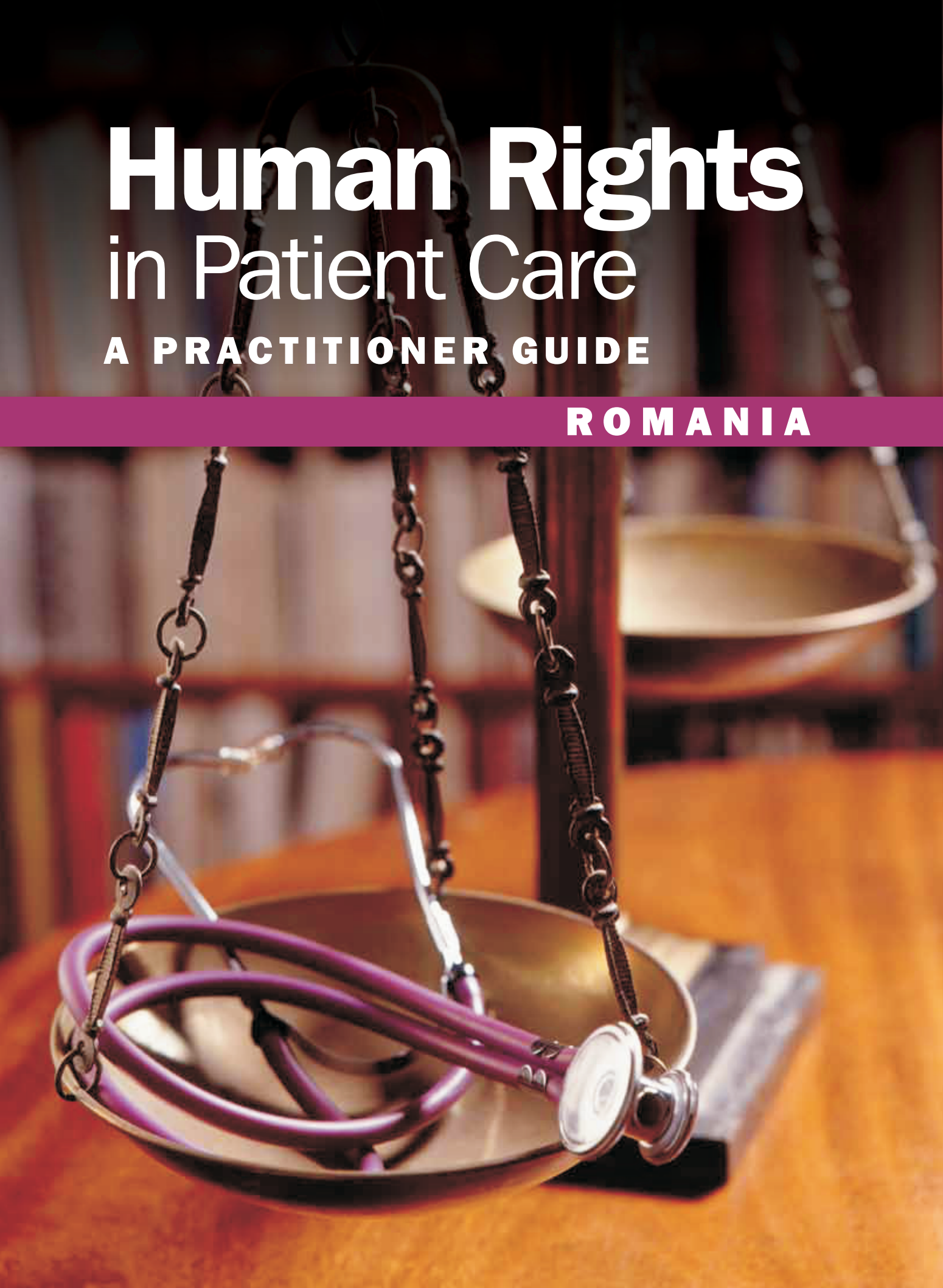
Human Rights in Patient Care

A PRACTITIONER GUIDE

ROMANIA



Human Rights in Patient Care

a Practitioner Guide

ROMANIA

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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

This guide is the product of the cooperative effort of a number of dedicated people and organizations. 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).

Thanks also to Roxana Mândruţiu, lawyer, who reviewed and amended the text of the Guide, offering important suggestions. We are nonetheless grateful to Laura Petrescu for supervising the translation into Romanian of Chapter 2, 3 and 4 on the international and regional framework.

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.

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REVIEW OF THE ROMANIAN EDITION

Authors offer readers exactly what the title of this guide promises to offer: an extremely useful tool for lawyers, judges, doctors, different persons that act in relation to the medical field (suppliers, manufacturers of medical equipment and tools), as well as for all persons interested in applying human rights in the public health field.

Since the end of the Second World War, the guarantee of human rights has been a major theme of the internal life of states and of international relationships. Consequently, such a goal became an essential element of the European construction. Therefore, fundamental texts have been adopted to protect human rights, such as the Universal Declaration of Human Rights, the European Convention of Human Rights, the European Charter of Fundamental Rights, the European Charter of Patients' Rights - these being real judicial tools to humanize the European Union.

This guide is therefore a real promoter of human rights and responsibilities in the medical health care, as well as of protection mechanisms of rights and freedoms (**Chapter 8** comprehensively analyses the procedures that are to be followed in case such rights are violated). Allowing the participants to medical acts (namely patients and providers of medical services) to know their own rights and responsibilities, this guide contributes in an indirect manner to improve medical services and people's health condition (e.g. patients awareness on their responsibilities towards the protection of public health leads to the prevention of contamination and spreading of different contagious diseases and infections).

Though the legislation in the medical field is extremely leafy and hard to understand for law practitioners due to many medical terms, this guide succeeds to put judicial norms into a practical context thanks to its precise and coherent method of presenting legal issues.

Following a review of the European and national legal framework applicable to each analysed right, authors present several practical examples of rights applications and violations, as well as judicial practice situations, that are extremely useful for law practitioners, as they comprehensively explain the analysed right and the conditions for its application.

The guide is very well structured, the reader is attracted by the passion to detail, as authors offer a detailed presentation of patient's rights and responsibilities, as well as of the supplier of medical services, without preferentially treating the first one. And this is exactly the way that should be, as the concept of human rights applied in relation to patient care refers to applying the general principles of human rights towards all actors involved in supplying medical services and acknowledges the interdependency between patients and suppliers rights.

Among the patient's right analysed in **chapter 6**, the following are listed as examples: the right to prevention measures, the right to access medical services, the right to safety, the right to confidentiality, the right to informed consent, the right to dignity, the right not to be discriminated, etc.

It has been enthusiastically remarked that authors challenge readers to a comprehensive understanding of subjects, by raising certain conflict issues between patient's rights and the rights of medical service providers (e.g. analysing the legality of the refusal of gynecologists to supply the legal medical act of abortion by request, according to article 33 of the Code of Medical Deontology from March 30, 2012 issued by the Romanian College of Physicians, the conflict between rights and freedoms being the doctor's freedom of thought vs. the patient's right to access medical care services).

Chapter 7 of the guide presents in detail the rights of suppliers of medical services (the right to decent working condition, the right to free association, the right to a fait trial, etc.), emphasising on the close relation between their rights and the patient's right (e.g. the doctor's right to decent working conditions is closely related to patient's right to safety).

In conclusion, I appreciate that this guide is very valuable tool both for law practitioners (lawyers, judges, prosecutors) and for actors involved in the medical act (patients, medical staff). I recommend readers to pay attention to this guide, especially for the topic analysed: human rights applied in relation to patients' medical care.

Ms. Roxana Mândruţiu, Attorney-at-law

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 OSF Foundations of Armenia, Georgia, Kazakhstan, Kyrgyzstan, Macedonia, Moldova, 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 legal landscape, which is often in rapid 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. Tese 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 laws governing human rights in patient care. They examine relevant "hard" and "soft" laws and provide examples of cases and interpretations of treaty provisions. These two chapters are identically organized around the established human rights applicable to both patients and providers. These are the 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; nondiscrimination and equality for patients; decent work conditions; freedom of association; and due process for providers. Chapter 4 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 Romania; explains the 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 it 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, informed 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. 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. Chapter 6 uses the rights enumerated in the European Charter of Patients' Rights as an organizing principle, but along with 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 right to work in decent conditions, the right to freedom of association, the right to due process, and other relevant country-specific rights.

Chapter 8 covers the national mechanisms for enforcement of both patient and provider rights and responsibilities. These mechanisms include administrative, civil, and criminal procedures and alternative mechanisms, such as the Office of the Public such as the Prosecutor and Ombudsperson.

Uses of the Guide

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

Companion 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 be periodically updated at www.health-rights.org. This international home page links to country websites, which include additional resources gathered by the country working groups that prepared each guide. These resources 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 providing feedback on the guides.

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 and it does not 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 Romania. The authors welcome any comments concerning errors or omissions, suggested additions to the guide, and questions about how the law might apply to a particular factual scenario.

As this guide illustrates, in Romania, the field of human rights in patient care is still new and evolving. 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 how, in practice, to apply human rights in patient care. This guide is, therefore, 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 Abbreviations

ABREVIATION	TITLE
CCR	Constitutional Court of Romania
CHPS	(CPSS in Romanian abbreviation) Center for Health Policies and Services
CLR	(CRJ in Romanian abbreviation) Center for Legal Resources
CPU	Emergency receiving compartments
ECHR	European Convention of Human Rights
ECPI	(CEIP in Romanian abbreviation) – Euroregional Center for Public Initiatives
ECPR	European Charter of Patients' Rights
ECtHR	European Court of Human Rights
EGO	Emergency Government Ordinance
EU	European Union
GD	Government Decision
GO	Government Ordinance
HCCJ	High Court of Cassation and Justice
L	Law
MoH	Ministry of Health
NBTI	National Blood Transfusion Institute
NHIH	National Health Insurance House
NPHI	National Public Health Institute
OPD	Out Patient Department
RCP	Romanian College of Physicians
UNSHIF	Unique National Social Health Insurance Fund
UPU	Emergency receiving units
WHO	World Health Organisation

1.4 Table of ratification

DOCUMENTS	Date of Accession	Date of Signature	Date of Ratification	Entry into Force	Applicable in-country Legislation	Reservation Entered
INTERNATIONAL						
International Covenant on Civil and Political Rights (ICCPR)		27.06.1968	09.12.1974		Decree no. 212 of 31.10.1974	
Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR – OP)			20.07.1993	20.08.1993	Law no. 39 of 28.06.1993	
International Covenant on Economic, Social and Cultural Rights (ICESCR)		27.06.1968	09.12.1974		Decree no. 212 of 31.10.1974	
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)		04.09.1980	07.01.1982		Decree no. 342 of 26.11.1981	
Convention for the Elimination of All Forms of Racial Discrimination (CERD)	15.09.1970		14.07.1970	28.07.1970	Decree no. 345 of 14.07.1970	*Reservation retracted through Law no. 144 of 09.07.1998
Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment (CAT)	18.12.1990		09.10.1990	10.10.1990	Law no. 19 of 09.10.1990	
Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT – OP)		24.09.2003	02.07.2009		Law no. 109 of 14.04.2009	
Convention on the Rights of the Child (CRC)		25.01.1990	28.09.1990	28.09.1990	Law nr. 18 of 27.09.1990, republished on 13.06.2001	
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)		26.09.2007	31.01.2011	31.01.2011	Law no. 221 of 11.11.2010	

DOCUMENTS	Date of Accession	Date of Signature	Date of Ratification	Entry into Force	Applicable in-country Legislation	Reservation 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		04.03.1997	24.04.2001	01.08.2001	Law no. 17 of 22.02.2001	
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	24.04.2001	01.08.2001	Law no. 17 of 22.02.2001	
Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin		20.02.2015				
Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research		17.07.2006				
Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research						
Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights)		07.10.1993	20.06.1994	20.06.1994	Law no. 30 of 18.05.1994	
European Social Charter 1961		04.10.1994				
European Social Charter 1996		14.05.1997	07.05.1999		Law no. 74 of 03.05.1999	
Framework Convention for the Protection of National Minorities 1995		01.02.1995	11.05.1995	01.02.1998	Law no. 33 of 29.04.1995	
EU Charter of Fundamental Rights		13.12.2007		01.01.2009	Law no. 13 of 07.02.2008	

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.[1]

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

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 Rights[2] 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)[3] 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 argue[4] 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.[5]

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. As part of this process, they issue what are known as "Concluding Observations." Finally, eight[6] 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

2 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.

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 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.

5 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.

6 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].

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:

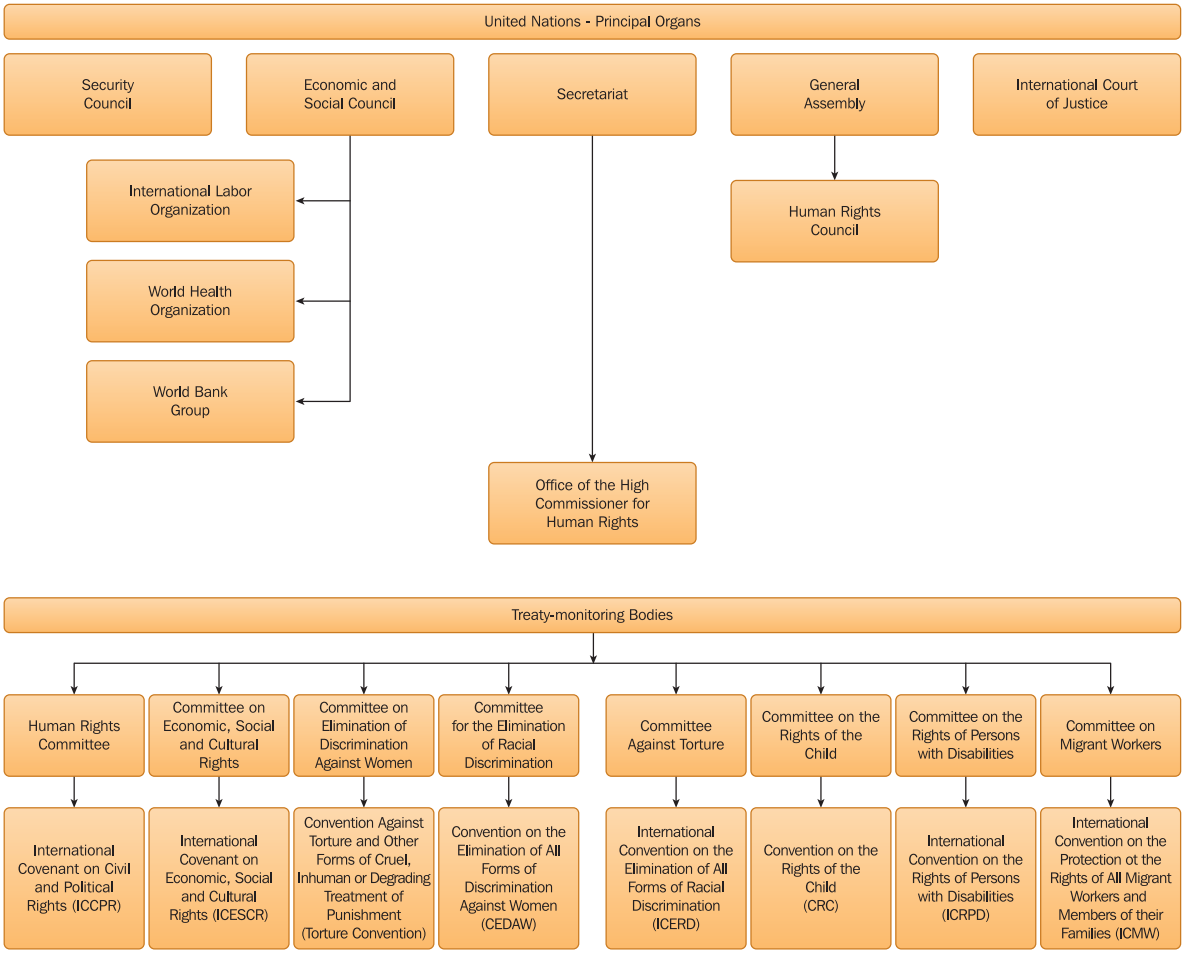
TREATIES

- **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**

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)[7]	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)[8]	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)[9]	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)[10]	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)[11]	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))[12]	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)[13]	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)[14]	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.

7 United Nations General Assembly. United Nations General Assembly Resolution 2200A [XX1]: International Covenant on Civil and Political Rights (ICCPR). UN Doc. A/6316. December 16, 1966.

8 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.

9 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.

10 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.

11 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.

12 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.

13 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.

14 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, CESCR, 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: CESCR, 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 Imprisonment**[15]

  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-Ata**[16]

  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 Women**[17]

  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.

15 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.
16 International Conference on Primary Health Care. Declaration of Alma-Alta. September 6, 1978.
17 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 Rights**[18]

  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 Rights19**

  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 Punishment**[20]

  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 Care**[21]

  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 Rights**[22]

  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 Prisoners**[23]

  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.

- **(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

18 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.

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

20 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.

21 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.

22 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.

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

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)[24]**

  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))[25]**

  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 Century[26]**

  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 Rights[27]**

  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)[28]**

  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.

24 WMA. Declaration on the Rights of the Patient. September/October 1981.
25 International Alliance of Patients' Organizations [IAPO]. Declaration on Patient-Centred Healthcare. February 2006.
26 WHO. Jakarta Declaration on Leading Health Promotion into the 21st Century. July 21–25, 1997.
27 Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights. September 28, 2011.
28 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.[29]

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 14[30] 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.

29 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.

30 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.

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.[31] 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.[32] 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.[33]

The right to security of person safeguards the individual's freedom from bodily injury, including protection from fatal injuries and non-intentional injury.[34] 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.[35] 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.
- **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.

31 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.

32 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.

33 CCPR. Concluding Observations: Bulgaria. UN Doc. CCPR/C/BGR/CO/3. July 25, 2011. para. 17.

34 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.

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; 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.

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 Imprisonment**[36]
  - **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 I 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.
- **International Ethical Guidelines for Biomedical Research Involving Human Subjects**[37]

  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 Care**[38]
  - **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

36 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.

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

38 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.

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 Patients[39]

- **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.

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.[40] Governments should ensure that the patient's views are respected in the process and that the interests of the patient are represented and defended.[41] 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.[42] The continuity of detention should be re-evaluated on a regular basis to ensure its necessity.[43]

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.

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

40 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.

41 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.

42 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.

43 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.

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.[44]

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.[45]

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.[46]

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.[47] 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.[48]

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.

44 CCPR. Concluding Observations: Estonia. UN Doc. CCPR/CO/77/EST. April 15, 2003. para 10.
45 CCPR. Communication No. 754/1997: A v. New Zealand. UN Doc. CCPR/C/66/D/754/1997. August 3, 1999.
46 CCPR. Communication No. 1061/2002: Fijalkowska v. Poland. UN Doc. CCPR/C/84/1061/2002. July 26, 2005.
47 OHCHR. International Guidelines on HIV/AIDS and Human Rights. July 2006. para. 105.
48 CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009.

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.[49]

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.[50] 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.[51]

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;

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

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

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

(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.[52]

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.[53] 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.[54]

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.[55] UN treaty-monitoring bodies have underscored that accessibility to information should not impair the right to have personal health data treated with confidentiality.[56]

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

52 CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009. para. 17.
53 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.
54 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.
55 CCPR. Communication No. 1482/2006: L.M.R v. Argentina. UN Doc. CCPR/C/101/D/1608/2007. March 29, 2011. para 9.3.
56 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.

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 Action**[57]
  - 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)**[58]
  - **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.
    - 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."[59] 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.[60]

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.

57 Fourth World Conference on Women. Beijing Declaration and Platform for Action. September 1995.
58 WMA. Declaration on the Rights of the Patient. September/October 1981.
59 CCPR. Communication No. 1482/2006: M. G. v. Germany. UN Doc. CCPR/C/93/D/1482/2006. September 2, 2008. para. 10.1.
60 CRPD. Concluding Observations: Hungary. UN Doc. CRPD/C/HUN/CO/1. October 22, 2012. paras. 48-49.

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.[61]

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.[62] Laws that interfere with this right in the interest 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."[63]

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.[64]

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.[65]

61 CRC Committee. Concluding Observations: Republic of Korea. UN Doc. CRC/C/KOR/CO/3-4. October 6, 2011. paras. 55-56.
62 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.
63 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.
64 CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009. para. 12.
65 CCPR. Communication No. 488/1992: Toonen v. Australia. UN Doc. CCPR/C/50/D/488/1992. March 31, 1994. paras. 8.5-8.6.

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;[66] (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;[67] 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.[68]

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…[69]

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.[70]

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.[71]

66 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.
67 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.
68 CRC Committee. Concluding Observations: Djibouti. UN Doc. CRC/C/15/Add.131. June 28, 2000.
69 CRC. Concluding Observations: Australia. UN Doc. CRC/C/AUS/CO/4. August 28, 2012. para. 41-42.
70 CCPR. Communication No. 1153/2003: Karen Noelia Llantoy Huamán v. Peru. UN Doc. CCPR/C/85/D/1153/2003. October 24, 2005.
71 CCPR. Communication No. 1610/2007: L.N.P. v. Argentina. UN Doc. CCPR/C/102/D/1610/2007. August 16, 2011. para. 13.7.

RIGHT OF ACCESS 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,[72] but also ensure that access to this information does not infringe on the patient's right to keep her/his information confidential.[73] 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.[74] 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.[75]

Additionally, access to information has been interpreted as an essential part of the accessibility component of the right to health.[76]

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;…

72 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.

73 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).

74 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).

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

76 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).

(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**[77]
  - **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.
- **WMA Declaration of Lisbon on the Rights of the Patients**[78]
  - **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.[79] 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.[80]

77 IAPO. Declaration on Patient-Centred Healthcare. February 2006.
78 WMA. Declaration on the Rights of the Patient. September/October 1981.
79 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).
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).

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 ;…*
- *(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.*[81]

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.[82] 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.[83]

CONCLUDING OBSERVATIONS ON 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.[84]

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

81 CAT Committee. Concluding Observations: Estonia. UN Doc. CAT/C/EST/CO/5. June 17, 2013. para. 20.
82 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.
83 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.
84 CRC Committee. Concluding Observations: Libya (Arab Jamahiriya). UN Doc. CRC/C/15/Add.209. July 4, 2003. paras. 37-38.

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.[85]

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 services[86] and for adolescents, access to information without parental consent based on the adolescent's maturity level.[87] Accordingly, UN treaty-monitoring bodies have urged governments to improve access in light of increasing teenage abortions and sexually transmitted diseases,[88] including HIV/AIDS,[89] with this right to access also extending to children.[90]

CONCLUDING OBSERVATIONS ON PANAMA RELATED 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.[91]

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

86 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.

87 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.

88 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.

89 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.

90 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.

91 CEDAW Committee. Concluding Observations: Panama. UN Doc. CEDAW/C/PAN/CO/7. February 5, 2010. para 40-41.

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.'"[92]

RIGHT TO BODILY INTEGRITY

The right to bodily integrity protects the individual from bodily injury.[93] In the patient care context, this right becomes relevant in cases of involuntary medical treatment and experimentation, among others.[94] 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.[95] 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

92 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).
93 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.
94 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.
95 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.

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;…
- **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[96]

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 Care[97]

- **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.

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

WMA Declaration of Lisbon on the Rights of the Patients[98]

- **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.
- **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

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

for this type of intervention.[99] Moreover, the government has the obligation to establish a monitoring and reporting system of mental health-care institutions.[100] 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.[101]

As explained above, threats to the bodily integrity of such individuals can be address 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.[102] If force or restraint is used, it must be made following a "thorough and professional medical assessment" that calls for this type of intervention.[103] Moreover, the government has the obligation to establish a monitoring and reporting system of mental health-care institutions.[104]

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.[105]

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.[106] 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."[107]

99 CCPR. Concluding Observations: Norway. UN Doc. CCPR/C/NOR/CO/6. November 18, 2011. para. 10.
100 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.
101 CRPD. Monitoring the Convention on the Rights of Persons with Disabilities Guidance for human Rights Monitors. UN Doc. HR/P/PT/17. April 2010.
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.
103 CCPR. Concluding Observations: Norway. UN Doc. CCPR/C/NOR/CO/6. November 18, 2011. para. 10.
104 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.
105 CCPR. Concluding Observations: Croatia. UN Doc. CCPR/C/HRV/CO/2. November 4, 2009. para. 12.
106 CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009. para. 13.
107 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.

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).

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.[108]

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."[109] 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.[110] 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.[111]

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.[112]

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

108 CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. November 4, 2009.
109 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.
110 CEDAW Committee. Concluding Observations: Burkina Faso. UN Doc. A/55/38 (Supp). August 17, 2000. para. 261.
111 CAT Committee. Concluding Observations: Slovakia. UN Doc. CAT/C/SVK/CO/2. December 31, 2009. para. 10.
112 CERD. Concluding Observations: Czech Republic. UN Doc. CERD/C/CZE/CO/7. April 11, 2007. para 14.

Szijjarto 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.[113]

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).[114] 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."[115] 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.[116]

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.[117]

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

113 CEDAW Committee. Communication No. 4/2004: Szijjarto v. Hungary. UN Doc. A/61/38. August 14, 2006. section 11.3.
114 CCPR. Communication No. 1520/2006: Mwamba v. Zambia. UN Doc. CCPR/C/98/D/1520/2006. April 30, 2010. para 6.8.
115 CCPR. CCPR General Comment 6: The right to life (Art. 6). April 30, 1982. paras. 1, 5.
116 CEDAW Committee. Communication No. 17/2008: Teixeira v. Brazil. UN Doc. CEDAW/C/49/D/17/2008. September 27, 2011. para 7.4.
117 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.

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.

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.[118] 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.[119]

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.

Emphasising 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

118 ECtHR. Dodov v. Bulgaria (59548/00). April 17, 2008.
119 CCPR. Communication No. 763/1997: Lantsova v. The Russian Federation. UN Doc. CCPR/C/74/D/763/1997. March 26, 2002. para 9.2.

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.[120]

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."[121] 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.[122]

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.[123]

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.[124] For example, a state should take measures to help women avoid unsafe abortions,[125] such as decriminalizing abortion, ensuring access to reproductive health services,[126] making contraceptives widely available, and establishing health care facilities in rural areas.[127]

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

120 CRC Committee. Concluding Observations: Australia. UN Doc. CRC/C/AUS/CO/4. August 28, 2012. paras. 64-65.
121 CCPR. CCPR General Comment 6: The right to life (Art. 6). April 30, 1982. para. 5.
122 See Open Society Foundations, Ford Foundation, and UNDP. Factsheet: Human Rights & the Three Diseases. October 5, 2011.
123 CCPR. Concluding Observations: Uganda. UN Doc. CCPR/CO/80/UGA. May 4, 2004. CCPR. para. 14.
124 United Nations. Report of the Human Rights Committee. UN Doc. A/67/40 (Vol. I). 2012. p. 46-47, para 15.
125 United Nations. Report of the Human Rights Committee. UN Doc. A/65/40 (Vol. I). 2009. p. 51, para 10.
126 United Nations. Report of the Human Rights Committee. UN Doc. A/65/40 (Vol. I). 2009. p. 94-95, para 13.
127 United Nations. Report of the Human Rights Committee. UN Doc. A/66/40 (Vol. I). 2011. p. 28-29, para 12.

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.[128]

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.[129]

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.[130] Health facilities, goods and services must be respectful of medical ethics, culturally acceptable, scientifically and medically appropriate and of good quality.[131] 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.[132]

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)."[133] 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]."[134] Moreover, States Parties are not allowed to take

128 CCPR. Concluding Observations: Cameroon. UN Doc. CCPR/C/CMR/CO/4. August 4, 2010. para. 13.
129 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.
130 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.
131 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.
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. 4.
133 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.
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. 31.

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." [135]

Violations of the right to health can result from both a deliberate act and a failure to act by the government.[136] In fact, states have been frequently condemned by the CESCR for failing to devote adequate resources to health care and services because of the obviously detrimental impact of that failure on patients.[137]

Additionally, the right to health is inclusive and covers freedoms in addition to entitlements.[138] 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.[139]

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

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. 32.

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. paras. 46-52.

137 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.

138 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.

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.

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.

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 I 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:…[a]ccess 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: [a]ccess 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 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.

Right to Health in the Context of Mental Health

The ICESCR, along with other relevant international legal instruments,[140] 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.[141] 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.[142]

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.[143]

140 Such instruments are not limited to human rights instruments (see e.g., WHO Constitution).
141 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.
142 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.
143 CESCR. Concluding Observations: Australia. UN Doc. E/C.12/AUS/CO/4. June 12, 2009. para. 30.

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.[144] 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.[145] Governments are also prohibited from discriminating against individuals based on their health status, such as HIV/AIDS and tuberculosis.[146]

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.[147]

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."[148] 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

144 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).

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. 16.

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. 18.

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

148 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.10, 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.

it.[149] For example, in addition to facilitating access to contraceptives and family planning,150 governments are to ensure the establishment of "education and training programmes to 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."[151]

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.[152]

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

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; 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.

150 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 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.

151 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).

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

line with health policies and practices attributed to the death of the patient and constituted a violation of the right to health.[153]

***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."[154]

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.[155] 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.[156] 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."[157] 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.[158] 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."[159] 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."[160]

International human rights law explicitly protects patients against torture in health-care settings and requires

153 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.
154 CEDAW Committee. Communication No. 22/2009: L.C. v. Peru. UN Doc. CEDAW/C/50/D/22/2009. November 4, 2011. para. 8.11.
155 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.
156 CCPR. General Comment 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment. October 3, 1992. para. 4.
157 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.
158 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.
159 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.
160 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.

the State to prevent, investigate, prosecute and punish violations by non-State actors.[161] 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;[162] and where medical personnel participate in acts of torture, they should be held accountable and punished.[163]

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.[164] The Special Rapporteur clarifies that "[m]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."[165] 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.[166]

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.[167] In relation to Article 10(1), the CCPR has found a violation where a prisoner on death row was denied medical treatment[168] and where severe overcrowding in a pretrial detention center resulted in inhumane and unhealthy conditions, eventually leading to the detainee's death.[169] 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 required[170] 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).[171]

In addition, denying access to pain relief, if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment.[172] Denying a detainee direct access to her/his medical records, particularly

161 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.

162 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.

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

164 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.

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. 39.

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. 84.

167 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.

168 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.

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

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

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

172 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.

where this may have consequences for her/his treatment, can likewise constitute a breach of Article 10(1).[173] 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.[174] Some of the worst abuses include: failure to provide new detainees with access to a medical professional and with sanitary living conditions;[175] failure to segregate those with contagious diseases such as tuberculosis;[176] completely unacceptable quarantine procedures;[177] insufficient provision of food, leading in some instances to conditions approaching starvation;[178] and mental suffering that could amount to mental torture.[179]

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.

173 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.

174 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.

175 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.

176 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.

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; 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.

178 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.

179 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.

- **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.
  (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 Imprisonment[180]

- **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 Officials[181]

- **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 Prisoners[182]

- 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

180 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.
181 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.
182 United Nations. Economic and Social Council Resolution 663 C (XXIV): Standard Minimum Rules for the Treatment of Prisoners. August 30, 1955.

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.

(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.[183] 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."[184] 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 during detention.[185] Often in conjunction with **Article 7**, it has gone on to find breaches of this obligation on numerous occasions.[186] 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.[187] Similarly, solitary confinement or deprivation of food is considered torture, and therefore illegal.[188]

Additionally, the CAT Committee has identified overcrowding, inadequate living conditions and lengthy confinement in psychiatric hospitals as "tantamount to inhuman or degrading treatment."[189] 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,190 in addition to lack of medical attention.[191]

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

184 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.

185 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.

186 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.

187 CCPR. Concluding Observations: Bosnia and Herzegovina. UN Doc. CCPR/C/BIH/CO/1. November 22, 2006.

188 United Nations. Report of the Human Rights Committee. UN Doc. A/65/40 (Vol. I). 2009. p. 90, para 21.

189 CAT Committee. Concluding and recommendation of the Committee against Torture: Russian Federation. UN Doc. CAT/C/RUS/CO/4. February 6, 2007.

190 CAT Committee. Concluding and recommendation of the Committee against Torture: Cameroon. UN Doc. CAT/C/CR/31/6. February 5, 2004.

191 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.

CONCLUDING OBSERVATIONS RELATING ON 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.[192]

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.[193]

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.[194] 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."[195] Likewise, forced sterilization of women living with HIV could amount to cruel, inhuman or degrading treatment.[196]

Additionally, failing to segregate inmates with infectious diseases (such as tuberculosis) in prisons has been considered a violation of this right.[197] At the same time, persons suffering from infectious diseases may be

192 CRPD. Concluding Observations: China. UN Doc. CRPD/C/CHN/CO/1. October 15, 2012. para 27-28.
193 CCPR. Communication No. 609/1995: Williams v. Jamaica. UN Doc. CCPR/C/61/D/609/1995. November 4, 1997.
194 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.
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. 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.
196 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.
197 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.

more vulnerable to ill treatment.[198] They are likely to be denied access to information, prevention, testing, treatment and support.[199]

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).

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.[200]

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.[201]

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

198 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.
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 CAT Committee. Concluding Observations: China. UN Doc. CAT/C/CHN/CO/4. December 12, 2008. para. 12
201 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.

right.[202] Likewise, forced castration or sterilization has been treated as a breach of this right.[203] 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.[204]

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 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.[205]

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.[206]

RIGHT TO PARTICIPATION IN PUBLIC POLICY

The right to participation in public policy has been treated as an underlying determinant of health,[207] 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.[208]

202 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.

203 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.

204 United Nations. Report of the Human Rights Committee. UN Doc. A/67/40 (Vol. I). 2012. p. 62, para. 9.

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

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

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

208 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.

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."[209] In addition, "promoting 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."[210]

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 suȓage 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:
    (3) Ensure that persons with disabilities can effectively and fully participate in political and

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. 43(f).
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. 54.

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**[211]
  - **Art. IV:** The people have the right and the duty to participate individually and collectively in the planning and implementation of their health care.
- **IAPO Declaration on Patient-Centred Healthcare**[212]
  - **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.[213] 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."[214] 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."[215] Care and support providers, as well as family, should also be involved in the process.[216]

211 International Conference on Primary Health Care. Declaration of Alma-Alta. September 6, 1978.
212 International Alliance of Patients' Organizations [IAPO]. Declaration on Patient-Centred Healthcare. February 2006. See also IAPO's Policy Statement on Patient Involvement.
213 FRA. The right to political participation of persons with mental health problems and persons with intellectual disabilities. October 2010.
214 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.
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. 60.
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.

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."[217] 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).

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.[218]

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.[219] States have been called to engage civil society, including patient groups, in the "formulation and implementation of public policies."[220] 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…[221]

217 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.

218 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.

219 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.

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

221 CEDAW Committee. Report of the Committee n the Elimination of Discrimination against Women. UN Doc. A/57/38(SUPP). 2002.

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.[222]

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.[223]

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.[224] 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."[225] 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."[226] 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.[227]

paras. 65-66.

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

223 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.

224 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.

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).

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 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.

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."[228] 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.[229] This type of discrimination includes stereotyping and acts of stigmatization. Therefore, while direct discrimination is defined by the purpose 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."[230]

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.[231] 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.[232] 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."[233] 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.[234] 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.[235] 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."[236]

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;[237] refugees of a particular nationality;[238] children, older persons, and persons with physical and mental disabilities;[239] and those living in rural areas where the geographical distribution of health services and personnel shows a heavy urban bias.[240] With respect to one country alone, the CESCR noted with regret the differential treatment in providing access to health services

228 Interights. Non-Discrimination in International Law: A Handbook for Practitioners. 2011. 18.
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.
231 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.
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. 37.
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. 12(b).
234 CERD. CERD General Comment No. 30: Discrimination Against Non Citizens. UN Doc. A/59/18. October 1, 2004. para. 36.
235 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.
236 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.
237 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.
238 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.
239 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.
240 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.

between one group of refugees and another,[241] the lack of mental health services in the country,[242] and the need to "reinforce reproductive and sexual health programmes, in particular in rural areas."[243]

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.

241 CESCR. Concluding Observations: Nepal, 2001. UN Doc. E/2002/22. June 6, 2002. para. 545.
242 CESCR. Concluding Observations: Nepal, 2001. UN Doc. E/2002/22. June 6, 2002. para. 550.
243 CESCR. Concluding Observations: Nepal, 2001. UN Doc. E/2002/22. June 6, 2002. para. 571.

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)[244]

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

IAPO Declaration on Patient-Centred Healthcare[245]

- **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[246]

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.

244 WMA. Declaration on the Rights of the Patient. September/October 1981.
245 IAPO. Declaration on Patient-Centred Healthcare. February 2006.
246 WMA. Resolution on Medical Care for Refugees. 50th World Medical Assembly. October 1998.

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 mental 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.[247]

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."[248]

Other international treaties and regional treaties, such as the ICRPD and the CRC, prohibit discrimination on grounds of disability.[249] 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.[250] 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."[251] 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."[252] 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.[253]

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

247 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.
248 ICRPD. Article 25(f).
249 Convention on the Rights of the Child. Article 2.
250 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.
251 CESCR. CESCR General Comment No. 5: Persons with disabilities. December 9, 1994. para. 15.
252 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.
253 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.

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.[254]

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.[255] 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.[256]

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.[257]

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.[258]

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. paras. 16, 47.
255 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.
256 CCPR. Concluding Observations: Zimbabwe. UN Doc. CCPR/C/79/Add.89. April 6, 1998.
257 CCPR. Concluding Observations: Republic of Moldova. UN Doc. CCPR/C/MDA/CO/2. October 29, 2009.
258 CCPR. Communication No. 488/1992: Toonen v. Australia. UN Doc. CCPR/C/50/D/488/1992. April 4, 1994. para. 8.7.

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.[259] Both groups, particularly women living in rural areas[260] and 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.[261] 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.[262]

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.[263]

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

259 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.

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

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

262 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.

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

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.[264]

***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 "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."[265]

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."[266] 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.[267] The right also entails at least compensatory relief and preventative measures.[268] 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."[269] 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.[270]

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]."[271]

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;

264 CCPR. Communication No. 1610/2007: L.N.P. v. Argentina. UN Doc. CCPR/C/102/D/1610/2007. August 16, 2011. para. 13.7.
265 CEDAW Committee. Communication No. 22/2009: L.C. v. Peru. UN Doc. CEDAW/C/50/D/22/2009. November 4, 2011. para. 8.11.
266 CCPR. CCPR General Comment No. 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant. May 26, 2004. para. 15.
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. 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.
270 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.
271 CCPR. Communication No. 972/01: George Kazantzis v. Cyprus. UN Doc. CCPR/C/78/D/972/2001. September 13, 2003. para. 6.6.

(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.

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.[272]

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

272 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.

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;

(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;…[273]

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."[274]

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.[275] 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.[276]

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 though the courts.[277]

273 CCPR. Concluding Observations: Bulgaria. UN Doc. CCPR/C/BGR/CO/3. para. 17.
274 CCPR. Communication No. 609/1995: Williams v. Jamaica. UN Doc. CCPR/C/61/D/609/1995. November 4, 1997.
275 CESCR. Concluding Observations: India. UN Doc. E/C.12/IND/CO/5. August 8, 2008. para. 13.
276 CESCR. Concluding Observations: Ukraine. UN Doc. E/C.12/UKR/CO/5. January 4, 2008. paras. 49, 52.
277 CESCR. Concluding Observations: India. UN Doc. E/C.12/IND/CO/5. August 8, 2008. para. 13.

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.[278]

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.[279] 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.[280] Likewise, the CCPR has been clear on the importance of the state obligation to provide redress to victims of sexual violence.[281]

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.[282]

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

278 CCPR. Communication No. 1473/2006: Tornel v. Spain. UN Doc. CCPR/C/95/D/1473/2006. March 20, 2009. para. 7.4.
279 CRC Committee. Concluding Observations: Mozambique. UN Doc. CRC/C/15/Add.172. April 2, 2002. paras. 38-39.
280 CAT Committee. Concluding Observations: Czech Republic. UN Doc. CAT/C/CZE/CO/4-5. May 14-15, 2012. para. 12.
281 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.
282 CAT Committee. Concluding Observations: Czech Republic. UN Doc. CAT/C/CZE/CO/4-5. May 14-15, 2012. para. 13.

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.[283]

2.4 Providers' 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.

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.[284] 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).[285] 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.[286] 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/

283 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.
284 CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 1
285 CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 2.
286 CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 23

his profession.[287] The individual must not be deprived from work unfairly.[288] Also, this right protects foreign workers who are employed in a State with valid work permits from being unlawfully deported.[289]

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.[290] 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.[291] The ICMW emphasizes states' obligations to foreign-born employees.[292] 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.[293] Under this right, workers who are not covered by collective bargaining are protected.[294] 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.[295] 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.[296] The State must take measures to eliminate discrimination against non-citizen workers in relation to working conditions and work requirements.[297] Workers should not face discrimination in employment on the grounds of political opinion.[298] The State must also develop regulations to penalize and remedy sexual harassment in the workplace.[299]

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,[300] as well as prohibits failure to pay medical staff for extended periods of work.[301] Medical staff cannot be subjected to low wages and substandard working conditions in hospitals.[302] With respect to women, this right establishes special protection against harmful types of work during pregnancy and requires the provision of paid maternity leave.[303] 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.[304]

287 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
288 CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 4
289 CERD. Communication No. 8/1996: B. M. S. v. Australia. UN Doc. CERD/C/54/D/8/1996. May 10, 1999.
290 CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 6.
291 CESCR. CESCR General Comment No. 18: The Right to work. UN Doc. E/C.12/GC/18. February 6, 2006. para. 18.
292 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Article 7.
293 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.
294 CESCR. Concluding Observations: Suriname. UN Doc. E/1996/22. December 12, 1996.
295 See ICRPD, specifically arts. 8, 9, 27. See also CESCR. CESCR General Comment No. 5: Persons with disabilities. December 9, 1994. para. 25.
296 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.
297 CERD. CERD General Comment No. 30: Discrimination Against Non Citizens. October 1, 2004. paras. 33–35.
298 CESCR. Concluding Observations: Germany. UN Doc. E/C.12/1993/17. January 5, 1994.
299 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.
300 CESCR. Concluding Observations: Suriname. UN Doc. E/1996/22. December 12, 1996.
301 CRC Committee. Concluding Observations: Solomon Islands. UN Doc. CRC/C/132. October 23, 2003.
302 CESCR. Concluding Observations: Georgia. UN Doc. E/2003/22. November 29, 2000.
303 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.
304 CESCR. CESCR General Comment 16: The equal right of men and women to enjoyment of all economic, social, and cultural rights

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) The 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

- **Art. 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

(Art. 3 of the International Covenant on Economic, Social and Cultural Rights). UN Doc. E/C.12/2005/4. August 11, 2005. para. 24.

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.

2. 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),**[305]
  - **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)**[306]
  - **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)**[307]
  - **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)**[308]
  - **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

305 International Labor Organization [ILO]. Occupational Safety and Health Convention, 1981 (No. 155). August 11, 1983.
306 ILO. Occupational Health Services Convention, 1985 (No. 161). February 17, 1985.
307 ILO. Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187). February 20, 2009.
308 ILO. Nursing Personnel Convention, 1977 (No. 149). July 11, 1979.

field of health, in consultation with the employers' and workers' organisations concerned.

- **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) the 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 I 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.[309]

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.[310]

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.[311] 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.[312] 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.[313] This right also requires allowing men and women to organize and join workers' associations that address their specific concerns.[314] As it relates to providers, such as hospital personnel, they are entitled to join organizations for the promotion and defense of workers' interests without previous authorization.[315]

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

309 CESCR. Concluding Observations: Suriname. UN Doc. E/1996/22. December 12, 1996.
310 CERD. Communication No. 8/1996: B. M. S. v. Australia. UN Doc. CERD/C/54/D/8/1996. May 10, 1999.
311 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.
312 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.
313 CCPR. Concluding Observations: Lebanon. UN Doc. A/52/40 (Vol. II). September 21, 1997.
314 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.
315 ILO. Freedom of Association: Digest of Decisions and Principles of the Freedom of Association Committee. 2005.

defenders who implement and protect social rights and fundamental civil rights, such as life and freedom from torture and inhuman or degrading treatment.[316]

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),**[317]
  - **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 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.

317 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) 1998**[318]
  - **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:

318 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.[319]

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.[320] It also protects the individual from reprisals for exercising free association rights and unnecessary interference in trade union activities.[321] Accordingly, under international human rights law, the existence of multiple trade unions should be lawfully guaranteed,[322] and the absence of enabling legislation on trade unions must be condemned.[323] 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.[324] Trade union protection includes ensuring that foreign workers are not barred from holding official positions and that unions are not dissolved by the executive.[325]

Consultation and co-operation are no substitute for the "right to strike."[326] Individuals are guaranteed participation in discussions concerning the determination of minimum wages.[327] With respect to health care workers, this right guarantees those employed in public hospitals the right to enjoy the right to collective bargaining.[328] 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.[329] 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.

RELEVANT PROVISIONS

- **UDHR**
  - **Art. 23(4):** Everyone has the right to form and to join trade unions for the protection of his interests.

319 CCPR. Concluding Observations: Belarus. UN Doc. CCPR/C/79/Add.86. November 19, 1997. para. 19.
320 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.
321 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.
322 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.
323 CCPR. Concluding Observations: Georgia. UN Doc. A/52/40 (Vol. I). September 21, 1997.
324 CESCR. Concluding Observations: Russian Federation. UN Doc. E/1998/22. June 20, 1998.
325 CCPR. Concluding Observations: Senegal. UN Doc. CCPR/C/79/Add.82. November 19, 1997.
326 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.
327 CESCR. Concluding Observations: Uruguay. UN Doc. E/1995/22. January 1, 1995.
328 ILO. 306th Report of the Committee on the Freedom of Association. 2009; ILO. Case No. 1882 (Demark). Complaint date: May 10, 1996; see ILO. Right to Organise and Collective Bargaining Convention (No. 98). July 1, 1949.
329 CCPR. Concluding Observations: Germany. UN Doc. A/52/40 (Vol. I). September 21, 1997.

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)[330]

- **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.

- **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

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

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)[331]

- **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.[332]

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

331 ILO. Right to Organise and Collective Bargaining Convention, 1949 (No. 98). July 1, 1949.
332 CCPR. Concluding Observations: Lebanon. UN Doc. A/52/40 (Vol. I). September 21, 1997.

that address the right to free expression and the right to impart information. These liberties are particularly significant, as they might offer protection to whistleblowers 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 courts[333] (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)[334] and 2) access to courts[335] (access includes the provision of legal aid).[336] This right requires that states provide for particular causes of action "in certain circumstances" and for competent courts to determine those causes of action.[337] 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),[338] 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.[339] 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,[340] failing to inform the litigant of her/his appeal date until after it has taken place,[341] refusal of an administrative tribunal to admit crucial evidence[342] and failure to permit one litigant to submit comments on the other side's submissions.[343]

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.

333 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.
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. para. 65.
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. paras. 8, 9, and 12.
336 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.
337 CCPR. Communication No. 547/1993: Mahuika v New Zealand. UN Doc. CCPR/C/70/D/547/1993. November 15, 2000.
338 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...."
339 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.
340 CCPR. Communication No. 289/1988: Wolf v. Panama. UN Doc. CCPR/C/44/D/289/1988. March 26, 1992.
341 CCPR. Communication No. 532/1993: Thomas v. Jamaica. UN Doc. CCPR/C/61/D/532/1993. December 4, 1997.
342 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.
343 CCPR. Communication No. 779/1997: Aarela and Anor v. Finland. UN Doc. CCPR/C/73/D/779/1997. February 4, 1997.

- **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.[344]

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).[345]

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.[346] 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."[347]

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]."[348]

344 CERD. Concluding Observations: Austria. UN Doc. CERD/C/AUT/CO/17. August 21, 2008.
345 CCPR. Communication No. 1755/2008: Nenova v. Libya. UN Doc. CCPR/C/104/D/1755/2008/Rev.1. July 10, 2012.
346 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.
347 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.
348 CCPR. Communication No. 972/01: George Kazantzis v. Cyprus. UN Doc. CCPR/C/78/D/972/2001. September 13, 2003. para. 6.6.

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.

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.[349]

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.[350]

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.[351] The state must provide protection under the law against any unauthorized interferences with correspondence[352] and ensure strict and independent (ideally, judicial) regulation of any such practices, including wiretapping.[353] An interference with this right can only be justified if it is lawful and not arbitrary—if it complies with an established legal procedure.[354]

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.[355]

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

349 CRC. Concluding Observations: Afghanistan. UN Doc. CRC/C/AFG/CO/1. April 8, 2011.
350 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.
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. 10.
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. 8; CCPR. Concluding Observations: Zimbabwe. UN Doc. CCPR/C/79/Add.89. April 6, 1998.
353 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.
354 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.
355 CCPR. Concluding Observations: Portugal. UN Doc. CCPR/CO/78/PRT. July 5, 2003.

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...

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.[356] 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.[357] 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.[358]

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.
- **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)[359]**
  - **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;

356 CCPR. Communication No. 780/1997: Laptsevich v. Belarus. UN Doc. CCPR/C/68/D/780/1997. April 13, 2000.
357 Joseph, Schultz, and Castan. The ICCPR-Cases, Materials and Commentary. 2004. p. 541.
358 Joseph, Schultz, and Castan. The ICCPR-Cases, Materials and Commentary. 2004. p.525.
359 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.

(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.

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.

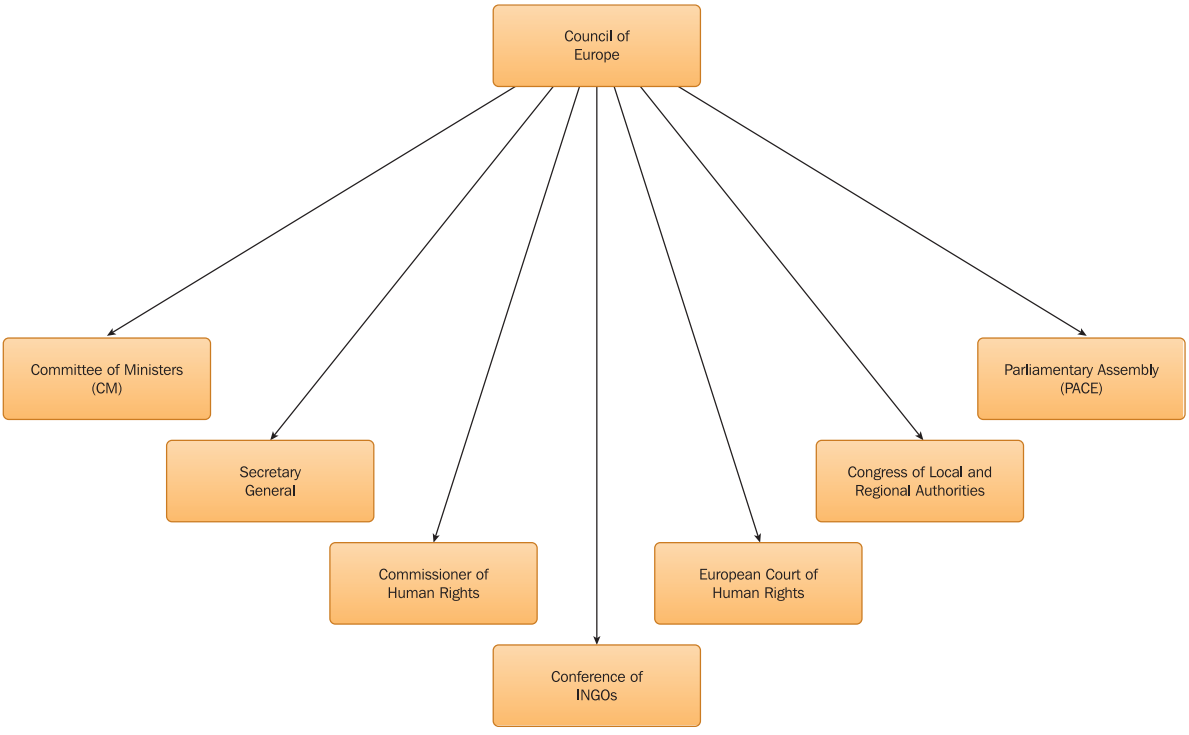
3.2 Key Sources

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.[360] 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



360 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 Union**[361]

  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.

- **Directive 2011/24/EU on the Application of Patients' Rights in Cross-Border Healthcare** [362]

  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.

- **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**[363]

  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**[364]

  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**[365]

  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.

361 Official Journal of the European Communities. Charter of Fundamental Rights of the European Union. OJ C 364/01. December 7, 2000.
362 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.
363 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.
364 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.
365 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.

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)[366]**

  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."[367] It is binding on ratifying states.

- **European Convention on Human Rights (ECHR)[368]**

  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)[369]**

  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[370]**

  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. States are to consider "the specific conditions of the persons belonging to national minorities."[371]

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[372]**

  This declaration was issued by the WHO Regional Office for Europe in 1994 and has been influential. It sets the International Bill of Rights,[373] the ECHR, and the ESC as its foundation and focuses on rights

366 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.
367 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).
368 COE. European Convention on Human Rights. ETS No. 5. November 4, 1950.
369 COE. European Social Charter. ETS No. 35. November 4, 1950.
370 COE. Framework Convention for the Protection of National Minorities. ETS No. 35. February 1, 1995.
371 COE. Framework Convention for the Protection of National Minorities. Article 4(2). ETS No. 35. February 1, 1995.
372 WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.
373 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).

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."[374]

- **The European Charter of Patients' Rights[375]**

  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.*[376]

  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.[377] 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.[378] It has also been used as a reference point to monitor and evaluate health care systems across Europe.

- **Ljubljana Charter on Reforming Health Care[379]**

  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."[380] 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.[381]**

  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.

374 WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.
375 Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.
376 ACN. European Charter of Patients' Rights. November 2002. Preamble.
377 The pharmaceutical company Merck & Co., Inc., also provided funding for this movement.
378 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.
379 World Health Organization [WHO]. Ljubljana Charter on Reforming Health Care. June 19, 1996.
380 WHO. Ljubljana Charter on Reforming Health Care.
381 COE. Recommendation Rec No. R (2000) 5. April 30, 2002.

3.3 Patients' Rights

This section is structured around nine 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.

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 Article 2 in cases in which preexisting obligations have not been fulfilled. 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.

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.[382] 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

382 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.

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.[383]

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.[384] 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.[385]

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;[386]
- Any commitment must be subject to a speedy periodic legal review that incorporates the essential elements of due process;[387] 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).[388]

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)[389] and the right to freedom from torture, cruel, inhuman or degrading treatment (ECHR, Art. 3).[390] 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.

383 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.
384 ECtHR. De Donder and de Clippel v. Belgium. App. No. 8595/06. December 6, 2011.
385 ECtHR. Ashingdane v. The United Kingdom. App. No. 8225/78. May 28, 1995.
386 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).
387 ECtHR. X v. The United Kingdom. App. No. 7215/75. July 7, 1977.
388 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).
389 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.
390 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.

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, four conditions must be satisfied:

(1) It must be reliably established through objective medical expertise that the person has a mental disorder;
(2) 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;
(3) The mental disorder must persist throughout the period of detention or confinement; and
(4) The period of confinement must also be under periodic review. [391]

Any detention must be "lawful"—it must be conducted according to a law with adequate substantive and procedural safeguards.[392] 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 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.[393]

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.[394] 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."[395]

***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.[396]

391 ECtHR. Winterwerp v. Netherlands. App. No. 6301/73. October 24, 1979; ECtHR. Stanev v. Bulgaria. App. No. 23419/07. November 22, 2012.
392 See ECtHR. Stanev v. Bulgaria (36760/06). January 17, 2012.
393 ECtHR. De Donder and De Clippel v. Belgium. App. No. 8595/06. June 12, 2011. para. 106.
394 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.
395 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).
396 ECtHR. Herz v. Germany. App. No. 44672/98. December 3, 2003.

***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.[397]

***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.[398]

***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.[399]

***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.[400]

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.[401]

According to the ECtHR, the essential criteria for lawfully detaining an individual "for the prevention of the spreading of infectious diseases" are:

(1)The spread of the infectious disease poses a danger to public health or safety;
(2)It is the least restrictive way of preventing the spread of the disease to safeguard the public interest; and
(3)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.[402]

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.

397 ECtHR. H.L. v. The United Kingdom. App. No. 45508/99. January 5, 2005.
398 ECtHR. Shopov v. Bulgaria. App. No. 11373/04. December 2, 2010.
399 ECtHR. Storck v. Germany. App. No. 61603/00. September 16, 2005.
400 ECtHR. X. v. Finland. App. No. 34806/04. November 19, 2012.
401 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).
402 ECtHR. Enhorn v. Sweden. App. No. 56529/00. January 25, 2005. para. 43.

CASE RELATING TO INFECTIOUS DISEASES AND THE 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.[403]

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.[404] 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.[405]

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).[406] 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).[407]

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).

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.[408]

403 ECtHR. Enhorn v. Sweden. App. No. 56529/00. January 25, 2005.
404 See Rebecca Cook. International Human Rights and Women's Reproductive Health. Studies in Family Planning, Vol. 24, No. 2 (March-April, 1993). p. 79.
405 ECtHR. P. and S. v. Poland. App. No. 57375/08. January 30, 2013.
406 European Commission. Communication from the Commission to the European Parliament and the Council: Towards the elimination of female genital mutilation. November 25, 2013.
407 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.
408 ECtHR. P. and S. v. Poland. App. No. 57375/08. January 30, 2013.

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 life[409] and has used the right to privacy to protect the individual from medical treatment or examination without her/his informed consent.[410] 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.[411]

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."[412] 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.[413]

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
- Is necessary in a democratic society and proportionate to the legitimate aim pursued.[414]

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."[415]

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.

409 ECtHR. Y.F. v. Turkey. App. No. 24209/94. October 22, 3003.
410 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).
411 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.
412 ECtHR. M.S. v. Sweden. App. No. 20837/92. August 27, 1997; ECtHR. Z v. Finland. App. No. 22009/93. February 25, 1997.
413 ECtHR. Z v. Finland. App. No. 22009/93. February 25, 1997.
414 ECtHR. L.L. v France. App. No. 7508/02. October 10, 2006; ECtHR. X. v. Finland. App. No. 34806/04. November 19, 2012.
415 ECtHR. L.L. v France. App. No. 7508/02. October 10, 2006.

- **COE Recommendation No. R (2004) 10**[416]
  - **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 Data**[417]
  - **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.
- **Declaration on the Promotion of Patients' Rights in Europe**[418]

  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**[419]
  - **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.

416 COE. Recommendation Rec No. R (2004) 10. September 22, 2002.
417 COE. Convention for the Protection of Individuals with Regard to Automatic Processing of Personal Data. January 28, 1981.
418 WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.
419 Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.

- **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**[420]
  - **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."[421] 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.[422] 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."[423] However, when determining someone's mental health status, authorities enjoy a wide margin of appreciation,[424] which will be evaluated based on "the degree of interference" in the patient's life and the "quality of the decision-making process."[425] Should the interference with the individual's private life be disproportionate to the legitimate aims of the government,[426] or should the decision-making process employed by the State be flawed[427] (including failure by the State to periodically re-access the individual's condition[428]), 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.[429]

***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.[430]

***Shtukaturov 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.[431]

420 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.
421 ECtHR. A.G. v. Switzerland. App. No. 28605/95. April 9, 1997.
422 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.
423 ECtHR. Shtukaturov v. Russia. App. No. 44009/05. June 27, 2008. para. 87
424 ECtHR. Shtukaturov v. Russia. App. No. 44009/05. June 27, 2008.
425 ECtHR. Shtukaturov v. Russia. App. No. 44009/05. June 27, 2008.
426 ECtHR. Shtukaturov v. Russia. App. No. 44009/05. June 27, 2008.
427 ECtHR. Salontaji-Drobnjak v. Serbia. App. No. 36500/05. January 13, 2010.
428 ECtHR. Lashin v. Russia. App. No. 33117/02. April 22, 2013; see ECtHR. Salontaji-Drobnjak v. Serbia. App. No. 36500/05. January 13, 2010.
429 ECtHR. Lashin v. Russia. App. No. 33117/02. April 22, 2013.
430 ECtHR. Salontaji-Drobnjak v. Serbia. App. No. 36500/05. January 13, 2010.
431 ECtHR. Shtukaturov v. Russia. App. No. 44009/05. June 27, 2008.

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.432 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.[433]

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.[434]

***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—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.[435]

***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.[436]

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 testing[437] and the health of their fetus[438]) or seek access to their medical records.[439] In fact, States have a positive obligation under Article 8 to ensure that individuals have meaningful access to their own medical records.[440] 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.[441]

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

432 ECtHR. Z v. Finland. App. No. 22009/93. February 25, 1997.
433 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.
434 ECtHR. Biriuk v. Lithuania. App. No. 23373/03. February 25, 2009; ECtHR. Armoniene v. Lithuania. App. No. 36919/02. February 25, 2009.
435 ECtHR. Colak and Tsakiridis v. Germany. App. No. 77144/01 and 35493/05. June 5, 2009.
436 ECtHR. Mitkus v. Latvia. App. No. 7259/03. January 2, 2013.
437 ECtHR. Tysiąc v. Poland. App. No. 5410/03. March 20, 2007.
438 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.
439 ECtHR. K.H. and Others v. Slovakia. App. No. 32881/04. April 28, 2009.
440 ECtHR. K.H. and Others v. Slovakia. App. No. 32881/04. April 28, 2009.
441 ECtHR. Open Door and Dublin Well Woman v. Ireland. App. No. 14234/88; 14235/88. October 29, 1992.

physical and mental integrity of the person, and decisions on whether to become a parent.[442]

In the context of abortion, the ECtHR has not interpreted Article 8 as conferring a right to abortion;[443] 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.[444] 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,[445] 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).[446] Medical procedures that limit a person's ability to conceive and bear children may be contrary to the right to privacy, including forced sterilization[447] and serious medical errors that deprive individuals of their reproductive capacity.[448] 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.[449]

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.[450]

***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.[451]

***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.[452]

***Tysiąc 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

442 ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010. para. 212.
443 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.
444 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.
445 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.
446 ECtHR. Evans v. The United Kingdom. App. No. 6339/05. April 10, 2007.
447 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.
448 ECtHR. Csoma v. Romania. App. No. 8759/05. January 15, 2013.
449 ECtHR. Dickson v. The United Kingdom. App. No. 44362/04. December 4, 2007.
450 ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010.
451 ECtHR. Costa and Pavan v. Italy. App. No. 54270/10. August 28, 2012.
452 ECtHR. Ternovsky v. Hungary. App. No. 67545/09. March 14, 2011.

effective mechanism that would determine her eligibility for a legal abortion was a violation of her right to privacy.[453]

***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.[454]

RIGHT OF ACCESS 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.[455] 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.[456] 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).[457]

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 Europe[458]**

  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[459]**
  - **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[460]**

453 ECtHR. Tysiąc v. Poland. App. No. 5410/03. September 24, 2007.
454 ECtHR. V.C. v. Slovakia. App. No. 18968/07. February 8, 2012.
455 ECtHR. Herczegfalvy v. Austria. App. No. 10533/83. September 24, 1992.
456 ECtHR. Guerra v. Italy. App. No. 14967/89. February 19, 1998.
457 ECtHR. Tysiąc v. Poland. App. No. 5410/03. March 20, 2007.
458 WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.
459 Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.
460 COE. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and

- **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 care**[461]
  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).

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.[462] 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.[463]

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.[464]

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.[465]

Medicine: Convention on Human Rights and Biomedicine. April 4, 1997.

461 COE. Recommendation Rec No. R (2000) 5. April 30, 2002.
462 ECtHR. Shopov v. Bulgaria. App. No. 11373/04. September 2, 2010.
463 ECtHR. Herczegfalvy v. Austria. App. No. 10533/83. September 24, 1992.
464 ECtHR. Lashin v. Russia. App. No. 33117/02. April 22, 2013.
465 ECtHR. Herczegfalvy v. Austria. App. No. 10533/83. September 24, 1992.

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.[466] 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 health[467] and the health of their unborn fetuses,[468] as well as the obligation to provide minors with access to information regarding abortion services.[469] This right includes information that is necessary to determine the legality of a woman's access to therapeutic abortion services.[470] 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.[471]

Furthermore, a government's efforts to prevent organizations from distributing information regarding the procurement of abortion services constitute a violation of this right.[472] 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.[473]

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.[474]

***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.[475]

***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.[476]

466 ECtHR. P. and S. v. Poland. App. No. 57375/08. January 30, 2013.
467 ECtHR. Tysiąc v. Poland. App. No. 5410/03. March 20, 2007.
468 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.
469 ECtHR. P. and S. v. Poland. App. No. 57375/08. January 30, 2013.
470 ECtHR. Tysiąc v. Poland. App. No. 5410/03. March 20, 2007.
471 ECtHR. V.C. v. Slovakia (, no. 18968/07).. February 8, 2012.
472 ECtHR. Open Door and Dublin Well Woman v. Ireland (, no. 14234/88; 14235/88).. October 29, 1992.
473 ECtHR. Open Door and Dublin Well Woman v. Ireland (, no. 14234/88; 14235/88).. October 29, 1992.
474 ECtHR. K.H. and Others v. Slovakia (, no. 32881/04). 6. November 6, 2009.
475 ECtHR. Open Door and Dublin Well Woman v. Ireland (, no. 14234/88; 14235/88). 29. October 29, 1992.
476 ECtHR. R.R. v. Poland (, no. 27617/04). 28. November 28, 2011.

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)[477] and the right to freedom from torture, cruel, inhuman or degrading treatment (ECHR, Art. 3).[478]

RELEVANT PROVISIONS

- **ECHR**
  - **Art. 3:** No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
  - **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**[479]
  - **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**[480]
  - **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 Europe**[481]

  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.

477 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.
478 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.
479 Official Journal of the European Communities. Charter of Fundamental Rights of the European Union. OJ C 364/01. December 7, 2000.
480 COE. Recommendation Rec No. R (2004) 10. September 22, 2002.
481 WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

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' Rights**[482]
  - **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.
  - **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**[483]
  - **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 Stork 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.[484]

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

482 Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.
483 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.
484 ECtHR. Storck v. Germany. App. No. 61603/00. September 16, 2005.

without appropriate psychiatric treatment had diminished his human dignity.[485]

***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.[486]

***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.[487]

***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.[488]

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.[489]

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

485 ECtHR. M.S. v. The United Kingdom. App. No. 24527/08. August 3, 2012.
486 ECtHR. Shopov v. Bulgaria. App. No. 11373/04. December 2, 2010.
487 ECtHR. Storck v. Germany. App. No. 61603/00. September 16, 2005.
488 ECtHR. X. v. Finland. App. No. 34806/04. November 19, 2012.
489 ECtHR. Enhorn v. Sweden. App. No. 56529/00. January 25, 2005.

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).[490] 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).[491]

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.[492]

***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.[493]

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.[494] 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.[495] 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.[496] 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

490 European Commission. Communication from the Commission to the European Parliament and the Council: Towards the elimination of female genital mutilation. November 25, 2013.

491 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.

492 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.

493 ECtHR. V.C. v. Slovakia. App. No. 18968/07. February 8, 2012.

494 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).

495 See ECtHR. Nitecki v. Poland. App. No. 65653/01. March 21, 2002; ECtHR. Erikson v. Italy. App. No. 37900/97. October 26, 1999.

496 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).

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."[497] 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.[498] 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"[499] – 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.[500] Moreover, to date, there have been only a few substantive decisions on euthanasia.[501]

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.[502] 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."[503]

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.[504]

***Reynolds v. United Kingdom* (ECtHR)(2012).** Upon admission, a voluntary psychiatric patient suffering from

497 ECtHR. Wiater v. Poland. App. No. 42990/08. May 15, 2012. para 34 .
498 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).
499 ECtHR. Cyprus v. Turkey. App. No. 25781/94. May 10, 2001.
500 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).
501 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.
502 ECtHR. Keenan v. The United Kingdom. App. No. 27229/95. April 3, 2001.
503 ECtHR. Keenan v. The United Kingdom. App. No. 27229/95. April 3, 2001.
504 ECtHR. Çoşelav v. Turkey. App. No. 1413/07. March 18, 2013.

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.[505]

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.[506] 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.[507]

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.[508]

***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. [509]

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.[510] 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.[511] 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.[512]

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 woman following a cesarean was found to be a violation of the right to life, holding that a "prompt examination

505 ECtHR. Reynolds v. The United Kingdom. App. No. 2694/08. June 13, 2012.
506 ECtHR. Salakhov and Islyamova v. Ukraine. App. No. 28005/08. March 14, 2013.
507 ECtHR. Salakhov and Islyamova v. Ukraine. App. No. 28005/08. March 14, 2013.
508 ECtHR. Oyal v. Turkey. App. No. 4864/05. June 23, 2010.
509 ECtHR. Salakhov and Islyamova v. Ukraine. App. No. 28005/08. March 14, 2013.
510 ECtHR. Evans v. The United Kingdom. App. No. 6339/05. April 10, 2007.
511 ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010.
512 ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010.

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."[513]

***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.[514]

***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.[515]

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.[516] 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 date[517]—only one of which falls into one of the contexts examined throughout this guide, namely sexual and reproductive health.[518] 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.[519] 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.[520] 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.[521] 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.[522] Accordingly, the conditions of stay in hospitals, including psychiatric

513 ECtHR. Byrzykowski v. Poland. App. No. 11562/05. September 27, 2006.
514 ECtHR. Evans v. The United Kingdom. App. No. 6339/05. April 10, 2007.
515 ECtHR. Vo v. France. App. No. 53924/00. July 8, 2004.
516 ECtHR. Hurtado v. Switzerland. App. No. 17549/90. January 28, 1994; ECtHR. Ilhan v. Turkey. App. No. 22277/93. June 27, 2000.
517 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.
518 ESCR. International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia, Collective Complaint No. 45/2007. March 30/, 2009.
519 COE. Conclusions of the European Committee of Social Rights. (XVII -2); Conclusions 2005. Statement of interpretation of Article 11.
520 COE. Conclusions: Denmark. (XV-2).
521 COE. Conclusions: United Kingdom. (XV-2).
522 COE. Conclusions: Denmark. (XV-2).

hospitals, must be satisfactory and compatible with human dignity.[523]

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.[524]

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**[525]
  - **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.
- **Declaration on the Promotion of Patients' Rights in Europe**[526]

  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

523 COE. Conclusions of the European Committee of Social Rights. (XVII -2); Conclusions 2005. Statement of interpretation of Article 11; Conclusions 2005: Romania.

524 COE. The Right to Health and the European Social Charter.

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

526 WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

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**[527]
  - **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.

Right to the 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.[528] This education should be available in schools throughout the school year. [529] 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."[530]

CASE RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO THE 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.[531]

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."[532] It cannot be interpreted in absolute terms

527 Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.
528 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.
529 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.
530 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.
531 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).
532 ECtHR. Hagyó V. Hungary. App. No. 52624/10. April 23, 2013. para. 39.

and the "ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3."[533] 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."[534] Examples of breaches of Article 3 in the context of patient care include: the continued detention of a cancer sufferer, causing „particularly acute hardship;"[535] significant defects in the medical care provided to a mentally ill prisoner known to be a suicide risk;[536] and systematic failings in relation to the death of a heroin addict in prison.[537]

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."[538] 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.[539] 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.[540] 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.[541]

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.[542] 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.[543] 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.[544]

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."[545]

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 fulfill their obligations under Article 3. Therefore, proof of the actual effects of the conditions of detention may not be a major factor.[546]

533 ECtHR. Hagyó V. Hungary. App. No. 52624/10. April 23, 2013. para. 40.
534 ECtHR. Hagyó V. Hungary. App. No. 52624/10. April 23, 2013. para. 40.
535 ESCR. Mouisel v. France. Application No. 67263/01. November 14, 2002. (finding the detention amounted to inhuman and degrading treatment).
536 ECtHR. Keenan v. The United Kingdom. App. No. 27229/95. March 4, 2001. (finding failure to refer to psychiatrist and lack of medical notes).
537 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).
538 ECtHR. Tanko v. Finland. App. No. 23634/94. May 19, 1994.
539 ECtHR. Wedler v. Poland. App. No. 44115/98. April 16, 2007; see ESCR. Mouisel v. France. App. No. 67263/01. November 14, 2002.
540 ECtHR. Hummatov v. Azerbaijan. App. No. 9852/03; 13413/04. November 29, 2007; ECtHR. Malenko v. Ukraine. App. No. 18660/03. February 19, 2009.
541 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.
542 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.
543 ECtHR. Hurtado v. Switzerland. App. No. 17549/90. January 28, 1994; ECtHR. Ilhan v. Turkey. App. No. 22277/93. June 27, 2000.
544 ECtHR. Khudobin v. Russia. App. No. 59696/00. January 26, 2007.
545 ESCR. Mouisel v. France. App. No. 67263/01. November 14, 2002.
546 ECtHR. Keenan v. The United Kingdom. App. No. 27229/95. April 3, 2001. (the treatment of a mentally ill person may be incom-

Experimental medical treatment may amount to inhuman treatment in the absence of consent,[547] 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.[548] In such cases, however, the necessity must be „convincingly shown," and appropriate procedural 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.[549]

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 detention[550] and that the diagnoses and care are prompt and accurate.[551] 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.[552] Contradictions in medical records have been held to amount to a breach of Article 3.[553]

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.[554] The CPT has emphasized the impact of overcrowding on prisoners' health.[555] 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.[556]

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**[557]

  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.

patible 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).

