated in terms of private life. The State observes and protects the intimate, family and private life.
- ▶ According to the **Law on Access to Information no. 982 of 11.05.2000**, personal information is the data that relates to a private identified or identifiable person, the disclosure of which would constitute a violation of individual privacy. These data are part of the confidential personal information. Every person has the right to provide consent when disclosure of personal information can affect some specific personal interests, the right to participate in the decision-making as an equal party, the right to anonymity in providing personal information by observing confidentiality, and the right of not to be identified automatically in the decision-making process over disclosure. **(Article 8, paragraph 3)**
- ▶ **Law on the Protection of Personal Data no. 133 of 08.07.2011** stipulates that information about requesting healthcare, about the health condition, diagnosis and other medical data from the patient's examination and treatment are personal and may not be disclosed **(Article 3)**.
- ▶ **Law on Healthcare no. 411 of 1995** protects the patient's right to privacy and observance of privacy through the professional obligations of healthcare workers not to disclose the secret information concerning the disease, the patient's private and family life. **(Article 14, paragraph 1)**
- ▶ **Law on Patient' Rights and Responsibilities no. 263-XVI of 27.10.2005**, in **Article 12**, provides that all data on the identity and condition of the patient, results of investigations, diagnosis, prognosis, treatment and personal data are confidential and must be protected also after the patient's death. Biological products, including organs and tissues, out of which identifiable data can be derived, shall be protected as such.
- ▶ **Law on HIV/AIDS Prevention no. 23 of 16.02.2007**, in **Article 14**, guarantees the right to privacy of persons seeking HIV testing or who are diagnosed with HIV.
- ▶ **Law on Mental Health no. 1402 of 16.12.1997** contains special stipulations to protect a patient's privacy. The person suffering from a mental disorder has the right to adequate privacy in mental health institutions. Information about mental illness, about the request for psychiatric care and treatment in a psychiatric institution, and other information about the person's mental health is a medical secret protected by law. **(Article 9)**
- ▶ **Law on Reproductive Health no.138 of 15.06.2012**, in **Article 8**, provides the right to confidentiality in meeting the reproductive rights of every person.

Data on infertility treatment by applying human reproductive medical care are confidential and represent a medical secret. **(Article 9 paragraph 8)**

Contraception counselling services are provided by specially-trained staff in facilities ensuring privacy. **(Article 5, (d))**

Any information of heterosexual couples, related to infertility treatment by the methods of in vitro fertilization, is a medical secret and will not be transferred to anyone else without the consent of the couple. **(Article 11, paragraph 9)**

In case of anonymous donation of sexual cells, the donor's confidentiality will be ensured. **(Article 12, paragraph 3)**

Disclosure of data regarding donations of sperm, oocytes and embryos represents a violation of confidentiality **(Article 9, paragraph 10, (f))**

- ▶ **Law on Transplantation of Organs, Tissues and Cells no. 42 of 06.03.2008** guarantees the confidentiality of all personal data, including genetic data, related to the person from whom organs, tissues or cells were taken and the personal data concerning the recipient, collected during activities related to transplantology. **(Article 25)**

C) SUPPORTING REGULATIONS/ DECISIONS/ORDERS

The Order of the Ministry of Health no. 266 of 03.08.2009 on the approval of standards to reduce risks associated with the consumption of injectable drugs and the psychosocial assistance for drug consumers stipulates that the personnel involved in the Program to Reduce Risks Associated with Consumption of Injectable Drugs will work under the principle of confidentiality and anonymity in relation to all beneficiaries. Thus, the staff will keep secret the personal data on the beneficiaries (in case they know it), such as names, addresses, HIV status, places of drug use. The only exception is when the patient is talking to staff about a serious crime (e.g., rape or murder); in this case, the staff member will talk with the standard manager and will inform the police.

D) PROVISIONS OF THE CODE OF ETHICS

A patient's right to privacy and confidentiality is protected by the **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** by promoting the obligation of medical staff to observe medical secrecy and dignity of patients. **Chapter VI** of the Code is entirely devoted to the description of these values.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The decision of the Ministry of Health to replace the description of diagnosis in sick leave forms with a special code comes in support of the right to privacy. Thus, the employer will not have access to information about the employee's illness and his/her health state, which represents the employee's confidential information. **(Actual situation)**
- Sixteen-year-old female patient K. consulted a doctor regarding her reproductive health issues without letting her parents know about it. K's mother, having heard about her daughter's visit to the medical institution, asked the doctor about K's pregnancy. The patient demanded complete confidentiality and has not given permission for her mother to be informed about her health. The doctor did not reveal any medical information on the basis of the rule of confidentiality. **(Hypothetical example)**

2. Examples of Breach

- The patient is a 46 year-old man, father of 3 children, a bus driver working on an inter-urban route through the mountains. The patient consulted a cardiologist with complaints of episodic crises of acute tachycardia that occurred during the last five months following the death of his mother. The first episode took place when the man was in the street; it started with a loss of all senses and feeling like dying. At the emergency hospital he had undergone the necessary examinations and he was informed that his heart is healthy, but due to stress, he was advised to rest. After returning from vacation, crises reappeared, especially when driving on the route in the mountains. He began to

believe that the trip could be dangerous with the risk of falling into the abyss. The patient continued to believe that he suffers from a heart disorder and denies the diagnosis of panic syndrome complicated by agoraphobia (fear of open spaces). He refused any consultation with a psychiatrist and any psychotropic treatment proposed and urged the cardiologist to prescribe cardiologic treatment. The patient stated that he refused the same treatment as his mother, who was treated for years for schizophrenia. At the same time, he continued to work as a driver on the same route because he had some old debts at work, which were to be paid from salaries. The doctor went to the patient's workplace and informed the management (employers) that the driver had a high risk of accident. The doctor claimed that with such a disease, this driver should not be allowed to drive a public transport vehicle and recommended his transfer from the position he was holding. **(Case from media)**

3. Actual Case)

- The district policeman submitted a request to Psychiatric Hospital asking for information on the treatment of citizen M. and his diagnosis. The request was unjustified because it was submitted without there being a criminal case. The Psychiatric Hospital issued to the policeman the requested information about the patient. Later, personal information about the citizen M. came to be known by his neighbours. M. came with a claim against the Psychiatric Hospital and the policeman, claiming violation of privacy and disclosure of confidential data. M. requested recognition of the violations and recovery of moral damages. The court partially admitted the application, recognizing violations, but reducing the amount of moral damages to one thousand MDL out of 10 thousand MDL requested. The hospital paid the damages. **(Case from the authors' practice)**
- In one primary care clinic in Chişinău it was decided to facilitate working with documents by marking patients' medical records with certain symbols in different colours. Thus, one of the marks was a yellow circle in the top right corner for HIV patients' records. HIV patients submitted a complaint regarding this decision because it violates the right to privacy – records with yellow circles could be immediately distinguished when seen by other people (e.g. when waiting in line at the doctor's door, other people could see the sign on the record). The court decided in favour of patients and ordered the institution to unmark the records. **(Case from the authors' practice)**

G) PRACTICAL NOTES FOR LAWYERS

Any information about the patient, such as the treatment he/she was subjected to or his/her diagnosis, represents information about his/her private life and nobody has the right to request it or receive it, except in cases established by law. (*Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005, Article 12, paragraph 4*)

With regard to the Right to Privacy and Confidentiality, the national legislation directly stipulates that some information is confidential, irrespective of the fact that disclosure of such information does or does not entail sanctions. In the absence of provisions imposing sanctions, violating the principle of confidentiality imposes the obligation to pay damages in accordance with the Civil Code. As a basis of imposing civil liability is the existence of civil wrong, factual circumstances are needed to ascertain whether disclosure was an intentional or negligent act.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Article 8 of the European Convention on Human Rights (ECHR) establishes the right of inviolability of private life. It states that there shall be no interference by a public authority with the exercise of this right except to the extent that this interference is required by law and only if it is a measure which in a democratic society is necessary for national security, public safety or the economic well-being of the country, prevention of disorder or crime, or for the protection of health, morals or the rights and freedoms of individuals.

ECHR uses the term *private life* to refer to the right to private life and expresses it in Article 8. The European Commission on Human Rights report on *Van Oosterwijk versus Belgium (Com. Rep. of 1979)* was recorded following the interpretation of the concept of privacy: "The right to *private life* is the right to intimacy, the right to live your life as you wish to, protected from publicity [...]. It comprises also to a certain degree the right to establish and maintain relationships with other human beings, in particular in the emotional field, for the development and achievement of one's own personality".

6.1.7 RIGHT TO OBSERVANCE OF PATIENT'S TIME

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right to receive necessary treatment within a certain period of time, depending on the degree of emergency of the case.

This right is not specifically mentioned in the national legislation. Particularly, there are no provisions about waiting lists, as the responsibility of the State in financing services is very limited.

However, legislation does stipulate that medical care is initiated without delay in clinical emergencies, even without consent of the patient (e.g. when a patient is in coma) or the consent of his/her legal representative (when the legal representative could not be contacted due to time constraints).

Health laws provide also for informing patients about various aspects of care. This definitely requires (from the doctor and other healthcare professionals) enough time to be devoted to information and explanations on the services provided.

Finally, respect for a patient's time can be understood as not having to wait for hours, especially if the patient was previously given an appointment.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The ***Constitution of the Republic of Moldova*** has no special provision covering patient's time. The right to health and a minimum of free medical insurance is guaranteed. **(Article 36)**
- ▶ ***Law on Healthcare no. 411-XIII of 28.03.1995***, in **Article 20**, stipulates the right to healthcare services in case of life-threatening emergencies from the minimum free health insurance through pre-hospital emergency medical services, primary care provided by a family doctor, and through medical outpatient or stationary institutions, within the limits of mandatory health insurance funds and the State budget for the year.
- ▶ According to **Article 21**, all persons in the Republic of Moldova are insured with emergency healthcare in case of danger to life (accidents, serious acute illness, etc.).
- ▶ People are guaranteed with medical care in emergency situations (natural disasters, catastrophes, accidents, mass diseases and poisoning, ionizing and non-ionizing irradiation, heavy environmental pollution and so on). **(Article 24)**
- ▶ ***Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005*** stipulates that the patient has the right to health insurance (mandatory and voluntary) **(Article 5, (f))**.
Each patient is guaranteed free access to emergency health services, carried out both by the family doctor and by outpatient or inpatient medical institutions within the limits of the patient's area of residence. **(Article 8, paragraph 3)**

A woman's right to life prevails when pregnancy presents a major and immediate risk factor for a mother's life. **(Article 9, paragraph 4)**

- ▶ According to the **Law on Mental Health no. 1402 of 16.12.1997** in the case of providing psychiatric care, a person suffering from a mental disorder has the right to be hospitalized in a psychiatric hospital only for the period of medical examination and treatment **(Article 5, (c))**.

In the case of mental disorders, the person can be declared, for a period of not more than 5 years, to have the right to a follow-up re-examination, if unable to perform certain professional activities and activities with increased risk. A restrictive decision is issued by a medical commission, authorized by the health authority, based on the conclusion about the person's mental health, and can be challenged in court. If, before the expiry of the five year period the person is not reviewed by a board (a commission of medical expertise of vitality), he/she becomes automatically deemed capable of carrying out the mentioned activities. **(Article 6, paragraph 1)**

Emergency psychiatric care is guaranteed by the State **(Article 16, paragraph 1 (a))**

- ▶ According to the **Article 5** of the **Law on Reproductive Health no. 138 of 15.06.2012**, any person has the right to benefit from screening services and early detection of diseases.
- ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** contains a number of conditions for observing the time of patients infected with tuberculosis or of those who have been in contact with persons who are infected and are at risk of disease. Since the development of tuberculosis as a malady is very dangerous for the patient, it is important to organize the access of patients, as early as possible, to prophylaxis and treatment measures. Thus, according to **Article 16** of the Law, the patient with a confirmed active form of tuberculosis or with a contagious form of tuberculosis is isolated and treated as early as possible in a specialized hospital for the whole period in which the causative agents of tuberculosis are eliminated. The length of hospitalization is determined by the treatment results and contagiousness of the patient. New-borns during a tuberculosis outbreak are isolated for a period of two months after TB vaccination. Children from tuberculosis outbreak places are isolated for preventive treatment in specialized healthcare institutions.

In providing TB healthcare services, persons who are being monitored for TB and TB patients have the right to diagnostic and treatment in specialized TB medical institutions or in outpatient facilities, depending on the manifestations of the disease and the hygienic conditions available, and to stay in a specialized TB medical institution for the time required for investigations and/or treatment **(Article 17, (c), (d))**.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- **Order 841/2010 of the Ministry of Health, Annex no. 3**, which establishes the criteria for inter-hospital transfers of critical patients within the regionalized emergency care service and intensive care in children.
- **Order 841/2010 of the Ministry of Health, Annex no. 4**, on the basis of which regulations on the organization and operation of the emergency admission department for patients coming to a hospital are elaborated. Each emergency reception department provides emergency, 24 hours/day, high-quality care in time and full volume.

D) PROVISIONS OF THE CODE OF ETHICS

The obligations of healthcare workers in emergencies cases are described in Chapter IX of the **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers**.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The patient was living in a village far from the district centre and was in a serious health condition. The patient's family requested emergency care service. The Emergency Service team from the district centre, having adequate transport units and equipment, reached the patient's village. It provided the necessary medical care and saved the patient's life. (**Actual situation**)
- Citizen A. lives below the poverty threshold and is entitled to free medical treatment due to the special government program for health insurance. Three months ago, he was diagnosed with a severe form of urinary disease, causing suffering and pain and making it difficult to urinate. Because of his conditions, patient A. was given priority over other patients on the hospital waiting list and was operated a few days after he was registered. (**Hypothetical example**)

2. Examples of Breach

Female citizen S. gave birth prematurely to twins in the maternity hospital of the district centre. The medical condition of the twins was serious and doctors requested the children's transfer to Chişinău because the district institution did not have the necessary equipment for life maintenance of premature new-borns. Aviasan transportation service is the organization whose role is to act promptly in cases of emergency. Aviasan Service answered that at that time all available transportation was busy and they had no free vehicles for transporting the children. Because of the delayed transportation of the children to a specialized republican unit, one of the children did not survive. No action was taken. (**From author's practice**)

3. Actual Case

There are no actual cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

According to the national legislation, the Right to Observe the Patients' Time intertwines with the obligation to provide timely and adequate treatment. If the State violates the mentioned medical standard, an affidavit from a competent medical expert must be obtained to establish what damages or losses resulted from the delay in administering the medical treatment and whether the delay increased the risk of injury.

Assessment of the time of providing healthcare services should be made based on all circumstances of the case. To avoid creating a conflict of interest, it is recommended that expertise is provided by experts in the field or forensic from other institutions, or if possible, from outside the locality where the event took place.

In case of allegations with respect to failure to deliver timely medical aid, it should be noted the time and date when the patient requested medical aid (these data are included in the application card), the registered time when the doctor consulted the patient (in medical documents, admission record), the volume and quality of healthcare services offered to the patient (investigations, procedures and medications, including the time of administration), are described in the patient's medical records.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The Right to Observe the Patient's Time is directly connected with the Right to Health, which provides access to necessary health services provided in the required time. Please find international and regional standards related to the right to observe the patients' time within the context of the right to the highest attainable standard of physical and mental health discussed in Chapter 2 (international) and Chapter 3 (regional).

6.1.8 RIGHT TO OBSERVANCE OF QUALITY STANDARDS

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right of access to high quality health services and to observance of fixed standards.

This right was partially discussed under the Right of Access. Accessibility of services implies adequate quality of services as well. Otherwise, if the services were accessible but were not of appropriate quality, patients could not exercise their right to benefit from healthcare services, because such services would not be able to improve and/or to maintain their health.

National legislation mostly addresses the right to observance of the quality standards through determining obligations (contained basically in the Law on Healthcare, and the Law on the Practice of the Medical Profession).

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ Although the ***Constitution of the Republic of Moldova*** does not stipulate directly the right to high quality services, this provision is found in the right to healthcare guaranteed to every citizen in **Article 36**.
- ▶ ***Law on Healthcare no. 411-XIII of 28.03.1995*** stipulates that the healthcare system is based on the principle of the responsibility of healthcare facilities for the availability, timeliness, quality and volume of medical services, and for the improvement of the quality of training and qualification of healthcare professionals and pharmacists (**Article 2**).
Moldovan citizens, regardless of their income, are given equal opportunity to obtain timely and quality healthcare services in the mandatory health insurance system. (**Article 20, paragraph 1**)
- ▶ ***Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005*** provides the patient's right to information on the quality of services. (**Article 5, (g)**)
Patients have the collective right to a form of representation at every level of the healthcare system, in making decisions on planning and reassessment of services, including the range, quality and provision of services. (**Article 10, paragraph 2**)
Article 8 (paragraph 8, (e)) of the Law stipulates that achievement of the social rights of the patient is ensured by the exercise of the control over the quality of healthcare services, provided and approved by law.
- ▶ ***Law on Reproductive Health no. 138 of 15.06.2012*** guarantees the development and organization of reproductive healthcare to ensure the equal access of women and men to quality healthcare services. The State shall ensure the supply of the population with quality products in terms of reproductive health, including contraceptives for people from vulnerable social groups. (**Article 5, (a),(c)**)

The reproductive rights are achieved by the provision of the guaranteed volume of services on reproductive health and family planning, by their quality and accessibility, and by the compliance with professional standards in the performance of special medical interventions in reproductive health **(Article 8 (f), (g))**

In order to provide the requisite quality, the Act stipulates that the medically-assisted human reproduction services may be provided both by public and private healthcare institutions/organizations, accredited or licensed for this activity. **(Article 9)**

Persons providing reproductive healthcare services must have special training in this area **(Article 17, paragraph 1)**

- ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** states that anti-tuberculosis care is guaranteed by the State and is based on principles of observance of the human dignity, privacy, gratuity and accessibility. **(Article 12, paragraph 1)**

The quality of medical services provided to persons under record with tuberculosis and tuberculosis patients is assured by recognizing their right to diagnostic and treatment in specialized anti-tuberculosis medical institutions or in outpatient conditions, depending on the manifestations of the diseases and the hygienic conditions available. **(Article 17, (c))**

The prejudice caused to a person's life or health when receiving anti-tuberculosis care, or by failure of health workers to provide such assistance in due time upon request, is remedied in accordance with the law. **(Article 22)**

- ▶ According to the **Law on Mental Health no. 1402 of 16.12.1997** for establishing diagnosis and administering treatment to persons suffering from mental disorders, only medical means and methods approved in accordance with the legislation on healthcare are applied. **(Article 10, paragraph 2)**

In case of psychiatric care, persons suffering from mental disorders have the right to psychiatric care in accordance with the hygienic and sanitary standards. **(Article 5, paragraph 2 (e))**

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- Continuous improvement and increasing accessibility of health services are the fundamental objectives of the Ministry of Health established in the **National Health Policy and Strategy for Health System Development for 2008-2017**.
- **Order of the Ministry of Health no. 380 of 02.10.2008 on the amendments and additions to the Order no. 6 of 01.06.2006 "On State Control of the quality of medicines and other pharmaceutical products in the Republic of Moldova"**
- **Order of the Ministry of Health on healthcare quality assurance in healthcare institutions no. 139/2010**

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** contains provisions about the authority of medical and pharmaceutical workers and the patient's trust. The Code states that a patient's trust in a health worker is subject to the quality of medical care that he/she was provided. **(Paragraph 24)**

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The patient is provided professional and high quality care, regardless of his/her income and social status. (**hypothetical case**)
- Mr. T, who is 55 years old, has been diagnosed with hypertension during his last three visits to his family doctor, Doctor E. The doctor prescribes an EKG investigation and lab analyses, including a comparatively expensive analysis – a lipid profile. The representative of the laboratory suggests not to order this study, which will not be covered by the insurance company and is proposed to be paid by the patient. However, Doctor E. explains that the lipid profile, according to the national practice guideline, is included on the list of routine lab analyses for the assessment of patients with hypertension. Finally, the analysis is done, and its expenses are covered by the insurance policy. (**Hypothetical example**)

2. Examples of Breach

- Patient S. came to an outpatient clinic with complaints of headaches. The doctor examined the patient superficially and without any further investigation prescribed analgesic pills. Two weeks later the patient repeatedly consulted with the doctor complaining of persisting pain. The doctor insisted on continuing the previously prescribed treatment. Over a period of time, because the pain did not stop, the patient went to the Diagnostic Centre. After a series of investigations, doctors from the Centre diagnosed him with a serious illness and recommended urgent hospitalization. The patient was asked why he did not seek medical care earlier, as such a serious advancement of the disease and unbearable pain he suffered could have been avoided. There were no judicial actions against the doctor who originally treated the patient. (**From author's practice**)

3. Actual Case

- New-born baby L., after being discharged from the maternity hospital, was put on record at the Centre of Family Physicians with a high risk congenital disease. A month later, the child's mother came to doctor R. with complaints that the child was coughing and had mucous nasal discharge. Doctor R. prescribed nasal drops and a cough mixture without making any investigations, although the child was at major risk of illness. Doctor R. did not monitor the state of the child, who was only under parental supervision at home. After 7 days the child died due to complications. According to the forensic report, the child died of bronchial pneumonia which developed into a more severe form. No action was taken. (**From author's practice**)

G) PRACTICAL NOTES FOR LAWYERS

In complicated cases concerning the quality and extent of medical services provided, medical expertise of a commission including an independent forensic expert is needed.

Examples of breaches by physicians of the rules of providing healthcare services:

- Lack of systematic monitoring of the patient (duly registered in medical records)
- Insufficient examination of the patient (missing data in medical records regarding consultations of specialists, lack of para-clinical investigations, etc.)
- Incorrect diagnosis, incorrect interpretation of performed investigation results
- Incorrect diagnosis leads to wrong and inappropriate prescription of the treatment
- Wrong treatment without observing clinical protocols.

To establish whether a medical service was of adequate quality or not, both parties (applicant and defendant) have to obtain affidavits from medical experts and/or expert medical opinions (provided during hearing) on what specific medical standards are to be met in certain territorial units. Namely, the standards are to establish what criteria qualify a medical treatment as being of high quality. Ultimately, the court shall consider evidence (expert opinions) obtained by the parties and shall decide if, in the disputed case, the medical treatment was in compliance with the quality standards.

The best sources of information about the adequacy of treatment for specific conditions are the national clinical practice guidelines, which are approved by the Ministry of Health. These guidelines could be used when dealing with complaints on the quality of medical care, also with complaints against an insurance company that does not cover the costs of certain types of services.

Lawyers should not only check whether the treatment provided by a physician was in line with the latest guidelines, but also whether there were special circumstances, specific to the patient that could explain and legitimize the treatment that differed from the instructions of the relevant guidelines.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The right to quality healthcare derives from a patient's right to health and right to life.

Please find a discussion of international and regional standards relevant to the Right to Observance of Quality Standards under the Right to the Highest Attainable Standard of Health in Chapter 2 and Chapter 3 and under the Right to Life in Chapter 2 and Chapter 3.

6.1.9 RIGHT TO SAFETY

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right to be held harmless of prejudices caused by the poor functioning of health services, medical malpractice and errors, and the right of access to health services and treatments that meet high safety standards.

The safety of patients is ensured through the provision of an adequate quality of services. However, ensuring safety could be considered an absolutely-required minimal standard of care. Therefore, this right can be linked to one of the four principles of modern medical ethics/bioethics – non-maleficence ("do no harm").

In many cases, the relevant national legislation specifically refer to the issue of patients' safety, particularly the following: safety of medical services, safety of medical equipment and technologies, safety of blood and blood products, safety of medicines and vaccines, safety of environment (including radiation and biological safety), control of nosocomial infections, etc. Safety of patients and health volunteers participating in the biomedical research is also specifically regulated.

Although not specified in the healthcare legislation, the right to patients' safety shall also be understood as a right to be free from physical assaults while in a healthcare institution. Obviously, all the general legislation provisions protecting individuals' lives and physical integrity are to be observed in healthcare establishments as well.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ **Article 36** of the *Constitution of the Republic of Moldova* provides that the State guarantees the right to healthcare to all citizens.

- ▶ In the *Law on Healthcare no. 411-XIII of 28.03.1995*, the right to health is guaranteed through the organization of qualified medical care, provided in accordance with the requirements of modern medicine and the legal protection of the right to health and damages for injuries to patients' health. **(Article 17, paragraph 2)**

Medical services in assisted human reproduction can be provided only in public accredited medical institutions and accredited private medical institutions operating in accordance with the laws and regulations in force. **(Article 33, paragraph 2)**

The law provides that if the patients have injuries caused by improper treatment which affect their health, causing permanent disability, are life-threatening or result in patients' death, a patient or his/her legal representative has the right to seek remedy of damages from healthcare institutions where the damage was caused. In the case when a poor health condition follows an inadequate healthcare, the patient has the right to request, as required, professional expertise and moral and material damages. **(Article 19)**

The right to health of persons in custody or detention is assured by prohibiting the creation of conditions that endanger their lives and health. **(Article 39)**

Provision of psychiatric care is within the exclusive competence of psychiatrists. Psychiatric treatment cannot be applied in the absence of a mental illness. **(Article 42, paragraph 2, 6)**

- ▶ *Law on Mandatory Medical Insurance no. 1585-XIII of 27.02.1998* stipulates that an insurer is financially responsible to the insured person for life and health injuries caused as a result of poorly or insufficiently provided healthcare services within the unique program of mandatory health insurance. **(Article 14, paragraph 2)**

The unique program of mandatory health insurance includes the volume of healthcare provided under the mandatory health insurance. It lists the diseases and conditions that require medical care financed by means of the mandatory health insurance. **(Article 2)**

- ▶ In the *Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005*, in **Article 5**, it is mentioned a patient's right to privacy, physical and moral integrity, provided discretion observed during the provision of health services.

Patients, through the health services, have the right to choose the safest method of ensuring reproductive health. Every patient has the right to effective and risk-free family planning methods. **(Article 9)**

- ▶ *Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005* provides that in carrying out their professional activities, physicians have no right to subject the patient to undue risk, even with the patient's consent. **(Article 17)**

According to **Article 18, paragraph 2**, the patient or his/her legal representative shall be informed by the physician on the possible risks that may occur during a medical intervention, observing the patient's right to decide and possibly to refuse the intervention.

- ▶ According to the *Law on Mental Health no. 1402 of 16.12.1997*, people suffering from mental disorders have the right to be hospitalized in a psychiatric hospital only for the period of medical examination and treatment. **(Article 5, paragraph I, (c))**

Minors suffering from mental disorders cannot be subjected to experiments, electroconvulsive therapy, scientific or teaching research, taken pictures, filmed, or any irreversible treatment (psychosurgical) without the minor's or his/her legal representative's consent. **(Article 5¹, paragraph 3)**

For establishing the diagnosis and treatment of persons suffering from mental disorders, only medical

means and methods duly approved by healthcare legislation can be applied. **(Article 10, paragraph 2)**

It is unacceptable the treatment of mental disorders using surgical and other methods that have irreversible consequences and using new medicines scientifically substantiated, but still not accepted for general use. **(Article 11, paragraph 5)**

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates that the reproductive health includes the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning, which they can choose themselves, and the right of access to medical services that enable women to safely go through pregnancy and childbirth **(Article 2)**.

The right to a safe pregnancy and to antenatal, intra-natal and postnatal care is guaranteed **(Article 4, (f))**.

Reproductive rights are protected by observing special professional requirements and standards in performing medical interventions in the reproductive health field **(Article 8, (g))**.

- ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** stipulates that in providing anti-tuberculosis treatment, persons on record with TB and TB patients have the right to diagnosis and treatment in specialized anti-tuberculosis medical institutions or in outpatient clinics, depending on the manifestation of the disease and the sanitary and hygienic conditions available, and to hospitalization in specialized medical institutions for TB patients for the period necessary for investigations and/or treatment. The patient has the right to anti-tuberculosis treatment under conditions that meet the requirements of the hygienic and anti-epidemic regime. **(Article 17)**

Patients have the right to compensation for damage to their lives or health when receiving anti-tuberculosis care or if the care was not provided in due time upon request. **(Article 22)**

- ▶ **Law on HIV/AIDS Prevention no. 23-XVI of 16.02.2007**, in **Article 33** stipulates the right of a person who was infected with HIV from blood transfusions or medical interventions to be insured with a pension under the legislation. Citizens have the right to compensation for moral and material damages as a result of HIV infection, paid by the healthcare facility where they got infected.

Complex treatment of people infected with HIV and suffering from AIDS is provided according to national protocols approved by the Ministry of Health. **(Article 18)**

- ▶ **Law on Medicines no. 1409 of 17.12.1997**, in **Article 12**, provides the protection of the rights of patients and volunteers involved in clinical trials. A clinical trial's applicant shall, prior to testing, conclude a life and health insurance agreement for the patient or volunteer as established by law. In case of occurrence of a hazard to the life or health of the patient or volunteer, as well as at the patient's or volunteer's will, the head of the clinical trials has the right to stop the trials.

- ▶ **Law on Transplantation of Organs, Tissues and Cells no. 42 of 06.03.2008** guarantees the implementation of quality and safety standards relating to organs, tissues and cells **(Article 3)**.

All donors selected for sampling will necessarily pass the clinical and laboratory examination to exclude any infectious disease, possible contamination or risk for the recipient. The organs, tissues and cells can be taken only if the donors have been examined and tested for infectious diseases, in accordance with the international standards **(Article 21)**.

All licensed tissue banks will act according to international standards, being inspected at least every two years. For transplantation purposes, only tissues and cells obtained from authorized tissue banks can be used. **(Article 22)**

The measures of punishment for violation of a patient's safety, and for damage to and infringement of professional duties of healthcare workers are described in Chapter 7 of this Guidebook.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- **Order of the MoH on approving standards for carrying out abortion in safe condition, 482/2011.** In the Annex of the Order there are standards for carrying out abortion in safe condition, based on the recommendations of the World Health Organization.

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** stipulates that the medical and pharmaceutical workers must show the utmost vigilance in providing professional service and avoid predictable complications in patients for whom they provide care.

Chapter IV of the Code is dedicated to medical mistakes and professional risks that must be taken into account by each physician.

The position to be taken by medical and pharmaceutical professionals concerning mistakes should have the patient's well-being as a main criterion.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- When considering all the risks and complications that may be the result of a medical act, the physician shall inform the patient on the treatment to be administered, and explains in detail the consequences that can occur following the administration of drugs. The physician is acting professionally, makes a thorough analysis of the prescribed treatment, is cautious regarding potential risks, and informs the patient about them; and the patient in turn takes responsibility for decisions. (**Hypothetical case**)

2. Examples of Breach

- Patient B., a 12 years-old child, was hospitalized in serious condition. The surgeon examined him and decided it was necessary to perform surgery. The anaesthesiologist prescribed the dose of anaesthetic in accordance with his age. During the surgery, the child died suddenly. The forensic report has shown that the administered dose of anaesthetic was much bigger than that required for the child. Verification of the anaesthesia equipment showed significant errors in its operation. The equipment has been received through humanitarian aid and has no certificate of metrological inspection. A criminal case was initiated. Because the matter happened in the period of writing this guidebook, we do not have information about its further development. (**Case from the authors' practice**)

3. Actual Case

- Citizen P. sued the Ministry of Health and C. District Hospital to obtain compensation for material and moral damages in the amount of MDL 500,000 for an HIV infection caused by a blood transfusion performed by physicians of the district hospital. This case was examined by several courts, including the Supreme Court, which upheld the civil case filed by patient P. against the Ministry of Health and C. District Hospital. A plenum of the Supreme Court decided that damages caused to the person from infection should be paid by the medical institution where P. got infected. The citizen's action was

fully admitted to court, and the hospital was forced to pay for the damages caused by the contamination with HIV. (**Reported case**)

G) PRACTICAL NOTES FOR LAWYERS

The cases of malpractice shall usually be approached in 2 ways: in a criminal procedure - to establish guilt and attach criminal liability to the person who is guilty of malpractice; and in a civil procedure - to determine liability, requesting financial compensation for damage to material and moral damage. It is important:

- To assess the costs incurred by the patient for medical treatment, which would be a material damage;
- That assessment of moral damage can be done through psychological evaluation by a psychologist who will determine the existence of trauma, consequences and intensity of trauma suffered by the patient or their relatives caused by the medical error;
- To establish a causal link between the illegal actions/inactions of the physician and the role of the medical institution and the death/or damage to health of the patient by requesting a repeated expertise by a committee involving experts in relevant fields.

Under the legislation in force, for the prejudice caused by bodily integrity injury or other harm to health or by death, members of the medical staff undergo not only criminal, but also civil liability. Compensation for the material and moral damage is regulated by **Articles 1419 - 1423** of the **Civil Code of the Republic of Moldova**, adopted on June 6th, 2002. But once the presumption of innocence is applied to the suspect in criminal proceedings, the lawyer's role is secondary to that of the criminal investigation body. While in civil proceedings, the lawyer is in control of planning and conducting the trial, which allows him/her to gather diverse evidence in support of the criminal liability of the defendant - physician or medical institution.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to Safety under the Right to Highest Attainable Standard of Health in Chapter 2 (international) and Chapter 3 (regional) standards of human rights in patient care.

The Right to Safety is also referred to the Right to Life and the Right Not to Be Subjected to Torture and Inhuman and Degrading Treatment, which are fundamental human rights and are also described in Chapter 2 and Chapter 3.

6.1.10 RIGHT TO INNOVATION

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

The patient has the right to innovative diagnostic and treatment procedures, according to international standards and independently of economic or financial considerations. The health services have the duty to promote and sustain research in the biomedical field, and the research results must be widely disseminated.

Although there is no specific mention of the right to innovation in the national legislation, the law does provide for the availability of appropriate care for patients with rare, uncommon diseases (Law on the Rights of Patients). Legislation also deals with biomedical research on human beings (Law on Health-

care, and Law on Medicines). Finally, the right to innovation is indirectly linked to the continuous education and professional development of healthcare personnel, which provides them with the possibility to offer up-to-date care.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ This right is reflected indirectly in **Article 36** of the *Constitution of the Republic of Moldova*, which guarantees citizens the right to health.

- ▶ Under the *Law on Healthcare no. 411-XIII of 28.03.1995*, in **Article 17**, the right of the population to health is guaranteed by ensuring qualified healthcare provided in accordance with the requirements of modern medicine.

The doctor can apply new methods of prevention, diagnostic and treatment and new drugs which are scientifically substantiated, but still not accepted for being widely used, provided a written consent of the patient capable of lucid reasoning and preserved discernment or written consent of the parents, guardian or curator of the patient under the age of 16 or the mentally ill. (**Article 28, paragraph 2**)

- ▶ *Law on Medicines no. 1409 of 17.12.1997*, in **Article 12**, stipulates that healthy people (volunteers) and patients during the treatment of diseases have the right to participate in clinical trials, concluding with the initiator of the trial a life and health insurance agreement having as beneficiary the patient or volunteer, as established by law.

- ▶ *Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005* provides the right of patients to express voluntary consent or refusal to participate in biomedical research. (**Article 5, (k)**)

Ensuring the rights of patients in biomedical research (clinical trials) related to the application of new methods of diagnostic, treatment, prevention and rehabilitation, medicines and other similar means is described in **Article 14** of the Law.

Dissemination and advertising, including in mass media, of methods of diagnostic, treatment, prevention and rehabilitation, medicines and other remedies that have not passed verification testing in accordance with the law are prohibited. (**Article 14, paragraph 9**)

- ▶ *Law on Reproductive Health no. 138 of 15.06.2012* stipulates that people have the right to treatment of infertility, including the use of assisted reproductive technologies. All conditions of using fertilization technologies are described in detail in the Law. (**Articles 9-13**)

State policy in the field of reproductive health includes supporting scientific research in reproductive health and undergraduate and postgraduate training of specialists in the field of reproductive health and reproductive rights in accordance with international standards. (**Article 14, (j), (k)**)

- ▶ In the *Law on State Surveillance of Public Health no. 10 of 03.02.2009*, the right to innovation is observed and promoted by the State by guaranteeing evidence-based decisions and/or decisions based on recommendations of competent international bodies. (**Article 3, paragraph 8**)

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- *Code on Science and Innovation of the Republic of Moldova no. 259-XV of 15.07.2004 published in the Official Gazette of the Republic of Moldova no. 125-129/663 of 30.07.2004*
- *Order of the Ministry of Health of the Republic of Moldova no. 20 of 12.01.2006 on the monitoring of adverse effects of medicines and other pharmaceutical products in the Republic of Moldova*

- **Order no. 22 of 12.01.2006 on amending the Order of the MoH of the RM no. 10 of 14.01.2002 "On the conduct of clinical trials of medicines in the Republic of Moldova"**
- **Order of the MoH no. 179 of 14.03.2011 "On approval of vaccines, serum and immune-biological preparations"**

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** in **Chapter XII** includes a range of professional obligations in conducting medical research involving human subjects. It is stipulated that in the process of clinical trial, the well-being of the individual outweighs the benefits for the society or science.

The patient cannot be forced to participate or cannot be involved by deceit in clinical trials.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Medical institutions are equipped with modern medical equipment for diagnostic and treatment and these services are available to the public. New, scientifically-proved and approved methods are used for testing and treatment.
- Clinical protocols for treatment of different diseases are constantly adjusted to new scientific innovations in the field and to recommendations made at international level.
- Clinical trials are transparent, in accordance with international rules of good practice.

2. Examples of Breach

- Treatment methods for cancer patients are outdated and of high risk to the health of patients. They have been replaced for a long time already in other European countries, with more efficient and secure ones. Administration of medical institutions and persons involved in the management of this service at the country level are not interested in implementing existing innovations in the field. **(Hypothetical)**
- The patient G. needs a complex heart surgery. In the Republic of Moldova, there are no equipment and qualified specialists for such surgeries. Such complex surgeries are performed in a partnership with a European Union country, involving specialists from a European advanced medical institution. A highly qualified team of surgeons come to Moldova for a week, bringing advanced equipment needed for heart surgeries. The expenses are fully covered by the European country.
- The patient G. is refused to be placed on a waiting list for surgery performed by European specialists, without justified reasons. **(Hypothetical)**

3. Actual Case

There are no actual cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

Lawyers should assess whether the current health system provides equal access to innovative treatment for patients, regardless of their income or any other discriminatory circumstances.

The given right is directly connected to the patients' right to equality and to prohibition of discrimination of any kind. The lawyer must prove that in the same circumstances and existence of a similar medical need, the treatment that was provided to other patients was illegally denied to the complainant. In the conditions of limited State resources, a complaint regarding legal acts regulating the matter can be filed with general courts of law applying administrative procedural rules, as well as with the Constitutional Court.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to Innovation under the Right to the Highest Attainable Standard of Health in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

6.1.11 RIGHT TO AVOID UNNECESSARY SUFFERING AND PAIN

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every individual has the right to avoid suffering and pain to the maximum possible extent, in each phase of his or her illness.

In the national health legislation, there are no specific provisions on the right to avoid unnecessary suffering and pain. However, avoiding and alleviating suffering and pain is the main objective of palliative care. Provisions regulating involuntary placement, seclusion and restraint of patients with mental disorders are closely connected to this right; and abuses in prison and in psychiatric facilities fall under its scope as well. Finally, this right is linked to the Right of Access, the Right to Observance of Quality Standards, the Right to Safety, and to the Right to Free Choice.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The ***Constitution of the Republic of Moldova*** does not contain an express provision on the patient's suffering. This principle is reflected in **Article 24** of the Constitution which guarantees the right of every person of not being subjected to torture or to cruel, inhuman or degrading punishments or treatment.
- ▶ ***Law on Healthcare no. 411-XIII of 28.03.1995*** guarantees emergency medical care to all persons in case of danger to life.
 - **Emergency situations in general.** People are guaranteed medical care in emergency situations (natural disasters, catastrophes, accidents, mass disease and poisoning, ionizing and non-ionizing irradiation, heavy environmental pollution etc.). (**Article 24**)
 - **End of life.** Medical equipment that keeps the patient's life in an extreme case may be disconnected only after brain death. The patient has the right to die in dignity. However, the patient's request to have his/her life shortened by medical means (euthanasia) cannot be satisfied. (**Article 34**)

- **Elderly.** Elderly people have the right to assistance to ensure their physical and psychological needs, to extend their active life period, and to ensure the socio-psychological adaptation in old age, prevention of chronic disease and disability. **(Article 38)**
 - **People in detention.** People in detention have the right to healthcare and living conditions which do not demean the dignity or endanger their lives and health. Persons under arrest or detention shall be guaranteed medical care. **(Article 39)**
 - **Persons with mental disorders.** Rights of persons suffering from mental disorders are observed by the professional activity of the physician providing medical care under the code of medical ethics. Psychiatric treatment will not be applied in the absence of mental illness. **(Article 42)**
 - **Hunger strike.** Hunger strike, being a potential medical emergency, requires mandatory healthcare throughout it. When the health and life of a hunger striker are found seriously threatened, the doctor is obliged, in accordance with the code of medical ethics, to make every effort to support the health and save the life of the person. **(Article 40)**
 - **HIV/AIDS.** People infected with the human immunodeficiency virus (HIV) and suffering from AIDS are provided with health and social care. **(Article 41)**
 - **Substance abuse or addiction.** Treatment of persons suffering from chronic alcoholism, drug abuse or addiction is performed usually on a voluntary basis, in outpatient or inpatient medical institutions, anonymously if desired. **(Article 43)**
- ▶ **Law on the Patient's Rights and Responsibilities no. 263 of 27.10.2005**, in **Article 5**, refers to the patient's right to attenuation of suffering and alleviation of pain caused by an illness and/or medical intervention, by all available legal means and methods determined by the existing level of medical science and the real possibilities of the healthcare provider.
 - ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** states that in carrying out their work, physicians have no right to subject patients to undue risk, even with the patients' consent. **(Article 17, paragraph 2)**
 - ▶ **Law on Mental Health no. 1402 of 16.12.1997** provides that the child suffering from a mental disorder shall not be subjected to experiments, electroconvulsive therapy, scientific or teaching research, taken pictures, filmed, and any irreversible treatment (psychosurgical) without the child's or his/her legal representative's consent. **(Article 5¹)**
 - ▶ **Law on the Social Inclusion of People with Disabilities no. 60 of 30.03.2012** guarantees that persons with incurable diseases at advanced or terminal stages are entitled to palliative care services, which imply the meeting of the physical, mental, emotional and spiritual needs of the patients and their families. Any person with disabilities is entitled to attenuation of the suffering and relief of the pain by all available legal means and methods provided by the current level of medical science and according to the actual capacity of healthcare providers.
People with disabilities are entitled, if necessary, to nursing services at home, provided in line with the law. **(Article 43, paragraphs 4-6)**
 - ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** stipulates that persons on record with TB and TB patients have the right to diagnostic and treatment in specialized anti-tuberculosis medical institutions or outpatient facilities, depending on the manifestation of the disease. **(Article 17, (c))**
 - ▶ **Law on Medicines no. 1409 of 17.12.1997**, in **Article 12**, stipulates that in carrying out clinical trials, in case of occurrence of a hazard to life or health of the patient or volunteer, as well when the patient or volunteer desires cessation of the trials, the head of the clinical trials is obliged to stop the trials.

- ▶ **Law on Transplantation of Organs, Tissues and Cells no. 42 of 06.03.2008** stipulates that organs, tissues or cells may not be taken from a person who is unable to express consent, except in the case of sampling of regenerative tissues or cells. The sampling of regenerative tissues or cells will be approved by the Independent Commission, with participation of the legal representatives of the donor or the guardianship authority, provided that the donation will benefit a person who is a 1st degree relative of the donor (for minor donor - brother, sister) and the procedure is of minimal risk to the donor. Written, verbal or otherwise-given refusal of the minor prevents sampling of any regenerative tissues or cells. **(Article 19)**
The Independent Commission for Approval is a body coordinating the activities of organ, human tissues or cells donation from a living donor. The Commission has no legal personality, is established under the Ministry of Health and operates on a voluntary basis according to the principles of legality, transparency, confidentiality and anonymity in the act of donation of organs, tissues and cells for therapeutic use. The structure, responsibilities and rights of the Commission are described in the **Regulation on organization and functions of the Independent Commission of the Ministry of Health approved by the Government Decision no. 1207 of 27.12.2010.**
- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates that in reproductive healthcare, risk-free motherhood is a priority. **(Article 3, (b))**
The State shall ensure the prevention of sexual violence, and the support and rehabilitation of victims of violence. (Article 5 (m))
To prevent suffering due to the aging process, **Article 7 of the Law (paragraph 1)** provides that elderly women and men have the right to benefit from high level sexual health services.
- ▶ Torture is punishable under the **Criminal Code of the Republic of Moldova, Article 309¹.**

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- **Order of the Ministry of Health on approval of National Standards for Palliative Care no. 884/2010**
- **Order of the Ministry of Health on organizing palliative care units for persons living with HIV/AIDS no. 60/2011.** The order provides that palliative care units for people with HIV/AIDS are established in order to reduce the impact of HIV infection and strengthen the quality of medical and social care, improving the quality of life of people living with HIV/AIDS.

D) PROVISIONS OF THE CODE OF ETHICS

Chapter XIII of the **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** stipulates the obligation of each health worker to do everything possible to reduce the suffering of an incurable patient, by respecting his/her dignity. However, the Code prohibits the act of euthanasia, i.e. the use of medicines or methods to cause death to a patient, regardless of the severity and prognosis of the disease, even if this act is urged by a perfectly-aware patient.

A health worker should not assist or encourage the patient to commit suicide or harm by giving tips or advice, borrowing tools and other means, and should refuse any explanation or help in this regard.

Mutilation of the patient should not be practiced without obvious and seriously-documented medical justification and without the patient's informed consent, except in cases of life-threatening emergencies.

Medical workers asked or obliged to provide medical care to inmates, including in a prison environment, should not cause, directly or indirectly, or favour, harm to the physical or mental integrity of any inmate, including his/her dignity. If a medical or pharmaceutical worker notices that the person in custody is in a vulnerable situation, one of the medical professional and moral obligations will be the intervention in the support and protection of the detainee. **(Paragraph 19)**

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

For patients suffering from major, unbearable pain, access to medications is ensured in order to relieve pain and suffering. One of the international recommendations in this context is the availability of morphine for oncologic patients. (**Actual situation**)

2. Examples of Breach

- The patient V. was brought by ambulance to the hospital with complaints of acute back pain in the lumbar region. The doctor determined that the pain was caused by stones found in the kidney being eliminated through the urinary tract. Even if the patient complained of severe pain, healthcare workers neglected the patient for an hour, without giving him any painkillers. At the request of the patient to be given something to reduce the pain, a doctor told him that they were busy with other more critical patients, and that "nobody died of kidney stones discharge". The patient was subjected to unjustified pain and suffering. (**Hypothetical**)
- The doctors from a medical institution in a prison have observed that the prison's workers exhibit inhuman behaviour towards the persons in detention. Physicians are required to perform acts causing suffering of prisoners to find out some information about their criminal life. The institution is not provided with analgesic and anaesthetic drugs to be administered to patients when they need to reduce their pain or suffering. (**Hypothetical**)

3. Actual Cases

The European Court of Human Rights, in a number of reviewed cases concerning Article 3 of the Convention, held that the State had an obligation to ensure access to medical services for all detainees and that failure to do so may result in inhuman and degrading treatment, an example of which is the **case of Khudobin v. Russia (Judgment of October 22nd, 2006)**. The plaintiff was HIV-positive, had various chronic diseases, among which epilepsy, hepatitis, various mental disorders, and during his detention of over a year, the plaintiff caught a number of extremely serious diseases (including measles, acute bronchitis and pneumonia). Because of his health condition, the plaintiff was frequently treated in an inpatient medical facility for contagious diseases. At the same time, the request of his family to perform a thorough medical examination was rejected. The Court specified that – given the HIV status of the detainee and that he had been suffering from a serious mental illness – lack of timely and quality medical care and the refusal to allow an independent medical examination must have led to a state of insecurity. The Court concluded that the plaintiff had not received the necessary medical care, and – while acknowledging that the medical care available in prison hospitals was not always of the same quality as that provided in the best medical institutions servicing the general public – the State should have made sure that the good health and well-being of the detainees were adequately secured by providing the necessary medical care.

G) PRACTICAL NOTES FOR LAWYERS

Lawyers should obtain more detailed information from their clients regarding the intensity of the pain incurred as a result of a deliberate inaction of physicians in providing healthcare.

An evaluation by an independent specialist regarding the accuracy of medical actions in relation to the situation and the circumstances of the case should be requested.

Lawyers should be aware that in any healthcare situation, physicians are obliged to take prompt and urgent action to relieve the patient's pain.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The right not to be subjected to unnecessary suffering and pain is apparent from the fundamental right to health, the right of not being subjected to torture, and inhuman and degrading treatment.

Please find a discussion of international and regional standards relevant to the Right to Avoid Unnecessary Suffering and Pain under the Right to the Highest Attainable Standard of Health in Chapter 2 on international standards and Chapter 3 on regional standards of human rights in patient care.

6.1.12 RIGHT TO CUSTOMISED TREATMENT

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every patient has the right to diagnostic or therapeutic programs tailored as much as possible to his or her personal needs in which economic criteria should not prevail over the right to healthcare.

Although any healthcare system should be aimed at offering citizens customised treatment and care, it often is hardly achievable under existing constraints in terms of financing and other resources. The national legislation addresses this by calling respect for a patient's dignity and honour and, what is more, by observing a patient's culture, religious convictions and personal values. Also, this right is linked to the Right to Privacy.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The ***Constitution of the Republic of Moldova*** does not expressly provide for this right; however it can be found in **Article 36** which guarantees the right of every person to healthcare.
- ▶ ***Law on Healthcare no. 411-XIII of 28.03.1995*** stipulates the patient's right to be informed and to decide, and the obligation of medical staff to comply with these rights. As a result, an individualized approach to patients' treatment emerges (**Articles 23, 25, 27, 28**).
- ▶ ***Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005***, in **Article 2**, stipulates the patient's right to have medical workers observe the patient's moral and cultural values and religious and philosophical beliefs when providing health services. The law recognizes the patient, and in the cases provided for by law, his/her legal representative as the main participant in the decision-making on a medical intervention. These provisions support the right of the patient to an individualized approach in receiving medical services.
- ▶ ***Law on the Practice of the Medical Profession no. 264 of 27.10.2005***, in **Article 18 (paragraph 1)**, stipulates that the relationship between doctor and the patient must be based on the patient's right to have an option for decision.

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates that reproductive health services are to be provided according to the specific age group, focused on the following priority areas: teenagers' sexual and reproductive health, sexual health of elderly people, sexual and reproductive health of men. **(Article 3, (e), (f), (i))**

Teenagers have the right to information and access to reproductive healthcare services tailored to their needs. Teenagers have the right to sex education tailored by age to ensure proper psychosexual development, prevention of sexually transmitted infections and HIV/AIDS, unwanted pregnancy and training skills for a responsible parenthood. Sex education and preparation for family life is carried out in educational and other establishments where there are teenagers and young people, including those with special needs, using special programs developed as part of the compulsory curriculum of educational institutions, taking into account the age, the sex and the peculiarities of psychosexual development. **(Article 6, paragraph 1, 2, 3)**

Men and women have the right to prevention of health problems during menopause and andropause. **(Article 7 paragraph 2, (a))**

- ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** foresees that persons on record with TB and TB patients have the right to diagnostic and treatment in specialized anti-tuberculosis medical institutions or outpatient facilities depending on the manifestations of the disease. **(Article 17, (c))**

People receiving treatment for tuberculosis benefit, where appropriate, from medical recovery and/or return to their professional activity. **(Article 19)**

- ▶ **Law on Mental Health no. 1402 of 16.12.1997** stipulates that in receiving psychiatric care, persons suffering from mental disorders have the right to all types of treatment (including sanatorium) in accordance with the therapeutic indications.

Information regarding the rights, the nature of mental disorders and the methods of treatment should be explained to patients in a comprehensible manner, taking into account their mental condition. **(Article 5)**

Placing children in mental health institutions requires habitual zones separate from adults and a secured environment adapted to children and their development needs. **(Article 5¹)**

- ▶ **Law on the Social Inclusion of People with Disabilities no. 60 of 30.03.2012** provides that the special needs of women with disabilities shall be considered when providing medical care, including during gynaecological treatment and counselling on family planning and reproductive health. **(Article 42, paragraph 12)**

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no specific acts on this subject at the time of writing this guidebook.

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** claims that in the exercise of their profession, medical and pharmaceutical workers are to give priority to the patient's interests that prevail over all other interests. **(Paragraph 9, (e))**

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Doctors prescribe treatment adapted to the needs of patients, ensuring proper information of patients about the methods applied and receiving their consent.
- The patient C. suffers from diabetes mellitus. The patient fell ill with a respiratory disease. The physician, when prescribing the treatment, takes into account the specific features of the patient and prescribes sugar-free cough syrups, which will not harm the patient. **(Actual situation)**
- The patient F. needs a transplant of heart valves. Usually pig heart valves are used, as they are well-accepted by the human body. The patient F. belongs to a religious denomination that does not accept pork consumption, and so does not accept pig valves as a material for transplantation. The patient refuses transplantation even though being in danger of dying of heart failure. The cardiologist found that there were positive scientific results after transplantation using bovine heart valves. The doctor contacted the group of researchers who published the results about the new type of transplant and suggested to patient F. to accept this type of transplant. The patient is happy that an individualized approach to his spiritual needs and values was found. **(Case reported in mass media)**

2. Examples of Breach

- The patient L. was hospitalized with serious haemorrhage after accidental damage to a blood vessel. The doctors established there was a need for blood transfusion. The patient refused transfusion for religious reasons and requested to be administered synthetic preparations for blood replacement. The doctor ignored the patient's desire, considering that the use of these preparations would have decreased the chances for healing the patient. The doctor administered sleeping drugs to the patient and carried out the transfusion, considering that it was for the patient's sake. After the patient's recovery, the patient accused the doctor of not observing his rights, but no action was taken. **(Case reported in mass media)**

G) PRACTICAL NOTES FOR LAWYERS

The foundation of this right lies in the principle of "do not harm" – one of the major statements in Hippocrates' Oath – as taking into account a patient's personal and special needs is a prerequisite to provide him/her a treatment that would not harm his/her health. In practice, this means that preventive measures during medical care must not be generalized to the extent that such generalization is against individual needs and is detrimental to the conditions of a specific patient.

Violation of the right to a customised treatment might take the form of administration of a medicine or treatment without prior diagnosis, or of failing to use adequate procedures while diagnosing. In order for the complaint to succeed in court, competent expert medical opinion should be obtained in advance.

Lawyers must take into account the fact that the violation of the patient's right to information and/or freedom of choice can often raise questions about the observance of the patient's rights to customised treatment, which is linked to the patient's freedom of choice based on adequate information on the treatment proposed.

Lawyers will need to obtain expertise/conclusion of a physician who shall answer the question of whether the treatment corresponded to the patient needs and desire.

Lawyers should note that the phrase stipulated in the European Charter of Patients' Rights "as much as possible" contains a restriction which means that professionals have the right to a margin of error in determining a customised treatment, which depends on the standards supported in each case.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The Right to Personalized Treatment is directly connected with the Right to the Highest Attainable Standard of Health and the Right to Non-Discrimination and Equality described in Chapter 2 (international standards) and Chapter 3 (regional standards).

6.1.13 RIGHT TO FILE A COMPLAINT

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every patient has the right to complain whenever he or she has suffered an unjustified harm and the right to demand explanations.

The right to complain and/or appeal to court is defined by the general legislation. However, this right is specifically articulated in the context of healthcare as well.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The **Constitution of the Republic of Moldova** includes a series of Articles which provide for the right of citizens to express their dissatisfaction:
 - **Article 20** stipulates the right of every person to receive effective protection from competent courts of law against acts that violate his/her rights, freedoms and interests. No law can impede access to justice.
 - The right to legal defence is guaranteed by **Article 26**.
 - Citizens have the right to address public authorities by petitions formulated only in the names of the signatories, and legally-constituted organizations have the right to forward petitions exclusively on behalf of the collectives they represent. (**Article 52**)
 - Any person prejudiced in his/her legitimate right by a public authority through an administrative document or by failure to settle a claim in legal terms is entitled to the recognition of rights, the cancellation of the document, and compensation for damages. (**Article 53**)
- ▶ **Law on the Contentious-administrative no. 793 of 10.02.2000** guarantees the right of any person injured in his/her right, recognized by law, by a public authority, through an administrative document or failure to settle a claim within the statutory period, to appeal to administrative court to obtain the cancellation of the document, the recognition of his/her rights and a compensation of the damage caused.
- ▶ **Law on Petitioning no. 190 of 19.07.1994** determines the ways of examining petitions of Moldovan citizens addressed to the State bodies, enterprises, institutions and organizations in order to protect their legitimate rights and interests. The petitioner, who is not satisfied with the received response to the preliminary application or has not received a response within the period specified by law, is entitled to notify the competent administrative court.
- ▶ Under the **Law on Healthcare no. 411-XIII of 28.03.1995**, in **Article 19**, a person can challenge illegitimate actions and decisions of State bodies and decision makers who have damaged their health. **Article 36** stipulates that in case of a patient's poor health condition following inadequate healthcare treatment, medical staff must take into account and observe the patient's right to require, as provided, a professional expertise and seek compensation for moral and material damage.

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005**, in **Article 5**, establishes the patient's rights to the assistance of a lawyer or other representative to protect their interests, as established by law; to information on the results of the review of complaints and requests, as provided by law; and to extrajudicial and judicial appeal of actions of health workers, other healthcare providers, and the officials responsible for ensuring healthcare and related services in the volume prescribed by law.

Chapter 4 of the Law is devoted to the protection of patient's rights and the way of fulfilling these rights. Thus, **Article 15** of the Law expressly establishes the patient's right to challenge the actions of healthcare providers. The patient can submit a complaint against the actions of healthcare providers in cases where the providers' actions damage the individual patient's rights, and against the actions and decisions of public authorities and persons holding responsible positions violating their social rights established by law. Patient's rights protection is ensured judicially and extra-judicially according to the law.

- ▶ **Law on HIV/AIDS Prevention no. 23-XVI of 16.02.2007**, in **Article 33, paragraph 2**, provides for the right of a person to compensation for moral and material damages as a result of HIV infection contracted in a healthcare institution.

The ways to handle breaches of laws are described in Chapter 7 on the National Procedures in this Guidebook.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

Order of Ministry of Health no. 303 of 06.05.2010 on access to information concerning personal medical data and the list of medical interventions that require informed consent

D) PROVISIONS OF THE CODE OF ETHICS

There are no direct provisions in this regard.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

The complaints received by the Ministry of Health from the population on the quality and volume of medical services provided in different medical institutions are analysed according to the terms provided by law; committees that evaluate each case are created and require the expertise of independent experts. Authors of petitions receive responses in due time and they are informed about the decisions and the action taken by the central and local government to resolve the cases. **(Hypothetical)**

2. Examples of Breach

Patients address extra-judicially various complaints to appropriate authorities for consideration and response, but they receive no replies. **(Hypothetical)**

3. Actual Case

Female citizen S. submitted a complaint to the administration of the hospital in which her minor daughter was treated, regarding the fact that the doctor refused to submit to her upon request the medical records of the child. Citizen S. asked the administration to investigate this case and to inform her about the results. Subsequently, she received an answer that the administration is not competent to examine such complaints. The citizen was forced to appeal to the court and request a copy of the medical records. The hospital was obliged to present all information from medical records to the patient's mother. **(Case from the authors' practice)**

G) PRACTICAL NOTES FOR LAWYERS

The constitutional right to file a complaint in order to seek a remedy is reflected in the current legislation. Therefore, prior analysis of the effectiveness of the various complaint procedures and alternative means of restoring rights is vital, together with being acquainted with existing court cases on different forms of claiming damages. Besides filing a complaint in court, there are administrative procedures, such as applying to supervisory and control agencies within the structure of the Ministry of Health. After consulting with clients and deliberating on clients' interests, the lawyer should decide which methods and procedures respond best to the clients' needs. These court and alternative procedures are further developed in Chapter 7 on the National Procedures in this Guidebook.

Lawyers should be familiar with all the possible ways to appeal the actions or inactions of physicians and hospital administrations and to select the most effective way of achieving the legal intentions of the client, which will involve less time and lower costs.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to File a Complaint in Chapter 2 on International Standards of Human Rights in Patient Care and Chapter 3 on Regional Standards of Human Rights in Patient Care.

6.1.14 RIGHT TO COMPENSATION

A) RIGHT STIPULATED IN THE EUROPEAN CHARTER OF PATIENT'S RIGHTS

Every patient has the right to receive sufficient compensation within a reasonably period of time, whenever he or she has suffered physical or moral and psychological harm caused by a health service.

The national legislation envisages the right of patients to seek compensation for the prejudice caused to them within the healthcare system. However, the only possibility (well-established system) to be compensated is through the court.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ **Constitution of the Republic of Moldova**, in **Article 20**, stipulates the right to free access to justice. Everyone has the right to an effective remedy by the courts of law against acts that violate their legitimate rights, freedoms and interests.

- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995**, in **Article 19**, provides that every person has the right to compensation for the prejudice caused to his/her health by violation of the anti-epidemic measures, sanitary and hygienic rules and regulations, labour protection, road traffic and malicious actions of other people. Patients and health insurance bodies have the right to receive compensation for the prejudice caused to patients by medical institutions, by non-compliance of the medical treatment, by prescribing contraindicated medications or inadequate treatment that worsens the health, causes permanent disability or is life-threatening for the patient or results in his/her death.
- ▶ **Law on Mandatory Medical Insurance no. 1585-XIII of 27.02.1998** stipulates that an insurer is materially liable for the damage to the life and health caused to the insured person as a result of poorly or insufficiently provided healthcare services provided by the Unique Program (**Article 14, paragraph 2**).
- ▶ **Law on Patients' Rights and Responsibilities no. 263-XVI of 27.10.2005, Article 5, (q)** determines the patient's right to compensation for damage to health, according to the law.
- ▶ **Law on HIV/AIDS Prevention no. 23-XVI of 16.02.2007**, in **Article 33, (paragraph 2)**, stipulates that compensation for the moral and material damages to the person/patient as a result of HIV infection is the responsibility of the healthcare institution where the person got infected.
- ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** stipulates the right of the person to receive compensation for life or health damages caused during anti-tuberculosis care or in the case when it was not provided in due time, if such care was requested. (**Article 22**)
- ▶ **Law on Transplantation of Human Organs, Tissues and Cells no. 42 of 06.03.2008** stipulates that if the health of the donor or the recipient is affected due to non-compliance with the legal standards, terms and conditions of sampling and transplantation of organs, tissues and/or cells, the healthcare institution shall be liable to the affected persons in accordance with the law. (**Article 31**)
- ▶ The **Civil Code of the Republic of Moldova** assumes liability for damages caused under **Articles 1418 - 1424**.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no provisions in this regard.

D) PROVISIONS OF THE CODE OF ETHICS

There are no provisions stipulating the patient's right to receive compensation for damages.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

A patient complains to the hospital X. administration about the actions of physicians who have prescribed a wrong treatment, which caused many negative consequences for the patient's health. The patient requests compensation of all costs incurred for the treatment and the moral damage caused. The hospital administration investigates the complaint, establishes the facts alleged in the

complaint and compensates the patient for the suffering caused and the costs of the treatment. **(Hypothetical)**

2. Examples of Breach

Patient V. suffers from a disease of the spine. He is admitted to a hospital for planned surgery. The surgeon makes a serious mistake during surgery, leading to leg paralysis. The patient, after further consultation with other specialists in the field, claims compensation of the costs for additional surgery to repair the surgeon's mistake and compensation for damage from the hospital administration. The hospital administration refuses to pay these costs. The patient is forced to appeal to the court. **(Hypothetical)**

3. Actual Case

The European Court of Human Rights accepted the amicable settlement of the parties in the **case of G. N. et al. v. Italy**, by its Judgment of March 13th, 2001 consisting of the payment for damages in the amount of EUR 2,324,056.05.

The plaintiffs, Mr. G. N., Ms. G. S., Mr. D. C., Ms. G. D. M., Mr. S. C., Ms. E. S. and Ms. D. C., are Italian citizens, relatives of the persons who have died of HIV and hepatitis C after blood transfusions performed by the national public health service in the 80's. In the initial ruling, the Court held that Article 2 was not violated in terms of the obligation to protect life. Instead, the ECtHR ruled that there was a breach of the reasonable period for addressing the plaintiffs' complaints. The Court ruled that the victims get EUR 39,000 each for pecuniary damages, and EUR 2 million for moral damages from the Italian State, as part of the amicable settlement.

G) PRACTICAL NOTES FOR LAWYERS

Lawyers should ensure the assessment of costs for the material damage incurred by the patient. To assess the amount of moral damages, it is necessary to provide psychological expertise that will establish the intensity of the suffering, and the causal connection between the suffering caused and the damage incurred.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to Compensation in Chapter 2 on International Standards of Human Rights in Patient Care and Chapter 3 on Regional Standards of Human Rights in Patient Care.

6.2 PATIENTS' RESPONSIBILITIES

The patient's rights are addressed under the conditions of certain responsibilities stipulated by the law.

6.2.1 THE RESPONSIBILITY OF TAKING CARE OF ONE'S OWN HEALTH, LIFE AND THE HEALTH OF OTHER PERSONS

A) EVERY PERSON IS RESPONSIBLE FOR HIS/HER OWN HEALTH AND THE HEALTH OF OTHERS

B) RESPONSIBILITY AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995**, in **Article 18**, stipulates the obligation of the population, with the aim to insure health, to possess knowledge about healthy lifestyles, individual hygiene, rational food, prevention of giving birth to children with congenital malformations, prevention of diseases; about the inadmissibility of medicines abuse, the symptoms of diseases and the provision of first medical aid; and about the damages of alcohol, narcotics and psychotropic substances.

Article 47 stipulates the obligation of parents to take care of the health of their child, his/her prenatal development, his/her physical, spiritual and moral education and to cultivate a healthy lifestyle. The parents, or other legal representatives, at the request of the healthcare facilities, shall take their child for medical examination and application of prophylactic measures.

Persons suffering from tuberculosis in an active form, who avoid voluntary treatment, violate the prescribed regime, are alcohol abusers or are drug-addicted shall be subjected to coercive treatment as stipulated in the legislation in force. (**Article 44**)

Article 45 of the Law stipulates the responsibility of persons with sexually- transmitted diseases who avoid treatment. In cases of avoiding medical examination and voluntary treatment, these persons will be subjected to coercive examination and treatment in a venereal diseases hospital. Persons, who, after being warned by the healthcare facilities, avoid coercive examination and treatment, are held liable according to the legislation in force for infecting other persons.

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005**, in **Article 7**, stipulates that the patient:
 - shall take care of his/her own health and lead a healthy lifestyle by excluding deliberate actions which harm his/her health and the health of other people;
 - in the absence of medical contraindications, shall undertake mandatory prophylactic measures, including immunization, the non-fulfilment of which threaten his/her own health and represent a social danger.
- ▶ **Law on HIV/AIDS Prevention and Control no. 23-XVI of 16.02.2007**, in **Article 29**, stipulates the obligation of HIV-positive people. HIV-positive persons are informed in writing by the healthcare institution (where the HIV condition is determined) about the necessity to follow the rules to prevent the spread of HIV infection, as well as about the criminal offence for both risking the contamination of another person and infecting another person deliberately. These persons shall demonstrate a responsible and safe behaviour.
- ▶ **Criminal Code of the Republic of Moldova no. 985-XV of 18.04.2002**, in **Article 212**, stipulates that a person who is aware of being infected with HIV and risks infecting another person deliberately shall

be punished with imprisonment of up to one year. Infection of another person with HIV by a person who knew that he/she is infected shall be punished with imprisonment for one to five years; and infection of two or more persons or infection of a minor shall be punished with imprisonment for three to eight years. Infection with HIV as a result of failure to perform or improper performance of professional duties by a healthcare worker shall be punished with imprisonment of up to five years with deprivation of the right to perform certain professional functions or to exercise a certain medical activity for a term of up to three years.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- *Regulation on the application of the coercive treatment to persons suffering from contagious tuberculosis approved by the Government Decision no. 472 of 07.08.2009.*

D) PROVISIONS OF THE CODE OF ETHICS

There are no specific provisions concerning this responsibility of the patient.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- A patient suffering from diabetes, being aware of his health condition, follows all the recommendations given by the doctor, receives treatment regularly and strictly follows the prescribed diet. Thus, he avoids the aggravation of the disease and the development of complications. **(Hypothetical)**
- The parents of a child with malabsorption are aware that their child needs special care, specific diet and food prepared according to certain recipes. The parents follow the prescriptions of the specialists, feed the child according to the prescriptions and thus they avoid the aggravation of the disease. **(Hypothetical)**
- A seropositive man warns his sexual partner about his HIV condition and takes measures to prevent infection, in a responsible manner. **(Hypothetical)**

2. Examples of Breach

- Patient H. suffers from hypertension. The doctor prescribed a treatment which needs to be administered regularly, diet and a special regime. The patient was made aware that he had to exclude alcohol and fats consumption, and to carry out physical exercise. The patient ignored the recommendations of the doctor, and consumed alcohol and foods high in fat content. As a result, the patient suffered a hypertensive crisis with a cerebral haemorrhage (stroke), which led to the paralysis of the right side of the body. The patient is bedridden. He suffers a lot because of his condition, and causes sufferings and big expenses to his family. **(Hypothetical)**
- Before marriage, all young people are advised to pass a series of standard medical tests. Mr. D. and Miss C. decide to get married and take the medical tests at a local healthcare facility. Mr. D. receives a positive HIV test result, but hesitates to inform his partner about it, as he is afraid that she will change her mind about marrying him. Miss C.'s test result is negative. After two years of marriage, Mrs. C gets pregnant and has a regular health check. Her HIV test result turns out positive. Mrs. C. asks her husband to take a HIV test, but he refuses to do so. **(Hypothetical)**

3. Actual Case

- A boy, 12 years old, is living with the mother and grandmother in the city peripherals. The child weighs 85 kg, with obvious signs of obesity. The paediatrician recommends his mother to initiate a proper diet for the child nutrition but she refuses, saying she feeds her child as she better knows. At his second visit, the doctor warns the mother that the Social Assistance Service will be notified because she is responsible for the child's health and specific measures will be taken if her actions endanger the child's life. **(Case from author's practice)**

G) PRACTICAL NOTES FOR LAWYERS

Because of the lack of experience in this area in the country at the time of the writing this guidebook, practical advice for lawyers cannot be given.

6.2.2 RESPONSIBILITY FOR DEMONSTRATING APPROPRIATE BEHAVIOUR IN HEALTHCARE FACILITIES

A) THE PATIENT IS HELD LIABLE, ACCORDING TO THE LEGISLATION IN FORCE, IN THE CASE HE/SHE DOES NOT FOLLOW THE RULES OF TREATMENT AND BEHAVIOUR IN A HEALTHCARE FACILITY, WHICH GENERATES MATERIAL AND MORAL DAMAGES

B) RESPONSIBILITY AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005**, in **Article 7**, stipulates that the patient shall:
 - follow the behaviour rules established for the patients in the healthcare facility, as well as the recommendations of the physician during the outpatient or stationary treatment;
 - exclude the use of pharmaceutical products and medicinal substances without the prescription or acceptance by the attending doctor, including drugs, other psychotropic substances and alcohol during the treatment period in the healthcare facility;
 - observe the rights and dignity of other patients, as well as of the healthcare personnel.
- ▶ **Law on Tuberculosis Control and Prevention no. 153-XVI of 04.07.2008** stipulates that persons affected by tuberculosis shall follow the medical-curative recommendations prescribed by the healthcare staff, the internal regulations of the specialised anti-tuberculosis healthcare facilities during hospitalization, and the sanitary-hygienic requirements for public places and habitual conditions, approved by the Ministry of Health (**Article 18**). These persons shall not avoid medical examination or treatment when they suffer from a contagious or active form of tuberculosis. In case of not complying with these provisions, these persons bear contravention liability.
- ▶ **Contravention Code no. 218-XVI of 24.10.2008, Article 76**, provides that persons suffering from tuberculosis and being eliminators of bacilli who avoid treatment and violate the prescribed regime shall be punished by a fine of 10 to 25 conventional units*.