547 ECtHR. X v. Denmark. App. No. 9974/82. March 2, 1983.

548 ECtHR. Jalloh v. Germany. App. No. 54810/00. July 11, 2006.

549 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).

550 ECtHR. Khudobin v. Russia. App. No. 59696/00. January 26, 2007.

551 ECtHR. Aleksanyan v. Russia. App. No. 46468/06. June 5, 2009.

552 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.

553 ECtHR. Radu v. Romania. App. No. 34022/05. October 3, 2012.

554 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.

555 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.

556 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.

557 WHO. Declaration on the Promotion of Patients' Rights in Europe. June 28, 1994.

- **European Charter of Patients' Rights**[558]
  - **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.

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."[559] 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.[560] 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.[561] 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.[562]

The State is also responsible for providing humane conditions in relation to detention, including adequate temperature control, food, and sanitary conditions.[563] The Court has found degrading treatment in violation of Article 3 in cases where living conditions in institutions housing mental health patients are insufficient.[564] Insufficient living conditions may include the failure on the part of the State to provide adequate food, heat, clothing, sanitary conditions and health services.[565] 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.[566]

CASES RELATING TO MENTAL HEALTH AND THE RIGHT TO FREEDOM FROM TORTURE AND CRUEL, INHUMAN AND 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.[567]

***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

558 Active Citizenship Network (ACN). European Charter of Patients' Rights. November 2002.
559 ECtHR. M.S. v. The United Kingdom. App. No. 24527/08. August 3, 2012.
560 ECtHR. M.S. v. The United Kingdom. App. No. 24527/08. August 3, 2012.
561 ECtHR. Renolde v. France. App. No. 5608/05. January 16, 2009.
562 ECtHR. Renolde v. France. App. No. 5608/05. January 16, 2009.
563 ECtHR. Stanev v. Bulgaria. App. No. 36760/06. January 17, 2012.
564 ECtHR. Stanev v. Bulgaria. App. No. 36760/06. January 17, 2012.
565 ECtHR. Stanev v. Bulgaria. App. No. 36760/06. January 17, 2012.
566 ECtHR. Stanev v. Bulgaria. App. No. 36760/06. January 17, 2012.
567 ECtHR. Claes v. Belgium. App. No. 43418/09. April 10, 2013.

compatible with the standard of treatment required in respect to a person suffering from mental illness.[568]

***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.[569]

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.[570] This right can be implicated when people living with HIV in prisons or detention centers are denied treatment.[571] 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.[572] 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.[573] 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.[574]

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 antiviral 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.[575]

***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.[576]

***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

568 ECtHR. Keenan v. The United Kingdom. App. No. 27229/95. April 3, 2001.
569 ECtHR. M.S. v. The United Kingdom. App. No. 24527/08. August 3, 2012.
570 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.
571 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).
572 ECtHR. McGlinchey and Ors v. The United Kingdom. App. No. 50390/99. July 29, 2003.
573 ECtHR. Sarban v. Moldova. App. No. 3456/05. January 4, 2006.
574 ECtHR. Hummatov v. Azerbaijan. App. No. 9852/03; 13413/04. Novemer 29, 2007.
575 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.
576 ECtHR. Khudobin v. Russia. App. No. 59696/00. January 26, 2007.

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.[577]

***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.[578]

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 vulnerability[579] 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.[580] Additionally, the Court has repeatedly recognized that forced sterilization constitutes humiliating and degrading treatment.[581] 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.[582]

CASES RELATING TO SEXUAL AND REPRODUCTIVE HEALTH AND THE RIGHT TO FREEDOM FROM TORTURE AND CRUEL, INHUMAN AND 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.[583]

***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.[584]

***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.[585]

RIGHT TO PARTICIPATION IN PUBLIC POLICY

577 ECtHR. Logvinenko v. Ukraine. App. No. 13448/07. January 14, 2011.
578 ECtHR. Vasyukov v. Russia. App. No. 2974/05. September 15, 2011.
579 ECtHR. R.R. v. Poland. App. No. 27617/04. May 26, 2011.
580 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.
581 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.
582 ECtHR. Collins and Akaziebie v. Sweeden. App. No. 23944/05. March 8, 2007.
583 ECtHR. Aden Ahmed v. Malta. App. No. 55352/12. July 23, 2013. paras. 97-100.
584 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.
585 ECtHR. V.C. v. Slovakia. App. No. 18968/07. February 8, 2012.

The right to participation in public policy has been treated as an underlying determinant of health;[586] 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.[587] 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.

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).[588]

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 care[589]

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 society[590]

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.

586 Halabi, Sam. Participation and the right to health: lessons from Indonesia. Health and Human Rights Journal, Vol. 11, No. 1. P, 2009. p. 51 .

587 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.

588 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.

589 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.

590 COE. Committee of Ministers Recommendation No. R (2006) 18. November 8, 2006.

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.

Ljubljana Charter on Reforming Health Care[591]

- **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.[592] 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. [593] The legal capacity of the patient is based upon official decisions.[594]

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.[595] 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."[596]

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.[597]

591 World Health Organization [WHO]. Ljubljana Charter on Reforming Health Care. June 19, 1996.
592 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.
593 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.
594 ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.
595 ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.
596 ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.
597 ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.

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.[598] 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.

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.[599]

RIGHT TO EQUALITY AND FREEDOM FROM DISCRIMINATION

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."[600] 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),[601] Article 14 is not a stand-alone provision—it must be argued in conjunction with one of the substantive provisions of the ECHR.[602] 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.[603] 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."[604] In this directive, Article 2(2) defines "direct discrimination" as

598 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.
599 CRF and UNFPA. Briefing Paper: The Right to Contraceptive Information and Services for Women and Adolescents. December 2010. p. 24.
600 COE. Conclusions: Portugal. (XVII -2).
601 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.
602 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.
603 Interights. Non-Discrimination in International Law: A Handbook for Practitioners. 2011. 18.
604 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).

"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 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.[605] For a more discussion on the issue, refer to Interights' "Non-Discrimination in International Law: A Handbook for Practitioners."[606]

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.607 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;

605 ECtHR. Hugh Jordan v. The United Kingdom App. No. 24726/94. May 4, 2001. para. 154.
606 Interights. Non-Discrimination in International Law: A Handbook for Practitioners. 2011.
607 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.

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[608]

- **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.[609] As such, the State enjoys a lower margin of appreciation when restricting the rights of vulnerable populations that have been subject to

608 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.
609 ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.

discrimination, such as mental health patients.[610]

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.[611]

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.[612] Where States afford differential treatment based on health status, the state has the obligation to provide a "particularly compelling justification."[613]

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.[614]

610 ECtHR. Alajos Kiss v. Hungary. App. No. 38832/06. August 20, 2010.
611 ECtHR. X. and Y. v. The Netherlands. App. No. 8978/80. 26 . March 26, 1985.
612 ECtHR. Kiyutin v. Russia. App. No. 2700/10. September 15, 2011. para. 57.
613 ECtHR. Kiyutin v. Russia. App. No. 2700/10. September 15, 2011. para. 65.
614 ECtHR. Kiyutin v. Russia. App. No. 2700/10. September 15, 2011.

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)[615] and Article 8 (right to respect for private and family life).[616]

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.[617]

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.[618] 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.[619] 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.[620] 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.[621]

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.[622] The remedy must be effective both in practice and in law, meaning that there must not be undue interference by State authorities.[623] The Court has explained, however, that the effectiveness of the remedy cannot depend on "the certainty of a favourable outcome" for the victim.[624]

Victims' ability to access courts is of critical importance to effectively exercise this right.[625] 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.[626]

615 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.
616 ECtHR. A, B and C v. Ireland. App. No. 25579/05. December 16, 2010.
617 ECtHR. E.B. v. France. App. No. 43546/02. January 22, 2008.
618 ECtHR. Hagyó V. Hungary. App. No. 52624/10. April 23, 2013. para. 96.
619 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.
620 ECtHR. Aksoy v. Turkey. App. No. 26211/06. January 12, 2011. para. 98.
621 ECtHR. Klass v. Germany. App. No. 5029/71. September 6, 1978.
622 ECtHR. Kudla v. Poland. App. No. 30210/96. para. 151.
623 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.
624 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.
625 ECtHR. Kudla v. Poland. App. No. 30210/96. October 26, 2000. paras. 147-148, 157.
626 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:
  4. to remove as far as possible the causes of ill-health;
  5. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
  6. 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:
  5. 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;
  6. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
  7. 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;
  8. 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:
  4. 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;

5. 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;
6. 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**[627]
  - **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 Efffective 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."[628]

CASE 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.[629]

***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.[630]

***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.[631]

627 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.
628 ECtHR. B. v. Romania (No. 2). App. No. 1285/03. February 19, 2013. para. 79.
629 ECtHR. B. v. Romania (No. 2). App. No. 1285/03. February 19, 2013.
630 ECtHR. Lashin v. Russia. App. No. 33117/02. April 22, 2013.
631 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.[632]

CASE RELATING TO INFECTIOUS DISEASES AND THE RIGHT TO 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.[633]

***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.[634]

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.[635]

CASE 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.[636]

632 See ECtHR. Logvinenko v. Ukraine. App. No. 13448/07. October 14, 2010; ECtHR. Kozhokar V. Russia. App. No. 33099/08. December 16, 2010.
633 ECtHR. Kozhokar v. Russia. App. No. 33099/08. December 16, 2010.
634 ECtHR. Logvinenko v. Ukraine. App. No. 13448/07. October 14, 2010.
635 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.
636 ECtHR. R.R. v. Poland. App. No. 27617/04. November 28, 2011.

***Tysiąc 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.[637]

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.

RIGHT TO WORK IN DECENT CONDITIONS

The European Committee of Social Rights (ESCR) 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.[638] 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.[639] While not analyzed under the right to work, the ECtHR found a violation under Article 8 (right to privacy) and Article 14 (freedom from discrimination) where an employee was dismissed based on his HIV status.[640] The right to equal opportunities and equal treatment in matters

637 ECtHR. Tysiąc v. Poland. App. No. 5410/03. September 24, 2007.
638 Conclusions are drawn from the Digest of September 2008, by the COE; ECSR. Conclusions XVI-1, Austria, p. 25.
639 COE. Conclusions: Iceland. (XVI-1).
640 ECtHR. I.B. v. Greece. App. No. 552/10. October 3, 2013.

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,[641] 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.[642] 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.[643] 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.[644]

Under EU law, Directive 2000/78/EC of 27 November 2000645 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.[646] 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.[647] 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.[648]

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." [649] 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.[650] Also, this right ensures that women and men are entitled to have "equal pay for work of equal value."[651] Accordingly, domestic law must provide for appropriate and effective remedies in the event of alleged wage discrimination.[652] Anyone who suffers wage discrimination on grounds of sex must be entitled to adequate compensation, sufficient to make good the damage suffered by the

641 COE. Conclusions of the European Committee of Social Rights. Conclusions (II and XVI-1). Statements of interpretation of Article 1§2.
642 David Harris et al. Law of the European Convention on Human Rights. Oxford: Oxford University Press, 2009. p. 607.
643 COE. Conclusions: Iceland. (XVI-1).
644 COE. Conclusions 2006: Albania.
645 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.
646 COE. Conclusions I. Statement of Interpretation on Article 2§1.
647 ECSR. Confédération Française de l'Encadrement CFE-CGC v. France. Collective Complaint No. 16/2003. October 12, 2004.
648 COE. Conclusions. (XIV-2). Statement of Interpretation on Article 2(1).
649 Conclusions 2003, France, p. 120
650 COE. Conclusions I. Statement of Interpretation on Article 4§2.
651 COE. Conclusions: Slovak Republic. (XV-2, addendum).
652 COE. Conclusions I. Statement of Interpretation on Article 4§3.

victim and to act as a deterrent to the offender.[653]

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.).[654] Under this right, workers, all workplaces, and all sectors of activity must be covered by occupational health and safety regulations.[655] 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).[656] The right applies to both the public and private sectors.[657]

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.
- **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;

653 COE. Conclusions. (XIII -5). Statement of Interpretation on Article 1 of the Additional Protocol.
654 COE. Conclusions 2005: Lithuania.
655 COE. Conclusions 2005: Estonia.
656 COE. Conclusions 2003: Bulgaria. p. 31.
657 COE. Conclusions II. Statement of Interpretation on Article 3.

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.[658]

***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."[659]

***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.[660]

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.[661] It also includes the freedom not to join an association or trade union.[662]

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."[663]

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.[664]

658 ESCR. Confédération Française de l'Encadrement CFE-CGC v. France. Collective Complaint No. 16/2003. October 12, 2004.
659 ESCR. Marangopoulos Foundation for Human Rights (MFHR) v. Greece. Collective Complaint No. 30/2005. December 6, 2006. §224 .
660 ESCR. Syndicat national des Professions du Tourisme v. France. Collective Complaint No. 6/1999. October 10, 2000. para. 32.
661 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).
662 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.
663 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".
664 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.

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.[665]

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.[666] Under this right, any form of compulsory trade union membership imposed by law is incompatible with the provisions of this right.[667] 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).[668] 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.[669]

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.[670] Under this right, trade unions and employers' organizations must be independent from excessive State interference in relation to their infrastructure or effective functioning.[671]

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

665 ECtHR. Albert and Le Compte v. Belgium. App. No. 7299/75; 7496/76. February 10, 1983.
666 COE. Conclusions I. Statement of Interpretation on Article 5.
667 COE. Conclusions III . Statement of Interpretation on Article 5.
668 COE. Conclusions VIII . Statement of Interpretation on Article 5.
669 COE. Conclusions: Denmark. (XV-1).
670 COE. Conclusions 2004: Bulgaria.
671 COE. Conclusions: Germany. (XII -2).

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.[672] 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.[673] 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.
- **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

672 COE. Conclusions: United Kingdom. (XV-1).

673 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.

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**[674]
  - **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.

CASE 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).[675]

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.[676]

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.[677]

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.

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

675 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.

676 ECtHR. Enerji Yapi-Yol Sen v. Turkey. App. No. 68959/01. April 21, 2009.

677 ECtHR. Unison v. The United Kingdom. App. No. 53574/99. January 10, 2002.

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.678 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.[679]

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.[680] 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.[681]

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).[682]

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.[683] Under this right, all procedures, including judicial and nonjudicial,

678 ECtHR. Ringeisen v. Austria. App. No. 2614/65. July 16, 1971.
679 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.
680 ECtHR. Fischer v. Austria. App. No. 33382/96. January 17, 2002.
681 ECtHR. Dombo Beheer BV v. The Netherlands. App. No. 14448/88. October 27, 1993.
682 ECtHR. Konig v. Germany. App. No. 6232/73. June 28, 1978.
683 ECtHR. Klass v. Germany. App. No. 5029/71. September 6, 1978.

will be examined.[684] 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.[685] 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.[686]

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.

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.[687]

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.[688] 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 voluntary waived.[689] 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.[690]

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.

684 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.
685 ECtHR. Aksoy v. Turkey. App. No. 219987/93. December 18, 1996.
686 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.
687 ECtHR. Aksoy v. Turkey. App. No. 26211/06. January 12, 2011. para. 98.
688 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).
689 ECtHR. Von Hannover v. Germany. App. No. 40660/08; 60641/08. February 7, 2012.
690 ECtHR. Von Hannover v. Germany. App. No. 40660/08; 60641/08. February 7, 2012. paras. 98-99.

- **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.

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.[691] 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.[692]

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.'"[693]

691 ECtHR. Guerra and Ors v. Italy. App. No. 14967/89. February 19, 1998.
692 ECtHR. Yankov v. Bulgaria. App. No. 39084/97. March 11, 2004.
693 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.[694]

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.

694 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,[695] 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.

695 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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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-relates 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 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 members 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, cooperatives, 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.

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UN 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/AdvisoryCommittee/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"696 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

696 Human Rights Complaint Procedure (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.

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 Rights[697]

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.

697 Based on *Reported Killing as Human Rights Violations* by Kate Thompson and Camille Giffard (published by the Human Rights Centre, University of Essex).

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)
- 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.[698] These are known as "minor complaints."

WHAT SHOULD YOUR APPLICATION CONTAIN?

Your initial letter should contain:

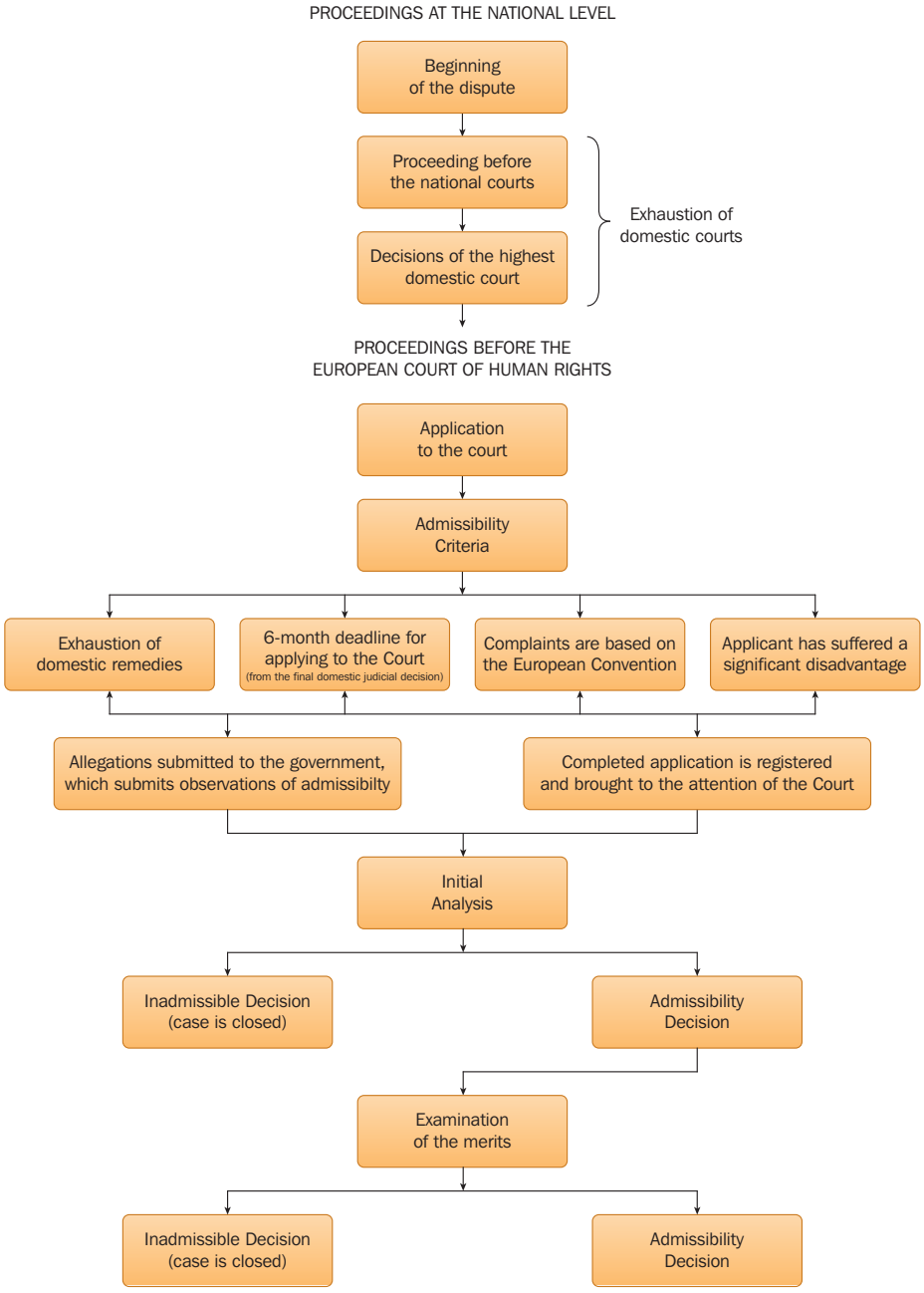
- A brief summary of your complaints;
- An indication of which rights in the ECHR you think have been violated;
- An indication of the domestic remedies you have used or attempted to use; and

698 Article 12 of Protocol 14 of the ECHR, amending article 35 of the ECHR.

- 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=).

Table: Basic Chronology of the Individual Complaint Procedure of the European Court of Human Rights[699]



699 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).

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.

- **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 Regional Law

5.2. Status of Precedent

5.3 Legal and Health Systems

5.3.1 Legal System

5.3.1.1 Classification of Juridical Norms Depending on their Legal Power

5.3.1.2 Judicial System Organisation

5.3.2 Health System

5.3.2.1 Levels of Organization

5.3.2.2. Main Health Care Services Providers

5

Country-Specific Notes

5.1 Status of International and Regional Law

The 1991 Romanian Constitution provides and guarantees a series of fundamental rights, including the right to protection of health, measures to ensure public hygiene and health, organization and structure of the medical care and social insurance system, and control over medical professionals and paramedical activities, along with other measures as determined by law (Article 34)[700]. However, in the Constitution, the right to the protection of health is phrased in a general manner, as it is usually the case with constitutional rights; thus, it is important to define and interpret this right using both national and international instruments. An overview is provided in this section with regards to the international human rights instruments signed and ratified by Romania.

- **The relationship between national and international law is set out in the Romanian Constitution of 1991, revised in 2003, in Article 11, as follows:**

  (1) The Romanian State pledges to fulfill as such and in good faith its obligations as deriving from the treaties to which it is a party.

  (2) Treaties ratified by Parliament, according to the law, are part of national law.

  (3) If a treaty to which Romania is to become a party comprises provisions contrary to the Constitution, its ratification shall only take place after the revision of the Constitution.

Thus, an international instrument becomes binding on the Romanian State only after it is signed and ratified by Parliament. According to legislative procedure, an international instrument is ratified through a law adopted by Parliament, and this is the reason why human rights treaties or protocols appear in the Romanian legal framework under two titles – their original international title and the number of the law through which they were ratified[701].

700 Romanian Constitution of 1991, revised in 2003 Art. 34:
(1) The right to the protection of health is guaranteed.
(2) The State shall be bound to take measures to ensure public hygiene and health.
(3) The organization of the medical care and social security system in case of sickness, accidents, maternity and recovery, the control over the exercise of medical professions and paramedical activities, as well as other measures to protect physical and mental health of a person shall be established according to the law.

701 For example, the European Convention of Human Rights was ratified by Parliament through Law no. 30/1994.

From the point of view of the legal interpretation technique applicable in the Romanian legal framework, some further explanations are required. Specifically, the Constitution provides guidance on how the national law must be interpreted in relation to international law. Article 20, paras. (1) and (2) contain two of the most important texts regarding the status of international law in the Romanian legal framework.

- **The Romanian Constituion of 1991, revised in 2003, Article 20**

  (1) Constitutional provisions concerning the citizens' rights and liberties shall be interpreted and enforced in conformity with the Universal Declaration of Human Rights, with the covenants and other treaties to which Romania is a party.

  (2) Where any inconsistencies exist between the covenants and treaties on the fundamental human rights to which Romania is a party, and the national laws, the international regulations shall take precedence, unless the Constitution or national laws comprise more favourable provisions.

As Romania signed and ratified almost all UN human rights treaties (some optional protocols to conventions have not been ratified, for example), it results that Constitutional provisions on fundamental rights, including those on the right to health, shall be interpreted and enforced in conformity with these international covenants. Where inconsistencies exist, the international regulations shall take precedence as provided by **Article 20** of the Constitution. However, if the Constitution or national laws are more favourable to the person from the standpoint of human rights protection as opposed to the international instruments, then the former take precedence. Consequently, if there is a difference in treatment between the national and the international framework, the most favourable provision shall be applied.

International/United Nations level

Romania has the Constitutional duty to implement in good faith all the international legal commitments undertaken. Thus, in assessing Romanian legislation and in developing new policies in relation to the right to health and human rights in patient care, due consideration should be given not only to the text of the treaty itself, but also to the relevant comments and recommendations formulated in relation to Romania by the different UN treaty monitoring bodies and by UN Special Rapporteurs (more importantly the Special Rapporteur on the Right to Health).[702] Such comments and recommendations shed light on the degree to which Romania has fulfilled its international obligations and indicate steps which Romania is required to take in order to comply with the international human rights standards. For instance, in the report issued by the UN Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Paul Hunt underlined the following challenges facing Romania in the area of health standards: "effective implementation (of health legislation); low budgetary allocations in health; corruption; weak participation of civil society in health-related decision-making processes; and accountability."[703]

European Region/Council of Europe level

Given that Romania signed and ratified the European Convention on Human Rights (the Convention) in the year 1994, the developing jurisprudence of the European Court of Human Rights (ECtHR) can be directly invoked before the national courts. Through its ratification by the Parliament, the Convention is part of the national law, and since the role of the ECtHR jurisprudence is to interpret the text of the Convention, it results that such interpretation is also binding upon national judges.

The ECtHR has approached the area of health and healthcare in its jurisprudence, interpreting the application of the Convention in these domains.[704] Notably, cases in which the ECtHR ruled against Romania included

702 As an example, for a compilation of all relevant recommendations in the area of reproductive health see: http://www.ecpi.ro/wp-content/uploads/2011/12/UN_Recommendations_to_Romania_SRHR_2.pdf.

703 Report of the Special Rapporteur on his mission to Romania, 21 February 2005, E/CN.4/2005/51/Add.4 available at: http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/111/56/PDF/G0511156.pdf?OpenElement.

704 For example, a series of ECtHR factsheets of judgments issued in the area of health can be consulted here: http://www.echr.coe.

cases regarding: violations of **Article 2** following the refusal of the public health authorities to provide medical assistance to a cancer patient, the failure of the authorities to provide the necessary medical treatment for inmates, or inadequacy of rules on forensic medical reports for cases of death while hospitalized; violations of **Article 3** due to inadequate medical treatment, particularly in case of inmates; violations of **Article 5** in case of illegal confinement based on the investigators' doubts as to the mental health of the applicant; and violations of **Article 8** in relation to malpractice leading to infertility, involuntary confinement of the applicant and placement in care of her children. In terms of execution of judgments, besides the payment of the damages and the possibility of improving the legislative framework, the ECtHR decisions also allow for reopening the cases as a part of both civil and criminal special procedures.[705]

Here is a brief list and description of some of the ECtHR cases decided against Romania which are relevant for human rights in patient care:

- *Ştefan Panaitescu v. Romania* (2012) – Article 2 violation following refusal to provide medical assistance to a person suffering of kidney cancer
- *Gagiu v. Romania* (2009) – Article 2 violation in the case of a detainee who did not receive the needed medical treatment
- *Eugenia Lazăr v. Romania* (2010) – Article 2 violation due to inadequate inquiry based on existing rules of forensics
- *Iacov Stanciu v. Romania* (2008) – Article 3 violation due to inadequate medical treatment
- *Rupa v. Romania* (2008) – Article 3 violation due to lack of appropriate medical attention in view of the applicant's vulnerable psychological state
- *C.B. v. Romania* (2010) - Article 5 § 1 (e) violation given the applicant's confinement in the context of proceedings brought against him by a policeman for bringing malicious accusations (confinement based on the investigators' doubts as to the applicant's mental health and on a medical certificate by a general practitioner who had never seen him; no alternative measure examined; use of force during arrest)
- *Csoma v. Romania* (2013) – Article 8 violation – in a malpractice case leading to sterility
- *Grand Chamber decision in Center of Legal Resources on behalf of Valentin Câmpeanu v. Romania* (2014) – Article 2 and 13 violations, in case of death in a psychiatric hospital of a young man of Roma origin who was HIV positive and suffering from a severe mental disability
- *B. v. Romania (2)* (2013) – Article 8 violation on account of the applicant's admissions to psychiatric institutions

Also, within the Council of Europe, Romania signed and ratified in 1995 the Revised European Social Charter. However, there is no ratification of the Additional Protocol providing for a system of collective complaints based on the Charter. The 2013 report of the European Committee of Social Rights included a section on the right to the protection of health (**Article 11** of the Charter) and the right to social and medical assistance (**Article 13** of the Charter).[706] Since there is no access to the collective complaints procedure, the role of the Committee with concern to Romania is limited to engaging in a dialogue with the authorities in order to reach conclusions ruling on the status of the Romanian State's conformity with the Revised European Social Charter. For instance, in its 2013 Conclusions on Article 11 of the Revised Charter- Right to Protection of Health, the Committee found that measures taken by Romania to reduce infant and maternal mortality rates have been insufficient and that counseling and screening for pregnant women and children are insufficient – both issues representing grounds of non-compliance with the Charter.[707]

int/Pages/home.aspx?p=press/factsheets&c=#n1347890855564_pointer

705 See Art.509, para.(1), pt.10 of the Romanian Civil Procedure Code and Art.465 of the Romanian Criminal Procedure Code.

706 European Committee of Social Rights, Conclusions 2013 (Romania), Articles 3, 11, 12 and 13 of the Revised Charter, 2013 available at: http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/State/Romania2013_en.pdf. See also 12th National Report on the implementation of the European Social Charter submitted by the Government of Romania (Articles 3, 11, 12 and 13 for the period 01/01/2008 – 31/12/2011).

707 European Committee of Social Rights, Conclusions 2013 (Romania), Articles 3, 11, 12 and 13 of the Revised Charter, 2013 available at: http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/State/Romania2013_en.pdf.

European Union level

As Romania became a Member State of the European Union in 2007, the EU legal framework, including the jurisprudence of the Court of Justice of the European Union, became applicable to the Romanian context, which led to the gradual harmonization of the domestic legal framework with the EU standards on public health as set in Article 168 of the Treaty on the Functioning of the European Union.[708]

So far, based on the interpretation given by the Court of Justice of the European Union regarding the four fundamental freedoms[709], including the freedom of movement of patients, the EU developed jurisprudence and legislation on cross-border healthcare. This is the case of Directive 2011/24/EU on patients' rights in cross-border healthcare, which Member States had until 25 October 2013 to transpose in their legislation. Romania transposed the Directive 2011/24/EU on 29 January 2014 through the adoption of Emergency Government Ordinance no.2/2014.

The main topics of interest for EU public health policies include: access to information on the right of EU citizens to receive healthcare anywhere in the EU, and on the quality and safety of the care received; the right to be reimbursed some or all costs for any treatment received in another EU country to which a person would have been entitled at home; the possibility to process prescriptions abroad so that a person can obtain abroad the medication needed; and the right to non-discrimination in access to health services.

Also relevant for the Romanian legal framework is Article 35 of the EU Charter of Fundamental Rights which provides for a right to health protection as 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". Furthermore, Article 35 of the Charter specifies that the Union must guarantee "a high level of protection of human health," meaning health as both an individual and social good, as well as health care. This formula sets a guiding standard for the national governments of Member States.[710]

5.2 Status of Precedent

The Romanian legal system belongs to the civil law legal systems, in which only the Constitution and other statutory legislation constitute legitimate sources of law. Thus, the Romanian legal system does not recognize judicial precedent or case law as a source of law. However, for the purposes of maintaining legal certainty and achieving uniformity, consistent and constant jurisprudence of the higher courts becomes relevant in the judgments of lower courts. The High Court of Cassation and Justice can use the institution of "**recourse in the interest of law**," oftentimes phrased as methodological guidance, in order to ensure **uniform interpretation and application of the law by the other courts**.

An exception from this rule consists in the relevance of the case law of the European Court of Human Rights and of the Court of Justice of the European Union. Though, in theory, the case law of these two European courts should inform and influence the reasoning of the Romanian courts, it is a rather gradual process for the judges to endorse and apply as sources of law the interpretation of the European Convention by the ECtHR or of *the acquis* by the CJEU.

708 In the European Union, the organisation and delivery of healthcare represent the responsibility of the individual member states. However, the EU develops specific actions which complement national policies and are designed to help countries achieve common objectives in certain areas of health (disease prevention, healthier lifestyles and well-being, cross-border health threats, access to healthcare, health information and education, patient safety, health systems and technologies, quality, and safety standards in re human organs, medicinal products and devices for medical use). For more information, please see the European Commission, Public Health – Improving Health for All EU Citizens, available at: http://europa.eu/pol/pdf/flipbook/en/public_health_en.pdf.

709 These are the free movement of goods, the free movement of services, the free movement of persons and the free movement of capital.

710 See EU Network of Independent Experts on Fundamental Rights, *Commentary of the Charter of Fundamental Rights of the European Union*, document available at: http://ec.europa.eu/justice/fundamental-rights/files/networkcommentaryfinal_en.pdf.

5.3 Legal and Health Systems

5.3.1 Legal System

The structure of the Romanian Legal System is based on the Romano-Germanic Legal System, which is also referred to as the continental legal system. The basis of this system is given by the juridical norm, being the main legal source, the jurisprudence of the Romanian courts having, at most, an indicative value for the judicial system. Therefore, as noted above, in Romania there is no legal precedent such as that found in the Anglo–Saxon legal system.

5.3.1.1 Classification of Juridical Norms Depending on their Legal Power

A. CONSTITUTIONAL NORMS

The Romanian Constitution of 1991, reviewed in 2003, is the main legal source, all other norms being aligned with its provisions. The Constitutional norms regulate the form of government, citizenship, civil rights and freedoms, citizens' fundamental duties, state powers and their (legislative, executive and judicial) exercise and mutual control. The Constitution also regulates the operating principles of the judicial authority, the Constitutional Court and the central and local public administration. The Parliament is defined by the Romanian Constitution within Article 61 Paragraph 1, as the sole law-making authority of the country.

Normative acts which have the power of law:

B. ORGANIC LAWS

Organic laws regulate areas of the social relationships which are deemed by the Constitution to be of high importance. Organic laws must be adopted by the Parliament with a majority of the members of the relevant Chamber.

Comment for jurists:

For this Practitioner Guide, the fact that Law no. 95/2006 on healthcare reform is an organic law is important. Responsibility for its adoption was assumed by the Government, before the Parliament, as a major healthcare policy.

C. ORDINARY LAWS

Ordinary laws are adopted by the Parliament with the majority of the present members.

D. DECREES AND GOVERNMENT EMERGENCY ORDINANCES

These normative acts have the legal power of a law. The decrees are issued by the Government under an empowerment law passed by the Parliament, as a general rule, for when the Parliament is on holiday. The

emergency ordinances may be adopted only in extraordinary situations and must provide the reason for the emergency, regardless of whether there is a parliamentary holiday or not, entering into force only after they are submitted for debate in the Parliament after their publication in the Official Gazette. The civil rights and freedoms provided for in the Constitution cannot be subject to the regulation of an emergency ordinance.

Normative acts with lower legal power/ secondary normative acts:

E. GOVERNMENT DECISIONS ISSUED FOR THE ORGANISATION OF LAW ENFORCEMENT

F. ORDERS AND INSTRUCTIONS ISSUED BY THE SPECIALISED CENTRAL PUBLIC ADMINISTRATION BODIES (MINISTRIES) OR AUTONOMOUS ADMINISTRATIVE AUTHORITIES FOR LAW ENFORCEMENT

All normative acts, either main or secondary, shall be published in the Official Gazette of Romania.

A way of unifying the juridical norms which refer to a certain matter is the adoption of Codes. Romania has recently adopted new Codes in civil[711], civil procedural[712], criminal[713] and criminal procedural[714] matters. They represent the general law in civil and criminal matters.

5.3.1.2 Judicial System Organisation

In the Romanian Judicial System (see Figure 1), justice is administered by the High Court of Cassation and Justice and the other courts[715], which form the judiciary power. Prosecutors are established in public prosecutors' offices operating within the law courts. All public prosecutors' offices collectively constitute the Public Ministry. The prosecutors' role is important because, beyond criminal prosecution, the Public Ministry represents the general interests of the society and the civil rights and freedoms. In particular, the prosecutor defends the interests of minors and persons who are considered by the law as lacking the legal capacity to exercise their rights. While judges are independent and are subject only to the law[716], prosecutors carry out their activity according to the principles of legality, impartiality and hierarchical control under the authority of the Minister of Justice[717]. Both their duties and disciplinary measures are managed by the Superior Council of Magistracy.

The general competences of the law courts and public prosecutors' offices attached to them are established in the Code of Civil Procedure and the Code of Criminal Procedure. As regards the organisation of the law courts, they are composed of civil and criminal divisions and, starting with tribunals, administrative divisions, labour and social security dispute divisions and civil divisions for minors and family are added. The new Codes introduce in Romania two levels of jurisdiction, the first instance and the appeal, the recourse being an extraordinary means of appeal. Both in civil and criminal matters, the general rule is that the appeal judgments are final and enforceable.

711 Law no. 287/2009 on the New Civil Code and Law no. 71/2011 for the application of the New Civil Code
712 Law no. 134/2010 on the New Code of Civil Procedure and Law no. 76/2012 for the application of the New Code of Civil Procedure
713 Law no. 287/2009 on the New Criminal Code and Law no. 187/2012 for the application of the New Criminal Code
714 Law no. 135/2010 on the New Code of Criminal Procedure and Law no. 255/2013 for the application of the New Code of Criminal Procedure
715 Article 126 paragraph (1), Romanian Constitution
716 Article 124 paragraph (3), Romanian Constitution
717 Articles 131 and 132, Romanian Constitution

Figure 1. Juridical System Organization

LAW COURTS	PUBLIC PROSECUTORS' OFFFICES
High Court of Cassation and Justice	Public Prosecutor's Office attached to the High Court of Cassation and Justice
15 Courts of Appeal	15 Public Prosecutors Offices attached to the Courts of Appeal
42 Tribunals and 4 Specialised Tribunals (1 Tribunal for Minors and Family and 3 Commercial Tribunals)	42 Public Prosecutors' Offices attached to the Tribunals
188 District Courts	188 Public Prosecutors' Offices attached to District Courts

5.3.2 Health System

Since 1998 Romania has a social health insurance system. This was introduced by the Law no. 145 of 24 July 1997. This was replaced by the Law no. 95 of 14 April 2006 that included multiple subsequent modifications and additions. According to its type, the health system in Romania is predominantly financed from the Unique National Health Insurance Fund (UNHIF) constituted in principal from contributions paid in different percentages by the insured and their employers, or fully paid by the insured or by other sources (i.e. the social security budget pays the unemployed contributions). Other sources of financing are: the state budget, the local budgets, direct payments, external sources. The fundamental principles of the social health insurance system are: mandatory contribution, solidarity and subsidiarity in fund constitution and administration, and autonomy in fund administration.

5.3.2.1 Levels of Organization

The health system in Romania is organized on two levels: national and local ("judeţean").

A. NATIONAL

The main institutions of the national level are (see Figure 2): the Ministry of Health, the National Health Insurance House and the professional organizations (the College of Physicians of Romania, the College of Dentists of Romania, the College of Pharmacists of Romania, the Order of Nurses and Midwives of Romania, the Order of Biochemists, Biologists and Chemists). The Ministry of Health represents the central administrative authority, having as its main roles: policy and strategy development, regulation, planning, coordination and evaluation. The National Health Insurance House administers the Unique National Health Insurance Fund, having the responsibility of ensuring that, in exchange for the paid contributions, the insured population receives the needed healthcare services, in accordance with the standards and terms established by law. The professional organizations have as their main activity the control and supervision of the practicing of respective professions, application of legislation and regulations that organize and regulate the practicing of the professions and representation of respective professions' interests. The institutions from the national level take common actions in the view of attaining the objectives of the national health policies and programmes. They also collaborate in establishing the conditions of providing health care within the social health insurance system, set in the Framework Contract. This document is developed by the National Health Insurance House, based on consultations with professional organizations and other stakeholders; and after being agreed by the

718 The Military Court of Appeal is not subject to this study, but only the civil law courts
719 The Territorial Military Tribunals are not subject to this study

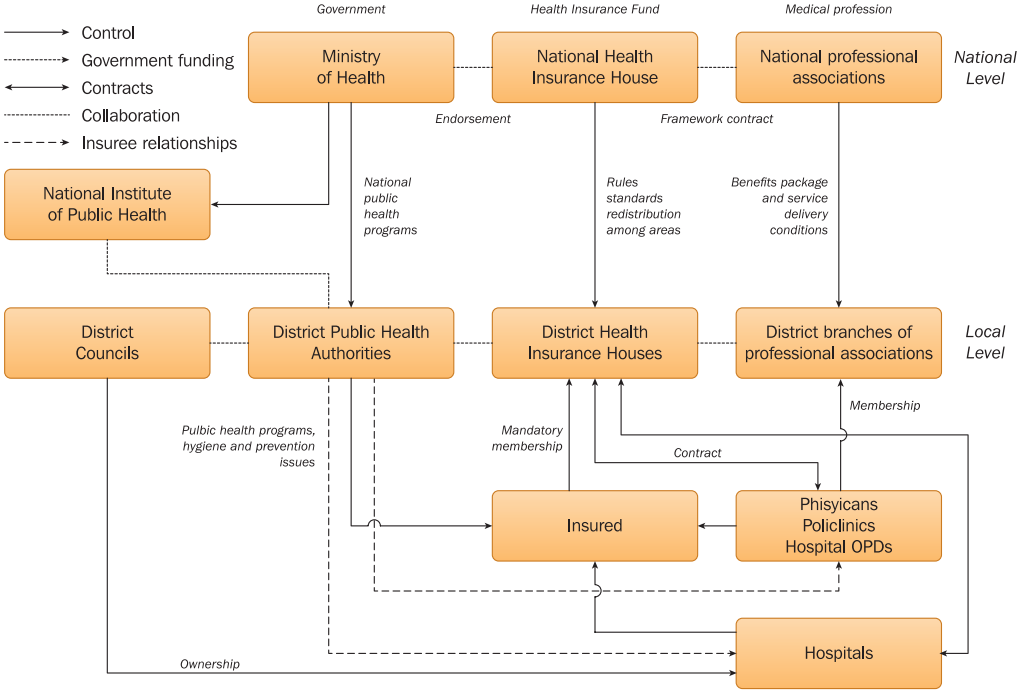
Ministry of Health, it is approved by Governmental Decision.

Also at national level, the National Institute for Public Health is the technical body of the Ministry of Health. Its main roles include roles in evaluation of population health, monitoring and control of diseases, development of regulation proposals in the field of public health, development of norms and methodologies and provision of technical assistance for the whole public health network. Six regional centres for public health coordinate the field activities of the Institute.

B. LOCAL

The representatives of the central institutions in the districts (*judeţe* in Romanian) constitute the local level of the health system. Thus, the Ministry of Health is represented at the local level by the district public health authorities – deconcentrated public services that apply locally the national health policies and programmes, identify priority public health problems at the local level, develop and implement local public health activities and verify the compliance with the public health regulations, and in case of nonconformity, they apply legal measures. The district health insurance houses and the health insurance house for people working in military, police and intelligence structures and the juridical system represent structures subordinated to the National Health Insurance House. The main attributions of the district health insurance houses are to collect contributions from people who pay insurance contributions directly (the other contributions being collected by the National Agency of Fiscal Administration of the Ministry of Finance), to conclude contracts with health care services providers, to keep the records of the insured and to monitor contract implementation. Each national professional organization has local branches that fulfil the organization's attributions at the local level. Beginning with assumption of control of hospitals in 2010, local authorities have increasing levels of involvement in the health system. The district councils have special commissions dealing with health problems in the district. Starting with 2010, local health authorities have taken over some attributions and competencies in the health area from the Ministry of Health, including the management and administration of 373 out of 435 hospitals.

Figure 2. Organizational Chart of the Statutory Health System



Source: Vlădescu C, Scîntee G, Olsavszky V, Allin S and Mladovsky P. Romania: Health system review. Health Systems in Transition, 2008; 10(3): 1-172.

5.3.2.2 Main Health Care Services Providers

Family physicians' practices. Family physicians are independent professionals who provide primary health care services on the basis of contracts signed between the medical practice and the district health insurance house. They represent the "gate" of the health system (the "gatekeepers"), the access to the other services being permitted on the family physician referral, excepting the cases of emergency, regular check-ups in certain chronic conditions or private services with direct payment. They practice in independent offices in solo practices, in associations of several family physicians, or as part of an outpatient clinic that has both primary care and specialists (secondary care) offices

Specialists' offices. Specialist physicians are also independent professionals, working in individual offices or associated into societies, or in the offices organized in the hospitals, providing ambulatory specialized clinical or laboratory health services.

Institutions providing inpatient healthcare (hospitals, sanatoria, preventoriums, etc.). They provide continuous or discontinuous inpatient care, being public institutions, subordinates of the local public administration or of the Ministry of Health or other ministries, or private institutions.*(Author's note: As mentioned above, most hospitals also have outpatient / ambulatory care departments; personnel are paid separately and they have separate contracts with the health insurance houses.)*

Healthcare providers offer services to the patients on the basis of the contract signed with the district health insurance house. There are specific benefit packages for each level of care (primary , ambulatory, inpatient, etc.) that are laid down in the norms of application of the Framework Contract that are periodically approved by common order of the President of the National Health Insurance House and the Minister of Health. The Framework Contracts are approved by a Government Decision. There are also different packages in accordance with the insured status of the patient: a basic package for the insured and a minimal package for the uninsured patients. Healthcare providers can also charge direct payments or can provide services within the health programme financed by the Ministry of Health.

6.1 PATIENTS' RIGHTS

6.1.1 Right to Preventive Measures

6.1.2. Right of Access

6.1.3. Right to Information

6.1.4 Right to Consent

6.1.5 Right to Free Choice

6.1.6. Right to Privacy and Confidentiality

6.1.7 Right to Respect for Patients' Time

6.1.8 Right to Observance of Quality Standards

6.1.9 Right to Safety

6.1.10. Right to Innovation

6.1.11 Right to Avoid Suffering and Unnecessary Pain

6.1.12 Right to Personalized Treatment

6.1.13 Right to Complain

6.1.14. Right to Compensation

6.1.15 Additional Patients' Rights in Romania

6.2 PATIENT RESPONSIBILITIES

6.2.1 Patient Responsibilities towards One's Own Health Status

6.2.2 Patient Responsibilities towards the Protection of Public Health

6.2.3 Patient Responsibilities towards the Health System

6

National Patients' Rights and Responsibilities

6.1 Patients' Rights

6.1.1 Right to Preventive Measures

A) RIGHT TO PREVENTIVE MEASURES AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR):

Every individual has the right to a proper service in order to prevent illness.

The health services staff has the duty to pursue this end by raising people's awareness, guaranteeing health procedures at regular intervals free of charge for various groups of the population at risk, and making the results of scientific research and technological innovation available to all.

B) RIGHT TO PREVENTIVE MEASURES AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003**[720]

  The right to preventive measures is mentioned indirectly in the Constitution of Romania by both **Article 34** that refers to the right to health care, including the right to physical and mental health protection measures, and **Article 35** that stipulates *the right to a healthy environment*, which represents a measure for preventing diseases.

720 The Romanian Constitution of 1993, revised in 2003, re-published in the Official Gazette no. 767 of 31 October 2003.

Legislation

Law no. 95/2006 on the Health Reform, republished in 2015

From the outset, Law no. 95/2006 on the health reform states prevention of disease as one of the purposes of public health assistance (**Article 2, para.2**). Further on, the Law covers the right to preventive measures in Title I and Title II. In **Title I - Public Health**, disease prevention and control is mentioned by **Article 5, pt. d** and **i** as part of the main functions of public health.

- In addition, **Article 5** states other main functions of public health which can be interpreted as preventive measures, such as developing *policies, strategies and programs aimed at ensuring public health* (pt.a), *monitoring and analysing the health status of the population* (pt.b), *planning in public health* (pt.c), *epidemiological surveillance, prevention and control of diseases* (pt.d), *public health regulation and controlling the application of those regulations* (pt.f), *researching, developing and implementing innovative solutions for public health* (pt.h), *prevention of outbreaks, including the declaring of outbreak alert* (lit.i), *protecting the population against environmental risks* (pt.j), *informing, educating and communicating for the promotion of health* (pt.k), *mobilizing community partners in identifying and resolving health problems* (pt.l), *ensuring the capacity of reaction to disasters and to the threats against population life and health …* (pt.p). The phrasing of the aforementioned points in Law no. 95/2006 reveals that, in order to properly exercise these functions, the State must take specific actions before the occurrence of public health problems, which qualifies these actions as preventive measures for the purpose of this Guide.
- A preventive approach can also be found in the phrasing of the basic principles of public health care, listed in **Article 7** of Law no. 95/2006. Such principles refer to focusing on primary prevention (pt.b) and the more explicit and relevant rule of making *in specific conditions, decisions based on according to the principle of precaution* (pt. g).

Title II – *National Health Programmes* of Law no. 95/2006 regulates the design and implementation of preventive national health programmes. According to the law, *a national health program package* is defined thus:

- **Article 48, para. 1, pt. a:** (…) *the group of multi-annual actions oriented towards the main areas of intervention in public health assistance;*

The main areas of intervention in public health assistance, relevant to the right to preventive measures, are:

- **Article 48, para. 2, pt. a:** *prevention, surveillance and control of transmissible and non-transmissible illnesses, monitoring the health status of the population, promoting health and a healthy lifestyle, monitoring the determinant factors in life and work;*

The responsibility to elaborate the National Health Programs belongs to the Ministry of Health, through a designated specialty structure. The aforementioned structure collaborates with the National Health Insurance House, other authorities, institutions and non-governmental organisations.

One type of essential medical services which can be performed in the family physicians' offices can be seen as falling in the preventive measures category:

- **Article 80, para. (2), pt. d:** *preventive medical services such as: immunisations, monitoring the evolution of pregnancy and post-partum health status, active identification of the risk of illness for illnesses selected according to scientific proof, active medical surveillance of adults and children who are asymptomatic, have normal risk or high risk, on gender and age groups.*

Preventive medical services are also part of the medical activity of out-patient health care providers:

- **Article 134:** *The objectives of out-patient medical assistance are: a) providing preventive services (…)*

Hospitals have also duties in the area of preventive medical care:

- **Article 163, para. 4:** *Medical services provided by the hospital can be preventive (…)*
- **Article 166, para. 1:** *The hospital ensures the conditions for (…) the prevention of hospital-acquired infections (…)*
- **Article 166, para. 2:** *The hospital is liable, according to law (…) for respecting the conditions of the prevention of hospital-acquired infections (…)*

The law provides that preventive medical services are part of the types of services covered by the Unique National Social Health Insurance Fund, either referring to primary prevention (**Article 235**) or secondary and tertiary prevention (**Article 236**):

- **Article 235:** *For the purpose of preventing disease, of early identification of illnesses and maintaining health, the ensured, directly or through service providers which have a contractual agreement with the health insurance houses, shall be permanently informed by the health insurance houses about the means of maintaining the health, reducing and avoiding the causes of illnesses and about the dangers posed by the use of drugs, tobacco and alcohol.*
- **Article 236:** *Insured persons have the right to medical services for (…) prevention of disease complications, rehabilitation (…), as the case.*

Law no. 268/2013 on the approval of the Emergency Ordinance no. 40/2013 for the financing of the National Institute for Research and Development in Microbiology and Immunology „Cantacuzino" in the view of the implementation of the National Intervention Plan for prevention of population mass diseases through epidemics and pandemics

Law no. 268/2013 completes the Emergency Ordinance 40/2013 and provides that *for the protection and improvement of the health state of the population, some specific activities in the area of health can be defined as services of general economic interest and approved through Government Decision. The performance of such services is assigned to the institutions under the coordination or under the authority of the Ministry of Health.*

Law no. 584/2002 on the measures for preventing the spread of AIDS in Romania and for protection of persons infected with HIV or having AIDS

Law no. 585/2002 regulates the main directions and sets the necessary measures for preventing the transmission of HIV infection and for efficient control of AIDS disease, and also for the special protection of the persons affected by this disease.

Law no. 319/2006 on the health and safety at work

The law of health and safety at work has the purpose of preventing diseases and accidents through the adoption of measures for eliminating the risk factors from the work environment and through information and education of workers. The obligation of ensuring workers' health and safety, in all aspects related to work, rests with the employer.

- **Article 25, para. 2:** *The surveillance of the workers' health is ensured through the occupational medicine physicians*. The occupational medicine physician, or any other physician in a contractual relationship with the employer, has the obligation to notify the district health authority of any suspicion of occupational disease or disease related to the occupation, detected during the occasion of medical services provided, in accordance with **Article 27, paras. 2 and 3**.
- **Article 46, para. 2** sets the attributions of the Ministry of Health in the field of health workers at work.

Law no. 123/2008 on healthy eating in the pre-university educational units

This law contains provisions on the prevention of the diseases caused by unhealthy eating and it applies to the children and school communities. According to this law the Ministry of Health establishes and updates the list of non-recommended food for pre-school and school children, taking into account the recommendations of the nutrition specialists. As well, the Ministry of Health through the State

Sanitary Inspectorate has the role of detecting the violations and the application of the sanctions set by this law.

- **Law no. 458/2002 on the quality of the drinking water, amended and supplemented by Government Ordinance no. 11/2010**

  Law 458/2002 regulates the quality of drinking water, having as objective the protection of population health against the effects of contaminated water, through ensuring quality, clean and sanogenous water. To this end, the law establishes specific attributions for the Ministry of Health and its subordinate institutions (district public health authorities, National Institute of Public Health, regional centres of public health) with regards to the ensuring and monitoring of the drinking water quality, including information and reporting. For technical norms regarding the drinking water quality, see Government Decision no. 974/2004 on the approval of the Norms for surveillance, sanitary inspection and monitoring of the drinking water quality, and of the Procedures for sanitary authorization of the drinking water production and distribution.

- **Law no. 104/2011 on the quality of air**

  Law no. 104/2011 establishes the attributions and responsibilities of the Ministry of Health and its territorial structures in the prevention of diseases caused by the air pollution (**Article 14**). These include: elaboration of strategies for prevention of the diseases caused by air pollution, elaboration of the methodologies for the evaluation of the risks on population health, risk evaluation, air quality monitoring, elaboration of norms and regulations on air quality, proposals for preventive measures, informing of population on the air quality- related health risks, and reporting to the international specialized bodies.

- **Law no. 349/2002 on the prevention and control of the effects of tobacco consumption, modified by Government Ordinance no. 5/2008**

  This law establishes certain measures regarding the prevention and control of the tobacco products consumption, through the smoking restriction in the closed public places, the inscription of tobacco products' packages, developing population information and education campaigns, with the purpose of protecting the health of smokers and non-smokers from the harmful effects of tobacco smoke. Law no. 439/2002 transposes Directive 2001/37/CE of the European Parliament and of the Council of 5 June 2001 on the approximation of the laws, regulations, and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products.

- **Law no. 457/2004 on the advertising and sponsorship of tobacco products, modified by Government Ordinance no. 6/2008**

  Law no. 457/2004 establishes measures regarding the advertising of tobacco products, as well the promoting of these products in the mass media and other written publications, in radio broadcasted shows, through services of informational society and the sponsorship in the tobacco field, including the free distribution of tobacco products, with the purpose of preventing the tobacco products' consumption. The current law transposes the Directive 2003/33/EC of the European Parliament and of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products. For regulations regarding measures to discourage the use of tobacco, see also the Order of the Ministry of Health no. 764/2004 on the approval of the norms regarding the use of colour photographs or other illustrations as health warnings on tobacco packages.

- **Law no. 487/2002 on mental health and protection of the persons with psychical disorders**

  - **Article 2:** *The Government of Romania, through its authorized bodies, takes measures for the promotion and protection of mental health, prevention and treatment of psychical disorders.*
  - **Article 4:** *The Ministry of Health elaborates The National Programme for Mental Health and prophylaxis of the psychiatric pathology, in accordance with the health requirements of the*

population.

The entire **Chapter II** of this law is dedicated to the mental health promotion and protection and prevention of psychiatric disorders. The main central public authority responsible for preventive measures in the area of mental health is the Ministry of Health, according to the law.

- **Government Ordinance no. 53/2000 on the compulsory reporting of diseases and compulsory vaccination, with subsequent modifications and integrations**

  Government Ordinance no. 53/2000 states measures regarding the disease reporting (who reports to whom, sanctions for not reporting), children's immunization (immunization registry, immunization personal book), and reporting of immunization completion, including the vaccination schedule.

- **Emergency Ordinance no. 61/2006[721] on the modification and supplementing of the Emergency Ordinance no. 78/2000 on the waste regime**

  Article 40 of the Emergency Ordinance no. 61/2006 provides responsibilities to the Ministry of Health in the field of waste administration to avoid effects of waste on the population health. The main attributions of the Ministry of Health are: to evaluate the impact of the waste on the population health, to elaborate the strategy and the programme for sanitary waste disposal, to elaborate specific regulations and to control the waste management activities, to ensure funds to the district public health authorities and to the Bucharest public health authority for the monitoring of sanitary waste management activities and to the medical units for the waste disposal.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Government Decision no. 400/2014 on the approval of the package of services and the Framework Contract on the conditions of health care provision within the social health insurance system for the years 2014 - 2015**

  The conditions of providing health care within the social health insurance system are stated in a Framework Contract approved periodically (annually or every two years) by a Governmental Decision. Usually, the Framework-Contracts provide rights of insured population as well as rights and duties of health care providers, including provisions on preventive measures.

- **Government Decision no. 206/2015 on the approval of the national health programmes for the years 2015 and 2016**

  Based on the law 95/2006, the Government approves periodically the national health programmes, while the technical norms for their implementation are approved by a Ministry of Health Order. The preventive health programmes implemented in 2015 and 2016 include the following: National programmes for communicable diseases, National programmes for monitoring of the environmental and occupational determinants of health, National programme for blood transfusion safety, National programmes for non-communicable diseases, and others. Since the national health programs are frequently subject to change, preventive measures should be searched for in the program which is applicable and in force in the respective year.

- **Government Decision no. 355/2007 on the surveillance of the workers' health**

  This Decision establishes the prophylactic medical services that the employer has to ensure for its workers to avoid the workers contracting occupational diseases caused by noxious chemical, physical, physico-chemical or biological agents, typical to the working environment, as well as avoiding the

721 This Emergency Ordinance transposes into the national legislation the Council Directive 75/442/EEC of 15 July 1975 on waste, published in the Official Journal of the European Communities no. L 194 from 25 July 1975, the Council Directive 91/689/EEC of 12 December 1991 on hazardous waste, published in the Official Journal of the European Communities no. L 377 from 31 December 1991, and the Directive 2006/12/CE of the European Parliament and of the Council of 5 April 2006 on waste, published in the Official Journal of the European Communities no. L 114/9 from 27 April 2006.

overloading of certain organs or systems of the body during the working process.

- **Government Decision no. 589/2007 on the establishment of the methodology for reporting and collecting data for the communicable diseases surveillance**

  Government Decision no. 589/2007 supports the implementation of the early warning system and rapid response that contributes to the prevention and control of communicable diseases, establishing the reporting requirements for different diseases and informational flow of data.

- **Order of the Ministry of Health and Family no. 141/2002 on the reorganization of the national network for surveillance and control of the communicable diseases**

  Order no. 141/2002 approves the reorganization of the national network for surveillance and control of communicable diseases, in the view of participation at the European Community network for epidemiological surveillance and control of communicable diseases, established by the Decision no. 2.119/98/EC and the subsequent regulations. The order establishes the attributions and responsibilities of the institutions and units included in the national network for surveillance and control of the communicable diseases.

- **Order of the Ministry of Health no. 860/2004 on the approval of the priority communicable diseases list for Romania**

  Order no. 860/2004 establishes the communicable diseases for which there are established methodologies for surveillance and reporting. The General Department of Public Health has the duty to elaborate the methodologies for surveillance and reporting of the diseases listed in the Order. For a better understanding of the diseases listed in the Order, see Order of the Ministry of Health no. 1163/2003 on the approval of the case definitions used in the national system for surveillance and control of communicable diseases

- **Government Decision no. 2108/2004 on the approval of the Implementing Regulation of Law no. 584/2002 regarding the measures for preventing the spread of AIDS in Romania and for protection of persons infected with HIV or having AIDS**

  Decision no. 2108/2004 sets the institutions with responsibilities in the field of HIV/AIDS prevention and control, as well as the measures necessary to be adopted for preventing the spread of AIDS and for protection of persons infected with HIV or having AIDS.

- **Order of the Ministry of Health no. 1611/2004 on the approval of the informational flow and the forms for reporting and surveillance of HIV/AIDS**

  Order no. 1611/2004 defines the informational flow in the surveillance of HIV/AIDS, and establishes the format of the forms for reporting the suspected cases of HIV/AIDS and the form for surveillance of HIV/AIDS.

- **Order of the Ministry of Health no. 1070/2004 on the approval of the programme for the surveillance and control of the sexually transmitted infections (STIs)**

  Order no. 1070/2004 provides measures for surveillance and control of syphilis, gonorrhoea, and Chlamydia trachomatis infection, including: sexually transmitted infections diagnostic and treatment guideline, specific attributions and tasks for medical units and medical personnel involved in surveillance and control of sexually transmitted diseases, the informational system for the sexually transmitted diseases and the forms used by it, the measures for epidemiological surveillance through laboratory and clinical medical exams for the general population and the populations at risk, and the surveillance systems for congenital syphilis.

- **Order of the Ministry of Health no. 824/2006 on the approval of the norms for the organization and functioning of the State Sanitary Inspection**

  The Order no. 824/2006 regulates the sanitary inspection activity that has as its main purpose

the identification of public health risks and their reduction or elimination. The norms regarding the organization and functioning of the State Sanitary Inspection defines the sanitary inspection activities, the involved institutions, their responsibilities and attributions, the inspection methods and procedures.

- **Government Decision no. 546/2008 on the quality management of water designated for bathing**

  This Decision regulates the conservation, the protection and improvement of the quality of the environment and the protection of the health of people, with relation to the surface waters used for bathing.

- **Order of the Ministry of Health no. 119/2014 on the approval of the norms for hygiene and public health in relation to the population life environment**

  The norms for hygiene and public health approved by the Ministry of Health are mandatory and apply to: living areas, water supply of localities, public and individual fountains used for drinking water supply, collection and discharge of used waters and meteoric waters, collection, disposal and treatment of solid waste, units for public use, biocide products and plant protection products used by the population, cemeteries administration, human crematoriums, inhumation, transport and exhumation of human dead bodies.

- **Order of the Ministry of Health no. 1955/1995 on the approval of the norms for hygiene in the care, education and training institutions for children and youth**

  The hygiene norms are compulsory for all institutions for care, education, training, rest and recreation of children and young adults, both public and private, and have the purpose of ensuring the hygiene conditions necessary for protection, preservation and promotion of their health status, their harmonious physical and psychical development and prevention of diseases.

- **Order of the Ministry of Health and Family no. 387/2002 on the approval of the norms for food with special nutritional purposes**

  The Order mainly regulates the composition and labelling of food products that meet special nutritional needs of certain categories (persons in special physiological conditions, babies, etc.), also called dietetic products.

- **Order of the Ministry of Health no. 1563/2008 on the approval of the list of food non-recommended for the pre-school and school children, and the principles at the base of healthy eating for children and teenagers**

- **Order of the Ministry of Public Health no. 341/2007 on the approval of the hygiene norms and the procedure for notification of the drinking bottled water, other than natural mineral waters or spring waters, commercialized as table water**

- **Order of the Ministry of Health no. 372/2006 on the norms for application of the Law no. 487/2002 on mental health and protection of the persons with psychical disorders, with subsequent modifications**

  Order no. 372/2006 establishes the public institutions authorized to take measures for mental health promotion and protection and prevention and treatment of psychiatric disorders.

  - **Article 2, para. 1:** *The Ministry of Health elaborates the action plan for mental health promotion and psychiatric diseases prevention in collaboration with the public institutions mentioned by Article 1, as well as with non-governmental organizations.*
  - **Article 3:** *Each institution mentioned at Article 1 elaborates and publishes on its own website an annual report on the activities undertaken for mental health promotion and psychiatric diseases prevention, together with the allocated budget.*

D) PROVIDER CODES OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**
  - **Article 21, para. 2:** *Professional behavior involves, without limitation, the doctor's constant and continuous concern for finding by any means, including through forms of medical education, the latest medical findings, methods and techniques that are learned and approved by the medical community.*
  - **Article 36:** *(1)* The doctor has the professional and legal obligation to care for the rules of hygiene and prevention. For this purpose, whenever he has the opportunity and if necessary, he will inform those persons about their duty towards themselves and to the community and collectivity. (2) The physician has the moral obligation to notify the competent authorities about any situation that is causing danger to public health.
- **Decision no. 2 of 9 July 2009 of the Order of Nurses and Midwives from Romania on the adoption of the Code of Ethics and Deontology of the Nurses and Midwives in Romania**
  - **Article 36:** *The general interest of the society (prevention and control of epidemics, of venereal diseases, of diseases with mass spreading potential and other similar situations provided by law) prevails over patient personal interest.*

E) OTHER RELEVANT SOURCES

Other relevant sources for legal provisions related to the patient's right to preventive measures were not identified.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

- **Example 1:**

  Heavy rains in 2012 caused flood in village M in district B. As a consequence, the District Public Health Authority provided family physician in M with 15 doses of vaccine against hepatitis A for children and 30 doses of anti-diphtero-tetanic vaccine for adults, in accordance with the population in the flooded area. The family physician reported the next day 8 children and 15 adults vaccinated with their voluntary consent. Since these are optional vaccines, the physician asked the priest to explain to the population that without vaccines they are at great risk of getting the diseases. In order to monitor the quality of water, representatives of the District Public Health Authorities periodically collected drinking water samples from the public fountains and sent them to the laboratory for analyses, until the area was cleaned. People also received advice from the community nurse who delivered a public conference at the village school and distributed leaflets on how to protect themselves against diseases in the given conditions: to use only bottled water for drinking, to use the water from fountains only for cooking and washing and only after boiling it, to eat only packaged /sealed or very well -cooked food, not to touch dead animals in the flooded areas but instead to call authorities to dispose of the dead animals' bodies, to avoid exposure to cold and humidity and to seek medical help immediately after the first signs or symptoms are experienced.

- **Example 2:**

  Each summer during the heat waves the Inspectorate for the Emergency Situations recommends to the population, through a press release, the following: to avoid sun exposure, to use UV protection products (hats, umbrellas, sunglasses, thin natural fabric white colours clothes), to drink up to 2-4

litres of liquids per day, to eat low fat food, to avoid coffee and alcohol, to take frequent moderate temperature showers, to avoid strenuous physical effort during the time of the day with maximum temperatures; and open air activity in sectors like agriculture, construction, or the activity on industrial sites where the appropriate microclimate cannot be ensured should be scheduled in the morning and in the evening.

The press release also mentions:

- the legislative provisions according to which the employers should adapt the working schedule and should provide sufficient quantities of mineral water for the workers exposed to high temperature;
- the recommendation to pay special attention to children and to permanently watch them. Thus, children should not be left in the car parked in direct sunlight, and they should not be taken for long distance rides in cars without air conditioning;
- that the elderly, especially those with cardiac and respiratory conditions, should avoid trips and crowded places during the high temperature;
- that the air conditioning devices should be set at no more than 5˚C less than the outside temperature.

As well, tents or shady areas are established in the cities for those who need to cool and rest, and first aid points are organized in the hospitals, dispensaries, medical practices, city halls, railway stations, central bus stations, market places, churches, pharmacies. These measures are taken every summer in the case of heat waves.

2. Examples of Violation

Example 1:

During June – August 2014, hundreds of newborns were not vaccinated free of charge against Hepatitis B in a Municipal Maternity Hospital. Despite the fact that according to the legislation the vaccination against Hepatitis B is done in the hospital free of charge, the vaccine was not available in the hospital, and mothers were asked to buy the vaccine from the outside hospital pharmacies for 100 lei. The mothers took the advice and bought the vaccine from pharmacies. By the end of August, because of unusual high demand, the pharmacies ran out of vaccine, and there was no other source for getting the vaccine. The situation was similar in other districts as well. The Ministry of Health had promised by the beginning of August to deliver to the district public health authorities in the country 50 thousand doses of vaccine, but at the end of the month the District Public Health Authority had not received any. However, it was reported in mass media in September 2014 that the Ministry of Health sent the vaccines.

Example 2:

One physician and two nurses were sanctioned by the Disciplinary Commission of an Infectious Diseases Hospital in the case of an HIV patient who, after blood collection, was sent with his/her own blood samples to a laboratory in the city because the hospital laboratory ran out of reagents. The patient used the urban transport buses, keeping in his/her hands the collection tubes with the infected blood. This decision attracted a very high risk of population contamination with the infected blood in the case of accident. The physician's right to practice was suspended for one year, following afterwards to be relocated to another department in the same hospital. The nurses were sanctioned by written warnings.

3. Actual Case

At the end of August 2008, following a road traffic accident, the patient O.I. was taken to the Emergency Hospital of Bacau District (EHBD), having multiple traumatic injuries: head, face, brain, chest, and both legs. The patient was admitted to the Orthopedic and Trauma Ward and had surgery the next day. The broken bones were fixed with a metal rod and screws and a plaster splint. Then he was transferred to the Intensive Care Unit for the pulmonary conditions caused by the chest injuries.

From there, on 1 September, he was transferred to the Lung Diseases Hospital Iasi, where he received medical care for the respiratory conditions. The deteriorated health status of the patient determined the referral to the Orthopedic Clinic of "St. John Hospital" Iasi, where microbiology tests revealed a Staphylococcus aureus infection. For longer than five years, the patient, who has a physical disability (mobility impairment that caused limitation of work capacity to 60%), has been fighting this infection.

In December 2012, the Law Court of Bacau, the court of first instance, ordered the Emergency Hospital of Bacau District to pay the patient 521,600 Euro as compensation for the physical disability acquired during treatment, based on the Law no. 95/2006 provisions regarding responsibility for hospital-acquired infections (former Art. 644, current Art.655 of the law republished). The Emergency Hospital of Bacau District hired a lawyer to defend the case by proving that the infection could have been acquired from anywhere, claiming that there is no clear evidence that the patient was infected during the hospitalization in the Emergency Hospital of Bacau District. The lawyer argued that the Staphylococcus aureus could have been present on the patient's clothes before being admitted in the EHBD or the patient could have been infected at other hospitals where he was transferred. Thus, the lawyer obtained the permission for a new expertise from the Court of Appeal. The Law Court Decision was maintained by the Court of Appeal in 2014. The hospital appealed again, this time to the High Court of Cassation and Justice. In January 2015, the High Court dismissed the appeal, so the EHBD should pay the patient 521,600 Euro. The lawyer of the hospital declared that the EHBD already started the payment procedures, and the patient will receive the money within the next 6 months (from the time of this writing in 2015).[722]

G) PRACTICE NOTES FOR LAWYERS

- When analysing a particular case brought against a public authority in the area of health care, lawyers should check the degree to which the acts and/or omissions of the authorities in that particular case comply with the purpose or functions of health care or with other general provisions or principles related to preventive measures provided by Law no. 95/2006 on the health reform. It is possible that, even if there is no specific and detailed provision on how a public authority should act in order to prevent the occurrence of a public health problem, lawyers can use arguments based on the authority's duty to act in good faith in order to comply with the main functions and basic principles of the health care general law. In other words, legal professionals should not dismiss the option to also build arguments relying on the more general provisions of the law.
- When arguing the failure to perform a specific duty by a public authority or health care provider, lawyers should distinguish between two types of duties: duty of diligence and duty to reach a specific result. Duties of diligence entail that the authority or provider must take all reasonable measures in order to reach a specific aim, whereas duties to reach a specific result are considered accomplished only when the result was achieved. In both cases when the duties were infringed, lawyers must provide evidence about the absence of the result which should have been reached, with the difference that in the case of duties of diligence, lawyers must also argue the inadequacy or insufficiency of the means employed. It is also worth mentioning, that the compliance with duties is more strictly evaluated by courts when the person obliged to perform a specific duty is a professional (as is the case with heath care professionals).
- Duties of diligence in the health care legal system can be identified through expressions such as "shall

722 Sources: Bacău.Net (2015), SJU Bacău, bun de plată în dosarul infecției cu stafilococ auriu. Spitalul trebuie să achite unui pacient peste 500.000 euro, [EDH Bacău good for payment in the *Staphylococcus aureus infection file. The hospital should pay over 500 000 Euro to a patient]* , 29 January 2015, available at http://www.bacau.net/sju-bacau-bun-de-plata-in-dosarul-infectiei-cu-stafilococ-auriu-spitalul-trebuie-sa-achite-unui-pacient-peste-500-000-euro/; Romania liberă (2014), Spitalul de Urgențe Bacău, bun de plată, după ce un pacient a fost infectat cu stafilococ auriu [Emergency Hospital Bacău, good for payment after infecting a patient with *Staphylococcus aureus*], 23 October 2014, available at http://www.romanialibera.ro/societate/sanatate/spitalul-de-urgente-bacau--bun-de-plata--dupa-ce-un-pacient-a-fost-infectat-cu-stafilococ-auriu--354519; Hotnews.ro (2014), Spitalul Bacau, obligat de instanta la plata unei despagubiri de 521.600 euro catre un fost pacient [Bacău hospital, forced by court to pay 521 600 Euro compensation to a former patient], 23 October 2014, available at http://www.hotnews.ro/stiri-esential-18365153-spitalul-bacau-obligat-instanta-plata-unei-despagubiri-521-600-euro-catre-fost-pacient.htm

take all available steps", "shall work to…", "to participate in…" etc. However, in a court case, the court shall interpret, after hearing all parties, the nature of the duty in question. In arguing about a violation of a duty of diligence, lawyers can also base their arguments on health professional standards (even if some these standards are not part of the law as such), existing quality standards or previous behaviour of the same authority or provider. Lawyers can also point out whether the authority/provider took any steps to check whether it had the available means to comply with its duties, look elsewhere for these means or even acknowledge the problem at stake.