*A conventional unit is equal to MDL 50.00. Fines could be applied to individuals from one to 150 conventional units, and to the responsible persons and legal entities - from 10 to 500 conventional units. The offender is entitled to pay half the established fine if paid within 72 hours after its infliction. In this case, the penalty of a fine is fully executed.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no specific provisions concerning this responsibility of the patient.

D) PROVISIONS OF THE CODE OF ETHICS

There are no specific provisions concerning this responsibility of the patient.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The patients follow the regulations of the healthcare facility. They accept visitors according to the schedule. They eat only products recommended by the doctor. They do not disturb other patients in the healthcare facility.

2. Examples of Breach

- A patient is admitted to a hospital in a severe condition. He was treated in the department of intensive care, where every patient has a separate room. The patient's condition has improved and, according to the internal regulations of the healthcare facility, the patient shall be transferred to the therapeutic department in a room for 4 persons. The patient refuses to be transferred and demands remaining in the department of intensive care until he is fully recovered and discharged from the hospital, arguing that that is the only place where he receives the treatment he needs. The patient violates the rules of the healthcare facility and creates problems for the procedure of patients' triage within the hospital. **(Hypothetical)**

3. Actual Case

- Female patient H., 24 weeks pregnant, is hospitalized in a gynaecological department of a hospital with the risk of miscarriage. The doctor prescribed treatment and bed rest. On holidays the patient left the hospital unaided and went home, without discussing with the doctor. Staying outside the hospital worsened the condition of the patient and on a Sunday evening she was brought to the hospital by the emergency service with severe vaginal bleeding. The woman has had a miscarriage. The doctor in charge of the case was reprimanded by the administration of the institution because the woman was officially hospitalized; therefore the surveillance of her health condition was the duty of the doctors. No action was taken **(Case from the medical practice)**

G) PRACTICAL NOTES FOR LAWYERS

Because of the lack of experience in this area in the country, practical advice for lawyers cannot be given.

6.2.3 RESPONSIBILITY TO PROVIDE INFORMATION

A) THE PATIENT HAS THE RESPONSIBILITY TO PROVIDE INFORMATION ABOUT HIS/HER HEALTH CONDITION IN ORDER TO PROTECT THE LIFE AND HEALTH OF OTHER PEOPLE

B) RESPONSIBILITY AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005**, in the **Article 7**, stipulates that the patient is obligated to communicate to the healthcare worker comprehensive information about the diseases he/she suffered from in the past or currently suffers from, about the diseases that represent a social danger, including in case of voluntary donation of blood, biological liquids, organs and tissues. If in contact with other persons, including healthcare workers, the patient shall follow the prevention measures, provided that he/she is aware of the fact that the disease which he/she suffers from represents a social danger.
- ▶ **Family Code of the Republic of Moldova no. 1316-XIV of 26.10.2000, Article 11, paragraph 2**, stipulates the obligation of persons who wish to get married to inform each other on their health condition.
- ▶ **Law on HIV/AIDS, Prevention and Control no. 23-XVI of 16.02.2007, Article 14**, stipulates that any person with HIV shall disclose his/her HIV status to his/her spouse or partner.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no specific provisions concerning this responsibility of the patient.

D) PROVISIONS OF THE CODE OF ETHICS

There are no specific provisions concerning this responsibility of the patient.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Mr. K. was informed that the result of his HIV testing is positive. In order to avoid social stigmatization, he tells neither his friends nor his relatives about the diagnosis. However, he immediately tells the truth to his wife in order for her to undergo a test. Starting the antiretroviral treatment as early as possible prevents the occurrence of complications specific for this infection; for this reason it is very important to test the persons from the risk group. **(Hypothetical)**

*(Authors' note; It should be noted that, according to the **National Guidelines for HIV and AIDS Treatment and Care (2009)**, asymptomatic patients are treated when the CD4 cell count <350 per mcl, irrespective of the value of the HIV RNA.)*

2. Examples of Breach

- An inhabitant of a rural area is detected seropositive (HIV infected). The woman is married, but she is afraid to discuss this with her husband. She continues her life and has unprotected sex with her husband. She becomes pregnant and gives birth to a child, without informing the obstetricians of her HIV-positive status. *(Authors' note: It is worth mentioning that HIV is transmitted from mother to child especially during birth and, in case when the doctors who assist the birth are informed that the mother is HIV- positive, they strive to minimize the contact time of the child with the maternal blood.)* Moreover, the woman continues breastfeeding the child, even though she knows that the virus is transmitted to the child through the maternal breast milk. She does not want to raise suspicions by not breastfeeding the child. **(Hypothetical)**

3. Actual Case

- There are no relevant actual cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

Because of the lack of experience in this area in the country, practical advice for lawyers cannot be given.



7.1 HEALTHCARE PROVIDERS' RIGHTS

7.2 HEALTHCARE PROVIDERS' RESPONSIBILITIES/OBLIGATIONS

7

NATIONAL HEALTHCARE PROVIDERS' RIGHTS AND RESPONSIBILITIES/OBLIGATIONS

7.1 HEALTHCARE PROVIDERS' RIGHTS

This section focuses on healthcare providers' rights, including the right to decent working conditions, the right to freedom of association, the right to a fair trial, and other relevant country-specific rights. The concept of human rights in patient care refers to the application of the general human rights principles to all stakeholders in the delivery of healthcare and recognizes the interdependence of patients' and providers' rights. Health workers are unable to provide patients with good care unless their rights are also observed and unless they can work under safe and respectful conditions. For each right outlined in this section, there is a brief explanation of how that right relates to healthcare providers; an analysis of its legal foundation in the country legislation, regulations, and ethical codes is provided; examples of compliance and violation are given; and practical notes for lawyers in litigation circumstances to protect providers' rights.

Legal Basis for Practicing Medical and Pharmaceutical Professions in Moldova

A healthcare provider can be:

1. Healthcare unit - is an enterprise, institution, organization which provides healthcare services. The legal capacity of the healthcare unit begins with its State registration. However, in order to be able to carry out its activity in providing healthcare services, each healthcare unit must be accredited in accordance with the **Law on Evaluation and Accreditation in Health no. 552 of 18.10.2001**⁷²⁴, and the private

724. Official Gazette, 2001, no. 155-157, art. 1234

healthcare unit must be additionally licensed in accordance with the **Law on Licensing of Entrepreneurial Activity no. 451 of 30.07.2001**⁷²⁵.

Healthcare institutions can be public or private, except those that in accordance with the law can only be public (**Law on Healthcare no. 411-XIII of 28.03.1995, Article 4**).

Law on Entrepreneurship and Business no. 845 of 03.01.92, Article 10, paragraph 3, establishes some types of healthcare, the practice of which is considered a State monopoly, namely: supervision and treatment of patients suffering from drug addiction, of patients with dangerous and extremely dangerous contagious diseases including venereal infectious diseases, as well as mental illness in aggressive forms and the issue of appropriate notice of approval. Also, only State institutions are allowed to perform expertise to determine the temporary or permanent loss of the working capacity and the periodic preventive medical examinations of citizens.

2. Physician - the individual with full legal capacity, who has undergraduate and postgraduate medical education and took the respective oath. The **Law on Healthcare no. 411-XIII of 28.03.1995** stipulates the conditions for practicing medical and pharmaceutical professions in Moldova (**Chapter II Practice of pharmaceutical and medical professions**). The procedure for the authorization of the practice of the medical and pharmaceutical profession is supervised by the Ministry of Health. The practice of medical and pharmaceutical professions can be independent (free practice) or dependent (in public institution).

The **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** regulates the basic rights and obligations of health workers, the content of the medical activity, the organizational conditions and forms of practicing the medical profession and the requirements for the person who wants to practice the medical profession. In accordance with **Article 4** of this Law, the medical profession may be practiced by any person who meets the following conditions:

- a) is a citizen of the Republic of Moldova; lives or has the right of residence in the Republic of Moldova;
- b) has completed medical university studies: university degree in the medicine profile, Bachelor's degree diploma in a specialty, received after completion of postgraduate medical studies, issued under the Moldovan legislation in force; postgraduate diploma in medicine profile received in another country approved by the Ministry of Health in accordance with the educational standards in force, if the international treaties to which the Republic of Moldova is a party do not provide otherwise;
- c) improves the theoretical knowledge and practical skills throughout his/her entire professional activity, in accordance with regulations developed and approved by the Ministry of Health, using for this all available opportunities;
- d) is capable of practicing the profession, from the medical point of view;
- e) is not subject to restrictions and incompatibilities foreseen by the law⁷²⁶.

Legislation in force allows activity of healthcare institutions based on private initiative, clearly stipulated conditions and documents required for licensing, and the conditions under which a license may be suspended or cancelled (**Articles 9¹, 9²** of the **Law on Healthcare no. 411-XIII of 28.03.1995**).

7.1.1 RIGHT TO WORK AND SOCIAL PROTECTION

A) THE RIGHT TO WORK IS ONE OF THE FUNDAMENTAL HUMAN RIGHTS THAT ENSURE THE EXISTENCE AND DEVELOPMENT OF HUMAN BEINGS AND REQUIRES AT THE SAME TIME PHYSICAL AND INTELLECTUAL ABILITIES, WHICH ALLOWS OBTAINING MATERIAL BENEFITS AND SUBSEQUENT INCLUSION IN THE SOCIAL AND POLITICAL LIFE

725.Official Gazette, 2001, no.155-157, art. 1234

726.Official Gazette, 2005, no. 172-175, art. 839

B) RIGHT AS STATED IN THE COUNTRY CONSTITUTION/LEGISLATION

The activity of the employees in the healthcare system, as other labour activity in any field, is coordinated by the legislative and normative acts of the Republic of Moldova, which provide basic principles of labour relations, rights and obligations of employers and employees.

- ▶ The **Constitution of the Republic of Moldova (Article 43)** declares that everyone has the right to work, to free choice of employment and satisfactory working conditions and to protection against unemployment. The right to negotiate on labour and the application of the binding nature of the collective agreements is guaranteed.

- ▶ **Article 6** of the **Labour Code of the Republic of Moldova**⁷²⁷ defines the right to work as an individual right to freely choose the place of work, occupation, profession or activity. The *Labour Code* provides certain guarantees and/or compensation in case of termination of the individual employment agreement (**Articles 183, 184, 185, 186**).

Article 86 of the *Code* describes cases in which individual employment agreement can be terminated by the employer.

Under **Article 21 (paragraph 2)** of the *Labour Code*, the heads of healthcare institutions have the right, within the salary fund, to reward employees and to provide financial aid, based on a regulation on rewards and financial aid, developed by each institution in cooperation with trade unions; in case if there is no trade union, the regulation is developed with the elected representatives of employees.

- ▶ **Law on Equal Opportunities between Women and Men no. 5-XVI of 09.02.2006** provides that the right to work is guaranteed to every citizen of the Republic of Moldova regardless of sex.
- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** stipulates that medical workers have the right to know their professional rights and obligations (**Article 14**). Thus, every medical and pharmaceutical professional has the right:
 - to employment after completion of postgraduate studies and to carry out medical activities in accordance with the specialization and qualification obtained;
 - to be remunerated in accordance with the position, professional qualification, scientific and didactic level, and the results of his/her work.
- ▶ The use of forced labour in any form is forbidden according to stipulations of **Article 44** of the **Constitution of the Republic of Moldova** and **Article 7** of the **Labour Code of the Republic of Moldova**.
- ▶ The **Law on Mandatory Health Insurance Funds** provides for each year the calculation of the basic salary for the 1st qualification category, through collective negotiations of the Ministry of Health, the National Health Insurance Company and the branch Trade Union "Sănătatea", given the financial resources available for salaries.
- ▶ To support young employees, some mechanisms of motivating them are described in **Article 11** of the **Law on Healthcare no. 411-XIII of 28.03.1995**. Thus, residency graduates and graduates of nursing schools, who immediately after graduation are employed, according to their assignment, in towns and villages (communities), including those from the municipalities of Chişinău and Bălţi, excluding other territories of these municipalities, during the first 3 years of work receive from the State budget:
 - a) compensation for rental housing expenses or free housing provided by the local public authority;
 - b) compensation in the amount of MDL 30,000 for doctors and pharmacists and MDL 24,000 for nurses and pharmaceutical workers with vocational education; MDL 7,500 and MDL 6,000 respectively, being paid at the end of the first month of work and later, at the end of each year of service;

727. Law no. 154-XV, 28.03.2003

- c) monthly compensation of costs for 30 kW/h of electricity and annual compensation for the cost of one cubic meter of wood and a ton of coal, including gas for heating.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- ▶ **Government Decision no. 381 of 13.04.2006 regarding the conditions of employment of the staff in budgetary units.**
- ▶ **Regulation on the salaries of employees of public medical institutions within the mandatory health insurance system approved by the Government Decision no. 1593 of 29.12.2003** provides the mechanism for calculating salaries for employees in the healthcare system, including the characteristics and conditions of calculating the remuneration of employees based on duties and complexity of tasks, involvement in extra administrative functions, volume and quality of work and level of training, and the results of the financial and economic activity of the institution.
- ▶ **Regulation on providing guarantees and compensations to employees combining work with study, approved by the Government Decision no. 435 of 23.04.2007** provides for certain guarantees and compensations in cases where employees combine work with study.

In the case of combining work with study in higher and vocational educational institutions, employees of medical and pharmaceutical institutions benefit from:

- reduced working time - 35 hours per week;
- additional paid leaves (keeping 75% of their average salary from the main workplace) for examination sessions, laboratory classes, colloquia - up to 30 days per year; during final examinations - up to 30 days; for preparing and defending the Bachelor or Master's thesis or diploma papers (projects) - up to 90 days;
- unpaid leaves, lasting up to 15 days (for employees enrolled in entrance examinations at higher and vocational educational institutions);
- annual leaves, before the beginning of studies in the respective educational institutions (based on demand);
- annual leaves attached to additional leaves granted to employees (based on demand),
- round trip travel expenses fully covered by the institution where they are employed, once per year, by train or road public transport (except taxis), after submitting travel documents, to the educational institution where they are studying for examination sessions, laboratory classes, colloquia, for defending the Bachelor or Master's thesis, diploma papers (projects) and for graduation examinations.

In case of combining work with specialized postgraduate studies (Master studies), employees of medical and pharmaceutical institutions benefit from:

- additional leave with a duration of up to 35 days, keeping 75% of the average salary from the main workplace, given annually during the studies (based on demand);
- additional paid leave, lasting up to 90 days, maintaining 75% of the average salary from the main workplace, for preparing and defending the Master's thesis;
- round trip travel expenses fully covered by the institution where they are employed, once per year, by train or road public transport (except taxis), after submitting travel documents, to the educational institution where they are studying.

- ▶ **Government Decision no. 1345 of 30.11.2007 regarding compensations for young medical and pharmaceutical specialists.**

D) PROVISIONS OF THE CODE OF ETHICS

Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers of the Republic of Moldova stipulates that medical activities can be carried out only if the personnel employed therein have sufficient training and practice in the field. Medical or pharmaceutical workers can only use the title to which they are entitled, in accordance with their professional training. **(Paragraphs 12, 14)**

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Spouses S., after finishing postgraduate residency training, are young licensed professionals. Mrs. S. is a family physician; Mr. S. is a surgeon. Spouses are referred by the Ministry of Health to work in a district. They are provided with housing and receive benefits under the legislation in force **(Real situation)**.

2. Examples of Breach

- Mrs. P., after 3 years' childcare leave decided to return to work as a doctor. The administration of the medical institution has accepted her reinstatement, with a timetable of 35 working hours per week with a 30-minute lunch break during a working day and three night shifts per week. Mrs. P. disagrees with the conditions set by the administration, because of her small child, and is convinced that her rights have been violated. No action was taken **(Case from the authors' practice)**
- Mr. B., a neurologist in a medical institution, decided to participate in entrance examinations at the State University of Moldova in a juridical specialty, part-time education. He did not inform the administration of his institution. After being admitted for studies, he submitted an application requesting the administration to observe his rights related to combining work and studies, namely payment of 75% of month salary during sessions. The administration rejected his request. **(Hypothetical)**

3. Actual Case

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

Healthcare workers and pharmacists, as well as employees in other areas, bear *disciplinary, financial, administrative and criminal* liability as provided by law for violation of labour laws and other normative acts containing norms of labour law as indicated in **Article 38** of the **Labour Code of the Republic of Moldova**. However, employees, in order to carry out their job duties, may bear responsibility for goods that are made available by the employer, which is widely stipulated in the **Government Decision no. 449 of 20.04.2004** on the approval of *Nomenclatures of positions held and the work performed by the employees with whom the employer may conclude written contracts on full individual or collective material liability*.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The right to work, to free choice of employment, and to protection against unemployment, including the regional framework for human rights in healthcare are described in Chapter 2 and Chapter 3 of this Guide.

7.1.2 RIGHT TO WORK IN DECENT CONDITIONS

A) HEALTHCARE WORKERS ENJOY A RANGE OF RIGHTS RELATED TO DECENT – SAFE AND HEALTHY – WORKING CONDITIONS WHEN PROVIDING CARE

Working in decent working conditions is an important prerequisite for the provision of high quality services by healthcare providers. The national legislation grants certified doctors the right to request adequate working environments from their employers. Furthermore, general legislation obliges all employers to guarantee safe working environments to their employees.

The medical and pharmaceutical workers are included in the category of employees who work in unfavourable working conditions - difficult and very difficult, harmful and extremely hurtful - and enjoy social protection.

B) RIGHT AS STATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The **Constitution of the Republic of Moldova (Article 43)** declares that every person has the right to equitable and favourable conditions of work. Employees have the right to labour protection. Protection measures concern safety, hygiene and regime of labour, repose and rest, and other specific situations. The right to negotiation on labour issues and the application of the binding nature of collective agreements is guaranteed.
- ▶ In accordance with **Article 242** of the **Labour Code of the Republic of Moldova** and to **Annex no. 4 of the Collective Agreement (branch level) for 2010-2013**, employees of pharmaceutical and medical units, working in harmful conditions, are given health protection food such as fresh milk or equivalent dairy products (in volume of 500 ml) - kefir, yoghurt etc. Substitution of these products with 250-300 ml of fruit juices with pulp is allowed.
Article 241 of the *Labour Code* stipulates that the employer is obliged to distribute free hygienic and sanitary protection materials.
- ▶ **Article 4 (paragraph 3)** of the **Law on Healthcare no. 411-XIII of 28.03.1995** confirms the obligation of the founders of medical (healthcare, preventive, epidemiological, pharmaceutical and other) institutions for their financial, technical and material assurance, for organization of healthcare services and their quality.
- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** in **Article 14, (b)** states the medical workers' right to be provided with the necessary conditions to carry out their professional activity in accordance with the rules and technologies of providing healthcare.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are a number of normative acts which stipulate that every employer is obliged to provide working conditions for employees that ensure the safety and health of employees at the workplace:

- ▶ **Government Decision no. 353 of 05.05.2010 on approval of minimum safety and health requirements at the workplace;**
- ▶ **Government Decision no. 1335 of October 10th, 2002 on Regulations regarding evaluation of the working conditions at the workplace and the ways of application of branch lists of works for which compensation bonuses for work in adverse conditions can be established;**
- ▶ **Government Decision no. 1223 of 09.11.2004 on the Approval of the Nomenclature of professions and positions with harmful working conditions.**
- ▶ **List of jobs with difficult and extremely difficult, harmful and extremely harmful conditions**, approved by the **Government Decision no. 1487 of 31.12.2004**. To this category can be assigned any physician, regardless of position, including heads of hospitals, departments, laboratories, pharmacists, nurses, and lower medical staff working in State or private medical and pharmaceutical institutions. Based on these considerations, the legislation establishes specific incentives and rewards for healthcare workers. For these categories, the reduced working week time is considered as full working time and is remunerated in the same amount as the work of employees whose working time is 40 hours per week.
- ▶ Persons working in difficult and harmful conditions in the healthcare system receive compensation, approved through *Collective Conventions* concluded in the respective branches and through collective labour agreements. Concrete amounts of compensation increments, at the levels negotiated annually in the *Collective Conventions* (national level) are determined according to the degree of harmfulness of the work performed. The mechanism of determining the amount of compensations is described in the **Regulation regarding the evaluation of the working conditions at the workplace and the ways of application of the branch lists of works for which compensation bonuses for work in adverse conditions can be established, approved by Government Decision no. 1335 of October 10th, 2002.**
- ▶ By agreement of the Ministry of Health, the National Health Insurance Company and the branch Trade Union "Sănătatea", a Joint Decision was signed on the *Collective Convention* (branch level) for 2010-2013, in which the **List of jobs with difficult and extremely difficult, harmful and extremely harmful conditions in branches "Health and social protection"**, for which employees receive fixed compensations, was approved.
- ▶ In the **Nomenclature of professions and positions with harmful working conditions approved by the Government Decision no. 1223 of 09.11.2004** and **Instruction on enforcement of the Nomenclature of professions and positions with harmful working conditions, approved by the Order of the MoH no. 366 of 07.12.2004** are described bonuses and compensations provided to healthcare professionals working in harmful working conditions. Thus, this category of employees benefits from a reduced daily work time from 5 to 8 hours of a five-day working week, additional paid leave - from 4 to 28 days added to the minimal paid annual leave with the duration of 28 days. The working time of a shift cannot be longer than 12 hours. In order to ensure continuous healthcare services, 24-hour shifts are allowed for staff on duty, with the written consent of the employees.
- ▶ According to the **Annex no. 1 of the Regulation on the salaries of employees of public medical institutions from the mandatory health insurance system, approved by the Government Decision no. 1593 of 29.12.2003**, the additional payment for work performed by night, in a determined number of public medical institutions and their subdivisions, is 100% of the salary for each hour worked by night.

Managers of the institutions, by agreement with Trade Unions, approve the concrete list of positions of employees, considering the working conditions in the institution, for which it is established the 100% supplement to salary for each hour worked by night. In the institutions in which the concrete list of positions is not approved, the additional payment for work by night time will be 50% of the salary for each hour worked at night. The **Collective Convention** (branch level) also includes this type of provisions.

D) PROVISIONS OF THE CODE OF ETHICS

The administration of medical institutions bears responsibility for organizing the working conditions and circumstances that would lead to the violation of moral and behaviour norms by the employees. This obligation is described in **Chapter XV (Responsibility of decision makers) of the Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers**. Decision makers of the institution, empowered with control or administration functions, should take the necessary measures to prevent the cases of violation of the rules of conduct of employees.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Equipment in the outpatient radiology department is checked frequently (according to standards) and placed appropriately to protect medical personnel from radiation, which may affect their health. **(Hypothetical)**

2. Examples of Breach

- In the medical institutions of penitentiaries the prevalence of infectious diseases is much higher than in the civilian medical institutions. In the absence of additional conditions for the protection of medical personnel who provide healthcare to people in detention, there is an increased risk of infection of doctors. **(Hypothetical)**
- Employees of a medical institution are working for two years without proper heating of offices throughout the cold season. In such conditions, it is impossible to properly examine patients requesting healthcare services. The administration explained that there are no financial resources to change the defective heating system. Due to the long stay in cold rooms, the medical staff is often sick. **(Real but unreported example)**

3. Actual Cases

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

To evaluate conformity, lawyers must use the relevant regulations for assuring health and safety and information on how these regulations have been interpreted by monitoring bodies.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The provisions of the Right to Work in Decent Conditions are described in Chapter 2 and Chapter III of the International and Regional Framework of Human Rights in Patients' Care.

7.1.3 RIGHT TO PROFESSIONAL INDEPENDENCE

A) THE RIGHT TO PROFESSIONAL FREEDOM INCLUDES FREEDOM OF PRESCRIPTIONS AND MEDICAL ACTS WHICH PROFESSIONALS CONSIDER NECESSARY WITHIN THE APPROVED STANDARDS

The right to independent professional judgment provides healthcare professionals the opportunity to take independent decisions without undue influence, for patients' benefit.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The freedom of opinion and expression is declared in **Article 32 (1)** of the **Constitution of the Republic of Moldova**, which states that all citizens are guaranteed freedom of thought, opinion and freedom of expression in public through words, images or by any other possible means.
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** under **Article 15** stipulated that medical and pharmaceutical workers have the right to defend against the intervention of individuals or government authorities, in the practice of their profession, except for cases of professional misconduct.
The Law requires that medical and pharmaceutical workers hold liability for incompetence and violation of professional obligations, as required by law (**Article 14**).
- ▶ The **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** stipulates that the medical profession can be practiced independently (*private practice*) or in a State healthcare institution (**Article 11**). A doctor is guaranteed professional and moral independence (**Article 15, paragraph 2, (e)**).
- ▶ The **Law on Mental Health no. 1402 of 16.12.1997**, in **Article 21**, stipulates the independence of a psychiatrist in psychiatric care. A psychiatrist whose opinion does not coincide with the decision of the medical committee has the right to give a separate opinion, which is attached to the patient's medical documentation.
A specific aspect of the medical activity is the right of health professionals **in emergency situations and in extreme cases**.
- ▶ In **Article 24** of the **Law on Healthcare no. 411-XIII of 28.03.1995** it is claimed that when a patient's life is in danger, the physician or other healthcare worker can use for free, as required, any type of vehicle to travel to the patient or to transport the patient to the nearest healthcare unit.
N.B.: The law does not implicitly say that they have the authority to "take" anyone's car to travel, but it is meant that they can take a private vehicle from a private citizen for this purpose (consultation with MoH).
- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** supports the right of healthcare workers to use without restrictions any means of transport on the State's account for practicing in emergencies, in accordance with specific situations (**Article 15, (g)**).

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no special regulations in this regard

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Worker** claims that doctors have professional independence, freedom for prescriptions and medical acts which they consider necessary within the approved standards and are responsible for the decisions taken. (**Paragraph 11**)

Clinical recommendations and prescriptions must be based on scientific evidence. When applying new methods, the patient's interest must prevail, and the clinical recommendations and prescriptions can be used only after a risk-benefit assessment. (**Paragraph 53**)

Health workers should not accept that the obligations stipulated in their employment agreements affect their professional independence in making medical decisions. (**Paragraph 67**)

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- A doctor recommends a test additional to those included in the standard National Clinical Protocol because he has some doubts regarding the diagnosis and subsequent treatment of the patient. The doctor provides reasons regarding his recommendation to a board of doctors, describing the complexity of the case. (**Hypothetical**)
- A doctor is present when a serious traffic accident takes place. There are some patients with life-threatening injuries that require immediate specialized care. The doctor stops a car and requests assistance for transporting the wounded to the nearest hospital. (**Hypothetical**)

2. Examples of Breach

- A doctor recommends a costly procedure to a patient based on the diagnosis of the patient's disease. For this procedure, it is necessary to have the approval of the administration of the institution. The manager refuses to sign the approval document for financial reasons (supposedly too much spending at the expense of the institution) and asks the doctor to change the treatment plan by choosing less expensive methods. The doctor refuses to change his decision, reasoning that this is exactly what this patient needs, based on his health condition. The manager threatens the doctor that in case he insists on this strategy, he will be deprived of his salary bonus at the end of the year. The physician is faced with the dilemma of choosing the patient's benefit at the expense of his own benefit (**Real but unreported case**)

3. Actual Case

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

Experience in protection in this regard is not rich; therefore, we cannot offer any practical advice to lawyers.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See the sections on the Right to Physical Integrity, the Right to Non-Discrimination and Equality and the Right to a Fair Trial in previous Chapters.

7.1.4 RIGHT TO IMPROVE PROFESSIONAL KNOWLEDGE

A) MEDICAL AND PHARMACEUTICAL WORKERS HAVE THE RIGHT AND OBLIGATION TO CONTINUOUSLY IMPROVE THEIR PROFESSIONAL KNOWLEDGE AND SKILLS DURING THEIR ENTIRE PROFESSIONAL ACTIVITY

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The **Labour Code of the Republic of Moldova**, in **Article 212**, defines *continuous professional education* as any learning process in which employees, who already have a qualification or a profession, are completing their professional knowledge by deepening knowledge in a particular area of their main specialties or learning new procedures or methods applied in the respective specialties.

The continuous improvement obligation refers to the employer - to ensure the necessary conditions and promote education, and to the employee, particularly the medical and pharmaceutical worker - to continuously improve theoretical and practical knowledge in the field. For this purpose, public or private healthcare or pharmaceutical institutions are required to spend at least 2 percent of the payroll fund of the unit (if the collective agreement does not require otherwise) for the training of health and pharmaceutical workers. This category of employees is obliged, every 5 years minimum, to improve their theoretical and practical knowledge through trainings in institutions or faculties of further education and other institutions in the country or abroad.

- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** stipulates that after graduating from higher educational institutions, doctors and pharmacists do postgraduate training, usually free. Health system authorities are responsible for the organization of trainings which are held for medical and pharmaceutical workers who must attend every 5 years of their practice in training institutions or universities, in other institutions in the country and abroad. Managers of healthcare institutions are obliged to create conditions for the pharmaceutical and medical workers to improve their professional knowledge (**Article 10**).

The persons who have not practiced as doctors or pharmacists for more than 3 years and who wish to return to work are required to update their knowledge in training or other institutions, having to be subsequently authorized for practicing medical or pharmaceutical professions by the Ministry of Health (**Article 9**).

- ▶ The right to improve their level of training and pass certification is mentioned in **Article 14, (c)**, of the **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005**. To maintain and increase the

level of their professional skills and responsibility, physicians undergo certification at least every 5 years in order to establish the level of their qualification. (**Article 12**)

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

The modality of certification of medical and pharmaceutical workers is established by the Ministry of Health that elaborates documents which describe in details the procedure and conditions for the continuous education of healthcare workers. Some of them are the following:

- **Order no. 75 § 1 of 02 .06. 2011 of the Ministry of Health on the attestation of doctors and pharmacists.**
- **Order no. 59 § 2 of 04.05.2011 of the Ministry of Health on the attestation of medical and pharmaceutical personnel with specialized secondary education.**
- **Order no. 58 § 1 of 03.05.2011 of the Ministry of Health on credits quantification in continuous medical education.**

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** states that medical and pharmaceutical workers must develop and continuously improve their professional knowledge and abilities throughout their professional activities. Self-training is an important and permanent responsibility of members of the medical and pharmaceutical community. (**Paragraph 51**)

Medical and pharmaceutical workers should be models of ethical and professional behaviour, always desiring to improve their professional and moral levels and to raise the authority and prestige of the medical profession to merit the esteem and confidence of patients and colleagues. (**Paragraph 52**)

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The manager of the healthcare institution provides in the annual budget of the institution a financing line for internships and training courses for the employees. The human resources service keeps records to refer employees to training courses. Employees' requests for financing their training courses or for being allowed to participate in trainings/specialization are supported by the administration of the institution. The administration is confident that such measures are beneficial for improving the quality of healthcare services provided by the institution. (**Example from authors' practice**)

2. Examples of Breach

- The administration of a medical institution requires medical staff to pass the training courses (mandatory under MoH orders) on their own account, taking unpaid leaves. Physicians' participation in trainings and scientific symposia are banned or there are intentionally-created barriers. (**Hypothetical**)

3. Actual Cases

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

There is no evidence in this regard to be able to offer practical advice to lawyers.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See the sections on the Right to Physical Integrity, the Right to Non-Discrimination and Equality and the Right to a Fair Trial.

7.1.5 RIGHT TO FREEDOM OF ASSOCIATION

A) HEALTH WORKERS HAVE THE RIGHT TO CREATE, JOIN AND PARTICIPATE IN VARIOUS ASSOCIATIONS. HEALTH WORKERS' ABILITY TO FORM, JOIN, AND PARTICIPATE IN ASSOCIATIONS, WITHOUT EXCESSIVE INTERFERENCE, IS CRITICAL TO THEIR ABILITY TO EFFECTIVELY DEFEND THEIR RIGHTS AND TO PROVIDE ADEQUATE SERVICES

The right to form and to join associations is a general right of every citizen of the Republic of Moldova. There are various provisions in healthcare legislation that enforce the role of professional associations in setting standards, certifying healthcare professionals, and ensuring quality of healthcare.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ Freedom of meetings and association to different social and political parties and organizations and freedom to join trade unions for the protection of the professional interests are described in **Articles 40, 41 and 42** of the *Constitution of the Republic of Moldova*.
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** supports the right of medical workers to associate in organizations, leagues, unions, professional societies and other associations to defend their professional and social rights (**Article 16**).
- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** states that for defending their rights and interests, physicians have the right to associate, on a voluntary basis, in accordance with the legislation on non-profit organizations, in local, central and international professional associations, based on individual or collective membership, and to register them as required by law (**Article 16, paragraph 1**).
Article 5 (Paragraph 2, 3) of this law stipulates that physicians, regardless of the form of ownership of the medical institution in which they work, can collaborate with professional and public organizations from the public health system, with social partners, or with public authorities.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no specific regulations applied in this specific context.

D) PROVISIONS OF THE CODE OF ETHICS

Ethics Committees are a form of meeting of professionals in order to promote fairness in the work of health workers and good professional image. The activity of these structures is described in **Chapter XIV (Ethics (bioethics) Committees)** of the **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Worker**.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- In the Republic of Moldova hundreds of doctors are members of various professional and NGO associations without any restrictions (Doctors League, Association of Family Physicians, Association of Urologists, Association of Surgeons, etc.). **(Actual situation)**

2. Examples of Breach

- Although professional associations have the right to participate in debates and decision-making activities in health system management, some organizations are deprived of this opportunity because of administrative obstacles and complicated bureaucratic procedures **(Hypothetical)**
- Dr. U. is a physician in a private medical centre. He wishes to join a professional association known to be very active in protecting the rights of doctors, actively promoting professional reputation and medical dignity. To be a member, Dr. U. needs a certificate to confirm his professional activity. The administration of the medical centre refuses to provide such a certificate to Dr. U., arguing that membership in this association will be of no benefit and that this desire is not justified. Dr. U. has not litigated this refusal for fear of losing his job. **(Real but unreported case)**

3. Actual Cases

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

There is no evidence in this regard to be able to offer practical advice to lawyers.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See sections on Freedom of Association in Chapter 2 on International Framework of Human Rights in Patient Care, and in Chapter 3 on Regional Framework of Human Rights in Patient Care.