- Every time when the patients' rights have been violated by an authority or provider's non-compliance with a duty to reach a specific result, lawyers should clearly point out to the court the nature of the duty. Some duties are provided by law as duties to reach a result, such as the mandatory application of universal precautions for preventing the transmission of HIV during medical care (see Law no. 584/2002, Article 6, pt. e), whereas other duties or procedures are interpreted by courts as representing such duties. For example, in a final decision of the Bucharest Court of Appeal, the court established that the duty of the dentist surgeon to insert adequate dental implants is a duty to reach a specific result[723].
- In litigating cases regarding the right to preventive measures, lawyers should consider that the national courts have framed the doctor's duty to treat the patient as a duty of diligence and that this duty also entails the duty of the doctor to ensure an efficient prevention, which means monitoring and supervising the patient[724].

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please review the information on Right to Preventive Measures provided under the Right to the Highest Attainable Standard of Health in Chapter 2 and Chapter 3.

6.1.2 Right of Access

A) RIGHT OF ACCESS AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

Every individual has the right of access to the health services that his or her health needs require. The health services must guarantee equal access to everyone, without discriminating on the basis of financial resources, place of residence, kind of illness or time of access to services.

The right of access is understood in the European Charter of Patients' Rights as having the following dimensions:

- An individual requiring treatment, but unable to sustain the costs, has the right to be served free of charge.
- Each individual has the right to adequate services, independently of whether he or she has been admitted to a small or large hospital or clinic.
- Each individual, even without a required residence permit, has the right to urgent or essential outpatient and inpatient care.
- An individual suffering from a rare disease has the same right to the necessary treatments and medication as someone with a more common disease.

723 Decision no. 1242R of 19 June 2013, published in Roxana Maria Călin, *Malpraxis: Răspunderea medicului şi a furnizorilor de servicii medicale [Malpractice. Physician and health services providers liability]*, 2014

724 Timiş Tribunal, Decision 105/A of 7 February 2013, published in Roxana Maria Călin, *Malpraxis: Răspunderea medicului şi a furnizorilor de servicii medicale, [Malpractice. Physician and health services providers liability]*, 2014

B) RIGHT OF ACCESS AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**
  - **Article 34** guarantees the right to protection of health:

    (1) The right to the protection of health is guaranteed.

    (2) The State shall be bound to take measures to ensure public hygiene and health.

    (3) The organization of the medical care and social security system in case of sickness, accidents, maternity and recovery, the control over the exercise of medical professions and paramedical activities, as well as other measures to protect physical and mental health of a person shall be established according to the law.

Legislation

- **Law no. 95/2006 on the Health Reform, republished in 2015, Title VIII, Chapter II, Section 1**

  This section of the Law on the Health Reform stipulates the scope of the public healthcare insurance in Romania. According to the law, all Romanian citizens and foreigners having a legal residence in Romania are obliged to contract for public healthcare insurance either directly with a national health insurance house or through the employer and pay a monthly contribution established based on the income of the employee (**Article 222**). In addition, there is a list of categories of persons who are insured by law without paying the contribution to the public health insurance fund (for example children, pregnant women, veterans, unemployed persons, retired persons having a small pension, parents in childcare leave, etc.) (**Article 224**)

  The insured persons have the right to the basic healthcare package, stipulated in the framework contract elaborated periodically by the National Health Insurance House, agreed by the Ministry of Health and approved by a Government Decision.[725]

  Beginning 1 April 2013, the insured persons must cover a co-payment for certain healthcare services they are entitled to (between 5 lei – 1.11 Euro and 10 lei – 2.22 Euro). Certain categories of insured persons are exempted from the co-payment such as children, patients having diseases covered by the national healthcare programs of the Ministry of Health if they do not have income (for example persons living with HIV, TB, diabetes, etc.), are retired persons having a small pension, or are pregnant women (**Articles 225 and 226**).

- **Law no. 95/2006 on the Health Reform, republished in 2015, Chapter IV of Title XIV**

  Chapter IV of Title XIV of the Health Reform Law regulates the obligation to provide healthcare to the patient. The law stipulates two situations. First, healthcare personnel working in healthcare institutions are obliged to provide healthcare to every person entitled to receive the respective healthcare service (**Article 665**). In only two circumstances may doctors interrupt services themselves or refuse the relationship with a patient (**Article 664, para. 1, pt. c**):

  - when the patient is referred to another doctor with higher qualifications, when this is required by the patient's condition, or
  - when the patient has been hostile and/or disrespectful toward a doctor.

725 See, for example, Government Decision no. 400/2014 on the approval of the package of services and thte Framework Contract on the conditions of health care provision within the social health insurance system for the years 2014 – 2015 and Section 6.1.1 of this Guide.

Second, healthcare personnel working outside a healthcare institution are obliged to provide healthcare to:

- all patients accepted, without discrimination on grounds such as ethnicity, religion, sexual orientation (**Article 663, para. 2**) and
- all patients who are in an emergency situation whose health or life may be seriously and irreversibly endangered (**Article 663, para. 3**).

Law no. 46/2003 on the Rights of Patients

The law states that patients have the right to the highest standard of healthcare existing in the society, in relation to the human, financial and material resources available (**Article 2**).

Law no. 584/2002 on the measures for preventing the spread of AIDS in Romania and for protection of persons infected with HIV or having AIDS

A particular situation regarding HIV/AIDS is prescribed in the Law 584/2002 by:

- **Article 9:** stipulating that all healthcare units are obliged to provide to patients living with HIV/AIDS the specialized healthcare they have been authorized to provide as a healthcare unit for all patients, according to the contract signed with the District Health Insurance House.
- **Article 6, pt. f:** All specialized healthcare units are obliged to provide the preventive measures to prevent HIV transmission from mother to child.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

The content of the basic healthcare package may be checked in the text of the following regulations establishing the general framework for concluding the health service contracts between healthcare providers and the district health insurance houses:

Government Decision no. 400/2014 on the approval of the package of services and the Framework Contract on the conditions of health care provision within the social health insurance system for the years 2014-2015.

Common Order of the President of the National Health Insurance House and the Minister of Health No.388/2015 on the approval of Methodological norms for the application during the year 2015 of the Government Decision no. 400/2014 on the approval of Framework Contract on the conditions to provide medical assistance within the public healthcare insurance for the years 2014-2015.

D) PROVIDER CODES OF ETHICS

Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians

- **Article 33** of the Code of Medical Deontology stipulates certain situations when doctors may refuse to provide healthcare services:
  - *in the cases stipulated by law;*
  - *when the specific request made by the respective patient interferes with the professional independence of the doctor or is affecting its image, moral values or if the request is not in compliance with the fundamental principles of the exercise of the medical profession, its aim and social role.*

The refusal may only be exercised under strict conditions stipulated by **Article 33, para. 2**:

- *in all cases, the doctor will explain to the persons the reasons for his/her refusal, will make sure that the refusal is not endangering the life or health of the person;*
- *when the refusal is against the moral beliefs of the doctor, he/she will direct the person to anther colleague or medical unit.*

E) OTHER RELEVANT SOURCES

There are no other relevant sources identified for this right.

F) PRACTICAL EXAMPLES

1. Example of Compliance

Pregnant women are automatically insured by law in Romania during pregnancy. Therefore, they have access to the basic package of healthcare services, including maternal healthcare throughout the pregnancy, at birth and post-partum. *(Authors' opinion: Oral contraceptives are included in the list of essential medicines approved by the World Health Organization, and family planning are primary healthcare services. Therefore, in the opinion of the author, access to primary healthcare should be ensured to all, irrespective of having healthcare insurance or not. In Romania, according to the Order of the Ministry of Health no. 136/1994, oral contraceptives are provided free of charge to certain categories of women who cannot afford buying them in the pharmacy.)*

2. Examples of Violation

- **Example 1:** No healthcare insurance in Romania – public or private – covers gender reassignment treatment for transgender persons, making the access to such treatment unaffordable in Romania or abroad.
- **Example 2:** The medical personnel in Romania is not specialized to carry out gender reassignment surgery, especially for female-to-male (FTM) transgender persons, making this healthcare service unavailable in Romania.
- **Example 3:** There are hospitals where all doctors in the Obstetrics and Gynecology Department refuse to provide abortion on request to women, despite this medical service being lawful in Romania until the 14th week of pregnancy. *(Author's note: See Practice Notes for Lawyers below for discussion of issue of doctors' refusals to treat.)*

3. Actual Case

Oana (her identity remained confidential during procedures) complained that she was refused to be admitted in the hospital for birth by Caesarean section by the head of the Obstetrics and Gynecology Department of a public hospital in Bucharest because she was HIV positive. She was recommended birth by Caesarean section to prevent mother-to-child HIV transmission by the obstetrician who consulted her in that hospital. The woman complained in civil court against the hospital and the head of department for direct discrimination in access to public services on the grounds of gender and the HIV status. The first instance court found a violation of the right not to be subjected to discrimination on the ground of HIV status in access to healthcare services and ordered civil compensation for moral damages to be paid by the hospital and the chief of department together.[726] The chief of the department appealed the case before the tribunal that overturned the first instance judgment. Oana introduced an appeal on grounds of law – complaining that some of the evidence was unlawfully administered, the judgment is contradictory, and the law was misapplied by the Bucharest Tribunal. The Court of Appeal of Bucharest was examining the case at the moment of drafting this publication.

726 The Court of the Sector 2 Bucharest, Civil Sentence No. 4999 of 27.03.2013 (the judgment is not final).

G) PRACTICE NOTES FOR LAWYERS

- Different than the case of private practice, in the cases concerning healthcare provided in hospitals or privately and publicly owned clinics, the issues regarding the right of access are to be dealt with in relation to the medical unit rather than its medical personnel, because it is the medical unit that is the service provider. It is the medical entity that enters into contractual relations with the patient. *(Author's note: this scenario does not refer to cases of alleged malpractice or disciplinary liability.)*
- In cases where the medical personnel breach the provisions of Articles 653-654 of the Health Reform Law, it is useful to allege the accountability of both the health care unit and the healthcare personnel in solidum. The health care unit is accountable for the acts of its employees and it usually has its own obligations to prevent certain behaviors such as breaches of the internal rules and procedures, internal protocols, and patients' rights, by adopting regulations and procedures, informing the personnel about them and monitoring the enforcement of these regulations and procedures.
- The services contract concluded by the medical unit with the district health insurance house contains the list of services that are provided to the patients based on the public health insurance. This is important evidence in cases involving the right of access. Aside from this list of services supported from the public health insurance, medical units are authorized to provide other services that are supported by the patients out-of-pocket.
- Many of the cases raising concerns related to discrimination occur in the field of the right of access. Therefore, the provisions of the Government Ordinance no. 137/2000 regarding the prevention and combating of all forms of discrimination are to be taken into account when arguing the case along with the legislation regulating the right of access.
- When arguing a case regarding the right of access, once the right is established for a particular patient, it is the service provider who has the burden of proving exceptional, objective reasons why the access was not provided to the person entitled. Moreover, it is the service provider, not the complainant, who has all available evidence regarding the situation in the medical unit – available personnel, workload, number of patients, etc. The approach to ensuring access and providing medical care should be systemic (medical units cooperating among themselves to ensure reasonable and effective referral of patients when necessary), and guided by the principle of foreseeability. Thus, if a medical unit, due to objective and unforeseeable reasons, is not able to provide a medical service, it should refer the person to another medical unit within reasonable reach of the patient. Only after this burden of proof is fulfilled, it is for the complainant to combat this evidence.
- There is some confusion around the legal framework applicable to the more and more frequent instances where gynecologists from public healthcare units refuse to perform legal healthcare services of abortion on request. Sometimes the refusals are based on religion or belief; sometimes they are simple personal choices the doctors claim they are entitled to make. A clarification regarding the legal framework may help the practitioner to make his/her way through this issue. It is important to take into account that abortion on request is legally permitted in Romania in the first 14 weeks of pregnancy. It is performed by gynecologists in public healthcare units or private practices and it is not covered by the public health insurance. The instances where doctors may refuse to provide healthcare services are strictly regulated by Article 653 of the Health Reform Law; and religion, belief or personal choices are not on the limited list. Only Article 33 of the Medical Deontological Code of 30 March 2012 stipulates that a doctor may refuse to provide health care assistance, under strict circumstances, if the health service requested by the patient contradicts the doctor's moral values. This article is invoked by doctors who refuse to provide abortion services, along with the constitutional freedom of religion and belief. However, a patient who has been refused services can defend her rights by arguing before the competent authorities or in Court that the Code is adopted by the Medical Doctors' Association and is not legally binding; the Code cannot add to the Health Reform Law (that has a limited list of cases where refusals are allowed, see above). Moreover, the Code's guidelines related to refusals on moral grounds are also challenged because they do not set forth minimal requirements such as a duty to inform a woman of all existing alternatives, safeguards to ensure that health care providers committed

and able to provide abortion care are available in a public hospital; the public hospital as a legal entity cannot invoke the freedom of religion and belief, as that is essentially an individual right. So far, there have been no cases challenging the practice of refusals to provide abortion on request.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please review the relevant information provided under the Right to Information and the Right to the Highest Attainable Standard of Health in Chapter 2 and Chapter 3.

6.1.3 Right to Information

A) RIGHT TO INFORMATION AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

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.

Health care services, providers and professionals have to provide patient-tailored information, particularly taking into account the religious, ethnic or linguistic specificities of the patient. The health services have the duty to make all information easily accessible, removing bureaucratic obstacles, educating health care providers, preparing and distributing informational materials. A patient has the right of direct access to his or her clinical file and medical records, to photocopy them, to ask questions about their contents and to obtain the correction of any errors they might contain. A hospital patient has the right to information which is continuous and thorough; this might be guaranteed by a "tutor". Every individual has the right of direct access to information on scientific research, pharmaceutical care and technological innovations. This information can come from either public or private sources, provided that it meets the criteria of accuracy, reliability and transparency.

B) RIGHT TO INFORMATION AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**
  - **Article 31** guarantees the right to information:

    (1) A person's right of access to any information of public interest shall not be restricted.

    (2) The public authorities, according to their competence, shall be bound to provide correct information to the citizens in public affairs and matters of personal interest.

    (3) The right to information shall not be prejudicial to the measures of protection of young people or national security.

    (4) Public and private media shall be bound to provide correct information to the public opinion.

    (5) Public radio and television services shall be autonomous. They must guarantee any important social and political group the exercise of the right to broadcasting time. The organization of these services and the parliamentary control over their activity shall be regulated by an organic law.

Legislation

- **Law no. 95/2006 on the Health Reform, republished in 2015**
  - **Article 5** provides the main functions of public health care, including *informing, educating and communicating for the promotion of health* **(letter k)**.
  - **Article 6** states the main area of intervention of public health care, including *promoting health and health education through… information-education-communication campaigns* **(letter c, pt. 1).**
  - According to **Article 21**, *the district public health authorities and Bucharest Public Health Authority organize the collection and processing of statistical medical information received from public or private health facilities and sent monthly reports to the relevant public institutions.*
  - **Article 230** stipulates the rights of the insured persons, including *the right to information in the case of medical treatments* (**para. 2, letter o**).
  - **Article 234** provides another right of the insured, namely *the right to be informed at least once a year, through the health insurance houses, of the services which he/she is entitled to, as well as of his/her rights and obligations.*
  - One of the attributions of the National Health Insurance House and the district health insurance houses is *to provide free of cost information, consultation and assistance in the field of social health insurance for the insured persons, the employers and the health service providers* **(Article 280, para. 1, letter m, Article 281, letter f)**.
  - According to **Article 660, para. 3,** in order for the health care staff to obtain an informed consent from the patient, they must provide information to the patient: *The information must contain: the diagnosis, the nature and purpose of the treatment, the risks and consequences of the proposed treatment, the viable alternatives to the treatment, their risks and consequences, the prognosis of the illness if the treatment is not applied.*

- **Law no. 46/2003 on the Rights of Patients**

  The Law contains a full Chapter on "The Patient's Right to Medical Information"
  - **Article 4:** The patient has the right to be informed with regard to the available medical services, as well as how to use them.
  - **Article 5:** *(1) The patient has the right to be informed about the identity and the professional status of the health care providers. (2) The patient who is admitted has the right to be informed about the rules and customs which must be respected during the time of admission.*

  The Law on the Rights of Patients contains other provisions regarding the right to information which shall be discussed in the next section, regarding the Right to Consent.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

There is no relevant secondary legislation on the Right to Information

D) PROVIDER CODES OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**
  - **Article 14 The previous and adequate provision of information to the person:** *(1) The physician shall request and receive the consent only after, previously, the respective person or the person entitled to consent to the medical intervention has received adequate information on the nature and purpose of the intervention, as well as on the consequences and risks which are predictable*

and generally accepted by the medical society. (2) As much as possible, the physician shall ensure that the information is adequate and relates to the person which would provide consent.

E) OTHER RELEVANT SOURCES

There are no other relevant sources identified for the right to information.

Note to readers:

In the Romanian legal framework, the right to information is provided in very close connection to the right to consent. Thus, the national legislation speaks of "informed consent". For the purpose of this guide, the authors have approached the Right to Information together with the Right to Consent. Consequently, further explanations, examples of cases and practice note for lawyers applicable to both rights shall be found in Section 6.1.4. Right to Consent.

6.1.4 Right to Consent

A) RIGHT TO CONSENT AS STATED IN THE IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

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 Charter provides, as explanatory notes for this article, that the healthcare providers and medical staff must give the patient all information on the treatment and medical intervention which is to take place, including the associated risks and discomforts, side effects, discomforts and existing alternatives. Such information must be provided at least 24 hours before the intervention, so that the patient can actively take part in the therapeutic choices.

The Charter also provides the obligation of the healthcare providers and medical staff to communicate with the patient in a known language and the language must be common, easy to understand. Even if, for reasons of health or lack of decision-making capacity, where the informed consent is expressed by the patient's legal representative, the patient in question must be involved in this decision-making process as much as possible.

The patient is also entitled to refuse the treatment or intervention, or to change his/her mind during the treatment, refusing to continue it. The patient is also entitled to refuse information related to his or her health.

As regards the right to information provided for in Article 3 of ECPR, which is a right providing access to medical information in general, this Article 4 refers to the case of making specific decisions on the health of the patient.

Author's Comment for Jurists

It is noted that the right to consent includes three components: a component related to the right to information regarding the decisions which the patient is to make, a component related to the patient's right to accept or refuse the proposed procedure, and a third component related to the patient's consent which must be clear; therefore, we talk about an informed consent.

B) RIGHT TO CONSENT AS STATED IN COUNTRY CONSTITUTION/NATIONAL LEGISLATION

Constitution

The Romanian Constitution of 1991, revised in 2003

The Constitution does not provide the patient's right to consent but only a general right for health care guaranteed by the state **(Article 34)**.

Article 22, referring to the right to life and physical integrity, could also be interpreted from the point of view of the right to informed consent. On one hand, the right to physical integrity assumes a negative obligation for any other person not to violate such right. On the other hand, it assumes the right of any person to decide on his physical integrity, including in case of medical decisions.

Legislation

Civil Code[727]

- **Article 68:** *(1) Any removal or transplant of organs, tissues and human cells from living donors shall be exclusively made in the cases and under the terms provided by the law, with the donors' free, prior and express written consent, and only after they have previously been informed of the intervention risks. In any cases, the donor may change his or her expressed consent, until the moment of the removal. (2) It is prohibited to take organs from minors and living persons, who are injudicious owing to a mental handicap, serious mental disorder or any other similar reason, except for the cases expressly provided by law.*
- **Article 81** *Removing organs from a deceased person: Removing the organs, tissues and human cells, for therapeutic or scientific purposes, from deceased persons, can be performed only under the conditions set out by law, with the written consent, expressed before their death, of the deceased person, or, for lack thereof, with the written, free, previous and expressed consent given by persons in the following order - the surviving husband, the parents, the descendants.*

Therefore, the New Civil Code expressly requires the rigor of informed consent in medical procedures only as regards to organ removal and transplant from living or deceased donors, without providing a general requirement of informed consent in the area of health care. However, some provisions on consent can be linked to the right to health, such as **Article 71, para. 2** on the right to private life, where the Civil Code states that *No one can be subjected to interference in their intimate, personal or family life (…) without their consent (…)*. For example, decisions such as using means of contraception or becoming a parent fall under the scope of private and family life and also have a medical component.

Authors' Comment for Jurists:

As regards invalid consent, the New Civil Code generally details it in **Articles 1.206-1.216***, the willful misrepresentation, which is a provision relevant for this study.* **Article 1.214** *details the willful misrepresentation as an error intentionally caused by the other party or when the latter has fraudulently omitted to give information on the circumstances which he/she ought to have disclosed. It can thus be interpreted that the omission of information or the improper information specified in Article 4 of the ECPR has as equivalent the willful misrepresentation which is specific to the Civil Code.*

Law no. 46/2003 on the Rights of the Patients

This law largely covers the rights provided in the European Charter of Patients' Rights, including the

727 Law no. 287/209 on the New Civil Code and Law no. 71/2011 for the application of the New Civil Code

right to consent, especially informed consent. The relevant provisions on information and consent can be found in articles 4 to 20, and a selection of these articles is provided below:

- **Article 6:** *The patient has right to be informed of his/her health status, proposed medical interventions, potential risks of every procedure, existing alternatives to the proposed procedure, including the non-performance of treatment and non-compliance with medical recommendations, as well as data on the diagnosis and prognosis.*
- **Article 8** provides the medical staff's obligation to communicate to the patient the medical information in a respectful, clear and understandable language; and if the patient does not speak Romanian, the information shall be communicated in the mother language or in another language which he/she speaks. *(Author's note: The law does not specify that this is to be provided by an interpreter, but this would be consistent with the treatment of non-Romanian speakers in other matters - e.g. in civil procedure)*
- **Article 9** provides the patient's right to decide if he wants to be informed, to ask not to be informed, or to choose another person who shall be informed about the above.
- **Article 13** states that the patient is entitled to refuse or stop a medical intervention. In this case, the text requires a statement in writing of such a decision from the patient and the obligation of the medical staff to inform the patient of the consequences of his/her decision.
- **Article 14** provides that if an emergency medical intervention is necessary and the patient cannot express his/her consent, the medical staff is entitled to deduce the consent by the patient's previously expressed will. *(Author's note: Article 14 does not specify the formal conditions which the previously expressed consent must meet in order to qualify under this provision. Consequently, since the law does not distinguish between, for example, oral or written consent, it results that both versions qualify.)*
- **Article 15:** If an emergency medical intervention is necessary, the legal representative's consent is no longer required. *(Author's note: The law is silent regarding consent of a legal representative in the situation when the legal representative is present.)*
- **Article 16:** If the legal representative's consent is required, the patient must be involved in the decision-making process as long as his/her capacity to understand allows.
- **Article 17:** If the legal representative does not express his/her consent, and the intervention is in the patient's best interest, the decision is forwarded to an arbitration specialty commission. *(Author's note: The law is silent regarding this occurrence in an emergency situation - but a systematic interpretation of law indicates that in case of an emergency, the arbitration commission is not required. The legislation does not provide additional details on the operation of the arbitration commission. In any case, the commission is constituted ad-hoc for each case – it is not a permanent body.)*
- **Article 18:** The patient's consent is compulsory for removing, keeping, and using of the removed biological products taken from his/her body in order to establish the diagnosis or required treatment.
- **Article 19** provides that the patient's consent is also compulsory if the patient takes part in clinical medical education and scientific research.

Law no. 487/2002 on Mental Health and Protection of People with Mental Disorders

The admission of a patient, either voluntary or non-voluntary, to a mental health facility, is a form of deprivation of liberty. For this reason, Law no. 487/2002 refers to the rights of the "people with mental disorders" (people with mental disabilities in the wording of UN treaties) and provides special rights compared to the general rights of the patients, considering the vulnerability persons with mental disorders based on their health, on the one hand, and deprivation of liberty in cases of admission, on the other hand.

- **Article 29:**

  (1) In the establishment and implementation of the therapy program, the psychiatrist must obtain the patient's consent and comply with his/her right to be assisted while giving the consent.

  (2) The psychiatrist may establish the treatment without the patient's consent if

  a) the patient's behaviour is an imminent threat of injury for himself or other persons;

  b) the patient lacks the psychic capacity to understand the disease and the need for medical treatment and has no legal representative or is not accompanied by a conventional representative

  c) the patient is a minor or has been placed under guardianship, in which case the psychiatrist must request and obtain the legal representative's consent.

  (…)

  (4) If the physician does not have information on the patient's legal or conventional representative mentioned in para. (3), the physician is obliged to immediately inform the guardianship authority, about this situation (…)

  (Author's note: A conventional representative is a person who can assist or represent a psychiatric patient in all aspects regarding medical admission and procedures. As opposed to a legal representative, it is much easier to appoint a conventional one, for example via a simple statement signed by the patient)

- **Article 44, para. 1** provides that after the admission into the mental health facility, each patient must be informed as soon as possible, in a way and language which he/she can understand, of his/her rights under the law, and such information shall be accompanied by the explanation of the rights and means to exercise the rights. *(Author's note: This should include generally applicable patients' rights, not only those under the Mental Health Law.)*

- **Article 44, para. 2** states that *if the patient is not capable to understand the information provided, and throughout the duration of such incapacity, his/her rights shall be communicated to his/her legal or conventional representative.*

- **Articles 54** and **58** contain provisions in the special case of involuntary admission This is possible according to law only if the attempts to admit the patient in a voluntary manner have not been successful and only if a competent psychiatrist decides that the patient suffers from a mental disorder and deems that: (i) due to the mental disorder, there is an imminent threat of injury to the patient or others; or (ii) in case of a person suffering from a serious mental disorder, the non-admission would lead to a serious impairment of his/her health or prevent him/her from receiving the proper treatment. In this case, the psychiatrist, after assessing the patient's health, must immediately inform that person and his/her legal representative regarding the involuntary admission and the treatment to be administered. The psychiatrist also notifies the involuntary admission commission so that it can commence the revision procedure and informs the person in question by means of the legal or conventional representative as regards his/her examination by the commission. Subsequently, the commission's decision is reviewed by the law court (discussed below).

- **Articles 58–61** provide more rights and duties regarding consent. If the consent of the patient's legal or conventional representative is not obtained or cannot be obtained, the psychiatrist establishes the diagnosis and treatment procedures which he/she deems necessary for a period of time as short as possible, and subsequently notifying such circumstance to the involuntary admission commission. The commission consists of two psychiatrists and a physician with another specialization (or a representative of the civil society), appointed by the hospital manager. The commission must make a decision within 48 hours from the admission. The eventual involuntary admission decision shall be recorded in the patient's medical records and immediately communicated to the patient, as well as to his legal or conventional representative. Within 24 hours as from adopting the decision to admit the patient, the commission's decision shall be submitted to the district court which has jurisdiction over the medical facility, together with the medical documents. Until the rendering of a

judgment- which actually represents the confirmation of the involuntary admission decision - the admitted patient shall periodically be examined by the commission. *(Author's note: The law does not set a maximum time limit for maintaining the person admitted in the psychiatric ward awaiting the judgment, nor a specific time limit for the district court to issue such a judgment; the law states that the court shall examine the case in an emergency procedure.)*

- **Article 30** provides the patient's right to withdraw at any time his/her consent regarding the therapy program. However, the psychiatrist is entitled to continue to apply the therapeutic measures for the strictly necessary period if the doctor considers that discontinuing the patient's treatment would result in danger to the patient or others due to his/her illness. The involuntary admission commission shall be notified of such cases and the cases shall be submitted for analysis by the commission. *The consent can be withdrawn any time by the patient or his/her legal or conventional representative, the psychiatrist having the obligation to inform the patient or his/her legal or conventional representative on the risks of interrupting the treatment. The psychiatrist has the right to continue to apply the therapeutic measures for the strictly necessary period when considering that interrupting the treatment would endanger the patient or other persons due to the patient illness. These cases will be notified to and analyzed by the commission for the procedure revision.*
- **Article 45** provides the patient's right to be assisted by a conventional representative appointed by the patient during the medical treatment.
- **Article 64** states that if a voluntarily-admitted patient withdraws his/her consent and the conditions on involuntary admission are met the attending physician shall initiate the involuntary admission procedure.

Law no. 95/2006 on Health Reform, republished in 2015

The concept of „informed consent" of the patient regarding the treatment or medical procedure proposed is included in **Title XV** on civil liability of the medical staff and medical, sanitary and pharmaceutical products and service providers.

- **Article 653, para. 3** provides that *the medical staff shall also have civil liability for the damage arising from the failure to comply with the regulation of this title on confidentiality, informed consent and obligation to provide healthcare.*
- **Article 661** provides the legal conditions to express the informed consent and the cases in which the liability of the medical staff occurs. The legal age to express the informed consent, according to the law, is 18. Minors may express their consent in the absence of their parents or legal representative in emergency situations when their parents or legal representatives cannot be contacted, and the minor has the required capacity to understand his/her medical situation. At the same time, minors aged over 16 can express consent by themselves in medical cases related to the diagnosis and/or treatment of sexual or reproductive health issues, at the express request of the minor.
- According to **article 662**, the attending physician, nurse and/or midwife shall be held liable (each can be held liable separately) when they do not obtain the informed consent of the patient or of his/her legal representative, except when the patient has a complete lack of judgment and the legal representative or the closest relative cannot be contacted due to the emergency. When the legal representative or closest relative cannot be contacted, the physician, nurse/midwife may request the authorization for the medical procedure from the guardianship authority or may act without its consent in emergency cases when waiting for the consent may irreversibly endanger the patient's health and life. *(Author's note: Since the law does not specify how the lack of judgment is distinguished, for the purpose of Article 662, para. 1, it results that the determination can be made by the medical staff at the time of the medical decision, without limiting the situation of cases of persons placed under guardianship) (Author's note: The guardianship authority is a municipal service, functioning under each city or town hall. Its main functions are to oversee the activity of appointed legal guardians and to ensure the protection of the rights of minors.)*
- As regards the rules governing the medical profession, **Article 382** establishes the principle of the

patient's will to decide on any kind of medical intervention. Thus, except for the events of force majeure, emergency or when the patient or representatives are unable to express their will or consent, the physician acts by respecting the patient's will and his/her right to refuse or stop the medical intervention. The medical liability of the health care staff terminates when the patient does not comply with the prescription or medical recommendation.

- With regard to the organ, tissue or human cell donation, **Chapter II of Title VI** of the law specifically refers to obtaining consent. The same situation is also met in the case of transplant which is regulated in **Chapter III of Title VI**.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

Norms of 10 April 2006 for application of the Law no. 487/2002 on mental health and protection of the persons with psychical disorders, with subsequent modifications

Annex 1 of the Norms for application of mental health law contains the Informed Consent Form of the person who wishes to be voluntarily admitted in a mental health facility. The form contains the person's information regarding the possibility to appoint a conventional representative who should assist him/her during the medical treatment, receive of information on the diagnosis, refusal to follow the treatment and the consequences of treatment interruption.

D) PROVIDERS CODES OF ETHICS

Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians

The Code provides a detailed chapter on the patient's informed consent **(Chapter II)**. The articles aim at properly informing the patient, rules on how to obtain the consent, including in case of under-aged patients, in cases of patients with a complete capacity of judgment and in medical emergency cases. In fact, the code reiterates the provisions from the Law on the Rights of Patients and transforms them into ethical duties of medical professionals.

Decision no. 2 of 9 July 2009 of the Order of Nurses and Midwives from Romania on the adoption of the Code of Ethics and Deontology of the Nurses and Midwives in Romania

The Code contains three articles regarding the patient's consent, which are similar to the provisions of the general legislation:

- **Article 30** *states that any medical procedure can be performed only with the consent of the patient or his/her legal representative. The patient has the right to refuse or stop a medical procedure, but has to undertake responsibility through a written statement.*
- **Article 31** *states that the patient's consent is required in the following cases: a) for the removal, keeping, or use of biological samples; b) for any medical intervention; c) for taking part in clinical medical education or scientific research; d) for photographing or filming the patient inside a medical unit; and e) for blood donations.*
- **Article 32** *states that the consent of the patient is not required if the patient cannot express his or her will, but an emergency medical intervention is necessary. In case of patients with legal representatives, if the legal representative refuses to consent but the medical staff considers the intervention to be necessary, the nurse/midwife shall notify the attending physician, which shall notify the arbitration commission.*

Code of Deontology of Dental Practitioners of 15 May 2010, Decision 15/2010 of the Romanian College of Dentists

The code states that the dental practitioner must obtain the informed consent of the patient or his/

her legal representative for treatment and investigations **(Article 11)**. If it is impossible to obtain such consent, then the dental practitioner can only provide emergency care **(Article 15)**.

E) OTHER RELEVANT SOURCES

There are no other relevant sources on the Right to Consent.

F) PRACTICAL EXAMPLES

1 Example of Compliance

Mrs. A. is admitted to a hospital in Bucharest for an operation. The physician, who is to perform the operation, previously informs Mrs. A., in a language which she understands, the diagnosis, nature and purpose of treatment, risks and consequences of proposed treatment and prognosis of disease without the treatment. After the information, Mrs. A. willingly signs the informed consent form.

2 Example of Violation

Young X., residing in Bucharest, is taken to the psychiatric hospital Z by his parents as a result of an episode of agitation. Having arrived on the spot, at the request of his parents, the psychiatrist A. decides to admit young X to the psychiatric hospital, against his will. Physician A. omits to inform the commission provided for in Article 61 of Law no. 487/2002, appealing to the reason that the admission shall not exceed, most likely, a few days.

3 Actual Case

A case concerning the right to informed consent was examined by the European Court of Human Rights in *Csoma v. Romania* (application no. 8759/05, 15 January 2013). The applicant was in her sixteenth week of pregnancy when the fetus was diagnosed with hydrocephalus. Following a consultation in May 2002 with her OBGYN, Dr. P.C., it was decided that the pregnancy should be interrupted. Several medical interventions were performed in order to induce the abortion, but with no result. Two days after her admission, the applicant developed fever and shivers. During this, time, she was not seen by doctors and was only given painkillers. Before being taken to the surgery room, she expelled the fetus and started bleeding profusely and continuously. She was diagnosed with disseminated intravascular coagulation (DIC) and sent to another higher ranked hospital (County Hospital), being assisted in the ambulance only by a nurse. At the County Hospital the doctors had to perform a total hysterectomy and bilateral adnexectomy in order to save her life. The applicant subsequently complained to the College of Physicians and lodged a criminal complaint against the doctor, but with no avail. The European Court of Human Rights held that there had been a violation of Article 8 of the Convention (the right to respect for private and family life). The Court observed that all the expert medical reports in the case showed that Dr. P.C. had failed to obtain the patient's informed consent prior to the procedure of inducing abortion, nor did the doctor perform the pre-operative check required. The Court stated that it "attaches weight to the existence of prior consent in the context of a patient's right to respect for his or her physical integrity" and that "any disregard by the medical personnel of a patient's right to be duly informed can trigger the State's responsibility in the matter" (para. 48). In addition, the ECtHR held that the applicant's profession as a trained nurse did not dispense the doctor from obtaining informed consent regarding the procedure – contrary to what the Romanian Government stated in its defense. Thus, the lack of informed consent represented one of the weightiest arguments in the Court's identification of a violation of Article 8 of the Convention.

G) PRACTICE NOTES FOR LAWYERS

- In analyzing the existence of informed consent given by the patient before a medical procedure, lawyers should complement their arguments based on national law provisions with other existing international human rights standards and jurisprudence. For instance, provisions regarding consent can be found in the 1997 Oviedo Convention on Human Rights and Biomedicine, where the entire Chapter II is dedicated to the issue of consent. International Human rights Standards regarding consent have also been developed by the European Court of Human Rights in cases such as *Csoma v. Romania* (2013) or *Codarcea v. Romania* (2009), *V.C. v. Slovakia* (2011). Lawyers should pay specific attention to ECtHR cases originating from Romania, since the findings of the Court are directly applicable to the Romanian State and are specifically relevant in cases where the State did not amend legislation and did not change policies after the issuing of the judgments.
- The obligation to obtain consent for medical procedures is phrased in Law no. 46/2003 on the Rights of the Patient and in the Code of Medical Deontology as a duty to reach a specific result. Namely, the existence of consent is mandatory before the performance of any medical intervention (with some exceptions provided by law which should be strictly interpreted and applied). Thus, it is important for lawyers who are litigating in cases where there are issues regarding consent to ask the court to order the health care provider to bring forward any type of documentation which proves the existence of consent.
- The existence of a purely formal consent does not dispense the health care provider from liability towards the patient. Lawyers should look closely on a case by case basis at the conditions in which consent was obtained from the patient, since the national legislation, as well as other international sources provide substantial conditions for informed consent, some of which depend on the specific situation of the patient. For example, the Code of Medical Deontology **(Article 14, para. 2)** provides that in order to obtain consent, the provider must offer adequate information, taking account of the patient's personal situation. Similarly, the Charter states that the provider must use a language which the patient can easily understand. The ECtHR also held that consent is not valid if, for interventions which are not imminent necessities, the patient is required to give consent during moments of pain, stress or under pressure from medical staff (see *V.C. v. Slovakia*, application no. 18968/07, 8 November 2011).

H) CROSS-REFERENCING 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 TO FREE CHOICE AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

Everyone is entitled to freely choose between different procedures and treatment providers, based on proper information.

The patient has the right to decide which diagnostic exams and therapies to undergo, and which primary care doctor, specialist or hospital to use. The health services have the duty to guarantee this right, providing patients with information on the various centres and doctors able to provide a certain treatment, and on the results of their activity. They must remove any kind of obstacle limiting exercise of this right.

A patient who does not have trust in his or her doctor has the right to designate another one.

Author's Comment for Jurists

It is noted that the right of free choice, as provided in the Charter, mainly assumes the right to choose between various procedures and treatment providers and, in addition, the right to properly be informed of the available options. We consider that the latter is a specific application of, and must be seen in the light of, the general right to information of which the patient must benefit under the Charter. In its turn, the right to choose considers both the treatment methods and the providers of such treatment (both hospitals and physicians).

B) RIGHT TO FREE CHOICE AS STATED IN COUNTRY CONSTITUTION / NATIONAL LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**

  The Romanian Constitution does not provide the patient's right to freedom of choice, but only a general right for healthcare guaranteed by the state **(Article 34)**.

Legislation

- **Law no. 46/2003 on the Right of Patients**

  Unlike, for example, the patient's right to information, the freedom of choice is not referred to as such in Law no. 46/2003. However, the law includes certain provisions which partially transpose the content of the Charter on this right:

  - **Article 11**, as regards the actual choice: *The patient is entitled to request and obtain a second medical opinion.*
  - **Article 4** may be interpreted as referring to the component related to the information associated with the freedom of choice: *The patient is entitled to be informed of the available medical services and how to use them.*

- **Law no. 95/2006 on the Health Reform, republished in 2015**

  The law contains provisions about patients' right to choose health care providers and services, as noted below. However, the legal provisions do not fully transpose the patient's right to free choice as

provided in the Charter, because the law considers only the concept of "insured", which does not fully overlap with the general concept of patient (since there are also uninsured persons).

- **Article 219, para. 3** provides, among other principles of the health insurance system, *the insured person's freedom to choose the insurance house,* and also *the insured person's freedom to choose the medical service, medicine and medical device providers under this law and the framework contract.*
- **Article 230, para. 2, pt. a** sets out the insured person's right to choose the *medical service provider and the insurance house at which he/she is insured under this law and the framework contract.* **Pt. b** provides the insured person's freedom to choose the family physician, stating that the insured person is entitled to *be registered on the list of the requested family physician, if he/she fulfils all the requirements of this law, bearing the costs of transport if he/she chooses a physician from another locality.* **Pt. c** mentions that the insured person is entitled to *change his/her appointed family physician only after the expiry of at least 6 months from the registration in the physician's lists. (Author's note: This provision limits the freedom of choice as regards the change of family physician, by imposing a period of 6 months. However, there are grounds to consider this period as a legitimate limitation, taking into account the need to provide an organised framework to carry out the activities of the family physicians.)*

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

Norm of 7 April 2004 for the application of Law no. 46/2003 on the Right of Patients

- **Article 15, para. 1** of the norm develops the legal text regarding the patient's right to choose, stating that *"At the request of admitted patients, the units provided with beds must ensure the required conditions so that they can obtain second medical opinions, and the accredited external physicians can provide medical services".*
- **Article 1** also specifies the information which the healthcare facilities must provide to the patients, referring to:

  a) available medical services and how to access them;

  b) identification and professional status of the healthcare providers;

  c) rules and practices which they must comply with during the admission to the facilities provided with beds;

  d) patients' own health;

  e) proposed medical interventions;

  f) potential risks of each procedure to be applied;

  g) alternatives for the proposed procedures;

  h) available data resulting from the scientific research and technological innovation;

  i) consequences of the failure to perform the treatment and to comply with the medical recommendations;

  j) diagnosis and prognosis of diagnosed diseases.

Government Decision no. 400/2014 on the approval of the package of services and the Framework Contract on the conditions of health care provision within the social health insurance system for the years 2014 - 2015

The framework contract considers the obligations of the healthcare providers to the health insurance house. These obligations include that of respecting the rights of the insured, including *"the insured's*

freedom to choose the physician and provider" **(Article 3, letter h).** *(Author's note: Similar to Law no. 95/2006 on health reform, on which its approval is based, the framework contract refers only to the "insured" category, which does not completely overlap with the "patient" category. Thus, the framework contract does not fully transpose the right to free choice as provided for in the Charter.)*

D) PROVIDER CODES OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**

  The Code, drawn up by the Romanian College of Physicians (the membership of the Romanian College of Physicians is compulsory for the exercise of the profession of physician), provides, under **Article 30**, the obligation of the physician *to comply with the patient's right to obtain a second medical opinion.*

- **Decision no. 2 of 9 July 2009 of the Order of Nurses and Midwives from Romania on the adoption of the Code of Ethics and Deontology of the Nurses and Midwives in Romania**

  The Code states that the patient's will in choosing his or hers nurse of midwife must always be respected **(Article 25)**.

E) OTHER RELEVANT SOURCES

There are no other relevant sources on this right.

F) PRACTICAL EXAMPLES

1. Example of Compliance

Mr. C, who is admitted to a hospital for a pulmonary condition, is unpleased with the treatment prescribed by his physician. Wanting to find out whether there are any viable alternatives of treatment for his problem, Mr. C requests by a written letter sent to the hospital where he is admitted to obtain the opinion of an external physician. Under Law no. 46/2003 on the patient's rights and its implementation procedures, the hospital approves the request written by Mr. C and ensures the presence in the hospital of an external physician who, as a result of an investigation, prescribes a new treatment to Mr. C.

2. Example of Violation

Mrs. B., who is registered as having his domicile in Bucharest, but residing in Constanţa, wants to register with a family physician in Constanţa. In this regard, Mrs. B. sends a written request to a family physician in Constanța, whereby she requests her registration on his/her lists. The physician chosen by Mrs. B. provides a negative answer to the request, stating that he/she cannot register a person domiciling in another town.

3. Actual Case

B.M. and B.O. are the parents of a girl born with physical disability. While B.O. was pregnant, the couple went to a local OBGYN doctor's office – Dr. A.M. – in order to monitor the evolution of the pregnancy and identify eventual anomalies of the foetus. According to the existing medical protocols in this domain, the ultrasound evaluation of the pregnancy entails performing at least three ultrasounds exams, one of each trimester. Dr. A.M. did not have the professional competence to perform ultrasound scans and did not inform the patient about this limitation. On the contrary, Dr. A.M. performed multiple ultrasound examinations during the pregnancy and repeatedly assured the couple that there was nothing wrong with the pregnancy. Finally, B.O. delivered a baby with severe malformation of the

lower limbs. This malformation could have been observed by a doctor with competence in interpreting ultrasound scans and it would have been a reason for terminating the pregnancy on medical grounds. The couple brought a civil suit against the doctor. The court awarded the claimants with moral damages and held that the claimants were deprived of their right to information by the fact that the doctor did not inform them about her lack of attested competence regarding ultrasound examinations. The court also stated that by performing ultrasound test during the whole duration of the pregnancy, the doctor abused the patient-doctor relationship. The court ordered the doctor to pay 20,000 RON (approx. 4,500 Euro) in moral damages[728]. *(Author's note: The case described above concerns the right to free choice because the OBGYN doctor did not provide the pregnant woman and her partner with the proper information in order to allow them to make a choice regarding the continuation of the pregnancy. In the proceedings before court, the claimants complained that the foetus abnormality would have easily been detected sooner by a competent doctor and would have led to the termination of pregnancy.)*

G) PRACTICE NOTES FOR LAWYERS

- There are certain cases, provided for in the legislation in force, in which a person is not entitled to refuse a certain treatment or medical measure or choose its termination or change, once it has been started. Thus, the Criminal Code provides, among the safety measures[729], the obligation of medical treatment **(Article 109)** and admission **(Article 110)**.
  - **Article 109: Obligation to medical treatment:**
    - *(1) If the perpetrator, due to illness, including those caused by chronic alcohol consumption or other psychoactive substances, is a threat to the society, he/she may be obliged to follow a medical treatment until he/she is recovered or until he/she obtains an improvement which should remove the risk.*
    - *(2) When the person against whom this measure has been taken does not follow the treatment, medical admission may be ordered.*
    - *(3) If the person obliged to follow the treatment is sentenced to a custodial sentence, the treatment shall also be followed while he/she serves the sentence.*
  - **Article 110: Admission**

    When the perpetrator is mentally ill, a chronic consumer of psychoactive substances or suffers from an infectious disease and is a threat to society, the admission to a specialized healthcare facility until he/she is recovered or registered an improvement which removes the risk, shall be ordered.
- **The Law on Mental Health no. 487/2002** also provides certain cases (when by his behaviour the patient may put in danger his own life or the life of the others) in which the medical treatment **(Article 29, para. 2)** or admission **(Article 53-68)** may be ordered in the absence of or against the patient's consent. Although the law does not expressly state it, the regulation of such measures results in the fact that the patients, for whom medical treatment or admission has been ordered, do not benefit of the right to free choice during the treatment.

H) CROSS-REFERENCING

Please find a discussion of international and regional standards relevant to the Right to Free Choice under:

728 Iași Tribunal, Civil Sentence no.2891 of 7 November 2012, published in Roxana Maria Călin, Malpraxis: Răspunderea medicului și a furnizorilor de servicii medicale [Malpractice. Physician and health services providers liability], 2014

729 According to Article 107 of the Criminal Code, the purpose of the safety measures is to remove a state of danger and prevent the commission of offences provided for in the criminal law. The safety measures are taken against the person who has committed an offence provided for in the criminal law and is not righteous.

- 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 TO PRIVACY AND CONFIDENTIALITY AS STATED IN THE IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

Every individual has the right to 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.

All the data and information relative to an individual's state of health, and to the medical/surgical treatments to which he or she is subjected, must be considered private, and as such, adequately protected.

Personal privacy must be respected, even in the course of medical/surgical treatments (diagnostic exams, specialist visits, medications, etc.), which must take place in an appropriate environment and in the presence of only those who absolutely need to be there (unless the patient has explicitly given consent or made a request).

B) RIGHT TO PRIVACY AND CONFIDENTIALITY AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**
  - **Article 26** of the Romanian Constitution guarantees the right to privacy, family life and private life:
    - *(1) The public authorities shall respect and protect the intimate, family and private life.*
    - *(2) Any natural person has the right to freely dispose of himself unless by this he infringes on the rights and freedoms of others, on public order or morals.*

Legislation

- **Law no. 95/2006 on the Health Reform, republished in 2015**

  This law stipulates the right to confidentiality of the insured persons **(Article 230, para. 2 pt. n)**, the institutions to which confidential information may be disclosed under certain conditions **(Article 335)**, and the accountability mechanisms available in cases of breaches of confidentiality **(Article 653, paras. 3 and 5)**. **Article 661** addresses privacy and confidentiality in the specific case of adolescents' access to sexual and reproductive health services.

  - **Article 230:** (…)*(2) The insured persons have the following rights: (…) n) the confidentiality of their information to be guaranteed, especially with respect to diagnosis and treatment; (…)*
  - **Article 653, paras. 3** and **5** states that the medical personnel is accountable in civil law for the damages caused by the breach of the provisions in the field of confidentiality from the law. The Law

on the Health Reform uses general wording; it does not distinguish or mention the types of specific civil damages. Moreover, when the acts reach the gravity of a criminal offence, criminal liability may be engaged. *(Author's note: it is important to stress that these are general provisions of law and there is no specific criminal offence to sanction breaches of confidentiality.)*

- The right to privacy and confidentiality is particularly important in the case of adolescents' access to sexual and reproductive health services. **Article 661** of the Law 95/2006 stipulates that 16-year-old adolescents may decide on their own, without parental consent, in medical situations connected to the diagnosis and/or the treatment of sexual and reproductive problems, if the adolescents especially ask for this and irrespective of age, in emergency situations, when the parents or the legal representatives cannot be contacted and the minors have the necessary discernment to understand their medical situations.

Law no. 46/2003 on the Right of Patients

The law has an entire chapter on the right to confidentiality and private life of the patient **(Chapter 4).** The law stipulates:

- the types of information that are confidential **(Article 21)**,
- the conditions for disclosing confidential information **(Articles 22, 23)**,
- the right of the patient to access his/her own file **(Article 24)** and
- the patient's right to be free from any interference with his/her private and family life **(Article 25)**.

The Civil Code

The Code stipulates the rights to private life and to the protection of personal data among several rights of the person guaranteed by the Civil Code **(Articles 71, 74, 75, 77)**.

- The Code explicitly mentions the right to privacy of the person who is receiving health care treatment **(Article 74, pt. g)**: *Under the reservation of the application of the Art. 75 provisions, the following can be considered as infringements of the private life:… disseminating materials containing images with a person who is under treatment in medical care units, as well as the personal data regarding the health state, the problems related to diagnostic, prognostic, treatment, circumstances related to the disease and other facts, including the result of autopsy, without the consent of the concerned person, and in the case the person is deceased, without the consent of his/her family or authorized persons;*

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

There are no supporting regulations, bylaws and orders we could find on this topic.

D) PROVIDER CODES OF ETHICS

Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians

The Code stipulates the doctors' obligation to respect the professional secret (**Articles 17** and **18**) and the private life of the person in relation to the information concerning the patient's health (**Articles 19** and **20**).

E) OTHER RELEVANT SOURCES

There are no other relevant sources on this topic.

F) PRACTICAL EXAMPLES

1. Example of Compliance

The medical consultation takes place in an intimate environment, outside the presence of persons who are not involved in the provision of the healthcare service to the patient (for example, other patients are not allowed to be present in the consultation room). *(Author's note: By ensuring the patient's privacy, the doctor or institution will ensure that he/she will be more open in the relation with his/her doctor and feel free to share information about his/her intimate and private life that could be essential for making a correct diagnosis or recommending the most adequate treatment).*

2. Examples of Violation

- **Example 1:** "The doctor asked me to climb on the gynecological table and performed the check-up. I was exposed with my intimate parts towards the part of the room where several persons were going in and out of the room the entire period of my check-up. They were probably medical personnel, among whom was a male who had nothing to do with my check-up. It was terrible... I felt humiliated and hurt."[730]
- **Example 2:** In several maternity hospitals in Romania, there is the practice of writing expressions like "mother with AIDS", "born from a mother with HIV", "the mother is carrying HIV virus" or "HIV" on individual labels and placing them on the beds of newborn children from women who live with HIV.[731]
- **Example 3:** Oana gave birth by Caesarean section to two children, one in 2007 and the second in the fall of 2010. In 2007, after birth, the medical assistant from Neonatology disclosed Oana's HIV status to Oana's mother-in-law: "The medical assistant asked me if I gave the treatment to child [with reference to the ARV]. My mother-in-law asked her what was wrong with the child". The medical assistant replied: "the child is fine, his mother has AIDS."[732]

3. Actual Case

The social assistance department of the mayor's office in Bucharest was handling personal data about the HIV status of the persons in its jurisdiction related to payments of a special social protection allowance. The office published on its internet website the list of persons living with HIV who receive the allowance, disclosing to the general public personal information about the health status of the persons on the list. One of the victims filed a civil case against the mayor's office. Judecătoria Sectorului 1 Bucureşti [The First Instance Court of the First District Bucharest] decided that the obligation of confidentiality was breached and ordered the mayor's office to pay the amount of 10,000 Euro compensation for moral damages to the complainant.[733]

G) PRACTICE NOTES FOR LAWYERS

- More often than in other cases, a complainant who files a case regarding the violation of the right to privacy and confidentiality needs to be ensured respect of confidentiality (to diminish as much as possible the damage to his privacy and confidentiality). This is a well-founded ground for a request to keep the hearing of the case in court or before the National Council for Combating Discrimination behind closed doors, according to **Article 213** of the Civil Procedure Code. More specifically, according

730 Case documented by ECPI in Drepturile sexuale şi ale reproducerii. Cazul femeilor care trăiesc cu HIV [Sexual and reproductive rights. The case of women who live with HIV], June 2011, p.28, available at http://www.ecpi.ro/wp-content/uploads/2012/01/Raport_femei-cu-HIV_website.pdf.

731 Case documented by ECPI in Drepturile sexuale şi ale reproducerii. Cazul femeilor care trăiesc cu HIV [Sexual and reproductive rights. The case of women who live with HIV],, June 2011, p.33, available at http://www.ecpi.ro/wp-content/uploads/2012/01/Raport_femei-cu-HIV_website.pdf.

732 Case documented by ECPI in Drepturile sexuale şi ale reproducerii. Cazul femeilor care trăiesc cu HIV [Sexual and reproductive rights. The case of women who live with HIV],, June 2011, p.33, available at http://www.ecpi.ro/wp-content/uploads/2012/01/Raport_femei-cu-HIV_website.pdf.

733 *Judecătoria Sectorului 1 Bucureşti* [The First Instance Court of the First District Bucharest], Civil Sentence of 16.03.2009, available at http://www.juridice.ro/100724/judecatoria-sectorului-1-daune-morale-pentru-publicarea-pe-internet-a-datelor-personale.html.

to **Article 213, para. 2** of the Civil Procedure Code, *in cases where the debate on the merits taking place in public will affect the morality, public order, the interests of minors, the private life of the parties or the interests of justice, respectively, the court ex officio or by request may order that the debate take place without the presence of the public for the entire procedure or part of it.* [734]

- When the breach of confidentiality takes place by publishing information online or in other public places, it is important for the lawyer to safeguard all evidence available as soon as he/she knows about the violation – for example making a print screen of the website, taking a picture of the announcement, bringing an eye-witness, taking the contact details of the eye-witnesses, etc. It is important that the date and time the evidence was collected appear on the written evidence, etc.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please review the information provided under the Right to Privacy and Confidentiality and the Right to Freedom from Torture and Cruel, Inhuman, and Degrading Treatment in Chapter 2 and Chapter 3.

6.1.7 Right to Respect for Patients' Time

A) RIGHT TO RESPECT FOR PATIENT'S TIME AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

Each individual has the right to receive necessary treatment within a swift and predetermined period of time. This right applies at each phase of the treatment.

The health services have the duty to fix waiting times within which certain services must be provided, on the basis of specific standards and depending on the degree of urgency of the case. The health services must guarantee each individual access to services, ensuring immediate sign-up in the case of waiting lists.

Every individual that so requests, has the right to consult the waiting lists within the bounds of respect for privacy norms.

Whenever the health services are unable to provide services within the predetermined maximum times, the possibility to seek alternative services of comparable quality must be guaranteed, and any costs borne by the patient must be reimbursed within a reasonable time.

Doctors must devote adequate time to their patients, including the time dedicated to providing information

B) RIGHT TO RESPECT FOR PATIENT'S TIME AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003**

  The right to respect for patients' time is not directly specified in the Constitution. Yet, the following articles are relevant:

  - **Article 22** on the Right to life and physical and psychical integrity:
    - guarantees to any person both the right to life and the right to physical and psychical integrity;

734 Code of Civil Procedure, Article 213, para. 2.

- bans the torture, punishment or inhuman or degrading treatment, as well the death penalty.

- **Article 34** on the Right to health protection:
  - guarantees to any person the health protection;
  - establishes as responsibility of the State to take measures in order to ensure public health and hygiene;
  - provides that special laws will regulate the organization of medical care and the social insurance system for disease, accidents, maternity and recovery, control of exercise of the medical professions and paramedical activities, as well as other measures for the protection of physical and mental health of the person

In order for rights to be practical and effective, and respective of a patient's time, then the medical services must be provided in time to allow the best chance for curing the patient. The State has the obligation to take appropriate legislative measures that provide the patient with the rights to life, health protection and medical services in the State medical units.

Social protection that certain categories of persons enjoy, respectively children **(Article 49)**, young people and persons with disabilities **(Article 50)**, also consists of granting medical care with priority.

Legislation

The Right to respect of patients' time is not expressly provided in the health care legislation. Yet, it implicitly derives from other provisions comprised in the law.

Law no. 95/2006 on the Health Reform, republished in 2015

The medical care in Romania is provided under the following forms: primary health care[735], emergency medical care[736]; specialised ambulatory care[737], and hospital care[738].

The legal provisions from the framework law highlighting the reviewed right are those relating to medical emergencies.

- Emergency medical care is provided both under private and public regimes[739].
- *The national system of emergency and qualified first aid medical services represents the ensemble of structures, forces, mechanisms and relations, organized following the same principles and rules, which use integrated, specialised and/or qualified management procedures* **(Article 92, para. 1, letter a)**.
- *Integrated emergency public care* refers to *the care provided by the public institutions within the structures of the Ministry of Health, Ministry of Administration and Internal Affairs and/or in the structure of the local public authorities, as well as by the Special Telecommunications Service, by the Directorate for sole emergency number 1-1-2, including the structure of logistic, technical and medical measures and activities intended mainly for saving and preserving life* **(Article 92, para. 1, letter b).**
- *Private emergency medical care* consists of *logistic and medical measures and activities, whose purpose is mainly to save and preserve life, provided by the emergency private services belonging to some non-governmental organizations, which are non-profit and function for humanitarian purposes, or to some companies, associations or natural persons which function for commercial purposes* **(Article 92, para. 1, letter c).**

735 Stipulated in Title III – Primary health care, which is provided by the family health services, consisting in the comprehensive, first - contact heath care, irrespective of the nature of the health issue, within the framework of a continuous relationship with the patients, in the presence of the disease or in its absence (Article 63).
736 Stipulated in Title IV - National system of emergency medical care and qualified first aid, which regulates emergency medical care under both public and private regimes.
737 Stipulated in Title V – Specialised ambulatory care, which is provided by clinical, paraclinical and dental services, performed by specialised doctors along with other specialised and authorized personnel (Articles 133 and 135);
738 Stipulated in Title VII – Hospitals.
739 Title IV – Chapter 1 Section III and Section IV.

Title IV, Chapter 1 Section II regulates basic first aid and qualified first aid as follows:

- **Article 93, para. 1** indicates the persons who can provide basic first aid: *without specific equipment, it can be any person trained in this respect or without prior training but who acts based on the indications of the specialised personnel within the emergency medical dispatching or SMURD*[740] *type pre-hospital emergency services and County or Bucharest municipality ambulance service, with the purpose to prevent complications and save life until the arrival of the intervention team (Authors' note: training here refers to training in first aid methods; it is provided in schools or for volunteers; an untrained persons can talk by phone to a doctor or a nurse and received indications on what to do or not to do for the patient until and emergency unit arrives.)*
- **Article 94, para. 1** establishes the civil and criminal liability of the persons with no medical training providing first aid based on volunteering, based on the indications supplied by a medical dispatching or some knowledge in the field of basic first aid, acting in good faith and with the intention of saving the life and health of a person *(Authors' note: the person giving first aid is not liable criminally or civilly, which means that the person will never be prosecuted for any crime and that the person in need of help may not file a civil claim for damages against the person who gave him aid)*
- **Article 93, para. 2** states the *obligation of any citizen to directly call the emergency services, or to make sure that emergency services were already called at the unique number 1-1-2, before or simultaneously with providing first aid, as well as the obligation to comply with the specialised indications given by the emergency dispatching service (Authors' note: the person who calls 112 and the person providing first aid can be one in the same or separate persons; in either instance they must comply with any indications offered to them by the emergency dispatching service.)*
- **Article 93, para. 3** establishes the state's obligation to provide qualified first aid[741], this being a citizen's right, while at the same time, banning the provision of qualified first aid for commercial purposes;
- **Article 93, para. 4** establishes that *qualified first aid is provided in an institutionalised framework, by the teams under the coordination of the emergency situations inspectorates, in collaboration with the local public authorities and structures of the Ministry of Health;*
- **Article 93, para. 8** establishes the maximal arrival time at the place of intervention following the emergency call for the purpose of granting qualified first aid, respectively:
  - 8 minutes in the urban areas, to at least 90% of the emergency cases;
  - 12 minutes in the rural areas, to at least 75% of the emergency cases.
- **Article 94, para. 2** states that *the civil or criminal liability of the paramedical personnel is discarded if it is found, according to the law, that they performed in good faith any action in relation to providing qualified first aid, in compliance within their individual competency, protocols and procedures established under the law.*

In other words, the State is bound to provide for the existence and functioning of some specific bodies that can provide, under emergency situations, timely, necessary medical care to the patient.

Title IV, Chapter II – Providing emergency medical and technical public care and qualified first aid establishes details on the manner and certain measures for providing public medical care as follows:

- *pre-hospital emergency public care is coordinated at the county or regional level by the specialised medical dispatching service, using the infrastructure of the National Sole System for Emergency Calls* **(Article 104)**;
- pre-hospital emergency public care is organised at rural, urban, county/Bucharest municipality

740 SMURD stands for Serviciul Mobil de Urgență, Reanimare și Descarcerare - Mobile Emergency Service for Resuscitation and Extrication.

741 Qualified first aid means performing life- saving actions of people who have suffered an injury or acute disease, by paramedical staff who attended special training courses and is equipped with specific equipment for this purpose, including semiautomatic defibrillators operating below form of first aid teams in an institutional framework (Article 92, para. 1 letter h).

and regional level, being provided at various levels of competence, starting from qualified first aid, provided by the teams at the rural level, up to the level of air rescue intervention with specialised medical personnel, operating at the regional level **(Article 105, paras. 1 and 2)**;

- *the medical and para-medical personnel trained on qualified first aid have the obligation to provide first aid, spontaneously or on request, to the persons in vital danger; if the aforementioned personnel are outside working hours, then they must provide first aid until taken over by a specialized intervention team* **(Article 105, para. 8);**

Title IV, Chapter III – Providing private emergency medical care regulates private medical care for emergency cases:

- the private medical care services supplier shall have its own dispatching service **(Article 110, para. 1)** and must have the necessary means for covering the concerned geographic area within the frame time envisaged for the public services for the various emergency categories **(Article 110, para. 2);**
- the ambulances and the equipment used by the private emergency service must comply with the minimum regulations and standard required for the public pre-hospital emergency public services **(Article 110, para. 3);**
- Private hospitals must reach the minimum standards required by the Ministry of Health for public emergency hospital services **(Article 111, para. 2)**;
- *Private hospital emergency medical care providers are obligated to stabilize any patient who arrives in that service in a critical condition or complains about health issues that raise the suspicion of a serious acute disease, irrespective of the patient's financial capacity to pay the costs of the treatment and quality of insurance, with the possibility of transporting this person to a clinical hospital, under appropriate conditions, only after the stabilization of the vital functions and providing of emergency treatment* **(Article 111, para. 3)**;
- *If private hospitals do not have on-duty emergency services within their structure, they must provide first aid and then call public emergency services at the unique 1-1-2 number* **(Article 111, para. 4)**.

Within Law no. 95/2006 on the Health Reform, republished, besides the title dedicated to emergency medical care, there are also other relevant articles such as:

- **Article 67, letter e** institutes the family doctor's obligation to provide for the continuity of primary medical care by performing emergency check-ups outside the normal working hours of the family medical practices, as well as perform on-call medical services;
- **Article 80, para. 2, letter a** enumerates the essential medical services within primary medical care offered by all the family doctors and interventions that are indispensable for medico-surgical emergencies;
- **Article 168** establishes that providing first aid and emergency medical care to any person who comes to the hospital, if the person's health condition is critical, is incumbent upon the hospital; and after the stabilization of the vital functions, the hospital shall provide, if applicable, mandatory medicalised transport to another specialised medico-sanitary unit;
- **Article 421, letter c** establishes the obligation of the members of the Romanian College of Physicians, deriving from their special capacity as doctors, to promptly and unconditionally provide emergency medical care as a professional and civic fundamental duty.

Law no. 46/2003 on the Rights of Patients

Indirectly, the Right to respect for patients' time is implicitly provided in this law, in relation to the patient's right to express his/her consent in relation to a specific medical intervention and the right to treatment and medical care.

- **Article 14** stipulates:
  - the rule according to which the patient must express his/her consent to the best of his/her knowledge before any medical intervention or administration of any treatment;
  - the exception, which emerges from the situation in which the patient cannot express his/her will, but an *emergency medical intervention* is necessary, so that the medical personnel have the right to infer the patient's consent from a previous expression of the patient's will.
- **Article 36** establishes the patient's right to emergency medical care, emergency dental care and pharmaceutical services, within an on-going program.

C) SUPPORTING REGULATIONS / BYLAWS / ORDERS

Order no. 48/2009 regarding the approval of the National Triage Protocol for patients in structures designed for receiving medical emergency cases

The National Triage Protocol at item III establishes that the time that triage occurs or when the patient entered the emergency structure is the time of the takeover of the patient by a person from the unit's personnel, and defines two parameters: *(I) The time patient entered the emergency service area is the moment of taking the patient into one of the treatment areas; (II) the time of taking the patient into one of the treatment areas is the time of the first medical check-up. The average time of triage must not take more than two minutes* per patient. The term is one of recommendation.

Government Decision no. 400/2014 on the approval of the package of services and the Framework Contract on the conditions of health care provision within the social health insurance system for the years 2014 - 2015

The framework contract particularly regulates the relations between the health services providers and the health insurance house, as well as the rights and obligations of the both insured and non-insured persons.

At **Annex 1, The minimal benefit package and the basic benefit package, Section 3: The minimal package of services for the hospital care** of the Framework-contract it is established the obligation of hospitals to provide emergency medical services to all patients in need, undifferentiated, no matter if they can or cannot prove that they are insured in the national health insurance system. The patient shall be discharged only if his/her health condition no longer represents an emergency[742].

Order of the Ministry of Health no. 1706/2007 on the running and organization of the units and compartments for emergency receiving (UPU and CPU)

According to the provisions of the Order, all patients have the right to be admitted and checked-up in UPU and CPU sections, when requesting emergency medical care.

- **Article 42:**
  - Emergency receiving units (UPU743) and emergency receiving compartments (CPU744) are

742 In accordance with Article 92, para. 1, letter e of the Law no. 95/2006 on the health reform, a medical emergency represents the accident or acute disease that requires provision of qualified first aid and/or emergency medical care, at one or several levels of competency, as it is the case. It can be an emergency of vital danger, where one or several intervention resources in the pre-hospital stage are necessary, continuing care in a local, district or regional hospital, or emergency without vital danger, where care can be performed, if applicable, with or without using pre-hospital resources, at an authorised centre or medical consulting room or if applicable, at a hospital.

743 Article 1, item 1 of the mentioned Order defines the emergency receiving unit (UPU) as being the section or clinical section within the structure of a district or regional hospital or in the structure of the hospitals belonging of the ministries and institutions which have their own health networks, their own personnel, specially trained, intended for the triage, evaluation and treatment in emergency situations of patients with acute diseases, who spontaneously come to the hospital on their own or are transported by ambulances.

744 Article 1, item 1 of the mentioned Order defines the emergency receiving compartment (CPU) as being the section within the structure of a city or municipal hospital or within the structure of the hospitals belonging to the ministries and institutions which have their own health networks, their own personnel, specially trained, intended for the triage, evaluation and treatment in emergency

opened to all patients requiring emergency medical care. Refuse of such emergency medical care is banned, without the evaluation of the patient's condition by a doctor within UPU or CPU, and the establishment of the lack of diseases requiring medical care within a UPU/CPU and the possible hospitalization of the patient **(Article 43)**;

- **Article 59:**
  - institutes the obligation of the on-duty doctors within the hospital to promptly answer the call to a UPU or CPU, irrespective of the time of the request, whenever the on-duty doctor within the UPU or CPU considers it necessary;
  - institutes the obligation of the on-duty doctors from the hospital, in the case of patients in critical condition or whose condition requires immediate specific specialised check-up, to come to the UPU or CPU within a maximum of 10 minutes from the request;
  - establishes the duration of the deadline by which the specialist doctors called from the hospital have the obligation to answer the requests; in the case of the stable patients this deadline being 60 minutes.
- **Article 78** establishes the UPU or CPU personnel's obligation to examine the patient as soon as possible.
- **Article 81** institutes the obligation of the teams transporting patients in critical condition to inform the UPU or CPU of their arrival, with at least 10 minutes before arriving at the hospital.
- **Article 92** establishes the conditions under which intra-hospital intervention teams can be created and institutes, for these teams, the mandatory timeframe within which they must act, respectively:
  - to be available immediately in case of a call;
  - to make their calling possible by using an interior number especially intended for this action and which must be available 24 hours a day, 7 days a week;
  - to arrive at the UPU or CPU within a maximum of one minute from receiving the call.

Order no. 1091/2006 on the approval of the protocols for the inter-clinical transfer of the critical patient

The Order approves the protocols for inter-clinical transfer (transfer between hospitals) of the critical patient, when the patient is transferred to a unit having a therapeutic capacity greater than the unit requesting the transfer **(Articles 2 and 4).**

For critical patients, such as those with unstable vital functions or with diseases that might have irreversible complications requiring investigations, interventions and/or special medical care provided by a complex, multidisciplinary team in a general or specialised intensive care clinic or section the Order provides that the hospital where the patient is initially brought can transfer the patient to another healthcare facility having a higher level of competence and/or equipment than the medical unit sending the patient **(Article 1).**

For carrying out the transfer, the doctor of the medical unit transferring the patient shall avoid unjustified delays (**pt. 2, sub-item 1, letter e** of the transfer protocol, Annex I to the Order no. 1091/2006). In this respect, too, there is a possibility of transfer of the patient without the prior consent of the medical unit where the patient in immediate need of life-saving treatment is transferred, with notification to the receiving medical unit as soon as possible **(Article 12)**.[745]

Order no. 125/2012 on the provision of medical care to the persons deprived of liberty in the

situations of the patients with acute diseases, who spontaneously come to the hospital on their own or are transported by ambulances.

745 The rule is that prior to the transfer of the patient, the doctor of the sending unit must obtain the consent of the receiving unit (item 1 sub-item 6 of the transfer protocol, Annex I to the Order 1091/2006). In the shown situation of the case of the critical patients requiring emergency intervention for the purpose of saving life at a district or regional hospital, this consent is no longer necessary; but the doctor making the transfer must inform the receiving unit as shortly as possible.

custody of the National Administration of Penitentiaries

- **Article 35** establishes that any medico-surgical emergency is to be presented at the medical consulting room within the premises of the penitentiary, immediately, where the doctor and/or the nurse take/takes necessary measures, within their limit of competence. **Article 35, para. 2**, establishes that in case the emergency cannot be dealt with medical measures within the penitentiary, the patient shall be taken to the closest hospital unit. The procedure is initiated by notifying the management of the penitentiary on the situation in order for the management to provide a means of transport and necessary escort or, if applicable, by calling the district ambulance service.

D) PROVIDERS CODES OF ETHICS

Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians

The right to respect of the patient's time is closely related to the patient's right to freely consent to any medical intervention or treatment.

The medical deontological code establishes:

- *the rule* that any intervention in the field of health can be carried out only after the concerned person has given his/her free consent and is fully aware of the situation **(Article 11, para. 1)** and
- *the exception*, meaning that in emergency situations, when the concerned person cannot give his/her consent, any necessary medical intervention can be performed for the benefit of the patient's health **(Article 15)**.

E) OTHER RELEVANT SOURCES

There are no other relevant sources regarding the Right to Respect for Patient's Time.

F) PRACTICAL EXAMPLES

1. Example of Compliance

Patient A, male, reached the emergency receiving unit (UPU) of a hospital complaining about unbearable pains in the abdominal area. When he went to register and provide the identity document, he fainted and the medical personnel from the section immediately called the on-duty doctor. Subsequently, an entire team of doctors and nurses provided him medical care – the patient was intubated and then operated on as he had an internal haemorrhage. When the patient regained consciousness, the doctor responsible for his case gave him full details about the operation that had been performed and recommended admission for at least 10 days, as well as the administration of a specific treatment for the patient's disease. The patient consented to admission and treatment.

2. Examples of Violation

Example 1: Patient A, male, called the ambulance at emergency number 112. The service arrived within the legal time-limit and the patient was transported to the closest emergency hospital and his care was subsequently taken over by the hospital medical personnel who checked him and concluded it was a medical emergency. However, they had neither the devices nor the qualified medical personnel for treatment. Thus, they sent the patient by ambulance to an emergency hospital. All this long while the patient was vomiting and could hardly breathe. The ambulance reached the emergency hospital in 20 minutes. Within this timeframe the patient fainted several times. At the emergency hospital, he was put on a stretcher in the hall until the arrival of the specialist doctor. The doctor checked the almost-unconscious patient after barely 30 minutes from the call and established that the patient was

stable and could wait, even though he was severely dehydrated. Three hours after the check-up, the patient went into a coma.

Example 2[746]: D. G, 57 years old, was admitted to the Iași Neurosurgery Hospital with the diagnosis of a brain tumour. He was not operated on for lack of blood in the hospital, as the hospital management argues. Upon admission, the patient was told that he would be urgently operated on, but he was submitted to preparatory tests for a few days. On the day he was notified that he was going to be operated on, he was prepared to be taken to the surgery room, but the surgery was postponed because an emergency patient had arrived. D.G was rescheduled for surgery within two days. But the day when he was to be operated on, the surgery was postponed again, without establishing an exact date, for the reason that the hospital had no blood matching his blood type. Doctors told the patient that the postponement of the surgery would not represent a problem for him and that he had chances of recovery if he had surgery. In the end the patient died without having surgery. The patient's relatives declared that they did not know that the operation had been postponed for lack of blood and, if they had known, they would have donated blood themselves. Furthermore, they stated that they would request the opening of an investigation.

Doctor F. G., who was part of the hospital staff, expressed his opinion that the patient suffered from glioblastoma, a very aggressive type of brain tumour and that he had very little chances of survival, even if he had had surgery. The doctor's explanation regarding the first postponement of the procedure was due to the other emergency patient, where the A2 blood necessary for the patient D.G was used. The doctor contended that the other alleged emergency case consisted of a case of an aneurism, and that the other emergency patient would have died in a few minutes if he had not immediately received the A2 positive blood transfusion. Furthermore, it was found that at Iași Blood Collection and Transfusion Centre (CRTS) Iași, no A2 positive blood was requested by the Neurosurgery Hospital, even though CRTS had the blood on store and, if it had been requested, it would have been delivered in time for the patient's surgery. Yet, the hospital manager, Dr. D. T, decided to perform no internal investigation because he thought that the deceased patient did not represent an emergency patient who needed surgery. *(Author's note: at the moment of writing of this Guide there is no knowledge of whether measures have been taken against the responsible medical personnel).*

3. Actual Cases

Case no. 1 – medical fault – postponement of the necessary surgery

This case is based on file number Xxx/xxx, registered with Suceava District Court, which refers to bodily injury, a crime based on the alleged fault of the defendant CC, a nurse within X Emergency Hospital. The injured party, patient BG, was the plaintiff.

Patient BG was admitted to X Emergency Hospital in order to undergo a surgical intervention after being diagnosed with a disc hernia. The next day after surgery, he was transferred to the ATI section for the administration of a medicinal treatment. Five days after surgery the patient complained about severe pains at the level of the right hand, pains that showed up after the intravenous administration (by injection) of (antibiotic) treatment, even though the injection was made in the left hand. Two hours after the administration of the treatment, the patient was checked by a doctor from the vascular surgery department who determined that the patient's hand needed surgery. The patient underwent several surgical interventions to save his hand, as the blood circulation had been severely affected; in the end the patient's hand was amputated.

From the medico-legal forensics in the case file, the forensic doctor reached the conclusion that there was a causal relationship between the injection administered by the defendant nurse and the complications suffered by the patient, complications that led to his hand's amputation. The finding of the causal link was based upon the fact that the administered substance was irritating the pathological background of the patient, considering the individual reactivity particularities. In the medical expertise reports, a conclusion was reached that the drug was most likely administered paravenously or intra-

746 Source: http://stirile.rol.ro/print/un-iesean-de-57-de-ani-a-decedat-pentru-ca-spitalul-nu-avea-sange-189076.html.

arterially, causing spasm and thrombosis of a brachial artery and acute ischemia of the left arm. With regard to the therapeutic attitude that followed the vascular surgery check-up, the forensic experts appreciated that it was conservative and not recommended in the given the patient's situation, and that the intervention of revascularization had to be performed as soon as possible, and its postponement by more than 8 hours compromised the patient's microvascularization and led to irreversible ischemia[747].

In the same time, the experts' committee established that the administration of the injection drug was performed through an improper technique. In the opinion of the Superior Forensic Commission it was acknowledged that the drug administration was incorrect and consisted in accidental penetration of the needle beyond or by the venous vascular lumen, most likely penetrating an arterial vessel. Additionally, the medical expertise showed that the patient was prescribed and administered a drug that was not necessary or recommended in post-surgery treatment for disk hernia ablation. But in this respect, the court considered that the defendant is not guilty of administration, given the fact that in her capacity of nurse, she did nothing but follow the instructions of the attending doctor.

The court of first instance found that no medical fault or perpetration of a crime by the defendant could be established and acquitted the defendant. Subsequently, the decision was contested, and the Suceava Court of Appeal reversed the lower court decision as a whole, convicting the defendant and granting the patient/plaintiff, moral and material compensation748. Thus, the appellate court considered that the court of first instance wrongly ignored the forensic expertises in the case file, even though they clearly showed that the defendant, by the defective technique of drug administration, had caused complications to the patient, complications that subsequently led to the amputation of the patient's left hand. The appellate court upheld the conclusions in terms of therapeutic attitude, meaning that the revascularization intervention had to be performed as soon as possible, and its postponement by more than 8 hours compromised the patient's microvascularization and led to irreversible ischemia.

Case no. 2 – wrong diagnosing. Delay in applying the appropriate treatment

Galaţi Court of Appeal by penal Decision no. 581/R/19.09.2005 ordered the conviction of the defendant doctor GH, for manslaughter against the patient.

In order to rule that a crime of manslaughter was committed by the defendant, the court considered the following arguments[749]:

- in establishing medical fault (s.n. by negligence in this case), what matters is the reasonable character of the doctor's conduct that must be evaluated, according to the specific circumstances of the case;
- medical fault implies the failure to act in accordance with the accepted standards, depending on the qualification of the concerned doctor;
- the patient was admitted on 09.06.1997 under the surveillance of the defendant doctor GH, being diagnosed with disc hernia, hepatic cirrhosis, and billiary colitis;
- upon admission, the victim/patient and her son informed the defendant doctor that the patient had taken for six months a treatment of 8 tablets a day of prednisone (cortisone) without medical surveillance, as such the defence capacity of the body is diminished – increasing the risk of infection that can lead to septicaemia and subsequently to death. Moreover, that as a rule, after a treatment with cortisone it is not recommended to undergo an injection treatment;
- yet, the defendant ordered an injection treatment with algocalmin, in doses of 6 and 9 phials, for a period ranging between 09.06 - 15.06.1997;
- the medical documents from the case file led to the determination that the infection in the patient's body peaked on 12.06.1997 and became aggravated on 16.06.97 because of the epidural injection administered by another doctor without mentioning the drug used in the

747 Criminal decision no. 94/13.02.2012.
748 Decision no. 582/14.06.2012.
749 Decision no. 581/R/19.09.05.

patient's medical observation sheet;

- on 18.06.97 another doctor noticed on the buttock of the patient a redness that could indicate a possible infection, thus inscribed in the patient medical record "pay attention to the right buttock" and recommended a nurse to inform the attending doctor *(Author's note: the defendant is the attending doctor)* on what he noticed and recommended that the nurse apply a bag of ice on the affected area on the patient's body;
- the doctor who first noticed the redness declared to the court that the concerned area was swollen, red, tumid possibly phlegmon in its development. Yet, as he was not the attending doctor of the patient, he could not establish a diagnosis, since this is the responsibility of the attending doctor;
- even though the nurse informed the defendant (the attending physician) of the red blotch on the patient's body, the attending doctor considered that there was no reason for worry and that ice bags should be applied further on;
- the forensic expertise performed in the case led to the conclusion that the defendant doctor should have taken precaution measures with regard to the patient's redness, *at the latest on 18.06.97. Only on 19.06.97 did the defendant examine the patient upon her family's request*, and established that it was not an infection but a form of cellulites and recommended the application of a bag of ice and rivanol compresses on the affected area;
- the expertise showed that the patient's death was due to the toxic - septic condition, the consequence of a gluteal phlegmon, with necrotising fasciitis having occurred following an injection, even though it was known that the patient was under chronic immunosuppressive treatment with corticoids;
- the experts established that the severe and irreversible evolution of the patient condition was also due to the lack of timely *detection of the infection and providing appropriate treatment which would have saved the patient's life;*
- the conclusion of the experts was that the *treatment in the first moment* of the infection would have allowed the survival of the patient;
- after 19.06.97, the defendant left the city and returned on 23.06.97. During this timeframe, the patient's condition was aggravated and was checked by a neurosurgeon, who after examining the patient concluded that he was suffering from septic shock;
- on 25.06.97 the patient died, after a team of doctors performed all the possible procedures within their capacity to save her life. The death was caused by generalised septicaemia.

Concluding, the court established that the defendant was guilty by patient death as he (i) did not prescribed an adequate treatment to prevent the infection of the patient and (ii) *did not examined the patient in proper time*, but only the second day, even if he knew about the redness on the patient body, and he examined the patient only at the family request.

G) PRACTICE NOTES FOR LAWYERS

In case the breach of the Right to Respect for Patient's time is caused by a significant delay in the administration of a new treatment or by not identifying a medical situation as an urgent one, the patient's lawyer must consider some of the following issues, before advising the client on the opening of the procedures for establishing the liability of the medical personnel and repairing the damages caused:

- **The exact factual situation, namely:**

• the moment when the patient came or was brought to the sanitary unit, was admitted by the medical personnel, and was checked by the doctor;

• the manner in which the check-up took place (for example, the check- up was superficial or, on the contrary, detailed);

- if the patient had a cooperating attitude and offered the doctor, within the procedure, relevant and complete information related to his/her current and/or past health condition;
- the type of medical unit which provided the care, such as emergency, sole specialty, general, etc;
- whether the medical unit was authorised to supply medical services of the nature of those for which the patient was admitted;
- whether all the preliminary diagnosis procedures were made in the given case;
- whether procedures regulating situations of the type of those for which the patient was brought to the medical unit should have existed and/or did exist.

The competencies of the medical personnel:

- whether the doctor was specialised or not (if not, and if there was a specialised doctor who did not come to check the patient, what was the reason or, if not, and if there was no doctor in the sanitary unit, what was the justification for this);
- whether the deed of the medical personnel, by which a damage was caused to the patient, was intentional or was due to negligence, or to the insufficient equipment of the health unit.

The medical documents:

- to what extent the doctor indicated investigation or laboratory tests;
- whether the indicated investigations or laboratory tests were specific to the case;
- what was the final diagnosis;
- what was the admission or provisional diagnosis.

The elaboration of the medical documents:

- whether all the necessary documents provided by law were drafted, starting from the admission sheet and ending with the patient's consent;
- the manner in which the patient's medical record, as well as other medical documents, was drafted, meaning if it complies with the relevant legislation.

Ttatements/opinions of some directly involved persons:

- eye witnesses;
- medical personnel, including the one on the ambulance, if applicable;
- patient's statement if possible; an important issue is that the lawyer finds out from the patient or from his/her relatives if he/she also suffered from other diseases that existed before the emergency intervention.

Taking into consideration the above mentioned issues, the lawyer can have an overview on the case, and analyse to what extent in legal terms the conditions of civil liability of the medical personnel can be established.

Subsequently, if the existence of a malpractice case can be considered, the lawyer can also request the opinion of an expert in the field, before informing the competent bodies on the possibility on engaging the malpractice liability of the responsible persons.

After analysing the case as a whole, along with the expert's opinion, the lawyer can recommend the client to start or not to start procedures for establishing liability of the responsible persons.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to respect for patients' time under the Right to the Highest Attainable Standard of Health in Chapter 2 and Chapter 3.

6.1.8 Right to Observance of Quality Standards

A) RIGHT TO OBSERVANCE OF QUALITY STANDARDS AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

Each individual has the right of access to high quality health services on the basis of the specification and observance of precise standards.

The right to quality health services requires that health care institutions and professionals provide satisfactory levels of technical performance, comfort and human relations. This implies the specification, and the observance, of precise quality standards, fixed by means of a public and consultative procedure and periodically reviewed and assessed.

B) RIGHT TO OBSERVANCE OF QUALITY STANDARDS AS STATED IN THE CONSTITUTION /NATIONAL LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**

  The right of the patients to benefit from the observance of quality standards in provision of medical services is not directly specified in the Constitution. As a rule, the right to the observance of quality standards is indirectly acknowledged especially by provisions that regard the right to health as a whole or the right to benefit from medical services based on *individual needs* for the purpose of receiving medical services at the highest standards.

  However, the patients' right to high quality medical services based on clearly established criteria and in compliance with precise standards is indirectly acknowledged by the following articles in Romania's Constitution:

  - **Article 34** on the right to health protection:
    - guarantees health protection to any person;
    - establishes the responsibility of the State to take measures for public health and hygiene;
    - establishes by special laws issues regarding the organization of medical care and the social insurance system for disease, accidents, maternity and recovery, and control of exercise of medical professions and paramedical activities, as well as other measures for the protection of physical and mental health of persons.
  - **Article 41, para. 2** on labour and the social protection of labour:
    - guarantees the right of the employees to social protection measures;
    - these social protection measures include employees' health, among others.
  - **Article 49, para. 2** on protection of children and young people establishes the right to benefits for the care of the ill or disabled child.
  - **Article 50** on the protection of persons with disabilities:
    - institutes as a responsibility of the State the obligation to provide for the carrying out of a national policy for equal opportunities, for the prevention and treatment of the disability, and for the actual participation of the persons with disabilities in community life, complying with the rights and obligations incumbent upon the parents and tutors.

Legislation

- **Law no. 95/2006 on the Health Reform, republished in 2015**

(Author's note: the framework law in the field often refers to the quality of the medical services in general but it does not define the notion of quality standard, which has raised and still raises issues in practice, respectively in litigious situations regarding the liability of the sanitary/health units for malpractice cases.)

The right to observance of quality standards derives from the right to benefit from medical services in general and is strongly related to the patient's right to information and security.

The main functions of public health care aim, among others, at providing quality of the public health services as well as the evaluation of quality, effectiveness, efficiency and access to medical services **(Article 5, letters g** and **m).**

Even though the framework law does not expressly describe the way in which a standard quality medical service is provided, the guarantee of quality medical services is indirectly derived from the provisions on:

- the procedures of authorization and accreditation of medical services providers (**Articles 164, para. 2, 173,** and **175**);
- the sanitary inspection procedure and the application of the penalties for the identified irregularities (**Title I: Public Health, Chapter IV: State sanitary inspection**);
- the management of hospitals and the penalties that can be applied to the manager and/or the managing board in case they do not abide by the conditions established by law **(Articles 176 and 178)** *(Author's note: Also see the Order of the Ministry of Health no. 1384/2010 on the approval of the framework model of the management contract and list of indicators of the public hospital manager activity performance);*
- the public procurement procedure for the purpose of procuring appropriate equipment for medical units (**Article 16, para. 1, letter h, Article 54, letter e, Article 58, para. 6, Article 177, para. 4, Article 187, para. 10 , letter d**);
- the regulation of the main areas of public health intervention by national health programmes (**Title II: National health programs**);
- the framework contract by which the rights of the insured persons in the public health system are established;
- the procedure of authorization of the insured patient to benefit from medical care in other states, too - cross border medical care (**Title XIX: Cross border medical care**);
- specialization of the doctors and the conditions they must fulfil in order to practice, as well as the penalties applied to them in case they breach the legislation in the field or the profession's deontology (**Articles. 376, 379, 380, 386, 387, 388, 389, 390, 391, para. 1, 412 and the following, and Article 666**);
- possibility of the doctors who come from non-EU states to perform their activity in Romania, in compliance with a prior approval procedure (**Title XII: Exercise of the doctor profession**. Organization and functioning of the Romanian College of Physicians, Chapter II: Provisions regarding the doctor profession on the Romanian territory by the doctors citizens of European Union member states, of a state belonging to the European Economic Area or of the Swiss Confederation):
- existence of practical guides for medical specialty (**Article 16, para. 1, letter g**);
- regulations on medical devices (**Title XX: Medical devices**).

A. Authorization and accreditation of medical service provider units. By regulating the procedures for the authorization and accreditation of the medical services provider units, the purpose was to create a legal framework that guarantees that medical services are safely performed.

B. State sanitary inspection. The inspection of the functioning of medical providers is carried out by the competent authorities through the sanitary inspection procedure. The state sanitary inspection is carried out in the following fields: (i) ***quality of medical care services***, (ii) public health, (iii)

pharmaceuticals, (iv) medical devices (**Article 26, para. 2**).

The competent authorities in the field of state inspection have attributions regarding the interdiction of the release for consumption, the withdrawal of the products, the temporary or final suspension of medical providers' activities, and the **withdrawal or cancellation of the sanitary authorization of the provider,** as well as of the sanitary approval of a medical services provider, of the approvals for activities and products, or any other measure as the case. **(Article 27, para. 3)**.

C. Management procedure of the public hospitals. The law establishes the management strategies and the objective criteria according to which a person can hold the position of hospital manager and his/her rights and duties **(Article 176, para. 2)**. *(Authors' note: a manager of a hospital, as a natural person or the legal representative of the legal entity as the appointed manager, must have (1) graduated from university with a specialty in medicine, economics or law; (2) graduated training classes in management and health management; (3) a master degree or doctorate in health management, economics or administrative science; a manager of a clinical hospital where clinical activity, education, and medical research take place must be an academic or physician and have graduated from training classes in management and health management.)*

D. Public procurement procedures. Public procurement represents the mechanism by which the state sanitary services buy the necessary goods for equipping the hospitals, in order to be able to provide medical services.

E. Framework contract. At the national level, there is a framework contract based on which service contracts are signed by the district health insurance houses and providers of medical services. The Framework contract is periodically adopted, and mainly regulates the conditions for providing medical care in the social health insurance system. The Framework contract also includes provisions regarding *the compliance with the quality criteria for the medical services offered within the service packages.*

According to **Article 249**, the National Authority of Quality Management in Health (hereinafter NAQMH) is the public institution with the duty to evaluate health care providers for the purpose of the accreditation of the providers. The evaluation is performed according to standards adopted by the NAQMH. The law also imposes a specific safeguard regarding quality healthcare, mainly the interdiction placed on the district health insurance houses to enter into contractual agreements with health care providers who do not meet a set of quality requirements, such as (1) having an adequate informational system for managing diagnosis and treatment, (2) using only drugs form the list of medicinal products for human use and (3) using only authorised sanitary materials and medical devices.

F. Cross border medical care. Under the conditions determined by law, the insured patients have the right to travel to third states in order to benefit from medical services. The value of these services shall be covered by the NHIH. *(Authors' note: NHIH will pay an amount equal to the value of services in Romania.)*

G. Exercise of the doctor's profession. The medical profession is a strictly regulated one[750], in the sense that a person can actually practice medicine only if certain eligibility conditions are fulfilled. In this regard, doctors must:

- be authorized by professional bodies, such as the Romanian College of Physicians;
- practice only the specialty for which they have been trained and authorised;
- practice only up to a certain age:
- prove the physical and mental skills regarding the exercise of the profession;
- perform a limited number of medical examinations of patients a certain day;
- successfully complete continuous medical training.

H. Clinical guidelines on the medical specialties. The framework law **(Article 16, para. 1, letter g)** also establishes the duty of the Ministry of Health to approve, by order of the minister, **the protocols**

750 As example, see Articles. 376, 379, 380, 386, 387, 388, 389, 390, 391, para. (1), 412 and the following, and Article 666 of Law 95/2006 on Health Reform.

standardised at the national level – Clinical guidelines elaborated by the specialty commissions of the Ministry of Health, by consulting the professional associations751.

I. Regulations on the medical devices. Law no. 95/2006 **(Title XX: Medical devices)** establishes the legal and institutional framework regarding:

- control of the medical devices and accessories which are commissioned and used,
- control of the activities of trade, distribution and service performance in the field of medical devices and accessories,
- prior approval and authorization of the distributors of medical devices and accessories and of the providers of maintenance services regarding medical devices and accessories.

The means of control of commissioned and in-use medical devices shall consist of (i) periodic checks, (ii) unannounced inspection and testing, (iii) surveillance during use **(Article 928).**

Law no. 46/2003 on the Rights of Patients

The patients' right to benefit from medical services of highest quality that the society can offer is expressly envisaged in this law **(Article 2)**. Even though it is established *expresis verbis*, the means by which this right is fulfilled by the authorities is not provided in the patients' rights law.

The quality of the medical services depends on available human, financial and material resources, there being no definition or criteria for the notion of quality in the provision of medical services **(Article 2).**

Law no. 263/2004 on the insurance of continuity of primary medical care by permanence centers

The law establishes the regime of medical care provided by permanence centres.

The permanence centres represent forms of organization of medical care, whether fixed or mobile, with no legal personality and which function outside the working hours of the family medicine consulting rooms **(Article 2, para. 1)**. *(Authors' note: the term "with no legal personality" means that the permanence centres are not separate legal entities; they work and function under the control of the district public health authorities.)*

The permanence centres can be fixed or mobile. Fixed permanence centres are health units with stable headquarters, with no legal personality that can be equipped with specialized vehicles for the performance home care. Mobile ones represent forms of organization of medical activity providing the continuity of primary health care in an on-duty regime, from the level of the ambulance services, family medicine consulting rooms or, if applicable, from the domicile of the doctor and that use specialized vehicles for home visits **(Article 2, para. 2 and para. 3).**

Other relevant normative acts that implicitly consider the right to observance of quality standards

Other relevant normative acts that implicitly consider the right to observance of quality standards refer to various categories of persons, such as those deprived of freedom, children, persons with disabilities, refugees, heroes of the Revolution in December 1989[752], war veterans and war widows[753] etc.

As a rule, all the normative acts equally establish the right of the categories of persons mentioned above to benefit from medical services in general, and in particular they establish the manner in which services are performed in the local or institutional situation, therefore establishing some guidelines that provide for the individualised treatment of their specific needs[754].

751 These guidelines are also published on the web site of the Ministry of Health at: http://www.ms.ro/index.php?pag=181&pg=1

752 Article 5 of the law no. 341/2004 - Law of gratitude towards heroes-martyrs and fighters who contributed to the victory of the Romanian Revolution in December 1989, as well as towards the persons that sacrificed their life and had to suffer following the anti- communist workmanlike revolt from Braşov in November 1987 establishes the right of the disabled persons who totally or partially lost their labour capacity to benefit from prostheses, orthoses and wheel chairs for free.

753 Article 16 letters j and letter k of the law no. 44/1994 on the war veterans as well as some rights of the war disabled and war widows envisages the right of this category of persons to free medical care in all the state civil or military medical institutions and the insurance of free drugs both in ambulatory treatments as well as during admission and to free treatment tickets in balneo-climateric resorts.

754 Order no. 125/2012 on the insurance of medical care to the persons deprived of freedom in the custody of the National Adminis-

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Norm of 7 April 2004 for the application of Law no. 46/2003 on the Rights of Patients**

  Article 3 of the Norms establishes that the medical units must use all the available means and resources in order to insure a high qualitative level of medical care.

- **Order no. 44/2010 on the approval of some measures for increasing the efficiency of the activity at the level of ambulatory medical care for the increase of the quality of medical acts within the social health insurance system**

  The provisions regard the organizational side of medical care, respectively the one regarding the scheduling of medical services, establishing certain criteria, according to the type of requested medical care **(Article 5)**.

- **Order no. 697/2011 on the approval of the methodological norms regarding the assurance of continuity of primary health care by the permanence centers**

  The Order approves the methodological norms regarding the insurance of continuity of primary medical care by permanence centres.

  The activity within the fixed permanence centres is carried out in an on-duty regime[755].

  Based on an association agreement between at least 2 family doctors, holders of family medicine consulting rooms, irrespective of the organization form, permanence centres can be constituted[756].

  In the permanence centres family doctors provide medical services consisting of:

  (I) Medical care in the acute disorders and medico-surgical emergencies, within the limits of competence of the family doctor and technical possibilities,

  (II) Sending patients to other specialties in order to be admitted in hospitals, in the situations that exceed the competencies of the family doctor,

  (III) Administration of the medication necessary for the emergency treatment which is provided from the emergency kit of the permanence centre or medical consulting room, in case the medical assistance is provided at the medical consulting room,

  (IV) Issuance of a medical certification for the patient, with which he shall go the next day to his/her family doctor for getting the prescription; on Saturdays, Sundays and holidays, the medication shall be provided from the emergency kit as long as it is necessary for the patient until he/she reaches his/her family doctor **(Article 7).**

  The medical services supplied by the permanence centres are provided to all the persons requesting them, irrespective of their insured degree status **(Article 8).**

  By Annexes 3 and 4 to the Norms approved by the Order the minimal standards for the endowment of the fixed permanence centres, as well as the component elements of the emergency kit, are established.

- **Order no. 1408/2010 on the approval of the criteria for the classification of the hospitals**

tration of Penitentiaries (Article 43, 125, 142); Law no. 254/2013 on the performance of privative punishments Article 71); Order no. 543/2006 on the manner of carrying the integrated programs of medical care, psychological and social care for the persons in freedom privative condition, drug consumers (Article 3); Order no. 426/2006 on the approval of the action plan for the implementation of the Strategy in the field of mental health (item 3.3), Law no. 448/2006 on the protection and promotion of the right of the handicapped persons (Article 6 letter a, 9, 10, 11); Law no. 272/2004 on the protection and promotion of the child rights (Article 46); Law no. 122/2006 on asylum in Romania (art. 17, letter m); Law no. 487/2002 of mental health and protection of persons with psychical disorders (Articles 24, 25).

755 Art. 2, 4, 5, 6, 9, 11, 13, 14 letter c), 16, 18, 19 para. (1) letter a) and b), 21, 24 para. (2), 35.

756 Second chapter of the methodological norms on assurance of continuity of primary health care by the permanence centres, from 25.05.2011.

according to their competence

The order classifies public hospitals in Romania according to their competence, establishing thus several categories of hospitals: very high, medium, basal and limited level of competence **(Article 1)**.

Article 2 of the Order describes the specific conditions that the hospitals must fulfil in order to be included into a certain category:

- Category I hospital, with a very high competence level
  - has the highest level of endowment with medical equipment and devices, as well as employment of human resources *(Author's note:. particularly specialised medical personnel)* and provides the supply of medical services with very high complexity degree.
  - the Category I is sub-classified into categories I[757] and I M[758];
- The Category II hospitals have a high level of competence, which refers to a high level of equipment with medical machines and devices, as well as employment of human resources, and provides the supply of medical services with high complexity degree. Category II is sub-classified, into category II[759] and respectively II M[760] hospitals.
- Category III: hospitals with average competence level for diseases with average degree of complexity.
- Category IV: hospitals with basic competence level where disorders with small degree of complexity can be treated.
- Category V: hospitals with limited level of competence which provide, if applicable, medical services (i) for the care of chronic patients, (ii) in one specialty (for instance, TBC, infectious diseases, psychiatry, recovery and others), or (iii) palliative services.

- **Article 3** establishes the criteria for the basis of the classification of hospitals according to competence, criteria that refer to elements such as:
  - hospital organizational structure approved according to the law;
  - type of the supplied medical services;
  - healthcare specialised personnel employed at the hospital; ;
  - continuity of medical care;
  - endowment with medical equipment and devices;
  - activity of guidance and methodological coordination in its field of activity;
  - training and scientific medical research activity, as well as continuous medical training; different quality of health care indicators: e.g. percentage of patients transferred to other units within 72 hours since admission, percentage of readmitted patients within 48 hours since admission, etc.

Order no. 1764/2006 on the approval of the criteria for the classification of the local, county and regional emergency hospitals in terms of competencies, material and human resources and their capacity to provide emergency medical care and final care to the patients under critical condition

This order, establishes the criteria according to which emergency hospitals are classified at local, county and regional levels.

- **Article 3** lists the criteria on which the classification of the emergency sanitary units is based:
  - available human resources - in general, if applicable, permanently at the level of the hospital, as well as the human resources permanently available if they are called at their homes (and must

757 Category I: hospital with very high extended competence that provides medical services in several medico-surgical specialties.

758 Category I M: has very high competence limited to its field of activity and provides medical services in one specialty in relation to other complementary ones; it can perform training and scientific medical research activities, activities of guidance and methodological coordination in its field of activity, as well as continuous medical training.

759 Category II: hospital has high extended competence and provides medical services in several medical and surgical specialties.

760 Category IIM: hospital with high competence limited to its field of activity and it provides medical services in one specialty in relation to other complementary and it can perform training and scientific medical research activities, as well as continuous medical training.

arrive within maximum 30 minutes to the hospital);
- technological and material resources within the hospital facility;
- access to technological and material resources within the hospital facility 24 hours a day, 7 days a week;
- the organizational structure of the said sanitary/health care unit and the presence of specialty sections or of specialty fields that are permanently accessible or, if applicable, shortly from the call;
- capacity of admission and care of the various categories of critical cases: trauma, burnt persons, cardiology, cardiovascular surgery and peripheral vascular surgery, neurology/neurosurgery, gynaecology-obstetrics, neonatology, toxicology, and respectively other cases requiring complex intensive care and emergency intervention.

The emergency hospitals are defined in **Article 1**. This categorisation of hospitals might be relevant for lawyers who represent patients, when the trial concerns the provision of emergency medical care. The categorisation, which can be consulted entirely in **Order no. 1764/2006,** contains the following type of hospitals:

(a) Emergency regional hospital with I A competence level;[761]

(b) Regional emergency hospital with level of competence I B;[762]

(c) Emergency hospital with level of competence II A;[763]

(d) Specialised emergency hospital with level of competence II B[764]

(e) Emergency hospital with level of competence III[765]

(f) Emergency hospital with level IV of competence[766]

- **Government Decision no. 400/2014 on the approval of the package of services and the Framework Contract on the conditions of health care provision within the social health insurance system for the years 2014 – 2015**
  - **Article 1, paras. 8** and **9** establish that:
    - the maximum number registered on the list of patients of a family doctor is 2,200 for the purpose of ensuring quality medical care,

761 This is a clinical (university) hospital which provides the receipt, investigation and final treatment of all the categories of traumatic, surgical, cardiovascular, neurological and neonatological critical emergencies, including burnt persons. Patients in critical condition are received here, and only in exceptional matters the hospital orders the transfer of some patients to another sanitary unit for the carrying out of the final treatment.

762 This is a clinical hospital, specialised institute/centre or clinical hospital that provides the admission, investigation and final treatment of one or several categories of critical emergencies, not being able to fully cover all the categories. Thus, the transfer of some patients to other regional hospitals is usually necessary, and the admission of some categories of emergencies is not always possible because of the lack of necessary human or material resources.

763 This is a district or municipal hospital that can provide the admission, investigation and final treatment for most critical cases. In this hospital's case it is necessary to urgently transfer some categories of cases to hospitals with a higher competence level, usually after granting emergency care or immediate investigation, and after establishing within the limit of possibilities a diagnosis that qualifies emergency regime. This transfer is necessary because of the lack of some material or human resources with appropriate level of experience.

764 This is a district/municipal specialised hospital that can receive, investigate and give final treatment for some critical cases other than trauma, depending on the specialty. Certain cases in these categories can require the emergency transfer to other regional clinical hospitals, usually after providing emergency care to the patient or following the appropriate immediate investigation, and after establishing a diagnosis within the possibilities of the emergency medical care regime. The transfer is necessary because of lack of some material or human resources with the appropriate level of experience in final care of the patients.

765 This is a district, municipal or city level hospital that can provide receipt, investigation and final treatment of some limited categories of critical cases. In these hospitals it is necessary to transfer most categories of critical cases to regional emergency hospitals with level of competence I or II, usually after providing emergency care, with or without the investigation and establishment of an emergency diagnosis. This transfer is necessary because of the lack of material or human resources with the appropriate level of experience in the final care of the said patients.

766 This is a municipal/city level hospital that can provide emergency care, stabilising the critical cases for transfer. In these hospitals it is mandatory to transfer the critical cases to a higher competence level hospital, usually regional or at least with competence level II.

- the optimal number of persons registered on the list of the family doctor for the purpose of providing quality services at the level of primary medical care and that is considered for establishing the necessary number of family doctors per administrative territorial unit /urban area is 1,800.

- **Article 3, letter a, Article 24, letter a, Article 59, letter a, Article 74, letter a** and **Article 92, letter a, Article 119, letter a,** and **Article 130, letter a,** institute the obligation of the medical services providers to comply with the quality criteria of the supplied medical services, in accordance with the legal provisions in force.

Methodological norms of application in 2014 of Government Decision no. 400/2014 on the approval of the service packages and framework contract that regulates the conditions of providing medical care within the social health insurance system for the years 2014-2015

The norms approve the models of medical services supply contracts that the NHIH concludes with the medical services providers. Thus, **Annex no. 3** includes the model medical services supply contract for primary medical care. According to **Article 10** of the Contract, the medical services supplied based on the contract must comply with the criteria for the quality of the medical services, elaborated in accordance with the legal provisions in force.

Identical provisions are also included in Annexes nos. 6, 9, 12, 16, 21, 26, 32, and 35 which establish model medical services supply contracts in different medical specialties and types of medical services, which must meet certain quality criteria.

- **Annex no. 6:** primary medical care, **(Article 5 letter a** and **Article 8);**
- **Annex no. 9:** specialised ambulatory medical care for clinical specialities and acupuncture **(Article 7, letter a** and **Article 10);**
- **Annex no. 12**: specialised medical rehabilitation for ambulatory sanitary units of medical rehabilitation **(Article 8, letter a** and **Article 13)**;
- **Annex no. 16:** specialised ambulatory medical care for dental medicine specialty, **(Article 7, letter a** and **Article 11);**
- **Annex no. 21**: specialised ambulatory medical care for paraclinical specialties[767] **(Article 7, letter a** and **Article 10)**;
- **Annex no. 26:** hospital services **(Article 6, letter a** and **Article 10);**
- **Annex no. 32:** home medical care/home palliative care **(Article 7, letter a** and **Article 10);**
- **Annex no. 35**: rehabilitation and recovery medical care in rest homes and preventoria, **(Article 6, letter a** and **Article 11).**

Order no. 1384/2010 on the approval of the hospital management contract model

- **Annex no. 1** of the Order contains the framework model of the hospital management contract.

Among the obligations that the manager has, the most relevant for the patients' right to observance of quality standards are the provisions regarding the liability of the manager and the managing board for medical investigations, treatment, accommodation, hygiene, food and prevention of hospital-acquired infections (**Article 5, para. 2 pts. 14** and **22**). These standards are provided according to the norms approved by Order of the Minister of Health, but chosen for the *quality of the medical act.*

Furthermore, Annex 2 of the Order lists the performance indicators of the public hospital manager activity. The failure to meet those indicators, if it is exclusively the manager's fault, leads to the termination of the management contract. By the removal of defective management, the compliance with the patient's right to observance of quality standards and to benefit from quality medical services is provided (**Article 22** of the model contract included in Annex no. 1).

767 According to the annex of the Order 1041/2010 issued by the Ministry of Health: 1.Pathology, 2.Epidemiology, 3.Hygiene, 4.Laboratory Medicine, 5.Forensic, 6.Nuclear Medicine, 7.Radiology - medical imaging, 8.Public Health Management.

- **Order of the Minister of Health no. 975/2012 on the organization of the structure for the management of the quality of the medical services within the sanitary units with beds from the network of the Ministry of Health and local public administration authorities**

  The order establishes the quality management structure within the hospitals, as well as its activities.

  - **Article 2** of the Order establishes the attributions of the quality management structure for medical services, including the following *(Author's note: Public hospitals must have in their organizational structure a structure responsible with the quality of the medical services provided by that hospital)*:
    - prepares and analyses the annual plan for quality management;
    - coordinates the activities for the elaboration of the documents of the quality management system: (i) quality manual and (ii) procedures;
    - coordinates and implements the program for the accreditation of all the services offered within the unit based on operational procedures specific to each section, laboratory, etc., and quality standards;
    - coordinates and implements the continuous improvement process of service quality;
    - implements instruments for quality insurance and evaluation of the offered services;
    - provides the implementation of the strategies and objectives regarding the quality management declared by the manager;
    - provides the implementation and maintenance of the conformity of the quality management system with the specific requirements;
    - coordinates the activities of analysis of the found irregularities and proposes to the manager the required corrective or improvement actions;
    - coordinates the analyses regarding the effectiveness of the quality management system;
    - provides the application of the sanitary strategy and quality policy of the unit in the medical field for the purpose of ensuring the patients' health;
    - assists the manager and answers all the requests of the manager in the field of quality management.

- **Order no. 320/2007 on the approval of the content of the administration contract regarding the medical section/laboratory or service within the public hospital**

  The model of the administration contract is included in **Annex no. 1** to the Order. Item IV sub-item A2 of the administration contract establishes the obligations of the medical section/laboratory/service head regarding the compliance with, increase in, and monitoring of the quality of the supplied medical act/service:

  - guidance and carrying out of the activity for providing medical care within the particular section and liability for the quality of the medical act;
  - carrying out of the specific performance indicators of the medical section/laboratory or service, in an annex to the administration contract;
  - responsibility for the creation of necessary conditions for providing quality medical care to the personnel in the medical section/laboratory or service;
  - responsibility for the quality of the medical services performed by the medico-sanitary personnel within the medical section/laboratory or service;
  - supervision of the therapeutic conduct, approval of treatment, prescription of para-clinical investigations, and of operatory indications and the operating program for the patients admitted within the section;
  - approval of admission of the patients in the section, based on the admission criteria, except for emergency admissions;
  - making decisions regarding continuing hospitalization in the first 24 hours from patients admission;
  - approval and responsibility for the manner of filling in and drawing up the medical documents

issued within the medical section/laboratory or service;
- coordination of the control activities regarding the quality of the services provided by the medico-sanitary personnel within the medical section/laboratory or service;
- provision of appropriate conditions of accommodation, hygiene, food and prevention of nosocomial infections within the medical section/laboratory or service, in accordance with the norms established by the Ministry of Public Health;
- compliance with the legal provisions regarding the patient's rights by the subordinate medical personnel and taking immediate measures when finding their breach, according to the legal provisions in force.

Order no. 914/2006 on the approval of the norms regarding the conditions that a hospital must fulfil for achieving the sanitary operation authorization

The annexes to the order contain the norms and conditions that any hospital must fulfil for the purpose receiving the sanitary operation authorization:

- Annex no. 1 establishes the norms regarding the hospital sanitary operation authorization procedure;
- Annex no. 2 establishes the norms regarding the hospital's general functional organization;
- Annex no. 3 establishes norms regarding the functional structure of the compartments and services of the hospital;
- Annex no. 4 establishes norms regarding the ensuring of the general hygiene conditions.

Order no. 972/2010 on the approval of the procedures, standards and methodology of hospital accreditation

The procedures, standards and methodology of hospital accreditation are contained in the Annex of the Order. **Article 1 letter c** of the Annex to the Order entitled "Procedures, standards and methodology for hospital accreditation" defines the notion of ***standard***, meaning the expectations regarding the performance, structure and processes in a hospital. *The standard represents the value of the targeted or aspired quality, with regard to the insurance of quality, safety and compliant care, treatment and services for each patient.*

In **Chapter III** of the Procedures standards and methodology for hospital accreditation the ***quality standards*** for hospital accreditation are enumerated. These quality standards are structured as a checklist and refer to the following areas:

a) The strategic management of the organisation768
b) The operational management of information769
c) The human resources management770
d) The care environment management771
e) The service quality management772

768 The checklist includes but is not limited to the following items: a) the strategic plan of the institution is based on the care and prevention needs of the patients; b) the organization of the institution provides for the making of decisions in an optimal manner; c) he institution's internal and external communication strategy is valid; d) the institution has a surveillance mechanism of its management; e) the collaboration between the sections and departments of the institution leads to the increase of the service quality throughout the hospitalization period; f) the institutional, strategic, departmental and general projects and objectives are periodically evaluated.

769 The checklist includes but is not limited to the following items: a) the information system corresponds to the institution's needs; b) management of the information complies with data confidentiality norms and security; c) the information system is constantly evaluated; and other.

770 The checklist includes but is not limited to the following items: a) the intra-organizational communication is integrated into the management policy of the human resources; b) the periodic evaluation of the personnel is performed according to written policies and procedures; c) the level of competence of the personnel is improved by continuous training; and other.

771 The checklist includes but is not limited to the following items: a) he supply of the activity sectors is continuously provided; b) he institution provides the security and maintenance of the equipment, installations and buildings; c) he rules of hygiene of food are complied with and balanced menus and meals are provided to patients; d) the quality, hygiene and circuit of lingerie are provided; e) the institution provides the security and hygiene of the spaces and equipment; f) the waste management complies with the principles of hygiene and protection of the persons and of the environment; g) the institution provides measures for the security and well-being of the patient as well as of its own personnel; h) he quality of the patient's care environment is evaluated; and other.

772 The checklist includes but is not limited to the following items: a) in the strategic plan, the institution has a quality policy it supports; b) the quality policy is based on the patients' needs; and other.

f) The patient rights and communication773
g) The management of patient data774
h) The health care management775
i) The risk prevention management776
j) The hospital-acquired infections management777
k) The transfusion and transplant safety778

- **Order no. 50/2004 on the methodology of sending abroad some categories of patients for treatment**

  For the situations in which a patient is not healed in Romania even though he/she followed the recommended medical treatment, Order 50/2004 regulates the conditions in which the patient can benefit from treatment abroad, disbursed[779] by the district public health authority from the domicile radius of the applicant patient.

  Sending patients abroad for treatment is approved by the Ministry of Health only for the disorders that cannot be treated in the country and the patients are registered on the list of a family doctor. For the approval of treatment abroad, the patient must prove that he/she went through all the levels of medical care treatment, namely primary medical care, specialised medical care, hospitalisation in sanitary units offering high professional and technical quality medical services, and yet the patient's health condition was not restored **(Article 1 para. 2 corroborated with Article 2 para. 1)**.

- **Order no. 308/2015 on the control by periodic checking of the medical devices commissioned and under use**

  The periodic check of a medical device means carrying out a set of activities[780] intended to evaluate

773 The checklist includes but is not limited to the following items: a) the right to medical care is protected without discrimination; b) the patient and his/her next of kin are informed of the hospitalization conditions; c) the information given to the patient shall be explained according to his/her level of understanding; d) the patient's medical treatment and investigation plan requires the patient's informed consent; e) the care must comply with the patient's intimacy and dignity; f) the institution has a system for the receiving and solving of the patients' claims and/or complaints; g) he institution's policy included the compliance with the patient's rights, his/her information and education; and other.

774 The checklist includes but is not limited to the following items: a) the management of the patient's data complies with the confidentiality and anonymity rules; and other.

775 The checklist includes but is not limited to the following items: a) the complexity of the patient's medical and personal needs are taken into consideration in designing the patient's care plan; b) the institution guarantees the continuity of the patient's care; c) the management of the patient with surgical potential is based on communication between specialised multidisciplinary teams; d) the sections and departments of the institution evaluate the professional practices and achieved performance; and other.

776 The checklist includes but is not limited to the following items: a) there is a policy for the prevention and management of risks and unwanted events; b) there are programs and protocols or guidelines for evaluation and intervention in emergency situations, disasters, natural catastrophes; and other.

777 The checklist includes but is not limited to the following items: a) the institution has a policy for reduction of infectious and epidemiological risk in the hospital environment; b) the institution focuses on the sterilization, maintenance of sterility and disinfection of instruments, medical devices and machines; c) he institution takes measures for the reduction of hospital-acquired infection risk; and other.

778 The checklist includes but is not limited to the following items: a) he institution provides for transfusion security by the training of specialists; and others.

779 Article 7 states as follows: *(1) The district public health authority pays the treatment in the account communicated by the clinic abroad where the patient should be treated, after the treatment is finished, based on original documents justifying the costs; (2) In care the clinic abroad asks for a payment in advance for the patients treatment or a part thereof, public health departments will pay the said advance, and at the end of the patients treatment will ask the clinic to provide them with documents to justify the overall cost of treatment; (3) In case of a medical emergency, based on recommendations of regional and specialized committees of the Commission's approval of the Ministry of Health, the patient can perform the recommended treatment abroad by supporting the costs by itself, including the cost of transportation or caregiver, if applicable. In this case within 3 days after returning home form treatment the patient must ask the health directorate to be reimbursed by health directorate, and also to bring documents which justify the costs, as provided by art. 6 para.* 2. In conclusion, the rule is that the district public health authority pays directly to the clinic abroad, and only in the exceptional case of medical emergency, the patient will pay the treatment, but will be reimbursed by the health directorate, after returning home from treatment.

780 The control by periodic check of medical devices is carried out through the following means: (i) evaluation of the security parameters, by examination and testing; (ii) evaluation of the performance-defining parameters, by examination and testing; (iii) check of fulfillment of the set of acceptability criteria for the medical device (required values, specified limits, accessories, etc.); (iv) issuing of a trial report that comprises the results achieved following the examinations and tests, in case the medical device does not fulfill the acceptability criteria and in case at least one of the measured values of the essential security or performance requirements is close to the admitted specified limits; (v) issuing of a periodic check sheet, based upon which the medical device can be used. (Article 4, para. 1).

the maintenance of some characteristics established by the manufacturer of the device or established by an authority in the field (**Article 2, para. 1, letter a**).

- **Order of the Ministry of Health no. 1119/2010 on the approval of the List of Romanian standards that adopt European harmonised standards whose provisions regard active implantable medical devices**

  The Annex to the Order includes the list of Romanian standards that adopt European harmonised standards with regards to active implantable medical devices.

- **Order no. 1142/2013 on the approval of the practical procedures for registered nurses**

  The order approves the practical procedures for nurses, which are annually updated **(Article 2)**. The procedures describe in detail the manner in which nurses must fulfil their attributions as well as the necessary materials for each medical procedure they perform.

  The procedures approved by the Order regulate the following: (i) the prevention of hospital-acquired infections, (2) autonomous, delegate interventions (performed under medical prescription), interventions to which the nurse participates next to the doctor, (3) special care in relation to fields of medicine (ophthalmology, ENT, paediatrics, for example.).

- **Order no. 240/2004 on the approval of the minimal standards for the accreditation of occupational medicine offices and minimal requirements for their equipment**

  Annex 1 of the Order includes the minimal standards for the accreditation of occupational medicine offices that refer to standards related to organization, material resources, human resources, general functional standards, specific functional standards, and standards regarding the information management. Annex no. 2 of the Order establishes the minimal requirements for equipping the occupational medicine office.

- **Order no. 860/2013 on the approval of the accreditation criteria in the field of transplant of organs, tissues and cells of human origin**

  The order approves the accreditation criteria of the medical services providers on the transplant of organs, tissues and cells of human origin **(Articles 1-6)**. The criteria are included in the annexes to the Order.[781]

- **Order no. 1226/2006 on the approval of the norms regarding the collection, biological control, preparation, preservation, distribution and transport of human blood components**

  The norms approved by the order and its annex especially regard the following procedures: The collection of total blood and human blood components (Chapter II); the biological control of blood and human blood components (Chapter III); the preparation of blood and human blood components (Chapter IV); the transport of the blood and human blood components (Chapter V); the distribution of the blood and human blood components (Chapter VI).

- **Order no. 6/2013 on the approval of the criteria for eligibility that must be fulfilled by all the health units that perform activities of recruitment, testing and donation of hematopoietic stem cells from non-related donors**

  The Order approved the eligibility criteria that must be fulfilled by the sanitary units that perform activities of recruitment, testing, and donation of hematopoietic stem cells from non-related donors.[782]

781 Annex 1 – Criteria for the accreditation of organ sampling centres; Annex 2 - Criteria for the accreditation of the organ transplant centres; Annex 3 - Criteria for the accreditation of HLA laboratories for the transplant activity; Annex 4 - Criteria for the accreditation of the packing, labelling and specialised transport for organs activities; Annex 5 - Criteria for the accreditation of the tissue transplant centres; Annex 6 - Criteria for the accreditation of the centres for transplant of central hematopoietic stem cells and from the peripheral blood.

782 The criteria are included in the annex to the Order, thus: (i) eligibility criteria for the centres of hematopoietic stem cells donors; (ii) eligibility criteria for the testing laboratories of the non-related donors of hematopoietic stem cells; (iii) eligibility criteria for the hematopoietic stem cells sampling centres.

In order to perform the activities of recruitment, testing, and donation of hematopoietic stem cell from non-related donors, he providers of medical services that perform those activities must fulfil all the eligibility criteria established in the annex to the order: (a) general criteria, (b) personnel criteria, and criteria regarding (c) support services, (d) policies and procedures, and (e) administrative issues **(Article 1).**

- **Order no. 1427/2013 on the approval of the general provisions of defence against fires at health units**

The general provisions for defence against fires at sanitary units focus on the prevention and reduction of the risks for fire occurrence and on the conditions for limiting the exacerbation of such risks through technical and organisational measures **(Article 1 of the Annex to the Order).** These provisions are mandatory for all the sanitary units located on the Romanian territory, irrespective of the property form, utilization or administration or the coordinating authority/institution **(Article 2 of the Annex to the Order).**

- **Clinical guidelines on the medical specialties, approved by the Ministry of Health**

The framework law no. 95/2006 on the Health Reform, republished, **(Article 16, para. 1, letter g)** also establishes the attribution of the Ministry of Health to approve, by order of the minister, the standardised protocols at national level elaborated by the specialty commissions of the Ministry of Health, by consulting the specialised medical societies.[783]

Below is a list of ministerial orders for the approval of the practice clinical guidelines in force at the time of writing of this practitioner guide, with the mention that a full list can be consulted on the Ministry of Health website:

- Order no. 1232/2011: medical practice guidelines for neonatology specialty;
- Order no. 1390/2010: medical practice guidelines for cardiology specialty;
- Order no. 1529/2010: medical practice guidelines for anaesthesia and intensive care specialty;
- Order no. 1393/2010: medical practice guidelines for medical radiology-imagery and nuclear medicine specialties;
- Order no. 1391/2010: medical practice guidelines for internal medicine specialty;
- Order no. 1454/2010: medical practice guidelines for geriatrics and gerontology speciality;
- Order no. 1283/2010: medical practice guidelines for psychiatric and paediatric psychiatry specialties;
- Order no. 1216/2010: medical practice guidelines for gastroenterology specialty;
- Order no. 1217/2010: medical practice guidelines for pathologic anatomy specialty;
- Order no. 1059/2009: several medical practice guidelines, (Annexes 1 to 12) on the following specialties: diagnosis and treatment for cerebral-vascular diseases, management of stable pectoral angina, diagnosis and treatment of acute coronary syndromes without ST segment over displacement, myocardial infarction, arterial hypertension, chronic pulmonary diseases, chronic obstructive pulmonary disease management, of cervix cancer, mammary cancer, prostate cancer, colorectal carcinomas, the care of patients with sugar diabetes.

…and other such guidelines on specialties such as dermato-venereology, cardiac surgery, labour medicine, medical oncology, medical rehabilitation, neurology, rheumatology, urology, endocrinology, obstetrics-gynaecology, etc

D) PROVIDER CODES OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**

With regard to the right to observance of quality standards, the Medical Deontological Code contains,

783 These guides shall be also published on the web site of the Ministry of Public Health, some of which are available here: http://www.ms.ro/index.php?pag=181&pg=1

among others, provisions related to professional and ethical obligations of the doctors meant to protect the interests of the patients. Namely, such provisions refer to the principle of professional specialisation **(Article 9)**, the obligation to abide by the professional ethical rules **(Articles 21 and 22)**, the limits of professional commitments **(Article 25)**, medical team consultation **(Article 28)**, and notification of professional errors **(Article 37)**.

E) OTHER RELEVANT SOURCES

There are no other relevant sources for the Right to the Observance of Quality Standards.

F) PRACTICAL EXAMPLES

1. Example of Compliance

Following a sanitary inspection, the public hospital X was sanctioned for insufficient equipment in the surgery room. Subsequently, the hospital started the procedure of public procurement of specific equipment and requested the Ministry for the opening of new positions in order to hire doctors from cardiology and neurosurgery specialties, given the fact that following a case study, the hospital showed that surgical emergencies existed in the past year that they had to transfer patients to another hospital located 30 km away, as they did not have the necessary equipment or specialised personnel. The procurement procedure was quickly carried out, the State unblocking the sums of money necessary for the performance of the procurement contract for the immediate supply of the equipment.

2. Example of Violations

Patient M.V. was to have a second heart intervention. The patient and the two surgeons who operated him no longer benefited from an operating room equipped for heart interventions because the hospital management decided that the patient should be moved to the *„cellar room"* of the hospital in a room that was not appropriately equipped. Even if the patient was bleeding after the first operation in a situation that required compliance with the emergency protocol, the surgeons were not allowed to enter the surgery room equipped for heart interventions but they were sent to operate in a room at the basement of the building, improper for this type of intervention.

Thus, in the moment when the patient's heart, intoxicated with adrenalin, stopped beating, the two surgeons had to resuscitate him by hand, because the *room had no medical resuscitation equipment.* The patient had pacemaker electrodes fixed from the first operation, so the threads just had to be connected to the pacemaker but this was not performed. Normally, an extra corporal circulation pump must exist in the surgery room and the patient is to be put on extra corporal circulation, but the machine to do such operation was not there.[784]

3. Actual Cases

Case no. 1: performance of a medical act by a person who was not competent to perform it[785]

The defendants RE and DD were called before the court to be held responsible for the crime of bodily injury, against the patient ML, the injured party and plaintiff in the. The case was examined by the Suceava District Court. According to the facts held by the court, on 25.06.2004 the patient came to the Suceava County hospital's obstetrics-gynaecology section, as she showed symptoms of early birth, the pregnancy being in week 35. The following day, the patient showed dilation, but the labour had not started and thus, Citothec ampule was administered to her by defendant DD – the on-duty doctor at the section where the patient was admitted. At 14.00h, the patient was moved to the birthing room where she was assisted by both defendants. In this procedure, RE had the capacity of midwife.

784 Source: http://www.ziuanews.ro/dezvaluiri-investigatii/cum-a-fost-omorat-un-pacient-la-spitalul-c-c-iliescu-partea-iii-120170.
785 Criminal sentence no. 364/01.06.2011.

During the procedure, the patient was agitated, as the defendant pushed her strongly on the belly and ordered the defendant midwife RE, to perform an episiotomy[786] for facilitating the expulsion of the foetus. The patient was not anesthetized for this purpose.

On 29.06.2004 the patient was discharged. On 04.05.07.2004 the patient called a nurse to her home to remove the stitches from surgery. During the procedure, the nurse found that faecal matters began to come out of the wound. She stopped the procedure and recommended the patient to urgently go to the doctor. Thus, on 05.07.2004 the patient was admitted in Suceava County Hospital and subsequently transferred in several stages to other hospitals and submitted to several surgical interventions for recto-vaginal fistula, post- surgery stenotic scar of external anal sphincter and a perineum tear with rectocel. The last surgical intervention took place on 21.10.2004 at a hospital in Bucharest.

In the trial before the court, several expert reports were considered by the court. Thus, he higher discipline committee of the College of Physicians established that the defendant DD had the obligation to personally assist the birth, given that it was a premature risk pregnancy. For that operation, the patient had to be anesthetised. The College of Physicians concluded that the professional errors of the defendant DD consisted in (i) the entrustment of his own obligations to another person not qualified to perform the surgical procedure in the given situation, (ii) non- maximal diligence in establishing the appropriate diagnosis and treatment and (iii) non-avoidance of predictable complications.

The higher committee of forensic medicine concluded that all the complications suffered by the patient are due to bad execution of the episiotomy by the defendant RE and to inappropriate care. At the same time, defendant DD was obliged to assist the patient in birth and proceed himself to the performance of the episiotomy and episiotomy, as well as to other medical acts specific to birth.

From all the evidence on the case file, the court acknowledged that the defendant breached good medical practices by the administration of a treatment with ignorance of its effects, by leaving the birth room without checking on the patient or the foetus, and by the non-performance of surgical interventions that were exclusively incumbent upon him. Thus, the court convicted both defendants for the commission of the bodily injury crime due to exclusive fault of the defendants, and ordered them to pay damages to the patient, as moral damages.

Case no. 2 – nosocomial infection, during admission[787]

The Bacău Tribunal ordered the Bacău Emergency Hospital to pay damages for the damages caused to the claimant patient because of the patient's infection with *staphylococcus aureus*, a hospital-acquired infection during the admission of the patient.

According to all the evidence held by the court, the patient was admitted in Bacău Emergency Hospital following a car accident, being hospitalized during the period 25.08 - 01.09.2008. Subsequently, he was transferred to several hospitals and submitted to several surgical interventions, including in clinics in Germany and Italy.

The patient underwent a surgical intervention at Bacău hospital and 15 days after the surgery a purulent secretion was found and was confirmed by a bacteriological exam as infection with *staphylococcus aureus*. According to the medical expert reports from the court file, the entire evolution of the patient was dramatically influenced by the occurrence of the infection with staphylococcus. In the absence of this infection (which became subsequently severe), the lesions that the patient showed would have healed in about 4 to 6 months (also including the necessary period for functional re-education) and would have no longer required the subsequent admissions to hospitals and surgical interventions. As a result of the infection, the patient's condition represents a permanent physical invalidity and an average loco-motor deficiency, with the reduction of work capacity to 60%.

786 Author's note: episiotomy represents a surgical intervention that consists in sectioning the vaginal mucosa and superficial muscles of the perineum with the purpose of facilitating the foetus' expulsion during a birth. The incision can be lateral or median from the posterior area of the vulva to the anus and is carried out ***under local anaesthesia***. The operated area is sewed after birth.

787 The Court of Bacău, Civil Sentence no. 2748/21.12.2012.

The court acknowledged that the harm suffered by the patient is the consequence of a nosocomial infection. The court considered that in this case the provisions of former Article 644 of the law 95/2006 on the reform in the field of health apply, according to which *the sanitary units, public or private, are liable for the harm caused to the patients if they are the consequence of hospital-acquired infections, among others.*

Consequently, the court ordered the Bacău hospital to pay damages to the patient for the harm caused to the latter due to a hospital-acquired infection.

Case no. 3 – incorrect diagnosis and treatment; deprivation of survival chance

The Drăgăşani City Court examined a case regarding the alleged crime of manslaughter, where the defendant was doctor AP. According to the facts held by the court, on July 27, 2006 RE, a family doctor within Medical clinic G, Olt County, vaccinated the minor GA with anti-poliomyelitis vaccine administered orally and tetanus diphtheria vaccine, DTP, by injection. According to the arguments of doctor RE, the vaccination campaign takes place between the 25th-30th of each month, according to age group.

The immunization was performed according to the medical norms, as confirmed by the Olt College of Physicians through the official address no. 760/26.09.2006 that also states the lack of elements of malpractice in dr. RE performance, *the subsequent evolution of patient condition not being related to the immunization service.*

The next day after having this vaccine, following the febrile condition of the minor, the minor was urgently transported to Drăgăşani municipal hospital and then admitted in the paediatrics section, under direct observation of the defendant Dr. AP. *The reason for admission*, registered in the patient clinical record is represented by fever, diarrhoea, bad general condition. *The diagnosis upon admission was "Post-vaccine reaction. Trisomy 21"; upon discharge, "Post-vaccine reaction. Trisomy 21, death – 30.07.2006, time 5,20".*

The defendant Dr. AP was the primary doctor paediatrician and the on-duty doctor of the paediatric section on the 28th-29th of July 2006 and he established as *treatment* for the victim the administration of algocalmin and Phenobarbital, also indicating in the general clinical observation sheet the presence of a tumefaction on the right foot thigh, the place where the minor had been vaccinated.

From the temperature chart follow up existing in the clinical observation, as well as from the declaration of the two nurses, VD and LD who looked after the minor during admission, it was derived that the minor permanently showed a febrile condition, with a constant temperature of around 39 degrees Celsius. Both nurses reported this situation to the defendant AP who ordered them to make ice packaging in order to lower the minor's temperature. Although the minor's febrile condition did not improve, *the defendant doctor AP did not introduce any antibiotic into the medication even though he knew that patient GA was diagnosed with Down's syndrome* (trisomy 21), a disease that strongly affects the immune system of the person.

The discipline committee within Valcea College of Physicians decided to punish the doctor AP by giving him a ‚warning' for the manner in which he decided to treat the patient. From the medico-legal autopsy finding report made in the case, the following conclusions were derived:

- The minor's death was due to acute cardio-respiratory insufficiency, consecutive to an acute interstitial pneumonia occurred in the child with acute post-vaccine reaction and congenital disease;
- *No paraclinical investigations (laboratory tests) that allow an accurate and complete diagnosis and the direct institution of an appropriate treatment were performed to the child;*
- *The treatment administered to the child was incomplete due to lack of administration of any drugs, such as antibiotics, that might have brought beneficial therapeutic effects and that might have prevented the child's death;*
- *By the non-performance of laboratory investigations, the non- performance of an appropriate medicinal treatment, and by not sending the child to a higher-level hospital in a specialised section of infectious contagious diseases, the child was deprived of the chance of survival.*

Finally, the court concluded that there was a direct causality between the inappropriate medical conduct during the hospitalization period, conditioned by the minor's immunity deficit characteristic to the pre-existing condition. The court identified the inappropriate medical conduct as the following: lack of establishment of accurate clinical diagnosis, lack of performance of paraclinical investigations, lack of interdisciplinary check-ups, prescription of an inappropriate treatment.

In this case there was an immediate fault and a direct fault, the harmful activity belonging to the doctor himself. The medical error and lack of cleverness or lack of ability led to the death of minor GA; and the diagnosis error in this case was not due to the lack of acknowledgment of the minor's medical past, but to *erroneous examination, erroneous interpretation of the symptoms, non-performance of some tests, failure to send the patient for specialised check-up at a higher medical unit or failure to change diagnosis in the case of the treatment that was ineffective*. This subjective error engages penal liability.

Thus, considering the fact situation acknowledged by the court after analysing the administered evidence, the court convicted the defendant AP, primary doctor paediatrician, for manslaughter. The doctor was served with a suspended sentence of six months in prison. The court also applied complementary punishment consisting in the prohibition of certain rights according to the Criminal procedure code (in force at that time). The court ordered the defendant *in solidum* with the hospital Costache Nicolescu from Dragasani to pay the civil party 20.000 lei moral damages and 300 lei judiciary expenses.

G) PRACTICE NOTES FOR LAWYERS

When the quality of the supplied medical service is of concern, a lawyer must, for the purpose of defending the interests of his/her client, take into consideration issues such as:

- The appropriate equipping of the medical services supplier unit (according to the legal criteria): equipment for the intervention or treatment undergone by the patient, necessary drugs.
- The existence of specialist doctors (according to the legal criteria), with special attention to the following aspects:
  - it is essential that the attending doctor should be specialist, so as to grant medical care to the patient, according to the latter's needs;
  - the medical personnel must be qualified/accredited;
- To order a specialized medical expertise whose objective should be among others the highlighting of the equipment, drugs and specialisation of the attending doctor by considering patient's needs. Another objective must establish if the supplied medical treatment/service was the required one and if it was administered/supplied in compliance with the protocols in the field, if applicable;
- To ascertain if the unit that supplied the medical treatment/service was appropriately equipped, which were the measures taken for the remedy of these insufficiencies.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

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 under the Right to Life in Chapter 2 and Chapter 3.

6.1.9 Right to Safety

A) RIGHT TO SAFETY AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR):

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.

To guarantee this right, hospitals and health services must continuously monitor risk factors and ensure that electronic medical devices are properly maintained and operators are properly trained.

All health professionals must be fully responsible for the safety of all phases and elements of a medical treatment.

Medical doctors must be able to prevent the risk of errors by monitoring precedents and receiving continuous training.

Health care staff that report existing risks to their superiors and/or peers must be protected from possible adverse consequences.

B) RIGHT AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003**

  The right to safety in the specific context of health care is not expressly provided by the Romanian Constitution. However, there are constitutional provisions which can be seen from the viewpoint of the right to safety.

  - **Article 22 Right to life, physical and mental integrity:**

    (1) The right to life, as well as the right to physical and mental integrity of person are guaranteed.
    (2) No one may be subjected to torture or to any kind of inhuman or degrading punishment or treatment.
    (3) The death penalty is prohibited.

  (Author's note: medical interventions which do not respect human rights standards can reach the gravity of inhuman and degrading treatments, as interpreted by the European Court of Human Rights. For example, see V.C. v. Slovakia, application no. 18968/07, 8 November 2011).

  - **Article 34 Right to protection of health** and **Article 35 Right to a healthy environment** are also implicitly linked to the Right to safety, especially since they impose duties on the state to take measures for the protection of physical and mental health.

Legislation

- **Law no 46/2003 on the Right of Patients**

  The right to safety is stated in the Law on the Rights of Patients, not distinctively, but referenced as follows:

  - **Article 30, para. 1, in Chapter VI, Patient Rights and Medical Care:** *Medical interventions to the patient will be made only if the conditions of necessary equipment and personnel accredited are fulfilled.*

Law no. 95/2006 on the Health Reform, republished in 2015

Law 95/2006 contains provisions related to safety in the field of organ transplants, pharmaceuticals, and cross-border health care. These provisions were mainly introduced by the subsequent amendments and integrations, in the process of transposing European Union legislation.

Title VI of the law is entitled *Performing prelevation and transplantation of organs, tissues and cells of human origin with therapeutic purposes* and has the following relevant provisions:

- **Article 141, para. 1:** *Donation and transplant of organs, tissues and cells of human origin are made with a therapeutic purpose, ensuring certain quality and safety standards for guaranteeing a high level of protection of human health (…)*
- **Article 142, pt. e:** defines the term *"agreed bank"* and mentions that it *must comply with the quality and safety standards provided by the Directive 2004/23/EC of the European Parliament and of the Council 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 and to evidence this by supporting documents*
- **Article 148, para. 19:** *The National Agency for Transplant can conclude agreements for exchange of organs with European organizations, if they comply with the requests stated in the Directive 2010/45/EU of the European Parliament and of the Council of 7 July 2010 on standards of quality and safety of human organs intended for transplantation (…)*

Several provisions related to safety are included in **Title XVIII** of the law and regulate pharmaceuticals. Besides the chapter on *pharmaco-vigilance*, provisions related to drug safety can be found in other chapters, such as: marketing, manufacturing and importation, labelling and package leaflet, distribution and brokerage, and advertising. Title XVIII transposes the Directive 2001/83/EC on the Community code *relating to medicinal products for human use*, including subsequent amendments brought to this Directive *(amendments regarding setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood components; traditional herbal medicinal products; medicinal products for human use; terms of marketing authorization for medicinal products; and pharmacovigilance).*

Title XIX called *Cross-border Health Care* also contains provisions on safety. This title transposes partially the Directive 2011/24/EU on patients' rights in cross-border healthcare.

- **Article 904** provides that the care must comply with both the national standards on quality and safety, and EU legislation on safety standards.
- **Article 910** provides that health care providers set in Romania have the obligation to inform patients on the treatment options, availability, quality and safety of the provided medical care.

Law no. 282/2005 on the organization of blood transfusion activity, human blood and blood components donation, as well as ensuring health quality and safety, in the view of their therapeutic use, republished

This law sets the norms that ensure blood and blood components quality and safety for the purpose of maintaining a high level of health protection, and applies to the collection, biologic control, processing, storage, distribution and use of blood and blood components. Among the principles governing this law there are also mentions regarding the quality and safety of human blood and blood components, irrespective of their provenience or their therapeutic purpose, and the fact that the therapeutic use of blood or blood components is done under medical supervision and responsibility in authorized units only. Law 282/2005 transposes the Directive 2002/98/EC on *setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components.*

The chapters with special provisions on the safety of transfusion are: **Chapter VII** *Haemo-vigilance system,* **Chapter V** *Quality management, and Chapter VI Therapeutic use of human blood and blood components.*

Law no. 584/2002 on the measures for preventing the spread of AIDS in Romania and for protection of persons infected with HIV or having AIDS

The law provides a safety measure for preventing the transmission of HIV in medical units. Thus, all medical units, either with our without beds are supposed to *mandatory apply universal precautions and ensure the necessary means in order to "prevent the transmission of HIV* **(Article 6, pt. e).**

Law no. 339/2005 on the legal regime of the plants, substances and preparations with narcotic and psychotropic content

The law sets the legal regime in regard to the cultivation, production, manufacture, storage, trade, distribution, transportation, possession, supply, delivery, commercial mediation, purchase, procurement, use and transit on the national territory of the plants and substances listed in the international conventions which were signed by Romania, as narcotic or psychotropic, as well as their preparations, which can be dangerous for the population health, because of the effects their use can produce. In addition, the law contains provisions related to the attributions and responsibilities of the Ministry of Health and its subordinated or coordinated institutions in the control and surveillance of the operations with such plants, substances and preparations covered by the law.

- **Article 7, para. 3:** *Within the medical-pharmaceutical production units or in other authorized places where operations with narcotic drugs or psychotropic substances are carried out, when there are signs of violation of the licit activity with these substances, the experts in the specialized unit for preventing and fighting against illicit drug trafficking and use within the General Inspectorate of the Romanian Police shall refer to the experts in the Ministry of Health exercising such powers, according to the Law, in order to check the respective situations.*

It should be mentioned that **Chapter X** entitled *Penalties* provides the measures that should be taken by the Ministry of Health (sometimes by the Ministry of Agriculture, Forests and Rural Development, the Directorate-General for Countering Organized Crime and Anti-Drug Directorate and the National Anti-Drug Agency) in case of non-compliance with the provisions of this law. Some measures refer to pecuniary fines served on the entities who infringe the law **(Article 52)**, while other sanctions refer to precautionary measures taken in the case of certainty or the justified assumption of an imminent and serious risk to health **(Article 50)**. In cases of repeated violations of some of the provisions of this law, the Ministry of Health can suspend the license for carrying out specific activities **(Article 51)**.

- **Article 50**
  - *a) blocking of the merchandise from the market and prohibition of the use of proprietary medicinal products, magistral formula and official preparations, as well as suspension of the activities, of advertising, and temporal closing of the premises, centres or services;*
  - *b) suspension of the production, prescription, issuance and supply of preparations undergoing clinical research or animal testing.*

For the technical provisions regarding the application of this law, see also Government Decision no. 1915/2006 on the approval of the Methodological norms for application of the Law 339/2005 on the legal regime of the plants, substances and preparations with narcotic and psychotropic content.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

Norm of 7 April 2004 for the application of Law no. 46/2003 on patient rights

According to the norms for the application of the law on patient rights, medical interventions to the patient can be made only if there are available appropriate equipment and accredited personnel, with the exception of extreme life threatening situations, in which, without immediate intervention, irrespective the conditions, the patient's life is endangered.