7.1.6 RIGHT TO FAIR TRIAL

A) HEALTH SERVICE PROVIDERS ARE POTENTIALLY SUBJECT TO A RANGE OF CIVIL AND ADMINISTRATIVE PROCEEDINGS - DISCIPLINARY ACTIONS, ALLEGATIONS OF MEDICAL NEGLIGENCE, ADMINISTRATIVE MEASURES SUCH AS WARNINGS, REPRIMANDS, SUSPENSION OF ACTIVITIES, ETC. - AND ARE ENTITLED TO THE RIGHT TO A JUST AND A FAIR TRIAL

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ The **Constitution of the Republic of Moldova** includes the right of every person to obtain effective protection from competent courts of law against acts that violate their legitimate rights, freedoms and interests. No law can restrict the access to justice (**Article 20**).
The presumption of innocence is declared in the *Constitution* in **Article 21**: "Every person charged with a crime is presumed innocent until his/her guilt is proven legally during a public trial at which he/she has all the guarantees necessary for his/her defence."
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** stipulates that the way to protect the rights of practicing the profession, of compensation for damages to medical and pharmaceutical workers is established by law (**Article 13**).
- ▶ The right to practice the medical profession is protected by the State. The **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** in **Article 15** provides that in defence of his/her professional and civic rights, the doctor has the right:
 - a) to appeal to national and international law enforcement bodies in accordance with the legislation in force;
 - b) to request settlement by the administrative court of litigation arising from an administrative act or failure to settle in due time a claim for recognition of a legal right, in which the other party is a public authority or an officer of that authority, in accordance with the legislation in force;
 - c) to have repaired damage caused by harm to the doctor's health in connection with the specific professional activity under conditions of permanent risk to health and life;
 - d) to seek the support of NGOs in the defence of professional rights and interests;
 - e) to have moral, economic and professional independence and social protection guaranteed;
 - f) to be supported by the employer at the stage of examination in court in litigations when practicing in accordance with the regulations in force.

N.B.: The law does not specify the mean of repaired damage.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

The Order no. 52 § 5 of the Ministry of Health of 20.04. 2011 on the subdivision of Human Resources in medical institutions.

D) PROVISIONS OF THE CODE OF ETHICS

There are no specific sections in the context of this right.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Doctor G. was sued on charges of negligence in performing a surgery. The doctor was immediately informed about that, receiving a notice both at his home address and at his working place. Court proceedings were conducted in compliance with fair trial standards. **(Hypothetical)**

2. Examples of Breach

- Citizen D. died a few hours after receiving medication prescribed by doctor V. The family of citizen D. filed charges in court, assuming a serious medical mistake made by doctor V. when prescribing treatment. The case is highly publicized giving details about the identity and place of work of doctor V. Even doctor V. learned of allegations in a show broadcasted on a national TV channel. After investigating the case, it has been shown that the cause of death of citizen D. was not motivated by the treatment given and the medical prescriptions were totally in accordance with the clinical protocol. However, as a result of this case, the image and honour of doctor V. have been harmed **(Hypothetical)**
- A hospital encounters a problem of insufficient budget (due to inefficient initial planning). The hospital administration informally requires that the medical staff take one month unpaid leave by rotation. Although such leave seems to be voluntary, in reality this is a decision unilaterally imposed without the opportunity to be challenged by the unsatisfied employees. Employees comply with the requirement imposed by the administration for fear of being punished. **(Real but unreported case)**

3. Actual Cases

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

For medical institutions, the right to a fair trial is one of great importance, as these institutions may be potential defendants in numerous complaints. From the perspective of the health legislation, the right to a fair trial refers to the existence of transparent, fast and efficient procedures, which would exclude admissibility of illegal complaints and providing solutions to such complaints.

Any violation of the right to a fair trial is considered a breach of Article 6 of the European Convention on Human Rights. In this case, lawyers should assess whether the procedures established by the national legislation meet the procedural criteria of free, impartial courts of law. Such criteria are set out in the European Court of Human Rights.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The general provisions to a fair trial are stipulated in:

- Articles 2 (3) and 14 (1) of the International Covenant on Civil and Political Rights

- Article 6 and 13 of the European Convention on Human Rights

In terms of freedom of expression:

- Article 19 (3) of the International Covenant on Civil and Political Rights, which limits free expression in order to protect the rights and reputation of other people.
- Article 10 (2) of the European Convention on Human Rights

A description of relevant international and regional standards protecting the right to a fair trial and protection is provided in Chapter II and Chapter III.

7.1.7 RIGHT TO REFUSE TO PROVIDE TREATMENT

A) THE PHYSICIAN HAS THE RIGHT TO REFUSE TO PERFORM A MEDICAL INTERVENTION, FOR LEGITIMATE REASONS. IN CASE THE DOCTOR CANNOT PROVIDE HEALTHCARE TO A PATIENT AS REQUESTED, HE/SHE IS REQUIRED TO REDIRECT THE PATIENT TO ANOTHER SUITABLY-QUALIFIED PROFESSIONAL

The doctor cannot refuse to provide care to a patient in emergency situations. This right is limited to cases in which there is no emergency and it is possible to ensure continuity of care, or when there would be considerable risk to the health and life of the provider during healthcare provision.

B) RIGHT STIPULATED IN THE COUNTRY CONSTITUTION/LEGISLATION

- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** in **Article 18, paragraph 3**, states that the doctor has the right to refuse assistance to a patient in the following cases:
 - The lack of professional competencies or medical technical possibilities necessary for the medical intervention;
 - Contradiction between carrying out the medical intervention and the ethical-moral principles of the physician;
 - Impossibility to create a therapeutic contact with the patient.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no additional regulations in this context.

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Worker** stipulates in **paragraph 17** that the medical and pharmaceutical worker cannot be forced to practice under conditions that could compromise the quality of care and the professional acts, except vital surgical and medical emergencies.

A medical worker may refuse to perform a medical act due to serious personal or professional reasons only after referring the patient to another health worker, except for emergencies. The medical worker is obliged to provide the colleague that takes over the patient with all medical information regarding the case. (**Paragraph 66**)

A medical and/or pharmaceutical worker cannot be involved in the performance of acts that are degrading for humans (**Paragraph 20**).

A medical worker shall refuse to perform any procedures that may harm or make the patient vulnerable in certain situations. (**Paragraph 67**)

For example, if they are asked by police, or prison employers (law enforcement agency) to intervene and to perform procedures to the patients

Any doctor is free, according to his/her own beliefs, to refuse the request for voluntary interruption of pregnancy without explanation. (**Paragraph 93**) Please note that this statement is valid when the pregnancy does not present any risk for the life of the woman seeking abortion.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Gynaecologist A. refuses the request of citizens H. to interrupt pregnancy within the term acceptable by law (up to 12 weeks). The physician's refusal is based on the physician's own moral and religious convictions. Doctor A. advises the patient to contact a colleague, a gynaecologist of the same category and qualification who performs such interventions. Doctor A. makes all required entries in the medical record and schedules the patient for consultation with his colleague. (**Hypothetical**)

2. Examples of Breach

- During the night the ambulance brought to the department of gynaecology of a hospital a 25-year-old woman complaining of acute abdominal pain and heavy vaginal bleeding. The woman said she was 10 weeks' pregnant. The gynaecologist recognized the patient, knowing that in the past she was a sex worker, used drugs and was HIV infected. The physician refuses to perform any manipulations and procedures on the hospitalized woman due to personal reasons. The physician was the only gynaecologist on duty in the institution. (**Example from authors' practice**)

3. Actual Case

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

As this is a poorly studied area in the country, we cannot offer any practical advice for lawyers in this regard.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

There are no references relevant in this context.

7.2 HEALTHCARE PROVIDERS' RESPONSIBILITIES/OBLIGATIONS

Responsibilities and obligations of medical and pharmaceutical personnel include generalities stipulated in the basic laws and regulations (e.g. *Labour Code*) such as: to observe the individual employment agreement; to observe the working time and the labour discipline of the unit; to carry out conscientiously the working duties; to perform a medical examination upon employment, etc. At the same time, there are a series of specific laws and regulations on the professional activity within the healthcare system.

7.2.1 OBLIGATION TO PROVIDE HEALTHCARE

A) THE PHYSICIAN IS OBLIGED TO PROVIDE HEALTHCARE TO ALL PERSONS, EXCEPT IN CASES STIPULATED BY LEGISLATION IN FORCE

See also the section on the Right of Access in Chapter VI on National Patients' Rights and Responsibilities.

B) RESPONSIBILITY AS STATED IN COUNTRY CONSTITUTION/ LEGISLATION

- ▶ The **Constitution of the Republic of Moldova** guarantees citizens the right to health. The minimum of the health insurance offered by the State is free (**Article 36**).
- ▶ According to the **Law on Ensuring Equality no. 121 of 25.05.2012, Article 8 (b)**, any form of discrimination in terms of access to medical services and other healthcare services is forbidden.
- ▶ **Law on Mandatory Medical Insurance no. 1585 of 27.02.1998** provides that mandatory health insurance is a system guaranteed by the State, to defend the interests of the population in healthcare through the establishment, via insurance premiums, of some money funds to cover the costs of treatment for the occurrence of insured events (diseases or illness). The insurer and the medical institution conclude an agreement for the provision of healthcare (healthcare services) under the mandatory health insurance, in accordance with which each medical institution is obliged to provide the insured persons with qualified medical care in the amount and terms included in the *Unique Program of Mandatory Health Insurance*. Children under 18 years, parturient, pregnant women, and women in the first weeks after delivery, and mothers with four or more children are insured by the State (**Article 4, paragraph 4**). This is included and detailed in the Unique Program. As a result, pregnancy, childbirth and puerperium were included in the list of diseases and conditions that require medical care financed from the mandatory health insurance funds.
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995, Article 20**, provides that the State in accordance with the Constitution guarantees to Moldovan citizens the minimum of the gratuitous health insurance, including:
 - a) epidemic prevention measures and medical services provided within the national programs from the State budget;
 - b) medical assistance in case of life-threatening medical and surgical emergencies, when one or more interventions are required to be provided by pre-hospital emergency medical services, primary healthcare provided by the family physician, or through outpatient or inpatient medical institutions,

within the limits of the mandatory health insurance funds and the State budget for the respective year;

- c) pre-hospital emergency care, primary care, specialized outpatient and hospital care for socially-conditioned diseases with a major impact on public health, according to a list established by the Ministry of Health;
- d) medical care provided within the Program of mandatory health insurance, to insured persons, including unemployed persons, for whom the State pays for the mandatory health insurance.

- ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** provides that anti-tuberculosis healthcare is guaranteed by the State, based on the principles of respect for human dignity, privacy, accessibility and gratuity. Financing of anti-TB care is done using funds from the mandatory health insurance, from the State budget, from grants, donations and other sources, provided in accordance with the law in force (**Article 12**).

Prevention of tuberculosis is a priority to vulnerable groups: children, immigrants, asylum seekers, refugees and beneficiaries of humanitarian protection, prisoners, and other disadvantaged groups. (**Article 8, paragraph 6**)

To prevent the spread of tuberculosis and its early detection, all employed persons are subject to prophylactic medical examination under the terms established by the Ministry of Health. (**Article 13**)

- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005**, in **Article 5, (a)**, requires that the activities of physicians include medical care in case of illness or injury to patients, regardless of their sex, age, national affiliation and race, social and financial status, political vision, religion, language, opinion.

A physician's obligation is to provide treatment until the patient's recovery or until passing of the patient to the care of another physician. In carrying out his/her professional duties, the doctor has no right to subject the patients to undue risk, even with their consent. (**Article 17**)

- ▶ According to the **Law on HIV/AIDS no. 23-XVI of 16.02.2007**, the State provides free access for HIV positive persons to ARV treatment and to treatment of opportunistic infections according to clinical and immunological indications. Persons infected with HIV and AIDS patients are provided with healthcare based on the **Unique Program of Mandatory Health Insurance**, in accordance with the legislation in force. (**Article 19**)

Refusal of admission, reception, access to medical services of HIV-positive persons in public or private medical institutions and spas is not allowed, neither are demands for increased fees for those services. (**Article 25**)

Under **Article 30** of the Law, the managers of public or private medical institutions are required to ensure the necessary conditions for preventing HIV infection in patients:

- a) during the instrumental and laboratory examination, including testing for HIV markers, performing surgery, gynaecological, dental interventions, medical and cosmetic procedures;
- b) in transfusion of blood, blood components and preparations.

Article 18 of the Law stipulates that National Protocols for the treatment of persons with HIV/AIDS guarantees access to drugs and hospitalization, including:

- a) diagnosis and treatment of HIV/AIDS, opportunistic diseases, sexually transmitted infections, other infections and complications,
- b) laboratory services;
- c) emergency treatment;
- d) psychological care;
- e) social assistance;
- f) palliative care.

- ▶ The **Law on Reproductive Health no. 138 of 15.06.2012** stipulates that by ensuring the accomplishment, by any person, of his/her rights of reproduction, the State guarantees observance of the human and civil rights and the legality, humanity, privacy and respectful attitude towards the person, which excludes humiliation of human dignity.

- ▶ According to the **Law on the Child's Rights no. 338 of 15.12.1994, Article 4**, access of a child or children to the use of the best technologies for treatment, recovery, and prevention of disease should be assured. If parents refuse medical care for their sick child, it can be provided against their will, the decision being taken by a council of physicians in the presence of a representative of legal authorities.

The State must ensure for a mother in the pre-and postnatal period the necessary conditions for a healthy child development, for the child's rational and harmless feeding, free qualified healthcare services, organization of preventive measures of diseases, and propagation of a healthy lifestyle.

- ▶ **Law on Social Inclusion of People with Disabilities no. 60 of 30.03.2012** prohibits discrimination against persons with disabilities in healthcare, medical insurance (mandatory and voluntary), life insurance, annual comprehensive medical examination, preventive measures, health education and receiving personal information about one's own health. Within healthcare, persons with a disability also have the right to home visits, aiming to fully satisfy all of their social and medical needs, determined by the type and degree of disability, in accordance with the law in force. Within the mandatory health insurance, the Government is the insurer for the persons with disabilities, and for certain categories of careers, in accordance with the legislation in force. (**Article 42**)

- ▶ **Law on Mental Health no. 1402 of 16.12.1997** in **Article 16** describes the volume of psychiatric care guaranteed by the State, which includes:

- a) emergency psychiatric care;
- b) consultative, therapeutic psycho-prophylactic care, rehabilitation in outpatient and inpatient conditions;
- c) all types of psychiatric expertise, establishing temporary disability;
- d) psychiatric care in case of natural calamities and catastrophes;
- e) community assistance in mental health field.

Financing of the activities of institutions and individuals providing psychiatric care, in proportions that ensure a guaranteed level and high quality of this care, shall be provided from mandatory health insurance funds, within the limits of medical services provided within the program of mandatory health insurance for the respective year; sources for provided services not included in the Program; other sources obtained in accordance with the legislation in force (grants, sponsorships, donations, etc.); or the State budget, in accordance with the law on the State Budget for the respective year. (**Article 17**)

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- Government Decision no. 1387 of 10.12.2007 on the approval of the Unique Program of Mandatory Health Insurance
- Government Decision no. 184 of 29.03.2012 "for approval of amendments and addenda in the Program of Mandatory Health Insurance";
- Government Decision "for approval of amendments and addenda in the Program of Mandatory Health Insurance, approved by the Government Decision no. 1387 of December 10th, 2007" no. 1099 of 02.12.2010;
- Government Decision no. 906 of 24.09.2010 on the establishment and operation of committees to examine appeals of Moldovan citizens residing in localities from the left bank (Transnistria) in categories for which the Government is an insurer;

- Government Decision no. 1015 of 05.09.2006 on the approval of some normative acts;
- Government Decision no. 1636 of 18.12.2002 on the approval of the standard Contract of providing healthcare (medical services) within the mandatory health insurance;
- Government Decision no. 594 of 14.05.2002 on the approval of the Regulation on the Establishment and Administration of Mandatory Health Insurance Funds;
- Government Decision no. 1432 of 07.11.2002 on the Measures for the Implementation of the Mandatory Health Insurance.
- *Order no. 1021/206 of 29.12.2011 on the approval of the Methodological Norms of Application in 2012 of the Program of Mandatory Health Insurance*
- *Order of the Minister of Health no. 695 of 13.10.2010 on Primary Healthcare in the Republic of Moldova*

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Worker** states the obligation of the medical and pharmaceutical worker to protect human physical and mental health, to promote healthy lifestyles, to prevent illness and to relieve suffering, to observe the right to life and dignity of human beings, regardless of age, sex, race, ethnicity, religion, nationality, social status, ideology, political affiliation or any other reason, both in peacetime and in wartime. (**Paragraph 7**)

From the moment of responding to a request, a medical or pharmaceutical worker is automatically morally employed to provide high quality patient care, including patient referral to a healthcare unit or specialist with higher qualification. (**Paragraph 15**)

Medical workers asked or obliged to provide healthcare services to inmates, including within the prison environment, should not cause, directly or indirectly, or promote hurting physical or psychical integrity of a prisoner, including his/her dignity. If a medical or pharmaceutical worker notices that the person in custody is in a vulnerable situation, one of the professional and moral obligations will be the intervention to support and protect the detainee. (**Paragraph 19**)

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The population that territorially is assigned to a primary care medical centre in the locality I. is provided with the entire volume of health services stipulated in the health insurance package. People from different age groups are invited to preventive checks by family physicians offering specialized advice in accordance with patients' needs. All insured persons receive compensated or partially-compensated treatment. (**Hypothetical**)

2. Examples of Breach

- A young family changed their residence to another city. The family has a small child, who is often ill. They requested care with the family physicians' centre in the village, but they were told that they can receive assistance only against fee, as they are registered in the database of the National Health Insurance Company in the records of the family physician in the place of their previous residence.

They were informed that they could receive free care starting next year, when there will be changes in family physicians' lists of population. Thus, the family was informed that with the change of residence, they lost opportunity to be provided care from the mandatory health insurance fund for a year. **(Hypothetical)**

3. Actual Cases

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

This is an area with insufficient experience at juridical level; therefore we cannot offer any specific advice to lawyers.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See sections on the Right to Life and the Right to the Highest Attainable Standard of Health and the Right to Non-Discrimination and Equality in Chapter 2 on International Framework for Human Rights in Patient Care, and Chapter 3 on Regional Framework for Human Rights in Patient Care.

7.2.2 OBLIGATION TO PROVIDE CARE IN EMERGENCIES AND IN EXCEPTIONAL CIRCUMSTANCES

A) HEALTHCARE PROVIDERS ARE OBLIGED TO PROVIDE EMERGENCY HEALTHCARE TO ALL PERSONS, REGARDLESS OF THEIR ABILITY TO PAY

This obligation is closely related to the patient's right to have access to health services.

B) OBLIGATION AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ The **Constitution of the Republic of Moldova** guarantees citizens the right to health. The minimum of the health insurance offered by the State is free (**Article 36**).
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** in **Article 24** guarantees emergency medical assistance to all persons in case of danger to life (accidents, serious acute illness, etc.). Emergency medical assistance is provided by the nearest health facilities, regardless of type of ownership and legal form. People are guaranteed medical care in emergency situations (natural disasters, catastrophes, accidents, mass diseases and poisoning, ionizing and non-ionizing irradiation, heavy environmental pollution and so on). Medical assistance in such cases is performed by local medical units and special brigades of permanent mobilization, formed by the Ministry of Health.

Medical and pharmaceutical workers are obliged to provide emergency first aid in the street, on the road, in public places and at home, regardless of time, place and other circumstances of the situation at any time of day or night. (**Law on Healthcare no. 411-XIII of 28.03.1995, Article 24 paragraph 4, Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005, Article 17, (g)**)

- ▶ **Law on State Supervision of Public Health no. 10 of 03.02.2009** establishes the basic principles of the sanitary and epidemiological assurance of the population in order to maintain health, to prevent and to combat the emergence and spread of infectious, non-infectious and occupational diseases, poisonings, dependent on harmful factors in the environment, production sector, habitat, education and human behaviour.
- ▶ **Law on Civil Protection no. 271 of 9.11.1994** establishes the fundamental principles of organizing civil protection in the country, its tasks, the legal framework of activity in this field of public authorities, enterprises, institutions and organizations, regardless of the type of ownership and organizational-legal form, and of the citizens.
- ▶ **Law on the State of Emergency, Siege and War no. 212 of 24.06.2004** establishes the grounds, ways and terms of declaring a state of emergency, siege or war, competence of authorities declaring it, the measures to be applied during the state of emergency, siege or war, and the rights, obligations and liability of legal entities and individuals during this period.
- ▶ **Law on Civil Protection and Emergencies no. 93 of 05.04.2007** establishes the legal framework, principles of activity, duties, obligations and rights of the Civil Protection and Emergencies Service, and the conditions of duty/activity performance in its subdivisions.
- ▶ **Criminal Code of the Republic of Moldova of 18.04.2002, Article 162**, states that not providing free emergency medical care without valid reasons by the medical personnel (persons who under the law or special rules are required to provide it) is considered a serious violation and is punishable by a fine of 200 to 500 conventional units or by unpaid community work of 100 to 240 hours. The same act that caused, through negligence, either serious bodily harm or harm to the health or the patient's death is punishable by imprisonment up to 5 years with deprivation of the right to occupy certain positions or to practice certain activities for a period of up to 3 years.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- *Government Decision no. 1076 of 16.11.2010 on the classification of emergencies and ways of accumulation and presentation of information in the field of protection of population and territory in emergency situations*, published in the *Official Gazette* no. 227-230 of 19.11.2010.
- **Government Decision no. 556 of 10.10.96 on the sanitary protection of the territory of the Republic of Moldova from importation and spread of conventional and extremely dangerous infectious diseases** establishes public measures to reduce the danger of importation and spread of conventional and highly dangerous infections in the Republic of Moldova.
- **Government Decision no. 919 of 30.08.2005 on Republican Anti-epidemic Extraordinary Commission** determines the main tasks, organization and functioning of the Republican Extraordinary Anti-Epidemic Commission on the coordination of activities of central and local public administration bodies, institutions, organizations and enterprises for localization and liquidation of epidemic complications caused by the emergence and spread of infectious and non-infectious diseases.
- **Government Decision no. 961 of 21.08.2006 on the approval of the Regulation on National Network of Laboratory Observation and Control of Contamination (Pollution) of the Environment with Radioactive, Toxic, Highly Toxic Substances and Biological Agents** establishes objectives of radioactive, chemical and biological control of the environment, the means of organization and composition of the national network of observation and laboratory control and its duties under exceptional circumstances.
- Order of the Minister of Health on the Committee for Emergency Situations of the Ministry of Health of 12.02.2010.

- Order of the Minister of Health no. 457 of 10.12.2007 on planning healthcare services for the population in exceptional circumstances.
- Order of the Minister of Health no. 528 of 04.06.2012 on the approval of the Guidelines on the development of a Plan for hospital preparedness and response to emergencies.
- Order of the Minister of Health no. 556 of 11.06.2012 on categorizing hospitals according to their involvement in the response to public health emergencies.
- **Order of the Ministry of Health no. 57 of 25.01.2012 on the implementation of the National Programme for the development of emergency medical care for 2011-2015. Order of the Ministry of Health 841/2010, Annex no. 3**, which establishes the criteria for inter-hospital transfers of critical patients within the regionalized service of emergency and intensive care in children.
- **Order of the Ministry of Health 841/2010, Annex no. 4** on the basis of which the regulation on the organization and operation of the hospital emergency admission department is elaborated. The emergency admission department provides emergency and high quality care in due time and full volume on a 24/24 basis.

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers** describes the moral obligations of medical professionals in emergency situations in **Chapter IX**.

- A medical or pharmaceutical worker who is beside an injured or endangered patient shall provide care at a level that is dependent on the possibilities, time and place, or shall ensure that the patient receives the necessary care.
- In case of danger to life, a health worker shall remain near the patient as long as the professional care is needed.
- In case of natural disasters or mass injury, a medical or pharmaceutical worker is obliged to respond to the call, even to voluntarily provide his/her professional services as soon as he/she hears about the event.
- In case of force majeure or exceptional circumstances, healthcare workers have no right to abandon patients, except when a competent authority allows this by issuing an order in accordance with the law.
- In emergency situations when a patient's life is in danger, and the patient cannot express his/her will and the relatives or legal guardians cannot be contacted, consent will be considered implicitly, and a medical worker will do everything possible to save the patient's life, being afterward informed about the extent of the medical act performed.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- The patient S. with severe trauma (fracture of both legs) as a result of a road accident near a medical institution requested emergency care in this unit. Doctors provided care, but for some services the patient was asked for informal payments. The patient paid but later challenged on this situation. The court required the institution to repay all illegal payments for emergency care. **(Hypothetical)**

(Authors' note: Such obvious cases are rare. Unlike situations where physical harm is caused to the person, it is often difficult to prove a claim for an illegal payment. The most frequent violation of the responsibility to provide free emergency care is the charge of money from the patient by some providers of healthcare services or by asking the patient to procure medicines or other materials necessary for treatment. In fact, this kind of case is very difficult to prove.)

2. Examples of Breach

- A young woman was brought to the emergency service unit with acute abdominal pain. She had signs of alcoholic intoxication, was untidy and had traces of injections on her arms, and doctors supposed she was a drug user. She was left until morning in the hospital admission department as the doctors on duty didn't want to provide her care. She was not accompanied by anyone, had no documents and no money. In a few hours the patient's condition got worse, further efforts to resuscitate her were ineffective. The woman died. No further legal action was taken (**Case selected from author's practice**)

3. Actual Case

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

When consulting patients regarding the responsibilities of healthcare providers described above and related to the rights of the patient, it is important for lawyers to remember the following: in cases of danger to life and/or health of a person, healthcare providers are required to provide emergency medical care for everyone, regardless of the availability of payment guarantees for services provided or other circumstances. Failure to provide emergency care by a doctor will result in the liability under the law, unless there are valid reasons to the contrary, as set out above.

It is important to distinguish between legal and non-legal obligations regarding liability, as there may be a moral duty to act, even if the legal framework imperatively categorizes the situation as an exception.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See sections on the Right to Life and the Right to the Highest Attainable Standard of Health and the Right to Non-Discrimination and Equality in Chapter 2 on International Framework for Human Rights in Patient Care, and Chapter 3 on Regional Framework for Human Rights in Patient Care.

7.2.3 OBLIGATION TO PROVIDE QUALITY SERVICES

A) EACH HEALTHCARE PROVIDER IS REQUIRED TO ENSURE ADEQUATE QUALITY OF SERVICES PROVIDED

This obligation is closely related to several rights of the patient: the right to timely treatment, the right to safety, the right to innovation, the right to avoid unnecessary suffering and pain, and the right to customised treatment.

B) OBLIGATION AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ **Law on Protection of Consumers no. 105-XV of 13.03.2003** describes the relationship between service providers and consumers, with the possibility of being applied in the context of the report of health service delivery.

- ▶ Under the **Law on Healthcare no. 411-XIII of 28.03.1995**, individuals and legal entities have the right to found medical institutions (curative, preventive, epidemiological, pharmaceutical and other) and are responsible for their financial and technical assurance, for the organization of healthcare services and their quality, in accordance with the legislation in force. (**Article 4, paragraph 3**)

Healthcare and pharmaceutical workers are held liable for professional malpractice and breach of professional obligations. (**Article 14, paragraph 3**)

In case of poor health condition following an inadequate healthcare, medical staff must take into account and observe the patient's right to have carried out, as required, the professional expertise and to moral and material compensation of damage. (**Article 36**)

- ▶ **Law on the Assessment and Accreditation in Health no. 552 of 11.10.2001** sets out the principles and procedures for the evaluation and accreditation of systems ensuring the quality of services provided by medical and pharmaceutical institutions and companies.

- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** describes a series of obligations of the physician to ensure quality of healthcare. Among the general principles of exercising the medical profession is competence, professional responsibility of the physician, high ethical and moral qualities, and observance of the principle of "do no harm". (**Article 3, (b)**)

Thus, the doctor is obliged to continually improve professional knowledge, to avoid iatrogenic illness, to begin treatment only after a medical examination carried out personally and, in exceptional emergency cases, to give indications for treatment by means of telecommunication. (**Article 18, paragraph 1**)

The doctor is obliged to avoid iatrogenic illness. Iatrogenic diseases are those diseases, processes and pathological conditions which appear due to professional activity of physicians or illnesses of other doctors, pharmacists and nurses, with foreseeable or unforeseeable medical risk (**Article 17, (d)**)

The doctor cannot prevent a patient from choosing another physician. (**Article 19, paragraph 3**)

According to **Article 8** of this law, the medical profession cannot be compatible with other situations, namely:

- a) with the pharmaceutical activity: the preparation, delivery, distribution and marketing of pharmaceutical products;
- b) with any activity or occupation that diminishes or harms professional dignity or violates the code of ethics;
- c) with health inadequate to the medical profile, attested by a medical certificate issued in accordance with law;
- d) with the use of medical knowledge at the expense of patient's health or with criminal purpose.

The profession of physician cannot be exercised by:

- a) a person who has been convicted of intentionally committing a crime in circumstances related to the medical profession;
- b) a person to whom the penalty of prohibition to exercise the medical profession was applied for a period determined by the decision of a final judgment;
- c) a person who has been declared by a court as having limited capability or incapable;
- d) a person who holds no Bachelor's degree diploma or certificate of completion of internship, residency or clinical fellowship studies.

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005, Article 5, (q)** states that the legislation in force determines the patient's right to compensation for damage to health.
- ▶ **Law on Mandatory Health Insurance no. 1585-XIII of 27.02.1998** requires that all medical institutions of the mandatory health insurance system must have licenses and accreditation certificates (**Article 4, paragraph 6**). An insurer is materially responsible to the insured person for the damages caused to the life and health as a result of healthcare services, included in the program, provided with poor quality or insufficiently. (**Article 14, paragraph 2**)
- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** states that among the basic principles of reproductive rights is to ensure the quality and accessibility of reproductive health. (**Article 8**)
- ▶ **Law on HIV/AIDS Prevention no. 23-XVI of 16.02.2007, Article 33, paragraph 2** stipulates that compensation for moral and material damages to the infected person is the responsibility of the medical institution where he/she got infected. Thus, it is outlined the major role of administration of medical institutions in organizing medical care in strict accordance with the law and excluding any violation of the rights or legitimate interests of the patient.
- ▶ **Law on the Control and Prevention of Tuberculosis no. 153 of 04.07.2008** requires that the damage caused to the life or health of a TB patient when providing healthcare or failure to provide healthcare in due time, if it was requested, is remedied in accordance with the law. (**Article 22**)
- ▶ **Law on Transplantation of Human Organs, Tissues and Cells no. 42 of 06.03.2008** guarantees quality assurance through the observance of standards and professional obligations in any interventions in the field of transplantation of organs, tissues and cells. (**Article 3**)

The Transplant Agency has the exclusive right to authorize the importation of organs, tissues and cells for transplantation and to take all measures for them to meet quality and safety standards. (**Article 5, paragraph 3**)

All licensed tissue banks will act according to international standards, being inspected at least every two years. (**Article 22**)

If the health of the donor or the recipient was affected due to failure to meet standards, legal terms and conditions of procurement and transplantation of organs, tissues and/or cells, the medical institution shall be liable to the patients in accordance with the law. (**Article 31**)
- ▶ **Law on Medicines no. 1409 of 17.12.1997** requires quality assurance of medicines authorized for use in the Republic of Moldova. The efficiency and safety of medicines that have passed control should be ensured, including their conformity with the standards of quality, fulfilling the requirements in the process of development and manufacturing of medicines to ensure compliance with the standards. (**Article 6, paragraph 3**)

Clinical trials will be conducted by highly qualified specialists in the field. Clinical trials of a medicine may be permitted only after issuance by the ethics committee of an approval on the ethical, moral and legal aspects of the trial program. (**Article 11, paragraph 5, 6**)
- ▶ The **Civil Code of the Republic of Moldova of 06.06.2002** includes the obligations of individuals and legal persons that can cause damage (**Chapter XXXIV, Articles 1415-1424**).
- ▶ Healthcare and pharmaceutical personnel are subject to liability for offenses based on statements of the Internal Affairs Bodies and are examined by the court for failure to comply with their duties. The **Code of Administrative Offences of the Republic of Moldova no. 218-XVI of 24.10.2008** includes the following provisions:
 - Disclosure of confidential information about medical examinations for detecting contamination with the human immunodeficiency virus (HIV) that causes AIDS by medical personnel or other persons

who, by virtue of their duties, have such information. This action is punishable by a fine of 50 to 70 conventional units (**Article 75**).

- Illicit practice of the medical and/or pharmaceutical activity, and carrying out pharmaceutical activity in places unauthorized by the Ministry of Health, and improper storage of medicines; violation of the rules of prescription of recipes and delivery of medicines; practice of pharmaceutical activity without the use of the informational system of evidence of medicines, or practice of folk medicine without a special authorization issued as provided by law (**Article 77**).
 - Deliberate light injuries of bodily integrity, which caused a short-term health disorder or an insignificant but stable loss of working capacity, is punishable by a fine of 50 to 75 conventional units or by arrest and detention of up to 15 days (**Article 78**).
 - Violation of legislation on blood donations by sampling of blood and blood derivatives and their unintentional alteration; use of donated blood, blood derivatives and blood preparations in order to obtain profits; illegal taking out of the country of the donated blood, blood derivatives and preparations; failure to preserve donated blood, blood derivatives and preparations (**Article 79**).
- ▶ **Criminal liability** regulated by the **Criminal Code of the Republic of Moldova no. 985-XV of 18.04.2002**, is the severest form of liability, which provides criminal penalties for the prejudicial deed (action or in-action), under the criminal law, committed with guilt and criminally punishable, committed by a health worker in the process or in connection with providing (or not providing) healthcare which threatens the life, health or property of the patient, causing serious bodily or health injury, the patient's death, or considerable material or moral damage. The physician cannot be convicted unless it is demonstrated that he/she voluntarily caused injury to the patient in the following situations:
- Violation due to neglect by the physician or by another medical worker of rules or methods of providing medical care if it caused:
 - a) serious bodily or health injury;
 - b) a patient's death, which shall be punished with imprisonment of up to 3 years with (or without) the deprivation of the right to occupy certain positions or to practice certain activities for a term of 2 to 5 years (**Article 213**).
 - The spread of epidemic diseases by failure to observe the measures of prevention or combat of epidemic diseases, if the failure caused the spread of such a disease, shall be punished with a fine of 200 to 400 conventional units or by imprisonment of up to 1 year; and the legal entity shall be punished by a fine of 1,000 to 2,000 conventional units with (or without) the liquidation of the legal entity. The same facts that resulted from negligence in serious or average injury to health or the death of a person shall be punished with imprisonment of up to 5 years, or a fine, applied to legal entities, of 1,000 to 2,000 conventional units with the liquidation of the legal entity (**Article 215**).
 - Deprivation of life due to negligence shall be punished with imprisonment of up to 3 years, and deprivation of life by negligence of two or more persons shall be punished with imprisonment of 2 to 6 years (**Article 149**).

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- **Order of the Minister of Health no. 139 of 03.03.2010 on quality assurance of medical services in medical institutions.**
- **Methodology of development and implementation of Institutional Clinical Protocols** developed by experts of the Preliminary Country Program "Millennium Challenge" for Good Governance
- **National clinical protocols** are elaborated based on international guidelines based on evidence of clinical and economic effectiveness. These are tools for clinical decision-making, and are elaborated by separate domains. Protocols are placed on the website of the Ministry of Health www.ms.gov.md.

D) PROVISIONS OF THE CODE OF ETHICS

A comprehensive approach to the qualitative aspect of medical care required is described in the **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers**.

In providing professional service and avoiding predictable complications in patients, the doctor must show the utmost vigilance, giving priority to the interests of patients, which prevails over all other interests.

Recommendations and clinical requirements must be based on scientific evidence. When applying new methods, the patient's interest must prevail, and the new methods can be used only after a risk-benefit assessment. **(Paragraph 53)**

The medical profession is incompatible with categories like hardness, apathy, ignorance, indifference, arrogance, impatience and so on, which both affect and discredit the authority of a particular member, as well as of the team and the medicine as a whole. **(Paragraph 26)**

Each member of the medical community has a moral obligation to support the professional authority by observing general common ethical categories such as honour, dignity, discipline, courtesy, politeness, and respect for the people. **(Paragraph 25)**

Confidence of patients is a reflection of their moral position in their relationship with the doctor and is supported by high moral qualities and professional skills of medical workers, manifesting themselves by the personal conviction of patients to follow medical advice and prescriptions. Confidence of patients is an indication of the medical service quality and is influenced directly by the professional authority. **(Paragraph 24)**

Chapter X of the Code describes the situations of incompatibility of the medical profession and the likely conflicts of interest.