- **Order of the Ministry of Health no. 916/2006 on the approval of the norms for surveillance, prevention and control of nosocomial infections in the health institution**

  Order 916/2006 sets the obligation of surveillance and prevention of nosocomial infections for the medical personnel in the health institutions. It provides that any harm to the patient produced by medical personnel failing to comply with the order provisions or with the professional norms on quality assurance of the health care provided to the patients related to the prevention of the nosocomial infections is the responsibility of the health personnel or health institution. **Annex III** of this order contains provisions on the epidemiological surveillance of the nosocomial infections and the measures to be taken in case of outbreak.

- **Order no. 607/2013 on the approval of specific norms regarding the authorization of the blood transfusion units from the health institutions**

  Authorization of the blood transfusion units of the health institutions represents a patient safety assurance measure. For obtaining the authorization, the institutions should have the following: evidence of the personnel structure and qualifications; existence of the quality management system; compliance with the haemo-vigilance system; adequate medical devices and equipment; standard operating procedures for the base activities; results of self-inspection in the previous year and functioning sanitary authorization.

- **Order no. 608/2013 on the approval of the norms regarding the grant of special authorization for the import and/or export of human blood and/or human blood components from or to other countries**

  The authorization for importing/exporting human blood or blood components is issued by the Ministry of Health at the proposal of the National Institute for Transfusion Haematology. The Institute must submit the proposal to the Ministry of Health based on the evaluation of the file containing documents to prove that the respective firm fulfils the norms and requirements for obtaining the authorization. Among these there are: documents presenting the results of the blood or blood components tests, documents proving that the import/export entity is qualified for this activity and it has proper technologic capacity for storage and transport of blood or blood components, and documents to show the existing of the system for ensuring the haemo-vigilance. All these measures contribute to the ensuring of the transfused patient safety.

- **Order no. 1.237/2007 on the approval of the national classification of human blood components for therapeutic use, with subsequent modifications and integrations**

  Order 1237/2007 sets the conditions for processing, preservation and administration for each substance, as well as the conditions for storage, transport and distribution for human blood and human blood components. The Order includes two annexes. Annex 1 defines the blood components and other specific terms. **Annex 2** specifies the physical conditions (i.e. temperature) for blood components storage, conservation and transport and the standards used for quality control. This order transposes the Directive 2002/98/EC on *setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood components*

- **Order no. 1.483/2011 on the approval of the action plan for ensuring the transfusion safety against post-transfusion transmission of West Nile Virus**

  The epidemiologic context caused by the increase of the number of cases of West Nile virus (WNV) infection in the European Union during 2008-2010 led to the need for elaborating guidelines on the measures to be taken for ensuring the blood transfusion safety in the affected geographic areas, in accordance to the estimated risk. This guide was submitted for debate to the EU member states. Romania was among the authors of the draft submitted for the debate. The action plan sets the measures that should be taken by the Ministry of Health, the National Institute of Hematology Transfusion „Prof. Dr. C T Nicolau" Bucharest, blood transfusion centers, and transfusion units from health institutions in order to prevent WNV transmission by blood transfusion.

- **Order no. 1.193/2007 on the approval of the norms regarding the information that should be offered to the human blood and blood components donors, as well as the information that should be given by donors at each donation, and the admissibility of human blood and blood components donors, with subsequent modifications and integrations**

  On one hand the provisions of this order have the role of ensuring safety of the donors by setting specific health and physical criteria of those admitted as donors (i.e. age between 18-65, over 50 kg, beneath 37.5 Celsius degrees temperature, regular pulse and blood pressure, etc). On the other hand it contributes to the preventing of transmission of certain diseases through blood transfusion by collecting specific information from the donors (i.e. previous surgery, tattoo, sexual partners, travels abroad, etc.). Order 1.193/2007 transposes the Directive 2002/98/EC *setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components*, and the Commission Directive 2004/33/EC implementing Directive 2002/98/EC as regards *certain technical requirements for blood and blood components*, as well as the Recommendations of the Council of Europe included in the Guide to the preparation, use and quality assurance of blood components, 12ve edition, 2006.

- **Order no. 1.228/2006 on the approval of the norms regarding the organization of haemovigilance system, the ensuring of traceability, as well as of the regulation regarding the system for recording and reporting in the case of occurrence of unexpected events and severe adverse effects related to the collection and administration of human blood and blood components, with subsequent modifications and integrations**

  Haemovigilance is a set of standardized procedures for surveillance of unexpected events or severe adverse effects that occur both to donor and recipient of blood during the transfusion, as well as for the epidemiological surveillance of donors. Traceability represents the set of information recorded and measures that allow to trace and identify each step of the activity, starting with the admission of the donor up to the therapeutic use of human blood and blood components. Traceability allows establishing links between donor and one or more recipients and from recipient to donor, and it is set using a national unique system of identification of blood units and persons.

  The National Institute for Blood Transfusion, Bucharest Blood Transfusion Centre and territorial blood transfusion centres have a donor identification system that include the donor personal ID number, the blood and blood component unit donation code and the blood donation institution code. The blood recipient is also identified by a system that includes the recipient personal ID number and the blood transfusion institution code. Information is archived for 30 years.

  The Order 1228/2006 also includes the forms for data collection regarding traceability, blood transfusion incidents and adverse reactions.

  Each hospital has a blood transfusion and haemovigilance commission. They report data to the territorial haemovigilance coordinator that reports further to the National Institute for Blood Transfusion – the national haemovigilance coordinator.

- **Order no. 1.343/2007 on the approval of the national guide for the rational therapeutic use of human blood and blood components**

  Order 1.343/2007 transposes Directive 2002/98/CE *setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components.*

- **Order no. 1.132/2007 on the approval of norms regarding the standards and specifications related to the system of quality of the health institutions that perform transfusions**

  This order transposes the Directive 2002/98/CE *setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components* and Commission Directive 2005/62/EC implementing Directive 2002/98/EC as *regards Community standards and specifications relating to a quality system for blood establishments.*

- **Order no. 1.226/2006 on the approval of the norms regarding the collection, biologic control, processing, preservation, distribution and transport of human blood and blood components**

  Complying with the norms regarding the collection, processing, preservation and transport of human blood and blood components ensures the safety of the transfusion. This order, that includes these norms as annex, applies to the national Institute of Blood Transfusion, territorial blood transfusion centers, and transfusion units from hospitals.

- **Safety regulations with regards to radiation**

  - **Order no. 300/2006 on the approval of specific regulations regarding the medical exposures to ionizing radiations for medical and/or bio-medical research.** These specific regulations regarding the medical exposures to ionizing radiations for medical and/or bio-medical research are in accordance with the recommendations of the European Commission in Radiation Protection 99 (1998), in the Guidance on medical exposures in medical and bio-medical research and apply to all situations in which radiation is administered to healthy volunteers or in the situations when the patients receive radiation as a supplement or in deficit compared to their clinical needs. *(Author's note: Since the radiation is used for the purpose of research in this instance, the level of radiation could be over or under the usual level used for treatment.)*
  - **Order no. 14/2000 on the approval of the basic norms for radiological safety.** This Order transposes the provisions of Articles 1-29 and Articles 38-53 of the Council Directive 96/29/ Euratom - ionizing radiation of 13 May 1996 laying down basic safety standards for the protection of the health of workers and the general public against the dangers arising from ionizing radiation. The norms for radiological safety are presented in the annex of the Order 14/2000. The responsible entities for the enforcement of these norms are the specific general directions within the National Commission for the Control of the Nuclear Activities.
  - **Order no. 285/2002 on the approval of the norms regarding the radioprotection of persons in case of medical exposure to the ionizing radiations.** According to the Order, all the medical exposures to the ionizing radiations should be justified in advance, taking into account the specific objectives for the exposure and the characteristics of the person involved. The therapeutic exposure should be justified by the ordering physician. The exposure in the research purpose should be previously examined and approved by an ethics committee. This means that if there is no adequate justification, the exposure should be avoided. This order transposes the Council Directive 97/43/ Euratom on *health protection of individuals against the dangers of ionizing radiation in relation to medical exposure.*
  - **Order no. 1.334/2004 on the specific actions regarding the health protection of individuals against ionizing radiations in relation to medical exposure.** The Order imposes the obligation for the medical institutions in which diagnostic radiology, intervention radiology, nuclear medicine, and radiotherapy activities are performed to elaborate their own specific regulations related to the health protection of individuals against ionizing radiations in relation to medical exposure.
  - **Order no. 173/2003 on the approval of the radiology safety norms for diagnostic radiology and intervention radiology practices, with subsequent modifications and integrations.** This order is followed by a series of orders specific to medical exposures to ionizing radiations of different patient categories, or to specific situations. These are:
    - Order no. 1539/2006 on the approval of specific regulations regarding the medical exposure of persons to ionizing radiations in case of medico-legal expertises;
    - Order no. 1540/2006 on the approval of specific regulations regarding the medical exposure to ionizing radiations in paediatric radiology;
    - Order no. 1541/2006 on the approval of specific regulations regarding the medical exposure to ionizing radiations of pregnant women;
    - Order no. 1542/2006 on the recording and reporting of the patients dose.

    These orders set responsibilities for both the ordering physicians and the radiology physicians.

- **Order no. 1393/2010 on the approval of the medical practice guide for radiology- medical imagery and nuclear medicine specialties** sets responsibilities for public health and medical imagistic specialists, including radiology physicians, but not for the ordering physicians

D) PROVIDER CODES OF ETHICS

- **Code of Deontology of Dental Practitioners of 15 May 2010**
  - **Article 7:** *The dental physician should not accept to practice the profession under conditions susceptible of compromising the quality of medical act and patient safety.*

E) OTHER RELEVANT SOURCES

Other relevant sources related to the patient's Right to Safety were not identified.

F) PRACTICAL EXAMPLES

1. Example of Compliance

The increased numbers of teenagers who start their sexual life at an early age changed the protocol of investigations at a Paediatric Hospital. This happened after the increase of the cases in which girls of 12 – 13 years of age found that they were pregnant exactly during the X-ray examination, a situation which is extremely harmful for the foetus. In the last five years, at the maternity there have been over 700 deliveries of teenage mothers. If a pregnant woman is exposed to ionizing radiations, the foetus could suffer malformations. Thus, before sending the patients under 18 years of age and therefore minors to X-ray exams, the doctors talk to those patients' parents, asking for their informed consent as required by law, to test their daughters for pregnancy first, as a protective measure. If the pregnancy test is positive, the pregnant teenager will avoid the radiological investigation.

2. Examples of Violation

Example 1: A patient during surgery fell from the operating table immediately after he went under anaesthesia, due to the operating table breaking. At the moment when the table collapsed, the surgeons were turned around, washing their hands. Following the fall, the patient did not suffer any harm, so the operation was still performed after replacing the operating table. The operating table was procured in 2009 within an operating theatres modernization project. The hospital manager ordered an expertise on the quality of all procured equipment in that project. Since this aspect should have been assessed by the procurement team when the equipment was delivered, the manager sanctioned them with written warnings.

Example 2: The Ministry of Health investigates a case at a Centre for Transfusions. The physicians of this centre are suspected of sending to the District Hospital blood infected with Hepatitis B virus, blood that has been already used for a patient. The donor is currently admitted to the Infectious Diseases Ward of the Hospital with the suspicion of Hepatitis B. Unfortunately the suspicion was raised after the blood donation.

3. Actual Case

On 16 August 2010, around 6:30 pm, in the Newborns Intensive Care Unit of the Neonatology Department of the Clinical Obstetrics-Gynaecology Hospital „Prof. Dr. Panait Sârbu", occurred a fire in which six newborns died and five newborns suffered severe injuries.

In the resulting legal case, the prosecutors attached to the Bucharest 6th District Court decided to prosecute five employees of the hospital: the nurse on duty who was not in the Unit when the fire

started – accused of involuntary manslaughter (causing the death of six newborns) and involuntary severe physical injury (affecting five newborns); the head of Technical Service Department; the hospital manager; the head of the Neonatology Department; and the electrician, all accused of negligence in performing their duties with extremely severe consequences. *(See practice notes for lawyers below.)*

The conclusions of the technical expertise done by the National Institute for Research and Development in Mine Safety and Protection from Explosion Petroşani[788] revealed that the fire was caused by overheating of the contact elements of the plug of the power cord of the air conditioning device. The cause was of electrical nature - an incendiary and non-explosive, physico-chemical process.

The court of first instance issued in July 2013 the following verdict: the hospital was sentenced to pay the criminal fine of 400,000 lei, the hospital manager was sentenced to pay the criminal fine of 6,500 lei, the nurse on duty was sentenced to 2 years and 2 months in prison, the electrician was sentenced to 2 years in prison, and the head of Technical Service Department received a suspended sentence of almost 4 years in prison. The sentences are not definitive and therefore the parties appealed. In April 2015 the Bucharest Court of Appeal maintained the sentence for the nurse on duty (2 years and 2 months in prison); the hospital manager at that time received a suspended sentence of 6 month in prison; the head of the Neonatology department was acquitted; and the electrician received a suspended sentence of 1 year in prison. The former head of the Technical Service Department died during proceedings, so the charges against him were dropped. The Court of Appeal also admitted the claims and evidence regarding actions formulated by the civil parties and obliged the hospital, the nurse on duty, the electrician and the ex-hospital manager, the Ministry of Health and the Bucharest town hall to pay jointly damages to the victims' families in the total sum of 4.3 million Euros. The decision is final.

G) PRACTICE NOTES FOR LAWYERS

- In the Criminal Code, at Chapter II: Crimes of service, Art. 298 Negligence provides: *Violations of misconduct by an official of a public service duties by its failure or improper fulfillment of it, if this is causing damage or harm to the rights or legitimate interests of a natural or a legal person, is punishable with imprisonment from 3 months to 3 years or a fine.*
- When arguing that a heath care provider has breached regulations and/or professional standards regarding safety, lawyers should also look into whether there are also internal regulations of the health care provider which stipulate safety rules. For instance, internal regulations of public hospital are or should be publicly available.
- While for proving some breaches of safety it is necessary to order a medical speciality expertise, for other infringements, the duties of heath care providers are clear from the text of the law. For example, the duty to put in place *universal precautions* is clear and represents an obligation to reach a specific result in Law no. 584/2002 on the measures for preventing the spread of AIDS in Romania and for protection of persons infected with HIV or having AIDS.
- Lawyers litigating cases with elements of negligence of health care providers should thoroughly look into professional standards or protocol and check any relevant details with health professionals, since such information is seldom provided in laws. For example, if a lawyer represents the victim of a negligent action in the operating room, then he/she should look into the professional responsibilities and protocols of the different type of professionals involved in the surgery. In a case from 2012, the Bucharest Tribunal held that the responsibility for failing to extract a foreign body after surgery rests with the surgeons and not the surgical nurse, since there were no clear procedures regarding the duties of the surgical nurse to check the surgical instrument and notify the surgeon if there are missing elements[789].

788 Mediafax.ro (17 septembrie 2010) Expertiză tehnică: La Maternitatea Giuleşti a fost un incendiu, şi nu explozie [Technical expertise: At Giuleşti Maternity it was a fire not an explosion] http://www.mediafax.ro/social/expertiza-tehnica-la-maternitatea-giulesti-a-fost-un-incendiu-si-nu-explozie-7288454

789 Decision no. 515A of 18 May 2012, published in Roxana Maria Călin, Malpraxis: Răspunderea medicului şi a furnizorilor de servicii medicale [Malpractice. Physician and health services providers liability], 2014

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to safety 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.

6.1.10 Right to Innovation

A) RIGHT TO INNOVATION AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

Each individual has the right of access to innovative procedures, including diagnostic 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, paying particular attention to rare diseases. Research results must be adequately disseminated.

B) RIGHT TO INNOVATION AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003 has no provision in reference to the right to innovation.**

Legislation

- **Law no. 95/2006 on the Health Reform, republished in 2015**
  - **Article 5** states the main functions of public health: *researching, developing and implementing innovative solutions for public health* (letter h), *informing, educating and communicating for the promotion of health* (letter k),
  - **Article 7** phrases the basic principles of public health care, including: *decisions based on the best scientific evidence existing at the particular moment (public health based on evidence* (letter f).

  The possibility of conducting research in all health institutions of specific areas is provided in Law no. 95/2006 in the following main titles: **Title III** Primary Health Care, **Title V** Ambulatory and Specialty Care, **Title VII** Hospitals.

- **Law 95/2006 provides special chapters related to**
  - development of the European reference networks,
  - cooperation with other member states of the European Union in the field of rare diseases,
  - cooperation and participation at the information exchange with the other EU member states,
  - cooperation in the field of Health Technology Assessment[790].

  This is accomplished especially by the law's subsequent integrations at **Title XIX** that partially transposes the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.

790 "health technology" meaning drugs, medical devices, medical and surgical procedures, as well as measures for the prevention, diagnosis and treatment of diseases, and organizational systems used in health care

All these provisions comply with the patients' right to innovation, ensuring them the possibility of getting new procedures, at the highest possible standards, in another EU member state, if those procedures are not available in the country of a patient's origin. For instance:

Title XIX, Chapter VIII Rare diseases, Article 920, letter b: *The Ministry of Health cooperates with the other EU member states in what concerns the increase of the capacity for diagnosis and treatment through the increased information delivered to patients, medical personnel and authorities responsible for the financing of health care in the provisions of the Regulation (EC) no. 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems related to the referral of patients with rare diseases to other EU member states for diagnostic and treatment if they are not available in the country.*

- **Law no. 584/2002 on the measures for preventing the spread of AIDS in Romania and for protection of persons infected with HIV or having AIDS**
  - **Article 13:** *Medical research in this field is a priority. It will be coordinated by the Infectious Diseases Institute „Prof. Dr. Matei Balş" Bucharest and the Centre for the human retroviruses study „Victor Babeş" Bucharest, in collaboration with the national and international medical centres.*

- **Law no. 264/2004 on the organization and functioning of the Academy of Medical Sciences**

  An important attribution of the Academy of Medical Sciences is to give value to the research results by using them in the methodological coordination of the medical institutions.

  - **Article 3** states that the Academy of Medical Sciences has as activity objective: *a) the development of medical and pharmaceutical sciences for the purpose of improving the health status of the population; b)promotion at the national level of the scientific research in the fields of bio-medicine, clinical medicine, fundamental medicine, preventive medicine, public health and pharmaceutical sciences; c) coordination of the scientific research activity in the fields of excellence of fundamental and applicative biomedicine, conducted in the institutions under coordination or subordination of the Ministry of Health or other institutions.*

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Order no. 1215/2013 on the approval of the establishment of the National Council for Rare Diseases**

  The role of the National Council for Rare Diseases is to provide the methodological and scientific coordination of the activities in the rare diseases field. The Council has a multidisciplinary composition and offers technical assistance to the Ministry of Health for organizing at the national level a functional network for diagnosis and treatment of rare diseases. Among its attributions is the provision of expertise on the performing of the therapeutic interventions for rare diseases according to the European and international standards, and ensuring the link between the Ministry of Health and The EU institutions, WHO, European networks in the field of rare diseases and other international organizations for the purpose of exchanging information and experience and enhancing capacity for the implementation of the national programme for rare diseases.

- **Government Decision no. 206/2015 on the approval of the national health programmes for 2015 and 2016**

  Through this Decision, the State funds certain national health programmes considered as essential for the improvement of the population health because the addressed diseases are considered public health priority problems. Such Decision on the approval of national health programmes are issued periodically, the programme themes being changed in accordance with public health priorities. The structure and the objectives of these programmes for 2015-2016 are included in the annex of the decision, such as: the national programme for rare diseases treatment, as well as programmes that

involve innovative procedures, such as the national programme for transplantation (with the sub-programmes: organs, tissues and human cells transplantation; central and peripheral hematopoietic stem cells; in vivo fertilization and embrio-transfer) or the national programme for high tech diagnostic and treatment.

The decision on the national health programs is usually followed by a common Order signed by the Ministry of Health (MoH) and the National Health Insurance House (NHIH) President on the application norms. The norms for the current Decision are not issued at the time of this writing. The MoH is responsible for the preventive programs, the NHIH is responsible for the programs providing treatment. The NHIH has specific orders on the inclusion criteria for patients to be treated under the national health programs, and special appointed commissions composed by experts in the specific field evaluate the patients' files and give a resolution.

D) PROVIDER CODE(S) OF ETHICS

No provisions have been identified in reference to the Right to Innovation.

E) OTHER RELEVANT SOURCES

No provisions related to the patient's Right to Innovation have been identified.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

Example 1: The Ministry of Health of Romania entered into a partnership (2009-2011) with the Sălaj District Council, the Zalău City Council and several NGOs from Romania and Norway in order to apply to the Norwegian Cooperation and Sustainable Development Programme in Romania for financing a project for setting a Pilot Reference Centre for Rare Diseases in Zalău791. The purpose of this project is to improve the quality of life of persons affected by rare diseases, through equal access to early diagnostic, quality treatment and rehabilitation services through an accessible and complex network of facilities and resources. The value of this project was almost two billion Euros, out of which the Ministry of Health's contribution was 80,000 Euros, the Sălaj District Council participated with 8,000 Euro, and the Zalău City Council offered the building for the functioning of the Pilot Reference Centre for Rare Diseases. *(Author's note: the Centre has continued to function with different funding sources since 2011.)*

Example 2: The German surgeon UR implemented a new surgical intervention procedure at the Institute of Cardiovascular Diseases and Transplant of Iași. It was the first time when this procedure was used in the Iași hospital. By going through this procedure, the patients with atrial fibrillation do not need complex medical treatment, do not need to take life-long anticoagulant therapy, have less hospital re-admissions, and are able to live a normal life. The German surgeon operated on the first patient and then assisted another two interventions performed by Romanian physicians. This new surgical intervention procedure was implemented after the management of the Institute of Cardiovascular Diseases and Transplant of Iaşi obtained funds from the Ministry of Health and procured the necessary equipment.

791 Zalău.Ziare.com, Un nou parteneriat romano-norvegian pentru pacientii cu boli rare [A new partneship Romanian-Norwegian for patients with rare diseases] http://www.ziare.com/zalau/stiri-actualitate/un-nou-parteneriat-romano-norvegian-pentru-pacientii-cu-boli-rare-5358342

2. Example of Violation

Eight month ago, the hree-year-old Edi's mother and father found that he has an extremely rare genetic disease – Hunter syndrome. They did not know much, but felt that it is something serious, especially when they found that it is just the 7th case in Romania. The treatment for this disease costs 8,000 Euro per month. With no treatment, the patients suffering from Hunter syndrome do not live longer than 10 years. Because in Romania the Hunter syndrome is not included on the rare diseases list, the Ministry of Health does not allocate funds for its treatment. Edi's parents are too poor to buy the treatment, so the little boy's life depends on the benevolence of people who want to donate money to the parents in order for the parents to be able to buy the treatment.

3. Actual Case

In a case initiated by a patient alliance on their behalf, seven patients with cancer, who sued the Government[792], the Ministry of Health and the National Health Insurance House, won in the court the right to receive 100% free medication. The decision was immediately binding. The three state institutions were obliged by the Bucharest Court of Appeal decision to ensure the claimants the drugs needed for cancer treatment without any personal financial contribution of the patients. Even though it was binding, to be applied immediately, the decision is still not final and can be contested by the Government, the Ministry of Health and the National Health Insurance House at the Supreme Court. The drugs needed by the seven patients are new drugs, which have not been introduced yet on the list of International Nonproprietary Names (INN) corresponding to the drugs included in the benefit package covered by social health insurance and approved by government decision, so there are no established prices for reimbursement. The list of drugs included in the benefit package was last updated in 2008, and patients cannot afford to pay from their pockets for the new drugs because they are very expensive. The lawyer representing the seven patients argued that the right to life for the patients is violated and asked the court not only for coverage of the seven patients' treatment, but also for the updating of the compensated drugs list. *(Author's note: the right to innovation is not mentioned in the Constitution; but the right to life and health care is. Additionally, the lawyer mentioned the EC Directive 89/105 that provides a time limit for the decision on an application to include a medicinal product in the scope of the public health insurance system.)*

G) PRACTICE NOTES FOR LAWYERS

- The right to Innovation is framed in a general manner in the European Charter of Patients' Rights. However, this should not discourage lawyers from finding particular and practical instances where this right was infringed. Such instances can refer to the duties of public authorities to fund research, to update the compensated drugs lists with new drugs, to update existing clinical guides, or the duty of medical practitioners to inform the patient of the least invasive procedures etc.

H) CROSS-REFERENCING 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 and Chapter 3.

792 Mediafax.ro 18 iunie 2014, Şapte bolnavi de cancer care au dat în judecată Guvernul, MS şi CNAS au câştigat dreptul de a primi medicamente compensate 100% [Seven patients with cancer who sued the Government, MoH and NHIH won the right to receive 100% compensated medicines] http://www.mediafax.ro/social/sapte-bolnavi-de-cancer-care-au-dat-in-judecata-guvernul-ms-si-cnas-au-castigat-dreptul-de-a-primi-medicamente-compensate-100-12784143

6.1.11 Right to Avoid Suffering and Unnecessary Pain

A) RIGHT TO AVOID SUFFERING AND UNNECESSARY PAIN AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

Everyone has the right to avoid suffering and pain as much as possible in each phase of his illness.

The health services must commit themselves to taking all measures useful to this end, like providing palliative treatments and simplifying patients' access to them.

B) RIGHT AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**

  This right is not expressed specifically as such in the Constitution or other Romanian legislation. However, there is a series of legal provisions establishing certain aspects which fall under the scope of this right, such as the patient's right to benefit from palliative care. Although the Romanian Constitution does not expressly provide this right, **Article 22** of the Constitution contains applicable provisions:

  - it establishes the right to life and physical and psychic integrity;
  - it provides that nobody can be subjected to torture and/or any kind of punishment or inhuman or degrading treatment.

Legislation

- **Romanian Civil Code**

  - **Article 58, para. 1:** *Any person is entitled to life, health, physical and psychic integrity, dignity, own self- image, observance of private life and other such rights acknowledged by the law.*
  - **Article 61, para. 1:** *The life, health and physical and mental integrity of any person are equally guaranteed and protected by the law.*
  - **Article 64, para. 2:** *Any person is entitled to physical and psychic integrity. The integrity of a human being can be interfered with only in the cases and conditions expressly and restrictedly provided by the law.*

- **Romanian Criminal Code**

  The Romanian Criminal Code prohibits the submission to maltreatment **(Article 280)** and to torture **(Article 281)** and in general forbids any crimes against the life and bodily integrity of persons.

  (Author's note: Although those articles do not strictly consider the avoidance of suffering, they can also be relevant in this field, even if no perfect overlap.)

- **Law no. 46/2003 on the Rights of Patients**

  Law 46/2003 contains the following provisions considering the avoidance of suffering and palliative treatment:

  - **Article 2:** *The patients are entitled to medical care of the highest quality existing in the society, in accordance with the human, financial and material resources.*
  - **Article 3:** *The patient is entitled to be respected as human being, without any discrimination.*
  - **Article 31:** *The patient is entitled to terminal care so that he could die with dignity.*

- **Article 32:** *The patient may benefit of the support of his family, friends, spiritual and material support and advice during the medical care. At the patient's request, as far as possible, the care and treatment environment shall be created as close as possible to the homely one.*

Law no. 95/2006 on Health Reform, republished in 2015

- **Article 236, para. 1:** *The insured is entitled to medical services to cure the disease, prevent its complications, recover or at least relieve suffering, as applicable. (Authors' note; However, the aforementioned legal provisions do not fully transpose the patient's freedom of choice, as provided in the Charter, because the law considers only the concept of "insured", a concept which does not fully overlap with "the patient" because there are also uninsured persons.)*

Law no. 487/2002 on Mental Health and Protection of People with Mental Disorders

- **Article 37, para. 1:** *It is prohibited to submit any person admitted to a psychiatric facility or admitted in recovery and rehabilitation centres to inhuman and degrading treatments or other maltreatment.*
- **Article 39** limits the cases in which the freedom of movement of the persons admitted to psychiatric facilities or recovery and rehabilitation centres may be restricted.
- **Article 40:** *The admitted persons may temporarily be isolated, without restraint, to protect them, if they are a threat to themselves or others. This measure must be applied with great caution and only if all other methods have proven to be inefficient.*
- **Article 41, para. 1:** *Any person with mental disorders is entitled to the best available medical services and mental health care.*
- **Article 42, para. 5:** *The activity of a patient within a mental healthcare facility must not allow his physical or psychic exploitation.*
- **Article 55:** *The involuntary admission is done only in psychiatric hospitals providing proper conditions for specialised care in specific conditions.*
- **Article 57:** *The transportation of the person in question to the psychiatric hospital is done, as a general rule, by means of the ambulance service. If the behaviour of the person in question is visibly dangerous for himself/herself or others, his/her transportation to the psychiatric hospital is performed with the support of the police, gendarmerie, or fire brigade, in compliance with all possible safety measures and observance of physical integrity and dignity.*

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

Norm of 7 April 2004 for the application of Law no. 46/2003 on patient rights

- **Article 3:** *The facilities must use all available means and resources to ensure a high level of quality of the healthcare.*

Order of the Ministry of Health no. 372/2006 on the norms for application of the Law no. 487 of 11 July 2002 on mental health and protection of the persons with psychical disorders

- **Articles 21 and 22** limit the cases in which the admitted persons may be restrained or isolated.
- **Article 31, para. 4:** *The transport of a person to hospital shall be done in the least restrictive conditions, providing the observance of his physical and psychic integrity and dignity.*

D) PROVIDER CODE(S) OF ETHICS

Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians

The Code provides the following obligations of the physicians:

- **Article 1:** *The entire professional activity of the physician is exclusively dedicated to protect the life, health, physical and psychic integrity of the human being.*
- **Article 4:** *In all medical decisions, the physician must ensure that the interest and welfare of the human being prevails over the interest of the society or science.*
- **Article 8:** *The physician shall dedicate his/her entire science and expertise to the interest of his/her patient and shall make every effort to ensure that the decision is correct and the patient benefits of all guarantees in relation to the concrete conditions, so that his/her health does not come to harm.*
- **Article 22** proclaims as unethical certain deeds or acts of the physician, including the following:
  - *d) the use of methods of diagnosis or treatment scientifically unsubstantiated or unsupported by the medical community, with a risk for the patient (Author's note: The code is silent in regard to use of scientifically unsubstantiated or unsupported methods if they are not a risk to a patient)*
  - *e) except for the vital emergencies, the exercise of the medical profession provided in a manner that it could compromise the profession or would impair the quality of the medical procedure.*

E) OTHER RELEVANT SOURCES

There are no other relevant sources on this right.

F) PRACTICAL EXAMPLES

1 Example of Compliance

Mr. C., voluntarily admitted to a psychiatric hospital in Bucharest, suffers during the admission an incident whereby he endangers his life. Although the nurse who determined the condition of Mr. C. recommends to the chief physician to restrain the patient, the physician considers that there are less restrictive methods to eliminate the threat over the life of Mr. C. and that his restraint can be ordered only if such measures are not enough. Therefore, the physician firstly orders an alternative measure for treatment for Mr. C., a measure which eliminates the threat, thus eliminating the need to apply the physical restraint.

2 Example of Violation

Mrs. B. is taken by her family to a psychiatric hospital in Constanța, as a result of an incident caused by the psychic disorder from which she suffers. On the spot, the hospital staff informs the family that the hospital has no free beds, so as it cannot admit Mrs. B., recommending to the family to take her to a neuropsychiatric recovery and rehabilitation centre nearby. The neuropsychiatric recovery and rehabilitation staff centre decides to accept, at the family's request, the involuntary admission of Mrs. B. until there are any free beds in the psychiatric hospital. Such involuntary admission is illegal because, under Law no. 487/2002, the involuntary admission can be only to psychiatric hospitals with the required conditions, but not in other types of institutions. *(Authors' note: In theory, a person cannot be involuntarily admitted to a psychiatric hospital without court approval; however, human rights NGOs such as the Centre for Legal Resources who monitor these mental health facilities have observed that this happens in practice. Although the law states that involuntary admission can be only to psychiatric hospitals with the required conditions, the legislation does not detail those conditions.)*

3 Actual Case

Case of the Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania (2014), brought before the Grand Chamber of the European Court of Human Rights[793]

The case originated in Romania where, in 2004, the young man Mr. Valentin Câmpeanu (aged 18) died in 2004 in the psychiatric hospital of Poiana Mare (PMH). Mr. Câmpeanu was found by representatives of the Centre for Legal Resources in a critical state: in the winter, in an unheated room, with a bed but no bedding and dressed only in a pyjama top. Mr. Câmpeanu was living with HIV and had an intellectual disability. He arrived at the Poiana Mare Hospital after subsequent transfers in between adults' social care centres who could not offer him care (he had to leave the child protection services because he turned 18). Since no one was found responsible for his death during the criminal proceedings in Romania, the case reached the European Court of Human Rights. There, the Court held that Romania violated the applicant's right to life (Article 2 of the Convention) and, regarding the conditions in the Poiana Mare Hospital (PMH), this is what the Court stated (§141):

"Moreover, placing Mr Câmpeanu's individual situation in the general context, the Court notes that at the relevant time, several dozen deaths (eighty-one in 2003 and twenty-eight at the beginning of 2004) had already been reported at the PMH; as mentioned in the CPT report of 2004, serious deficiencies were found at the relevant time in respect of the food given to the patients, and in respect of the insufficient heating and generally difficult living conditions, which had led to a gradual deterioration in the health of patients, especially those who were the most vulnerable (see paragraph 77 above). The appalling conditions at the PMH had been reported by several other international bodies, as described above (see paragraph 78); the domestic authorities were therefore fully aware of the very difficult situation in the hospital.

Despite the Government's assertions that the living conditions at the PMH were adequate (see paragraph 123 above), the Court notes that at the relevant time, the domestic authorities had acknowledged before the various international bodies the deficiencies at the PMH regarding the heating and water systems, the living and sanitary conditions and the medical assistance provided (see paragraph 78 above)."

G) PRACTICE NOTES FOR LAWYERS

- The ECPR Right to avoid suffering and unnecessary pain is not expressly provided in the Romanian health legislation; however, it can represent an important right for lawyers who are interested in strategic litigation or legal advocacy and wish to promote this right as much as possible before national courts and competent authorities. Thus, even if the lawyer in a particular case regarding unnecessary suffering rests his argument on specific national provisions, the lawyer can also frame these arguments under the ECPR Right to avoid suffering and unnecessary pain, with the aim of convincing the court to reiterate this perspective in the final court judgment.

H) CROSS-REFERENCING

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 and Chapter 3.

793 For the full text of the Court judgment, please see: http://hudoc.echr.coe.int/eng?i=001-145577

6.1.12 Right to Personalized Treatment

A) RIGHT TO PERSONALIZED TREATMENT AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR):

Each individual has the right to diagnostic or therapeutic programmes tailored as much as possible to his or her personal needs.

The health services must guarantee, to this end, flexible programmes, oriented as much as possible to the individual, making sure that the criteria of economic sustainability does not prevail over the right to health care.

B) RIGHT TO PERSONALIZED TREATMENT AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **Romania Constitution of 1991, revised in 2003**

  There is no constitutional provision in reference to the right to personalized treatment.

Legislation

- **Law no. 46/2003 on the Right of Patients**

  The right to personalized treatment is mentioned in the Romanian legislation only in relation to the place where the treatment is provided, not with the treatment itself. Thus, **Chapter VI** of the law provides patients with the right to treatment and medical care. **Article 32** states that: *At the patient's request, as far as possible, the treatment and care environment will be created as close as possible to his/her familial environment.*

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Government Decision no. 562/2009 on the approval of the strategy on decentralization in the health care system**

  The strategy on decentralization in the health care system, approved by the decision 562/2009, mentions the *Focus (centralization) on the citizen* as one of the decentralization outcomes, having the following meaning: *The Romanian health system should become a system that helps people to be healthier, a correct system in which people trust and expect to be there where it is needed. The way the health services are provided within the system should be personalized.*

D) PROVIDER CODES OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**
  - At **Article 24**, referring to *unmediated nature of the physician-patient relationship*, the Code states: *Unless there are objectively exceptional circumstances and they are impossible to remove, any medical decision will be based primarily on personal and unmediated examination of the patient by that physician. Para. (Author's note: This statement could be seen as a contribution to the provision of personalized treatment.)*

- **Decision no. 2 of 9 July 2009 of the Order of Nurses and Midwives of Romania on the Adoption of the Code of Ethics and Deontology of the Nurses and Midwives in Romania**
  - **Article 39** states that *"Persons with physical disorders benefit from medical and health care at the same quality standards as other categories of ill persons, adapted to their specific health status requests". (Author's note: By this provision the right to treatment tailored to specific needs is provided for a category of patients)*

E) OTHER RELEVANT SOURCES

- **Regulations for the Organization and Functioning of the National Clinical Centre for Children's Neuropsychomotor Rehabilitation „Dr. Nicolae Robănescu" Bucharest of 6 August 2013**

  This internal regulation of the specific rehabilitation centre for children with physical and neuropsychomotor deficiencies sets provisions related to personalized treatment of its patients:
  - **Article 4, para. 5:** *The rehabilitation treatment is personalized in accordance with the diagnostic particularities of each child.*
  - **Article 16, para. 2:** *The treatment is personalized for each child, in accordance with his/her functional level, his/her pathology, his/her level of understanding.*

F) PRACTICAL EXAMPLES

1. Example of Compliance

Children and adults with autism spectre disorders in Romania may receive speciality care and certain therapies free of charge in 40 centres for counselling and care for persons with autism that function in 35 districts of the country and in Bucharest. These centres were established through the project "They must have a chance, too!" by the Foundation Romanian Angels Appeal in partnership with the Ministry of Labour, Family, Social Protection and Elderly – the Directorate of Child Protection and the General Directorate of Social Assistance of the Bucharest Municipality. These centres were opened in March 2012 and offer personalized interventions to each beneficiary, in accordance with his/her age and the degree of impairment. Psychologists and/or psychopedagogists working in the 40 centres are trained on how to work with persons with autism. They evaluate each patient, including his/her family, and make an action plan for medium and long terms, according to the needs. The working sessions are individual or group sessions. To date, 568 persons between 2 and 50 years of age have benefited from care offered in the 40 centres.

2. Example of Violation

Patient X, 37 years of age, went to the dentist office for an intervention to a dental prosthesis done one and a half years ago[794]. The dentist administered to the patient one dose of anaesthetic and started the intervention. During the intervention, as the patient experienced pain, the dentist gave him two more doses of anaesthetic, knowing from previous experience that there is no risk to harm the patient. After approximately one hour, the patient left the dentist's office, but just after a few steps he became ill. A physician in the neighbouring office who was immediately called measured the patient's blood pressure and found a systolic value of 270 mmHg. The patient received oxygen and the emergency service was called, but before the ambulance arrived, the patient developed a hemiparesis on the left side and barely could talk. The patient was taken to the Neurosurgery Hospital, but on the way he became unconscious. The diagnosis entered into the hospital record was cerebrovascular accident. The patient had hypertension and renal failure, but the dentist did not ask the patient about

794 Ziarul de Iași. 28.05.2008 În comă la ușa stomatologului [In a coma, at the dentist door] http://www.ziaruldeiasi.ro/local/in-coma-la-usa-stomatologului~ni4pra

other diseases and did not measure his blood pressure, so he failed to take into consideration the particularities of the stomatological treatment in patients with cardiovascular diseases.

3. Actual Case

Patient MM, 65 years of age, was brought by ambulance to the Emergency District Hospital Slatina, with *pronounced psychomotor agitation*[795]. The physician on duty from the Emergency Unit referred the patient to the Psychiatry Department, without any previous investigation, with the diagnosis of "acute alcohol intoxication; *psychomotor* agitation". The man died approximately 9 hours after being sent from the Emergency Unit to the Psychiatry Department. In the meantime, the blood alcohol test showed that the patient did not intake alcohol. This was confirmed also by the autopsy that revealed that the man had pulmonary and cardiac disorders that were responsible for his death. According to the death certificate, the direct cause for death was "acute cardio-respiratory failure caused by an acute interstitial pneumonia". The physician on duty was referred to the Disciplinary Commission of the Hospital, which fired him. He subsequently sued the hospital but lost the case and now does not work as a physician anymore. Additionally, the physician is under criminal investigation in order to clarify the facts and to determine whether those facts establish criminal liability.

G) PRACTICE NOTES FOR LAWYERS

- Although the right to personalized treatment is phrased in a general manner, lawyers litigating cases of non-compliance should identify as much as possible the application of this right to the specific facts of the case. For example, lawyers should look into the professional standards of medical practitioners in order to establish the duty of the doctor to check and consider the history of the patient before prescribing treatment. It can be the case that such duties are not provided in legal text, but rather in health care training manuals.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion of international and regional standards relevant to the Right to Personalized treatment under the Right to the Highest Attainable Standard of Health in Chapter 2 and Chapter 3 and under the Right to nondiscrimination and equality in Chapter 2 and Chapter 3.

6.1.13 Right to Complain

A) RIGHT TO COMPLAIN AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR)

Each individual has the right to complain whenever he or she has suffered a harm and the right to receive a response or other feedback.

The health services ought to guarantee the exercise of this right, providing (with the help of third parties) patients with information about their rights, enabling them to recognise violations and to formalise their complaint. A complaint must be followed up by an exhaustive written response by the health service authorities within a fixed period of time.

795 Eveniment de Olt 19 februarie 2012. Medicul Fulga cercetat pentru ucidere din culpă [Dr. Fulga under investigation for manslaughter] http://www.evenimentdeolt.ro/eveniment-new/eveniment/medicul-fulga--cercetat-pentru-ucidere-din-culp--a124521e6e-8f4458a206c715dfbafafc

The complaints must be made through standard procedures and facilitated by independent bodies and/or citizens' organizations and cannot prejudice the patients' right to take legal action or pursue alternative dispute resolution.

B) RIGHT AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**

  The right to complain is acknowledged for any person, both by the Constitution and by the provisions of other laws. The Constitution guarantees the free access to justice of every citizen or legally established organisations. The patient's right to file a complaint regarding a medical act or service is also circumscribed by the general right to submit petitions provided for in the Constitution.

  - **Article 51** on the right to complain establishes:
    - the right of citizens and legally established organisations to address the authorities by petitions;
    - the exemption from tax of the exercise of the right to complain by filing of a petition;
    - the public authorities' obligation to answer to petitions within the time limits and under the conditions established by law.
  - **Article 21** on the free access to justice establishes:
    - the right of every person to bring cases before the courts for the defence of his/her legitimate rights, liberties and interests;
    - the prohibition to restrict this right by any law;
    - the parties' right to a fair trial and a solution of their cases within a reasonable period;
    - the gratuitous and optional quality of special administrative jurisdictions.
  - **Article 24** on the right to defence
    - The Constitution guarantees the right to defence;
    - It guarantees the parties' rights to be assisted by a lawyer of their own choosing or appointed *ex officio*, throughout the trial.

Legislation

The right to complain is stipulated in the health care legislation in terms of determining liability of medical staff and providers responsible for the damages caused to the patient through a medical act. This stipulation entails the right of the patient to seek redress and to do so by filing a complaint with a court or other competent body.

In regard to medical personnel, the Romanian legal system regulates three types of liability: (i) civil liability with the purpose of providing redress for material and/or moral damages caused to the patient, (ii) criminal liability if the action of the medical personnel reaches the gravity of a crime and (iii) disciplinary liability of the persons responsible for the improper medical act or service.

- **Law no. 95/2006 on the Health Reform, republished in 2015:**

  The law regulates in **Title XVI**, the **civil liability** and in **Title XII**, **Chapter III**, **Section 6**, the **disciplinary liability** of the medical personnel and medical, sanitary and pharmaceutical products and service providers.

A. Civil liability:

- **Article 653:**
  - establishes that *medical personnel* refers to physician, dentist, pharmacist, nurse and midwife, providing medical services;
  - defines *malpractice* as a professional error committed in the exercise of the medical or medical and pharmaceutical act which causes damages to the patient, involving the civil liability of the medical personnel and medical, sanitary and pharmaceutical product and service provider;
  - establishes the medical personnel's civil liability for the damage caused to patients:
    - by error, which includes negligence, recklessness or insufficient professional medical knowledge, through individual acts during prevention, diagnosis or treatment procedures,
    - by failure to comply with the legal regulations on privacy, informed consent and compulsory medical assistance,
    - during the exercise of the profession and when the medical personnel exceeds the limits of his/her competence, except for the cases of emergency when there is no available medical personnel with the necessary competence.
  - establishes *expresis verbis* that the medical personnel's civil liability does not exclude the criminal liability if the act causing the damage is an offence under the criminal law.
- **Article 654:**
- establishes that all persons involved in the medical act shall be held liable to a degree which is proportional to the fault of each of them;
- establishes the cases in which medical personnel shall not be held liable for medical acts committed in the exercise of the profession, namely:
  - when the damages are due to the working conditions, poor diagnosis and treatment equipment, hospital-acquired infections, adverse effects, complications and generally-accepted risks of the investigation and treatment methods, hidden defects of sanitary materials, medical equipment and devices, or used medical and sanitary substances;
  - they act in good faith in emergencies, respecting their conferred competences.
- **Article 655:**
- establishes the civil liability of healthcare facilities as medical service providers according to the common civil law rules[796] for the damage caused during prevention, diagnosis or treatment procedures;
- provides that the medical service provider shall be liable for the damage when such damage is caused by:
  - hospital-acquired infections, except when the existence of an external cause which could not be controlled by the provider is proven;
  - known defects of medical devices and equipment which have been used abusively, without being repaired;
  - use of sanitary materials, medical devices, drug and sanitary substances, after the expiry of their warranty or validity period, if applicable;
  - acceptance of medical equipment and devices, medical supplies, drugs and sanitary substances from suppliers without the insurance provided by the law, and subcontracting of non-medical and medical services from providers who do not have civil liability insurance in the medical field.
- establishes the civil law joint liability (bound *in solidum*) of healthcare facilities with employed medical personnel for the damage caused by the latter[797].

796 Articles 1349 and the following on the civil liability provided in the Romanian Civil Code.
797 Articles 1372 and the following of the Romanian Civil Code.

- **Article 656** establishes the civil liability of healthcare facilities (both public and private) for the damages caused, directly or indirectly, to patients, and which have been incurred by the failure to comply with the internal regulations of the healthcare unit.
- **Article 657** provides that public or private healthcare providers and the manufacturers of medical equipment and devices, drugs and medical supplies are liable under the civil law for the damages caused directly or indirectly to patients by the hidden defects of equipment and medical devices, drugs and medical supplies during the warranty/validity period, according to the law.
- **Article 658** establishes the liability of healthcare or non-healthcare service providers subcontracted by public or private healthcare providers for the damage directly or indirectly caused to patients as a result of rendered services.
- **Article 659** stipulates the utility providers' civil liability to the healthcare facilities for the damage incurred to their patients by the improper supply of utilities.
- **Article 667:** establishes the obligation of the medical personnel to obtain malpractice insurance in case of professional civil liability for the damage caused by the medical act; provides that the possession of valid insurance by the medical personnel is a compulsory requirement for their employment within the healthcare facilities.
- **Article 668:**
  - establishes the right of persons ascertained to have been subject to a medical malpractice act to be compensated by the medical personnel's insurer for the damage caused by malpractice and for the possible costs incurred by judicial proceedings;
  - stipulates that the civil liability insurance shall include all types of medical treatments to be performed in the specialization and professional competence of the insured professional (medical personnel) and in the range of medical services provided by the related facilities.
- **Article 673:**
  - provides that the amount of compensation may be established amiably by the parties (insured, insurer and injured party) if there is certainty regarding the civil liability of the insured professional
  - stipulates that the damages shall be paid only based on a final court decision if the parties (insured, insurer and injured party) either agree or do not agree, it there is certainty about the guilt of the insured professional..
- **Articles 679 and 683**
  - regulate the existence, at the level of the county and Bucharest public health authorities, of a Commission of monitoring and professional competence in case of malpractice (further referred to as the Commission);
  - provide that the Commission's role is to establish, by a decision, whether the case brought to its attention is an act of malpractice. The decision shall be communicated to all persons involved, including the insurer, within 5 calendar days.
- **Article 681** identifies the persons who can submit claims to the Commission, namely,
  - the person who is victim of the malpractice act or, if applicable, his/her legal representative,
  - the successors of the person deceased as a result of malpractice during prevention, diagnosis and treatment.
- **Article 684:**
  - establishes the right of any involved party, including the insurer of the involved medical personnel, to appeal the Commission's decision;
  - the appeal period is 15 days from the communication of the decision to the party and the appeal must be submitted to the county court which has territorial jurisdiction over the place where the alleged malpractice act has taken place **(Article 687)**;
  - establishes that the procedure for determining malpractice within the Commission does not

preclude the free access to justice under the common civil law; one can address the court without addressing the Commission first.

- **Article 688** establishes the period during which a common civil law malpractice claim may be filed, namely within 3 years from when the damage occurred, except for when the facts represent crimes (in which case specific criminal law time limitations apply).

B. Disciplinary liability

- **Article 450** provides the general provision that the medical professional is subjected to disciplinary liability for violating the following types of rules:
  - laws and regulations of the medical profession
  - the Code of Medical Deontology and the rules on good professional practice
  - the Statute of the Romanian College of Physicians
  - the decisions adopted by the Romanian College of Physicians as well as for any acts related to the profession which can damage the honor and prestige of the profession or Romanian College of Physicians.
- **Article 451**
  - establishes the right of any person who justifies an interest to file a complaint against a physician;
  - provides that a complaint against a physician shall be submitted to the college where the professional is a member;
  - if the physician in question is a citizen of another member state of the European Union, of a state belonging to the European Economic Area or the Swiss Confederation, the complaint shall be submitted to the college in whose area of medical practice the physician carries out his/her activity;
  - the person who submitted the complaint is entitled to appeal a decision to dismiss his/her complaint.
- **Article 456:**
- the decision by the particular college of which the physician is a member shall be communicated to the sanctioned physician, the Office for enforcement of decisions within the Romanian College of Physicians, and to the person who has filed the complaint;
- the person who has filed the complaint, the sanctioned physician, the Ministry of Public Health, the president of the territorial college or the president of the Romanian College of Physicians may appeal the decision to the Superior Discipline Commission of the Romanian College of Physicians, within 15 days from the communication of the decision.

C. Other relevant provisions included in the Law no. 95/2006 on the Health Reform, republished in 2015

- **Article 913** establishes the following regarding the repayment of expenses incurred by the patient/insured in cross-border medical assistance:
  - the right of persons insured in the public health system to appeal the refusal of the District Health Insurance House to which they belong to approve the requests for repayment of the cross-border medical assistance;
  - the appeal shall be submitted to the District Health Insurance House where the insured is registered within 15 days from the acknowledgement of the refusal and the Fund must answer within 15 days from the appeal registration.
  - subsequent to the communication of the response to the appeal or at the expiry of the term of 15 days mentioned above, the insured may appeal to the administrative court according to the provisions of Law no. 554/2004 on the Administrative Litigation.

(Authors' note: The Fund's answer to the patient/insured's appeal may then be appealed to the

appropriate administrative courts under a different law, the Law no. 554/2004, as further amended and supplemented. Identically, the patient shall submit an appeal directly to that court upon the expiry of the 15-day period from the registration of the patient's appeal at the fund to which he/she belongs.)

Romanian Civil Code

The Civil Code includes general provisions on:

- the people's right to life, health and integrity (Book I, Title II, Chapter II, Section II),
- the defence of non-property rights (Book I, Title V),
- civil liability (Book V, Chapter IV).
- **Book I, Title II, Chapter II, Section II** includes provisions on:
- the legal safeguard and protection of the life, health and physical and mental integrity of persons **(Article 61, para. 1)**;
- the prevalence of the human well-being and interests over the sole interest of society or science **(Article 61, para. 2)**;
- prohibition of interventions on the genetic characters aiming to change the person's lineage, except those regarding the prevention and treatment of genetic diseases as well as the prohibition of interventions aiming to create a human being genetically identical to another living or dead human being and the creation of human embryos for research **(Article 63, para. 1** and **para. 2)**;
- inviolability of the human body **(Article 64, para. 1)**;
- prohibition of experiments, tests, removals, treatments or other interventions for therapeutic purposes or scientific research on persons, except for the cases and conditions expressly established and exhaustively provided by the law **(Article 67)**;
- removals and transplant from live persons shall exclusively be made in the cases and conditions provided by law, with the persons' free, previous and express, written agreement and only after they have previously been informed of the intervention risks **(Article 68)**;
- defence of the person's rights to life, health and integrity by filing a request to the court, in order to take all required measures to prevent or cease any illegal damage on the human bodily integrity and to determine the reparation of material and moral damage (Article 69).

Book I, Title V includes the provisions on the defence of non-property rights:

- in order to defend non-property rights which have been breached or threatened, the individual may request the court at any time **(Article 253, para. 1):**
  - to prohibit the illegal act, if it is imminent ;
  - to terminate the breach and prohibit it in the future, if it continues;
  - to determine the illegal nature of the offence if the disturbance which it has caused subsists.
- the person who has suffered a violation of his/her non-property rights has the right to ask the court to oblige the offender to fulfil any measures deemed necessary by the court to restore his/her violated right, such as for instance those listed in **Article 253, para. 3**:
  - to order the offender, at his/her expense, to publish the court order containing the conviction *(Authors' note: in each case, the court establishes the means of publication; it can be in a widely-circulated newspaper or in a public space, for example);*
  - To order any other measures necessary for the termination of the illegal act or the reparation of damage.
- provides the right of the injured person to compensation for the damage, even non-property damage, which has resulted from the violation of non-property rights; each judicial action for damages is subjected to time limitations **(Article 253, para. 4).**
- the person claiming the violation of his/her non-property rights may also request the court, even before filing the action in the first instance, to order precautionary measures **(Article 255, para. 2, letters a** and **b)** especially consisting in:
- the prohibition of the respective violation or the provisional termination of the respective violation;
- taking the measures necessary to preserve evidence.
- acknowledges the right of the surviving spouse or any relative of the deceased and any of his/her

relatives up to the 4th degree to start an action for the restoration of the non-property right belonging to the deceased **(Article 256, para. 1)**.

Book V, Chapter IV includes the following provisions on civil liability:

- every person is obliged to comply with the rules of conduct which the law or local custom requires and not to damage, through actions or inactions, the rights or legitimate interests of other persons; otherwise, the offender shall be liable to repair the damage caused **(Article 1349, para. 1)**;
- in cases provided by the law, a person is liable to repair the damage incurred by the action of third parties and/or the goods under his/her guard **(Article 1349, para. 3)**;
- any person must comply with contractual obligations, and in case of breach of such obligations the person can be held liable and pay damages to the other party **(Article 1350);**
- a person whose health has been injured has the right to receive compensation from the guilty or responsible person for the limitation of the enjoyment of family and social life **(Article 1391, para. 1)**;
- in case of death of the victim due to the damage caused, the court may grant compensation to the ascendants, descendants, brothers, sisters and spouses for the pain caused by the victim's death, and any other person who, in his/her turn, might prove the existence of such damage **(Article 1391, para. 2)**;
- the court can order the person who has caused the harm to pay the expenses for the victim's health and/or funeral expenses, if he/she has died as a result of the harmful event **(Article 1392)**;
- the method for determining the extent of redress is equally regulated, meaning that the damage shall be fully compensated and should cover the actual loss, the income which, in ordinary circumstances, the injured person could have earned and has been deprived of, and the expenses which the injured person has incurred to avoid or limit the damage **(Article 1385, paras. 1** and **3)**;
- compensation may also be granted for a future damage if its occurrence is certain and if the unlawful act has determined the loss of chance to obtain an advantage or to avoid damage; in the latter case, the redress shall be proportional to the possibility of obtaining the advantage or, as applicable, avoiding the damage, considering the circumstances and concrete situation of the victim **(Article 1385, paras. 2** and **4)**.

Romanian Criminal Code

The medical personnel shall be criminally liable if the act causing the damage is an offence under the criminal law. The patient has the possibility to request the reparation of the damage within through a civil action brought during the criminal trial[798]. Although most of the provisions of the Criminal Code are general and applicable to any person, there are some crimes which have a particular relevance in the medical field. These are:

- Killing upon request by the victim **(Article 190)**
- Determining or facilitating suicide **(Article 191)**
- Manslaughter **(Article 192)**
- Battery and other acts of violence **(Article 193)**
- Bodily Harm **(Article 194)**
- Battery and bodily harm causing death **(Article 195)**
- Bodily harm with basic intent **(Article 196)**. Here, the criminal proceeding is initiated following the preliminary complaint of the injured person **(para. 6)**
- Illegal termination of pregnancy **(Article 201)**
- Harming the fetus **(Article 202)**
- Abandoning an individual in distress **(Article 203)**

798 Art. 19 and the following of the Code of Criminal Procedure.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **The methodological norm for the application of Title XV „Civil liability of the medical personnel and medical, sanitary and pharmaceutical product and service provider" of Law no. 95/2006 on health reform of the 14th of March, 2007**[799]

  The norm establishes in **Article 14** two alternatives of the persons injured by malpractice, namely the rights to address either: (1) the Commission for monitoring and professional competence in case of malpractice, (2) or the competent courts, under the law. *(Authors' note: the injured person/patient can address both the Commission and the court at the same time.)*

D) PROVIDER CODE(S) OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**

  The Code regulates the principles according to which the judgment of ethical causes is carried out **(Chapter VIII)**. Some provisions refer to the celerity of the case settlement **(Article 54)**, the presumption of innocence **(Article 55)**, the impartiality of the persons judging the case **(Article 56)**, the written contradiction **(Article 57)**, the expertise **(Article 58)** and the method of conducting hearings by the discipline Commission **(Article 59)**.

  The Code does not expressly regulate the patient's right to file complaints against the persons responsible for a medical act but provides certain general rules which must be considered by the competent professional forums for the settlement of complaints or notifications received directly from patients.

E) OTHER RELEVANT SOURCES

- **Statute of the Romanian College of Physicians**

  The Statute includes procedural provisions regarding the procedure on the physicians' disciplinary liability **(Chapter VI)**.

  The Statute does not expressly provide the right of the patient in notifying the competent professional bodies for the disciplinary liability of physicians, but **Article 101** acknowledges the right of the person who has sent a complaint alleging an act of malpractice by a physician to appeal the discipline Commission's decision within the competent college of physicians to the Superior Discipline Commission.

F) PRACTICAL EXAMPLES

1. Example of Compliance

The patient addressed the Discipline Commission of the College of Physicians X to initiate the procedure for the disciplinary liability of physician Y who provided medical care as a result of which the patient's health worsened and the patient was forced to be operated on in another member state of the European Union. The Commission took the case under observation, ordered the hearing of the persons in question, namely the attending physician and the auxiliary medical personnel, requested the opinion of an expert in the field and, within the legal period, provided a solution, sanctioning the physician in question by reference to his/her effective guilt and the applicable legal provisions.

799 Published in the Official Gazette, Part I no. 237 of the 5th of April, 2007.

2. Example of violation

Patient X filed a claim against physician Y under civil liability law. The court rejected the patient's action in the first court hearing invoking ex officio the exception of the failure to fulfil the previous administrative procedure before the malpractice

3. Actual Cases

At the time of the writing of this Guide, there have been no health cases subject to the violation of the patient right to complain – the right to notify either the competent bodies for establishing the disciplinary liability of medical personnel and medical service providers or to complain directly to the court.

However, there have been cases in which, by reference to the special legal provisions, the person's right to free access to justice has been violated.

- Thus, by the Civil Sentence no. 304/2008 of Craiova County Court, regarding the complaint against the prosecutor's solution, the court established that, although the Code of Criminal Procedure does not also include the hypothesis in which the defendant files a complaint against the solution ordered by the prosecutor, this right of the defendant is acknowledged by the provisions of the Article 21, para. 1 of the Romanian Constitution according to which any person can go to court to protect his/her legitimate rights, liberties and interests, and Article 6 of the European Convention of Human Rights. Therefore, the court admitted the defendant's complaint.

Also, the Constitutional Court has examined a case regarding the unconstitutionality of certain legal provisions providing the performance of administrative procedures prior to the court notification.

- Thus, by the Decision 266/2014, the Court admitted the unconstitutionality exception and established that the provisions of Article 2 paragraphs 1 and 1 index 2 of Law no. 192/2006[800] on the mediation and organisation of the mediator profession are unconstitutional[801].

G) PRACTICE NOTES FOR LAWYERS

- To seek reparation for the damage caused to the patient by a medical act, his/her lawyer must firstly consider the concrete situation and subsequently analyse the possible actions available to protect the interests of his/her client.
- There are three ways in which the lawyer may request on behalf of the patient the payment of damages, namely (i) amiably, by direct negotiation either with the person responsible for the harm to the patient, or his/her insurer, (ii) by the court through civil proceedings, or (iii) in the civil proceedings within the criminal trial, if the offence committed by the medical personnel is an offence under the criminal law.
- It is important to note that in order to claim the reparation for the damage caused to the patient, no further prior administrative procedure has to be performed before bringing an action to a common civil law court. Thus, filing a complaint with the malpractice Commission is not mandatory, but if the patient avails himself/herself of this avenue, then he/she must follow the procedure through.
- The notification of the discipline and/or malpractice Commissions under the law is a right of the patient and not an obligation as a prerequisite of the court notification.
- In case of dispute, the lawyer could be faced with the necessity of requesting a specialized medical expertise in order to establish the medical negligence – which is usually the case in practice. *(Authors'*

800 Art. 2. - (1) If the law does not provide otherwise, the parties, individual or legal entities, must take part in the briefing on the mediation advantages, including, if applicable, after the initiation of a trial before the competent courts in order to amiably settle the disputes in civil, family matters, and other matters under the law. […]. (12) The court shall dismiss the writ of summons as inadmissible in case of the plaintiff's failure to fulfil the obligation to take part in the briefing on mediation, prior to the introduction of the writ of summons or after the initiation of the trial until the court hearing established by the court to this end, for the disputes in the matters provided for in article 601 paragraph (1) letters a) -f).

801 At the time of the writing of this Guide, the Court decision has not been yet published in the Official Gazette of Romania and, therefore, the authors of this Guide cannot prepare the Court reasoning for inclusion here. Until its publication, the legal provisions found as unconstitutional are suspended.

note: The civil procedure code does not impose the use of specific proof. The use of medical expertise is not an obligation, but more a strategy in order to ensure that the judge is faced with specialty information and conclusions regarding the facts of the case. A trial can go on without the ordering of expertise, if the parties do not agree, but the judge might not be able to ascertain the medical truth if there is no expert witness.)

H) CROSS-REFERENCING INTERNATIONAL AND REGIONAL RIGHTS

Please find the relevant information to the Right to Complain in Chapter 2 and Chapter 3.

6.1.14 Right to Compensation

A) RIGHT AS STATED IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS

Each individual has the right to receive sufficient compensation within a reasonably short time whenever he or she has suffered physical or moral and psychological harm caused by a health service treatment.

The health services must guarantee compensation, whatever the gravity of the harm and its cause (from an excessive wait to a case of malpractice), even when the ultimate responsibility cannot be absolutely determined

B) RIGHT AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**
  - **Article 52** guarantees the right to remedy when the person has been affected by an act of a public authority.[802] However, this provision is limited to "public authorities".
  - **Article 21** guarantees the right to access to justice, for defending the person's rights, liberties and legitimate interests.

Legislation

- **Civil Code**

  Articles 1349-1395 of the Civil Code stipulate the conditions for tort liability. The compensation may be awarded for material damages and non-pecuniary damages. In particular:

  - **Article 1387** describes the compensations awarded for the damage of corporal integrity and health; these damages consist of the loss of income resulting from loss of the work capacity of the person, the expenses incurred for medical healthcare, and the expenses incurred for the need to create improved living conditions for the person, as well as any other material damage.
  - For non-pecuniary damages, **Article 1391** stipulates that when there was damage of the corporal integrity or health of the person, the court may also award compensation for the restraint of possibilities of living a family life and a social life. It also stipulates the possibility to award

802 Romanian Constitution, Article 34 Right to protection of health: *(1) The right to the protection of health is guaranteed. (2) The State shall be bound to take measures to ensure public hygiene and health. (3) The organization of the medical care and social security system in case of sickness, accidents, maternity and recovery, the control over the exercise of medical professions and paramedical activities, as well as other measures to protect physical and mental health of a person shall be established according to the law.*

compensation to the family of the deceased for the suffering incurred because of his/her death.

Criminal Procedure Code

In the Romanian legal framework, criminal liability is not incompatible with civil liability. In a criminal trial, the victim has the right to become a "civil party" to the proceedings and the criminal authorities have the duty to inform the victim about this right.

- **Article 19, Purpose and use of a civil action**[803]:
  - *(1) A civil action initiated in criminal proceedings seeks to establish the civil liability in tort of the persons liable under the civil law for damages caused by having committed an act that is the subject matter of criminal action*
  - *(2) A civil action is used by a victim or by their successors, who become a civil party against the defendant and, as applicable, against the party with civil liability.*
  - *(3) When a victim lacks mental competence or has a limited mental competence, a civil action shall be initiated on their behalf by their legal representative or, as applicable, by the prosecutor, under the terms of Article 20, paras. 1 and 2, and pursues, depending on the interests of the person whose behalf this is initiated, to hold the responsible persons person with civil liability in tort.*
  - *(4) A civil action is settled within the criminal proceedings, if this does not lead to exceeding the reasonable duration of the trial.*
  - *(5) Material and moral damages shall be remedied according to the stipulations of civil law.*

Other relevant Criminal Code Provision on Civil Liability can be found in **Articles 20-28.**

Law no. 95/2006 on the Health Reform, republished in 2015

- **Articles 667 to 678** regulate the mandatory civil liability insurance for medical practitioners and the main rules for compensating victims of malpractice. In essence, medical professionals are obliged to sign a malpractice insurance for cases of civil liability for damages inflicted through the medical act.
- **Article 669, para. 1:** *Damages are awarded for sums which the insured professional is obliged to pay as damages and judicial expenditures for the person or persons affected by the performance of an inadequate medical assistance which can even result in the bodily harm. (…)*
- **Articles 679 to 685** establish rules regarding the legal procedures for establishing the civil liability of health professionals.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

Norms of 14 March 2007 on the application of Title XV "Civil liability of medical staff and providers of medical, sanitary and pharmaceutical products and services" of Law no. 95/2006 on the health reform

D) PROVIDER CODE(S) OF ETHICS

There are no provisions on this topic in the provider code of ethics.

E) OTHER RELEVANT SOURCES

There are no other relevant sources on this topic.

803 Translation provided by the Government of Netherlands and the Romanian Ministry of Justice, available here: http://www.just.ro/LinkClick.aspx?fileticket=uoJx07a1STU%3D&tabid=89

F) PRACTICAL EXAMPLES

1. Example of Compliance

Patient X decided to undergo a gastric bypass surgery for weight loss prescribed by her doctor, Z. Subsequently the patient experienced significant post-operative complications that were not timely and correctly diagnosed or treated. The patient considered that she has suffered significant damage on her health and for this reason was unable to go to work for a period of 6 months. The patient, through her lawyer, informed the doctor that she would bring civil claims for the material damages inflicted through the medical operation. She would ask the Court for 300,000 RON (approx. 68,000 Euro) in pecuniary damages. Thus, the patient filed a suit with the Z County Court (the competent court of first instance) and provided evidence regarding the damages (forensic medical expertise reports, documents issued by her employer regarding her absence from work and witnesses who attest the hardships that she is suffering in everyday life after her medical intervention). At the trial, the doctor admitted the errors that he had done in the medical intervention and acceded to the claims of the patient (according to the rules of the Civil Procedure Code on acceding, Article 463). Thus, a final decision was rendered by the Z County Court and the victim was paid 200,000 RON after the court evaluated the actual damage suffered by the patient. According to Article 662 of Law no. 95/2006 on the health reform, damages can only be paid following a final court decision. The patient, after receiving the final court decision, was paid damages by the private insurer of the doctor.

2. Example of Violation

Mrs. B is a pregnant woman who contacted Dr. H, an OBGYN, to assist her during child birth. Mrs. B decided that that she'll have a natural childbirth. When hearing her option, the doctor did not take into consideration essential aspects regarding the woman's physical state, such as the small dimension of her pelvis, the large dimension of the fetus and other important indicators of a high risk pregnancy. During the delivery, the fetus was seriously injured. The other maneuvers performed during the delivery resulted in multiple cervix ruptures for the woman. Consequently, the patient filed criminal charges against the doctor, for bodily harm (Article 194 of the Criminal code) and harming the fetus (Article 202 of the Criminal Code) and also wishing to become a civil party to the trial and claim 500,000 RON in damages. The patient filed criminal charges; however, the criminal investigators were slow in registering the complaint and ordering the investigation to take place. For long periods of time there were no criminal investigation acts performed, and there were no initiatives to establish the facts and the responsibility of the doctor. When asked about the new developments of the case, the authorities would reply in a stereotypical manner that "they are taking all necessary steps". This situation led to the criminal responsibility of the doctor to become time-barred and Mrs. B received from the prosecutor of the case a solution to not prosecute based on this reason. Consequently, Mrs. B has also lost the right to claim civil damages and receive a compensation for the infringement of her rights.

3. Actual Case

Mrs. O.S. was 37 weeks pregnant and was admitted to the Hospital C, under the supervision of Dr. L. M. with a series of concerning symptoms (light bleeding, high blood pressure). The doctor performed an ultrasound on Mrs. O.S. and decided that the best option would be a cesarean section which was scheduled for the next day. The last monitoring of the state of health of the patient took place that night around 11 p.m. Mrs. O.S. was not supervised at all during the night, although there was a chief doctor on call, Dr. P.C. The next morning, at 6 a.m., the nurse who was monitoring the patient observed the lack of fetal heartbeat and called the doctor on call, Mr. M.C. He performed an ultrasound and, according to the claims of Mrs. O.S. refused to provide information to Mrs. O.S. At. 7:45 a.m. the doctor of Mrs. O.S, Dr. L.M. came to the hospital and, observing the lack of fetal heartbeats induced labour, but the fetus had already died. Mrs. O.S. complained to the College of Physicians who found that the doctors involved in treating the patient had violated professional standards and decided to issue disciplinary sanctions against Dr. L.M. (prohibition of performing the medical profession during 6

months and to undergo mandatory obstetrics training in the next 6 months) and Dr. P.C. (admonition). The applicant also filed for damages in civil procedure with the Sector 1 Bucharest County Court, arguing that the doctors provoked the damages by not respecting professional standards in the cases of pregnant patients with her symptoms. The patient stated that her life was endangered and that she suffered both physical and mental pain. From the report of the College of Physicians attached to the civil file, the court observed that following the medical investigation performed on Mrs. O.S. on her admission, the cesarean section should have been performed immediately and not the following day. Moreover, the chief doctor on call has the obligation to directly examine all new admitted patients – which the court held Dr. P.C. did not do, but was satisfied with being presented the case orally by Dr. L.M. The court also found that Dr. P.C. breached professional standards when supervise the subordinated medical staff who did not monitor the patient's health status during the night. The Court also found Dr. M.C liable for not providing the patient with any information after finding out that the fetus did not have a heart beat and for not providing the patient with mental support, rather waiting for the return of Dr. L.M. at 7:45 a.m. Being confronted with a serious case, Dr. P.C. and M.C. who were on call should have taken emergency measures to induce labor and inform the patient. As regards to the damage, the Court held that the moral damage produced by the death of the fetus is obvious. In addition, the Court underlined that the mental suffering was worsen through the doctors' misinformation of the patient following the procedures. Consequently, the Court accepted the patient's claims based on the Civil Code and ordered the medical staff and hospital to pay moral damages consisting in 200,000 RON, which the court considered to be a just satisfaction.[804] The decision has been challenged by the defendants and is currently being re-examined by the court of appeal after being sent for review by the court of recourse on 6 May 2015.

G) PRACTICE NOTES FOR LAWYERS

- In order to claim for compensation, lawyers must prove the existence of damage created by the inadequate medical action, and thus must adduce evidence before the Court with regards to this damage. In some cases, the damage is implied and the claimant is not obliged to provide additional proof– especially in moral damages. For example, in the case mentioned above under *Actual cases*, the first instance Court held that, in order for the evaluation of moral damages to not be purely subjective, the Court must notice the physical and moral suffering which the person can reasonably be considered to have felt though the death of the fetus.
- When claiming material damage, lawyers should make all efforts to adduce as much proof as possible before the court, such as medical documents, medical expert reports, documents showing lack of work capacity, forensic medical examinations, or even witness testimonies showing the damage inflicted on the patient. This proof must show not only that the damage is real and can be determined, but it also must show the length of the prejudice, and the claim for compensation must be proportional to the prejudice invoked. The Court has the final decision on evaluating the length of the damages, irrespective of the sum of money claimed by the claimants.
- When deciding on ordering additional medical expertise during judicial proceedings, lawyers must thoroughly inform their clients about the cost of such expertise and make decision regarding this procedure only after receiving a firm confirmation from their clients. Such precaution is necessary in civil suits where the losing party must pay judicial expenses.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

Please find a discussion on international and regional standards relevant to the Right to Compensation in Chapter 2 and Chapter 3.

804 Sector 1 Bhcuarest County Court, Civil sentence no. 11541 of 26 June 20013, published in Roxana Maria Călin, *Malpraxis: Răspunderea medicului şi a furnizorilor de servicii medicale [Malpractice: Physician and health services providers liability]*, 2014.

6.1.15 Additional Patients' Rights in Romania

RIGHT TO DIGNITY

A) THE RIGHT TO DIGNITY IS NOT DEALT WITH SEPARATELY IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR).

This right becomes particularly important in the Romanian context, however, due to specific provisions such as the inviolability of human dignity (spelled out in Article 1 of the EU Charter of Fundamental Rights) as well as relevant provisions in the Romanian legislation.

B) RIGHT AS STATED IN COUNTRY CONSTITUTION/LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003**

  The Constitution, in **Article 1, para. 3** recognizes human dignity as one of the foundational constitutional values: *Romania is a democratic and social state, governed by the rule of law, in which human dignity, the citizens' rights and freedoms, the free development of human personality, justice and political pluralism represent supreme values, in the spirit of the democratic traditions of the Romanian people and the ideals of the Revolution of December 1989, and shall be guaranteed.*

Legislation

- **New Civil Code of Romania, 2009, Article 58 and Article 72 provide for personality rights and the right to dignity**
  - **Article 58:** *(1) Any person has the right to the protection of the intrinsic values of the human being, such as life, health, physical and psychic integrity, dignity, privacy, freedom of conscience, scientific, artistic, literary or technical creation. (2) These rights are not transmisibile.*
  - **Article 72, para. 1**: *Any person has the right to respect for his or her dignity.*
- **Law no. 95/2006 on the Health Reform, republished in 2015**
  - **Article 380** on the main principles applicable in making medical decisions which include non-discrimination among patients and respect for human dignity: *Medical decisions and rulings will be taken having regard to the interests and patient rights, medical principles generally accepted, non-discrimination between patients, respect for human dignity, the principles of ethics and medical ethics, care for health of the patient and public health.*
- **Government Ordinance no. 137/2000 on the prevention and sanction of all forms of discrimination, republished**
  - **Article 15** protects the right to personal dignity. It prohibits infringement of dignity based upon *race, nationality, ethnic group, religion, social category or belonging to a disadvantaged category, on account of beliefs, gender or sexual orientation, and considers such infringement to be an offence under this law – unless the action committed falls within the realm of criminal law.*[805]

805 Article 15 - *Under the ordinance herein, any public behaviour with a nationalistic-chauvinist character, any incitement to racial or*

- **Law no. 46/2003 on the Rights of Patients**
  - **Article 3** states that *the patient has the right to be respected as a human person without any discrimination* without actually providing for an adequate mechanism for sanctioning the breach of this right.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

There were no identified relevant bylaws to the right to dignity.

D) PROVIDER CODES OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**
  - **Articles 3 and 7** state the respect for the dignity of a human being and the specificity of the relationship of doctor-patient[806]
- **Decision no. 2 of 9 July 2009 of the Order of Nurses and Midwives from Romania on the adoption of the Code of Ethics and Deontology of the Nurses and Midwives in Romania**
  - **Articles 13, 48 and 50** discuss the obligation to observe the dignity of patients in different conditions (sick persons; persons with mental illness; and persons deprived of liberty)[807]

E) OTHER RELEVANT SOURCES

There are no other relevant sources for this right.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

Exemple 1: A., a young woman living with HIV went for the first time to a dentist's office seeking medical help. She disclosed her positive status to the dentist. When hearing her statement, the nurse supporting the doctor made a negative remark. The doctor reprimanded the nurse, explaining that all patients are entitled to care and that they should be actually thankful to A. for sharing her medical status, and focused the discussion on the dental problems of A. When treating her, the doctor used universal precautions and treated the patient politely and carefully.

Exemple 2: C. is a 42-year-old lesbian woman who never had sexual relations with men. She went to the obstetrics-gynecology practitioner after experiencing pain for a while. After the first five minutes

national hatred, or any behaviour having as objective or aiming to infringe a person's dignity or to create a hostile, degrading, humiliating or offending atmosphere, perpetrated against a person, a group of persons or a community, on account of race, nationality, ethnic group, religion, social category or appurtenance to a disadvantaged category, on account of beliefs, sex or sexual orientation shall constitute an offence, unless the deed falls under the incidence of criminal law.

806 Art. 3- In all cases the professional act, in any form or way it might be concluded, will be carried out with strict observance of human dignity as a fundamental value of the professional personnel.
Art. 7- The relation of the doctor with the patient will be one that is completely professional and will be based on the respect of the former for human dignity, understanding and compassion for suffering.

807 Art.13 – The medical nurse/midwife has the duty of impeccable physical, mental and emotional conduct in relation with the sick person, always observing his or her dignity.
Art. 48 – Any person affected by mental illness must be treated humanely and with respect for human dignity and must be protected against any form of economic, social or any other type of exploitation, against damaging or degrading treatments. No discrimination based on a psychical illness is allowed.
Art. 50- The medical nurse/midwife who takes care of a person deprived of liberty is prohibited to infringe upon the physical, psychical integrity or the dignity of that person.

of discussion with the doctor, focused on questions about her sexual life, questions she was hesitant in responding to truthfully, she explained her situation. The doctor answered that he wished that she had trusted him from the very beginning as her sexual orientation was a relevant factor to be taken into consideration in the medical investigations leading to a diagnosis. He also mentioned that he was under an obligation to maintain confidentiality and that he hopes they will manage to build trust as in any other patient-doctor relation.

2. Example of Violation

D. was a pregnant Roma woman from a traditional community. During a storm the electrical cables in the community broke and collapsed on the ground. Unfortunately, D. was in the proximity of the place where the cable broke and was electro-shocked. Her family took her to the nearest hospital where her access was denied, the doctors claiming that they do not have the competency to deal with cases so severe. She was further taken to another hospital where eventually she was admitted in the emergency unit. As her condition worsened, the doctors and nurses in the hospital started shouting at the family members who brought her, calling them "irresponsible, filthy Gypsy" and "criminals." The family members tried to explain that they were rejected by the first hospital, hence the delay, but the doctors decided to call the police instead to ask for the family to be removed from the premises of the hospital. The police threatened the family with an administrative fine for misdemeanours and made them leave the premises of the hospital.

3. Actual Case

In a 2009 case, a Roma NGO filed a complaint with the National Council on Combatting Discrimination (NCCD) showing that Ms. B, a young Roma woman who was 2 months pregnant went to the Ob Gyn Târgu Neamț hospital to seek a medical evaluation. Doctor X assessed her condition, said that in spite of her pain she was OK and sent her home warning her that''this is how you Gypsies are." Two days later she went again in pain to the hospital and Doctor X was again on call. The doctor refused to see her while he took in other patients who were not Roma. In the evening she returned to the hospital and the doctor refused to consult her but sent a nurse to give her a shot. When she sought medical consultation from a private doctor, she found out that she had an extra-uterine pregnancy which stopped in its evolution. As she returned to the public hospital, the same doctor finally gave her a prescription but also told her "Leave or I will take the stick" and warned the nurses "Do not accept Gypsies anymore. Beat them with the broom when you see them on the stairs." The NCCD issued a warning against the doctor carrying no financial penalty and merely advising the doctor to refrain from such practices. No other remedies were available.

G) PRACTICE NOTES FOR LAWYERS

- While not specifically defined by the Romanian legislation, the infringement of the right to dignity is oftentimes based on the recognition of the uniqueness of human nature (RCC, Decision nr. 1.109 of 8 Sept 2009) or as "an inalienable quality of the human person", being recognized by the Romanian Constitutional Court as "an intrinsic value of the human being", "a fundamental value of the rule of law" (RCC, Decision nr. 1.576, of 7 Dec 2011). The Constitutional Court maintained that the right to dignity entails both a positive obligation of the state (including, among others, enhanced protection for vulnerable persons – RCC, Decision nr. 1594 of 14 Dec 2011) as well as negative obligations linked to the respect and protection of privacy or of the right of the person to decide regarding his or her own life.
- The action for infringement of the right to dignity can be filed as a civil claim, seeking pecuniary and moral damages either by the patient or by the interested persons. Other remedies which can be sought by the person whose dignity was infringed might be: a) public apologies, b) the right to reply, c) publishing a refutation of degrading or misleading information.
- In cases when the infringement of the right to dignity also includes discriminatory treatment, besides

filing a civil complaint for damages, the plaintiff may also file a complaint before the national equality body, the National Council for Combating Discrimination on grounds of the Romanian Anti-discrimination Law. In such a case, the finding of the infringement of the right to dignity will lead to an administrative sanction – warning or fine.[808]

- Both in front of the civil courts and before the NCCD, the plaintiff may seek for the personal identification data to be kept confidential and for the hearings to be conducted in camera, in order to limit the negative damages of the infringement of the right to dignity and to further protect the honor or reputation of the person.
- The claims can be filed against both individuals and legal persons (for example doctors and hospitals, journalists and the newspapers holdings) given that there is a link between the entities (authorship and employment relation or venue supporting dissemination).

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See discussion concerning human right to life and respect for human dignity during health care provision in the context of: right to life, illustrated in Chapter 2 and Chapter 3 above. Also relevant, is the Article 1 of the EU Charter of Fundamental Rights.

RIGHT TO NON-DISCRIMINATION

A) THE RIGHT TO NON-DISCRIMINATION IS NOT DEALT WITH SEPARATELY IN THE EUROPEAN CHARTER OF PATIENTS' RIGHTS (ECPR), BEING MENTIONED SOLELY IN THE PREAMBLE AND IN THE CONTEXT OF THE RIGHT TO ACCESS.

It is particularly important in the Romanian framework due to specific provisions such as the equality and non-discrimination principle spelled out in Article 21 of the EU Charter of Fundamental Rights as well as relevant provisions in the Romanian legislation. Notably, discrimination (including discrimination in access to health services) can be sanctioned as a minor offense unless it amounts to a criminal deed and it is sanctioned as abuse in service with the infringement of the rights of a person. Non-discrimination is important as a right with its own standing as well as a transversal concern to be assessed in the enjoyment of any other right from the moment of access to the medical services, including treatment while in the hospital. The right to non-discrimination in access to health services is specifically mentioned by Directive 43/2000/EC, the Race Equality Directive which is transposed in the Romanian legislation by the Governmental Ordinance 137/2000.

B) RIGHT AS STATED IN COUNTRY CONSTITUTION/LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003**
  - **Article 4, para. 2** provides for the principle of equality: *Romania is the common and indivisible homeland of all its citizens, without any discrimination on account of race, nationality, ethnic origin, language, religion, sex, opinion, political adherence, property or social origin.*

808 See section 8 on procedures and remedies.

Legislation

- **Law no. 95/2006 on the Health Reform, republished in 2015**
  - **Articles 380** and **663** on the main principles applicable in making medical decisions include non-discrimination among patients. **Article 663, para. 2** specifically applies to medical doctors, dentists, nurses, and midwives and prohibits them from refusing to provide medical assistance / health care on ethnic, religious, sexual orientation or other discriminatory criteria prohibited by law.[809]

- **Government Ordinance no. 137/2000 on the prevention and sanction of all forms of discrimination, republished**
  - **Article 2** lists the protected grounds against discrimination, while **Article 10, pt. b** provides for the prohibition of discrimination in access to health services (for example, choice of a family doctor, medical assistance, health insurance, first aid and rescue services or other health services).
  - **Article 2, para. 1** includes any difference, exclusion, restriction or preference as "discrimination" if based upon race, ethnicity, language, religion, social status, beliefs, sex or sexual orientation, or disfavoured category and aims or results in restriction or prevention of equal recognition, use or exercise of human rights and fundamental freedoms in the "public" arena. Behaviour may be active or passive and triggers contraventional liability unless it is a criminal act, according to **Article 2, para. 2**. (See Practice Notes for Lawyers below.) *(Authors' note: In order to find that discrimination occurred, the courts or the national equality body will analyze the existence of a differential, unfavourable treatment regarding the exercise of the right to health, treatment which is linked to a protected criterion: race, nationality, ethnic belonging, language, religion, social status, beliefs, sex or sexual orientation, belonging to a disfavoured category or any other criterion, aiming to or resulting in a restriction or prevention of the equal recognition, use or exercise of human rights and fundamental freedoms in the political, economic, social and cultural field or in any other fields of public life.)*

- **Law no. 46/2003 on the Rights of Patients**
  - **Article 1** defines discrimination for the purposes of the law and lists the grounds for non-discrimination **as a distinction made between persons in similar situations on grounds of race, sex, age, age, ethnic belonging, national or social origin, religion, political options or personal ill feelings**[810].
  - **Article 3** mentions that the patient has the right to be respected as a human person without any discrimination but without further providing any enforcement mechanism to provide an adequate sanction for breach of these provisions.

- **Criminal Code**
  - In **Article 297**, the Code sanctions the abuse in the exercise of authority, the action of the civil servant who during the exercise of work-related tasks, limits the exercise of a right of a person or creates a situation of inferiority on grounds of race, nationality, ethnicity, language, religion, gender, sexual orientation, political membership, wealth, age, disability, non-contagious chronic disease or HIV/AID which is punishable with prison sentences from two to seven years and the prohibition to take a public position.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

There are no identified other relevant regulations for the right to nondiscrimination.

809 For Article 380, see above.

810 Art. 1 Law 46/2003 defines as discrimination the distinction made between persons in similar situations on grounds of race, sex, age, ethnic belonging, national or social origin, religion, political options or personal ill-feelings.

D) PROVIDER CODES OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**
  - **Article 2** establishes the non-discrimination principle in the medical act, including discrimination based upon the state of a patient's health or a patient's prognosis for healing.[811]
- **Decision no. 2 of 9 July 2009 of the Order of Nurses and Midwives from Romania on the adoption of the Code of Ethics and Deontology of the Nurses and Midwives in Romania**
  - **Article 3, pt. e, Articles 21, 42 and 46** discuss the obligation to non-discrimination, including of patients in general and patients in different conditions such as those who have a mental illness.[812]

E) OTHER RELEVANT SOURCES

There are no other relevant sources.

F) PRACTICAL EXAMPLES

1. Examples of Compliance

See both cases of compliance mentioned in relation to the section on right to dignity supra.

A medical unit adopted non-discrimination clauses in its internal regulations both in relation to its own personnel and in relation with patients. This internal regulation contains both the interdiction for medical staff not to discriminate, as well as concrete sanctions for the medical staff who engage in discriminatory behavior and a complaint mechanism for patients who consider themselves to be victims of discrimination.

2. Examples of Violation

Example 1: Denial of access to premises or to medical services, ill-treatment on any of the protected grounds, harassment of the patients or of their families on grounds of race, nationality, ethnic belonging, language, religion, social status, beliefs, sex or sexual orientation, belonging to a disfavoured category or any other criterion perpetrated by the medical personnel or the auxiliary stuff would be sanctioned as discrimination unless due to the severity of the deed it qualifies as a criminal offence and it is sanctioned accordingly.

Example 2: Placing the poster "HIV/AIDS" on the door of the room where HIV infected children are kept in a general hospital or writing with big visible letters on the medical chart of a patient his HIV positive status was considered by the national equality body as a violation of the right to non-discrimination and sanctioned with an administrative warning carrying no financial penalty.[813] *(Authors' note: as an example of a case filed before the national equality body, in which there was no process,*

811 Art. 2 – *The professional act and the entire activity of a medical doctor will be exercised and carried out without any discrimination, including discrimination on grounds of state of health or the chances of the patient to healing.*

812 Art. 3: *The fundamental principles that basis the professions of nursing and midwifery in Romania are the following:… e) services are provided at the highest possible quality standards based on a high competency level practical skills and professional performance, without any form of discrimination;*
Art. 21: *The medical nurse/midwife, while carrying out her work, can make no discrimination on grounds of race, sex, age, ethnic belonging, national or social origin, religion, political option or personal ill-feelings towards the patients.*
Art. 42: *Any person affected by mental illness must be treated humanely and with respect for human dignity and must be protected against any form of economic, social or any other type of exploitation, against damaging or degrading treatments. No discrimination based on a psychical illness is allowed.*
Art. 46, para. 1: *Patients living with HIV or having AIDS have the right to non-discriminatory health care and treatment, the nurse and the midwife having the obligation to ensure the prescribed health care and treatment for these patients.*

813 NCCD, K.E. v. Arad Hospital (Decision from 06.04.2004)

ruling, etc. – just the investigation and the warning.)

Example 3: Prosecutors started criminal investigations in 2014 against a doctor accused of denial of medical supplies (for example blood needed for transfusions) based on the Roma ethnicity of the patients or their social origin (poverty). At the time of writing the Guide no information regarding the outcome of the investigations was available.

3. Actual Cases

Example 1: In two cases initiated by the NGO ACCEPT in 2005 and 2007 against the Ministry of Health for the National Institute of Haematology the National Council for Combating Discrimination (NCCD) decided on the legitimate interest in public health and blood safety from the perspective of the measures proposed by the Ministry of Health of permanent exclusion of gay men from donating blood. This total and automatic exclusion was considered both inadequate and unnecessary.[814]

The same line of argument was adopted in July 2014 by Advocate General Mengozzi in the CJEU *Leger* (Case C-528/13),[815] in which the applicant had been prevented from donating his blood through France's prohibition on donations from men who have sex with men (MSM).

Example 2: In 2009, Romani CRISS (who promotes the rights of Roma persons) filed a petition with the NCCD on behalf of a young patient and his mother who had been segregated after admission in the Timisoara Hospital and who had been treated discriminatorily during the treatment based on their Roma origin. The NCCD found that no discrimination occurred and dismissed the case.[816] Romani CRISS appealed the decision before the Court of Appeal which re-assessed the evidence in the case and decided to quash the NCCD decision and imposed an obligation on the NCCD to re-open the investigation in the case.[817]

G) PRACTICE NOTES FOR LAWYERS

- Discrimination claims can be filed either before civil courts under general torts procedures (seeking damages or reinstatement, status quo antes) or before the national equality body (NCCD) under the special procedure established by the Anti-discrimination Law seeking an administrative sanction against the perpetrator (fine or warning). The two venues are not mutually exclusive and they can be initiated simultaneously. Filing an action before the NCCD does not does not however suspend the prescription of the administrative or civil action.
- In order to find that discrimination occurred, the courts or the national equality body will analyze the existence of a differential, unfavourable treatment regarding the exercise of the right to health, treatment which is linked to a protected criterion: race, nationality, ethnic belonging, language,

814 NCCD, ACCEPT v. the Ministry of Health for the National Institute of Haematology, Decision 337, (21.11.2005) and NCCD, ACCEPT v. the Ministry of Health, Decision 260, (29.08.2007).

815 Conclusion of Advocate General M. PAOLO Mengozzi submitted on 17 July 2014 in C-528/13 Geoffrey Léger contre Ministre des Affaires sociales et de la Santé contre Établissement français du sang available at: http://curia.europa.eu/juris/document/document.jsf?text=&docid=155166&pageIndex=0&doclang=FR&mode=req&dir=&occ=first&part=1&cid=623869. The French Court asked in the referral whether France's blanket ban was compatible with Directive 2004/33, which permanently excludes donations from persons whose "sexual behaviour" puts them at high risk of contracting severe infectious diseases. In his opinion, the Advocate General suggests that "sexual behaviour", for the purposes of Directive 2004/33, must relate to some form of specific conduct or practice. The simple fact that a man engages in sexual intercourse with another man cannot, without further consideration of the circumstances of that intercourse, constitute sufficient behaviour which would justify permanent exclusion under the Directive. The Advocate General notes that Member States are free to adopt stricter controls on their blood donation services than those established in the Directive, but that such restrictions should not "threaten" fundamental rights and freedoms. In the specific context of France's prohibition, the Advocate General noted that the measure pursued the legitimate aim of reducing contamination risks and promoting a high level of protection of public health. However, he was less convinced that the nature of the prohibition – a lifetime blanket ban on all MSM – was either necessary or proportionate. The Advocate General also notes that, under the current regime (which mirrors practices in many other Member States), France is applying its prohibition in an arbitrary and disproportionate manner.

816 NCCD, Romani CRISS v. Spitalul Clinic de Urgență Timișoara, [Emergency Clinic Hospital Timișoara) Decision 873 from 15.10.2008.

817 Curtea de Apel București [Court of Appeal Bucharest], Sectia a VIIIa de Contencios Administrativ si Fiscal, Sentence no/ 3173 from 7.07.2010.

religion, social status, beliefs, sex or sexual orientation, belonging to a disfavoured category or any other criterion, aiming to or resulting in a restriction or prevention of the equal recognition, use or exercise of human rights and fundamental freedoms in the political, economic, social and cultural field or in any other fields of public life

- Other remedies which can be sought in discrimination cases might be public apologies, and publishing a refutation of degrading or misleading information in a local or national newspaper.
- Video and audio recordings as well as statistical data might be used in order to prove direct or indirect discrimination.
- In discrimination cases the burden of proof shifts from the plaintiff to the defendant. Thus, once the plaintiff provides the information to conclude that there is a prima facie case of discrimination, the court might presume that discrimination occurred and it is for the defendant to rebut this inference. The plaintiff has to provide facts in order to show the less favourable treatment affecting a right due to belonging to a protected ground. In turn, it is for the defendant to provide cogent proof that the facts do not amount to discrimination or that they meet legitimate reasons provided by the legislation.
- Both in front of the civil courts and before the NCCD, the plaintiff may seek for the personal identification data to be kept confidential and for the hearings to be conducted in the closed council room, in order to limit potential negative risks.
- The claims regarding discrimination can be filed against both individuals and legal persons (for example doctors and hospitals, journalists and the newspapers holdings) given that there is a link between the entities (authorship and employment relation or venue supporting dissemination).
- NGOs are granted legal standing by Art. 28 of the Romanian Anti-discrimination Law.[818]
- Cases under anti-discrimination legislation are tax exempted.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

See discussion on right to non-discrimination and equality, illustrated in Chapter 2 and Chapter 3 above. Also relevant, are Articles 20 and 21 of the EU Charter of Fundamental Rights.

818 Article 28 *(1) Human rights non-governmental organizations can appear in court as parties in cases involving discriminations pertaining to their field of activity and which prejudice a community or a group of persons. (2) The organizations provided in the above paragraph can also appear in court as parties in cases involving discrimination s that prejudice a person, if the latter delegates the organization to that effect.*

6.2 Patient Responsibilities

In Romania, patient responsibilities are not explicitly provided by law. The law on patient rights does not have a corresponding section referring to patient responsibilities. However, there are several regulations in regard to the obligations of the persons insured in the social health insurance system. In a few cases, the responsibilities of certain categories of patients are specifically stated in the law. In most of the cases, the patient responsibilities are implicitly assumed from provisions that regulate certain health care situations. Analysis of the existent legislation identified three categories of patient responsibilities: responsibilities towards one's own health status, responsibilities towards the protection of public health, and responsibilities towards the health system. In most of the cases the law refers to the „insured person", and not to the „patient", and this is in the conditions in which not all patients are insured, though according to the law, health insurance is compulsory for all Romanian citizens living in Romania.

6.2.1 Patient Responsibilities towards One's Own Health Status

A) PATIENT RESPONSIBILITIES TOWARDS OWN HEALTH STATUS AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution of 1991 revised in 2003** has no provision in reference to the responsibilities of patients or individuals/potential patients in order to contribute to the improvement, promotion or preservation of their own health status.

Legislation

- **Law no. 95/2006 on the Health Reform, republished in 2015**
  - **Title VIII - Social Health Insurance, Article 231** provides the obligations of the insured persons. Among these, several obligations make the patient accountable for his/her own health status, such as: enrolment with a family physician, notifying the physician every time changes in his/her the health status occur, attending all prophylactic medical check-ups, and compliance with the physicians' treatment and recommendations.
  - **Title XII - Practicing of the medical profession, Article 382** provides indirectly some patient responsibilities related to the treatment to be taken:
    - para. (1) sets the patient responsibility for the acceptance or non-acceptance of a medical intervention recommended by the physician – *Excepting the cases of force majeure, of emergency, or when the patient or his/her legal or appointed representatives has no possibility of expressing his/her will or consent, the physician actions must be in accordance with the patient's will and comply with the patient's right of rejecting or interrupting a medical intervention*
    - para. (2) provides the patient responsibility regarding the compliance with the medical prescription – *The physician's responsibility ceases in the situation in which the patient does not comply with the physician's prescription or recommendation.*
- **Law no. 46/2003 on the Right of Patients**

  Patient responsibility on the acceptance or non-acceptance of the medical interventions recommended by the physician is stated here. **Article 13** of this law provides that while the patient has the right to refuse or to discontinue a medical intervention, the patient has the obligation to provide such a refusal in writing. The consequences of not accepting the intervention should be clearly explained to the patient.

B) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Government Decision no. 355/2007 on the surveillance of workers health**
  - **Article 39** of the Decision provides the obligation of workers to attend the workplace health surveillance examinations, and **Article 16 para. 2** the obligation to submit, when getting hired in a new job, a copy of the medical file recorded by the occupational medicine office serving the previous working place.

C) PROVIDER CODE OF ETHICS

There are no relevant sources on this topic.

D) OTHER RELEVANT SOURCES

Healthcare providers, especially hospitals, have their own internal regulations or codes of conduct for their patients. These include, besides the obligations provided by the law, provisions related to the patients' responsibilities towards their own health status, such as: complying with the recommended diet, reporting to the medical personnel all about their health status and the treatments or recommendations prescribed by other physicians outside the hospital, interdiction to leave the hospital without medical permission during hospitalization and other such responsibilities.

E) PRACTICAL EXAMPLES

1. Example of Compliance

Patient X is brought by the ambulance services to the hospital with symptoms of acute abdomen of surgical cause. The patient is examined in the emergency unit and blood samples are taken for testing. Following a presumptive diagnosis, the patient receives the adequate emergency treatment and the doctor recommends hospital admittance and surgical intervention. The doctor explains to the patient all the consequences and risks in case of refusing the hospital admittance and the surgical intervention and tells him that in case of his refusal of medical recommendations, he should assume the responsibility of his decision and confirm it by his signature. The patient accepts the hospital admittance and the surgical intervention, understanding that without the operation his life is in danger.

2. Example of Violation

A young man of 27 years of age, who a few days earlier was in a road traffic accident, was admitted to the Hospital J. with polytrauma (head, facial, femur, lower leg) and a ruptured spleen. Taking into account that several successive operations were needed, the medical team considered that the patient needed blood transfusions. The patient was conscious, able to talk and refused the blood transfusion. His family also refused, based on religious beliefs. After not too long, the patient went into a coma. The family who was present in the hospital during the treatment still refused the blood transfusion. Because of the blood deficiency, the patient's health status worsened. In this situation the doctors were unable to provide the patient with life-saving treatment based on the patient's refusal to consent to such treatment.

3. Actual Case

After losing vision in the right eye, the patient M sued Doctor X and the District Hospital Bistriţa, claiming that loss of vision was due to medical intervention he underwent in District Hospital Bistriţa.

Patient M was admitted to the District Hospital Bistriţa, Ophthalmology Department with the diagnosis of complicated cataract in the right eye. Such a disease can cause blindness. The patient received a surgical intervention by Doctor X. The patient also had several cardiovascular diseases. At the post-operative eye examination, two weeks after surgery, the doctor noticed small dense formations that could mask a possible retinal detachment. He referred the patient to another hospital for an eye ultrasound, because the District Hospital Bistriţa does not have an ophthalmic ecograph. The patient was supposed to return with the ultrasound results, and depending on the results, to receive further treatment until complete cure of corneal edema, in order to be able to implant the IOL (artificial lens). Doctor X proved all these with the medical letter. The patient did not follow Doctor X's recommendations but addressed another medical facility where he received a surgical intervention. The legal action was dismissed as unfounded as no causal relationship was proven between the surgical intervention done by doctor X and the plaintiff's vision loss, because the patient underwent another subsequent surgery done by another doctor[819].

F) PRACTICE NOTES FOR LAWYERS

- In the Romanian legal framework, two of the essential elements of civil liability are the existence of guilt and existence of damages as a result of an illegal behaviour. According to the Romanian Civil Code **(Article 1.371)**, if there is a common guilt between the person held responsible and the victim, then the person held responsible must only cover the damages which he/she has provoked and not the damage made or increased by the victim. This provision is relevant in complex cases where, for example, part of the damage was provoked by the health care professional, and another part of the damage was the result of the patient not complying with responsibilities towards one's own health such as following prescribed medication after surgery. In these cases, the lawyer of the patient must clearly show the link between each person's behaviour and the damages created and provide the court with thorough evidence in order to help the judges understand that the defendant is still responsible for part of the damage.

6.2.2 Patient Responsibilities towards the Protection of Public Health

A) PATIENT RESPONSIBILITIES TOWARDS THE PROTECTION OF PUBLIC HEALTH AS STATED IN COUNTRY CONSTITUTION /LEGISLATION

Constitution

- **The Romanian Constitution** has no provision in reference to the responsibilities of patients or citizens related to public health.

Legislation

- **Law no. 95/2006 on the Health Reform, republished in 2015**
  - **Article 3** is related to the role of individuals in the protection of public health: *Public health protection is an obligation of central and local public administration authorities, as well as of all natural and legal persons.*

819 Lege AZ (2015), Legea de la A la Z *[Law from A to Z]*, Jurisprudență și spețe de drept civil *[Jurisprudence and civil law case examples]*, (http://legeaz.net/spete-civil/respingere-actiune-in-raspundere-civila-257-2012, Accessed on 31 August 2015)

- **Law no. 584/2002 on the measures for preventing the spread of AIDS in Romania and for protection of persons infected with HIV or having AIDS**

  Law 584/2002 provides specific responsibilities for the persons infected with HIV or having AIDS for the purpose of preventing the contamination of healthy persons and spreading the infection. **Article 8** of this law provides the obligation of the HIV/AIDS patient to notify the doctor or the dentist about his/her health status (para. 3), and his/her criminal liability for the voluntary transmission of HIV/AIDS, if he/she knows if his/her own HIV infected status and the transmission is produced from reasons attributable to him/her (para. 4). *(Author note: Infected with HIV means that the patient has the virus, but not the disease. He/she is a healthy carrier. There is nothing dangerous for the patient but extremely dangerous for the others. S/he might not even know s/he carries HIV since s/he has no symptoms and no blood test performed. This might be used to absolve the patient of the responsibilities mentioned in law [584]. Having AIDS means the patient has developed the disease, and there is a very low possibility of not knowing s/he is ill.)*

B) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Order no. 125/2012 on the provision of health care for persons deprived of liberty, in custody of the National Administration of Penitentiaries**

  Patients living in conditions deprived of liberty have the same rights and obligations as the other patients in Romania. Thus, the order that regulates the provision of health care for these persons reiterates the provisions of other laws. For example, **Article 103** of Order 125/2012 provides the obligation of patients who are HIV/AIDS positive to notify their doctor or dentist about their health status, when they are aware of it. The criminal liability for the voluntary transmission of HIV/AIDS is also mentioned, as regulated by Law no. 584/2002. In addition, among the obligations of the persons deprived of liberty is the compliance with the regulations regarding the individual and collective hygiene, a measure that contributes to the preservation of health of the prison community.

C) PROVIDER CODES OF ETHICS

There are no relevant sources on this topic.

D) OTHER RELEVANT SOURCES

There are no other relevant sources on this topic.

E) PRACTICAL EXAMPLES

1. Examples of Compliance

Example 1: A patient who has lived with HIV for 17 years was interviewed in a local newspaper. He confesses: „I had problems with my teeth. I have tried to go to several doctors in our city, but when I told them I was a patient with HIV, all declined me politely. I went to the neighbouring city X, where there were some caravans treating patients with AIDS, and there I found a doctor who respected his duty to treat me and since then I have been visiting him regularly." *(Authors' note: this example of compliance with his responsibility to protect public health by the patient in disclosing his HIV status to doctors is also an example of a violation of his rights by those doctors who refused to treat him after learning of his HIV status.)*

Example 2: Mrs. C. is a woman living with HIV since childhood, when she was transmitted the virus in a public hospital through unsterilized needles. In September 2013, Mrs. C became pregnant and wished to consult an OBGYN professional about the risks of her pregnancy and which method of delivery would be more appropriate for her. She went to Dr. H and after a preliminary discussion about her pregnancy, she disclosed her HIV positive status to the doctor. Dr.H. immediately informed the patient that there are medical measures which can be taken in order to reduce the risk of transmission of HIV from mother to foetus and that the most appropriate method of delivery for her is caesarean section.

2. Example of Violation

A very well known singer, carring the HIV virus but having no symptom of the disease, had unprotected sexual intercourse with several men. One of them has the infection. The singer found she was HIV positive almost 10 years ago, when she delivered a baby, but she kept the secret in order to protect her reputation and career.

3. Actual Cases

Case 1: A man from Botoşani was sentences to 14 years in jail after it was proved and he was convicted of intentionally infecting his wife with the HIV virus[820]. Additionally, the man was ordered to pay moral and civil damages in the sum of 12,700 lei to his former in-laws and to his child, as well as a monthly payment to his child of 600 lei, up to his 18th birthday. The man met his wife in 2009 and they married in June 2010. They decided to get married when their daughter was already 3 months old. Three months after the wedding, by the end of August, the woman died with AIDS. The woman's parents showed the prosecutor a note written by the man to his wife, announcing that he was infected with HIV and, most probably, she also had the disease. The prosecutors from the Botoșani Court of Law established that the patient knew even from May 2010 that her husband had AIDS. More than that, the woman accepted to mislead the family physician who was supposed to compile the premarital health certificate required by the Civil Status Office. The investigation shows that the women knew she was infected but she showed to the family physician a negative HIV/AIDS test. The deceased woman was under criminal investigation for charges of forgery, and instigation to intellectual forgery. As she is dead it was decided to stop the criminal investigation against the woman.

Case 2: 2014, a young man F from the city S of Romania died; and following his death, a friend found out that F was HIV positive. Immediately, a state of panic arose in the city since F had sexual relations with several girls who did not know about the health status of F. The girls have also had sexual relations with other persons and the fear of the HIV transmission grew in the community, so the case immediately became a hot topic for the press and TV channels. In October 2014, the prosecutor's office started a criminal investigation for the crime of voluntarily transmitting HIV. According to the press[821], the prosecutor heard members of the community, including the parents of F in order to find out if they knew about the young man's HIV status. In 2015 the investigation was on-going and there was no news about the outcome.

F) PRACTICE NOTES FOR LAWYERS

- In a case concerning the spread of infectious/contagious diseases, finding the source of the infection can be an important process, in order to prevent and mitigate the effects of the disease, and, eventually, find the person who could be held responsible.

820 Ziare.com 3 February 2012 Condamnat la 14 ani de închisoare pentru că și-a infectat soția cu HIV [Sentenced to 14 years in jail because he infected his wife with HIV] http://www.ziare.com/stiri/inchisoare/condamnat-la-14-ani-de-inchisoare-pentru-ca-si-a-infectat-sotia-cu-hiv-1148808

821 Mediafax, *Audieri la Parchet în cazul tânărului din Segarcea care ar fi infectat cu HIV mai multe persoane, [Hearings in the case of the young from Segarcea that infected with HIV several persons]* 27 October 2014, available at: http://www.mediafax.ro/social/audieri-la-parchet-in-cazul-tanarului-din-segarcea-care-ar-fi-infectat-cu-hiv-mai-multe-persoane-13470333

6.2.3 Patient Responsibilities towards the Health System

A) PATIENT RESPONSIBILITIES TOWARDS THE HEALTH SYSTEM AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution** has no provision in reference to the responsibilities of patients or citizens / potential patients related to the functioning of the health system.

Legislation

- **Law no. 95/2006 on the Health Reform**

  Title VIII - Social Health Insurance, Article 231, provides the obligations of insured people. Some of them refer to the obligations of the insured in relation to health providers (to enrol with a family physician, to notify the physician every time changes in his/her health status occur, to attend all prophylactic medical check-ups, to comply with the physicians' treatment and recommendations, to have a proper conduct towards health care personnel). Others refer to the obligations in relation to the third-party payer – the health insurance house (to notify the health insurance house of any change regarding the inclusion criteria in a certain insured category, to pay the insurance contribution and the required direct payments, and to submit to the providers the documents that certify their insured status).

  Title VIII also includes articles that regulate financial obligations that insured persons have towards the Unique Social Health Insurance Fund. Taking into account the mandatory feature of the social health insurance system, in principle, all Romanian citizens living in Romania should be insured against the payment of a monthly contribution. In fact, some population categories are insured without contribution payment, while others are insured based on the contribution paid by other sources **(Article 224)**. There is also a category of uninsured patients, either because the insurance is not compulsory for them (non-Romanian citizens living in Romania) or because they do not pay the insurance contribution. The uninsured receive a minimal package of benefits free of charge and pay directly for the services not included in the minimal benefit package. The benefit packages are described in the common National Health Insurance House and Ministry of Health Order that approves the norms of application of the Framework Contract on the conditions of health care provision within the social health insurance system, issued periodically

B) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Order no. 345/2006 on the approval of the model of the social health insurance contract**

  The obligations of the insured persons within the social health insurance system are set in detail by Order no. 345/2006 on the approval of the model of the social health insurance contract of the President of the National Health Insurance House. The model presented in the annex of this order is used by the district health insurance houses in concluding contracts with the insured persons, directly or through the employers. Besides the obligations already mentioned in the law 95/2006, the order includes provisions related to the correctness of sick leave and cash benefits (the insurer has the obligation to accept the control of the health insurance house in this regard), waiting lists (the patient should comply with the appointment time for the provision of services included in the base benefit package, according to the waiting list), and compliance with the patient flow (the patient goes to the specialist in ambulatory or hospital settings, only based on the referral from a family doctor, except in cases of emergency or certain chronic conditions that allow direct access to the specialists, mentioned in the framework contract and its application norms).

C) PROVIDER CODES OF ETHICS

Patient responsibilities towards the health system are not provided in professional codes of ethics.

D) OTHER RELEVANT SOURCES

Healthcare providers, especially hospitals, have their own regulations or codes of conduct for their patients. These include, besides the obligations provided by the law, provisions related to the patients' compliance with the provider internal regulations, and procedures to follow for admittance, discharge, transfer or other processes in which patients are involved.

E) PRACTICAL EXAMPLES

1. Example of Compliance

Patient X, 32 years of age, self-employed, was brought by the ambulance services to the hospital with suspicion of acute myocardial infarction. At the Emergency Unit of the hospital, the diagnostic was confirmed by the clinical examination and electrocardiogram. The patient was referred to the Coronary Surveillance Unit where specific treatment and monitoring were initiated. As the case evolution was favourable, with no complication, after 48 hours the physician recommended transfer to a post-infarct surveillance room. During completion of the transfer paperwork it was found that the patient was not insured in the Romanian social health insurance system or the health system of another EU country, since he actually did not pay his health insurance contribution for the past 2 years. The patient was told that the emergency treatment received was free of charge being included in the minimal benefit package for which uninsured patients are entitled, but that he must pay for the continuation of the treatment in the hospital. The patient pays for the due contribution and addresses again the hospital for the continuation of the treatment, bringing the evidence that has no debt to the health insurance fund.

2. Example of Violation

A patient, aged 68, is a pensioner, but at the same time hired as an administrator by the Tenant Association of the block of flats through a service contract in which it is stipulated that she will pay all the taxes and contributions due to the state and social security system. She also realizes income from renting rooms at her home, but does not pay the contributions to health insurance system due to extra-pension incomes. She uses the health services on the basis of pensioner status. *(Authors' note: Pensioners with income under a certain level are among the persons insured based on contributions paid from other sources, namely the social security budget. If their income exceeds a certain level, or they receive income from other sources, they have to pay a health insurance contribution as a percentage from the supplementary income.)*

3. Actual Case

Approximately 300 persons sued the Maramureş District Health Insurance House after receiving payment summons for the sums due to the Unique National Health Insurance Fund. These were authorized natural persons practicing a liberal profession, such as: physicians, notaries, lawyers, artists, or other categories that have realized incomes from intellectual property, author rights, etc. The sums these persons had to pay to the health insurance fund were from 50 lei to several thousand lei. For old debts, penalties and interests should have been paid, which in many cases were higher than the due contributions. Ninety-nine per cent (99.9%) of the court decisions on this matter were in the favour of the Maramureş District Health Insurance House.

F) PRACTICE NOTES FOR LAWYERS

- Health care services covered by the different health insurance packages are provided in a general manner in Law no. 95/2006 on the Health Reform. However, when it comes to specific medical interventions such as tests, surgeries, consults etc., the authority which knows precisely which services is covered by the different health insurance packages is the National Health Insurance House. If lawyers have any doubt as regards the coverage of a certain medical service, one practical way to obtain this information is by sending a public information request to the National Health Insurance House, based on Law no. 544/2001 on the free access to public information requests.

7.1 PROVIDERS' RIGHTS

7.1.1 The Right to Work in Decent Conditions

7.1.2 The Right to Freedom of Association

7.1.3 The Right to Due Process

7.1.4 The Right to Pursue Professional Activities

7.2 PROVIDERS' RESPONSIBILITIES

7.2.1 The Obligation to Provide Emergency Medical Treatment

7

National Providers' Rights and Responsibilities

7.1 Providers' Rights

This section focuses on providers' rights, including the rights to work in decent conditions, freedom of association, due process, and other relevant country-specific rights. 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 and recognizes the interdependence of patients' and providers' rights. Health workers are unable to provide patients with good care unless their rights are also respected and unless they can work under safe and respectful conditions. For each right outlined in the section, there is a brief explanation of how that right relates to health providers; and examination of its basis in country legislation, regulations and ethical codes; examples of compliance and violation; and practical notes for lawyers on litigation to protect provider rights.

7.1.1 The Right to Work in Decent Conditions

A) HEALTH WORKERS ENJOY A RANGE OF RIGHTS RELATED TO DECENT, SAFE, AND HEALTHY WORKING CONDITIONS WHEN PROVIDING CARE.

(Author note: The providers' right to work in decent conditions is also closely related to the patient's right to safety.)

B) RIGHT AS STATED IN THE COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003**
  - **Article 41** of the Romanian Constitution establishes the right of employees to social protection

measures, measures concerning *inter alia* the right to occupational safety and health. To protect their interests, including working conditions, the employees have the right to strike **(Article 43)**. The conditions and limits of exercising this right are further determined by other national laws.

Legislation

The right to work in decent conditions is also established through other legal provisions in detail, as follows:

Law no. 53/2003 on the Labour Code

The Code does not define *"decent working conditions"* or *"proper working conditions"*, but imposes certain obligations on the employer in connection therewith, as well as rights of the employees.

- **Article 6** establishes the right of the employees to labour conditions appropriate for the activity carried out, social protection, occupational health and safety, as well as respect for their dignity and conscience, without discrimination.
- **Article 39, para. (1) letter i)** acknowledges the right of employees to take part in the determination and improvement of their working conditions and working environment.
- **Article 40, para. (2) letters a) and b)** establish the employer's obligation
  - to inform the employees about the working conditions and aspects of the employment relationships;
  - to permanently provide high technical and organizational conditions considered in developing appropriate labour standards and working conditions.

The Code also regulates under **Title V** the occupational security and health of the employees:

- includes an obligation for the employers to ensure the safety and health of employees in all aspects of work **(Article 175, para. (1))**;
- provides the rules and regulations of labour protection may set **(Article 176, para. (2))**: general labour protection measures to prevent occupational accidents and occupational diseases, applicable to all employers; labour protection measures specific to certain professions or activities; specific protection measures applicable to certain categories of personnel; and provisions on the organization and operation of special bodies to ensure occupational safety and health;
- establishes an employer's obligation to take all the necessary measures to protect the safety and health of the employees **(Article 177, para. (1))**;
- it establishes the employer's obligation to be responsible for organizing the activity of ensuring occupational health and safety, and include special provisions of such activity in the internal regulations **(Article 178, paras. (1) and (2))**;
- stipulates the employer's obligation to insure all employees for prevention of occupational accidents and diseases, under the law **(Article 179)**;
- provides the obligation to organize training for its employees in the field of occupational safety and health, regularly and also upon employment **(Article 180)**.

Law no. 319/2006 on Occupational Health and Safety

According to this law, the employer (public or private) has additional obligations incumbent on occupational health and safety, respectively:

- to ensure the safety and health of workers in all aspects of work **(Article 6)**;
- to take necessary measures to: ensure the safety and health protection, prevention of occupational hazards, information and training of workers, ensuring the organizational framework and of the means necessary for the occupational safety and health **(Article 7)**;
- to take the necessary measures for first aid, fire extinguishing and evacuation of workers and to establish the necessary connections with the specialized services, particularly regarding the first aid, emergency medical service, ambulance and fire-fighters **(Article 10 para. (1))**;

- in the event of serious and imminent danger: (i) to inform all workers who are or may be exposed to this serious and immediate danger about the risks involved and the measures taken or to be taken to protect them; (ii) to take action and provide instructions to give workers the opportunity to stop work and / or to leave the workplace immediately and move to a safe area; and (iii) to refrain from requiring workers to resume work in case the danger still remains (Article 11);
- the obligation to conduct a risk assessment for occupational health and safety, including for those sensitive risk groups, and decide on the protective measures to be taken and, where appropriate, the protective equipment to be used **(Article 12, para. (1), letters a) and b)**;
- to ensure occupational security and health and prevent occupational accidents and diseases, the employer has the following obligations **(Article 13)**:
  - to adopt solutions in accordance with the legal provisions on occupational health and safety, the enforcement of which will eliminate or reduce the risks of injury and illness of the workers, from early stage of research, design and execution of construction, work equipment and of developing manufacturing technologies;
  - to draw up a plan for prevention and protection consisting of technical, health, organizational and other measures based on risk assessment, to be applied to the appropriate working conditions specific to the workplace;
  - to obtain functioning authorization in terms of occupational safety and health, before starting any activity. *(Authors' note: such authorizations must be obtained from the Labour Inspectorate, as provided in a special provision in the Rule on implementing the provisions of the Law on Safety and Health 319/2006.)*
  - to determine, based on the job description file of each employee, the duties and responsibilities incumbent upon them in the occupational health and safety field, according to their responsibilities;
  - to develop instructions for completion and / or applying the occupational health and safety regulations, taking into account the characteristic activities;
  - to secure and control the knowledge and enforcement by all workers of the measures provided for the established prevention and protection plan and the legal provisions on occupational safety and health by the designated workers, based on their own competences or through external services;
  - to take action on informing and training the workers relative to occupational health and safety, such as posting posters, leaflets, films and filmstrips;
  - to inform new employees about the risks to which they are exposed at work, as well as the required prevention and protection measures;
  - to take measures in order to authorize the exercise of trades and professions provided by specific legislation;
  - to employ only persons who, upon medical examination and, where appropriate, psychological testing of the skills, correspond to the work load they will take, and to ensure periodic medical examination and, where appropriate, periodic psychological testing, after employment;
  - to keep track of high-risk and specific areas;
  - to ensure proper and permanent operation of the protection systems and devices, and measuring and control devices, as well as installations for the capture, detention and neutralization of harmful substances issued during the technological processes;
  - to ensure work equipment without danger to the health and safety of the workers and personal protective equipment;
  - to provide new personal protective equipment, if the previous equipment is lost or the quality of protection is degraded.
- to provide protection catering to people whose working conditions require this **(Article 14)**;
- to provide free hygienic and sanitary materials **(Article 15)**;
- to provide the necessary conditions so that each employee receives enough and appropriate

training in the occupational health and safety field, particularly in the form of information and work instructions, specific to the workplace and job **(Article 20)**.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Government Decision no. 1091/2006 on the minimum safety and health requirements for the workplace**

  The Decision lays down minimum safety and health requirements for the workplace, and further develops these requirements in **Annexes I and II.**

  The Decision must be fully implemented by employers along with the provisions of the Law no. 319/2006 for occupational safety and health, without prejudice to the more stringent and/or specific provisions of the Decision under review **(Article 3)**.

  The Decision imposes on the employer, for the purpose of ensuring the safety and health of workers, the obligation to take action in order to: (i) preserve permanent free access routes; (ii) provide technical maintenance of the workplace, and of the equipment and devices, especially those referred to in Annexes 1 and 2 of the Decision; (iii) immediately remedy the lack of conformity likely to affect the safety and health of the workers; (iv) ensure regular cleaning of the equipment and devices at work and (v) ensure maintenance and checking the equipment and security devices to prevent or eliminate dangers **(Article 8)**.

  The employer is also required to inform the workers and/or their representatives of all measures to be taken in the occupational safety and health field **(Article 10)**.

  Particularly, the employer is required to inform the personnel working in isolation on (i) handling work equipment, its condition (reliability and accessibility), (ii) the risk of injury and how to act in case of occurrence thereof, (iii) appropriate behaviour in the event of a failure or the occurrence of an emergency, (iv) the use of personal protective equipment, (v) first aid, and (vii) use of surveillance and connection with the outside system **(Article 11)**.

  At the same time it establishes the employer's obligation to consult and ensure participation of workers and/or their representatives on matters relating to occupational health and safety **(Article 12)**.

- **Government Decision no. 1092/2006 on the protection of workers from risks related to exposure to biological agents at work**

  The Decision applies to all activities where workers, due to the nature of their job, are or are likely to be exposed to biological agents **(Article 7)**.

  The Decision establishes specific obligations for the employers, such as:

  - to establish the nature, level and duration of exposure, in order to assess any risk to the health and safety of the workers and in order to determine the measures to be taken, as well as periodic renewal of the risk assessment **(Article 8)**;
  - to avoid the use of a harmful biological agent, and to replace it with a biological agent which, according to the terms of use and current state of knowledge, is not hazardous or is less hazardous to workers' health **(Article 11)**;
  - to take other measures such as **(Article 15)**:
    - ensure appropriate conditions for workers, such as not to serve meals and beverages in work areas where there is a risk of contamination by biological agents;
    - provide appropriate protective clothing or other appropriate special clothing for the workers;
    - provide spaces equipped with adequate hygienic and sanitary facilities, which may include solutions / eye washes and / or skin antiseptics substances;
    - provide personal protective equipment to be placed correctly in a place, separated from the

other garments of the workers, to be checked and cleaned, if possible before, and in any case, after each use, to be repaired or replaced before a new use, if faulty;
- establish procedures for taking, handling and processing samples of human or animal origin;
- to ensure disinfecting, cleaning and, when needed, destruction of workers' protective equipment, if contaminated by biological agents **(Article 16)**.

The Decision establishes specific obligations for employers especially for medical and veterinary services, such as:

- **Article 31:** The employer will assess the risks, and will particularly consider: (i) uncertainties about the presence of biological agents in the organism of the patients or animals, as well as biological samples or products resulting from them, (ii) the danger that is constituted by the biological agents that are or may be present in a patient's or animal's body, as well as in samples taken from them, and (iii) the inherent risks due to the nature of the activity. The employer shall take all appropriate measures to ensure the health protection and safety of the workers in the health services, namely: (i) specifying the appropriate decontamination and disinfection procedures, and (ii) implementing procedures enabling safe handling and disposal of the contaminated waste;
- **Article 32:** The employer must choose between the isolation measures set out in column A of **Annex no. 5**, the decision under review, in order to minimize the risk of infection, for services of isolation or quarantine stations where there are human patients or animals who are or may be contaminated with biological agents in groups 3 and 4 of the same Annex.

The practical recommendations for the health surveillance of workers are found in **Annex no. IV** to the Decision:

- The health surveillance of the workers must be provided according to the principles and practices of occupational medicine and should include at least the following measures: (i) registration of the medical and occupational history of each worker, (ii) a personalized assessment of the health of workers, and (iii) where appropriate, biological monitoring for detection of early and reversible effects. Other tests may be ordered for each worker who undergoes health surveillance in light of the latest knowledge of occupational medicine **(point 2)**.

Particular emphasis may be given to **Annex no. V** referring to the indication of measures and isolation levels that must be applied depending on the nature of the activities, risk assessment for the worker and the nature of the biological agent involved being presented in a table.

Order no. 1479/2010 on approving the Regulation regarding the composition and the use of personal protective equipment of high visibility by the personnel of the emergency ambulance services within the county and the Bucharest–Ilfov Ambulance Service, the Norms for equipping the personnel, and the rules for their application

- The following personnel of the ambulance service benefit from uniforms: doctor, nurse, ambulance driver, and driver (**Article 1** of the Norms).
- According to **Article 4** of the Order, the personal protective equipment is unique and mandatory for the intervention personnel in the county ambulance services and in the Bucharest - Ilfov Ambulance Service during normal or extended work programs.

Order no. 508/2002 on the approval of the General labour protection norms - Ministry of Labour and Social Solidarity

The general Norms for labour protection of 2002 comprise the general principles of prevention of occupational accidents and occupational diseases as well as the general directions for applying them and they constitute the general framework for developing their own specific norms and instructions of labour safety **(Article 1)**.

The norms are mandatory and are applicable to all activity sectors in Romania, both public and private (industrial, agricultural, commercial, administrative, services, educational, cultural, recreational, etc.),

to all natural or legal persons, Romanian or foreign, carrying out activities in Romania, as provided by the law, both as an employer and as an employee as well as to apprentices, pupils and students for the period of professional practice, except domestic activities (**Article 2** of the Norms).

- **Article 5, para. (4)** of the Norms establishes the obligation of employers to develop their own occupational safety instructions, aimed at detailing and customizing the provisions of general and specific norms of the standards and other regulations in the field, depending on the particularities of the work processes.

The Norms treat in detail:

- Organizing labour protection at the employer level, developing the **(Title II)**:
  - Employer obligations on occupational health and safety;
  - Obligations and rights of the employees on occupational health and safety;
  - Organization principles and criteria;
  - Organizing the compartment of labour protection;
  - Organizing the Committee for Occupational Safety and Health;
  - Training of the personnel;
  - Methods and means of promoting;
  - Providing personal protective equipment and individual work equipment;
  - Providing hygienic and sanitary materials and protective food;
- Work tasks which concern **(Title III)**: the design and distribution of work tasks, organizing the working time, rest periods, and shift work, physical effort, mental effort, work performed by women, youth work;
- Buildings and other constructions **(Title IV)**:
  - General obligations of the designer, contractor, beneficiary
  - The location of buildings, warehouses and other types of construction
  - Traffic routes
  - Building height, surface sizing and of the minimum volume for each employee[822]
  - Technical and commercial installations
  - Social and sanitary facilities, first aid points, drinking water needs, waste collection and removal
  - Workplace
- Technical equipment **(Title V)**
- The work environment **(Title VI)**

D) PROVIDER CODE(S) OF ETHICS

The medical ethics code contains no provision of the right to decent working conditions.

E) OTHER RELEVANT SOURCES

No other relevant sources were identified at the moment of drafting this PG.

822 Acording to article 206 the areas of work where work processes are carried out will have a minimum height of 3 m, and each person will secure a volume of 12 m3 and a minimum area determined under the rules in force the specific activities.
For areas where there are processes that produce heat, humidity, dust, gases, fumes etc., height and room volumes are determined by calculation taking into account the provision of air changes and the means of combating harm.
Workrooms where the administrative and commercial activities can have a minimum height of 2.6 m, and each person will be provided a minimum volume of 10 m3 and a minimum area determined under the rules in force at work specific.

F) PRACTICAL EXAMPLES

1. Example of Compliance

The TM Cardiology Hospital provides its employees, cardiology doctors, all equipment necessary to enable them to perform some of the most complex heart surgery. Also, the surgeons and auxiliary medical personnel are provided with the appropriate protective equipment.

2. Example of Violation

Although the procurement procedure for equipping the emergency receiving department of Municipal Hospital X has been started, and the construction work has been paid for, the Hospital management forgot to purchase the supplies necessary for the purchased equipment, which makes them unusable.

3. Actual Cases

At the time of writing this guide no relevant case law was discovered on the relationship between the medical staff and the employing hospital unit having labour disputes on ensuring decent working conditions.

On the other hand, there is extensive case law regarding other types of employer's obligation to provide its employees with a safe working environment and to train its personnel on the equipment used. Thus, a medical professional can also refer his/her case to the competent courts to settle a labour dispute arising from the breach of obligations by the employer on occupational health and safety, given that they are employees *(Authors' note: doctors can sue their employers according to the special legal provisions of the labour code and other relevant laws if those doctors have concluded an employment contract with the employer and no other kinds of contracts).*

Thus, below are some of the solutions of the law courts related to the right to work in decent conditions, which, with the exception of one, although not healthcare-related, explain applicable principles regardless of the specific field of employment:

Prahova County Court - Sentence no. 102 / 03.03.2009 - Cancellation of an administrative act [823]***:***

- The court noted that complainants F.V. and P.O., both doctors, were disciplined by the relevant professional bodies;
- The court dismissed the complainants and upheld the sanctions, given that the produced evidence showed that the complainants are guilty of violating several rules of conduct;
- However, the court also considered the facts accepted by the Superior Commission of Discipline that the ethical attitude of the doctors and their therapeutic behaviour were due *also to the poor organizational conditions regarding the emergency neurosurgical assistance in the hospital, as well as the lack of a neurosurgeon on call.*

Iaşi Court of Appeal - Decision no. 510/CA/2008 - Occupational accident:

- The court noted the following facts: on 01.03.2007, at around 12.35hrs, the workers P.G. and C.C. transported a dresser towards the entrance of the unit and reached the entrance ramp and climbed the access ramp; but due to an incorrect handling, C.C. fell from the edge of the ramp from a height of 2.8 m and was badly injured, and on 05.03.2007 he died. The accident was due to lack of guard rails on the access ramp to the premises of „IG" LTD Iasi, breaching the provisions of Article 13 letter l of Law no. 319/2006, according to which *to ensure the occupational security and health conditions to prevent occupational accidents and occupational diseases, the employer is required to ensure proper and permanent operation of the protection systems and devices during technological processes*. The court held that the employer admitted to the transportation of the furniture in storage in the headquarters without completing the action equipping the entrance ramp with the guard rails,

823 This case is treated in detail in Chapter "obligation to provide emergency medical treatment", Case law Section.

conditions in which an operation was performed with high risk, breaching the laws on occupational health and safety.

- The employer did not contest the facts found by the control authority, but argued that it is not his responsibility, but of other unit, namely the „A.C." LTD who must perform finishing work and repairs to the building where the employer was located.
- The court did not accept this defence because, due to the provisions of Article 5 of Law no. 319/2006, the employee C.C. had a legal employment relationship with the employer „I.G." LTD, and under Article 6 of the same law, the employer (in this case I.G LTD) is required to ensure the safety and health of workers in all the aspects of work and if the employer outsources (as in this case) it is not relieved of its responsibilities in this field.

Iaşi Court of Appeal - Decision no. 164/2008 of March 25, 2008 – Occupational accident:

- The Court held that the employee (the plaintiff) was employed for the position of bookbinder at a publishing house (the employer), but in fact he worked on complex machinery unrelated to his position. Moreover, the employer has failed to fulfil its obligation to instruct the employee on how to use the equipment;
- Due to lack of training, the employee was injured at one of the employer's machines, destroying both of his arms;
- The court held that in the present case, the fault for the occupational accident falls exclusively on the employer, primarily because it has not taken the measures to ensure occupational safety and health, and secondly, because it has not fulfilled its legal obligation to train the personnel (including the plaintiff) on how to use the equipment.

Paşcani Court – Criminal sentence no. 327/2010 of November 15, 2010 – Occupational accident:

- The court noted that on 3.11.2009 when conducting work in a mobile site - work point organized by SC XYZ Bucharest - Iaşi Branch on rehabilitation of the Moţca Paşcani water supply - during mounting a supply pipe for water, a fatal injury to the worker B.V. occurred;
- Actually it was found that it is the case of an occupational accident whose cause is due to: (i) the absence of minimum requirements on the stability and robustness of mobile or fixed workstations located at depth (without support from banks), contrary to the legal provisions; (ii) lack of a proper security plan for the job, also not appointing and locating the areas of high and specific risk from the activity of SC XYZ Bucharest - Iaşi Branch (or the obligation belongs to the employer); and (iii) failure by the employer to comply with the obligation to provide sufficient and appropriate training for the victim in the occupational safety and health field regarding the specific risks of the activity that the victim was performing at the time of the accident;
- The court held that there was a breach of the laws on occupational health and safety according to which: *(i) the employer must ensure conditions for each worker to receive sufficient and appropriate training in occupational health and safety, particularly in the form of information and work instructions specific for the workplace and his job and (ii) the employer also did not assess the risks of accidents and occupational diseases caused by the developed activities and did not establish security and occupational health risks measures, corresponding to the identified risks;*
- The employer has been sanctioned by the competent authorities in the field, for failing to ensure a sufficient and appropriate training to the victim, failure to take measures to flag based on assessing the risk of injury of the high and specific risk areas, as well as failing to assess the risks of injury arising from the performed excavation and not setting the appropriate occupational security measures corresponding to the identified risks, violating the provisions of Article 20 paragraph 1,2 , Article 39 paragraph 9 letter d, Article 7 al 4 letters a, b of Law 319/2006 (of occupational health and safety);
- The court concluded that the overall results of the research in the case shows with certainty that the insufficient training of the victim is the direct cause that led to the event, which is evidence of the offense set by Article 37 paragraph 2 of Law 319/2006, namely *failure to take any of the legal measures for occupational safety and health by the person who had the duty to take such measures, if it causes a serious and imminent danger of an occupational accident or occupational disease* and consequently ordered criminal prosecution against C. N, manager of SC XYZ Bucharest - Iaşi Branch.

G) PRACTICE NOTES FOR LAWYERS

- In a specific litigation regarding malpractice, a lawyer who is representing the medical practitioner can bring up before the court issues regarding the employer's (the hospital, for example) obligations to provide a safe working environment. Thus, a lawyer, depending on the facts, can argue that the harmful medical act resulted not from the doctor's negligence, but from the non-compliance of the employer's obligation regarding safety at work. In this case, if a causal link is established between the employer's non-compliance and the damages caused to the patient, then there is no civil liability on behalf of the medical professional. For example, it might be the hospital management's obligation to check the adequacy of an operating room table, and not the surgeon's. In addition, in order to strengthen the arguments regarding the liability of the employer, lawyers can check the specific duties contained by each medical facility's internal regulations.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

The right to work in decent conditions is also established in:

- **Article 7** of the International Covenant on Economic, Social and Cultural rights (See the right to appropriate salary and working conditions in Chapter 2)
- International and regional aspects of the right to work in decent conditions in the second and third chapters of this guide.

7.1.2 The Right to Freedom of Association

A) HEALTH WORKERS' ABILITY TO FORM, JOIN, AND RUN ASSOCIATIONS WITHOUT UNDUE INTERFERENCE IS CRITICAL TO THEIR ABILITY TO EFFECTIVELY DEFEND THEIR RIGHTS AND PROVIDE GOOD CARE.

B) RIGHT AS STATED IN THE CONSTITUTION / LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**
  - Article 40 of the Romanian Constitution guarantees the right of citizens to freely associate in political parties, trade unions, employer associations and other forms of association.

  The Constitution also enshrines the right of the employees to strike **(Article 43)** in order to defend their professional, economic and social interests, so by default also regarding the right to the freedom of association, if that right would be restricted.

Legislation

- **Law no. 62/2011 on Social Dialogue**

  According to **Article 3** of the law, the persons employed with individual labour contracts, civil servants and public officials with special status under the law, employed members of cooperatives and farmers are entitled, without any restriction or prior authorization, to constitute and / or to join a union.

No one may be compelled to belong or not, or to withdraw or not from a trade union.

Law no. 53/2003 on the Labour Code

The Labour Code sets *expresis verbis* in **Article 7** the right of employees and employers to associate freely to protect their rights and promote their professional, economic and social interests.

Law no. 31/1990 on Commercial Societies

Law no. 31/1990 is the framework law for the companies established for the purpose of carrying out commercial activities.

- According to **Article 1** of the law, to conduct the activities for profit, individuals and legal entities may participate and establish companies with legal personality.

Medical services may be provided through medical units established by the law 31/1990[824]. Subsequent to establishment, to operate legally, the legal representatives of the respective medical units, in person or by proxy, must obtain the necessary permits and authorizations[825].

Government Ordinance no. 26/2000 on Associations and Foundations

The Ordinance establishes the right of individuals and legal entities that pursue certain activities of general interest or in the interest of communities or, where applicable, their private non-patrimonial interest, to establish associations or foundations **(Article 1)**.

The Ordinance is an expression of the fundamental right to association, governing the establishment, operation and termination of an association or foundation.

Government Ordinance no. 124/1998 on the Organization and Operation of Medical Practices

The right to free association of the doctors is ensured by regulating the way they can exercise their profession.

Thus, ambulatory medical services are provided through medical practices, the medical units with legal personality established under Law no. 31/1990 regarding the companies or the medical practices with structures of non-profit organizations, foundations and associations with medical activities, professional associations, religious groups and places of worship, as appropriate[826].

Ordinance no. 124/1998 establishes the forms of exercise of the medical profession: the individual doctor's office, the doctors' grouped or associated offices and the medical civil company.[827]

Article 2 (paras. 2 and 3) establishes that any individual medical practices can be grouped to form group medical practices, to create common economic facilities, maintaining their individuality in relation to third parties; these also can be associated, forming associated medical practices in order to jointly exercise their activity and ensure the permanent access of the patients to complete medical services. The doctors, owners of associated practices, maintain their individual rights and responsibilities prescribed by the law.

Paragraph 4 of the same article regulates the right of the doctors (at least two) to associate for the purpose of establishing a medical civil society.

824 Article 1 of the methodological norms regarding establishment, organization and operation of medical offices of 26.02.2003.

825 According to art. 172 para. (8) in conjunction with art. 173 of Law no. 95/2006 on healthcare reform, the private hospital undergoes endorsement by the Ministry of Health. After obtaining the notice, the hospital enters the accreditation procedure. To authorize the operation of medical facilities other than hospitals, they must have regard to the provisions of Order no. 153/2003 of the Ministry of Health and Family approving the Methodological Norms on the establishment, organization and operation of medical offices. Also, see the website of the Ministry of Health, permits section, available here: http://www.ms.ro/?pag=25.

826 Methodological Norms of 26 February 2003 on the establishment, organization and operation of medical practices, Article 1.

827 Art. 1 of the Ordinance, in conjunction with art. 6 of methodological norm of 26 February 2003 on the establishment, organization and operation of medical practices.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

- **Methodological Norms of 26 February 2003 on the establishment, organization and operation of medical practices**

  These Norms have the purpose of offering detailed rules on how to apply Government Ordinance no. 124/1998 on the Organization and Operation of Medical Practices.

D) PROVIDER CODE(S) OF ETHICS

The medical ethics code contains no provision of the right to free association.

E) OTHER RELEVANT SOURCES

No other relevant sources were identified at the time of writing of this PG.

F) PRACTICAL EXAMPLES

1. Example of Compliance

The Federal Trade Chamber of the Doctors in Romania was established, legally operates, and represents an organization of physicians and health professionals with higher education with activities connected to the medical act, which has as objectives the defending of the economic, social, professional, sporting and cultural interests of its members. *(Authors' note: So far no complaints of infringement of the rights of this organization have been reported, meaning no interference on the legal establishment and functioning of thereof.)*

2. Example of Violation

Several doctors specializing in cardiology wanted to establish an association to promote education among the population about heart diseases and how to prevent them. Although the recording was legally made, the College of Physicians in Romania requested the dissolution of the association on the grounds that such associations are already well established on a national level, and that the newly formed association's activity affects the image of the College, which in turn is part of an association with a similar profile.

3. Actual Cases

At the time of writing this Guide, no relevant case law has been found on the infringement of the right of the health workers to freely associate.

Decision of the Constitutional Court no. 939/2012

However, Romania's Constitutional Court has received a plea of unconstitutionality regarding the provisions of Article 3 paragraph (2) of the Social Dialogue Law no. 62/2011. The exception was raised by the appellant „Speranța" Union from Orăștie in solving a civil remedy.

In motivating the exception of unconstitutionality, the appellant argues that the criticized provisions of law are against Article 53 of the Constitution, since they allow setting up a union with a number of 15 employees and require more stringent requirements for the establishment of a union than those found in the Constitution.

Analyzing the exception raised, the Court established the following:

- This fundamental socio-political right, which is not an absolute right, is exercised through participation in establishing associations or joining existing associations. The constitutional provisions establish certain limits to the right of association, involving 3 aspects: a) purpose and activity; b) members; c) nature of the association resulting from its mode of establishment. The law may impose certain mandatory conditions on the establishment and conduct of the activity of the associates;
- On imposing by law a minimum number of members to form a union, the Court found that this provision falls under the conditions that the law may impose under Article 9 of the Constitution: *Setting the minimum number of members is required to provide the established trade union a minimum representation to perform the specific activities of protecting the rights and interests of its members;*
- Consequently, the Court dismissed the objection of unconstitutionality raised by the appellant.

G) PRACTICE NOTES FOR LAWYERS

- In the event that there is an interference with the right to freedom of association, the lawyer can build arguments by first considering the constitutional provisions and the Constitutional Court case law in this respect, as well as that of the European Court of Human Rights, and in subsidiary the laws applicable to the legal establishment and operation of an entity resulting from the exercise of the right to freedom of association. This suggestion is based on the fact that international human rights instruments and jurisprudence take precedence over the national law, if the latter offers less protection to human rights. In addition, if a certain law is, in the lawyers' opinion, contrary to the Constitution, then the lawyer can bring up an unconstitutionality objection directly before the judge, during the trial.

H) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

General provisions on the right to free association and / or the right to strike, which are also applied properly to the medical staff includes:

- Article 5(d)(ix) of the Committee on the Elimination of Discrimination based on race;
- Article 22 of the International Covenant on Civil and Political Rights;
- Article 8 of the International Covenant on Economic, Social and Cultural Rights;
- Article 11 of the European Convention on Human Rights;
- Article 5 and Article 6 of the European Social Charter;
- The 87 Convention of the International Labour Organization ratified January 2, 2006;
- The 98 Convention of the International Labour Organization ratified November 12, 2003.

Please find a discussion of international and regional standards relevant to the Right to Freedom of Association in Chapter 2 (International) and Chapter 3 (Regional).

7.1.3 The Right to Due Process

A) HEALTH CARE AND SERVICE PROVIDERS ARE POTENTIALLY SUBJECT TO A RANGE OF CIVIL AND ADMINISTRATIVE PROCEEDINGS--DISCIPLINARY MEASURES, MEDICAL NEGLIGENCE SUITS, ADMINISTRATIVE MEASURES SUCH AS WARNINGS, REPRIMANDS, SUSPENSION OF ACTIVITIES, ETC.--AND ARE ENTITLED TO ENJOYMENT OF DUE PROCESS AND A FAIR HEARING.

B) RIGHT AS STATED IN COUNTRY CONSTITUTION / LEGISLATION

Constitution

- **Romanian Constitution of 1991, revised in 2003**

  The Constitution provides in **Article 21** the right to free access to justice, according to which everyone can go to court to protect their rights, freedoms and legitimate interests without any interference. The parties have the right to due process, a fair trial and settlement of cases within a reasonable time.

  Equally, **Article 24** of the Constitution guarantees the right to defence, in the sense that throughout a lawsuit, the parties have the right to be assisted by a lawyer, chosen or appointed **ex officio**. The right to defence is an essential part of the right to due process, a fundamental right also established by Article 6 of the European Convention of Human Rights and by Title VI of the Charter of Fundamental Rights of the European Union.[828]

  Also, in connection with the right to due process / fair trial is the right to petition, guaranteed by the Constitution, according to which the citizens are entitled to address public authorities through petitions, with correlative obligation of the latter to respond to petitions within time-limits and conditions established by laws **(Article 51 of the Fundamental Law)**.

Legislation

- **Code of Civil Procedure**

  - **Article 6** of the Romanian Code of Civil Procedure states as a fundamental principle the people's right to a fair trial within optimal and predictable time. According to it, everyone is entitled to a fair trial of his/her case within an optimal and predictable time by a court that is independent, impartial and established by law. For this purpose, the court is obliged to order all measures allowed by law and to ensure a speedy judgment. The same provisions are applicable during foreclosure.

- **Romanian Criminal Procedure Code**

  The Criminal Procedure Code regulates the general principles under which any criminal trial must be conducted.