Health and pharmaceutical workers cannot propose or apply to the patient empirical remedies or procedures which are insufficiently proved as beneficial or risk-free. It is prohibited to practice any form of cheating.

A medical or pharmaceutical worker cannot, under any circumstances, condition the diagnostic and treatment of patients, seeking from them, their relatives or their guardian any informal (unofficial) payments, gifts, services and other benefits.

Any collaboration with or support of persons illegally practicing medicine should be avoided. Medical and pharmaceutical workers have the obligation to inform legal authorities about the existence of such situations.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Citizen J. is in detention and suffers from serious health problems. He needs further investigation and surgical treatment. The medical institution of the prison does not have the equipment and conditions necessary for the examination. Citizen J. is transferred to a public clinic where he is provided with all medical care, adequate to the disease from which he suffers. **(Hypothetical)**

2. Examples of Breach

- According to the legal acts in force, in particular those related to centralized drug procurement procedure in the health system, one of the basic criteria for selection is the price. Thus, drugs with a lower price are purchased, but they may be of lower quality. As a result, many of the drugs offered as compensated through the health insurance system are not sufficiently effective and some patients prefer to buy (sometimes based on the doctors' recommendations) drugs with the same active ingredient offered by other manufacturers, but of much higher quality, and respectively, of a higher price. **(Case collected from author's practice)**
- Mrs. A., 35, married, gave birth to a boy with a serious genetic problem transmitted by inheritance. The child now is 15 years old, cannot self-care, and is in a wheelchair for life (atrophy of skeletal muscles of the arms, legs and intercostal). Previously, Mrs. A gave birth to a daughter, who died a few days after birth in the hospital. Doctors said the girl had a serious heart defect. The woman wanted very much to give birth to another child hoping he/she will be healthy. For this reason, she was consulted at a Family Planning Centre. She had a series of costly examinations following which the doctor informed her that there was no risk of having children with birth defects and that she could give birth to a healthy child. Mrs. A. decided to have another child. The pregnancy was developing very well. She was going regularly to the Family Planning Centre, to the same doctor. At an advanced term she decided to undergo amniocentesis, which is a method of detecting genetic disease and abnormalities in unborn children by collecting a sample of amniotic fluid - the fluid that surrounds the baby in the womb. This is a procedure that is considered to involve a high risk for pregnancy; however, Mrs. A. wanted to be sure that she had a healthy baby. The doctor informed her in more than 2 weeks after the test that the results were good and that there was no genetic defect. The woman gave birth at term to an apparently healthy baby girl. However, at the age of 6 months the child began to show some symptoms of disease, very similar to those of the genetic disease from which the older child suffered. Mrs. A. insisted that the Family Planning Centre perform additional specific tests. The physician did not disclose the results for 4 months, telling Mrs. A. that they were not ready yet. The condition of the girl became worse, the disease progressed, and manifestations became obvious. After much insistence from the family of this child, the laboratory test results were announced confirming that the second child was the bearer of the same genetic defect as the older brother, having the same severely disabling disease for life.

One of the explanations of the physician from the Family Planning Centre was that perhaps the power went out on one of the nights and refrigerators did not work; and thus biological samples were altered and were not qualitative, which influenced the further laboratory results and did not show the presence of a disease. No action was taken. **(Case collected from author's practice)**

3. Actual Cases

- There are no relevant cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

Lawyers should note that it is always necessary to have the opinion of a medical expert (and usually more than one opinion) for each case.

Specifics of the medical profession allege the increased risk of unexpected and unwanted results due to a medical act. Unlike many other professions, in medicine errors can have the most serious implications, culminating in the disabling or death of the patient. It is necessary to make distinctions between the causes of errors occurring in the medical practice. Thus, we distinguish subjective and objective errors.

Objective error occurs due to an imperfection of medical science at a certain time, a particular reactivity of the patient or some features of the disease, such as lack of symptoms or non-specific symptoms, or

false information given by the patient. In case of an objective error, any physician under the same conditions would act the same.

Subjective errors consist in the misrepresentation of the medical reality caused by poor professional training or defective practice of specialized techniques and manoeuvres. Under the same working conditions, another doctor could avoid damage to a patient due to incompetence, omitted doubts, superficial appreciation of the case, or unsuitability of the physician. Here are also included diagnostic errors due to the lack of knowledge of the patient's medical history, erroneous examination, misinterpretation of symptoms, failure to perform some tests, failure to refer patients to specialists, or failure to revise the diagnosis if a treatment does not work. Subjective errors entail the doctor's liability.

Malpractice is a professional error committed in the exercise of the medical or pharmaceutical act, due to negligence, carelessness, or insufficient medical knowledge and generating prejudice to the patient, involving liability of the medical personnel and/or the provider of medical products and services.

From a legal perspective, professional (medical) errors generating damage take the form of fault. In this field are known the *fault of medical technique* and the *fault of omission*.

The *fault of medical technique*, or professional misconduct, is the violation of the rules of exercising the medical profession due to ignorance or deviations from the rules recognized and recommended for the practice of the profession, resulting from negligence, carelessness, or failure to follow specific methods and procedures. In turn, the *fault of medical technique* is divided into:

- *professional fault by incompetence*
- *professional fault by carelessness*
- *professional fault by negligence*

Negligence or carelessness in medical practice takes the form of hurry and superficiality, and unconscious fulfilment of obligations.

Negligence: Specifically, negligence can take the form of: failure to record a proper anamnesis (case history), failure to properly perform the clinical examination, lack of routine laboratory tests, or failure to take all aseptic measures for an intervention. This category also includes failure to apply interdisciplinary consultation, deprivation of chance, and late referral of the patient to a specialist. Gross negligence is considered to be: failure to detect certain diseases or conditions prior to the initiation of treatment, which can generate an initial worsening or death of the patient; failure to isolate a contagious patient; failure to administer anti-tetanus therapy in tetanogene wounds; injecting medication with expired usage period, or injecting by confusion a substance other than the one desired.

Carelessness: Frequently, professional carelessness is manifested by one or more of the following: not performing competent clinical examination of a patient; ignoring the risks to which the patient is exposed; inadequate immobilization of a fracture; making improper injection or puncture; causing hearing loss of a child by treating the mother with streptomycin; occurrence of notorious undesirable effects (listed in the medication leaflet) due to usage of dosages exceeding the maximal ones; burns after antiseptics or radiation therapy; ignoring poor working conditions; misery, inadequate sterilization. Fault by carelessness is characterized by underestimation of risks of the medical action or overestimation of the potential action.

Fault by omission adds responsibility for everything a doctor refuses to do, the same as for all he/she does. Fault by omission takes the following forms: refusal to respond to the patient's request; refusing to perform surgery (not assuming risk); refusal to send the patient to a higher level provider or medical institution (deprivation of chance); failure to assure the patient's right to a second opinion in the same medical case; or refusal to continue to treat a patient without a legitimate/legal basis for continuing treatment.

The physician cannot be convicted unless it is demonstrated that he/she voluntarily caused injury to the patient. Voluntarily causing injury, however, does not mean that the physician intended to cause the injury but rather that the action he/she took was done as an act of his/her own free will (not coerced, for example).

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See sections on the Right to the Highest Attainable Standard of Health and the Right to Non-Discrimination and Equality in Chapter 2 on International Framework for Human Rights in Patient Care, and Chapter 3 on Regional Framework for Human Rights in Patient Care.

7.2.4 OBLIGATION TO INFORM THE PATIENT

A) THE OBLIGATION OF HEALTHCARE WORKERS TO INFORM THE PATIENTS IS IN CLOSE RELATION WITH THE RIGHT OF PATIENTS TO BE INFORMED (TO RECEIVE INFORMATION)

The general principle of access to the information of public interest is stipulated in the legislation. In the healthcare area the patient, without any discrimination, has the right to information on the healthcare provider, the healthcare services, his/her own health condition, treatment, prophylaxis, etc.

B) OBLIGATION AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ The **Constitution of the Republic of Moldova** states the right of the individual to information (**Article 34**). The public authorities, according to the established level of competence, shall ensure that citizens are correctly informed both on public affairs and matters of personal interest.
- ▶ **Law on Access to Information no. 982-XV of 11.05.2000** stipulates the conditions of the access to private information.
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** stipulates the right to information about the health condition, which invokes the responsibility of the physician to inform the patient and his relatives about the health condition, the medical procedures applied and their potential risk, the therapeutic efficiency, the alternative methods of treatment, as well as about the diagnosis, prognostic, treatment and prophylaxis recommendations (**Article 27**).

The healthcare workers shall inform the parents, the tutor or the curator about the disease of the child and the treatment. (**Article 50, paragraph 3**)

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005** stipulates the responsibility of the healthcare workers to inform the patient by enunciating the rights of the patient to information about the healthcare provider, including the profile, the quantity and quality, the cost and the means of provision of healthcare services; the right to exhaustive information about his/her own health, the methods of diagnostic, treatment and recovery, and prophylaxis, as well as about their potential risks and therapeutic efficiency; the right to comprehensive information on the harmful factors of the environment (**Article 5, (g), (i), (j)**)

The patient is entitled to information, education and services necessary for a normal sexual life and reproductive health, without any discrimination (**Article 9, paragraph 3**).

- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** stipulates that in the relationship with the ill person, the physician shall inform this person about his/her health condition directly, or through the legal representatives or close relatives. (**Article 17, (k)**)

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates the right of every person to comprehensive and accurate information on the state of his/her reproductive health and family planning (**Article 4, paragraph 1, (e)**).

- ▶ **The Law on Mental Health no. 1402 of 16.12.1997** ensures the right of persons suffering from psychological disorders to information on their rights, on the nature of psychological disorders and treatment methods, presented in a form accessible for the patients, taking into account their psychological condition (**Article 5, (b)**).

In order to enjoy his/her legal rights and interests, a person suffering from psychological disorders or his/her legal representative may receive, at his/her request, information on the state of his/her psychological health and the psychiatric care provided. (**Article 9**)

- ▶ **Law on Prevention and Control of Tuberculosis no. 153 of 04.07.2008** stipulates that while providing anti-tuberculosis medical care, people registered in connection with tuberculosis and people suffering from tuberculosis are entitled to information, provided in an accessible way, on their rights and responsibilities, the nature of the disease from which they suffer, and the investigative and treatment methods applied. (**Article 17**)

- ▶ According to the **Law on Control and Prevention of HIV/AIDS no. 23-XVI of 16.02.2007** in case a person requires HIV testing, a specialist in counselling, who possess an appropriate level of competence, shall provide the necessary pre- and post-testing information. The access to services provided by the counselling and testing centres shall be free and non-discriminatory for any person. (**Article 12**)

Should a planned medical intervention imply certain risks for the patient, the physician shall inform the patient or his/her legal representatives about the potential risks and complications, as well as about the possibility of an eventual refusal of the medical intervention. (**Article 12**)

- ▶ **Law on the Transplantation of Human Organs, Tissues and Cells no. 42 of 06.03.2008** stipulates that specialized doctors, authorized to perform the sampling and transplantation of organs, tissues and cells, shall provide accurate information in a form that is understandable for the donor and the recipient or for the persons who are 1st degree relatives. The close relatives of the deceased donor shall be informed on the necessity to perform the testing in order to establish the compatibility of the donor, as well as on the testing consequences. Living donors shall be informed about the required testing to establish the compatibility of the donor, about the purpose and the nature of the sampling, as well as about the potential risks and consequences. The recipient shall be provided comprehensive information on the nature of the procedure, as well as on the potential risks and consequences. (**Article 24**)

Sampling of organs, tissues and cells from a person who is unable to give consent is forbidden except for the sampling of regenerative tissues or cells. In this case, the sampling will be authorized by an Independent Commission for Approval with the consent of the legal representatives of the donor or the tutelary authority, provided that the donation will be for the benefit of the person for whom the donor is a 1st degree relative (for the donor who is a minor, these relatives are his/her brother, sister), and the procedure has minimal risk for the donor. (**Article 19**)

- ▶ **Law on the Pharmaceutical Activity no. 1409 of 17.12.1997, Article 12**, stipulates that the patient, the volunteer or their legal representatives shall be informed about the content of testing, the properties of drugs, the expected effect, the potential consequences and the level of risk to which the patient or the volunteer will be subjected.

- ▶ The **Code of Administrative Offences of the Republic of Moldova of 24.10.2008** stipulates that violation of legal provisions with regard to access to information and petition by a decision maker shall be punished by a fine of 40 to 50 conventional units. Submission of an answer with manifestly erroneous data shall be punished by a fine of 45 to 55 conventional units applied to a decision maker. (**Article 71**)

- ▶ The ***Criminal Code of the Republic of Moldova no. 985 of 18.04.2002*** stipulates punishment for deliberate violation by a decision maker of the legal procedure on ensuring and enjoying the right to access to information. If this violation caused damages in considerable proportions to the rights and interests, protected by the law, of the person who required the information regarding the protection of population health, public security, or environment protection, punishment shall be a fine of 150 to 300 conventional units with (or without) deprivation of the right to occupy certain positions or to exercise a certain activity for a period of up to 3 years. (**Article 18**)

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- ***Order of the Ministry of Health no. 303 of 06.05.2010 on ensuring the access to information about personal data and the list of medical interventions, which require the informed consent in writing***, describes the way of providing medical information from the medical records to the patient. The ***Guideline on ensuring the access to information regarding personal medical data from the medical records*** is approved through this Order.

According to the described procedure, the information contained in the primary medical records documentation for outpatient and stationary facilities (hereinafter – medical record) regarding personal medical data, investigation results, and received treatments and care is issued to the patient personally. For persons under 18 years old, as well as for persons declared disabled or with limited mental capacity, the information is provided to their legal representatives (or close relatives), informing the patient at the same time to an extent adequate for his/her exercise capacity. When the patient does not want to be informed personally, the information, at his/her request, is presented to a person nominated by him/her. In case of requiring information on the medical data about a deceased patient, the information may be issued to the close relatives, provided that the informed consent signed by the deceased patient during his/her lifetime does not indicate expressly the wish of the patient regarding absolute confidentiality about the data on his/her health.

The manager of the healthcare facility shall ensure access to the information on medical data of the patient.

D) PROVISIONS OF THE CODE OF ETHICS

The ***Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers, Chapter V*** stipulates that the healthcare worker shall provide to the patient, at the patient's request, comprehensive and comprehensible information about the patient's health condition, the treatment stages, the expected risks and results. Any medical documents should be explained to the person to whom they are referred.

The manner in which the information is presented requires a tinge of optimism; it shall inspire hope and confidence, without omitting the importance of the psychical factor. The right of the patient to a decision shall be observed, without imposing personal beliefs of the healthcare worker or exercising psychical pressure on the patient. The more complex and risky the medical act expected, the more ample shall be the information on potential risks and alternatives, which is provided to the patient.

The patient shall be informed with caution and tact about a serious unfavourable prognosis, taking into account his/her psychical condition. The prognosis shall be communicated to the family only with the patient's consent. If the doctor, after a joint consultation with his/her colleagues or other specialists (if needed), considers that the disclosure of an unfavourable prognosis will affect the psycho-affective state of the patient by endangering his/her health, the communication to the patient of the entire prognosis will be avoided. Nor will the real prognostic information be disclosed when the patient declares from the beginning of treatment his/her wish of not knowing the truth. In such case, some family members of the patient may be informed according to the patient's indications.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Patient L. is admitted to a hospital for a planned surgical intervention. Upon being hospitalized, the patient is explained all the terms for hospitalization. Subsequently, the surgeon explains to patient L. the purpose and the extent of the intervention to be performed. The doctor describes the potential risks and complications, which may occur as a result of the intervention, as well as the measures which are being or will be undertaken in order to avoid or to solve them. The patient receives answers to all the questions he addressed to the doctor about his disease and the intervention to be performed. The patient then gave his consent. **(Hypothetical)**

2. Examples of violation

- Patient V., 32 years old, is admitted to the emergency unit, during the night, in a district hospital with the diagnosis of acute appendicitis. During the medical intervention, the doctor discovered a *large ovarian cyst* and the decision was made to perform the resection of the ovary in order to avoid the cyst's rupture, which would have had severe complications. The post-intervention period went without complications and the patient was discharged soon after the intervention. The surgeon on duty, who operated on the patient, went on vacation a day after Mrs V. was admitted to the hospital; the surgeon on duty, who was performing the post-operative dressings, did not consider it necessary to provide details to the patient he did not operate. Thus, nobody informed the patient about the ovary resection, performed additionally. After 5 years, the patient went to consult a gynaecologist regarding certain hormonal dysfunctions. Besides other investigations, the gynaecologist ordered an ultrasound, which detected the absence of the ovary. The patient was surprised about the discovery and, being upset, submitted a complaint in the district court against the surgeon who had operated her. She was convinced that the surgeon accidentally injured the ovary and, as a result, it was extracted by mistake. The patient asserts that because of this reason the information about the ovary resection was not disclosed. The case was cancelled due to the lack of data because too much time had passed. **(Case selected from the author's practice)**

3. Actual Case

- ▶ There are no relevant actual cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

When a decision is necessary regarding the quantity and quality of information provided to a patient, the opinion of independent experts in the medical area will be necessary.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See sections on the Right to Information in Chapter 2 on International Framework for Human Rights in Patient Care, and Chapter 3 on Regional Framework for Human Rights in Patient Care.

7.2.5 OBLIGATION TO OBTAIN INFORMED CONSENT

A) THE OBLIGATION OF THE HEALTHCARE WORKERS TO SEEK THE PATIENT'S INFORMED CONSENT IS LINKED TO THE RIGHT OF THE PATIENT TO MAKE A CHOICE REGARDING ONE'S OWN HEALTH, WHICH GIVES HIM/HER THE POSSIBILITY TO CONSENT, REFUSE OR CHOOSE ANOTHER OPTION PROVIDED

B) OBLIGATION AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ The **Constitution of the Republic of Moldova, Article 24**, stipulates that the State guarantees everybody the right to physical and psychological integrity. This right is manifested through the freedom of the patient to voluntarily express the consent for the performance of a medical act.

At the same time, **Article 51** stipulates that nobody can be subjected to coerced medical treatment, except for those cases that are provided under the law.

- ▶ **Law on Healthcare no. 411-XII of 28.03.1995, Article 23**, stipulates that consent shall be sought for the provision of healthcare services. The patient's consent is necessary for any healthcare service recommended (prophylaxis, diagnostic, therapy, recovery), however, in the absence of manifested opposition, the consent is assumed for any services, which do not imply important risks for the patient or are not likely to harm his/her privacy.

For a patient incapable of discernment, the consent is given by the legal representative; in the absence of the latter – by the closest relative. For patients under 16 years, the consent is given by their legal representatives. In case of imminent death or serious threat to health, the healthcare services can be provided without the consent of the legal representative. The consent or refusal of the patient or his/her legal representative is confirmed in writing by the signature of the attending doctor or the signatures of the team of doctors who are on duty; in exceptional cases, the signature of the management of the healthcare facility is required.

Article 28, paragraph 2, of the Law stipulates the terms for the informed consent given by the patient to participate in scientific research. The physician may apply new methods of prophylaxis, diagnostic and treatment, as well as new medications, scientifically proved, which are not yet admitted for use in mass, only with the written consent of the patient capable of lucid reasoning and with discernment or with the written consent of the parents, tutor or curator of a patient under 16 years or a patient with psychological disorders.

Voluntary surgical sterilization for women and men is performed only at their wish or at the indication of the doctor with the written consent of the person in public or private healthcare facilities in cases and ways established by the Ministry of Health. (**Article 31, paragraph 1**)

The persons suffering from tuberculosis in active form, who avoid voluntary treatment, violate the regime prescribed, are alcohol abusers or drug-addicted are referred to coercive treatment in the manner established by the legislation in force. (**Article 44**)

Psychical patients lacking discernment, who can endanger their own life or bodily integrity, as well as the lives of others, are subject to coercive medical treatment in a healthcare facility according to the law provisions. These patients are admitted to a hospital urgently in cooperation with a police officer at the request of the psychiatrist. (**Article 42, paragraph 2**)

Persons being in contact with other persons suffering from venereal diseases are subject to mandatory medical examination and prophylactic treatment. In case of avoidance of the voluntary medical examina-

tion and treatment, these persons shall be subjected to coercive examination and treatment in a hospital of venereal diseases. **(Article 45)**

Persons in regard to whom there are sufficient data to assume that they suffer from venereal diseases shall be subjected to mandatory medical examinations. Persons who have been in contact with other persons suffering from venereal diseases are subject to mandatory medical examination and prophylactic treatment. In case of avoidance of the voluntary medical examination and treatment, these persons shall be subjected to coercive examination and treatment in a hospital of venereal diseases. **(Article 45)**

- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** stipulates that the physician shall require the patient to consent for any healthcare service according to the legislation and shall register the refusal of the patient for any healthcare service, when this is expressed explicitly, with full knowledge of the facts and subsequent effects. **(Article 17, (h), (j))**

Any medical intervention can be performed with the patient's consent, unless the physical and psychical state of the patient does not allow him/her to take a conscious decision or in other cases established by the law. **(Article 18, paragraph 4)**

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005, Article 13** stipulates how the informed consent of the patient shall be given. This is described in detail in **Chapter 6. (See the Patient's Right to Consent)**

- ▶ **Law on Mental Health no. 1402 of 16.12.1997** stipulates that psychiatric care is provided at the voluntary request of the person or with his/her consent, except for those cases that are provided under the law. Persons under the age of 18, as well as persons declared legally incapable, as established by the law provisions, are provided psychiatric care at the request or with the consent of their legal representatives. **(Article 4)**

A minor suffering from psychical disorders shall not be subjected to experiments, electroconvulsive therapy, scientific or teaching research, shall not be taken pictures, filmed and/or administered any irreversible treatment (psychosurgical) without his/her consent or the consent of his/her legal representative. **(Article 5¹, paragraph 3)**

Explanations on the possible consequences shall be given to a person refusing or interrupting the treatment or to his/her legal representative. The refusal or interruption of a treatment and the information provided on the potential consequences are registered in the medical records and signed by the patient or his/her legal representative and by the psychiatrist. **(Article 12)**

A person suffering from psychical disorders, who committed actions dangerous for the society, is subject to coercive medical measures based on a court decision, according to the provisions of the Criminal Code and the Criminal Procedure Code. The coercive medical measures are applied in psychiatric institutions of the healthcare system. **(Article 13)**

- ▶ **Law on Prevention and Control of Tuberculosis no. 153 of 04.07.2008** stipulates that anti-tuberculosis medical care shall be provided to people who require this voluntarily or based on their consent, except for those cases that are provided under the legal and normative acts in force. Children under 18 and persons declared legally incapable are provided anti-tuberculosis medical care based on the consent of their legal representatives, except for those cases that are provided under the legal and normative acts in force. **(Article 13, paragraph 1, 2)**

A person suffering from a contagious form of tuberculosis that violates the sanitary-epidemic regime or avoids medical examination for tuberculosis detection or avoids treatment for tuberculosis shall be admitted to a specialized phthisiopneumological hospital for coercive treatment based on a court decision. **(Article 15)**

Medical surveillance of the patient with tuberculosis is compulsory, regardless of his/her consent or the consent of his/her legal representative. The decision on the need for medical surveillance of the patient with tuberculosis or the interruption of surveillance is taken by a medical council with the participation

of a professional specialized in phthisiopneumology and is attached to the medical records, about which the person subject to surveillance is informed. (**Article 14**)

- ▶ According to the **Law on Prevention and Control of HIV/AIDS no. 23-XVI of 16.02.2007**, testing for HIV markers is performed only upon written voluntary and informed consent of the individual (**Article 13**). Any form of blind testing is forbidden.
- ▶ **Law on Reproductive Health no. 138 of 24.05.2001** stipulates that healthcare workers shall observe the right of every person to free decision-making with regard to reproduction (**Article 4**).
- ▶ **Law on the Transplantation of Human Organs, Tissues and Cells no. 42 of 06.03.2008** stipulates that healthcare workers shall seek consent in case of organ donation. **Article 13** describes the terms of sampling from dead bodies, which is only possible if the person gave his/her consent before death and the consent is expressed according to the legal provisions. The sampling may not be performed in any way if during lifetime the deceased person expressed his/her wish against donation through a writ of refusal written by hand or given in another legal form. The donation is possible without the consent of close relatives or the legal representative provided that neither the close relatives nor the legal representative, after the legal declaration of death, expressed the option regarding the donation, or there is no information regarding the possibilities of contacting close relatives or the legal representative of the deceased person.

Article 15 describes the terms of sampling of organs, tissues and cells from living persons. This is possible only when persons have full mental exercise capacity and only if the written voluntary, prior and express consent of these persons exists.

- ▶ The **Civil Procedure Code of the Republic of Moldova, Article 79** stipulates that legal rights, freedoms and interests of persons who do not have full mental capacity and of those with limited exercise capacity are protected by parents, adoptive parents, tutors or curators, or by other persons to whom this right is guaranteed under the legal provisions. A guardianship is established and a guardian is appointed, by a court decision, for a person lacking discernment; a curatorship is established and a curator is appointed for a person who, as a result of alcohol abuse or consumption of drugs and other psychotropic substances, undermines his/her family's material state and is limited in his/her legal mental capacity by the court.
- ▶ The **Criminal Code of the Republic of Moldova no. 985 of 18.04.2002** stipulates that illegal surgical sterilization of a patient by a doctor shall be punished by a fine of up to 200 conventional units with (or without) deprivation of the right to occupy certain positions or to exercise a certain professional activity for a period of up to 3 years. If this action caused, by imprudence, a lasting health disorder or severe injury of corporal or health integrity or caused, by imprudence, the patient's death, the responsible person shall be punished with prison of 3 to 6 years with (or without) deprivation of the right to occupy certain positions or to exercise a certain professional activity for a period of up to 5 years. (**Article 160**)

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

- **National Strategy on Reproductive Health (2005-2015)**, approved by the **Government Decision no. 913 of 26.08.2005**.
- **Order of the Ministry of Health no. 303 of 06.05.2010 on ensuring access to information about personal data and the list of medical interventions, which require informed consent in writing.** The *List of medical interventions which require the informed consent in writing and the Template of informed consent in writing* are approved by this Order.
- **Order of the Ministry of Health and Social Protection no. 370 of 27.10.2005 with the Annex Guidelines on the use of the method of voluntary surgical sterilization of a woman.**

- **Regulation on the application of coercive treatment for persons suffering from contagious tuberculosis**, approved by the **Government Decision no. 472 of 07.08.2009**.

D) PROVISIONS OF THE CODE OF ETHICS

The **Framework Code of Ethics (Deontology) of Medical and Pharmaceutical Workers, Chapter VII**, stipulates that doctors shall seek informed consent from the patient.

The patient's consent can be accepted orally with mandatory attendance of witnesses (relatives of the patient and healthcare personnel) or in writing, which shall explicitly indicate the name and terms of the planned medical act, the potential risks, and is to be confirmed mandatorily by the signature of the patient and the healthcare worker.

The consent shall be deemed implicit when the patient addresses the doctor on his/her own initiative to benefit from certain medical services (laboratory analysis, prophylactic control, etc.) or when a medical consultation is required at home.

The consent shall be accepted only after providing comprehensive information by the patient's doctor or health worker on the diagnosis, prognosis, alternative therapies, risks and their benefits to the patient. The consent shall be deemed valid only if the patient is lucid and has discernment, being able to repeat correctly to the doctor or healthcare worker the information regarding his/her health. The healthcare professional shall ensure that the decision of the patient is taken with full mental capacity and not in a moment of affection or mental overload.

N.B.: The nurse also can inform the patient and get the informed consent, this is why the term of health worker is used.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Patient K., 40 years old, the victim of a road accident is admitted to hospital as case of emergency, being suspected of internal bleeding. The patient is conscious. The doctor manages to take the anamnesis and to fill in the required forms. Mrs K. manages to inform the doctor that she is seropositive (infected with HIV), but requires full confidentiality of this information. In particular she emphasizes that she does not want her family to know this. The patient is operated, but the damage to internal vessels is so severe that the patient does not survive. The relatives are informed. The husband of Mrs K. requires an integral copy of the medical record of Mrs K. in order to make sure that all actions undertaken by the physicians to save the life of his wife were correct. The doctor refuses to issue a copy of the medical record. Mr P. says he will make an appeal to the court because he assumes that the physicians are hiding something important. Considering the presence of the explicit request of the patient for protecting confidentiality of the information after her death and the doctor's obligation stipulated in the art.6, paragraph 6 of the *Law on the Practice of the Medical Profession no. 264-XVI of 27.10* to keep the patient confidentiality even after his/her death, the court did not open the case. **(Case selected from authors' practice)**

2. Examples of Violation

- Mr. N, 46 years old, is the father of 2 children. He has been registered with the oncologist for 3 years with *benign prostatic hyperplasia*. Meanwhile, the tumour became malignant. Mr. N. is admitted to a hospital for an intervention on his prostate. Before the surgery, he was informed about his health condition and the volume of the planned intervention. The informed consent form was signed. During the intervention procedure, the surgeon determined a more ample process. The surgeon decided to perform the *prostate-vesiculectomy* (an intervention which affects the sexual and reproductive capacity of the man). After the intervention, Mr. N. was very angry on doctor's decision, considering that the treatment applied to him proved to be harmful and affected his right to reproduction and decision. He asserts that he would not have given consent for such an intervention. No further action was taken. **(Case selected from authors' practice)**
- Patient M., 35 years old, suffers from long-term depression with decreased interest or enjoyment in current activity, lack of concentration or will, sleepless at night and drowsiness during the day, permanent tiredness, alternating with moments of agitation, feelings of worthlessness, anorexia, etc. She was admitted to the psychiatric clinic at the request of her physician, who detected thoughts of possible suicide in the patient. This state started 3 years ago, after the death of her mother with whom the patient was living. After this, she remained alone without close relatives. She works as technical personnel in a company. While hospitalized in the clinic, she is visited by nobody and has no friends. In one of the discussions with the psychiatrist of the clinic, the patient told that she had worked illegally in Turkey for a period of 5 years when she was 18 years old. The patient says that she does not remember the type of activity she performed in that period. The attending doctor detected a rash on the patient's body, which he determines as Herpes Zoster resulting from the fact that the patient would be in the high-risk group for HIV infection. But the patient refuses taking any tests, stating their uselessness and her wish to die as soon as possible. Any attempt to convince the patient was in vain. The attending doctor describes the situation to his colleagues from the department. One of the doctors considers that: "The decision taken under the effect of antidepressants is an incorrect one, because she is influenced by the medicines". The head of the department announces his decision saying that the actions taken shall be oriented towards the patient benefit. If the test is positive, than the ARV treatment shall be started as soon as possible. The hospital lawyer explains them that the HIV testing of this patient without her consent has no legal basis and the doctors have to wait for her psychological recover to obtain consent. **(Case selected from the author's practice)**
- The woman S., 36 years old, married for the third time, has 4 minor children. The woman lives in poverty. None of the spouses has permanent job. The woman is taken to the district hospital by the emergency service complaining of acute abdominal pain. The surgeon starts the surgical intervention for an appendectomy. The physician is acquainted with the situation of the family of this woman and considers that he would do good thing if he would tie off the fallopian tubes in order "not to allow the poverty to multiply" as he told to his colleague. The doctor has no intention to inform the woman about the sterilization procedure that he performed, considering it senseless. He explains: "She fulfilled herself as a mother; it is time to fulfill as member of the society". The woman was sterilized. When being discharged, she was sure that only the appendix was extracted and she did not know that the doctor sterilized her. **(Case from the authors' practice)**

3. Actual Case

- There are no relevant actual cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

Since the medical activity is one of the most extensive and complicated (resulting from the diversity of human diseases), the term *informed consent* shall be analysed through the peculiarities of various fields and situations. Of course, it is impossible to place in the same category the therapeutic chronic patients and the acute psychiatric patients, or cases of emergency, where the doctor shall decide the method of treatment resulting from his/her qualifications and duties and acting in accordance with the legislation in force. However, some general aspects in the process of seeking informed consent, including from seropositive patients, can be emphasised:

- The information provided to the patient, in an accessible way (presented in a language and at a level that the patient can understand), shall contain the cause and the symptoms of the disease, and the expected prognosis;
- In case of recommendation of a medical intervention, the following shall be explained: the purpose, the expected effect, the potential risk(s), the possible medical-social, psychological and economic consequences, as well as any alternative options of medical treatment and care;
- The patient shall have the opportunity to ask questions and to receive answers to all questions.

The patient's consent can be expressed in several ways:

- *"Implicit" consent* – when the patient goes voluntarily to the doctor for examination or treatment, or the patient calls for the doctor at home. However, this type of agreement also needs to be accompanied by an information element, which will help the patient to make an informed choice. Such consent is valid only for current medical acts or usual procedures.
- *Verbal (oral) consent* – is desirable to be obtained in the presence of a third party: nurse, family member, for example. However, depending on the character and temperament of the patient, and also of the concrete circumstances, it is recommended to insist on having the patient to sign the consent.
- *Written consent* – authorization which means the implication of the patient in relationships similar to those mentioned in a contract, which will determine mutual obligations, both legal and moral, on behalf of both parties determining the form and level of responsibilities. The informed consent shall not provide the objective itself but only the way of carrying out the dialogue. For high-risk medical interventions, written consent is compulsory and is performed by filling in a special form signed by the patient or his/her legal representative and by the attending doctor.

The consent does not exempt the physician from the liability for mistake and negligence.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

- *Declaration on the Rights of Mentally Retarded Persons* (1971), proclaimed by the General Assembly of the United Nations Organisation and states that: "The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings."
- *Declaration on the Rights of Disabled Persons* (no. 3447-XXXI of 09.12.1975).
- Decision of the General Assembly of the United Nations Organisation *"The protection of people with mental illness and the improvement of mental healthcare"* (no. 46/119 of 17.12.1991).
- Recommendations of the Council of Europe Parliamentary Assembly related to the *"Human Rights and Psychiatry"* (no. 1235 of 12.04.1994).
- Recommendations of the World Health Organisation *"Mental Healthcare Law: Ten Basic Principles"*, Geneva 1996.
- *European Parliament Resolution (February 19th, 2009) on Mental Health*.

- It is worth mentioning the two Declarations adopted at the Congresses of the World Psychiatric Association (*Declaration of Hawaii, 1977* and *Madrid Declaration on Ethical Standards for Psychiatric Practice, 1996*).
- *Convention on Making Referral for Persons Suffering from Psychical Disorders to Undergo Coerced Treatment* dated 28.03.1997, ratified by the Republic of Moldova through the *Law no. 1190-XV* of 04.07.2002.

See sections on the Right to Bodily Integrity in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

7.2.6 OBLIGATION TO MAINTAIN CONFIDENTIALITY OF INFORMATION ABOUT THE PATIENT

A) THE RESPONSIBILITY OF HEALTHCARE WORKERS TO KEEP SECRET THE INFORMATION FOUND OUT DURING THE PERFORMANCE OF JOB DUTIES AND TO OBSERVE THE PRIVATE LIFE OF PATIENTS IS IN CLOSE CONNECTION WITH THE RIGHT OF PATIENTS TO PRIVATE LIFE AND CONFIDENTIALITY

The information about the patient (including information about the health condition or the social situation) shall not be disclosed to other persons, unless with the consent of the patient or, in case of children, with the consent of their legal guardians.

See also the section on the Right to Privacy and Confidentiality in Chapter VI on National Patients' Rights and Responsibilities.