  Thus the fairness and reasonableness of the term of the criminal trial are guaranteed **(Article 8)**, in that the judicial bodies have an obligation to prosecute and conduct the judgment with respect to the procedural safeguards and the rights of the parties. This means that criminal authorities and courts must ascertain the facts constituting crimes in a timely and complete manner so that *no innocent*

828 The Constitution stipulates that the constitutional provisions on the rights and liberties of the citizens shall be interpreted and enforced in accordance with the Universal Declaration of Human Rights, with the covenants and other treaties to which Romania is a party; and if any inconsistencies exist between the covenants and treaties on the fundamental human rights to which Romania is a party and the domestic laws, the international regulations shall take precedence, unless the Constitution or the domestic laws include more favourable provisions (Article 20).

person is to be prosecuted. Any person who has committed a crime is punishable by law, within a reasonable time.

Relevant to the right to due process is also guaranteeing the rights of defence and the benefit of doubt[829], without which the right to a fair trial as a whole cannot be conceived.

Law no. 95/2006 on the Health Reform, republished in 2015

There is no text of law in the framework legislation in the field to pinpoint the right to due process. However, all civil or criminal procedures based on Law no. 95/2006 on the Health Reform must comply with all the rules regarding a fair trial provided in the Codes of Civil and Criminal Procedures.

- **Article 653, para. 5** establishes that the civil liability of medical personnel governed by Law no. 95/2006 does not remove the criminal liability if the act that caused the damage is a crime under the law. As shown above, the criminal procedure law contains provisions on the right to a fair trial / due process.

In the case of disciplinary liability of healthcare professionals, doctors may appeal the decision of the professional association they are part of to the Superior Commission of Discipline. Subsequently, the doctor may also appeal against the decision of the latter commission, formulating for this purpose an action for annulment, to the administrative department of the court who has jurisdiction over the territory where the doctor practices medicine[830]. In the trial, the provisions of the Code of Civil Procedure will be applicable, and, by default, the ones on the right to due process / fair trial.

Regarding the fair term for settling of cases, the Framework law establishes in **Article 682, para. (3), second thesis,** the obligation for the Malpractice Commission to issue a decision within 3 months from the date a malpractice claim was filed with the Malpractice Commission.

Law no. 53/2003 on the Labour Code

The labour disputes between employees and employers, relating to the conclusion, performance, amendment, suspension and termination of individual employment contracts, shall be settled urgently by the competent courts[831]. Thus, dates of hearings cannot be longer than 15 days, and the summons procedure is deemed to be duly fulfilled if performed within at least 24 hours before the time of the trial.

Although the right to a fair trial or due process is not expressly provided for in the Labour Code, the provisions of **Article 275**, containing the special rules for settlement of labour disputes, shall be complemented with the provisions of the Code of Civil Procedure, namely implicitly with the rule on the right to due process.

Law no. 62/2011 on Social Dialog

According to the provisions of **Article 212,** requests to the court regarding the settlement of individual labour disputes shall be settled expeditiously. The Court establishes trial hearings with a maximum of ten days from one hearing to another, until the trial ends. Implicitly, the right to a fair trial/due process results from the provisions of **Article 216** on the completion of specific provisions of Law no. 62/2011 along with those of the Code of Civil Procedure, which set *expresis verbis* the parties' right to a fair trial/due process.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

Statute from 10 February 2009 of the Order of General Nurses, Midwives and Nurses from Romania

829 Article 4 and respectively Article 10 of the Romanian Code of Criminal Procedure.
830 Article 456, para. (4) and Article 459.
831 Article 266 in conjunction with Article 271.

The 2009 Statute provides the right of the members of the Order to be judged by the disciplinary departments of the Order *based on the presumption of innocence* **(Article 13, letter k))**. At the same time, the Statute provides the types of disciplinary sanctions which can be applied **(Article 40)**, as well as the deeds which are considered to be discipline violations **(Article 39)**. Thus, the legality and predictability of disciplinary procedures are guaranteed.

D) PROVIDER CODE(S) OF ETHICS

The medical ethics code does not state the right to a fair trial or due process, but has an entire chapter – **Chapter VIII** - with regard to judging ethics cases (when it comes to disciplinary liability of the doctors), setting out the rules by which cases involving breaches of ethics of the medical profession will be judged:

- Promptly, the persons designated with researching the alleged unethical act, are required to act with utmost diligence, not delaying or prolonging the performance of its functions or communication of the required data **(Article 54);**
- The research and analysis of any complaints shall be made taking into account and granting the benefit of the doubt to the doctor **(Article 55)**, meaning that until the final judgment of conviction, the person in the case, the doctor, is innocent[832];
- The person designated to conduct the research regarding the complained act or the members of the disciplinary commission must be impartial in resolving the case submitted for their judgment **(Article 56)**
- The proceedings before the disciplinary committee must take place in compliance with the adversarial principle, meaning that each party involved has the right to express his/her position before the commission. This position can also be provided in writing. **(Article 57)**.

(Authors' note: the ethics codes of dentists, midwives, and nurses do not contain provisions on respecting safeguards in disciplinary procedures)

E) OTHER RELEVANT SOURCES

No other relevant sources were identified at the moment of drafting this PG.

F) PRACTICAL EXAMPLES

1. Example of Compliance

Hospital X, as employer of Doctor Y, terminated Doctor Y's individual employment contract, following a disciplinary investigation. Although the doctor asked to be assisted by a lawyer during the procedure of disciplinary research, the employer's representatives argued that this is not necessary, as technical issues specific to the medical profession will be discussed. Later, after he was fired, Doctor Y brought an action against his employer alleging that the dismissal decision was unlawful.

The Court established a short term for the first hearing from the date it was invested with the doctor's claim and solved the case with the lawful priority. The Court ruled in favour of the plaintiff, finding that the dismissal decision was unlawful because Doctor Y did not benefit from legal assistance although he specifically requested it, thus violating his right to defence, and thus the right to a fair trial and due process.

2. Example of Violation

Doctor X was sanctioned by the Disciplinary Commission. Being dissatisfied with its decision, he

832 Article 23, para. (11) of the Constitution.

appealed the decision to the Superior Commission of Discipline. This committee upheld the sanction without hearing the doctor in question and listening to his point of view.

3. Actual Cases

In terms of case law relating to the individual's right to a fair trial/due process, it should be noted that frequently the courts in judicial review have found a violation of this right. However, at this point, no judgment of a court of law has been found that established that the right to due process and a fair trial of medical personnel has been violated.

However, below are some excerpts from considerations of various judgments of the courts, for the purposes of illustrating the acts that may be considered as a violation of the right to due process. Having in mind the fundamental nature of this right, it results that regardless of the particular facts of a case, the principles regarding the application of the right to due process can also be extrapolated in cases involving medical staff.

Bucharest Court of Appeal - Decision no. 20/2008 - Unlawful summoning and the court not ruling on an application for deferral due to lack of defence, violations of the right to a fair trial/due process:

- "[...] *in the file there is no proof of summoning the defendant with a copy of the request for summons*. Although in the introduction of the sentence it was stated that the summoning procedure was duly performed, there was no proof that the procedural act was fulfilled, requiring the existence of the minutes of summoning, both under the Code of Civil Procedure and the Insolvency Bulletin. [...] The Dispositions of Article 85 *(Author's note: these are the provisions of the previous Code, which was repealed and replaced)* of the Code of Civil Procedure establish under absolute nullity that the judge cannot judge the case until after *summoning or appearance of the parties, which is a guarantee of the right to a fair trial/due process of the party. The need for summoning the defendant under the Code of Civil Procedure has also been established by the Constitutional Court's Decision no.1137/4.12.2007.*
- [...] the defendant submitted to the Court a request for deferment of judgment for lack of defence, [...] *which entails the national court to rule on it.* However, from the introduction of the sentence, no mention of this request results, and *total disregard of a request by the parties is another reason to dispose of the sentence* [...] *because the right of defence of the party is guaranteed by the Romanian Constitution through the provisions of Article 24, thus ignoring a request on this shall entail the nullity of this decision."*

Section of Administrative and Fiscal Litigation of the High Court of Cassation and Justice (hereinafter referred to as HCCJ) - Decision no. 460/2014 – court's obligation to motivate the decision, warranty of the right to a fair trial/due process

- According to Article 261 paragraph (1) Code of Civil Procedure *(Author's note: these are the provisions of the previous Code, which was repealed and replaced)*, the court of first instance's decision shall include, *inter alia*, the pleas of fact and law which led to the court's opinion, and those for which the party's affirmation have been removed. This text established the principle that the decisions must be motivated, [...] the role of the text being that *of ensuring a good administration of justice and in order to exercise judicial review by higher courts;*
- Moreover, even the ECtHR (see the case Albina against Romania, case Gheorghe against Romania) emphasizes the role that the reasoning of a decision has to comply with Article 6, paragraph 1 of the European Convention on Human Rights and shows that *the right to a fair trial can be considered effective only if the parties' submissions are reviewed by the court, this having the obligation to carry out an effective examination of the means, arguments and evidence or at least appreciate them;*
- Not motivating a decision or not showing the reasons for the decision and not presenting the arguments for which submissions of the parties have been removed, is equivalent to *not examining the merits.*

The Civil Section of HCCJ - Decision no. 4902/2013 – reasoning of the judgment, warranty of the right to a fair trial

- The aspects that can lead to a failure to state reasons for the purposes of the legal provisions mentioned are the most diverse: *existence of a contradiction between the recitals of the decision, meaning that from some of them results the lack of substance of the action, and of others that the action is founded; blatant contrariety between the opinion and considerations, such as the admission of the action through the opinion, and justify in considerations of the solution to reject the application for summons; failure to state reasons for the solution in the opinion or insufficient reasoning thereof or exclusive presentation of considerations that are foreign to the nature of the case;*
- This does not mean, however, as the appellants claim, that the court is required to respond to every argument used by the parties in developing a ground of appeal and not even to each individual reason, when several grounds of appeal have a common determinant element, either for admitting or rejecting them together; it is sufficient that the court, in its analysis, groups them and discusses them together, the most important being only *the obligation not to leave unexplored all the grounds to be reviewed by the court for judicial control;*
- [...] *failure to state reasons or insufficient motivation of judgments - is also the purpose of finding a violation of the right to a fair trial*, as stated by Article 6 of the European Convention on Human Rights, in the case of failure to analyze the issues raised on appeal [...] or not saying anything on a decisive argument for solving the case [...] where the Court reiterated that the duty of the courts to undertake an *effective analysis of the case requires that the injured party can expect a specific and explicit response to the decisive means for the outcome of that procedure*

Criminal Division of the HCCJ - Decision no. 2817/2013 – benefit of the doubt

- The benefit of the doubt provides that *the burden of proof falls under the responsibility of the criminal prosecution body and the court of law (eius inbumbit probatio qui dicit, non qui negat)*. Even though the presumption of innocence is a relative one, in a case, when given all the evidence necessary to solve the case, there can be found reasonable doubt, and thus the evidence in this case is not able to prove the guilt nor the innocence of the defendant;
- Or, in this case, the doubt that remains is equivalent to a positive proof of innocence, according to the principle *in dubio pro reo*.

F) PRACTICE NOTES FOR LAWYERS

- Article 6 of the European Convention on Human Rights is a human rights provision which is frequently invoked in domestic civil and criminal proceedings in Romania, and also has different human rights safeguards in either civil or criminal procedures. Medical practitioners can find themselves involved in disciplinary, civil and criminal proceedings, where their right to fair trial must be respected. Lawyers should consider that for the European Court of Human Rights, the national/domestic law is treated as a factual element of the case, and not as a law binding on the Court. Thus, is might be the case that the domestic law defines the impugned behaviour as a disciplinary offence rather than a criminal offence. Irrespective of the domestic classification, the ECtHR shall use its own interpretation in order to establish whether an administrative or disciplinary sanction amounts to a criminal offence and thus must benefit from the safeguards instituted by Article 6. The Court has provided a three-stage analysis for this purpose, namely (a) the categorisation made by the national law and authorities; (b) the actual nature of the offence; and (c) the nature and degree of severity of a penalty imposed on the person concerned. (See also *Engel and Others v Netherlands*, 1976). A manual for lawyers regarding the interpretation of ECHR Article 6 can be found on the INTERIGHTS website, here: http://www.interights.org/document/106/index.html

G) CROSS-REFERENCING RELEVANT INTERNATIONAL AND REGIONAL RIGHTS

References on the right to due process and a fair trial can be considered:

- Article 2(3) and 14(1) of the International Covenant on Civil and Political Rights;

- Article 6 and 13 of the European Convention of Human Rights.
- The provisions on the freedom of expression can also be considered:
- Article 19(3) of the International Covenant on Civil and Political Rights, restricting the freedom of expression to protect the rights and reputation of others;
- Article 10(2) of the European Convention of Human Rights.

7.1.4 The Right to Pursue Professional Activities

A) THE RIGHT TO UNDERTAKE PROFESSIONAL ACTIVITIES IS ESSENTIAL FOR THE POSSIBILITY OF THE MEDICAL PERSONNEL TO EXERCISE THEIR PROFESSION.

B) RIGHT AS STATED IN THE CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003**

  The right to work and choosing one's profession is guaranteed by the Constitution **(Article 41. para. (1))**, forced labour being prohibited **(Article 42 para. (1))**.

  The right to work cannot be restricted and the choice of profession, trade or occupation and the workplace is free.

Legislation

- **Law no. 95/2006 on Health Reform, republished in 2015**

  Law no. 95/2006 allows exercising the medical professions, without any discrimination, in the conditions set by it in the following:

  Title XII on the exercise of the medical profession. Organizing and functioning of the College of Physicians in Romania, which provides that:

  - the medical profession is exercised in Romania by individuals holding a formal qualification in medicine, who are citizens of the Romanian state, nationals of a Member State of the European Union, of a State of the European Economic Area or the Swiss Confederation, the spouse of a Romanian citizen and direct ascendants and descendants irrespective of their nationality, family members of a citizen of one of the countries of the European Union, or a state belonging to the European Economic Area, or the Swiss confederation, or by the citizens of third states, beneficiaries of permanent resident in Romania status, by the beneficiaries of the statute of long term residency of one of the countries in the EU or a state belonging to the European Economic Area, or to the Swiss Confederation **(Article 376, para. (1))**;
  - the medical profession is exercised only by persons who:
    - have not been sentenced for committing intentional crimes against humanity or life, in circumstances related to the exercise of the medical profession for which rehabilitation has not occurred;
    - have no penalty imposed against them prohibiting medical practice during an established time by court order or disciplinary decision **(Article 388)**;
  - the medical profession is exercised only by persons who:
    - are not employees or collaborators of the production or distribution units of pharmaceuticals

and medical supplies;

- have the appropriate physical and mental health to practice the medical profession **(Article 389)**; *(Authors' note: the law does not expressly provide how the state of health is evidenced; usually, when registering for practicing a specific profession, the person must provide some kind of medical certificates attesting the state of health.)*

- The medical profession is exercised only by persons who:
  - have a formal qualification in medicine;
  - are not found in any of the cases of indignity and incompatibility referred to in Article 388 and Article 389 of the Law (mentioned above);
  - are medically able to practice the profession of doctor;
  - are members of the College of Physicians in Romania, except in the cases of temporary or occasional provision of medical services in Romania by foreigners, provided they are registered during this period at the College of Physicians in Romania.

Title XIII on the profession of dentist. The organization and functioning of the College of Dentists in Romania provides that:

- the profession of dentist may be exercised by persons who are citizens of the Romanian state, nationals of a Member State of the European Union, of a State of the European Economic Area or the Swiss Confederation, the spouse of a Romanian citizen and direct ascendants and descendants, family members of Romanian citizens, irrespective of their nationality, family members of a citizen of one of the countries listed above, citizens of third countries, or beneficiaries of long term resident status in Romania, granted by one of the States abovementioned **(Article 477);**
- the profession of dentist may be exercised by persons who are not unworthy to exercise it respectively:
  - they were not sentenced for committing intentional crimes against humanity or life, in circumstances related to practicing dentistry and for which rehabilitation did not intervene;
  - no penalty has been applied prohibiting them to practice the profession during the established time, by court judgment or disciplinary decision **(Article 489);**
- the profession of dentist may be exercised by persons who are not incompatible to exercise it respectively:
  - are not employees or collaborators of the production units or distribution of pharmaceuticals, medical supplies and dental technique materials;
  - do not practice as dentists directly in activities of production, trade or services;
  - have no occupations (in additional to practicing dentistry) likely to harm the dignity of a dental practitioner or morality;
  - physical or mental health condition is appropriate for that profession, as is attested by a medical certificate issued by the board of medical expertise and recovery of working capacity;
  - do not knowingly use dental medical knowledge to the detriment of the patient's health or for criminal purposes **(Article 490);**
- the profession of dentist may be exercised by persons that **(Article 484):**
  - have a formal qualification in dentistry;
  - are not found in any of the cases of indignity and incompatibility set out above **(Article 489 and Article 490);**
  - are medically capable for practicing dentistry;
  - are members of the College of Dentists in Romania or, in a case of temporary or occasional provision of services, dentists have notified the Ministry of Health of the temporary or occasional provision of dental medical services in Romania and are registered during this time with the College of Dentists in Romania.

Title XIV on practicing the profession of pharmacist. The organization and functioning of the College of Pharmacists in Romania provides that:

- the profession of pharmacist is exercised in Romania by individuals holding a formal qualification in pharmacy, and who are citizens of the Romanian state, nationals of a Member State of the European Union, of a State of the European Economic Area or the Swiss Confederation, the spouse of a Romanian citizen and direct ascendants and descendants, family members of Romanian citizens, irrespective of their nationality, family members of a citizen of one of the countries listed above, citizens of third countries, or beneficiaries of long term resident status in Romania, granted by one of the States abovementioned **(Article 563)**;

- the profession of pharmacist shall be exercised by persons who are not unworthy to exercise the profession, respectively **(Article 572)**:
  - they were not sentenced by a court for committing intentional crimes against humanity or life, in circumstances related to the profession of pharmacist that have not been rehabilitated;
  - no penalty of prohibition to practice pharmacy was imposed on the respective person either by a Court of law or by a disciplinary body, for a period established by a Court's decision or by a disciplinary decision;
- the profession of pharmacist is exercised by persons who are not incompatible to exercise the profession, respectively **(Article 573)**:
  - are not doctors;
  - they have no occupations (in addition to practicing pharmacy) likely to harm the dignity of the profession of pharmacist or morality, according to the Code of Ethics of the pharmacists;
  - their physical and mental health condition is suitable for practicing pharmacist profession *(Authors' note: this law does not expressly provide the type of evidence or certificate for the proving the health status);*
- the profession of pharmacist is exercised by persons who meet certain conditions, respectively **(Article 570)**:
  - have a formal qualification in pharmacy;
  - are not found in any of the cases of incompatibility or indignity above;
  - are medically capable of practicing the profession of pharmacist;
  - are members of the College of Pharmacists of Romania.

Emergency Ordinance no. 144/2008 on the profession of general nursing, midwifery, and the nursing profession, and the organization and functioning of the Order of General Nurses, Midwives and Nurses in Romania *(Authors' note: a "general nurse" has a broader training while a "nurse" has a narrower specialization (i.e. laboratory, nutrition, balneology, etc.)*

The Ordinance states in **Chapter I** the conditions for exercising the professions it regulates, respectively:

- the professions of general nurse, midwife and nurse are exercised in Romania by individuals holding a formal qualification in the profession of nurse practitioner, midwife, or nurse, respectively, and who are citizens of the Romanian state, nationals of a Member State of the European Union, of a State of the European Economic Area or the Swiss Confederation, the spouse of a Romanian citizen and direct ascendants and descendants, family members of Romanian citizens, irrespective of their nationality, family members of a citizen of one of the countries listed above, citizens of third countries, or beneficiaries of permanent resident status in Romania **(Article 1)**;
- the professions of general nurse, midwife and nurse are exercised by persons who are not unworthy to perform the profession, namely **(Article 14)**:
  - they were not sentenced for an offense related to the profession;
  - no sanction has been applied to prohibit their practicing the profession;
- the professions of general nurse, midwife and nurse are exercised by persons who are not in a

state of incompatibility, respectively, who do not exert actions that prejudice professional dignity under the Code of Ethics and Conduct of the General Nurse, Midwife and Nurse **(Article 15)**;

- the professions of nurse practitioner, midwifery and nursing can be practiced by people who meet certain conditions, namely **(Article 12)** they:
  - possess a formal qualification of nurse practitioner, midwife, or nurse;
  - are not in any of the cases of indignity and incompatibility described above;
  - are medically fit for the profession of nurse practitioner, midwife and nurse;
  - are members of the Order of General Nurses, Midwives and Nurses of Romania, with the exception of the cases of temporary or occasional provision of services, when foreign nurse practitioners, midwives and nurses must notify the Ministry of Health on providing temporary or occasional medical services in Romania and must be registered during this period at the Order of General Nurses, Midwives and Nurses in Romania.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

There are no supporting regulations, bylaws, or orders for the right to pursue professional activities.

D) PROVIDER CODE(S) OF ETHICS

The codes of ethics of the medical professions of doctor, dentist, pharmacist, midwife, nurse practitioner, and nurse do not contain provisions on the right to pursue professional activities.

E) OTHER RELEVANT SOURCES

No other relevant sources were identified at the moment of drafting this PG

F) PRACTICAL EXAMPLE(S)

1. Example of Compliance

Doctor X, a German citizen, informed the Bucharest College of Physicians that he will exercise his profession in Romania for two months in a row, in the specialty of cardiology. The College asked for several documents that Doctor X has turned in. During the legal term, the College admitted the doctor's request, so that the latter enjoyed his right to pursue professional activities without interference.

2. Example of Violation

In the previous example, if the doctor's request to practice temporarily in Romania were denied without a legal basis, then his right to pursue professional activities would have been infringed.

3. Actual Cases

At the time of writing this Guide no decisions of the courts of law on the right to pursue professional activities by medical professionals were found.

G) PRACTICE NOTES FOR LAWYERS

- In the case of doctors who are citizens of non-EU countries, according to Law no. 95/2006, republished in 2015, their right to practice the medical profession is linked to their right to permanent residence in Romania. Thus, a lawyer who is representing such a medical professional whose right to

practice medicine in Romania is debated in court/before authorities, must also analyse the Emergency Ordinance no. 194/2002 on the Legal Status of Foreigners in Romania, especially Chapter IV on prolonging the right for temporary residence and granting the right for permanent residence.

H) CROSS-REFERENCING INTERNATIONAL AND REGIONAL REFERENCES REGARDING THE RIGHT OF MEDICAL PROFESSIONALS TO PURSUE PROFESSIONAL ACTIVITIES

- Please find a discussion of international and regional standards relevant to the Rights to Due Process in Chapter 2 (International) and Chapter 3 (Regional).
- Also see: Article 6 of the International Covenant on Economic, Social and Cultural rights;
- Comment 18 of the Committee on Economic, Social and Cultural rights, paragraph 4;
- Article 1 of the European Social Charter.

7.2 Providers' Responsibilities

7.2.1 The Obligation to Provide Emergency Medical Treatment

A) MEDICAL PERSONNEL ARE REQUIRED TO ENSURE EMERGENCY MEDICAL ASSISTANCE TO ANY PERSON WHETHER OR NOT THE PERSON CAN PAY FOR THE SERVICES PROVIDED.

The obligation of medical personnel, particularly doctors, to provide emergency medical treatment is correlative to the right of respect for patients' time. A broad development of that patient right was given in section six of this material. However, in the following section there are several key elements contained in the relevant legislation that reflect the obligation for the doctors to provide emergency medical treatment.

B) OBLIGATION AS STATED IN THE CONSTITUTION / LEGISLATION

Constitution

- **The Romanian Constitution of 1991, revised in 2003**

  The doctors' obligation to provide emergency medical assistance is not directly specified by the Constitution.

  However, **Article 34** (on the right to health protection) establishes that the right to health protection is guaranteed; the State is obliged to take measures to ensure public hygiene and health, and to establish through law the organization of healthcare and social security system for sickness, accidents, maternity and recovery, the control of practicing the medical professions and paramedical activities, and other measures to protect the physical and mental health of the person.

Legislation

- **Law no. 95/2006 on Health Reform, republished in 2015**

  Title IV of Law no. 95/2006 governs the national emergency care and qualified first aid (discussed in Section 6 of this Guide). The law establishes obligations regarding medical personnel in rendering emergency medical services, as well as organizing public and private ambulance services, including emergency assistance in the event of collective accidents, calamities and disasters in the pre-hospital phase.

  The following articles specifically establish the obligation of healthcare providers to provide emergency medical assistance:

  - **Article 6 letter h) pct. 2**, sets out the main areas of intervention of the public healthcare, including emergency services in the event of disasters and calamities;
  - **Article 32** identifies the units providing emergency medical assistance, respectively the specialized emergency units and medical transport, public or private, as well as emergency accommodation structures, organized for this purpose;
  - **Article 67, letter e)** establishes the obligation for the family doctor to ensure continuity of primary medical care in emergency consultations registered through the national emergency system, outside the normal working hours of the family medicine practices and also the on-call regime, through permanent centres;

- **Article 105 establishes**
  - the levels at which the pre-hospital emergency public assistance is organized at rural, urban, county / Bucharest and regional level, *from certified first aid so that there are teams in rural areas, to the air rescue intervention with trained medical personnel operating at the regional level*. **(paras. (1) and (2))**;
  - the hospitals where emergency care is granted, i.e. city, municipal, county and regional hospitals, and those of the Bucharest Municipality, as well as those of the ministries and public institutions with their own sanitary networks **(para. 5)**;
  - *expresis verbis* that qualified first aid and **emergency medical assistance is granted without discrimination related, but not limited to, income, gender, age, ethnicity, religion, nationality or political affiliation, whether or not the patient has medical insurance status (para. (7));**
  - the obligation of the medical and paramedical personnel trained in qualified first aid to grant First Aid outside their working hours, regardless of the place, spontaneously or upon request, to vital endangered people, until their takeover by a specialized intervention team **(para. (8))**;
  - the possibility that in special cases, the public health emergency teams and the trained first aid teams can provide emergency assistance, also outside their areas of geographic responsibility, upon request of the emergency dispatchers **(para. (9))**;
  - the obligation of the organizer of outdoor shows, festivals and sporting events to seek ensuring emergency care, signing contracts in this regard with private or public pre-hospital emergency services; otherwise, the events in question will not be approved by the competent authorities.
- **Article 109** establishes the obligation of county and regional emergency hospitals to accept the transfer of critically ill patients, if the hospital or centre where the patient is originally admitted does not have the human resources and / or materials needed for properly and finally granting emergency assistance, if the transfer is necessary in order to save the patient's life;
- **Article 111**
  - establishes the obligation of private medical services in case of a hospital emergency *to stabilize any patient who arrives in that service in a critical state or complains of issues that raise suspicion of a serious acute condition, regardless of the patient's financial capacity to pay the costs of treatment or his quality of insurance; the patient will be taken to a public hospital only after stabilizing the vital functions and providing emergency treatment* **(para. (3))**;
  - establishes the obligation for private hospitals to provide first aid and alert the public emergency services through the unique emergency number 1-1-2, if they don't have on-call services in their structure **(para. (4))**.
- **Article 112, para. (2)** sets out the main aim of the county ambulance services and of the Bucharest Municipality, namely to provide emergency medical assistance and assisted medical transportation;
- **Article 124, para. (1)** refers to the competent bodies in coordinating response to collective accidents, calamities and disasters when emergency care is needed; these bodies include the county inspectorates for emergencies, and those of Bucharest Municipality, or direct activity by the General Inspectorate for Emergency Situations under the national approved plans;
- **Article 168, para. (1)** establishes the obligation for any hospital to grant first aid and emergency care to anyone who comes to the hospital, if his/her health condition is critical. After stabilizing the vital functions of the patient, the hospital will provide, if appropriate, compulsory medical transport to another healthcare facility which has the proper resources (including proper means, sections and professionals) to treat the patient. The hospitals must always be prepared for providing medical assistance in case of war, disasters, terrorist attacks, social conflicts and other situations of crisis and are required to respond with all their resources to eliminate the effects thereof;

- **Article 230, para. (2), letter h)** establishes the right of the persons insured under the public health system to benefit from emergency medical services;
- **Article 421, letter c)** establishes that among the obligations of the members of the Romanian College of Physicians, arising from their special certification as doctors, is the responsibility to provide prompt and unconditional emergency medical care, as a fundamental, professional and civic duty;
- **Article 519, letter c)** establishes that among the obligations of the members of the Romanian College of Dentists, arising from their special certification as dentists, is the responsibility to provide prompt and unconditional emergency medical-dental care, as a fundamental, professional and civic duty;
- **Article 596, letter e)** establishes that among the obligations of the members of the Romanian College of Pharmacists, arising from their special qualifications as pharmacists, is the responsibility to promptly provide pharmaceutical emergency assistance, as a fundamental, professional and civic duty;
- **Article 663, para. (3)** establishes the obligation of the medical personnel, doctor, dentist, nurse / midwife to accept emergency patients, when the lack of medical care can endanger, seriously and irreversibly, the health or life of the patient.

Law no. 46/2003 on the Rights of the Patient

The law establishes *expresis verbis* under **Article 36** the right of the patient to emergency medical care in emergency dental care and pharmaceutical services, in an ongoing program. The medical staff is obliged to provide these services, even when there is no equipment, necessary conditions and approved personnel **(Article 30)**.

The medical personnel will provide the patient with emergency care, even when the patient is unable to express his/her will, and without needing the consent of the legal representative, in expressly provided exceptional cases **(Articles 14 and 15)**.

Emergency Ordinance no. 144/2008 on the general nursing, midwifery and nursing professions, as well as the organization and functioning of the Order of General Nurses, Midwives and Nurses in Romania

- **Article 7 letter g),** establishes, among the specific activities of midwifery, also the requirement that in critical situations, they must administer emergency measures to be taken in the doctor's absence, particularly those included in the manual for removal of the placenta, possibly followed by a manual examination of the uterus.

C) SUPPORTING REGULATIONS/BYLAWS/ORDERS

Order of the Ministry of Public Health no. 2021/2008 approving the Norms Implementing Title IV „The national system of emergency care and trained first aid" of Law no. 95/2006 on healthcare reform

This Order provides the implementing rules in the field of integrated public emergency care.

In terms of the medical personnel obligation to provide emergency care to patients, the Norms distinguish between the pre-hospital phase and the hospital one. Thus, **Article 2** determines that for the pre-hospital phase, the integrated intervention for medical emergencies during the pre-hospital phase is provided simultaneously, sequentially or independently, on the following **levels**:

- I) Qualified first aid, *provided by teams with specific training* specialized in first aid,
- II) emergency consultations at home, provided by *general practitioners, doctors in the specialties: internal medicine, paediatrics and medical residents starting from the third year of training in the*

specialties listed in the agreement with the program director or coordinator, under the coordination of the medical dispatches of the public ambulance service or the integrated dispatches where available,

- III) emergency medical assistance at the team level led by a *medical assistant with specific training in emergency medical assistance,*
- IV) emergency medical assistance at the team level led by a *doctor who has competence / is certified in emergency medicine or, a primary or specialist doctor in emergency medicine without a job in an emergency unit,*
- V) mobile intensive care at the level of *resident doctor starting with the third year / primary or specialist doctor in emergency medicine or anaesthesia intensive care, with the main job in a hospital.*

The Norms also list the categories of personnel who grant integrated public pre-hospital emergency assistance, at all levels, namely **(Article 3 of Annex 2)**:

- I) Doctors with the Emergency Medicine Specialty,
- II) Doctors with the Anaesthesiology and Intensive Care Specialty,
- III) Doctors with competences/certificate in the pre-hospital emergency medicine,
- IV) Family doctors or general practitioners,
- V) Resident doctors with the emergency medicine specialty, intensive care anaesthesiology from the second semester of the third year of training, with the consent of the Director or Coordinator of the Residency Program,
- VI) Residents in the specialty of family medicine and internal medicine starting with the first semester of the third year of training with the consent of the Director or the coordinator of the residency program,
- VII) Nurse practitioners with certification / training in emergency medical assistance,
- VIII) Paramedical personnel with specific training in qualified first aid and in team emergency care,
- IX) Ambulance drivers with specific training in basic first aid and team emergency care,
- X) Volunteers with specific training in emergency medical assistance and team qualified first aid.

Ministry of Health Order no. 1706/2007 on the management and organization of the emergency receiving units and departments (UPU and CPU/ER)

Relevant for the obligation to provide medical treatment is **Chapter IV** of the Order relative to receiving patients and rendering emergency medical assistance in the emergency receiving unit (UPU) and the emergency receiving department (CPU).

The Order defines the UPU and CPU:

1. Emergency receiving unit (UPU) is the department or ward of a district, regional hospital or of hospitals belonging to ministries and institutions with their own health networks, with dedicated staff specially prepared to provide patients with the proper triage and emergency treatment of patients;

2. Emergency department reception (CPU) is a department within the structure of a city or municipal hospital, or in hospitals belonging to ministries and institutions with their own health networks, with dedicated staff specially prepared to provide patients with the proper triage and emergency treatment of patients. *(Authors' note: Consequently, depending on the type of the hospital - district, regional, city, municipal - it will either have an UPU or a CPU).*

- **Article 41** establishes the obligation of the CPU personnel to provide emergency care for the patient in critical condition, within the CPU personnel's competence and training. *The personnel are required to call the on-call experts in the hospital or at home, in cases requiring their involvement in emergency medical assistance and possibly in definitive treatment.*

Under **Articles 42 and 43** of the Order, the UPU and CPU wards are open to all patients who require emergency medical assistance after the occurrence of acute new symptoms or for acute episodes of chronic diseases. It is *strictly prohibited to deny emergency medical care to a patient who requests it* without assessing his/her condition by a doctor from the UPU or CPU, and to establish the lack of conditions that require medical treatment within the UPU / CPU and the possible hospitalization of the

patient.

Also, **Article 16** establishes the obligation of health units in which the CPU or UPU units are dissolved, on county capital level, to receive the patients assisted in the UPU from the respective municipality.

Expression of the obligation to provide emergency treatment is the obligation imposed by **Article 17** in the responsibility of the doctors on call within specialized medical units and outer wards, other than children's hospitals, to ensure a receiving unit for specific cases, even if there are no CPU or UPU wards.

Physicians in the specialty of orthopaedics and traumatology are required to also ensure consultations within the UPU / CPU, at the request of the doctors on call in these structures, for the patients with orthopaedic injuries, under **Article 49**.

The doctors on call at the hospital are required to respond promptly to a ER or CPU call, regardless of the time of the request, whenever the on-call doctor in the UPU or CPU deems it necessary. For the patients who are critically ill or whose state requires immediate specific professional consult, the on-call doctors from the hospital are required to arrive at the UPU or CPU within 10 minutes from the time of request, under **Article 59.**

In order to get expert advice for treating a patient in critical condition in the UPU or CPU, the personal presence of the on-call doctor in charge from the ward requesting the consultation is mandatory. The on-call doctor in charge of the ward is bound to personally consult the patient at the moment of the patient's discharge, if at the time he was called he/she was in the operating room or was involved in treating another patient in critical condition in the hospital **(Article 60)**.

- **Article 62, para. (6)** imposes on the hospital laboratories and imaging services the obligation to give priority to the investigations requested from the UPU or CPU.
- **Article 92, para. (4)** imposes on the personnel of the wards to begin basic resuscitation manoeuvres until the arrival of the intervention team.

Methodological Norms for applying in 2014 the Government Decision no. 400/2014 approving service packages and the Framework Contract which regulates the conditions for medical assistance within the social health insurance system for the years 2014-2015, of 30.05.2014

- **Annex 1 to the Norms, letter A, point 1,** establishes the minimal package of health services in primary care, for uninsured people, that in addition to other medical services, also includes medical and surgical emergency **(sub-point 1.1)**. The emergency medical services for the medical-surgical emergencies include medical history clinical examination and treatment and are given within the competence and technical equipment of the practice in which the family doctor operates.
- **Annex 1, letter B point 1,** establishes that the basic package of health services in primary care, for insured people, that in addition to other medical services, includes medical and surgical emergencies, acute, sub-acute diseases, flares of chronic conditions and chronic diseases (sub-point 1.1). Curative medical services for medical and surgery emergency involve history, clinical examination and treatment provided within the competence and technical equipment of the practice in which the family doctor operates **(sub-point 1.1.1)**.
- **In Annex 7, letter A** concerning the minimal package of health services in outpatient specialist care for clinical specialties, it is established that in this package are included surgical emergency consultations (pt. 1, sub-point. 1.1). The medical services for the medical and surgical emergencies include medical history, clinical examination and treatment and are given within the competence and the technical equipment of the practice in which the specialist doctor operates.
- **Annex 22 of Chapter II, point 1, letter a)**, on the criteria upon which the admission of patients is based and is performed under continuous hospitalization, establishes also as one of the criteria that of medical surgical emergency where the patient's life is endangered or potential for life endangerment exists until solving the emergency. **Point 3** establishes a hospital's obligation to

provide emergency medical services, patient assessment and discharge thereof, if the emergency care is no longer justified.

D) PROVIDER CODE(S) OF ETHICS

- **Code of Medical Deontology of 30 March 2012 of the Romanian College of Physicians**

  Implicitly, the provisions of **Article 15** of the Code show the doctor's obligation to act in medical emergencies, even – in exceptional cases – without the patient's consent.

- **Code of Professional Ethics of Dentists**

  The Code of Ethics of Dentists contains two articles that implicitly show the obligation to provide emergency medical assistance:

  - **Article 12, para. (2)** according to which the dentist, *except in cases of emergency*, has the right to refuse a patient for professional or personal reasons;
  - **Article 15** which states that the dentist may provide medical dental care without the consent of the patient or the patient's legal representative, only in emergency cases.

- **Code of Ethics of Pharmacists – Annex to the Romanian Pharmacists College Decision no. 2/2009**

  The Code of Ethics of Pharmacists establishes the obligation for the pharmacists to provide emergency medical assistance in the following Articles:

  - **Article 31, para. (1)** which provides that, *in order to ensure continuity of assisting the population with drugs, the pharmacists must provide emergency pharmaceutical services;*
  - **Article 32** establishes, *in order to achieve within the best conditions emergency pharmaceutical services, the pharmacist's obligation to provide first aid within his/her competences, and to seek the intervention of specialized services, informing the specialized services personnel about the action taken on his/her own initiative;*
  - **Article 33, para. (1), letter f)** establishes the situations in which the pharmacist can dispense drugs without a prescription, *including other emergencies in which the pharmacist will decide, as appropriate, whether to release a drug for a limited time, until receiving a prescription, with the guidance of the family doctor, the health or continuous care centre or the compartment or emergency unit, or by calling the emergency number 112;*
  - **Article 33, para. (2)** provides the possibility to the rural pharmacies *to provide emergency pharmaceutical services also if in the village where there are no medical practices or the doctor is not present.*

- **Decision no. 2 of 9 July 2009 of the Order of General Nurses, Midwives and Nurses from Romania on the adoption of the Code of Ethics and Deontology of the General Nurses, Midwives and Nurses in Romania**

  Obligation of the medical personnel to render emergency medical care results from the following articles of the Code:

  - **Article 28** establishes the obligation of the general nurse, midwife and nurse not to refuse to provide care in emergency situations;
  - **Article 32, letter a)** determines that no consent is required from the patient or the legal representative when an emergency medical intervention is required;
  - **Article 41, para. (2)** determines that it is not necessary to obtain the consent of the patient with mental disorders when urgent intervention is needed;

- **Article 53** establishes that in the case of a minor patient, in emergency situations, any technical and / or care manoeuvre and / or treatment can be performed without the consent of the minor's legal representative.

E) PRACTICAL EXAMPLES

1. Example of Compliance

Patient X was brought to the Y hospital ER unit, being unconscious. The doctor on call was called in and immediately assembled a team and decided that the patient was ready for surgery, although the patient had not given consent for this purpose, because he was unconscious. The action taken by the doctor was essential to save the patient's life.

2. Example of Violation

Patient X presented himself to the emergency unit of the public hospital Y describing unbearable pain in the abdominal area. Upon registration in the records of receiving the emergency, the patient was asked if he was insured by the national health system. The patient was not, and he was refused admission. He was told that if he wanted to be urgently received he must immediately pay the amount of the medical services.

3. Actual Cases

Case no. 1 – Cancellation of an administrative act. Rejection: the doctor's duty to give care in the ICU

The referring court (the Court), by sentence no. 642 / 24.11.2010, dismissed the claimant F.C. - doctor, on the annulment of decision no. 39/2010 issued by the Romanian College of Physicians and of the Decision no. 6/2009 issued by the Olt College of Physicians.

The court noted the following facts:

- the complainant F.C., doctor, was sanctioned by the Disciplinary Committee of the Olt College of Physicians applying the sanction of prohibiting the right to practice the medical profession for a period of six months, and he was ordered to take 20 hours of training courses and medical education in the field;
- the disciplinary investigation was ordered because on 22.01.2009, at 13.30 hrs, the patient C.M. was taken to the emergency ward of Slatina County Hospital where he was diagnosed by the complainant (Dr. F.C.) with malnutrition of degree II / III, blood pressure of 120/70 mm Hg and sent to the Chronic Diseases ward;
- from the Chronic Diseases ward the patient was returned to the ER and then sent to the Internal Diseases ward where he was consulted by another doctor and later returned to the Chronic Diseases ward; from here the patient was again sent to the ER where he died;
- from the medical-legal information, results showed that the death was due to acute cardio-circulatory failure, as a consequence of a myocardial stroke;
- from the content of the documents in the case file and the testimony of the people involved in the event, it was found that related to the patient C.M. who died, complete clinical and laboratory tests were not performed, nor were his vital signs established at his arrival at the emergency room, when he was received by the complainant;
- according to Health Ministry Order no. 1706/2007 on managing and organizing the emergency units and departments receiving emergencies, the on-call doctor has among his duties the obligation to perform the consult and investigations that are required for the patient or the ability to call to the ward the doctor on call in the intern ward;
- it was also found that the patient in question was not monitored, tested or treated within the return to the UPU, and that there is no record or statement on the performance of resuscitation manoeuvres to the patient by the doctor within the UPU;

- it was also found that the records that needed to be filled in for each patient received in the UPU ward did not exist, although in the time frame 13.30 - 17.00 there was no massive influx of patients, as stated by the persons interviewed;
- also, from the produced evidence it was proved that the UPU unit from the hospital had the necessary equipment to carry out all examinations and testing for a diagnosis and emergency treatment, and the manoeuvres necessary to treat and resuscitate the patient (subsequently).

Accordingly, the court held that the applicant did not comply with Article 57[833] or Ministry of Health Order no. 1706/2007 and also breached the provisions of Article 53[834] of the medical ethics code through the passive attitude shown. Therefore the court upheld altogether the provisions of the contested decisions.

Case no. 2 – Cancellation of an administrative act. Failure to provide timely medical care

The Prahova County Court through sentence no. 102 / 03.03.2009 upheld the decisions sanctioning the plaintiffs F.V., MD in plastic surgery, and P.O., emergency medicine physician. The trial parties were the plaintiffs and the defendant Bucharest College of Physicians.

From the evidence produced, the court noted the following facts:

- the complainant doctors were sanctioned through the contested decisions, each with a fine of 1,000 lei and were required to take a training course in emergency medicine;
- on 07.23.2006, at 4.35 hrs., the patient C.A. presented himself to the emergency department of the emergency county hospital in Ploieşti, with a left temporal scalp contusion wound of approximately 2 cm contaminated, consequent to an aggression (he was hit with a rock during a mission, the patient being a professional gendarme);
- he was examined by the complainant F.V. (a plastic surgeon) who determined that there was no change of the focal neurological type and that the skull radiographs revealed no injuries;
- the wound was sutured; tetanus vaccine was administered by a nurse and not by the doctor; and then the patient was taken to the plastic surgery department for advice. The complainant consulted the patient and sent him home advising the patient to return if the condition worsened;
- the patient returned to the ward at 6.00 hrs and was accommodated in the cloakroom, on a chair;
- at 7.20 hrs, the complainant P.O. (emergency physician) was notified by telephone of the patient's arrival, but she, without examining the patient, decided that he should await the arrival of the neurosurgeon on call, MD Z.V.;
- at 8.35 hrs, the ER MD N.M. found that the patient's state was worsening and that he was in a coma; Dr. N.M. decided to take a cranial-cerebral CT scan. Following the procedure, a voluminous epidural hematoma left TP with mass effect and a left T skull fracture was observed. Only then was the neurosurgeon informed;
- at 10.05 hrs, the neurosurgeon operated on the patient who remained in a coma;
- after the surgery the patient was taken to the intensive care unit; and at 8 o'clock on the day of 24.07.2006 he was moved to the ward. The patient's condition remained very serious, and he died on 26.07.2006 due to cardio- respiratory arrest;
- during the disciplinary investigation, the Superior Discipline Commission concluded that in this case an important role was played by the poor organizational conditions for emergency neurosurgical care in the hospital, and especially the lack of a neurosurgeon on call;
- regarding the complainant F.V., it was held that the doctor did not record data in the patient's history file, suggesting a superficial consultation. Moreover, according to the internal memo, by not admitting the patient to the hospital for bed rest, even though hospitalization was required in this case,

833 Article 57: The doctors specialized in various specialties of the hospital are invited to consult after the ER has established a presumptive diagnosis based on final examinations and investigations, except for patients in critical condition, where, if necessary, the call of specialists from different sections may be necessary from the first moment of the arrival of the patient in the ER.

834 Article 53 quoted by the court has no counterpart in the new Code of ethics of the date of writing this Guide. At this point Article 5 will be considered (the doctor should make all efforts and ensure that any intervention of a medical nature that he performs or a professional decision he makes are compliant with the norms and professional obligations and rules of conduct of the case in question) and respectively Article 8 (the doctor will devote all his knowledge and skill in patient interest and put all due diligence to ensure that the decision taken is correct and the patient benefits from maximum guarantees in relation to the concrete conditions so that his health does not suffer) in the Code.

shows negligence of the complainant F.V.;

- regarding the applicant PO – the ER MD on call when the patient returned to the emergency, it was held that she did not consult the patient even though consultation was mandatory, nor did she request the consult of the neurosurgeon, resulting in loss of extremely precious time;
- Moreover, according to the protocol (Authors' note: protocol of the hospital) the neurosurgical patients will be screened by the doctor on call at the ER ward -in this case the complainant PO, and the doctor on call at the ER will require a neurologist for cases with signs of outbreak specific to a condition which requires neurologic consult. The neurosurgeon will decide the appropriateness of admission and will prescribe the treatment.

The court concluded that the patient died as a result of several factors, including lack of proper care, meaning that doctors did not provide the patient with timely, quick, effective and proper care. Consequently, the court rejected the plaintiffs' action.

F) PRACTICE NOTES FOR LAWYERS

- First, lawyers must consider the relevant provisions on the compulsoriness of the medical staff to provide emergency medical assistance. As shown, the law and medical ethics code set *expresis verbis* that requirement.
- Secondly, in relation to the actual facts of their case, lawyers must analyze whether the patient's situation can be described as a medical emergency. In order to do so, before initiating litigation, it is helpful to consult with medical experts who can issue specialty opinions on the emergency nature of the patient's problem.
- Equally, even if absurd, if in emergency situations, the medical personnel would not be required by law to act; or if there is a specific exception to this requirement, when it comes to establishing the liability of the persons responsible, the moral obligations that they have as members of their profession should also be considered.
- In regard to specific criteria used to determine whether a particular case is an emergency, the authors did not identify such criteria established by a particular law or a bylaw in research for this guide. Only Law no. 95/2006 defines what a medical emergency is, respectively an acute injury or illness that requires qualified first aid and / or emergency medical assistance according to one or more proficiency levels, as appropriate. It can be a life-threatening emergency, where it is necessary / required for one or more resources to intervene in the pre-hospital phase, continuing care in a local, county or regional hospital; or a medical emergency may refer also to the situation when the patient's condition is not a life-threatening emergency, where health care can be provided, with or without the use of pre-hospital resources, or in an authorized medical office or, where appropriate, to a hospital **(Article 92, para. (1), letter e)** from Law no. 95/2006 on the Health Reform, republished in 2015).

8

National Procedures

8.1 Mechanisms to Protect/Enforce Rights and Responsibilities

In Romania, the protection of rights (including the patients' rights) is mainly achieved by the following mechanisms:

- Administrative protection
- Court of law protection: civil and criminal proceedings
- Alternative mechanisms

The principles and mechanisms for the protection of rights are established in principle by the Romanian Constitution, especially in the following articles:

Article 16: Equality of rights

(1) Citizens are equal before the law and public authorities, without any privilege or discrimination.

(2) No one is above the law.

(3) Access to public, civil, or military positions or dignities may be granted, according to the law, to persons whose citizenship is Romanian and whose domicile is in Romania. The Romanian State shall guarantee equal opportunities for men and women to occupy such positions and dignities.

(4) After Romania's accession to the European Union, the Union's citizens who comply with the requirements of the organic law have the right to elect and be elected to the local public administration bodies.

Article 20: International treaties on human rights

(1) Constitutional provisions concerning the citizens' rights and liberties shall be interpreted and enforced in conformity with the Universal Declaration of Human Rights, with the convenants and other treaties Romania is a party to.

(2) Where any inconsistencies exist between the covenants and treaties on the fundamental human rights Romania is a party to, and the national laws, the international regulations shall take precedence,

unless the Constitution or national laws comprise more favourable provisions.

- **Article 21: Free access to justice**

  (1) Every person is entitled to bring cases before the courts for the defence of his legitimate rights, liberties and interests.

  (2) The exercise of this right shall not be restricted by any law.

  (3) All parties shall be entitled to a fair trial and a solution of their cases within a reasonable term.

  (4) Administrative special jurisdiction is optional and free of charge.

- **Article 22: Right to life and physical and psychic integrity**

  (1) The right to life, as well as the right to physical and mental integrity of person are guaranteed.

  (2) No one may be subjected to torture or to any kind of inhuman or degrading punishment or treatment.

  (3) The death penalty is prohibited.

- **Article 24: Right to defence**

  (1) The right to defence is guaranteed.

  (2) All throughout the trial, the parties shall have the right to be assisted by a lawyer of their own choosing or appointed ex officio.

- **Article 51: Right to petition**

  (1) Citizens have the right to address the public authorities by petitions formulated only in the name of the signatories.

  (2) Legally established organizations have the right to forward petitions, exclusively on behalf of the collective body they represent.

  (3) The exercise of the right of petition shall be exempt from tax.

  (4) The public authorities are bound to answer to petitions within the time limits and under the conditions established by law.

- **Article 52: Right of a person aggrieved by a public authority**

  (1) Any person aggrieved in his/her legitimate rights or interests by a public authority, by means of an administrative act or by the failure of a public authority to solve his/her application within the lawful time limit, is entitled to the acknowledgement of his/her claimed right or legitimate interest, the annulment of the act and reparation for the damage.

  (2) The conditions and limits on the exercise of this right shall be regulated by an organic law.

  (3) The State shall bear patrimony liability for any prejudice caused as a result of judicial errors. The State liability shall be assessed according to the law and shall not eliminate the liability of the magistrates having exercised their mandate in ill will or grave negligence.

8.2 Administrative Procedure

Claiming a right and defending it in administrative procedures is based on the **Romanian Constitution** of 1991, revised in 2003. **Articles 51 and 52** recognize the fundamental right of citizens to address public authorities by petitions or to address a claim to the Court within the statutory period established by the special law, against acts issued by public authorities or against the public authorities' refusal to answer the petitioner. The petitioner aims through these claims to get recognition of his/her right, or to get the annulment of the unlawful administrative act, and also to receive damages for the harm done to the petitioner.

8.2.1 General Description

When individuals in general and patients in particular are guaranteed certain rights by the state, correlatively, there is a state's obligation to provide the means to defend the existence and exercise of those rights. The violated right can be defended or protected by the holder of that right by appealing to administrative means for the protection of that right. *(Author's note: patients' appeals to administrative means for recognition and protection of their rights related to the State's obligation to ensure and safeguard the patients' life and provide the means for health care or for healthcare providers to fulfil legal or contractual obligations should be the rule, and appealing to the courts should be the exception, given certain conditions that make this latter procedure more cumbersome and costly. We consider formalism, starting with a certain form required for the claims, the costs consisting of stamp duties or value of different expert reports or cost of legal aid, specific procedures, longer duration, etc.)*

Substantially, defending a right administratively consists in the claimant's right to request and obtain through pleadings, requests, complaints, intimations, objections - referred to as petitions - the protection of the right allegedly infringed or unrecognized. The petitions may be addressed to the public authority or institution or healthcare provider who in some way or another violated his right or to a superior body with attributions of control over the activity of the former.

The are competent authorities in the field of health care for the purposes stated above, the Ministry of Health, the National Health Insurance House, District Health Insurance Houses, the Romanian College of Physicians, the Romanian College of Pharmacists, the Romanian College of Dentists, and their territorial structures, all under Law no. 95/2006 on the Health Reform, republished in 2015. *(Authors' note: the nursing and midwife profession is regulated by a different law – Emergency Ordinance 144/2008 on the practicing of general nurse, midwife and nurse, and the organization and functioning of the Order of Nurses Midwives and Medical Assistants in Romania)*

Apart from the abovementioned authorities, the persons concerned can call for the administrative defence of the rights related to health by addressing two important institutions in this area, respectively the Ombudsman[835], and the National Supervisory Authority for Personal Data Processing[836]. The purpose for which these institutions were established is precisely to provide to persons the legal grounds and procedural means to administratively protect their rights.

The administrative procedure is non-contentious and is a procedure by which the individual requests:

- the public authority or institution or healthcare provider who violated, hurt or disregarded some right, to review the situation and where appropriate to reconsider a decision, to order a certain measure, or to do or not to do something;
- the superior body of the authority or institution mentioned above at point (a) to intervene based on the subordination relations that exist and to request or ask, as appropriate, to restore legal order and respect

835 The Ombudsman is operating under Law no. 35/1997 on the organization and functioning of the Ombudsman published in Official Gazette Part I no. 27 of 15.04.2014.

836 The supervisory authority of the processing of personal data was organized and is operating under Law no. 677/2001 for the protection of individuals in regard to the processing of personal data and on the free circulatron of such data published in Official Gazette Part I no. 790 of 12 December 2001

the rights;

- the competent public authority, to exercise its legal powers for the purposes of determining the recognition or respect of the right.

8.2.2 The Petition

The petition is the main instrument through which the violated rights can be administratively defended in that, as shown, the request is addressed to the competent public authority or institution or the hierarchically-superior body so that the latter (using the subordination relations) orders a certain measure.

Government Ordinance no.27/2002 on regulating the solution of petitions

The notion of petition has, under **Article 2 of Government Ordinance no. 27/2002** on regulating the solution of the petitions, a broad meaning. The term "petition" covers requests, complaints, or suggestions formulated in writing or submitted by electronic mail.

Under the same **Article 2**, the petition is addressed to central and local public authorities and institutions, decentralized services of the ministries and other central bodies, companies and national corporations, trading companies of county or local level, as well as autonomous administrations, hereinafter referred to as public authorities and institutions.

The essence of the legal concept of "petition" is that through the petition, the complainant generally requests the correction of a factual situation, action or inaction of an authority, institution, a healthcare provider or a particular organizational structure.

Ordinance no. 27/2002 is the common law relating to petitions and contains rules on:

- a) the right of citizens and legally-constituted organizations to submit petitions in their own name or the collective body they represent **(Article 1)**;
- b) the meaning of the concept of petition **(Article 2)**;
- c) to whom is the petition is addressed **(Article 2)**;
- d) measures that public authorities and institutions or other institutions and bodies must have in place in order to ensure the implementation of the law and ensuring the possibility of exercise of the right to petition **(Articles 5** and **6);**
- e) deadlines for filing a petition **(Articles 3, 6[1], 8** and **9);**
- f) the person responsible for organizing the petition settlement mechanisms **(Article 4);**
- g) the duties of the authority in relation with the petitioner **(Articles 6[1]** and **8);**
- h) internal procedure for filing the petition **(Articles 5, 6., para. 1** and **4, Articles 7, 9, 10, 11, 12 and 13;**
- l) penalties in the event of failure to comply with the legal provisions concerning the right of individuals to submit petitions **(Article 15)**.

Although the Ordinance does not expressly regulate the content of the petition, from the systematic and teleological interpretation of the text of the law, it is clear that this must include at least the following elements:

- a) the identification data of the petitioner; if the petition is submitted by the lawyer, there will be proof of representation, by attaching the power of attorney to the petition;
- b) petitioner's contact details for the authority's communication of the reply;
- c) description of the facts;
- d) revealing the aspects which, according to the petitioner, represent an injury to a specific legal right;
- e) the actual claims of the petitioner regarding the desired result;
- f) documents can be indicated or annexed to the petition, to certify the relevant matters or aspects that may be of particular relevance to the alleged violation or injury, if these documents exists or can be produced;
- g) petitioner's signature or, if the case may be, the lawyer's signature.

8.2.3 Specific Administrative Paths to Protect the Rights of Patients

A. PROCEDURES BASED ON LAW NO. 95/2006 ON HEALTH REFORM, REPUBLISHED IN 2015

The law contains extensive regulations on the organization and functioning of the health system in Romania, including the financing of the system and health insurance, rights of the patients and insured persons, exercise of the medical profession, organization and functioning of the health care institutions and the authorities for medical professions, liability of healthcare providers and the legal status of the drugs. *(Authors' note: the specific provisions as applicable to this Guide are discussed throughout the text in Chapters 5 to 7)*

According to the law, a number of public authorities and institutions have explicit powers and responsibilities to ensure and guarantee the proper functioning of the medical system in Romania. Depending on the complained facts and the duties and responsibilities of each authority or institution under the law, petitions may be formulated to ensure compliance with these rights.

According to this law, the authorities and institutions responsible for the proper functioning of the health system are:

- 1) Ministry of Health and its decentralized structures or public health departments;
- 2) The National Health Insurance House and its territorial structures, namely the district health insurance houses, and that of the Municipality of Bucharest;
- 3) Romanian College of Physicians;
- 4) Romanian College of Dentists;
- 5) Romanian College of Pharmacists.

(Authors' note: the nurse and midwife professions are not regulated by law 95/2006, but by Government Ordinance 144/2008.)

Depending on the tasks and responsibilities that each institution has, people whose rights have been violated in the context of medical or health services can address petitions to the respective institutions.

Competent public authorities and institutions under Law no. 95/2006 on the Health Reform, republished in 2015

The Ministry of Health represents the central authority and has responsibilities related to public health, national health programs and their funding, organization and functioning of the entire health system in Romania, including emergency and first aid. The duties shall be exercised by the Ministry of Health either by issuing, under the law, of normative acts, or by coordination activities, monitoring, control, approval or authorization, as appropriate.

The District Public Health Authorities are deconcentrated structures of the Ministry of Health in their area of supervision, namely the territorial administrative unit, and carry out a series of tasks related to the coordination, supervision, control and authorization of medical services. In the same measure, a range of competences and duties of the Ministry of Health such as those related to national health programs, public health, authorization or approval of certain medical activities are carried out with the participation of public health departments, based on their legal duties.

The National Health Insurance House is a specialized body of the central government which administers and manages the health insurance system having a number of tasks and responsibilities in ensuring patients' rights to medical services. Mainly, The National Health Insurance House ensures:

- the development of the framework contract, which is a fundamental document regarding the rights of the ensured persons **(Article 229, para. 2)**;
- implementing the Government policies and programs coordinated by the Ministry of Health in the health sector **(Article 276)**;
- the operation of health insurance system **(Article 280)**.

The district health insurance houses, and that of the Municipality of Bucharest, are subordinated territorial structures of the National Health Insurance House which enable effective enforcement and operation of the law, through signing and tracking the performance of medical services supply contracts with various health care providers. These contracts with the healthcare providers are concluded both based on Law 95/2006 on the Health Reform, as well as based on following the framework contract and its implementing rules. The framework contract is approved by Government Decision for a period of 2 years and the rules for applying the framework contract are approved by joint order of the Ministry of Health and the President of the National Health Insurance House.

When a person intends to claim or defend some rights related to health insurance or healthcare, these two laws are essential. It might also be the case that the help of specialist doctors and lawyers is necessary in order to correctly interpret the provisions of these laws, given the highly technical nature of the two acts, the complexity of the legal relations and the mixture of legal terminology with the medical one.

The Romanian College of Physicians, the Romanian College of Pharmacists, the Romanian College of Dentists and their territorial structures are public bodies whose main responsibility is to ensure the exercise of the health care professions in good conditions, according to professional standards, and in the public interest of the respective professions. In its specific area of expertise, each professional body shall develop and adopt rules of professional conduct for the exercise of their profession and monitor their implementation. *(Authors' note: regulation for the nursing and midwife professions can be found in Government Ordinance no. 144/2008)*

Within each professional territorial structure there is an organized disciplinary committee which receives petitions from patients who believe that the professional service provided by the respective professional was not up to the standards of the respective profession.

The Discipline Committee, based on the referral made and the disciplinary investigation carried out in that case, confirms the alleged facts and provides a solution which upholds the complaint, recognizes the existence of the infringement and the non-compliance with the rules of the profession and applies one of the penalties provided by law. The sanctioned doctor or the person who made the complaint has the right to appeal the decision of the Disciplinary Commission at the local level, in which case the appeal will be solved by the Higher Disciplinary Commission at the national level.

A special mention must be made in case of complaints against a doctor who is a member of the national governing bodies of the professional organisation, from the local or national level. In that instance, the complaint shall be submitted to and settled directly by the Higher Disciplinary Commission held at the Romanian College of Physicians **(Article 451, para. 4).**

General provisions on the form and content of a petition are no longer applicable to complaints against medical professionals. In this, case, since there are special regulations on the matter, the special rule provided in **Article 105** of the **Statute of the Romanian College of Physicians** applies[837]. The complaint shall be submitted in person or by registered letter with acknowledgment of receipt. If it is sent by a conventional representative of the patient, then there will be a power of representation attached. For lawyers, the power of attorney is provided in the specific form regulated by the respective County Bar Association. According to **para. 3 of Article 105**, the bodies of the health care profession shall not act on complaints sent by email, fax or filed or submitted in copy.

837 According to the rules of legal interpretation applicable in the Romanian legal system, special rules are given priority over general rules. For example, in this case, even though the Government Ordinance no.27/2002 is the general law regarding the right to petition, the right to petition the bodies of the medical professions is regulated by a special framework. Thus, the special framework is applied with priority over the general one. At the same time, another legal interpretation rule states that whenever special rules are silent on a matter, they shall be complemented by the general rules.

The monitoring and professional competences Commission for the malpractice cases

The Commission is organized and operates under:

- **a) Law 95/2006 on the Health Reform, republished in 2015, Title XVI** entitled *Liability of healthcare professionals and of the medical products and medical, healthcare and pharmaceutical services provider,* **Chapter VI** entitled *Procedure for establishing professional liability cases against doctors, pharmacists and other people in the healthcare field,* **Articles 679 to 685;**
- **b) Minister of Health Order no. 1343/2006** approving the *"Regulation for organization and functioning of the monitoring and professional competence committee for the malpractice cases"*. Subsequent to publication, the Order was amended by Order no. 1016/2010 On the completion of the Regulation for organization and functioning of the monitoring and professional competences committee for the malpractice cases, approved by Ministry of Public Health no. 1.343/2006;
- **c) Minister of Health Order no. 1344/2006** approving the list of national medical experts. Subsequently, this order was amended by other two orders: Order no. 112/2010 amending the list of national medical experts approved by Order of the Minister of Health no.1344/2006 and Order no. 326/2011 amending the list of national medical experts, approved by Order of the Minister of Public Health no. 1344/2006;
- **d) Minister of Health Order no.1398/2006** approving the payment modality for the medical experts.

Under the above-mentioned legislation, the Commission is organized and operates within the county public health departments and the public health department of the Bucharest Municipality. It is composed of representatives of the respective health department, the county insurance agency, territorial structures of the professional associations (district branches of the Romanian College of Physicians, the Romanian College of Pharmacists, the Romanian College of Dentists, the National Order of Nurses and Midwives), and a forensic expert.

The purpose for establishing and organizing such a Commission is to try to reach an administrative settlement for the claim made by the person entitled to payment of damages for injury caused by malpractice.

The persons entitled to file a malpractice claim are the victims of alleged malpractice acts, or the victim's heirs if the victim of an alleged malpractice act died. The complaint can also be filed by parents on behalf of minors or through an attorney – in which case appropriate evidence of the representation shall be attached, under penalty of rejection.

The time limitation for such a complaint is 3 years and is set by Article 688 of Law 95/2006 on healthcare reform and begins on the date the damage/injury occurred.

Under the sanction provided by **Article 28** of the Rules of organization and operation of the monitoring and professional competence committee for malpractice cases, when the complaint is rejected as unfounded and the case is closed, the notification must include the following mandatory data required by **Article 26** of the same Regulation, namely:

- a) name of the person who made complaint;
- b) name of the person entitled to file a claim, in the meaning of **Article 25** of the Regulation;
- c) name and surname of the person who is considered a victim of the malpractice case (if different from the person making the complaint);
- d) name and surname of person who committed the act of malpractice in the exercise of activities of prevention, diagnosis or treatment;
- e) date of the act of the alleged malpractice act;
- f) description of the offence and its circumstances;
- g) damage caused to the victim of the alleged act of malpractice.

The following documents shall be attached to the complaint:

- a copy of the identity document of the person making the complaint,
- proof of legal standing when complaint is made by:
  - the parent for the minor,
  - the successor of the deceased as a result of a case of malpractice, or
  - the special proxy (authenticated by a notary public) when the claim is filed by a conventional representative or power of attorney when the complaint is filed by a lawyer.
- the medical documents in possession of the complainant.

B. PROCEDURE BASED ON LAW NO. 677/2001 ON THE PROTECTION OF INDIVIDUALS WITH REGARD TO THE PROCESSING OF PERSONAL DATA AND ON THE FREE CIRCULATION OF SUCH DATA

One of the patients' rights is that of the privacy of data on their health status. Such data pertain to private life and, consequently, enjoys special protection.

To the extent that this right is violated, its administrative defence can be obtained either by complaining to the Romanian College of Physicians (first to the territorial structure) or by complaining to the National Supervisory Authority for Personal Data Processing.

The national supervisory authority (the Authority) was organized and operates under Law no. 677/2001 on the protection of individuals with regard to the processing of personal data. In regard to the free circulation of such data, the authority has as its main duty to monitor and control the way the law provisions regarding the processing and protection of personal data are respected by public or private institutions.

Under **Article 21, para.3, letter f)**, the Authority receives and resolves complaints, referrals or requests from individuals and communicates the solution, or, where appropriate, the measures taken for the settlement of the case.

For drawing up a petition it is important to understand the facts claimed by the patient, and then to determine the object of the petition. That imperatively requires one to study the relevant legislation especially in terms of how the law phrases the right and the institutions empowered to supervise and control the actions of the particular types of claims. Finally, drafting the petition must comply with the formal requirements imposed by the common law in the particular case or the special legislation where appropriate.

C. PRIOR ADMINISTRATIVE PROCEDURE

The prior administrative procedure was based on the provisions of Law no. 554/2004 on administrative litigation and is useful when what is desired to be abolished or amended is an administrative act issued by a public authority in connection with its duties and through which it is affecting a legal right **(Article 1)**. This provision also applies to Romanian citizens as patients in connection to their access to certain medical services or drugs.

The petition requesting as appropriate the rescission or amendment of the act is called a prior administrative complaint and is addressed to the body issuing the administrative act. Similarly, where there is a relationship of subordination, the prior administrative complaint may be addressed later also to the body superior to the one that issued the criticized administrative act.

The deadline for reply by the issuing authority of the administrative act in such a prior administrative complaint is 30 days **(Article 2, para. (1), letter h), Article 7, para. (1))**.

D. PROCEDURE BEFORE THE NATIONAL EQUALITY BODY AND IN CASES REGARDING THE RIGHT TO EQUALITY AND NON-DISCRIMINATION, BASED ON GOVERNMENT ORDINANCE NO. 137/2000 ON THE SANCTIONING AND COMBATING ALL FORMS OF DISCRIMINATION

Romania adopted the Governmental Ordinance 137/2000 (hereafter referred to as 2000 Anti-discrimination Law or GO 137/2000) which was amended subsequently in 2002, 2003, 2004, 2006 and 2013 to enhance transposition of the Directive 2000/43/EC and the Directive 2000/78/EC.

The GO 137/2000 introduces a mixed system of civil and administrative remedies (the administrative remedies are referred to in the Romanian legal framework as "contraventions") which can be pursued separately or simultaneously in cases of alleged discrimination on grounds of race, nationality, ethnic origin, language, religion, social status, beliefs, gender, sexual orientation, age, disability, chronic disease, HIV positive status, belonging to a disadvantaged group or any other criterion. *(Authors' note: "any other criterion" comes from Article 14 of the ECHR and Protocol 12 of the ECHR; it means that the list of protected grounds is not a closed list and new categories of marginalization could be protected as they appear; however, the problem arises when the intention behind the prohibition of discrimination is lost due to the broadness of the interpretation of "any other criterion" –which can actually dilute the very principle of equality and nondiscrimination by turning arbitrary likes and dislikes into categories worthy of protection similar to race, religion, gender, etc.)*

The law sanctions direct and indirect discrimination as well as harassment, the instruction to discriminate and the multiple discrimination. Discriminatory denial of access to health services or discriminatory conduct during provision of health services is also sanctioned by the law, unless due to its seriousness it qualifies as a criminal deed and is sanctioned accordingly by the criminal law.

The National Council for Combating Discrimination (the Romanian Equality Body)

The person who considers himself or herself discriminated against can file a complaint with the National Council for Combating Discrimination (NCCD) within a year from the date when the alleged deed of discrimination took place or from the date when the person could have known about the discrimination. The filing is free of charge and the petition can be filed by regular mail, e-mail, fax, phone or in person.

Legal Representation and Process

Professional legal representation is not essential before the NCCD, as the institution is mandated to provide legal assistance to potential victims and, once the petition is filed, the NCCD is also mandated to carry out its own investigations. The GO 137/2000 provides for a legal term of 90 days for the Steering Board of the NCCD to investigate, organize hearings, and issue a decision.

Remedies and Sanctions

When discrimination is found, the sanction can be either a fine or an administrative warning carrying no financial penalty. Following the 2013 amendments to the Anti-discrimination Law, the fines range from RON 1,000 (approx. €220) to RON 30,000 (approx. €6.600) when perpetrated against an individual and between RON 2,000 (approx. €450) and RON 100,000 (approx. €22,000) when discrimination is perpetrated against a group or a community.

As a possible remedy, the amendments also mention establishing an obligation for the perpetrator of discrimination to publish the decision of the NCCD or of the courts in a newspaper.

Appeal against the NCCD Decision

The NCCD decisions can be appealed before the administrative courts within 15 days after their communication to the parties; otherwise they become final and are binding. The NCCD does not have a functional mechanism for monitoring the enforcement of its decisions or the observance of the recommendations made, but it may order the defendant to notify the NCCD regarding the enforcement. Legal representation before courts is not mandatory but it is helpful.

Special legal standing for NGOs before the NCCD

According to **Article 28, para. (1)** of GO 137/2000, *Non-governmental organizations which protect human rights or which have a legitimate interest in combating discrimination have legal standing in the case when the discrimination occurs in their field of activity and affects a community or group of people.* In addition, the law provides special legal standing for NGOs in the case when *the discrimination affects a natural person, at the request of that person*, meaning that NGOs can represent individual victims of discrimination only based on the latter's request.

Remedies for discrimination before the civil courts, based on GO 137/2000

The person who considers herself discriminated against has also three (3) years to file a complaint for civil damages before the civil courts, requesting moral and pecuniary damages, or re-establishing status quo antes or, nullifying the situation established as a result of the discrimination, according to civil law.

The courts of law can also decide, according to **Article 27** of the Anti-discrimination Law, that the public authorities will annul or suspend the functioning authorization of legal persons who caused significant damage as a result of discriminatory action or who repeatedly infringed the provisions of the anti-discrimination legislation.

Such cases are based on the general civil law provisions as provided by **Articles 1351-1395** of the Civil Code on liability for damages. Discrimination complaints filed in civil courts are exempted from judicial taxes, according to GO 137/2000.

8.3 Civil Procedure

8.3.1 General Description

- **Article 21** of the Constitution of Romania guarantees the right to access to justice for defending the person's rights, liberties and legitimate interests. Two newly-introduced articles in the civil code detail this principle and introduce a new method of defense of non-pecuniary rights[838].

- **Article 252** of the Civil Code stipulates that every individual has the right to protection of the innate values of the human being, such as life, health, physical and mental integrity, dignity, privacy of his/her private life, freedom of belief, and intellectual property.