B) OBLIGATION AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ The **Constitution of the Republic of Moldova, Article 28**, states "*The State shall observe and protect private and family life*".
The patient's medical data is one of the basic elements of the right to private life. Following this right is necessary for strengthening the democratic values towards which the country tends.
- ▶ **Law on Personal Data Protection no. 133 of 08.07.2011** defines personal data as any information relating to an *identified* or *identifiable* natural person. Information on the request for healthcare services, the health condition, diagnosis and other data obtained by the physician during the examination and treatment of the patient constitute *personal information* and *professional secret* of the physician and shall not be disclosed (**Article 3**)
Data processing operators and third parties who have access to personal data are obliged to maintain the confidentiality of data, unless the processing relates to data disclosed to the public voluntarily and manifestly by the subject of personal data; and the personal data was depersonalized. (**Article 29**)
- ▶ According to the **Law on Access to Information no. 982 of 11.05.2000**, the information providers, holders of personal data, shall maintain the confidentiality of the private life of the person. (**Article 8**)
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** stipulates that doctors, other medical-sanitary workers, and pharmacists shall keep secret the information about the disease and the private and family life of the patient of which they become aware while exercising their profession, except cases of contagious

diseases that are at risk of being spread, which may be divulged at the reasonable request of the prosecuting authorities or the courts of law. **(Article 14, paragraph 1)**

- ▶ **Law on the Practice of the Medical Profession no. 264 of 27.10.2005** stipulates that the doctor shall keep professional secret **(Article 13, paragraph 1)**. Disclosure is allowed for information which is a professional secret to other persons in the interest of examination and treatment of the patient, performance of scientific investigations, use in the teaching process, and for other purposes only with the consent of the patient or his/her legal representative. **(Article 13, paragraph 3 and 4)**

At the same time, disclosure of private data without the patient's consent or the consent of his/her legal representative is allowed only in the following cases:

- a) examination and treatment of a patient who is unable to express his/her will due to his/her health condition;
- b) the spread of contagious diseases, intoxication and some socially-dangerous diseases;
- c) at the request of the prosecution authorities and the court in connection with criminal proceedings or with a judicial investigation;
- c¹) at the request of the ombudsman and the members of the advisory council established by the Centre for Human Rights in order to ensure protection to persons against torture and other cruel, inhumane or degrading treatment or punishment;
- d) the provision of medical help to a person with limited mental exercise capacity, who is unable to inform his/her parents or his/her legal representative;
- e) in some circumstances when it can be supposed that the harm caused to the person's health is a consequence of an illegal action.

Persons who received information which represents a professional secret are liable for the disclosure of information they received, according to the legal provisions. The professional secret may not be disclosed after the treatment is finished or after the patient's death. **(Article 13, item 6)**

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005, Article 12**, stipulates that healthcare workers shall observe the patient's confidentiality. The confidentiality of information regarding the request of medical care, examination and treatment, including other information which constitutes professional secret, shall be ensured by the attending doctor and the specialists involved in providing healthcare services or in biomedical research (clinical study), as well as by other persons to whom this information became known due to the performance of professional and work duties.

Information deemed to be confidential can be disclosed only when the patient gives his/her consent explicitly or at the request of his/her legal representative (a close relative) in the terms consented by the patient, to the extent of his/her capacity for understanding, in situations when the patient has limited or lack of mental exercise capacity or if the legal provisions request this expressly.

Any interference with private and family life of the patient is forbidden without the patient's consent. Disclosure of confidential information without the patient's consent or the consent of his/her legal representative (or a close relative) is admitted:

- a) when it is necessary to involve in the treatment process other specialists in the area, including in cases of emergency examination and treatment of a person unable to express his/her will due to his/her mental or physical health condition, but only to the extent necessary to take a proper decision;
- b) when it is necessary to inform the authorities and institutions of the sanitary-epidemiological service in case of real danger of spread of contagious diseases, mass food contaminations;
- c) at the reasonable request of the prosecution authorities or the court in connection with criminal proceedings or with a judicial investigation according to the legislation;
- c¹) at the request of the ombudsman and the members of the advisory council established by the Centre for Human Rights in order to ensure protection to persons against torture and other cruel, inhumane or degrading treatment or punishment;

- d) when it is necessary to inform the parties or the legal representatives of persons under the age of 18 in case they are provided medical care;
- e) in some circumstances, when it can be supposed that the harm caused to the person's health is a consequence of some illegal or criminal actions, in this case the information shall be submitted to the competent juridical authorities.

The medical-sanitary and pharmaceutical personnel or other persons who, while performing their duties, received confidential information bear responsibility for the disclosure of a medical secret according to the legislation and taking into account the damage caused to the patient by disclosing the information. (art.12)

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates that healthcare workers shall maintain confidentiality of clients in all consultations and shall observe their decisions related to reproduction. (**Article 8, (d)**)
- ▶ According to the **Law on Mental Health no. 1402 of 16.12.1997**, the information about psychical disorders, the request of psychiatric care and treatment in a psychiatric hospital, as well as other information regarding the psychical health of a person, constitutes medical secrecy protected by law. (**Article 9**)
- ▶ **Law no. 23-XVI of 16.02.2007 on Prevention and Control of HIV/AIDS** (according to the last updates) guarantees the right to confidentiality for a person who requests HIV testing or for a person diagnosed with HIV (**Article 14**). The result of HIV testing is confidential and shall be issued only to the following persons: the tested person, the parent or the tutor of a tested minor; the legal representative of a person lacking discernment; the healthcare personnel involved in the treatment process and/or medical and epidemiological surveillance, provided that confidentiality and security of medical and personal information is maintained; or the court issuing the decision on mandatory testing.

Persons who received information which represents a professional secret are liable for the disclosure of information they received according to the legal provisions.

The healthcare personnel (and the institutions where they work) who, by virtue of their job duties, hold information on the results of medical examinations with regard to HIV infection (or AIDS disease) are obliged to ensure mandatory guarantees of confidentiality and security of the personal information. These guarantees shall contain as a minimum a set of guidelines for the maintenance of confidentiality and security of the information, which shall include mandatory:

- a) justification of the need to hold the information;
 - b) mandatory training of employees on matters of ensuring the confidentiality of medical information and signed non-disclosure statements;
 - c) documentation on the access to personal information for the staff;
 - d) a person responsible for the policy on maintaining the confidentiality;
 - e) ensuring notification of the obligation to keep medical secrecy on subsequent reporting between institutions on paper as well as when reporting by automated processing of personal data.
- ▶ The **Code of Administrative Offences of the Republic of Moldova no. 218-XVI of 24.10.2008, Article 75**, stipulates the liability for disclosure of confidential information in the medical field, or for disclosure of confidential information on medical examination to detect the infection with the human immunodeficiency virus (HIV), which causes AIDS. Thus, disclosure of confidential information about medical examinations to detect infection with the human immunodeficiency virus (HIV) by the healthcare personnel or by persons who, by virtue of their job duties, hold such information shall be punished by a fine of 50 to 70 conventional units.
 - ▶ The **Criminal Code of the Republic of Moldova no. 985 of 18.04.2002, Article 177**, stipulates the terms under which the violation of the inviolability of private life shall be considered and punished. Thus, illegal collection or unwittingly dissemination of information, protected by the law, about the private life

which constitutes personal or family secret of another person, without the consent of this person, shall be punished by a fine of 300 conventional units or by non-remunerated work for the benefit of the community of 180 to 240 hours.

The dissemination of information mentioned in previous paragraph:

- a) in a public speech or through mass-media; or
- b) by deliberately taking advantage of job duties

shall be punished by a fine of 200 to 500 conventional units or by deprivation of the right to occupy certain professional positions or to exercise a certain professional activity for a term of 1 year, or by non-remunerated work for the benefit of the community of 180 to 240 hours; or by a fine, applied to a legal person, of 1,000 to 2,000 conventional units.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no specific provisions for this chapter.

D) PROVISIONS OF THE CODE OF ETHICS

The Framework of Code of Ethics (Deontology) of the Medical and Pharmaceutical Worker, Chapter VI stipulates that doctors shall observe the confidentiality of patients while practicing the medical profession.

Disclosure of personal information, in exceptional cases accepted by the law, shall be performed carefully, without causing moral harm to the patient and by showing maximum respect towards his/her dignity. The doctor's duty is to mitigate the psychological discomfort of the patient while breaching the confidentiality as allowed by the law.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Mr. Z., 51 years old, addressed the family doctor together with his wife, Mrs. X, 30 years old. Mr. Z. suffers from major depression due to many social factors causing stress. These include: his recent diagnosis with AIDS; his wife was diagnosed with HIV; their inability to conceive a child; the high costs for artificial/in vitro fertilization; and the expenses for his wife to be operated (recto-vaginal fistula). Mr. Z. insists to receive an answer from the doctor to his question on the unclear way of infection with HIV because he did not use intravenous injections, did not practice unprotected sex, and had sexual relations only with his wife. As well, he insists on detailed investigations to detect the cause of infertility of his wife. Mr. Z. is also desperate because the doctor, as it seems, does not support him in his endeavour, "as if he has something to hide". Mr. Z. is always thinking of his problems, which destroy him. He feels guilty towards his wife, considering that he infected her with HIV and, in this way, he "killed her". He suffers from the thought that he will never become a father. In fact, the personal doctor of Mr. Z. was many years the doctor of Mrs. X also, before their marriage. The doctor knows that Mrs. X. was born as a boy and changed her sex at the age of 18 years old through surgical intervention in Brazil, which was sponsored by a wealthy gentleman. After changing the sex, Mrs. X

provided sexual services for money and, in this period, she got infected with HIV. When they married, Mrs. X told Mr. Z. neither about HIV infection nor the truth about her initial sex. Mrs. X does not want the doctor to disclose this information to her husband because this "will destroy" him more than the depression he is passing through now, and will lead him to suicide. The doctor does not tell the truth to the husband about the situation of Mrs. X. **(Hypothetical example)**

2. Examples of Breach

- A patient aged 34 was admitted to the psychiatric clinic after an attempt of suicide. The patient is 4 weeks pregnant. She is part of an ethnical minority and, together with her family, lives in the house of her parents-in-law. With the assistance of an interpreter, she informed the doctor she had decided to emigrate for the unification of her husband's family, but this change affected her very much. She does not know the language of the country where she came, and she feels like a prisoner in her husband's family, being exploited and compelled to perform hard physical work. Her husband does not support her. They already have five small children and are waiting for the sixth one. In a desperate moment she tried to throw herself under a car to interrupt her life, but she was taken to the emergency hospital by a police officer. In the hospital, the doctors noticed her state of depression for which reason she was transferred to a psychiatric hospital. She does not have attempts of suicide anymore, but she is very upset with her relatives and does not want to see them. The woman thinks that if they know about the attempts of suicide, they will make her life even more miserable and her situation will worsen. The family does not understand why she is hospitalized together with the "mad persons" and they want to take her home. The parents consider being their right to receive full information on the hospitalization of their daughter-in-law and insist on the psychiatrist to provide them the requested information. The psychiatrist tells the truth to the parents-in-law. **(Example selected from author's practice)**

3. Actual Case

- There are no relevant actual cases to be included.

E) PRACTICAL NOTES FOR LAWYERS

Violation of the right to confidentiality is considered not only when the doctor actively provided information to someone else than the patient, but also when the healthcare worker, passively, by negligence or inattention, allowed the leak of such information to third parties. For example, a doctor may be accused of negligence in maintaining the confidentiality if the information about the patient can be easily obtained from the computer or the personal office of the doctor by a third party. The doctor shall ensure inviolability of data about the patients, regardless of how data is stored and kept.

Unfortunately, in our society the stigma and discrimination phenomenon is still met by some groups of patients with certain health problems, even though there are laws which protect their rights. Therefore, the following information needs to be maintained confidentially: the results of some tests to investigate the health condition, the established diagnosis, the adoption of a behaviour with risk to health (ex. multiple partners, commercial sex, consumption of narcotics, etc.), the association (partner, family member) with a person having certain health problems, respectively, **all the information** found out about the private life of the examined person, directly or indirectly, while performing the medical profession.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See sections on the Right to Privacy in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

7.2.7 RESPONSIBILITY TO TREAT PATIENTS WITH RESPECT

A) MEDICAL AND PHARMACEUTICAL WORKERS SHALL TREAT PATIENTS WITH RESPECT, WITHOUT AFFECTING THEIR PERSONALITY AND DIGNITY

B) RESPONSIBILITY AS STATED IN CONSTITUTION/LEGISLATION OF THE COUNTRY

- ▶ The respect for the personality and dignity of every individual is promoted by the **Constitution of the Republic of Moldova** in several articles. The State guarantees every person the right to life, and to physical and mental integrity. No one may be subjected to torture or to cruel, inhuman or degrading punishment or treatment. **(Article 24)**

It is the foremost duty of the State to respect and protect the human person. All citizens of the Republic of Moldova are equal before the law and the public authorities, without any discrimination as to race, nationality, ethnic origin, language, religion, sex, political affiliation, personal property or social origin. **(Article 16)**

As well, the State shall observe and protect private and family life. **(Article 28)**

The freedom of conscience is guaranteed, and its manifestations shall be in a spirit of tolerance and mutual respect. **(Article 31)**

- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** stipulates the terms of ensuring medical care, without discrimination or other acts that would harm the dignity of the patient, especially of those who are in vulnerable situations.

The right to health insurance is guaranteed to all the inhabitants of the country, irrespective of the nationality, race, sex, social affiliation and religion. **(Article 17)**

The citizens of the Republic of Moldova, regardless of their own income, shall be provided equal possibilities to obtain opportune and good quality healthcare within the system of mandatory health insurance. **(Article 20)**

It shall be observed the right of every individual to freely choose the doctor and the form of medical care. **(Article 25)**

The patient has the right to receive or refuse spiritual and moral support, including on behalf of a servant of his/her religion, within the healthcare facilities. The patient has the right to die with dignity. **(Article 34)**

The State shall ensure that the elderly benefit of medical-social assistance according to certain programs on medical-social rehabilitation focused on the support of physical and psychological needs, for the extension of the active lifetime, including in domestic conditions, the improvement of the capacity for social-psychological adaptation to the old age, the prevention of chronic affections and disabilities. **(Article 38)**

The right to healthcare services of persons under arrest or detention is ensured by forbidding certain conditions which demean the dignity and endanger their life and health. People under arrest or detention are guaranteed medical-sanitary assistance according to the legislation in force. **(Article 39)**

Provision of specialized medical care to persons suffering from psychical disorders is performed based on the principles of legality, humanity and charity, taking into account the assumption of mental and physical capacity, which implies the right of every individual to enjoy one's own health, as well as the basic responsibility of the doctor to provide healthcare to the patient according to the medical ethics code. **(Article 42)**

Treatment of persons suffering from chronic alcoholism, drug abuse or addiction is performed, as a rule, based on voluntary principles, in outpatient or stationary conditions, in curative-prophylactic institutions, and if requested anonymously. **(Article 43)**

- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** stipulates that among the general principles of the medical profession is the respect for the primacy of life and the inherent right to life of each human being. The doctor shall observe the rights and interests of the patient, as well as the rights and interests of the patients' relatives. **(Article 3, (c), (d))**

The doctor shall provide healthcare services in case of illness or injury of the patient, regardless of the sex, age, national and racial affiliation, social and material status, political and religion views, language, opinion. **(Article 5, paragraph 2 (a))**

Any medical act shall be performed exclusively in the interest of preserving, recovering and strengthening the health of an individual and in the interest of the society. In this regard, physicians are required to manifest availability, devotion and respect towards the human being in any conditions of exercising the profession. **(Article 6)**

The physician shall, by making use of all his/her professional skills and knowledge, contribute to the protection of population health, combat all forms of cruelty and humiliation of human dignity, maintaining respect towards the human being. **(Article 7)**

- ▶ **Law on the Patient's Rights and Responsibilities no. 263 of 27.10.2005** stipulates a series of requirements to ensure the respect of patient's dignity and personality by healthcare workers. Thus, the patient shall be treated with respect and a humane approach by the healthcare provider, regardless of the patient's age, sex, ethnic affiliation, socio-economic status, or political and religious beliefs. The provision of healthcare services shall ensure security of life and physical, psychical and moral integrity of the patients. Healthcare workers shall act to reduce suffering and alleviate pain caused by illness and/or medical intervention, by using all legal and available methods and means, determined by the existent level of medical science and the real possibilities of the healthcare provider. The patient is entitled to terminal care worthy of a human being. **(Article 5, letter (b), (c), (d), (p))**

- ▶ **Law on Children's Rights no. 338 of 15.12.1994, Article 4**, stipulates that no child can be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

The State shall protect the inviolability of the child's personality, protecting him from any form of exploitation, discrimination, physical and psychical violence by not admitting cruel, rude and contemptuous behaviour, insults and maltreatment, involvement in criminal actions, alcohol consumption, illicit use of narcotic drugs and psychotropic substances, the practice of gambling, begging, inducement or coercion to practice any illegal sexual activity, exploitation with the purpose of prostitution or other illegal sexual activity, in pornography and pornographic materials, including on behalf of the parents or guardians, relatives. **(Article 6)**

Every child is entitled to protection of dignity and honour. The offence on the honour and dignity of the child shall be punished according to legal provisions. **(Article 7)**

- ▶ **Law on Mental Health no. 1402 of 16.12.1997** stipulates that when providing psychiatric assistance, the person suffering from psychological disorders shall be treated with a human and reverent attitude,

which would exclude the humiliation of the human dignity and discrimination by sex criterion. The psychiatric care shall be provided in conditions which meet the hygienic and sanitary standards, by ensuring adequate privacy within the institutions of mental health, including rest facilities, so that women can sleep separate from men. **(Article 5, paragraph 2)**

For the admission of minors to mental health hospitals, habitual spaces shall be provided, separated from adults' spaces and an environment adapted to the age of minors and their developmental needs. **(Article 5¹)**

The diagnosis of psychological disorders is established according to the national and international standards, universally recognized, and shall not be based only on the fact that a person rejects the moral, cultural, political and religious values accepted by the society or on other facts which do not directly address his/her psychological health. **(Article 10)**

- ▶ **Law on Reproductive Health no. 138 of 15.06.2012** stipulates that by ensuring the enjoyment of the rights to reproduction by every person, the State guarantees the observance of human and citizen rights. **(Article 4)**
- ▶ **Law on Prevention and Control of Tuberculosis no. 153 of 04.07.2008** stipulates that anti-tuberculosis medical care is guaranteed by the State and is based on the principles of respect for human dignity, confidentiality, gratuitousness and accessibility. **(Article 12, paragraph 1)**
- ▶ While receiving anti-tuberculosis medical care, the persons registered in connection with tuberculosis and the persons suffering from tuberculosis have the right to a human and respectable attitude by the healthcare personnel and other persons participating in the process of provision of the anti-tuberculosis medical care. **(Article 17, (a))**
- ▶ **Law on the Transplantation of Human Organs, Tissues and Cells no. 42 of 06.03.2008** stipulates that physicians having performed the sampling of organs, tissues and cells from a deceased person shall ensure the restoration of the body and of its physiognomy by applying specific means, including surgical if necessary, for the deceased to have a dignified appearance. **(Article 14)**

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no specific provisions for this chapter.

D) PROVISIONS OF THE CODE OF ETHICS

The responsibility of a medical and pharmaceutical worker is to protect the physical and mental health of the individual, to promote a healthy lifestyle, to prevent illnesses and to alleviate sufferings, by observing the right of the human being to life and dignity, without any discrimination as to age, sex, race, ethnicity, religion, nationality, social condition, ideology, politics or for any other reasons, during periods of both peace and war. **(Paragraph 7)**

While exercising the profession, the medical and pharmaceutical worker shall give priority to the patient's interests, which take precedence over any other interests. The respect towards the human being is maintained even after the death of the person. **(Paragraphs 9, 10)**

The healthcare worker, who was asked or obliged to provide medical care to a prisoner, shall not cause, directly or indirectly, or favour the affection of physical or psychological integrity of any detainee, including his/her dignity. Should the medical or pharmaceutical worker notice that the detainee is in a vulnerable situation, one of the moral and medical professional obligations is to support and protect the detainee. The medical and pharmaceutical worker shall not be involved in the performance of acts which are degrading to the human being. **(Paragraph 19, 20)**

The medical and pharmaceutical worker involved in biomedical research (study) shall promote and protect the life, health, privacy and dignity of human subjects who take part in the research. **(Paragraph 76)**

Every healthcare worker shall do his/her best to alleviate the suffering of a terminally ill person by respecting his/her dignity. **(Paragraph 86)**

Healthcare workers shall manifest an equitable attitude without restrictions for couples who requested artificial/in vitro fertilization, and the child born as a result of this procedure shall benefit from all rights that a child naturally conceived enjoys. **(Paragraph 94)**

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- Patient S. was diagnosed with pulmonary tuberculosis and requires hospitalization in a specialized medical institution. She was fully informed about her health condition and the danger posed by this infection. When being admitted to the hospital, patient S. was ensured adequate sanitary conditions, a pleasant environment was created for her, and she is treated with respect by the healthcare workers. **(Hypothetical)**
- A prayer room for patients and their relatives is created within a healthcare facility. For patients in severe condition and terminally ill patients, the hospital administration allows the invitation of a priest to the patient bed for certain religious rituals. **(Hypothetical)**

2. Examples of Breach

- In a maternity, women of a certain minority ethnicity are placed in special rooms, separated from women who are part of the majority population of the country. The conditions of these rooms are different, more modest, and the personnel have a discriminatory and cruel behaviour with the parturient women and their new-borns. **(Example selected from the author's practice)**

3. Actual Case

- There are no relevant actual cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

It is worth mentioning that the obligation to treat patients with respect is tangential with the majority of patients' rights. For example, by ignoring the wish of the patient for full confidentiality, a doctor violates his/her dignity.

H) CORRELATION WITH RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See sections on the Right to the Highest Attainable Standard of Health and the Right to Non-Discrimination and Equality, the Right to Privacy and Confidentiality in Chapter 2 on International Framework for Human Rights in Patient Care, and Chapter 3 on Regional Framework for Human Rights in Patient Care.

7.2.8 OBLIGATION TOWARDS ONE'S COLLEAGUES

A) A MEDICAL OR PHARMACEUTICAL WORKER SHALL TREAT COLLEAGUES WITH RESPECT THE SAME WAY S/HE WOULD LIKE TO BE TREATED. THE INTEGRITY OF THE MEDICAL PROFESSION AND THE IMAGE OF HEALTHCARE WORKERS ARE VALUES OF MAJOR IMPORTANCE FOR THE SOCIETY

B) OBLIGATION AS STATED IN THE COUNTRY CONSTITUTION/ LEGISLATION

- ▶ The **Constitution of the Republic of Moldova** does not have any specific provisions with respect to this subject.
- ▶ **Law on Healthcare no. 411-XIII of 28.03.1995** stipulates that the performance of medical-sanitary and pharmaceutical professions is supervised by the Ministry of Health. (**Article 8, paragraph 3**)
- ▶ **Law on the Practice of the Medical Profession no. 264-XVI of 27.10.2005** stipulates that the practice of the medical profession is incompatible with any activity or occupation which diminishes or causes damage to the professional dignity or violates the deontological code. (**Article 8, (b)**)

The doctor shall observe the ethical-professional established norms. (**Article 17, paragraph I**)

Article 19 of the Law states the norms of the doctor-doctor relationship. The relationships between doctors shall be based on correctness, cooperation, mutual respect, brotherhood, solidarity. Only professional actions and deontological behaviour may be subject to criticism. The professional reputation of a doctor is based on the results of his/her activity. The doctor shall show a respectful attitude towards the medical personnel of low and intermediate levels.

The relationship between the doctor and the pharmacist shall develop in a spirit of cooperation, within the limits of established specific competences. Relationships between doctors and pharmacist are not subordination relationships. (**Article 20**)

- ▶ **Law on the Patient's Rights and Responsibilities no. 263-XVI of 27.10.2005** stipulates that the doctor shall ensure, as established by the law, that the patient's request or the request of his/her legal representative (or a close relative) for an alternative medical opinion or for receiving the recommendations of other specialists is satisfied.

C) SUPPORTING REGULATIONS/DECISIONS/ORDERS

There are no specific provisions for this chapter.

D) PROVISIONS OF THE CODE OF ETHICS

Chapter X of the **Framework Code of Ethics (Deontology) of the Medical and Pharmaceutical Worker** describes the situations of incompatibility of the medical profession and the likely conflicts of interest.

The medical and pharmaceutical worker shall not make use of a mandate, administrative position or other circumstance to increase the number of patients. An agreement between two doctors, between a doctor and a pharmacist, or between a doctor and auxiliary staff with a view to obtain medical benefits is not considered ethical.

Every medical or pharmaceutical worker is morally obliged to report or to declare voluntarily his/her own mistakes (errors) to a specialist in the same field or the mistakes (errors) detected during the activity of their colleagues, since the values of life, health and patient's interest may be affected. Detecting an error, whether by omission or perpetration, remains a crucial criterion necessary to identify the level of responsibility of the medical worker (the ratio of necessity and professional freedom). A competent, honest and dedicated attitude on behalf of colleagues serves as moral rehabilitation for the medical or pharmaceutical worker having committed the detected error.

Chapter XI of this Code describes the deontological norms of peer and collective relationships of medical and pharmaceutical workers. Blaming and defamation of colleagues in the presence of patients, sanitary personnel, etc., as well as any expression or act that can compromise the trust in the attending doctor and his/her authority constitute violation of ethical rules.

The medical or pharmaceutical worker shall request the opinion of his/her colleague or shall recommend to the patient to consult other doctors (colleagues) if s/he considers that his/her own skills and knowledge are insufficient.

In the case when a patient consults a team of specialists, they shall afterwards withdraw to discuss the case. After the specialists come to a consensus, the attending doctor shall communicate to the patient the result of the consultation.

Within a joint medical examination there shall be maintained an atmosphere of mutual respect, and any manifestation of superiority towards the attending doctor shall be excluded. The medical case and critical remarks shall not be discussed in the presence of the patient or other strangers, even if the discussion is about subordinate medical and pharmaceutical workers.

The doctor who has been invited for consultation will not subsequently examine the patient on his/her own initiative or without the permission of the attending doctor, except in emergency cases. If the medical opinion of a group of specialists differs from that of the attending doctor, the patient shall be informed about this. The attending doctor is free to withdraw if the opinion of the doctors participating at the examination prevails in the opinion of the patient and his/her relatives.

Should the proposal for a medical consultation come from the part of the patient or his/her relatives, the attending doctor shall organize the consultation.

E) OTHER RELEVANT SOURCES

There are no other relevant sources to be included.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- While examining a patient, doctor D. detected a mistake in the diagnosis due to misinterpretation of laboratory data by the specialist who had previously examined the patient. Doctor D. explained to the patient that he needed to discuss with the doctor who had examined him, to clarify some data about the diagnosis. The patient gave the contact details of the other doctor. Doctor D. contacted his colleague and, together, they discussed the laboratory results and the final diagnosis. Subsequently, the patient was informed about the decision to which the doctors came regarding the diagnosis.
(Hypothetical example)

2. Examples of Breach

- Patient L. is in the hospital in serious condition. The patient's relatives have doubts about the therapeutic conduct set by the attending doctor. The relatives invite a well-known specialist in the respective field to examine the patient. On the arrival of the specialist, the attending doctor from that section manifested his rebellion and expressed angrily to the patient's family that, once the consultation of another doctor was requested, he refused to treat this patient and would discharge him from the hospital. **(Case selected from authors' practice)**
- Spouses A. addressed to the district hospital with their 5 years old child who had a fracture of the femur. The surgeon on duty performed the intervention, the set of splints. However, after the intervention the child had severe pain. The parents asked for advice to another surgeon from that section, being perplexed by the cause of this severe pain. The doctor said that "probably the intervention was not performed correctly"; but he had to go home and did not get involved in this case because this was not his patient. Being alarmed by such an answer, the parents forcibly discharged the child and took him themselves to the hospital in the capital, where the child needed a repeated emergency intervention in order to correct the mistake made at the first intervention. **(Case selected from authors' practice)**
- In order to attract more patients, doctor L. spreads gossip and lies about the incompetence of his colleagues. **(Hypothetical case)**

3. Actual Case

- There are no relevant actual cases to be included.

G) PRACTICAL NOTES FOR LAWYERS

Due to insufficient experience in this area, practical advices for lawyers cannot be given for this chapter.

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- 8.1 MECHANISMS TO PROTECT/ENFORCE RIGHTS AND RESPONSIBILITIES IN COURT**
 - 8.2 CONTENTIOUS-ADMINISTRATIVE PROCEEDINGS**
 - 8.3 CIVIL PROCEEDINGS**
 - 8.4 CRIMINAL PROCEEDINGS**
 - 8.5 ALTERNATIVE MECHANISMS TO PROTECT/ENFORCE RIGHTS AND RESPONSIBILITIES**

8

NATIONAL PROCEDURES

8.1 MECHANISMS TO PROTECT/ENFORCE RIGHTS AND RESPONSIBILITIES IN COURT

WHAT ARE THE NATIONAL MECHANISMS FOR THE PROTECTION OF THE PATIENT'S RIGHTS AND FOR THE REMEDY OF THE VIOLATIONS?

There are two ways of legal protection of a patient's rights at the national level: extra-judicial (or administrative) protection and judicial protection.

Extrajudicial protection

According to **Article 52 of the Constitution** of the Republic of Moldova, any citizen has the right to submit a complaint or a petition to the public authority, in person or through a representative, to claim a violation of his/her rights.

Article 16 of the Law on Patient's Rights and Obligations no. 263-XV of 27.10.2005 (hereby referred to as the Law no. 263-XV) indicates the following institutions to which a person may lodge a complaint or a petition regarding the protection of his/her rights as a patient:

- | | |
|--|---|
| a) Ministry of Health; | d) Health insurance organisations; |
| b) Regional Health Directorates; | e) Professional organisations of doctors, patients' associations, or public associations for health services consumers. |
| c) Medical-sanitary and pharmaceutical institutions; | |

Judicial Protection

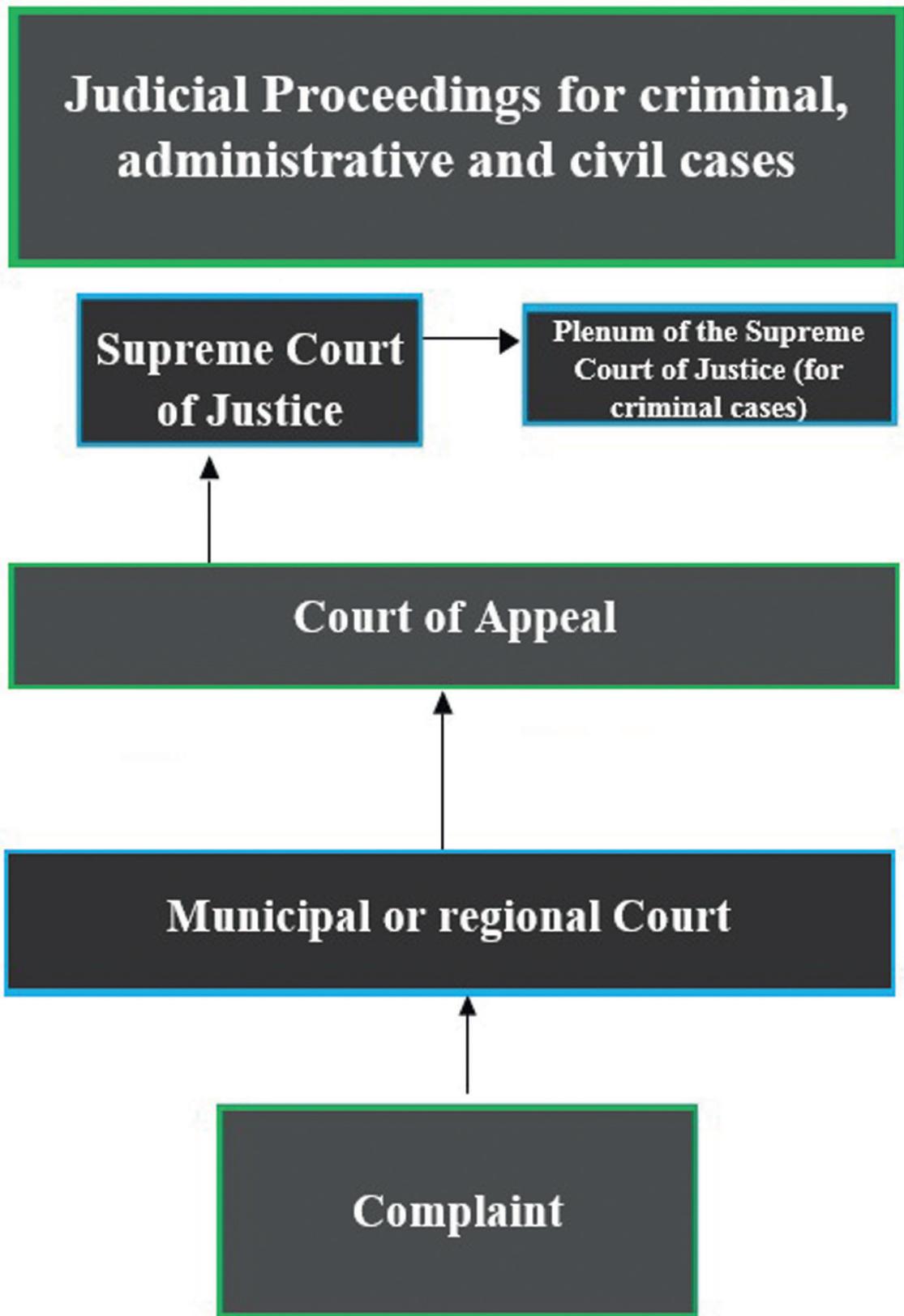
The judicial protection of the patient's rights, according to **Article 17 of the Law no. 263-XV**, allows for the submission of a statement of claim by an individual or his/her lawyers **with the competent court** with the aim to protect his/her rights and seek the remedy for the violation suffered. A statement of claim may be submitted through both civil proceedings and contentious-administrative proceedings.

National judicial system of the Republic of Moldova

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graph TD; A["National judicial system of the Republic of Moldova"] --> B["Mechanisms to Protect Enforce of the Rights in Judicial Proceedings for criminal, administrative and civil cases"]; A --> C["Alternative Mechanisms to Protect Enforce of the Rights and Responsibilities"];
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**Mechanisms to
Protect Enforce of the
Rights in Judicial
Proceedings for
criminal,
administrative and
civil cases**

**Alternative
Mechanisms to
Protect Enforce of the
Rights and
Responsibilities**



Extra Judicial Proceedings

**Office of the
Ombudsman**

**The Council on the
Prevention and
Elimination of
Discrimination and
Ensuring Equality**

**Complaints
Regarding a Human Rights
Violation**

**Complaints
Regarding a
Discrimination Case**



Extrajudicial Proceedings

From the Law on Patient's Rights and Obligations

Chapter 4

PROTECTION OF PATIENT'S RIGHTS

▶ Article 15. Protection of patient's right to challenge the actions of the health service providers

- (1) *The patient or his/her representative may challenge the actions of the health service providers which led to the violation of the patient's individual rights, as well as the actions and decisions of the public authorities and individuals in official positions, which led to the violation of his/her social rights provided by the legislation.*
- (2) *The patient has the right to a review and solution of his/her requests (complaints) in a prompt, equitable and efficient manner.*
- (3) *The protection of the patient's rights is ensured through extrajudicial and judicial proceedings, according to law.*

▶ Article 16. The extrajudicial protection of patient's rights

- (1) *The extra-judicial protection of the patient's rights is carried out, where appropriate, by:*
 - a) *The Ministry of Health;*
 - b) *Regional Health Directorates;*
 - c) *Medical-Sanitary and Pharmaceutical Institutions;*
 - d) *Health Insurance Organisations;*
 - e) *Professional organisations of doctors, patients' associations, or public associations for health services consumers;*
 - f) *Other organisations created and accredited according to law.*
- (2) *Each medical-sanitary institution is obliged to display, in a place accessible to the public, the information on the patients' rights, the modality and terms for the submission of petitions and suggestions.*
- (3) *The patients' requests or complaints addressed to the bodies mentioned in para. (1) are reviewed on the basis of the Law no.190-XIII of July 19th, 1994 regarding petitions and other legal documents. The patients or their legal representative (or close relative) and the health service provider against whom a complaint was submitted are informed of the results of the review and the adopted decision.*
- (4) *In case of disagreement by the patient or his/her legal representative (or close relative) with the results of the review and the decision taken, the patient or legal representative can appeal to the independent committee of professional medical expertise, which is created and acts according to the regulations approved by the Ministry of Health.*

▶ Article 17. The judicial protection of the patient's rights

- (1) *Any individual considering that his/her rights and legitimate interests have been violated is entitled to, in order to protect them, appeal to the competent court.*
- (2) *The proceedings in court is in compliance with the provisions of the law.*

▶ Article 18. Liability for the violation of the patient's rights

- (1) *The liability for the violation of the social rights of the patient to medical care lies with the central and local public administration authorities of the health system at all levels, while for the violation of the individual rights, stipulated by the present law – to the health service providers.*
- (2) *Individuals responsible for the violation of the patient's rights, stipulated by the present law, are liable in accordance with the legislation.*

LEGAL PROVISIONS THAT REGULATE THE EXTRAJUDICIAL PROTECTION MECHANISMS FOR THE PATIENTS' RIGHTS

The extrajudicial mechanisms for the patients' rights protection are regulated first by the **Law no. 263-XV** regarding the rights and obligations of the patients, this being the *lex specialis*⁷²⁸ for the area of public health. Also the **Law no. 190-XIII** of July 19th, 1994 regarding petitions (hereinafter referred to as the Law no. 190-XIII) and the **Law on the Contentious-administrative no. 793-XIV** of February 10th, 2000 (hereinafter referred to as the Law no.793-XIV) are both applicable.

Attention!!!

Extrajudicial mechanisms could solve unjustified and abusive limitation of patients' rights, but cannot ensure the reinstatement of rights and the compensation for the material and moral damages to the patient. Therefore, consider using these extrajudicial proceedings to gather evidence and estimate the position of the medical institution involved. For simpler issues, like access for the client to his/her own medical and diagnosis file, you may address the head of the medical institution with an official letter and talk to the doctor who refuses the access to information. Reference to a possible lawsuit, usually has a "wake-up call" effect on the medical personnel and with less stress the client may receive the necessary information.

THE COMPLAINT PROCEDURE

Individuals considering that their rights have been violated by the health service providers may submit a written complaint in person, or through a lawyer, to the supervisory body or to the law enforcement authority, depending on the gravity of the violation that has occurred.

!!! IMPORTANT

According to the Law on the Bar no. 1260 and Article 80, 81 of the Civil Procedure Code, the person may be represented in courts of law only by licenced lawyers.

It is important to also note that the complaint should be addressed to the head of the institution or even the Ministry of Health in order to involve in the resolution of the case an official with a higher rank than that of the person acting illegally.

The individual/patient may complain about the violation of his/her individual rights as well as to challenge the actions and/or decisions of the medical public authorities and of the individuals acting in official positions, who led to the violation of his/her rights.

(Authors' note: "Public authorities" here and in the law means only those who are responsible for health-care - those who hold management positions, such as the head of the health institution, head of the health service in the mayoralty, or local councils. These types of complaints do not cover confidentiality of personal data, but rather cover situations such as a claim for access to a medicine that a hospital states that it does not have.)

As explained in **Article 15 of the Law no. 263-XV**, the individual/patient has the right to have his/her complaint examined and solved in a timely manner, efficiently and lawfully. This means that public authorities are obliged to reply to the individual's complaint in the time limits given by the current legislation, while the reply must be a result of a multilateral (considering all aspects) and objective review of the complaint.

⁷²⁸Lex specialis – law with specific provisions in the field

Article 16 Para. (3) of the **Law no. 263-XV** specifies that *the patients' requests or complaints addressed to the bodies mentioned in para. (1) are reviewed on the basis of the Law no.190-XIII of July 19th, 1994 regarding petitions*. Thus, when the claim/complaint is submitted and reviewed, the provisions of the Law no. 263-XV on the patient's rights and responsibilities must be taken into consideration, as well as those of Law no. 190-XIII of July 19th, 1994 regarding the petition procedure. By complaint, within the meaning of Article 4 of the Law no. 190-XIII, is meant any request, reclamation, proposal, or intimation addressed to the competent bodies, including the preliminary request contesting an administrative act (usually a decision of a medical staff or board) or the non-solving of a request in due term, as set by the law.

The submission of a complaint to the public authorities mentioned in Article 16 para. (1) of the Law no. 263-XV is important as an extrajudicial procedure aiming to solve the matter, which does not involve high costs or require much time. It is also important if the individual intends to lodge, at a later stage, a claim before the court using the law on the contentious-administrative, which requests an exhaustion of the preliminary extrajudicial procedure before going to the court.

The complaint is submitted to the issuing body whose decision or action is contested. In the case where the issuing body has a supervisory body, the complaint shall be addressed to it. The individual who is not satisfied by the reply received after having his/her complained examined, or who did not receive a reply in the terms set by the law (usually 30 days), has the right to start a lawsuit against the issuing body in the competent contentious-administrative court (see *Section 2 below*).

The complaint shall be submitted in writing, through the post office, or electronically when possible, according to Article 5 of the Law no. 190-XIII, in the State official language or in the Russian language in compliance with the Law regarding the Functioning of the Languages Spoken on the Territory of the Republic of Moldova. The complaint lodged electronically should correspond to the requirements governing an electronic document, including the application of the digital signature, according to the legislation in force.

The complaint must contain:

- a) Petitioner's identification data, such as: name, surname, home address and/or mailing address, and contact data for his/her representative/solicitor, if applicable
- b) Identification data of the health services provider whose actions or decision are complained against in the claim/complaint
- c) Name of the public authority to which the claim/complaint is addressed
- d) Description of the facts on which the complaint is based
- e) Attachments with copies of the relevant documents to support the claim/complaint
- f) Submission date and signature of the author
- g) Statement of claim

If the claim/complaint is submitted by the representative/lawyer of the individual, then the power of attorney should be attached as well.

!!! IMPORTANT

Attach to the complaint only copies of the documents needed to be sent, never the originals, because there are chances that the patient/petitioner will not get them back. The original documents may be shown upon request but always should be kept in the possession of the petitioner. The lawyers have the right to certify copies of documents as being in conformity with the originals.

WHAT HAPPENS IF THE INDIVIDUAL MADE MISTAKES OR INACCURACIES IN THE TEXT OF THE COMPLAINT?

The minor errors or inaccuracies made by the petitioner due to his/her lack of knowledge about some facts or legal provisions that do not essentially influence the substance of the complaint to be examined have no major importance for the public authority examining the complaint and sending a reply. But, if the complaint contains inaccuracies or errors essential for the prompt, equitable and efficient examination of the complaint, as required by the provisions of Article 15 of the Law no. 263-XV, then there is a risk that the individual will not receive the expected reply, while the review of the claim will lack efficiency. In the latter case, a new complaint shall be submitted, because without a clear reply to the submitted complaint, an efficient solution of the problem cannot be expected. Also, the individual can submit an additional request to fill or complete the initial petition.

TO WHICH AUTHORITY OF THOSE LISTED IN ARTICLE 16 PARAGRAPH (1) OF THE LAW NO. 263-XV MUST THE COMPLAINT BE SUBMITTED?

The complaints are submitted to the official bodies or individuals, in whose competency is their solution. The complaints, in which a document, a decision, an action or inaction of an administrative body or official individual is challenged, which affected the rights and legal interests of the petitioners, are submitted to the superior body.

The local and public authorities are listed in Article 16 para. (1) of the Law no.263-XV, according to the hierarchic level, where the Ministry of Health is the hierarchically supervisory body to the other institutions, while the health insurance organisations are the lowest. Professional organisations of doctors, patients' associations, or public associations for health services consumers are not part of the institutional system, being independent; that is why a complaint to those associations may contain only the request for assistance to solve the matter, but not solving it. Thus, if the complaint refers to the violation of rights or contests a decision taken by, for example, a medical-sanitary or pharmaceutical institution, then the request will be submitted to the hierarchically- superior body which is the regional health directorate.

The complaints that challenge the decisions of the organisations which do not have supervisory bodies, as well as the decisions of the district executive bodies and mayors' offices of the cities of republican subordination, are submitted to the administrative courts.

WHAT HAPPENS IF THE COMPLAINT IS NOT SUBMITTED TO THE COMPETENT BODY?

If the complaint is submitted to a public authority that is not competent to provide an opinion on it, the individual will be informed where to apply or the public authority will re-direct it, according to Article 9 para. (1) of the Law no. 190-XIII, to the competent body in a 3-working-day period from the date of registration of the complaint. The author of the complaint will be informed about this. The law prohibits sending petitions/complaints to bodies or individuals in official positions whose actions or decisions are challenged by the same complaint that has been submitted by the individual.

ORAL OR WRITTEN COMPLAINT?

Each of the public authorities competent to review the complaint/claim mentioned in Article 16 para. (1) of the Law no. 263-XV is obliged to make public its reception hours and the procedure for the individuals to submit complaints/claims about their rights being limited or violated. The individual is free to decide, depending on the specific situation and the complexity of the facts, if he/she will submit an oral complaint during public reception hours or will submit a written complaint/claim. Obviously, in urgent cases, indi-

viduals express orally their disagreements with the actions, decisions or violation of their rights so that the issue can be solved immediately. In cases when the immediate solution is not obvious or the solution is delayed, it is preferable to submit a written complaint in order to receive a written reply which would allow the individual to go eventually to court, if not satisfied with the received reply. It is recommended to submit the written complaint through the post office in order to track the complaint lodged.

THE TIME FRAME REQUIRED FOR THE EXAMINATION OF THE COMPLAINT

According to the provisions of Article 8 of the Law no. 190-XIII, complaints are examined by the applicable competent bodies within 30 days from the date of their registration. Those not needing additional study and examination are to be answered without any delay within 15 days from the date of registration. In special cases, the time frame for the examination may be extended by the manager of the respective body by one (1) month at the most, about which the individual is informed. The preliminary request is reviewed by the issuing body or the superior within 30 days from its registration, the decision being presented to the individual immediately.

WHAT ARE THE OBLIGATIONS OF THE PUBLIC AUTHORITIES AND WHAT IS THE EXAMINATION PROCEDURE?

The public authority or the official to whom the complaints were submitted is obliged:

- a) to review the complaints, including the preliminary ones, in the time frame set by the law;
- b) to ensure the remedy of the violated rights and, in the conditions of the current legislation, the damage caused;
- c) to provide the execution of the decisions adopted following the review of the petitions.

The issuing body (to whom the petition was addressed and who will reply to the petition) has the right to reject the complaint or the preliminary request or to accept it and, if necessary, to cancel or modify the challenged decision (and, as follows, the administrative act). In the case when the violation of the rights claimed by the petitioner is found and, depending on the gravity of the violation, the petitioner will be ensured of observance of his/her rights, the individual responsible for the violation may be disciplinarily sanctioned. The supervisory body has the right to cancel the administrative act, in whole or partially, to oblige the subordinated body to secure the rights of the respective individual or, if necessary, to cancel the issued administrative act.

During the review of the complaint, it is prohibited to disclose personal information related to the private life of the individual or other personal data against his/her will. Also, it is prohibited to make public any personal data of the individual, if it does not relate to the content of the complaint/claim.

Every institution has an official, appointed to organise the work with complaints/charges, as well as to keep their registry, to archive them. For the violation of the examination and storage procedure of petitions/complaints, these officials - specially trained and hired for this job, may be subject to disciplinarily sanctions. In those institutions where such officials are absent, the responsibility for the accuracy of the storage and examination of the complaints lies with the manager. For this reason, it is advisable for an individual to register a written complaint with the public authority that he/she wants to examine her/his issue. The registration of the complaint guarantees at least the receipt of an official reply containing the position of the institution in the given matter.

The public official, within the authority responsible for the examination of the petition, may be subjected to administrative sanctions for unreasoned refusal to examine the petition, for delaying the examination of the petition violating the time limits set out by the law, for issuing unlawful decisions, or for disclosing personal information about the petitioner's private life without his/her consent.

Attention!!!

Article 75 of the Code on Administrative Offences expressly provides for the liability of the medical staff regarding the disclosure of medical data. It is advisable to ask for the preparation of the report about the administrative offence and the application of a sanction if the disclosure is obvious. A potential administrative sanction will facilitate the burden of proof in proceedings concerning the compensation for moral and material damages.

The author of the petition may not be subjected to any forms of persecution for having submitted a petition or for having expressed a critical opinion in it. The public official who persecuted the individual, or unreasonably refused to examine the petition or delayed its examination, or adopted unlawful decisions, or disclosed information about one's (the patient, in this case) private life without his/her consent may be subjected to criminal liability if any of these actions were accompanied by abuse of power or official position or negligence towards his/her job duties which resulted in considerable violation of the petitioner's rights.

Attention!!!

Article 8 (c) of the Law on Freedom of Expression provides for an individual's immunity against defamation for the statement made by the individual in requests, letters or complaints regarding violations of legitimate rights and interests, sent for review to public authorities.

WHAT IS THE FORMAT OF THE REPLY GIVEN AND WHAT ARE THE OPTIONS OF THE INDIVIDUAL WHO IS IN DISAGREEMENT WITH THE REPLY HE/SHE RECEIVED?

It is mandatory that the result of the examination of one's complaint is presented to the petitioner in a written or electronic form, and, with his/her consent, in an oral form. The reply must be based on the materials gathered during the examination and contain references to the legislation, with the explanation of the right to challenge the reply or decision with the superior body or in court.

Once the petitioner's claims are found to be lawful and true, the public authority that examined the complaint is requested to consider taking measures in accordance with the law to compensate for material damages and to identify the individuals and their liability for the patients' rights violations.

Complaints that have similar content, submitted for the second time and which do not contain new arguments or information on the matter already examined, are not reviewed again. The petitioner is informed about this either by a letter via post or e-mail.

HOW CAN THE REPLY TO THE COMPLAINT/CLAIM BE CHALLENGED?

The individual, who considers that his/her rights have been violated and disagrees with the decisions of the body or public official that examined the complaint/claim, has the right to appeal to the court within 30 days from the day he/she received the written reply or should have received it. The court reviews the claim according to the provisions of the Law on the Contentious-administrative no. 793-XIV of February 10th, 2000 (hereinafter referred to as the Law no. 793-XIV).

8.2 CONTENTIOUS-ADMINISTRATIVE PROCEEDINGS

The contentious-administrative provides a special procedure which gives the petitioner the possibility to exercise his/her right set by Article 53 of the Constitution – which is to submit complaints against illegal actions of the public administration bodies, institutions and organisations and other individuals in decision-making positions who restrain or violate the legal rights and interests of the individual.

Since the health service providers are, mostly, State institutions and organisations, the patients who think that their rights guaranteed by the Law no. 263-XV were violated may use the contentious-administrative proceedings to challenge the decision or the alleged illegal actions of the officials from the respective institutions.

The contentious-administrative proceedings is governed by the Law no. 793-XIV on the contentious-administrative, as being *lex specialis*; and according to the provisions of Chapter 24 of the Civil Procedure Code, takes place according to the general rules for the civil procedure following the provisions of the Law no. 793-XIV.

WHAT IS THE SUBJECT MATTER OF THE LAWSUIT IN CONTENTIOUS-ADMINISTRATIVE?

The subject matter of a lawsuit in the contentious-administrative proceedings may be the administrative acts with the normative and individual nature, that violate a patient's right guaranteed by the law (example: hospital regulations on access to personal files), including the right of a third party, issued by the:

- a) public authorities and authorities assimilated to those;
- b) subdivisions of the public authorities;
- c) officials from the structures listed in (a) and (b) above.

The subject matter of the lawsuit in contentious-administrative may also cover the non-examination of the petition within the time limits set out by the law.

Attention!!!

It is important to clarify in the request for contentious-administrative which rights of the client were violated and which decisions or actions served as the basis for such violation, as this is the scope of the contentious-administrative proceedings.

WHAT IS THE TERM LIMIT FOR FILLING THE STATEMENT OF CLAIM FOR THE CONTENTIOUS-ADMINISTRATIVE PROCEEDINGS?

The claim, by which is sought the annulment of an administrative document or the recognition of the alleged violated right, may be submitted within 30 days, as set out below. The 30-day term is a prescription term, which means that the request must be submitted before the expiration of this term; and its omission leaves the individual without the chance to protect his/her rights in this proceedings.

The 30-day term is calculated from:

- a) the date of receipt of the reply to the preliminary request or the date of expiration of the term provided by the law for its solution;
- b) the date of informing about the refusal to solve a complaint/claim by which is requested the recognition of the alleged right, or the date of expiration of the term provided by the law to solve such a complaint/claim;

- c) the date when the petitioner learned about an administrative document, in the case when the law does not provide the preliminary procedure.

!!! IMPORTANT

In the case where the individual who is alleging a violation of his/her rights submitted statement of claim to the court without requesting non-pecuniary damages, the prescription period starts on the date when the respective individual knew or should have known the amount of damage. In the case when the damages were not sought together with the annulment of the administrative document, the request for damages is addressed to the competent common law court, within the general prescription term, provided by the Civil Code.

THE FORM AND THE CONTENT OF THE STATEMENT OF CLAIM IN THE CONTENTIOUS-ADMINISTRATIVE PROCEEDINGS

The statement of claim in the contentious-administrative court is submitted in a written form according to the requirements of the Civil Procedure Code, and must contain:

- a) The name of the court;
- b) The name of the plaintiff, his/her home address;
- c) The name of the respondent, his/her home address or legal address;
- d) The essence of the alleged violation and the claims of the plaintiff;
- e) Factual and legal circumstances on the basis of which the plaintiff is submitting his/her claims;
- f) Evidence confirming the circumstances;
- g) The plaintiff's claims towards the respondent;
- h) Data on following the procedure of seeking a preliminary solution for the litigation by an extrajudicial path;
- i) Documents annexed to the statement of claim.

The statement of claim may contain other data important for the case as well as the plaintiff's requests, according to the civil procedure. The statement of claim is signed by the plaintiff or his/her lawyer.

!!! IMPORTANT

The statement of claim in the contentious-administrative proceedings does not require a stamp duty.

The statement of claim is annexed with:

- a) copies of the statement of claim and of the documents, in a number equal to the number of the respondents;
- b) documents confirming the observance of the procedure for a preliminary solution for the litigation: the copy of the preliminary request with the proof of sending or receipt by the respective body; the challenged administrative document; or, if necessary, the reply of the public authority or the note of refusal of the preliminary request or of the complaint/claim;
- c) Power of attorney, the mandate of the lawyer.

THE PROCEDURE OF THE EXAMINATION OF THE REQUEST IN THE CONTENTIOUS-ADMINISTRATIVE PROCEEDINGS

The judge decides to accept or reject the statement of claim within 3 days from the date of filling of the statement of claim. It is important for this date to be, at the latest, the last day of the 30-day prescription time frame.

Attention!!!

During the contentious-administrative proceedings, while filing a claim, you can ask to suspend the challenged administrative act until resolution of the case on the merits. Thus, if the violation of a client's rights arises from an administrative act or decision, suspension of execution can be a quick and effective solution to stop the violation.

The court can review the case on the merits on the first day, if the parties declare that they are prepared for court hearings. In other cases, the court will appoint the date for the examination of the case on the merits within a reasonable time.

Attention!!!

According to the Law no. 87 on the compensation by the State of the damage caused through violation of the right to trial of a case within a reasonable time or the right to enforcement of a judgment within a reasonable time, which has been in force since July 1st, 2011, to determine the reasonable time, the following should be considered: conduct of the parties and of the court, length of proceedings, complexity of the case, number of parties in the proceedings and importance of the case for the plaintiff.

THE PROCEDURE OF EXAMINING THE STATEMENT OF CLAIM IN THE CONTENTIOUS-ADMINISTRATIVE PROCEEDINGS

The contentious-administrative court examines the statement of claim, with the participation of the plaintiff and the respondent, with the participation of the parties' lawyers if applicable.

Attention!!!

It is very important to correctly identify the medical institution to name as a respondent in the hearings. A well-written and well-founded civil claim is not sufficient. It should be filed against the respondent whose actions led to violation of your client's rights. For example, in her claim, Ms. E. J. specified that the respondents were the public health institution "National Centre of Narcology" and the Ministry of Finance, from which she requested compensation for material and moral damage. While going through all the stages of the civil proceedings, it was only the Supreme Court of Justice that issued a decision on February 23rd, 2011 to find that doctor A.B. was not an employee of the Centre of Narcology and thus the Centre was not responsible for the actions of the doctor.

Avoid filing a claim against several respondents when it is not strictly necessary. First, there is a greater likelihood that a case would be delayed in the absence of any party, as is the difficulty to pin the responsibility on the one directly involved in the violation of your client's rights.

The burden of proof is on the respondent, while in the matter of damages recovery for the illegal action, the burden of proof is on both the plaintiff and the respondent. This means that the respondent (the public health service provider) will have to prove that the plaintiff's claims are ungrounded and that the challenged decision or action was legal at the time it occurred. Both the plaintiff and the respondent must provide evidence proving or denying the amount of moral and material damages, as well as the causal link between the illegal action and the damage.

The administrative court has the right to decide, officially upon its own initiative or upon the parties' request, the legality of the documents or actions which provide the basis of the issue of the challenged administrative document. In the cases when the determination of the legality of these documents or actions is within the competency of the superior contentious-administrative court, the exception of illegality (*change of court's competence*) shall be raised in front of this court according to the present law.

When an action is accepted by the contentious-administrative court, it decides as well, at the plaintiff's request, the issue of the recovery of the material and moral damage caused by the illegal administrative document or by the non-review of the preliminary request within the required time limit.

The amount of the moral damages is established by the contentious-administrative court, disregarding the material damage, depending on the following: nature and gravity of the psychological or physical suffering caused by the actions complained about; the degree of guilt of the respondent; and whether the guilt is a condition for liability. In doing so, the court takes into consideration the circumstances in which the damages were caused as well as the social status of the damaged party.

Attention!!!

Avoid initiating a contentious-administrative litigation when it is only based on the patient's emotions and the patient's distrust of the medical staff. For example, Ms. T.R., a person with 2nd degree disabilities from childhood, who was subjected to multiple surgeries with the Ilizarov's equipment, requested the Ministry of Health to provide her with a referral to a hospital in the city of Kurgan, Russian Federation, to be operated with the same equipment, which was presumed to be better by the patient. The forensic expertise report no. 430 on the patient's health, following surgery, showed that her health deteriorated due to the physiological advancement of the disease and not due to surgeries. The civil action against the administrative act issued by the Ministry of Health which rejected the issuance of a referral lasted from 21/04/2009 to 02/03/2011, while the patient was still there where she started.

Identify correctly the subject of the litigation – the violated right, as well as the right solution for the remedy of such right. Use procedural mechanisms that are relevant to the patient's situation.

THE DECISION OF THE CONTENTIOUS-ADMINISTRATIVE COURT

The contentious-administrative court makes its decision following the provisions of the Civil Procedure Code.

The administrative act, annulled in whole or in part, ceases to have legal effect from the moment when the decision of the administrative court becomes irrevocable.

Taking into account the specific circumstances and the eventuality of negative legal consequences, the contentious-administrative court may find, by its decision, that the norms declared void will not have legal effect from the date the legal document was adopted.

The decision of the contentious-administrative court on the matter tried on the merits may be challenged by appeal, within 15 days from the date the decision was announced or from the date the parties in the case received the reasoning of the decision, in the case when the action is examined in the absence of one of the parties involved in the proceedings.

HOW TO CHALLENGE THE DECISIONS OF THE CONTENTIOUS-ADMINISTRATIVE COURTS?

The decisions of the contentious-administrative court are challenged by appeal. The grounds for the declaration of the appeal are the following:

- a) the circumstances which have an importance for the solution of the matter on the merits were not fully found and elucidated;
- b) the circumstances considered as established by the first instance court were not proved;
- c) the conclusion of the first instance court, presented in the decision, contradict the circumstances of the matter;
- d) material/substantive or procedural law was violated or misapplied.

Any of these grounds indicate a poor quality of the decision that has been pronounced by the court. Respectively, the provisions of the law are considered as having been violated or misapplied in the case when the court did one of the following: did not apply the law proper to this matter or litigation, or did apply a law that should not have been applied to this matter, or misinterpreted the law.

The term for the declaration of the appeal

The appeal must be declared within 20 days from the date the decision was pronounced or from the date when the reasoning for the decision was issued. For the parties to the case, the term for the declaration of the appeal starts on the date they learned about the content and reasoning of the decision. The appeal suspends the enforcement of the decision.

The petitioner may attach new evidence to his/her appeal. The appeal in the contentious-administrative court proceedings does not carry a stamp duty. If the appeal is submitted by a lawyer, then a power of attorney should also be attached.

The chairman of the court, whose decision is challenged by appeal, after receiving the appeal with the annexed documents, registers the appeal the next day after its receipt at the latest.

8.3 CIVIL PROCEEDINGS

WHAT IS THE GROUND FOR THE INITIATION OF THE CIVIL PROCEEDINGS?

Compared to the contentious-administrative proceedings, (see *Section 2*), the civil proceedings cover a wider range of grounds upon which submission of the statement of claim filed against the public health service providers may be based.

The Law no. 263-XV guarantees the right of the individual (patient, in this instance), in person or through his/her lawyer, to challenge the actions of the health service providers which led to the violation of the individual rights of the patient, as well as the actions and decisions of the public authorities and individuals in official positions which led to the violation of his/her social rights set by the law. Thus, any violation or unjustified limitation of the rights guaranteed by the Law no. 263-XV may provide grounds for a civil action, which would not be limited to a specific object as in the contentious-administrative proceedings.

AGAINST WHO IS THE CIVIL ACTION INITIATED?

According to Article 18 of the Law no. 263-XV, the liability for the violation of the social rights of the patient to medical care lies with the local and central public authorities and the health authorities at all levels, while liability for the violation of the individual rights, stipulated by the present law, lies with the health service providers.

Thus, the civil action must show as a respondent the health service provider that has directly committed the violation or limitation of the patient's rights, providing grounds to address the court with the lawsuit.

IS THE SUBMISSION OF THE COMPLAINT MANDATORY PRIOR TO THE FILLING OF THE STATEMENT OF CLAIM FOR THE CIVIL PROCEEDINGS?

Although Article 16 of the Law no. 263-XV describes the procedure for the submission of the complaint (*also described above, see Section 1*), this is not a mandatory stage for the common law civil liability proceedings. Every individual is free to decide, depending on the circumstances of the matter, the most

efficient way to solve the issue. If the fastest solution can be obtained by addressing a complaint, then this is preferred to the lengthy judicial proceedings which are also much more expensive.

Also, it is important to differentiate between 1) the complaint submitted with the aim to exhaust the preventive solution procedure of the matter, followed by the request submitted to the contentious-administrative court and 2) the complaint submitted in attempt to solve the matter by avoiding the high costs of a civil lawsuit. In the first case, the individual understands from the very beginning that the violation or limitation of his/her rights comes from an administrative document or illegal action of a public authority; and, in order to cancel it in a contentious-administrative proceedings, it is necessary to submit a preliminary claim/complaint. Also, the possibilities during the contentious-administrative proceedings are very limited. The court may just cancel the administrative document as being issued against the law, with the violation of the procedure or competency, ordering payment of moral and material damages. In the second situation, when the violation or limitation of the rights of the individual does not result from an administrative document, the submission of the complaint is not mandatory. This procedure may be used only to find out the position and the reaction of the respondent to the issue in order to decide upon the position that shall be taken by the patient in the civil lawsuit. The civil court, following the review of the matter, may find a violation of the patient's rights and the liability of the respondent (health service provider); and it may prohibit certain actions or behaviour and order a remedy for the situation and the payment of moral and material damages.

THE FORM AND THE CONTENT OF THE STATEMENT OF CLAIM

Article 17 of the Law no. 263-XV recognises the right of any individual (patient, for example) who considers his/her legitimate interests and rights provided by the present law as being violated to appeal to the competent court in order to protect them.

Articles 166 and 167 of the Civil Procedure Code stipulate the requirements of the statement of claim for the civil matter.

THE COURT COMPETENT TO EXAMINE THE CIVIL LAWSUIT

According to Article 30 of the Civil Procedure Code, the lawsuit is initiated in the home court or the nearest court to the address of the respondent. If the action is submitted against a legal entity, such as the health service providers, Health Insurance Organisations, Medical-Sanitary and Pharmaceutical Institutions, or against local and central public authorities, such as the Regional Health Directorates and the Ministry of Health and Social Protection, the lawsuit shall be initiated in the court nearest the legal entity's place of business.

Article 39 of the Civil Procedure Code provides the plaintiff with the option to address the civil lawsuit to the competent court. Thus, the action based upon the activity of a branch or representative office of a legal entity or another organisation may be initiated in the court from the place where the branch or representative office is located.

!!! IMPORTANT

Thus, although the district hospital reports to the Ministry of Health, the civil action against the hospital should be filed to the district court where the hospital is located and not to the court where the Ministry of Health is based. Claims for compensation for damage caused by injury of the bodily integrity or other harm to the health or by death may be lodged to the court from the plaintiff's place of residence or the court from the place of damage.

!!! IMPORTANT

Thus, although the district hospital is subordinated to the Ministry of Health, the civil lawsuit against the hospital will be initiated in the district court where the hospital is located and not where the Ministry of Health is located. The actions for the payment of damages caused by the injury to the bodily integrity, or by any other harm to the health, or by death, may be initiated in the court from the place of residence of the plaintiff or the court from the location of the damage.

THE TERM FOR THE EXAMINATION OF THE CIVIL LAWSUIT

The Civil Procedure Code does not have a fixed term for the examination of the civil lawsuits, but obliges the courts to issue a decision in a reasonable time. The criteria for the determination of the reasonable time are: the complexity of the matter, the behaviour of the parties during the trial, the behaviour of the court, the duration of the procedures, and the importance of the matter for the plaintiff. The same criteria are found in the Law no. 87 regarding the payment by the State of the damages caused by the violation of the right to a trial in a reasonable time or the right to enforce court decisions in a reasonable time, in force since July 1st, 2011.

!!! IMPORTANT

The following matters are examined in an emergency and priority manner: the protection of the rights and interests of minors; the payment of damages caused by the injury to the bodily integrity or by another harm to the health or by death; the challenge of the decisions, actions or inactions of the public authorities, other bodies and organisations, and the individuals in official positions and public servants.

The particularities of the proceedings in civil lawsuits resulting from the violation of the patient's rights in a special procedure:

According to Articles 279 and 280 of Title C of the Special Procedure of the Civil Procedure Code, the court reviews, in a special procedure, several principles, among which, relevant to the public health area, are those regarding a) the approval of a forced hospitalisation and forced treatment and b) the approval of the psychiatric examination or hospitalisation in the psychiatric institution.

In the special procedure, the court reviews the cases with the participation of the patient, other interested individuals, and the representatives of the medical-sanitary institutions.

!!! IMPORTANT

In the case of David v. Moldova, application no. 41578/05, judgment of 27/11/2007, the European Court recalled that a person cannot be considered "mentally unsound" under Article 5 § 1 of the Convention, and deprived of his/her liberty, unless at least the following three conditions are met: there should be credible evidence that the person is mentally unsound; the mental disorder should be of such a nature or degree as to justify compulsory confinement; and the validity of continued detention depends on the persistence of such disorder. The circumstances of this case prove that none of the above conditions were met. The court decision of March 14th, 2004, based on which the applicant was admitted to a psychiatric hospital, was only intended to determine the applicant's ability to lodge the claim which was filed against the State, and not to protect himself or others. Therefore, his forced detention from the time when he expressed his will to leave the hospital was contrary to the essence of the exception provided for in the sub-paragraph (e) of the Article 5 § 1 of the Convention. See also the case Shtukaturiv v. Russia, application no. 44009/05, Judgment of 27/03/2008 where the Court reiterated that when deciding forced hospitalization of an individual in a psychiatric hospital, that individual is entitled to appear before the court and to have the opportunity to address questions to the court, otherwise, the individual's right to a fair trial under the Article 6 § 1 of the Convention is violated.

Approval of the forced hospitalisation and treatment

THE LEGAL PROVISIONS GOVERNING THE FORCED HOSPITALISATION AND TREATMENT

Chapter 29 of Title C of the Special Procedure of the Civil Procedure Code governs the particularities of the procedure for the approval of the forced hospitalisation and treatment for an individual in a medical-sanitary institution.

First of all, it should be taken into consideration that the forced hospitalisation and treatment of an individual may be determined only by the court and carried out only on the basis of a court decision. That is why the law obliges the medical-sanitary institution from the place of residence of the individual to file a statement of claim with the court of the place of domicile of the individual or of his/her commonly-known place of stay.

Law no. 713 of 06.12.2001 regarding the control and prevention of the abusive consumption of alcohol, the illegal consumption of drugs and other psychotropic substances (*hereinafter referred to as the Law no. 713*) stipulates the procedure to order an individual to a forced treatment in a hospital, stationary or outpatient.

WHO MAY BE SUBJECT TO FORCED HOSPITALISATION OR TREATMENT?

Thus, Article 11 of the Law No. 713 stipulates that **individuals abusively consuming** alcoholic drinks or illegally consuming drugs and other psychotropic substances, also individuals suffering from chronic alcoholism, drug-addiction and toxic addiction, **may benefit, at their choice, from treatment in outpatient narcological institutions or hospitals or in special private clinics**, as well as from short-term treatment in territorial curative-preventive institutions. **The narcological treatment is voluntary, at-will, and anonymous**, except in cases provided by the Law no. 713.

The exception is stipulated in Article 13 of the Law no. 713, which sets certain conditions that a person cumulatively must meet prior to the submission of the requests to the court for a forced hospitalisation on behalf of the medical-sanitary institution. Thus, the individual must:

- abusively consume alcohol or illegally consume drugs or other psychotropic substances,
- cause, by the abusive or illegal consumption, material difficulties to the family or by provoking, in a drunken state or without discernment, conflict situations in the family or in public places,
- have been warned or sanctioned repeatedly by the legal bodies (police, court), and
- have avoided voluntarily requesting the consulting or treatment assistance from regional medical institutions.

HOW IS THE LAWSUIT INITIATED?

The civil action is initiated at the request of the committee for social problems or at the request of the public prosecutor addressed to the court. The forced hospitalisation and treatment request submitted by the medical-sanitary institution shall argue the legitimacy of such measures. The request, which is mandatory, shall have annexed the note of the medical committee of the medical-sanitary institution on the need of forced hospitalisation or treatment, including the note of the narcological committee, in the case when an examination was carried out.

!!! IMPORTANT

Although the law refers to "the commission for social matters", the latter is not defined by other legal acts and is generally presumed to be the territorial social assistance body.

THE MODALITY OF REFERRAL OF AN INDIVIDUAL TO A FORCED TREATMENT AND ITS ENFORCEMENT

In 3 days from the submission, the court reviews the request for a forced hospitalisation and forced treatment. The participation in the court hearing of the individual whose hospitalisation is sought and the representative of the medical-sanitary institution which initiated the case is mandatory. In the case where the health of the individual does not allow him/her to appear in court, the hearing of the matter of the forced treatment or hospitalisation of the person is carried out in his/her absence but he/she will be represented by a lawyer appointed by the State.

The request for mandatory narcological treatment must be reviewed by the court within a month from the date the request was submitted. After the review of the claim on the merits, the court issues a reasoned decision by which it admits or rejects the forced hospitalisation or treatment request. The decision by which the request was admitted (fully accepted by the court) represents the ground for the forced hospitalisation and treatment of the individual for the duration provided by the law.

The court, after issuing a decision on the mandatory narcological treatment, may appoint a curator from the patient's close relatives. Thus, the forced hospitalisation request will be reviewed together with the procedure of limitation of the mental exercise capacity of the individual in conformity with the Civil Code.

CEASE AND EXTENSION OF THE FORCED TREATMENT OR HOSPITALISATION

The mandatory narcological treatment stops:

- a) at the expiration of the term of forced treatment or hospitalization set by the court;
- b) based on a court decision for its reduction; or
- c) in a situation that makes the continuation of the mandatory treatment impossible, as a fact determined by the narcological committee and presented to the court.

The court may issue a decision on the repeated administration of the mandatory narcological treatment only after at least 3 months from the expiration of the last mandatory treatment. In the case when the loss of the individual's mental exercise capacity and his/her social links is found, the court issues a decision on the placement of the individual in one of the placement institutions of the Ministry of Labour, Social Protection and Family.

The approval of the psychiatric examination or hospitalisation in a psychiatric hospital

Chapter 30, of Title C, Special Procedure of the Civil Procedure Code, regulates the particularities of the procedure for the approval of the psychiatric examination and hospitalisation in a psychiatric hospital without the free consent of the individual, which is applied through the provisions of Law no. 1402 of 16.12.1997 regarding mental health (*hereinafter referred to as the Law no. 1402*).

WHEN IS THE PSYCHIATRIC EXAMINATION OF AN INDIVIDUAL NEEDED?

Article 22 para. (1) and para. (4) and (4¹) of the Law no. 1402 explains that the psychiatric examination is needed to determine the existence of mental disorders, the need to provide psychiatric care and its type. The psychiatric examination can be carried out without the consent of the individual or his/her legal representative in the case when he/she commits actions which serve as grounds to acknowledge severe mental disorders which might cause:

- a) a direct danger to himself/herself and people around; or
- b) severe damage to his/her own health if no psychiatric care is provided.

In the second case, the psychiatrist, based only on the court decision, carries out the psychiatric exam without the consent of the individual or his/her legal representative.

PROCEDURE FOR THE INITIATION OF THE APPROVAL OF THE PSYCHIATRIC EXAMINATION

The request for the psychiatric examination may be submitted by any of the relatives of the individual, or by any doctor or decision-maker (the relevant body of the local public administration, police, or fire-fighters service) who has knowledge of the patient and his/her behaviour.

The request must be motivated (argued). In the case of non-existence of a direct threat to himself/herself or the people around, the written request for the psychiatric examination of the individual must contain detailed data showing the need for such an examination, as well as a proof that the individual or his/her legal representative refuses the care of the psychiatrist. Finding that the request for the psychological examination without the free consent of the individual or his/her legal representative is grounded, the psychiatrist submits information to the court with jurisdiction over the place of location of the medical hospital: a written note motivating/arguing the need for such an examination, the request to carry out a psychiatric examination and other materials. Within 3 days after the receipt of the corresponding request, the court decides whether to order the psychiatric examination.

FILLING THE REQUEST WITH THE COURT

The request for the psychiatric examination without the free consent of the individual or his/her legal representative is submitted to the court from his/her place of residence. The request for hospitalization in the psychiatric hospital without the free consent of the individual is submitted to the court with jurisdiction over the location of the psychiatric hospital where the individual is hospitalised.

The court starts the proceedings for the approval of the psychiatric examination without the free consent of the individual at the request of the psychiatrist. The request for hospitalization in the psychiatric hospital without the free consent is submitted to court by the psychiatric institution where the individual is hospitalised.

DURATION OF COURT PROCEEDINGS

The **request for the psychiatric examination without the free consent of the individual** or his/her legal representative shall contain the circumstances that indicate the need to carry out the psychiatric examination. The request addressed to the court mandatorily must include, as an annex, the written note of the psychiatrist and, if necessary, other materials, including the motion, addressed to the psychiatrist by the relatives of the individual, or by any doctor or the decision-makers or other individuals who have knowledge of the individual and his/her behaviour, which confirm the need for such an examination.

The **request for the hospitalisation into a psychiatric hospital without the free consent of the individual** or his/her legal representative must contain the justification for the legitimacy of the hospitalisation and the circumstances proving his/her inadequate behaviour. Attached to the request is the reasoned note of the psychiatrist commission, concluded in accordance with the internal procedure, on the need of the individual to continue the stay in the psychiatric hospital.

THE REVIEW OF THE REQUEST BY THE COURT

The request for the hospitalisation in a psychiatric hospital without the free consent of the individual is reviewed by the judge within 5 days from the day the request was registered with the court. The court reviews the request with the participation of the psychiatrist who submitted the request, the legal representative of the individual and other stakeholders. The individual whose psychological health has to be assessed has the right to take part in the review of the matter if the psychiatrist considers that the individual's health allows him/her to do that. The court shall receive a reasoned note about the patient's health condition that prevents him/her from being present at the court trial.

THE MANDATORY PARTICIPATION OF A LAWYER

If the individual whose hospitalisation into a psychiatric hospital is requested from the court is not represented in court by a lawyer, the judge requests the co-ordinator of the regional office of the National Council for the State Guaranteed Legal Aid to appoint a defender to represent his/her interests. According to the legislation on the state-guaranteed legal aid, the legal assistance in this case is provided for free.

!!! IMPORTANT

Article 7 of the Law no. 1402 stipulates that the protection of rights and legitimate interests of the individual to whom psychiatric care is provided can be ensured by the lawyer, while the administration of the institution providing psychiatric care ensures the possibility to invite a lawyer. Because the Law grants the right to legal aid as optional and does not oblige the psychiatrists to inform the National Council for State Guaranteed Legal Aid when there is a request for a defender, the real situation increases the patient's vulnerability.

COURT DECISION

The court decision allowing an individual's psychiatric examination or hospitalisation in a psychiatric hospital constitutes the ground for the psychiatric examination without the consent of the individual or his/her legal representative. The court decision may be challenged in accordance with the civil law.

!!! IMPORTANT

Patients admitted to the psychiatric hospital are under the supervision of this institution which is responsible for the patients' well-being and actions. Thus, if a patient is suffering from worsening health or dies, either due to medical personnel's actions or those of other patients, the criminal and delictual liability is held by the psychiatric hospital. According to Article 1408, paragraph (1) of the Civil Code, the guardian or the institution in charge of supervising a person without legal capacity is liable for the damage caused by that person. This conclusion was also reached by the Supreme Court of Justice, when it issued the judgment of May 19th, 2010 and fully upheld the civil action filed by Ms. S.L. and ordered the public healthcare facility "Psychiatric Hospital" to pay the material damage in the amount of MDL 54,039.60 and moral damages in the amount of MDL 100,000 for not having prevented the patient's death as a result of blows inflicted by another patient.

THE MODALITY TO CHALLENGE THE CIVIL COURT DECISIONS

The decisions issued by the first instance courts may be challenged by appeal, before they become final. The Court of Appeal, based on the evidence from the file and those presented supplementary, verifies the accuracy of the findings on the factual circumstances of the case, the application and applicability of the material law norms, and the procedure followed in the case during the trial by the first instance court.

The appeal may be declared within 20 days from the date of the issue of the reasoned decision and it suspends the enforcement of the decision pronounced by the court of first instance. If the individual withdraws the appeal based on a certain ground, he/she loses his/her right to lodge the appeal again.

The appeal request is filed in a written form with the court whose decision is challenged, with a proof of the stamp duty paid in the case if applicable. The appeal request and the new evidence not presented to the court of first instance are submitted in the same number of copies as that of the participants to the trial, plus a copy for the Court of Appeal. The copies of the evidence should be notarised according to the law.

The term and the procedure for the examination of the appeal

The Court of Appeal, within 30 days from the date it received the case file with the appeal, prepares the case for the examination: sends summons to the participants, along with copies of all the documents submitted to the court, and invites the parties to submit written briefs in reply to the appeal at the latest 3 days before the trial. References and briefs are submitted in the same number of copies as that of the participants to the trial, plus a copy for the Court of Appeal.

The burden of proof during the appeal

The parties and the other participants, if applicable (translator, witnesses), in the trial are entitled to express their positions regarding the evidence presented to the court of first instance and may submit new evidence of their own. The Court of Appeal is obliged to accept and examine the new evidence and new circumstances, if applicable, to give a just and lawful decision in the case. Witnesses that have been heard in the first instance court may be summoned to come before the Court of Appeal if their testimonies are challenged. During the examination of the appeal, the procedural status of the parties cannot be changed; neither can a new ground nor new object of the action be raised.

The Court of Appeal verifies, within the limits of the appeal, the submitted briefs and objections, the lawfulness of the challenged decision as regards the factual circumstances, and the law applied in the case by the court of first instance. Within the limits of the appeal, the Court of Appeal verifies the legal relationship as established to have taken place in the case as well as those which were not found to have occurred or to be directly linked to the case, but which may be important to render a fair solution. The Court of Appeal evaluates the evidence submitted before the first instance court and before itself by the participants to the trial. In the case where the appeal is not argued or the arguments do not cover new evidence and facts, the court decides on the merits based on the arguments invoked in the first instance.

THE CHALLENGE OF THE CIVIL COURT'S DECISIONS

Decisions pronounced by the courts of appeals as the appeal court may be challenged by recourse. The interim orders issued by the appeal instance may be challenged by recourse only at the same time with the decision, except those that, according to the law, may be challenged by recourse separately and when the interim orders make the continuation of the trial impossible. The recourse against the decision is considered being declared against the interim orders, even if those were issued after the pronouncement of the decision challenged by recourse.

The review of the recourse against the decisions of the courts of appeals is in the competence of the Supreme Court of Justice. The admissibility of the recourse is first decided by a panel of three judges appointed by the chairman of the respective Division of the Supreme Court of Justice. Then the review of the admissibility of the recourse is carried out by an extended division of the Supreme Court of Justice, formed by 5 judges, which is constituted by the Chairman or, if necessary, by the Deputy-Chairman, of the Supreme Court of Justice, usually from the judges of the respective college. The Chairman of the Supreme Court of Justice, the Chairman and the Deputy-Chairman of the respective college are by law Chairmen of the extended division.

The ground for the declaration of the recourse

Any party in a case may declare recourse when an essential violation or the misapplication of the material law norms or procedural law norms are invoked, according to the provisions of the Civil Procedure Code.

!!! IMPORTANT

An eloquent example of this is the case of I.B. v. the Government's Administration, from which he requested compensation for moral and material damages for a poor-quality surgical operation, which put his life in danger. Although the first instance court and the court of appeal dismissed his claim as groundless, the Supreme Court of Justice, based on the evidence collected by I.B., ordered the retrial of the case. The Supreme Court of Justice noted that the lower courts did not appreciate the evidence, did not take into account the forensic assessments, which establish a causal relationship, and applied erroneously the rules of substantive law. It is regrettable that the courts' errors in the case of I.B. led to unjustified delays in the civil trial which started on August 3rd, 2004 and is still unfinished.

The term for the declaration of the recourse

The recourse must be declared within 2 months from the date the decision was pronounced. The 2-months term is a decay term and cannot be restored (recourse will be forever barred if not filed within the 2-month period).

The submission of the recourse

The recourse is submitted by a party in the case to the Supreme Court of Justice, accompanied by as many copies as there are participants to the trial, paying the stamp duty if applicable. If the recourse is declared by a party's lawyer, the power of attorney shall be attached to it.

The recourse is registered with the court clerk service of the Supreme Court of Justice.

If the recourse does not correspond to the provisions of Article 437 CPC, the court, by an interim order signed by the Chairman or the Deputy-Chairman of the respective division, returns it within 5 days. The interim order cannot be challenged. The return of the recourse does not prevent the party from lodging it repeatedly after the shortcomings indicated in the interim order have been solved. If the recourse corresponds to the provisions of Article 437 CPC, the court clerk service of the Supreme Court of Justice submits the recourse to the orderly room of the respective division, which will register the initiation of the recourse.

The procedure for the review of the admissibility of the recourse

The panel of 3 judges decides, by an irrevocable, motivated/reasoned decision, the admissibility or inadmissibility of the recourse. The admissibility of the request is decided without a hearing and in the absence of all parties in the case.

During the examination of the recourse, the court verifies, based on the file documents, within the limits of the recourse, the lawfulness of the challenged decision, without accepting new evidence. The recourse court is obliged to make a statement on all the grounds invoked in the recourse. In trying the reply, when it is found that the solution of the matter may lead to a contradiction with a previous decision of the Supreme Court of Justice, or an important legal issue is raised, or when the solution of the matter represents a high interest for the case law or for the evaluation of the legislation, the extended college of the Supreme Court of Justice will examine the recourse.

Once a decision is quashed, it has no legal power. Insurance orders and the enforcement documents prepared on the basis of a decision that has been quashed lose their legal power if the recourse court does not decide otherwise. Following the examination of the recourse, the court of recourse issues both decisions and interim orders, except the Plenary of the Supreme Court of Justice, which issues only decisions. The interim orders of the recourse instance become irrevocable on the moment of pronouncement. Following the trial of the recourse, the court has the right to pronounce only the solution for the case which will later be argued in the decision in one month term.

8.4 CRIMINAL PROCEEDINGS

The disciplinary procedures initiated against medical personnel, due to the negative consequences that might follow (license withdrawal, negligence statement, or guilt), fall under Article 6 of the European Convention as "civil litigation" with procedural guarantees provided by paragraphs 2 and 3 of the same article (Albert and Le Compte v. Belgium, pl. 7299/75, 7496/76, decision of February 10th, 1983). As a consequence, the guarantees provided to a suspect during a criminal matter are applicable to the disciplinary procedures when their object is tightly-linked with the right to practice medicine. The impartiality and the objectivity of the Medical Council follow the same conditions imposed on a set of judges in a trial (Gubler v. France, pl. 69742/01, decision of July 27th, 2006), or the challenge of the decision of the Medical Council through judicial proceedings should be available (Defalque v. Belgium, pl. 37330/02 decision of April 20th, 2006).

!!! IMPORTANT

The application of a disciplinary sanction to medical staff enables the patient to claim compensation for moral and material damages from the medical institution that allowed the breach of the clinical guidelines for applying the medical treatment. For example, Ms. N.O. received MDL 6,000 from the district public healthcare facility Ceadr-Lunga District Hospital for incorrect curettage that led to endometritis, as a result of disciplinary sanctions imposed to the gynaecologist Lidia Gagauz and the midwife Antonina Manastîrî.

THE BODIES EMPOWERED TO START THE CRIMINAL INVESTIGATION

Depending on the nature and the gravity of the deed that serves as the object of the criminal complaint, the individual may submit a complaint to the public prosecutor or the police. Article 262 of the Criminal Procedure Code provides that in the cases stipulated in the law, when the opening of the criminal investigation is initiated only after a preliminary complaint or with the agreement of the public authority where applicable, the criminal investigation cannot start without them. In the case where the criminal investigation body directly identifies a criminal offence, it prepares a report with the description of the circumstances and orders the registration of the offence with the law enforcement. In a case of death of an individual in the State custody related to the criminal investigation or the enforcement of the punishment, the prosecutor refers the initiation of the criminal investigation by itself.

THE CONTENT OF THE COMPLAINT TO THE CRIMINAL INVESTIGATION BODY

The criminal investigation body or, if necessary, the prosecutor, may be notified about a crime by a complaint or denunciation. **The complaint** is the notice made by an individual or legal entity to whom/to which damage was caused through a criminal offence. **The denunciation** is the notice made by an individual or legal entity about a criminal offence that has occurred.

The complaint or, if applicable, the denunciation must contain:

- name, surname, capacity and domicile of the petitioner,
- description of the fact which forms the object of the complaint or denunciation,
- indication of the offender, if known, and
- means of evidence.

Anonymous complaints and denunciations cannot serve as grounds for the initiation of the criminal investigation, but the criminal investigation body may initiate by itself the criminal investigation.

THE PROCEDURE AND TERM FOR THE REVIEW

Article 274 of the Criminal Procedure Code stipulates that the notified criminal investigation body orders the initiation of the criminal investigation in the case when the content of the notification document or the fact-finding documents results in a reasonable suspicion that an offence was committed and there are no circumstances that would exclude the criminal investigation. The investigation body must inform the individual who submitted the notification.

The order to initiate the criminal investigation is subject to confirmation by the public prosecutor who manages the criminal investigation activity and sets the investigation period. If the content of the notification document results in one of the cases that prevent the initiation of the criminal investigation, such as non-existence of an offence, then the deed does not represent an offence (see Article 275 of the Criminal Procedure Code). In this situation, the criminal investigation body submits to the prosecutor a decision with the proposal not to start a criminal investigation.

When the prosecutor refuses to initiate the criminal investigation, he/she confirms this fact by a motivated decision and informs the individual who submitted the notification.

HOW CAN THE DECISION NOT TO INITIATE THE CRIMINAL INVESTIGATION BE CHALLENGED?

The decision to refuse to initiate a criminal investigation may be challenged by a complaint, first to the hierarchic prosecutor, according to Article 299¹ of the Criminal Procedure Code, who has the obligation to review it and to reply within 72 hours. Then, if the individual disagrees with the solution given by the hierarchic prosecutor, he/she may challenge the decision with the investigative judge, in accordance with Article 313 of the Criminal Procedure Code.

!!! IMPORTANT

To have your complaint reviewed as soon as possible against the motion not to commence criminal prosecution, we suggest to submit your complaint to the judge as soon as the 72 hours have passed since the notification of the hierarchic prosecutor.

Article 313 of the Criminal Procedure Code governs the procedure of submission and review of complaints against illegal actions and documents of the criminal investigation body (prosecutor, police) which

contain the complaint against the decision to refuse the initiation of the criminal investigation, but also other actions which affect the constitutional rights and freedoms of the individual. The complaint may be submitted within 10 days to the investigative judge of the place of location of the body which committed the violation, and shall be reviewed by the investigative judge within 10 days.

The ruling given by the investigative judge may not be appealed.

WHAT STATUS MAY THE PATIENT HAVE IN A CRIMINAL CASE AND HOW DOES HE/SHE OBTAIN IT?

The Criminal Procedure Code distinguishes the victim and the injured party, providing a different range of procedural rights and obligations.

Victim

A victim is considered to be any individual to whom moral, physical or material damages were caused by an offence. The victim has the right for his/her claim to be registered immediately with the police following legal procedures, to have it solved by the criminal investigation body, and to be informed about the solution. The rights and the obligations of the victim are provided by Article 58 of the Criminal Procedure Code.

The victim is always warned in writing by the criminal investigation body about the criminal liability for defamatory accusations, but this should not take the form of a threat or intimidation of the victim in order to make him/her withdraw the complaint or the denunciation. The victim benefits of his/her rights and his/her obligations in person or, if the law allows, through representatives. If the victim is a minor or a legally irresponsible individual (a person who was declared legally irresponsible by the court, due to his/her mental health status), his/her rights are exercised by his/her legal representative according to the Criminal Procedure Code.

Injured party

An injured party is considered to be the individual to whom moral, physical or material damage was caused as a result of an offence, recognised in this capacity with his/her own consent. The minor to whom damage was caused through an offence will be considered an injured party without his/her own consent. Thus, the first differentiation between a victim and an injured party status is the agreement of the victim to be recognised as an injured party in the criminal proceedings. The recognition of the individual as an injured party is realised through an order of the criminal investigation body. Article 61 of the Criminal Procedure Code allows the criminal investigation body to cease the participation of the individual/victim as an injured party in a criminal procedure, by a motivated order, in the case where, after the recognition of the individual as an injured party, circumstances were found proving the lack of damage caused to him/her. Article 60 of the Criminal Procedure Code provides the rights and obligations of the injured party.

The injured party, as well as the victim, may exercise his/her own rights by himself/herself or through representatives, lawyers. In the case when the injured party is a minor or an irresponsible individual, his/her rights are exercised by his/her legal representatives according to the provisions of the Criminal Procedure Code.

INSTITUTION OF THE REPRESENTATION AND SUCCESSION IN A CRIMINAL PROCEEDINGS

Individuals declared as legally irresponsible, as well as minors, exercise their rights through their legal representatives. According to Article 75 of the Criminal Procedure Code, those who are incapable in the criminal procedure matter are considered to be:

- 1) individuals recognised in this capacity according to the civil or criminal procedure;
- 2) the injured party or the civil party who has not reached the age of 14.

The criminal investigation body or, if appropriate, the court, by a motivated decision, shall admit as legal representatives one of the parents, adoptive parents, tutors or curators. It is not allowed in a criminal matter for an individual charged with causing, by offence, any moral, physical or material damage to the civil party to be a legal representative of the victim, injured party, or civil party. The capacity of legal representative ceases with the reaching of the majority age by the injured party, civil party, suspect, charged, or culprit and the acquisition of his/her/their full legal capacity.

The successor of the injured party or civil party

In a criminal matter, the successor of the injured party or civil party is recognised to be one of the close relatives who manifested the will to exercise the rights and obligations of the deceased injured party or who, following the offence, lost the capacity to express consciously his/her own will. A successor of the injured party or civil party cannot be a close relative who caused material, physical or moral damage to the injured party.

The recognition of a close relative as successor of the injured party or civil party is decided by the prosecutor leading the criminal investigation or by the court, with the condition that the close relative requests this capacity. In the case when more close relatives request this capacity, the decision to choose the successor is made by the prosecutor or the court. If, at the moment of the respective request, the prosecutor lacks sufficient grounds to recognise the individual as the successor of the injured party or civil party, the decision is taken immediately after establishing these grounds.

The successor of the injured party or civil party taking part in the criminal proceedings instead of the injured party or civil party is summoned and heard as a witness.

THE CIVIL ACTION IN A CRIMINAL PROCEEDINGS

Besides the status of injured party, the individual may be recognised also as a civil party. Article 61 of the Criminal Procedure Code defines the civil party as an individual believed to have suffered material or moral damages caused by the criminal offence and who filed a statement of claim with the criminal investigation body or the court for payment of these damages by the suspect who bears patrimonial liability for his/her criminal deeds. The civil action is examined by the court in the criminal proceedings along with the criminal charge if the amount of damages is incontestable by the evidence gathered by the investigation. Article 62 of the Criminal Procedure Code lists a range of rights and obligations for the civil party that refers to the filling and review of the civil action during criminal proceedings.

The civil action may be initiated at any moment from the initiation of the criminal proceedings to the end of the court investigation, on behalf of the individual by his/her representatives, lawyer or successor. The civil action in criminal proceedings is solved in accordance with the provisions of Chapter 1 of Title VII of the Criminal Procedure Code and the norms of the civil procedure if they do not contravene the criminal law principles.

!!! IMPORTANT

If the civil action was rejected within the criminal proceedings, the plaintiff does not have the right to initiate the same action separately within the civil proceedings.

The examination of the civil action during criminal proceedings, regardless of the value of the civil action, is carried out by the court in whose competence resides the criminal matter. Along with the conviction, the court resolves also the civil action by admitting it fully or partially or by rejecting it. If the solution of the civil action cannot be reached due to lack of important evidence, the court may grant in principle the

civil claims of the injured party to the suspect and leave it to be examined in separate civil proceedings after providing the solution in the criminal case.

!!! IMPORTANT

If the court leaves the civil action without solution in criminal proceedings, in the case of adoption of a judgment on termination of investigation for the expiry of the limitation period or acquittal due to the lack of crime components, this does not prevent the person who initiated the civil action to file it in civil proceedings. For example, in the case of B.G. and B.R. v. Ștefan Vodă District Hospital, the intervener Bujujan Andrei was released from criminal liability under the Article 213 letter a) of the Criminal Code for the expiry of the limitation period, the Court of Appeal on January 24th, 2008 compelled the hospital to pay moral damages in the amount of MDL 10,000, to provide the lady with medicines until 2020, and to repay the court charges in the amount of MDL 1,237.21. This decision was upheld by the Supreme Court of Justice under the Article 1418 of the Civil Code.

WHO HAS THE RIGHT TO APPEAL THE JUDGEMENT?

An appeal against a judgement may be initiated by:

- The prosecutor and the convicted person, on the criminal part and on the civil part;
- The injured party on the civil part;
- The civil party and the civilly-liable party, only on the civil part of the sentence;
- Any individual whose legitimate interests were prejudiced by an action or document of the court.

The appeal may be declared on behalf of the above-mentioned individuals by the solicitor or their legal representative.

THE CONTENT OF THE APPEAL AND THE FILLING TERM

The term for filling an appeal is 15 days from the delivery of the criminal judgment in whole or from the date the copy of the reasoned criminal judgment was handed out to the parties. An appeal declared after the expiration of the term provided by the law is considered to be on time if the Court of Appeal finds that the delay was caused by justified circumstances, and the appeal was filed no later than 15 days from the beginning of the enforcement of the sentence/judgement or the payment of damages. Until deciding on re-instating the term, the Court of Appeal may suspend the enforcement of the decision of the first instance court.

The appeal is filed with the court whose decision is challenged, in as many copies as the number of participants in the case. The arrested individual may submit the request for the appeal to the administration of the place of detention, without annexing copies. After the expiration of the term set for the declaration of the appeal, the court which pronounced the sentence sends, within 5 days after the expiration, the criminal file together with the appeal and its copies to the court of appeal which will inform the parties that the appeal has been filed.

THE TERM AND PROCEDURE FOR THE REVIEW

Within 10 days from the date he/she was assigned the appeal, the chairman of the panel of judges to whom the case was assigned sets the hearing date for the appeal, and if necessary, sets the term for the preliminary hearing. The summons of the examination of the appeal is served to the parties along with the copies of the appeal.

The failure of the summoned parties to appear in the Court of Appeal does not prevent the examination of the matter. If necessary, the Court of Appeal may declare mandatory the presence of the parties and may undertake measures to ensure their presence. At the hearing, the participation of the prosecutor, as well as the defender, if it is in the interest of justice, is mandatory. The appeal may be examined in the absence of the lawyer if this does not violate the accused person's right to defence.

The Court of Appeal, by examining the case, verifies the lawfulness of the challenged criminal conviction judgment based on the evidence reviewed in the court of first instance, documents and testimonies in the file and any new evidence presented to the Court of Appeal.

The Court of Appeal may give a new appreciation to the evidence in the file and accept, at the request of the parties, any new evidence which it considers necessary and relevant to the case. The Court of Appeal is obliged to pronounce itself on all the grounds raised in the appeal. If a party in the case invokes violation of the reasonable time for the examination of the criminal charge by the first instance court, the Court of Appeal is bound by the law to make a statement on this allegation as well.

THE DECISION ISSUED BY THE COURT OF APPEAL

The criminal conviction judgment may be quashed only with regard to certain facts or individuals involved in the case or only as regards the criminal charge or civil claims, if this does not prevent the just settlement of the case. The decision of the Court of Appeal is enforceable from the moment it is pronounced.

The Court of Appeal is entitled, where applicable, to decide upon the re-examination of the case by the first instance court, or application of preventive measures, or to order additional payment of damages and the court's expenses as well as other matters directly linked to the essence of the case and the appeals that were lodged.

8.5 ALTERNATIVE MECHANISMS TO PROTECT/ENFORCE RIGHTS AND RESPONSIBILITIES

8.5.1 Office of the Ombudsperson

WHO MAY NOTIFY THE OMBUDSPERSON?

The citizens of the Republic of Moldova, foreign citizens and individuals with no citizenship, who live permanently or temporarily on the territory of the Republic of Moldova, and whose rights and freedoms have been violated may notify the ombudspersons with a petition which will be reviewed based on the Law no. 1349 of October 17th, 1997 regarding ombudspersons.

The ombudsperson for the protection of children's rights reviews petitions regarding the protection of a child's rights and, within his/her competences, may act by his/her own initiative.

The requests are submitted to the ombudsperson in writing in the State language or another language, according to the Law on the Functioning of the Spoken Languages in the Republic of Moldova, and are exempted of stamp duty.

The ombudspersons also review requests remitted by the Members of the Parliament, in the case where the subject of the intimation is in their competencies.

The request addressed to the ombudsperson must be submitted before the expiration of one year from the date of the alleged violation of the constitutional rights and freedoms of the petitioner or from the day when the petitioner found out about the alleged violation. It must be signed by the petitioner, including

his/her name, surname (surname and father's name), and domicile address. In case some of these data are missing, the request is considered anonymous and is not reviewed.

THE PETITION REVIEW PROCEDURE

After the receipt of the request, the ombudsperson has the right:

- to accept the request for review;
- to reject the request, explaining to the petitioner the procedure s/he is entitled to use in order to protect his/her rights and freedoms; or
- to remit the request to the competent bodies for review in conformity with the Law on petitioning.

Within 10 days after receipt of the request, the ombudsperson notifies the petitioner about the acceptance of his/her request for review, its remittal to the competent bodies or its rejection, explaining the grounds for rejection.

WHAT IS THE RESULT OF THE PETITION REVIEW BY THE OMBUDSPERSON?

The refusal to accept the request for examination cannot be challenged. The repeated notification is accepted for review only in the case of new circumstances.

In the case where there are truthful data on the massive or severe violation of the constitutional rights and freedoms of the citizens, in cases of special social importance, or in the case where it is necessary to protect the interests of some individuals who cannot use on their own the procedure provided by the law, the ombudsperson is entitled to act by his/her own initiative, taking, within the limits of his/her competencies, the corresponding measures.

The ombudsperson is entitled to initiate by his/her own initiative a matter related to the discovered facts of violation of the human rights and freedoms.

After receiving the request for review, the ombudsperson is entitled to request the involvement of the relevant bodies and individuals in decision-making positions in the organisation to verify the circumstances described in the request.

THE COMPETENCIES OF THE OMBUDSPERSON IN THE SETTLEMENT OF PETITIONS ON THE PATIENT'S RIGHTS

The Law no. 1349 provides four commissions of ombudspersons, equal in rights, out of which only one is specialised. The specialisation relates to children's rights protection. The law does not have an express provision on the settlement of the petitions regarding patients' rights. In its turn, the Law no. 263 regarding the patient's rights and obligations does not make reference to the ombudspersons.

For this reason, any petition which refers to the violation or limitation of a patient's rights shall be reviewed according to the same procedures as for other petitions.



ANNEXES



Appendices to Documents & Forms

INFORMATION INQUIRY FORM

To: Mr. /Ms., Head of the _____
(Name of the institution you are addressing)

Address: city of Chişinău, street _____
(Address of the institution you are addressing)

From: Mr. /Ms. _____
(Your name or the name of your representative)

Address: city of Chişinău, street _____
(Your address or the address of your representative)

Information Inquiry

In accordance with the Law No. 982/2000 "on access to information" of the Republic of Moldova, while accessing health services provided by your institution, I suffered damages due to the violation of my right to health guaranteed by the Article 36 of the Constitution of the Republic of Moldova, and the Article 5 and 8 of the Law no. 263/2005 "on the patient's rights and responsibilities" of the Republic of Moldova.

As a consequence, for further settlement of the case I need specific information regarding to services I was provided. According to article 11 of the Law no. 263/2005 "on the patient's rights and responsibilities", the medical institution is obliged to provide any requested information regarding health services provided and other relevant data.

In accordance with Articles 6-8, 10, 11, 12 the Law no. 982/2000 "on access to information" and Articles 5, 8, 11 of the Law no. 263/2005 "on the patient's rights and responsibilities":

I CLAIM

1. to have this inquiry accepted for examination.
2. to be provided with materials pertaining to internal inquiries conducted regarding my person, Ms./Mr.
3. to be provided with the copy of the following documents:
 - a) [Example] Copy from the register of patients
 - b) [Example] Copy of the consultation sheet

Date:

Signature:

CIVIL CASE COMPLAINT FORM

Defendant: Ministry of _____
(Name of the institution you are suing)

Address: city of Chişinău, street _____
(Address of the institution you are suing)

Postal index: _____

Plaintiff: Mr. /Ms. _____
(Your name or the name of your representative)

Address: city of Chişinău, street _____
(Your address or the address of your representative)

Postal index: _____

Alternative address: _____

Telephone number: _____

E-mail: _____

COMPLAINT

Facts of the complaint: [Example]

In the period of January 15th to 21st, 2015 I was hospitalized in Chişinău Municipal Hospital no. 21 for lung treatment. I was examined by the doctor, Ms. E.V., who diagnosed me with pneumonia and prescribed a 7 days stationary treatment in Chişinău Municipal Hospital no. 21.

I received daily medicines, pills, injections and perfusions. Despite of the treatment administered, I was feeling worse with every day. I was describing my pains and worries daily to the nurse and the doctor, Ms. E.V. Every time she was reassuring me by saying that that was a normal situation in this kind of treatments.

On January 21st, 2015 I was discharged from Chişinău Municipal Hospital no. 21 with huge pain in my lungs. I was feeling exhausted and couldn't normally breathe. Ms. E.V. assured me that in a few days I would feel better and the pains will disappear.

The next day, on January 22th, 2015 I was taken by paramedics with the ambulance to the Republican Institute for Pulmonology. I was diagnosed with severe Asthma. After medical investigations, the doctors from Republican Institute for Pulmonology concluded that because of a wrong diagnosis and treatment my lungs were significantly harmed. I had to be administered a new treatment which lasted from January 22th, 2015 to February 21st, 2015 and couldn't be covered by medical insurance.

As a consequence of a wrong diagnosis and treatment, my health was significantly damaged and I had to spend MDL 55,000 for the additional treatment.

Legal framework: [Example]

I suffered damages due to the violation of my right to health assured by Article 36 of the Constitution of the Republic of Moldova which stipulates that that the right to healthcare is guaranteed.

Due to the failure of Chişinău Municipal Hospital no. 21 to provide a correct diagnosis and treatment, my rights to adequate medical care provided by Article 5 and 8 of the Law

no. 263/2005 "on the patient's rights and responsibilities" of the Republic of Moldova was violated.

As a consequence, I suffered physical and psychological damages that mainly referred to huge lung pains, shortness of breath, suffocation, disappointment by the healthcare system and depression.

The right to moral damages is regulated by the Articles 1422 – 1423 of the Civil Code of the Republic of Moldova.

In accordance with Articles 6 – 8 of the Law no. 263/2005 "on the patient's rights and responsibilities", the Articles 5, 6, 166, 167 of the Civil Procedure Code, Articles 1422, 1423 of the Civil Code, Article 36 of the Constitution

I CLAIM

1. to have this complaint for review accepted.
2. to acknowledge that there was a violation of the right to healthcare.
3. to acknowledge that the respondent is to pay the plaintiff the amount of MDL 55,000 as moral damages:
4. to acknowledge that the respondent is to pay the plaintiff the amount of MDL 100,000 as moral damages.

Appendices:

- a) *[Example] Copy of the plaintiff's identity card*
- b) *[Example] Copy of the examination form issued by Chişinău Municipal Hospital no. 21*
- c) *[Example] Copy of the examination form issued by the Republican Institute for Pulmonology*

Date:

Signature:

Note: The complaint shall contain, in accordance with Article 166 of the Civil Procedure Code of the Republic of Moldova, the following information:

1. Petitioner's identification data, such as: name, surname, domicile address and/or mailing address, telephone number, e-mail and contact data of his/her representative/lawyer, if applicable
2. Identification data of the health services provider whose actions or decisions are challenged in the claim/complaint, such as: name of the institution, office address and/or mailing address, telephone number, e-mail (if available)
3. Name of the public authority to which the claim/complaint is addressed and office address and/or mailing address, telephone number, e-mail (if available) of the authority
4. Violated right/s and the description of the facts on which the complaint is based
5. Description of the evidences on which the complaint is based
6. Statement of claim
7. Attachments with copies of the relevant documents to support the claim/complaint
9. The submission date and signature of the author

Human Rights in Patient Care: A Practitioner Guide

is a practical, how-to manual for lawyers taking human rights cases in health care settings. Each volume in the series contains information on rights and responsibilities of both patients and providers, as well as procedures for ensuring that these rights are protected and enforced at the international, European, and national levels.

This is the first compilation of diverse constitutional provisions, statues, and regulations organized by right and responsibility, paired with practical examples of compliance, violation, and enforcement. The guide explores litigation and alternate forums for resolving claims, such as ombudspersons and ethics review committees. The *Practitioner Guide* is a useful reference for lawyers and other professionals working in a region where the legal landscape is often in flux. The full series is available for multiple countries at www.health-rights.org.



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