- **Article 253** of the Civil Code stipulates the methods that the individual whose non-pecuniary rights have been breached or are threatened may use to defend these rights in civil court:
  - The individual whose non-pecuniary rights have been breached or are threatened may ask the court at any time:
    - to prohibit the unlawful act, if it is imminent;
    - to stop the violation and prohibit it for the future, if it is still persistent;
    - to establish the unlawful nature of the act, if the effect is persistent.
  - The individual whose non-pecuniary rights have been breached may ask the court to oblige the person who committed the violation to carry out any actions that are considered by the court to lead to restoring the right, such as:
    - obliging the violator to publish the judgment in a media outlet, on its own website, etc. on his/her expense (the exact means to be established by the court);
    - any other necessary measures to stop the unlawful act or to remedy the damage.
  - The individual whose non-pecuniary rights have been breached may ask for compensation for damage, even for the non-pecuniary damage, if the violator is liable for the damage. In this last case the action for compensation is subjected to a time limit of three (3) years.

  In the last case above, the general provisions regulating civil law liability apply. According to **Articles 1349-1395** of the Civil Code, every individual whose rights or legitimate interests have been violated by the actions or inactions of a person who behaved against the law or the custom is entitled to compensation for material damages and non-pecuniary (moral) damages *(Author's note: It is not clear how custom is determined for the purposes of this section of the civil code and if it has the same legal weight as a law)*. The aforementioned articles are the main articles that are to be invoked in a civil action suit to protect violated rights in the health sector.

- **Article 253 vs. Articles 1349-1359 of the Civil Code**

- **Article 253** of the Civil Code is a new legal provision, introduced after the adoption of the new Civil Code of Romania. In principle, it offers to the victim of non-pecuniary rights violations a wide range of remedies, making this a good legal ground for a civil action in the field of healthcare violations. Moreover, according to **Article 2.502, para. (2), point 1** of the Civil Code, but for the action for compensation, there is no time limit for introducing a civil action for the defense of non-pecuniary rights under **Article 253 of the Civil Code**. At the same time, one should take into account that it will take some time for the jurisprudence to develop regarding these new provisions. Therefore, it is safer for a complainant to ground a civil action (also) on civil law liability provisions (**Articles 1349-1359** of the Civil Code), subject to a three -year time-limit for introducing the civil action.

838 The new Civil Code adopted on 27 July 2009 entered into force on 1 October 2013.

8.3.2 Court Procedure for Obtaining Compensation

- **Articles 1387 and 1391 – Compensation**

  In the claims based on civil law liability, the complainant may ask for compensation for material damage and compensation for moral damage, thus:

- **Article 1387** describes the compensations awarded for the damage of corporal integrity and health; these damages consist of the loss of income resulting from loss of the work capacity of the person, the expenses incurred for medical care, and the expenses incurred for the need to create improved living conditions for the person, as well as any other material damage.

  - For non-pecuniary damages, **Article 1391** stipulates that *when there is damage of the corporal integrity or health of the person, the court may also award compensation for the restraint on the possibilities of living a family life and a social life.* It also stipulates the possibility to award compensation to the family of the deceased for the suffering incurred because of his/her death.

  Compensation for material damage needs to be proven. Compensation for moral damage does not have to be proven; however, the complainant should substantiate as well as possible the moral damage, including by calling witnesses who can describe the emotional and psychological suffering that affected the complainant, changes in behavior after the alleged acts occurred, etc. In the end, it is the judge who evaluates and establishes a certain amount of money as compensation for moral damage based on his/her personal assessment; there are no guidelines to judges as to criteria for evaluating moral damage. *(Author's note: this is one of the reasons why the level of compensation for moral damage in Romanian case-law varies a lot; it is unpredictable and often it is very low compared to compensation awarded in common-law systems)*.

  Besides the legal ground for introducing the action, the complainant should know from the very beginning the persons against whom he/she is introducing the action, meaning the persons who are responsible for violations of his rights. One should take into account that there might be several persons, at different levels, who carry responsibilities in the context of healthcare services, from the Ministry of Health and the Local Directorates for Health (at county level) to the healthcare unit, chief of clinic, and the medical personnel that are providing the actual healthcare service. The liability may be found for the acts and omissions of the ministry, local health directorates, or management of a healthcare unit or clinic (**Articles 1349-1350** of the Civil Code) or for the acts and omissions of their employees who acted in this capacity at the workplace (**Article 1373** of the Civil Code). In this last case, at the complainant's request, if liability is established, the court may award the compensation to be paid by the employer and employee together (in solidum), meaning that the complainant can collect the entire amount of compensation from any of the defendants.

  In general, the civil action for damages will require payment of court fees, proportionate to the amount of compensation requested. There are a few exceptions stipulated by the **Government Emergency Ordinance No.80/2013** on court fees or by special laws, such as:

  - when civil compensation is requested for alleged violations of Article 2 (the right to life) and/or Article 3 (the right not to be subjected to torture, inhuman and degrading treatment or punishment) of the European Convention on Human Rights (according to **Article 29.(1) point j** of the Government Emergency Ordinance No.80/2013 on court fees);
  - when the civil compensation is requested for alleged discrimination (according to **Article 27.(1)** of the Government Ordinance No.137/2000 regarding the prevention and sanctioning of all forms of discrimination);
  - one can try and argue in court that the patient is a consumer and if this is accepted, then every action in defense of consumers' rights is exempted from court fees by the law (according to **Article 29, para.(1), point f** of the Government Emergency Ordinance No.80/2013 on court fees) *(Author's opinion: nevertheless, because the interpretation is not clear-cut, de lege ferenda, an amendment of the Law No.46/2003 on patient's rights should be introduced to explicitly*

stipulate the exemption from the payment of court fees in cases of court actions introduced by patients to defend their patients' rights, similar to the case of the defense of consumers' rights.)

Beside court fees, the complainant has to cover the cost of legal assistance and of expert examination he/she proposes as evidence in the case. The claimant can claim for the defendant to compensate these expenses at the end of the trial, if his/her action is admitted and the claimant wins the trial. The legal assistance provided in a case involving health rights can be challenging because it involves some insight into the healthcare system, not only in terms of healthcare legislation, but also organization and functioning of healthcare units, medical protocols and guidelines, etc.

The trial in a first instance court may take between a few months and a few years, depending on many factors such as the workload of the court, the complexity of the case, and the behavior of the parties. The trials in Romania usually take a long time.

In general, the first instance court (*judecătorie* in Romanian) is mandated to examine civil actions in this field when the pecuniary claims are up to approximately EUR 45,454 (RON 200,000 lei) (**Article 94** of the Civil Procedure Code). Another general rule is that the civil action should be introduced at the first instance court which has jurisdiction over the place of domicile of the defendant (**Article 107** of the Civil Procedure Code).

Each civil action must contain certain information that is mandatory according to the law (**Articles 194-197** of the Civil Procedure Code):

- names, addresses, personal identification numbers of the complainant(s) and of the defendant(s);
- name of the representative of the complainant if a representative is designated, the name and address of the lawyer, and the power of attorney or proof of representation;
- the claims and the pecuniary evaluation of claims, if they can be expressed in money, as well as the calculation that led to the amount of money requested and the relevant evidence in case of material damage;
- an account of the facts and the law that is thought to be relevant in the case;
- all evidence that proves each of the claims
  - written evidence will be annexed to the complaint
  - if the defendant is proposed to be interviewed by the court, this should be indicated in the complaint
  - when the interview is carried out in written form according to the law, the list of questions for the interview must be annexed to the complaint)
  - if witnesses are proposed, their names and addresses must be indicated in the complaint;
- signature of the complainant or his/her representative;
- evidence of the payment of court fees;
- the civil action will be filed in the number of copies equivalent to the number of parties, plus one copy for the court;
- all written evidence will be certified by the complainant by his/her signature attesting that the evidence is according to the original documents and will be filed in the number of copies equivalent to the number of parties, plus one copy for the court.

Before the judge actually schedules hearings in the case, he/she will check whether all these conditions are met (regularization procedure stipulated in **Article 200** of the Civil Procedure Code). If the judge finds an omission, he/she will communicate with the complainant requesting additional information, explanations or documents. The complainant will have a strict time limit of ten (10) days to fulfill the requirement of the judge; otherwise the civil action will be declared void by the judge.

According to **Article 201** of the Civil Procedure Code, once the civil action passes the regularization procedure, it is communicated by regular mail to the defendant(s) who is given a strict time limit of twenty-five (25) days to respond indicating also all evidence and arguments in his/her defense. Afterwards, the complainant is communicated the response and has ten (10) days to send a written

reply to the court. After this exchange of written communications and evidence, the judge will schedule the first court hearing within 60 days.

According to **Article 249** of the Civil Procedure Code, the person who makes an allegation before the court has the burden of proving it, except for certain cases explicitly stipulated by law. One of these exceptions is in cases of alleged discrimination: **Article 27 of the Government Ordinance No.137/2000** on the prevention and sanctioning of all forms of discrimination stipulates that the complainant and the defendant share the burden of proof in the following way: at first, the complainant must prove facts from which the court can presume discrimination (circumstantial evidence); afterwards, the defendant must prove that he/she acted in compliance with the principle of equal treatment (e.g. he/she applied objective and non-discriminatory criteria).

In civil procedure, there is a limited list of acceptable means of presenting evidence before a court: written evidence, witnesses, presumptions, acknowledgement of one party, interview of the party, expert examination, material evidence, and field research carried out by the court in exceptional situations. In cases of alleged discrimination, statistical data and audio-video recordings are also allowed in civil cases before courts (**Article 27 of the Government Ordinance No.137/2000** on the prevention and sanctioning of all forms of discrimination).

8.3.3 Special Considerations Regarding Cases of Alleged Health Rights Violations

One should take into account that the burden of proof in cases of health rights violations may be difficult for many reasons. The evidence gathering may be challenging because the patient might not have sufficient awareness of different types of primary medical records and, in their absence, of secondary medical records that may contain partial information about the patient and the treatment process or other data important to the case. In these circumstances, a consultation with a person who works or used to work in the healthcare system and is aware of these details can be very useful. In addition, according to **Article 293** of the Civil Procedure Code, each party has the right to ask the court to order the other party to present a certain document that only this party possesses. Usually, a refusal to present the document can be interpreted by the court as confirmation of the allegations regarding the content of the document made by the party who proposed this evidence (**Article 295** of the Civil Procedure Code). These legal provisions are especially important in cases concerning health rights violations because often most of the medical records are at the healthcare unit.

Another instance in which a prior consultation with a healthcare expert could be very helpful is when drafting the questions and preparing for the interview of one of the parties or of witnesses and for deciding on the need to ask for an expert examination on certain issues. The aims are to ask the right chain of questions that would not allow the witness or party to avoid an answer or would show contradictions in his/her responses and to ask the expert the questions for addressing essential issues in the case. In this respect, it is important to know the facts of the case very well, but also background information about how the health care system works, certain terminological terms, deontological standards, and other similar information depending upon the specific case.

8.4 Criminal Proceedings

8.4.1 General Description

The criminal trial can be understood as representing all activities carried out by the judicial bodies, with the participation of other persons, for the purpose of holding criminally liable the persons who have committed offences determined to be criminal in nature.

The criminal trial has three phases: criminal prosecution, preliminary chamber and judgment.

8.4.2 Relationship Between the Criminal and the Civil Action for Compensation

In the criminal trial, **criminal proceedings** aim at holding criminally liable the persons who have committed criminal offences, and the **civil proceedings** aim at holding civilly liable the persons responsible under the civil law for the damage incurred by committing the offence which is subject to the criminal proceedings.

The civil proceedings are the actions whereby the **civil party** in the criminal trial (or the lawful inheritors or successors) aim to require the **defendant** or, if applicable, the **civilly-responsible party** to repair the damage incurred by the offence subject to criminal proceedings.

The civil proceedings shall be settled in the criminal trial, **under the civil law**, if it does not exceed the reasonable period of the trial. The court may disjoin the civil proceedings, when its settlement determines the exceeding of the reasonable period established for the settlement of the criminal proceedings.

The act of becoming a civil party is a prerequisite for the exercise of the civil proceedings in the criminal trial. The act of becoming a civil party shall be made **until the start of the judicial inquiry**. The judicial bodies must inform the injured party of the right to become a civil party.

If the injured party has not become a civil party in the criminal trial, he/she does not lose the right to legal redress, taking the proceedings to the civil court.

8.4.3 General Information Regarding the Criminal Trial

A. THE PARTICIPANTS IN THE CRIMINAL TRIAL

According to the Code of Criminal Procedure, the parties in the criminal trial are: judicial bodies, lawyer, parties, main interested parties and other interested parties.

Judicial bodies

The specialized state bodies conducting the judicial activity are:

- criminal investigation bodies;
- prosecutor;
- rights and freedoms judge;
- preliminary chamber judge;
- law courts.

Main procedural parties

The main interested parties are the suspect and the injured party.

The suspect is defined as the person related to which, according to the data and evidence existing in the case, there is a reasonable suspicion that he has committed an offence provided for in the criminal law. The suspect's rights are those provided for the defendant unless the law provides otherwise. These rights are:

- the right not to make any statement during the criminal trial, bringing to his/her attention that if he/she refuses to make statements, he/she shall not suffer any adverse consequence; but if he/she makes statements, they could be used as means of proof against him/her;
- the right to be informed of the offence for which the suspect is under investigation and its legal classification;
- the right to consult the case file, under the law;
- the right to be assisted by a lawyer and, if he/she does not retain a lawyer, in the cases of compulsory assistance, the right to a public defender;
- the right to propose the production of evidence under the legal terms, to raise exceptions and make submission;
- the right to file any other requests related to the settlement of the criminal and civil side of the case;
- the right to benefit, free of charge, from an interpreter when he/she does not understand, speak well or communicate in Romanian;
- the right to appeal to a mediator in the cases permitted by the law;
- the right to be informed of his/her rights;
- other rights provided by law.

The injured party is the person who has suffered a physical, material or moral injury by the criminal act. In the criminal trial, the injured party has the following rights:

- the right to be informed of his/her rights;
- the right to propose the production of evidence by the judicial bodies, to raise exceptions and to make submissions;
- the right to file any other requests related to the settlement of the criminal side of the case;
- the right to be informed, within a reasonable period, of the criminal prosecution phase, at his/her express request, provided that he/she specifies an address in Romania, an e-mail or electronic messaging address where he/she can receive such information;
- the right to consult the case file, under the law;
- the right to be heard;
- the right to ask questions to the defendant, witnesses and experts;
- the right to benefit, free of charge, from an interpreter when he/she does not understand, speak well or communicate in Romanian;
- the right to be assisted by a lawyer or representative;
- the right to appeal to a mediator in the cases permitted by the law;
- other rights provided by law.

Parties to the trial

The parties in the criminal trial are the defendant, civil party and civil responsible party.

The defendant is the person against whom criminal proceedings have been initiated (a suspect in the list of pre-trial main interested parties above). The defendant's right are specified in **Article 83 of the Code of Criminal Procedure** (mentioned above as the suspect's rights).

The civil party is the injured party exercising civil proceedings in the criminal trial and is a party in the criminal trial. In order to exercise the civil proceedings within the criminal trial, the injured party must submit a

request to the prosecutor's office or to the court, detailing the nature and amount of its claims, together with the corresponding evidence. The injured party's successors are also civil parties if they exercise the civil proceedings in the criminal trial. Exercising the civil proceedings in the criminal trial means firstly to establish oneself as a civil party and then ask the court for civil compensation for the damages caused by the crime. The civil party's rights are the same as the injured party's rights with respect to the criminal proceedings. The difference between the civil party and the injured party is that only if an injured party establishes herself as a civil party can she claim compensation for damages incurred by the criminal act. A person can have both standings – as a civil and injured party – before the court.

The civil responsible party is the person who, under the civil law, has the legal or conventional obligation to redress in whole or in part, alone or jointly, the damage caused by the offence and is summoned to respond is a party to the criminal trial. The rights of the civil responsible party are those provided for the injured party. The rights of the civil responsible party are exercised within the limits and for the purpose of settling the civil proceeding.

The lawyer

The lawyer assists and represents, in the criminal trial, the parties or the main interested parties under the law.

The suspect or defendant is entitled to be assisted by one or several lawyers during criminal prosecution, preliminary chamber procedure and judgment, and the judicial bodies are responsible to inform him/her of this right. The legal assistance is considered by the law and court to be provided when at least one of the lawyers is present.

In certain cases, the legal assistance for the suspect or defendant is compulsory. If legal assistance is compulsory, and if the suspect or defendant has not retained a lawyer, the judicial body shall take measures to appoint a public defender. Legal assistance is compulsory in the following:

- when the suspect or defendant is a minor, is admitted to a detention centre or an educational centre, when he/she is detained or arrested even in another case, when the safety measure of admission has been ordered against him/her, even in another case, or in other cases provided by law;
- when the judicial body considers that the suspect or defendant could not defend himself;
- during judgment, in cases in which law provides life imprisonment or a custodial sentence of more than five years for the committed offence;

The specific rights of the suspect's or defendant's lawyer are:

- the right to be present during any procedural act undertaken by the prosecution (such as collecting evidence, hearing witnesses etc.), except
  - (i) when special surveillance or investigation methods are used and
  - (ii) during the body or vehicle search in the case of flagrant offences;
- the right to be informed of the date and time of any procedural act to be undertaken or hearing conducted by the rights and freedoms judge;
- the right to take part in the hearing of any person by the rights and freedoms judge, to file complaints, requests and written submissions;
- during the preliminary chamber procedure and judgment, the right to consult the case files, assist the defendant, exercise his/her procedural rights, to file complaints, requests, written submissions, exceptions and objections;
- the right to benefit from the required time and facilities to prepare and make an effective defence.

The injured party, civil party and civilly-responsible party are also entitled to legal assistance in the criminal trial, under specific conditions.

B. EVIDENCE IN A CRIMINAL TRIAL

The Code of Criminal Procedure defines as **evidence** any element used to determine the existence and non-existence of an offence, to identify the person who has committed it and to know the necessary circumstances for the fair settlement of the case and contribute to finding the truth in the criminal trial.

The means of proof are those means whereby certain evidence is obtained. The Code of Criminal Procedure allows any means of proof which are not prohibited by the law, specifying, as example, the following means of proof:

- suspect's or defendant's statements;
- injured party's statements;
- civil party's or civilly-responsible party's statements;
- witnesses' statements;
- documents, expert assessments or finding reports, other reports, photographs, material means of proof.

Burden of proof

In criminal proceedings, the burden of proof rests with the prosecutor and in civil proceedings, to the civil party or, as applicable, the prosecutor exercising the civil proceedings if the injured party has no capacity to act or has a limited capacity to act. The suspect or the defendant benefits from the presumption of innocence, not being required to prove his innocence, and is entitled not to accuse himself/herself. In the criminal trial, the injured party, suspect and parties are entitled to propose to the judicial bodies to allow the parties to produce evidence.

Production of evidence

During a criminal prosecution, the prosecution body must collect evidence both for and against the suspect or defendant, ex officio or upon demand.

During the judgment, the court administers evidence at the request of the prosecutor, injured party or parties and, in addition, *ex officio*, when it deems necessary to form its opinion. The court administers the evidence proposed by the prosecutor and parties and can also order *ex officio* that any party produce evidence.

The judicial bodies may dismiss a request regarding the administration of evidence when:

- the evidence is not relevant in relation to the trial;
- it is considered that in order to prove the element which is the subject of proof, enough means of proof have been produced;
- the evidence is not required, because the fact is notorious;
- the evidence is impossible to obtain;
- the request has been filed by a unjustified person (meaning a person who does not have the legal standing to request evidence);
- the production of evidence is contrary to law.

The evidence obtained by torture or illegally cannot be used in the criminal trial.

8.4.4 Specific Provisions regarding the Criminal Investigation

The criminal and criminal procedure rules may become incident in health-related laws when the violation of a health right is also a criminal offence. In those cases, the first step is usually to notify the competent bodies.

A. NOTIFICATION OF THE COMPETENT PROSECUTION BODY

The prosecution bodies in Romania are: prosecutor, criminal investigation bodies of the judicial police and special criminal investigation bodies. Their subject-matter competence required for prosecution is determined according to the nature of offence. For example, in case of murder, the prosecutor is the one who directly conducts the criminal prosecution.

The prosecution bodies may be notified by **complaint[839], denunciation, ex officio notification and documents concluded by fact-finding bodies provided by law**. For certain offences, the prosecution bodies cannot be notified by a denunciation or *ex officio*, but only by the victim of the offence, by means of a preliminary complaint.

The competent prosecution body which has been notified shall check:

- (i) whether the notification fulfils the legal admissibility requirements[840] and
- (ii) whether there exist any of the circumstances preventing the criminal proceeding provided for in Article 16, para. (1) of the Code of Criminal Procedure[841].

If the notification does not fulfil the legal admissibility requirements, it shall administratively be returned to the petitioner, specifying the missing elements, and allowing the petitioner to repair the irregularities. If it finds the incidence of **Article 16, para. (1)** of the Code of Criminal Procedure, the prosecution body shall submit the case file to the prosecutor with a proposal for dismissal of the complaint. If the prosecutor accepts the proposal of the prosecution body, he/she shall order the dismissal of the case by an ordinance. If the criminal complaint fulfils the admissibility requirements (either initially or as a result of the petitioner's additions) and if there are no other circumstances preventing the criminal proceedings **(Article 16, para.(1))**, the prosecution body shall order the **initiation of criminal prosecution in the case**.

There are also two exceptional cases to the aforementioned procedure: (i) prior verifications and (ii) flagrant offence. The first exception considers the case in which a previous authorisation or the fulfilment of another previous condition is required to initiate the criminal prosecution. In this case, the prosecution body is responsible to conduct prior verifications. The second exception considers the flagrant offence, namely the offence discovered during its commission or immediately after its commission. In this case, the public order and national security bodies shall prepare a report recording all found aspects and activities, which is immediately submitted to the prosecution body.

839 A complaint is an official notification made to the police or prosecutor by the victim of a crime. A denunciation is an official notification made by someone other than the victim who has information regarding the committing of a crime.

840 The admissibility requirements refer to the observance of the requirements provided by the law and the clear and full description of the offence.

841 Article 16 para. (1) of the Code of Criminal Procedure: *A criminal proceeding cannot be initiated and when it has been initiated it can no longer be exercised if: a) the offence does not exist; b) the offence is not provided by the criminal law or it has not been committed with the guilt/intent provided by the law; c) there is no evidence that the person has committed the offence; d) there is a justified cause or a non-imputable cause; e) the previous complaint, authorisation or notification of the competent body or other requirement provided by the law, which is necessary for the initiation of criminal proceeding, is missing; f) amnesty or expiration of the statute of limitation, death of the individual suspect or defendant has occurred or the annulment of the legal entity suspect or defendant has been ordered; g) the previous complaint has been withdrawn in case of offences for which its withdrawal removes the criminal liability, the conciliation has occurred or a mediation agreement has been concluded under the law; h) there is a case of non-punishment under the law; d) there is res judicata; j) a transfer of proceedings with another state has occurred, under the law.*

B. CONDUCTING THE CRIMINAL INVESTIGATION

If the criminal complaint fulfils the legal admissibility requirements and if there are none of the circumstances provided for in **Article 16, para. (1)** of the Code of Criminal Procedure, then the prosecution body must **open a criminal file with respect to the offence *(in rem)***, without any prior formalities. Only after a criminal file has been opened can the criminal prosecution start against a determined person.

If, according to the data and evidence existing in the case, there are reasonable indications that a certain person has committed the offence for which criminal prosecution has been initiated, then the criminal prosecution is conducted regarding that person, who becomes a suspect (prosecution *in personam*). The criminal prosecution regarding the suspect may exclusively be ordered by the prosecutor, by means of an ordinance. The capacity of "suspect" subsists until the **initiation of criminal proceeding** or until the adoption of a solution for **dismissal or waiver of criminal prosecution** against him/her, as applicable.

The person who becomes a suspect is informed, before his/her first hearing, of this status, the offence for which he/she is suspected, the legal classification thereof and the procedural rights provided for in **Article 83** of the Code of Criminal Procedure.

C. INITIATION OF THE CRIMINAL ACTION AGAINST THE SUSPECT

If, during the criminal prosecution, the **prosecutor** finds that there is sufficient evidence (simple indications are not enough) that a person has committed an offence and there is no reason to dismiss the prosecution provided for in **Article 16, para. (1)** of the Code of Criminal Procedure, **he/she shall initiate the criminal action** by means of an ordinance. The person against whom the criminal court proceeding has been initiated shall acquire the capacity of **defendant** and shall keep it until the court order becomes final (if he is not indicted) or until the criminal prosecution is dismissed or waived, as applicable. The initiation of a criminal action shall be communicated to the defendant by the prosecution body which summons him/her for hearing.

D. SOLUTIONS FOR NON-PROSECUTION AND NON-ARRAIGNMENT TAKEN DURING THE CRIMINAL INVESTIGATION

After examining the notification, when the prosecutor ascertains that the evidence required under Article 285 of the Criminal Procedure Code has been collected, the prosecutor shall, upon the proposal of the prosecution body (expressed by means of a report prepared by such body) or *ex officio*, settle the case by means of an ordinance, ordering (**Article 314** of the Criminal Procedure Code):

- **(1) the dismissal**, because of the existence of one of the conditions provided for in **Article 16, para. (1)** of the Code of Criminal Procedure; or
- **(2) the waiver of criminal prosecution**, if there is no public interest in the criminal prosecution of the defendant.

Dismissal may be complete or partial. If the dismissal proposal has been submitted to the prosecution body's prosecutor, and that prosecutor considers that the dismissal requirements are not met, he/she shall order the return of the case file to the prosecution body for the continuation of criminal prosecution.

The waiver of criminal prosecution is incident when the prosecutor considers that there is no public interest in the prosecution of an offence. The prosecutor is the only one who can order such a measure, by means of an ordinance, if all of the following conditions are met (**Article 318** of the Criminal Procedure Code):

(1) the offence for which criminal prosecution has been initiated is punishable with a criminal fine or imprisonment not exceeding seven (7) years;

(2) in relation to the contents of the offence, the method and means of commission, the purpose and the specific circumstances of its commission, the consequences or those which could have been produced by the offence, the prosecutor ascertains that there is no public interest in the prosecution thereof;

(3) when the author of the offence (suspect or defendant) is known, his/her behaviour prior to the offence and efforts made to remove or reduce the consequences of the offence shall also be considered into to the discretion regarding whether the offence is of the public interest.

The prosecutor may order, after consulting with the suspect or defendant, that he/she fulfils one or more of the following obligations (**Article 318** of the Criminal Procedure Code):

- (1) to remove the consequences of the offence or repair the damage or agree with the civil party on how to repair it;
- (2) to publicly apologise the injured party;
- (3) to provide unpaid community work for a period between 30 and 60 days, if, due to his/her health, the person cannot provide work;
- (4) to attend a counselling program.

The deadline for the fulfilment of such obligations shall be established by an ordinance and cannot exceed six (6) months; the time cannot exceed nine (9) months in case of obligations undertaken by a mediation agreement concluded with the civil party.

E. FINALISATION OF THE CRIMINAL INVESTIGATION AND THE SETTLEMENT OF CASES

As soon as the criminal prosecution is completed, the prosecution body shall submit to the prosecutor the case file together with a report based upon which the prosecutor proposes the arraignment, dismissal or waiver of criminal prosecution or, if it the case, taking the case to criminal court.

If the prosecutor ascertains that the criminal prosecution is incomplete or has not been conducted by complying with the legal provisions, the prosecutor shall return the case to the body which has conducted the criminal prosecution to complete or re-conduct the criminal prosecution or to submit the case to another prosecution body.

When the prosecutor ascertains that the legal provisions guaranteeing the truth have been complied with, the criminal prosecution is complete and there is the required and legally-produced evidence, the prosecutor shall:

- issue the indictment ordering the arraignment, if the prosecution material ascertains that the offence exists, that it has been committed by the defendant and that he/she can be held criminally liable before court (meaning for example, that there is no reason, such as minority, that would prevent the suspect from being held criminally liable) ; or
- issue the ordinance dismissing or waiving the prosecution, under the legal provisions.

The indictment is the writ of summons. It is limited to the offence and person for whom a criminal prosecution has been conducted and properly includes the following (**Article 328** of the Criminal Procedure Code): circumstances provided for in **Article 286, para. (2)**; data regarding the offence for which the defendant has been found guilty and its legal classification; evidence and means of proof; legal expenses and fees; information regarding the preventive, protective and safety measures, if applicable; the arraignment decision and other information required for the case settlement. The legality and reliability of the indictment shall be checked by the chief prosecutor within the public prosecutor's office or, as applicable, by the general prosecutor of the public prosecutor's office attached to the court of appeal. When he/she has prepared the indictment, the check shall be made by the superior prosecutor. When it is prepared by the prosecutor within the Public Prosecutor's Office attached to the High Court of Cassation and Justice, the indictment shall be checked by the chief prosecutor of the division; and when he/she has prepared it, the check shall be made by

the general prosecutor of that public prosecutor's office. In cases of arrest, the check shall be made urgently by the appropriate prosecutor and before the expiry of the preventive detention period (**Article 328** of the Criminal Procedure Code).

F. THE RIGHT TO COMPLAIN AGAINST MEASURES AND PROSECUTION ACTS TAKEN DURING THE CRIMINAL INVESTIGATION

This particular right to complain is provided in **Articles 336 to 341** of the Criminal Procedure Code.

Any person can file a complaint against the measures and prosecution acts that infringe his/her legitimate interests. The complaint can be made against acts taken by the criminal investigation bodies r by the prosecutor and shall be resolved by the supervising prosecutor or, respectively, to the higher hierarchical prosecutor. This complaint procedure guarantees that the any party or person's right is respected during the criminal investigation and that the investigation acts do not harm these rights and interests.

The **dismissal or waiver of prosecution** represent prosecution acts taken during the criminal investigation which, considering their importance, benefit from a special complaints procedure. Thus, the complaint shall be made within 20 days from sending the copy of the document whereby the resolution has been ordered by the prosecutor. If the complaint of a person against the dismissal or waiver of prosecution has been rejected by the superior prosecutor, that person can file a complaint, within 20 days from the communication of the order of resolution, to the preliminary chamber judge within the competent court under the law, to judge the case in the first instance. If the superior prosecutor does not comply within the initial 20-day period to settle the complaint, the injured party may address the preliminary chamber judge at any time after the expiry thereof, but no later than 20 days from the communication of the complaint settlement, once it has been settled. *(Authors' note: If the prosecutor does not reply after the complaint, then the complainant can wait longer than 20 days. However, if after the expiry of the 20 days the prosecutor finally replies and the complainant did not send a complaint previously, then 20 days start to run from the moment of communication of the prosecutror's reply. Essentially, 40 days applies to the situation when the prosecutor actually replies, whereas if the prosecutor does not reply, then the term can be longer and the complainant is allowed to wait for the reply.)*

The ruling and the solution issued by the preliminary chamber judge shall vary depending on the initiation or non-initiation of the criminal proceedings in that case:

- In the cases in which **the initiation of criminal proceeding has not been ordered**, the preliminary chamber judge may order one of the following solutions:
  - (1) reject the complaint, as late or inadmissible or, as applicable, groundless;
  - (2) admit the complaint, cancel the appealed solution and submit the case as reasoned to the prosecutor to initiate or complete the criminal prosecution or, as applicable, to initiate the criminal proceedings and complete the criminal prosecution; or
  - (3) admit the complaint and change the legal ground of the appealed dismissal if doing so does not incur a more difficult situation for the person who made the complaint.
- In the cases in which **the initiation of criminal court proceedings has been ordered by the prosecutor,** the preliminary chamber judge will be able to issue one of the following solutions (**Article 346** of the Criminal Procedure Code):
  - (1) reject the complaint, as late or inadmissible; or
  - (2) check the legality of the production of evidence and the criminal prosecution, exclude the evidence which has been produced illegally or, as applicable, sanction the prosecution acts made by breaching the law and:
    - a) reject the complaint as groundless;
    - b) admit the complaint, cancel the appealed solution and submit the case as reasoned to the prosecutor to complete the criminal prosecution;

- c) admit the complaint, cancel the appealed solution and submit the commencement of judgment regarding the offences and persons against whom the criminal proceeding has been initiated during the criminal investigation, when the legally-produced evidence is enough, submitting the case file for assignment to a single judge or a panel via random distribution among the judges/panels of the court;

d) admit the complaint and change the legal ground of the appealed dismissal if doing so does not incur a more difficult situation for the person who has made the complaint.

The decision whereby the preliminary chamber judge settles the complaint is, with some exceptions, final.

8.4.5 Preliminary Chamber Procedure – brief description

The preliminary chamber is a new institution in the Romanian juridical regulation, introduced by the new Code of Criminal Procedure. Its role is to expedite criminal cases, by examining the legality of arraignment, competence of the particular court called to try the case, and legality of the production of evidence and criminal prosecution. However, the preliminary chamber judge is not competent to order the prosecutor to produce new evidence, but only to decide on the legality of already-produced evidence.

Considering the reasons for which the preliminary chamber has been introduced and its purposes, **the new Code of Criminal Procedure does not provide the possibility to return the prosecution case file to the prosecutor during judgment, providing this opportunity only to the preliminary chamber judge**. Also, the (absolute or relative) nullities of the documents made during criminal prosecution or preliminary chamber procedure may be appealed only until the completion of the preliminary chamber procedure.

The duration of the preliminary chamber procedure may be, under the Code of Criminal Procedure, no more than 60 days. In theory, this period is deemed a recommended period, there being no sanction for exceeding it.

After the entering into force of the Code of Criminal Procedure, on 1 February 2014, some of the provisions regarding the preliminary chamber were declared unconstitutional by Constitutional Court Decision, issued at the end of 2014[842]. The replacement of the provisions which thus became void is still pending at the moment of writing the present Practitioner's Guide. This section is a brief overview of the procedure and the solutions which a preliminary court judge can issue in a case.

The preliminary chamber judge may deliver the following solutions:

- **(1) order the commencement of judgment** and find the legality of the court notification, production of evidence and prosecution acts, if no requests and exceptions have been filed or exceptions have been raised ex officio;
- **(2) return the case to the public prosecutor's office,** if:
  - (i) the indictment is irregularly issued and the irregularity has not been remedied by the prosecutor within the aforementioned 5-day period, if the irregularity leads to the impossibility to establish the object or limits of judgment;
  - (ii) the judge has excluded all pieces of evidence produced during the criminal prosecution; or
  - (iii) the prosecutor requests the case return or does not answer within the legal period; or
- **(3) order the commencement of judgement,** in all other cases in which he/she has ascertained irregularities of the writ of summons, excluded one or several produced pieces of evidence or sanctioned the prosecution acts made by violating the law. The excluded evidence cannot be considered during the first instance judgment of the case.

The preliminary chamber judge ordering the commencement of judgement shall exercise the judgment in that case.

842 Decision no. 641/2014 of the Constitutional Court of Romania.

8.4.6 The Criminal Court Judgment

A. GENERAL DESCRIPTION

The Court judgment is the third phase of the criminal trial. According to the Code of Criminal Procedure, the law court shall settle the case pending before it by guaranteeing the observance of the interested parties' rights and providing for the production of evidence to completely explain the circumstances of the case in order to find the truth, by fully complying with the law.

As a general rule, the court judgement takes place in **the public hearing**, by complying with the principles of oral hearing, contentious debates and directness.

The court judgment may take place only if the injured party and other parties have legally been summoned and the procedure has been followed. The defendant, civil party, civilly-responsible party and, as applicable, their legal representatives shall be summoned *ex officio* by the court. The court may order the summoning of other interested parties when their presence is required for the case settlement. The appearance of the injured party or the other party before the court, in person or through a representative or appointed or public lawyer, if the latter has contacted the represented person, shall cover the court's non-compliance with the summoning procedure.

The party or other main interested party may be present in person, through a representative or defence lawyer at a court hearing. If the party or other main interested party, whether in person, through a representative or defence lawyer or the official or the person in charge with the receipt of correspondence, has legally been served the summons for a court hearing, s/he shall no longer be summoned for the subsequent hearings, even if s/he misses one of such hearings. An exception to this latter rule is when the party's presence is compulsory by law. Persons in the military and person serving prison sentences are summoned *ex officio* (automatically) for each court hearing.

The prosecutor's participation in a trial is **compulsory**. The judgment may take place in the absence of the defendant if he/she is missing, avoids the trial or changes his/her address without informing the judicial bodies and, as a result of the verifications, his/her new address is unknown. The judgement may also take place in the absence of the defendant if, although legally summoned, he/she is unaccountably absent at the case judgment. The defendant, including when he/she is deprived of liberty, may request, in writing, to be judged *in absentia*, being represented by his appointed or public lawyer.

The defendant, civil party or civilly-responsible party may file requests, raise exceptions and make submissions. The injured party benefits from the same rights but only as regards the criminal side of the case.

B. THE STRUCTURE OF THE JUDGMENT IN THE FIRST INSTANCE

The judgment in the first instance shall be limited to the offences and persons specified in the writ of summons. Thus, it is possible to extend the criminal trial for other offences and persons during the judgment period. The court judgment phase is regulated all throughout Title III of the Criminal Procedure Code (**Articles 349 to 477**1) and the following description of this phase is based on these provisions.

Communication of the accusation, explanations and requests

At **the first court hearing** when the summoning procedure is legally fulfilled and the case is pending trial, the presiding judge shall order the court clerk to read the document ordering the arraignment (the indictment) or, as applicable, the one ordering the commencement of judgment (the decision of the preliminary chamber judge for the settlement of the complaint against the prosecutor's documents whereby the preliminary chamber judge orders the commencement of judgment) or to provide a briefing thereof.

The presiding judge shall explain the accusation to the defendant, inform the defendant of the right not to make any statement, bringing to the attention that whatever the defendant states may be used against them. The judge shall also point out the right to ask questions to the co-defendants, to the injured party, other parties, witnesses, and experts and the right to make statements during the judicial inquiry when the defendant deems necessary.

The presiding judge shall inform the civil party, civilly-responsible party and injured party of the evidence produced during the criminal prosecution which has been excluded and not considered in settling the case and shall inform the injured party that he/she can become a civil party until the commencement of the judicial inquiry.

The presiding judge shall ask the prosecutor, parties and injured party if they propose the production of evidence. If production of evidence is proposed, the following must be specified: the offences and circumstances to be proven, means used to produce such evidence and place to find such means, and, as regards the witnesses and experts, their identification and address. The evidence produced during the criminal prosecution and not appealed by the parties shall not be re-produced during the judicial inquiry. They are included in the argumentative debate of the parties and considered by the court for deliberation. The prosecutor, injured party and other parties may request to produce new evidence during the judicial inquiry. The court may order ex officio the production of evidence required for finding the truth and the fair settlement of the case. *(Authors' note: in other words, the court does not only rely on the evidence submitted by the parties, but it also may require them to produce specific evidence.)*

The judicial inquiry

The next phase of the judgment in the first instance is the judicial inquiry, where, after hearing the defendant, injured party, civil party and civilly-responsible party, the court proceeds to evaluate the evidence which it has previously approved. In this phase, the witnesses or experts are also heard, if applicable. If there are any material means of proof, the court shall, upon demand or *ex officio*, order their introduction and presentation, if possible.

If the judicial inquiry results show that it is necessary to produce new evidence to clarify the facts or circumstances of the case, the court shall order either the further case judgment or its adjournment to produce the evidence.

Before declaring termination of the judicial inquiry, the presiding judge shall ask the prosecutor, injured party or other parties if they have any further explanations or new requests to file in order to complete the judicial inquiry. If no requests have been filed or if the requests have been dismissed or if the required additions have been performed, the presiding judge shall declare the judicial inquiry as terminated.

The debates

After completing the judicial inquiry, the court shall proceed to debates, giving the floor in the following order: the prosecutor, injured party, civil party, civilly-responsible party and defendant. The presiding judge may also give the floor in reply to the other parties. Before completing the debates, the presiding judge shall give the floor to the defendant. While the defendant is speaking, he/she cannot be asked any questions. If the defendant reveals new facts or circumstances which are essential for the case settlement, the court shall order the resumption of judicial inquiry. Having completed the debates, the court may ask the parties to make written submissions. The prosecutor, injured party and other parties can make written submission, even if the court has not requested them.

The court deliberation and sentencing

The deliberation and sentencing shall be made either on the date on which debates have taken place or a subsequent date, but no later than fifteen (15) days from the completion of debates. In exceptional cases, when, related to the complexity of the case, the deliberation and sentencing cannot take place on the aforementioned hearing date; then the court may adjourn the sentencing once for no more than fifteen (15) days.

The sentence must be the result of the judicial panel members' agreement on the decisions taken on the issues, subject to deliberation. When unanimity cannot be met, the sentence shall be taken by a majority vote. If the deliberation results in more than two opinions, then the judge who chooses the most severe solution must choose the one closest to his/her opinion. The result of the deliberation shall be recorded in the official minutes, signed by the judicial panel members.

The court shall decide on the accusation against the defendant, delivering, as applicable, the conviction, waiver of penalty enforcement, adjournment of penalty enforcement, acquittal or termination of the criminal trial. **A conviction shall be delivered if the court finds, beyond any reasonable doubt, that the deed occurred, is a criminal offence, and was committed by the defendant.** The court shall also rule in the same decision on the civil proceeding. *(Authors' note: civil liability results after the criminal court decides that the defendant is the performer of the deed which produced the damage. Thus, the civil law liability is linked to identifying a criminal guilt, and the latter can only be ascertained following the criminal trial rules. However, it might be the case that the defendant is acquitted or the criminal trial ends without a conviction, in which case the civil action shall be left unsolved by the criminal court and the injured party can resort to the civil court.)*

The sentence shall be delivered (pronounced) in the public hearing by the panel's presiding judge, assisted by the court clerk. After pronouncement, a copy of the minutes shall be sent to the prosecutor, parties, injured party and, if the defendant is arrested, the administration of the detention facility, to exercise their right to appeal. After the sentence is put into writing, all of the aforementioned shall receive the sentence in its entirety. The sentence shall be drafted in writing in no more than thirty (30) days from the date of its pronouncement.

C. THE RIGHT TO APPEAL THE FIRST COURT DECISION

As a general rule, all sentences (first instance judgments), in which the merits of the case have been settled, may be appealed. The Code of Criminal Procedure provides a large category of persons who have the right to appeal **(Article 409)**: prosecutor, defendant, civil party, civilly-responsible party (can appeal the civil side; and, as regards the criminal side, as far as the solution in the criminal case has influenced the solution in the civil side), injured party (can only appeal the criminal side), witness, expert, interpreter and lawyer (can only appeal the legal expenses and fees, compensations due to them and imposed judicial penalties). The law also provides the right to appeal to any individual or legal entity whose legitimate rights have directly been prejudiced by the measures taken by the court in the trial. For all those persons, except for the prosecutor, the appeal may also be filed by the legal representative or lawyer. For the defendant, the appeal may also be filed by his/her spouse.

For the prosecutor, injured party and parties, the deadline for appeal is ten (10) days, if law does not provide otherwise, starting from the receipt of the communication of the copy of minutes. For the other persons, the deadline starts from the date when they have been informed of the act or measure causing the prejudice (**Article 410** of the Criminal Procedure Code). *(Authors' note: an exceptional provision allows that an appeal filed after the expiry of the deadline under the law is deemed filed within that period if the court of appeal considers that the delay has been caused by an event that justifiably prevented filing a timely appeal, and the request for appeal has been filed within at most ten (10) days after such event has ended.)*

The appeal shall be filed by a written request and the grounds for appeal shall be stated in writing, specifying the reasons in fact and in law on which it is based. The appeal, if filed within the deadline, suspends the enforcement of the court sentence (both the criminal and civil elements of the sentence), unless the law provides otherwise (**Article 416** of the Criminal Procedure Code). The court shall judge the appeal only with regard to the person who filed it and the person referred to in the appeal statement (**Article 417** of the Criminal Procedure Code). In settling the case, the court of appeal cannot create a more difficult situation for the person filing the appeal. The court of appeal can also rule with respect to parties who have not appealed the first instance ruling, but it cannot thus create a more difficult situation for them as compared to the first

instance ruling.

The judgment of appeal is similar to the judgment in the first instance. The court of appeal may deliver the following solutions (**Article 421** of the Criminal Procedure Code):

- 1. reject the appeal, upholding the first instance judgment:
  - a) if the appeal is late or inadmissible;
  - b) if the appeal is groundless;
- 2. admit the appeal and:
  - a) cancel the sentence of the first instance and announce a new decision, proceeding under the rules to settle the criminal proceeding and civil proceeding in the first instance;
  - b) cancel the sentence of the first instance and order a new judgment by the court whose decision has been cancelled because the judgment in that court took place in the absence of a party who has illegally been summoned or who, being legally summoned, has been unable to appear and to inform the court of such impossibility, appealed by that party. A new judgment by the court whose decision has been cancelled shall be ordered when there is one of the cases of absolute nullity, except for the case of court non-competence, when a new judgment is ordered by the competent court.

D. EXTRAORDINARY MEANS OF APPEAL

The Code of Criminal Procedure acknowledges four types of extraordinary means of appeal (**Articles 426 to 470**): appeal for annulment, appeal in cassation, review and reopening of a criminal trial, and appeal in case of judgment in the absence of the convicted person. These are considered to be extraordinary because they can be used only in exceptional and limited situations. The purpose of these means of appeal is to correct the procedural errors which have occurred in final criminal court sentences. Another consequence of the extraordinary status of these means of appeal is that they can be grounded only on specific grounds provided by the Criminal Procedure Code, meaning that the type of arguments which can be brought are limited to the ones provided in the Code for each means of extraordinary appeal.

8.5 Alternative Mechanisms

8.5.1 The Ombudsman

A. LEGAL BASIS AND DUTIES

The Ombudsman's activity is regulated by Law no. 35/1997 on the organisation and operation of the Ombudsman's Office. According to this normative act, the Ombudsman's institution aims at protecting the rights and freedoms of the individuals in their relations with the public authorities. The rights to which this law refers may also include the rights considered by this guide book, so that an alternative solution to remedy their violation may be the notification of the Ombudsman.

There are regulations in the law on formulating of the petitions, the authority's obligations with respect to the petitioners and the measures that may be ordered by the Ombudsman if the petition is founded. *(Authors' note: the law does not state anything specific to health care petitions; and the special law states no specific conditions related to enforcement; consequently, common law shall apply.)* Through the petitions addressed to the Ombudsman the petitioner may request the intervention of this institution both for the violation of rights by public authorities and institutions, and the situation of violation of some rights by certain acts issued by the public authorities and institutions to achieve the responsibilities with which they have been invested.

The deadline for complaining to the Ombudsman is **one year** from the date on which the alleged violation(s) occurred or the date on which the person became aware of them.

The Law specifies the following duties of the Ombudsman, relevant to the protection of right in the healthcare field:

- coordinates the activity for the prevention of torture in detention facilities, carried out by the division on prevention of torture in detention facilities;
- decides on the petitions filed by individuals prejudiced by the violation of their rights or freedoms by the public authorities;
- checks the activity for legal settlement of received petitions and requests the authorities or public clerks in question to terminate the violation of the individual rights and freedoms, along with the reinstatement of the petitioner and the redress;
- fulfils duties regarding the constitutionality of national laws, such as: submits opinions at the request of the Constitutional Court; may notify the Constitutional Court as regards the unconstitutionality of laws before their promulgation; may directly notify the Constitutional Court about an exception of unconstitutionality of laws and ordinances;
- may notify the administrative court under the administrative court proceedings act;
- fulfils other duties under the law.

B. PETITIONING TO THE OMBUDSMAN

The Ombudsman exercises his duties *ex officio* or **on demand** by means of **petitions**. The latter procedure is the most frequent means through which the Ombudsman is activated in cases of rights violations.

Under the law, the petitions addressed to the Ombudsman's institution must be made in writing and specify the name and address of the individual whose rights and freedoms are prejudiced, the alleged violated rights and freedoms and the responsible administrative authority or public servant. The petitioner must prove the delay or denial by the public administration to legally settle the petition. **Thus, the redress for infringement must first be requested, through administrative channels, to the institution in question before notifying the Ombudsman.**

The law also states that anonymous petitions cannot be considered, and the petitions made against the alleged violation of specific individual rights and freedoms by acts or deeds of the public authorities shall be addressed to the Ombudsman's institution **no later than one year from the date on which the alleged violation has occurred or from the date on which the person in question has become aware of the violation.** The Ombudsman may reject the petitions which are distinctly groundless by stating the reasons or may request additional data to analyse and settle the petitions.

C. SETTLEMENT OF PETITIONS

If the Ombudsman's institution finds that the settlement of the petition falls within the area of competence of the judiciary, the Ombudsman may address, as applicable, the Minister of Justice, the Superior Council of Magistracy, the Public Ministry or the presiding judge who has authority to communicate the measures.

If, after examining the petitions, the Ombudsman finds that the petition of the prejudiced individual is grounded, the Ombudsman's institution shall address in writing the public authority which has allegedly violated the individual's rights. The Ombudsman can require that institution to reform or revoke the administrative document and redress and return the prejudiced individual to the situation prior to the violation. *(Authors' note: there are no legal standards regarding what makes a petition qualify for the Ombudsman to act and solve the issue; every petition is examined on a case-by-case basis, and sometimes the Ombudsman starts investigations in order to clarify the facts that were invoked in the petition.)*

The public authorities in question shall immediately take the measures necessary to remove the found illegalities, to redress and remove the causes producing or facilitating the violation of the prejudiced person's rights and to inform the Ombudsman's institution in this regard.

If the public authority or public clerk does not remove, within 30 days from the notification, the committed illegalities, the Ombudsman's institution shall address the superior public authorities which must report back to the Ombudsman on the measures taken within a maximum of 45 days.

If the public authority or public clerk belongs to the local public administration, the Ombudsman's institution shall address the prefect of that specific county. A new 45-day period shall start from the submission of the notification to the county prefect.

The Ombudsman is entitled to notify the Government regarding any illegal administrative act or deed of the central public administration and the county prefects. The Government's failure to adopt, within a maximum of 20 days, measures addressing the illegality of the administrative acts or deeds notified by the Ombudsman shall be communicated by the Ombudsman to the Parliament.

The Ombudsman's institution shall inform the person who has filed the petition how it shall be settled. It may be made public by the Ombudsman through mass media. *(Authors' note: it is not required that the Ombudsman first inform the person who filed the petition before making the information public through mass media; however, as a general rule, the Ombudsman should observe the protection of the applicant's personal data; the Ombudsman does not publish the petition itself, only the solution.)*

According to Law no. 554/2004 on administrative court proceedings, the Ombudsman, as a result of the verification, if he/she considers that the illegality of the act or denial of the administrative authority to fulfil its legal duties can be removed only by justice, may notify the competent administrative court which has jurisdiction over the petitioner's domicile. The petitioner shall acquire by right the capacity of plaintiff, being summoned by the administrative court in this capacity. If the petitioner does not acquiesce to the action filed by the Ombudsman at the first court hearing, the administration court shall dismiss the case.

D. ADDITIONAL PROTOCOL TO THE CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING PUNISHMENTS OR TREATMENTS

By Law no. 109/2009, Romania ratified the Optional Protocol adopted in New York on the 18th of December 2002 to the convention against torture and other cruel, inhuman or degrading punishments or treatments adopted in New York on the 10th of December, 1984. The Convention aims to impose on the member states various obligations for the prevention of torture and inhuman or degrading treatments. The Optional Protocol establishes a system of periodic visits made by the international and national independent bodes into the facilities where individuals are deprived of liberty, to prevent torture and inhuman or degrading punishments or treatments on the persons under custody.

Thus, the mechanism considered by the Optional Protocol may indirectly contribute to the identification and, as applicable, redress for infringement of the rights considered in this guide book, if their violation is classified within the scope of Protocol. In Romania, the national body in charge of the monitoring visits referred to in the Optional Protocol is the **Ombudsman**, by means of the **Division on prevention of torture in detention facilities.**

In the Optional Protocol and Law no. 35/1997, a "detention facility" means any place where individuals are deprived of liberty under a decision of an authority, on its demand and with the express or tacit consent thereof. Deprivation of liberty means any form of detention or imprisonment or placement by the decision of any judicial, administrative or other authority of a person into a public or private detention facility from where he/she cannot leave when he/she wants.

Law no. 35/1997 on the organisation and operation of the Ombudsman's Office specifies, as examples, the following types of detention facilities:

- penitentiaries, including penitentiary hospitals;
- educational centres and detention centres;
- detention and preventive arrest centres;
- residential services for minors who have committed criminal offences and cannot be held criminally liable;
- hospitals of psychiatry and for safety measures (in which patients have mental health issues, have committed a criminal offence, and have been ordered by a judge to psychiatric treatment), psychiatric hospitals;
- transit centres;
- accommodation centres for foreign citizens in public custody, under the subordination and administration of the General Inspectorate for Immigration;
- special reception and accommodation centres for asylum seekers under the subordination of the General Inspectorate for Immigration, with the legal status of the transit area;
- centres where assistance is provided to drug consumers who are in custody;
- any other facility fulfilling the requirements provided for in paragraph (1) or being part of the health or social care system.

Duties of the Division on prevention of torture in detention facilities: According to Law no. 35/1997, the Division on prevention of torture in detention facilities shall regularly monitor the treatment of persons in detention facilities to consolidate their protection against torture and inhuman or degrading punishments and treatments and exercise without discrimination their fundamental rights and freedoms, by:

- the announced or unannounced visit of the detention facilities to check the detention conditions and treatment of persons deprived of liberty;
- submitting recommendations to the managers of the visited detention facilities;
- submitting proposals to the Government and/or Parliament for the amendment and completion of the law

in that field or notes regarding the legislative initiatives existing in the field;

- drafting the project on preventing torture within the annual report of the Ombudsman's activity;
- submitting proposals and notes to the Government on the elaboration, change and completion of public strategies and policies in the prevention of torture and inhuman or degrading punishments or treatments under the law;
- maintaining the connection with the United Nation Sub-committee for the prevention of torture and cruel and inhuman treatments;
- analysing, implementing, monitoring and assessing, under the management of the Ombudsman, international technical and financial assistance programs to achieve the purpose of the Division on prevention of torture in detention facilities;
- coordinating the organisation of information, education and training campaigns to prevent torture and cruel, inhuman or degrading punishments or treatments;
- fulfilling any other duties established by the Ombudsman, under the law.

Visits: The visiting teams shall make announced and unannounced visits in the detention facilities provided for in Law no. 35/1997. The visiting team is composed of at least one physician, depending on the required specialisation, and a representative of active non-governmental organisations for the protection of human rights, selected according to their activity, by the Ombudsman.

The visits are made *ex officio*, under an annual visitation plan, proposed by the Deputy Ombudsman for the Division on prevention of torture in detention facilities and approved by the Ombudsman, or unannounced, or based on **the notification by any person** or the information received by any means of the existence of torture and cruel, inhuman or degrading treatments in a detention facility.

Under the law, the visited institutions must make available to the visiting team representatives, before, during and after the visit, any documents or information made available to them or which they can obtain, requested by the team for the fulfilment of their legal duties. The management of the visited detention facilities is responsible to provide assistance and meet the visiting team members to achieve the visit's purpose.

To fulfil their legal duties, the visiting team members can confidentially meet any person deprived of liberty within the visited institution. Upon the request of the visiting team members, the visited institution must make available a proper location for the meeting. The meetings shall take place only with the consent of the person deprived of liberty or his legal representative and are confidential. The representatives of the detention facility can take part in the meeting only at the express request of the visiting team members and for their protection. In this case, the representatives of the detention facility shall provide only visual surveillance, by observing the confidentiality of the meeting. The name and other personal information of the interviewed person can be made public only with his/her or his/her legal representative's written prior consent. The visiting team members may request meetings with any other person whom they consider can provide pertinent information, with his/her consent.

The findings from the visits shall be included in a visit report which, if irregularities are noted, is accompanied by justified recommendations for the improvement of the treatment and conditions of persons deprived of liberty and the prevention of torture and inhuman or degrading treatments. The visit report shall be prepared by the visiting team members within a maximum of 30 days from its completion and is then approved by the Ombudsman.

The visited institution must send, within thirty (30) days after the receipt of the visit report, a justified answer on the proposals and recommendations included in the visit report, specifying its opinion regarding the findings, the justified period in which measures shall be taken for the compliance with their contents or, if applicable, the reasons why it cannot comply. For good reasons, the period may be extended by thirty (30) days, with the approval of the Deputy Ombudsman for the Division on prevention of torture in detention facilities. If the visited institution does not comply, the Ombudsman or, as applicable, the Deputy Ombudsman for the Division on prevention of torture in detention facilities shall give information about this issue to the superior authority or local or central public administration which issued the operating permit in case of private

detention facilities and may act under the provisions of this law and the Regulation on the organisation and operation of the Ombudsman's institution.

The visiting report and the justified answer, when it has been sent, are public and shall be displayed on the webpage of the visited institution, the superior authority or the local or central public administration issuing the operating permit, and the Ombudsman, except for those parts related to the personal data or classified information.

If a violation of human rights by torture or cruel, inhuman or degrading treatment representing an imminent risk for the life and health of a person is ascertained, a preliminary report is urgently issued. The deadline for the preparation and adoption of the preliminary report is 3 days and may be extended for justified reasons by 3 more days. The visited institutions must urgently comply with the proposals and recommendations of the preliminary report and submit an answer within maximum 3 calendar days from the date of receipt of the report.

The Ombudsman is responsible to immediately notify the judicial bodies, when, in exercising his/her duties, he/she finds indications of the commission of offences included in the criminal law.

8.5.2 The Public Ministry

According to **Article 131** of the Romanian Constitution, the Public Ministry represents the general interests of the society and defends order and civil rights and freedoms. Considering its constitutional role of defender of the civil rights and freedoms, the Public Ministry (by means of the prosecutors established in public prosecutors' offices) is responsible to defend the rights considered in this guide book according to its constitutional and legal duties.

The most important manifestation of this capacity is achieved in the criminal trial (discussed in detail in section 8.4 above), but there are other legal provisions which fall within the Public Ministry's role of public defender of civil rights.

Thus, according to Law no. 554/2004 on administrative court proceedings, the Public Ministry, when, as a result of the duties provided for in its organic law, considers that the violation of the legitimate rights, freedoms and interests of persons is due to the existence of unilateral individual administrative documents of public authorities issued with abuse of power, with the consent of the harmed person, **shall notify the administrative court within the domicile of the injured individual or the registered office of the injured legal entity**. The petitioner shall acquire by right the capacity of plaintiff, being summoned by the administrative court in this capacity.

The prosecutor has also certain duties regarding the protection of persons with limited capacity to act or lacking the capacity to act. For example:

- the prosecutor may exercise the civil proceeding, within or outside the criminal trial, on behalf of those persons;
- the prosecutor may request the re-examination of the persons subject to involuntary admission to a psychiatric institution according to the provisions of Law no. 487/2002 on mental health and protection of people with mental disorders.

International Glossary

Related to Human Rights in Patient Care

A

ACCEPTABILITY

One of four criteria set out by Committee on Economic, Social and Cultural Rights by which to evaluate the right to the highest attainable standard of health. Acceptability: means that all health facilities, goods and services must be respectful of medical ethics, culturally appropriate, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned (Committee on Economic, Social and Cultural Rights, General Comment 14). *See also* "Accessibility" "Availability," and "Quality."

ACCESSIBILITY

One of four criteria set out by Committee on Economic, Social and Cultural Rights by which to evaluate the right to the highest attainable standard of health. Accessibility: means that health facilities, goods and services have to be accessible to everyone without discrimination. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic feasibility (affordability), and information accessibility (Committee on Economic, Social and Cultural Rights, General Comment 14). *See also* "Acceptability," Availability," and "Quality."

ACCESSION

The act whereby a state that has not signed a treaty expresses its consent to become a party to that treaty by depositing an "instrument of accession." Accession has the same legal effect as ratification. Accession is generally employed by States wishing to express their consent to be bound by a treaty where the deadline for signature has passed. However, many modern multilateral treaties provide for accession even during the period that the treaty is open for signature.

ACTIO POPULARIS (PUBLIC ACTION)

A legal action brought by any member of a community in vindication of a public interest.

ADOPTION

The formal act by which negotiating parties establish the form and content of a treaty. The treaty is adopted through a specific act expressing the will of the States and the international organizations participating in the negotiation of that treaty, e.g., by voting on the text, initialing, signing, etc. Adoption may also be the mechanism used to establish the form and content of amendments to a treaty, or regulations under a treaty. Treaties that are negotiated within an international organization are usually adopted by resolution of the representative organ of that organization. For example, treaties negotiated under the auspices of the United Nations, or any of its bodies, are adopted by a resolution of the General Assembly of the United Nations

ADOPTION THEORY

A theory maintaining that international law becomes an automatic part of domestic law following treaty accession or ratification, without further domestication.

AMICUS CURIAE (FRIEND OF THE COURT)

A legal document filed with the court by a neutral party generally advocating a particular legal position or interpretation. The plural form is amici curiae.

AMBULATORY CARE

Medical care including diagnosis, observation, treatment and rehabilitation provided on an outpatient basis.

AVAILABILITY

One of four criteria set out by Committee on Economic, Social and Cultural Rights by which to evaluate the right to the highest attainable standard of health. Availability: means that functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity. This should include the underlying determinants of health, such as safe drinking water, adequate sanitation facilities, clinics and health-related buildings, trained medical personnel, and essential drugs (Committee on Economic, Social and Cultural Rights, General Comment 14). *See also* "Acceptability," "Accessibility," and "Quality."

B

BASIC NEEDS

Used largely in the development of community to refer to basic health services, education, housing, and other goods necessary for a person to live.

BIOETHICS

Refers to "the broad terrain of the moral problems of the life sciences, ordinarily taken to encompass medicine, biology, and some important aspects of the environmental, population and social sciences. The traditional domain of medical ethics would be included in this array, accompanied now by many other topics and problems." (Encyclopedia of Bioethics, Warren T. Reich, editor-in-chief, New York: Simon & Schuster Macmillan, 1995, page 250)

BIOMEDICINE

The term unifies fields of clinical medicine and research for health purposes. Broadly it is also defined as the application of the principles of the natural sciences, especially biology and physiology, to clinical medicine.

C

CONCLUDING OBSERVATIONS

Recommendations by a treaty's enforcement mechanism on the actions a state should take in ensuring compliance with the treaty's obligations. This generally follows both submission of a state's country report and a constructive dialogue with state representatives.

COUNTRY REPORT

A state's report to the enforcement mechanism of a particular treaty on the progress it has made in implementing it.

CONVENTION

This term is used interchangeably with treaty, but it can also have a specific meaning as a treaty binding a broad number of nations. Conventions are normally open for participation by the international community as a whole, or by a large number of States. Usually instruments negotiated under the auspices of an international organization are entitled conventions. The same holds true for instruments adopted by an organ of an international organization.

CUSTOMARY INTERNATIONAL LAW

One of the sources of international law. It consists of rules of law derived from the consistent conduct of States acting out of the belief that the law required them to act that way. It follows that customary international law can be discerned by a widespread repetition by States of similar international acts over time (State practice). Acts must occur out of a sense of obligation and must be taken by a significant number of States and not be rejected by a significant number of States. A particular category of customary international law, jus cogens refers to a principle of international law so fundamental that no state may opt out by way of treaty or otherwise. Examples might include prohibitions against slavery, genocide, torture and crimes against humanity. Other examples of customary international law include the principle of non-refoulement and, debatably, the right to humanitarian intervention.

D

DE FACTO (IN FACT, IN REALITY)

Existing in fact.

DE JURE (BY RIGHT, LAWFUL)

A situation or condition that is based on a matter of law, such as those detailed in ratified treaties.

DECLARATION

An interpretative declaration is a declaration by a State as to its understanding of some matter covered by a treaty or its interpretation of a particular provision. Unlike reservations, declarations merely clarify a State's position and do not purport to exclude or modify the legal effect of a treaty.

DIGNITY

The quality of being worthy, honored, or esteemed. Human rights are based on inherent human dignity and aim to protect and promote it.

DISCRIMINATION

Distinction between persons in similar cases on the basis of race, sex, religion, political opinions, national or social origin, associations with a national minority or personal antipathy (World Health Organization- WHO).

DOMESTICATION

The process by which an international treaty is incorporated into domestic legislation.

DUAL LOYALTY

Role conflict between professional duties to a patient and obligations—express or implied, real or perceived—to the interests of a third party such as an employer, insurer, or the state.

E

ENTRY INTO FORCE

The moment in time when a treaty becomes legally binding on the parties to the treaty. The provisions of the treaty determine the moment of its entry into force. This may be a date specified in the treaty or a date on which a specified number of ratifications, approvals, acceptances or accessions have been deposited with the depositary.

ESSENTIAL MEDICINES

Medicines that satisfy the priority health-care needs of the population. Essential medicines are intended to be available at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford.

EXHAUSTION OF DOMESTIC REMEDIES

Refers to the process required before submitting a complaint on behalf of a victim to any regional or international tribunal. All available procedures must first be used to seek protection from future human rights violations and to obtain justice for past abuses. There are limited exceptions to the requirement that domestic remedies be exhausted: remedies may be unavailable, ineffective (i.e. a sham proceeding) or unreasonably delayed.

G

GENERAL COMMENTS/RECOMMENDATIONS

Interpretive texts issues by a treaty's enforcement mechanism on the content of particular rights. Although these are not legally binding, they are widely regarded as authoritative and have significant legal weight.

H

HEALTH

A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmary (WHO).

HEALTH CARE

1. The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical, nursing, and allied health professions. This definition and similar ones sometimes are given for "patient care" as well. The World Health Organization states that this embraces all the goods and services designed to promote health, including preventive, curative, and palliative interventions, whether directed to individuals or populations.

2. Any type of services provided by professionals or paraprofessionals with an impact on health status (Online Glossary, European Observatory on Health Systems and Policy).

3. Medical, nursing or allied services dispensed by health care providers and health care establishments (Declaration on the Promotion of Patients' Rights in Europe, WHO, Amsterdam, 1994). *See also* "Patient Care."

HEALTH CARE ESTABLISHMENT

Any health care facility such as a hospital, nursing home, or establishment for disabled persons (Declaration on the Promotion of Patients' Rights in Europe, WHO, Amsterdam, 1994).

HEALTH CARE PROVIDERS

Physicians, nurses, dentists, or other health professionals (Declaration on the Promotion of Patients' Rights in Europe, WHO, Amsterdam, 1994).

HEALTH CARE SYSTEM

The organized provision of health care services.

HUMAN RIGHTS

Entitlements, freedoms, and privileges which adhere to all human beings regardless of jurisdiction or other factors such as ethnicity, nationality, religion, or sex. Human Rights are universal legal guarantees protecting individuals and groups from interference with fundamental freedoms and human dignity. Some of the most important characteristics of human rights are that they are:

- guaranteed by international standards
- legally protected
- focus on the dignity of the human being
- oblige states and state actors
- cannot be waived or taken away
- interdependent and interrelated; and
- universal

(The United Nations System and Human Rights: Guidelines and Information for the Resident Coordinator System, Geneva, March 2000).

HUMAN RIGHTS INDICATORS

Criteria used to measure compliance with international human rights standards.

HUMAN RIGHTS IN PATIENT CARE

Concept that refers to the application of basic human rights principles to all stakeholders in the delivery of health care services. It is complementary to bioethics but provides a set of universally accepted norms and procedures for making conclusions about abuses within health care settings and providing remedies. It uses standards contained in the international human rights framework, which are often mirrored in regional treaties and national constitutions. It differs from patients' rights, which codify particular rights that are relevant only to patients rather than applying general human rights standards to all stakeholders in health care service delivery, including

providers. It draws on concepts such as dual loyalty, which attributes much human rights abuse in health settings to health care providers simultaneous and often conflicting obligations to their patients and to the State. *See also* "Dual Loyalty."

I

INTERDEPENDENT/INDIVISIBLE

The term used to describe the relationship between civil and political rights and economic and social rights. Interdependence and indivisibility mean that one set of rights does not take precedence over the other, and that guaranteeing each set of rights is contingent upon guaranteeing the other.

INDIRECT DISCRIMINATION

Descriptive term for a situation in which the effect of certain imposed requirements, conditions or practices has a disproportionately adverse impact on one group or other. It generally occurs when a rule or condition applying to everyone is met by a considerably smaller proportion of people from a particular group, the rule is to their disadvantage, and it cannot be justified on other grounds.

INDIVIDUAL RIGHTS IN PATIENT CARE

More readily expressed in absolute terms than are social rights in health care. When made operational, can be made enforceable on behalf of an individual patient (Declaration on the Promotion of Patients' Rights in Europe, WHO Amsterdam, 1994, Guiding Principles). *See also* "Social Rights in Health Care" and "Patient's Rights."

INFORMED CONSENT

A legal condition in which a person can be said to agree to a course of action based upon an appreciation and understanding of the facts and implications. The individual needs to be in possession of relevant facts and the ability to reason.

INFORMED CONSENT IN THE HEALTH CARE CONTEXT

A process in which a patient participates in health care choices. A patient must be provided with adequate and understandable information on matters such as the treatment's purpose, alternative treatments, risks, and side-effects.

IN-PATIENT

A patient whose care requires a stay in hospital or hospice facility for at least one night.

INTERNATIONAL HUMAN RIGHTS LAW

Codifies legal provisions governing human rights in various international and regional human rights instruments.

INTERNATIONAL LAW

The set of rules and legal instruments regarded and accepted as binding agreements between nations. International law is typically divided into public international law and private international law. Sources are (a) custom; (b) treaties; (c) general principles of law and (d) judicial decisions and juristic writings (Article 38(1)(d) of the Statute of the International Court of Justice).

J

JUS COGENS

Peremptory principle of international law (e.g., prohibition on torture) from which no derogation by treaty is permitted.

M

MAXIMUM AVAILABLE RESOURCES

Key provision in Article 2 of International Covenant on Economic, Social and Cultural Rights obliging governments to devote the maximum of available government resources to realizing economic, social and cultural rights.

MEDICAL INTERVENTION

Any examination, treatment, or other act having preventive, diagnostic, therapeutic or rehabilitative aims and which is carried out by a physician or other health care provider (Declaration on the Promotion of Patients' Rights in Europe, WHO, Amsterdam, 1994).

MONITORING/FACT FINDING/INVESTIGATION

Terms often used interchangeably, generally intended to mean the tracking and/or gathering of information about government practices and actions related to human rights.

N

NEGATIVE RIGHTS

Rights under which a State is obliged to refrain from unjustly interfering with a person and/or their attempt to do something.

NEGLECTED DISEASES

Diseases affecting almost exclusively poor and powerless people in rural parts of low-income countries that receive less attention and resources.

O

OUT-PATIENT

Patient receiving treatment without spending any nights at a health care institution.

P

PARTY

A State or other entity with treaty-making capacity that has expressed its consent to be bound by that treaty by an act of ratification, acceptance, approval or accession, etc., where that treaty has entered into force for that particular State. This means that the State is bound by the treaty under international law (Article 2(1)(g) of the Vienna Convention, 1969).

PATIENT

1. User(s) of health care services, whether healthy or sick (Declaration on the Promotion of Patients' Rights in Europe ,WHO, Amsterdam 1994). 2. A person in contact with the health system seeking attention for a health condition (Online Glossary, European Observatory on Health Systems and Policies).

PATIENT AUTONOMY

The right of patients to make decisions about their medical care. Providers can educate and inform patients, but cannot make decisions for them.

PATIENT CARE

The services rendered by members of the health professions or non-professionals under their supervision for the benefit of the patient. *See also* "Health Care."

PATIENT-CENTERED CARE

Doctrine recognizing the provision of health care services as a partnership among health care providers and patients and their families. Decisions about medical treatments must respect patients' wants, needs, preferences, and values.

PATIENT CONFIDENTIALITY

Doctrine that holds that the physician has the duty to maintain patient confidences. This is to allow patients to make full and frank disclosure to their physician, enabling appropriate treatment and diagnosis.

PATIENT MOBILITY

Concept describing patient movement beyond their catchment area or area of residence to access health care; mobility can take place within the same country or between countries.

PATIENT RESPONSIBILITY

Doctrine recognizing the doctor/patient relationship as a partnership with each side assuming certain obligations. Patient responsibilities include communicating openly with the physician or provider, participating in decisions about diagnostic and treatment recommendations, and complying with the agreed-upon treatment program.

PATIENTS' RIGHTS

1. A set of rights calling for government and health care provider accountability in the provision of quality health services. Associated with a movement that has emerged out of increasing concern about human rights abuses in health care settings, particularly in countries where patients are assuming a greater share of health care costs and thus expect to have their rights as "consumers" respected.

2. A set of rights, responsibilities and duties under which individuals seek and receive health care services (Online Glossary, European Observatory on Health Systems and Policies).

3. What is owed to the patient as a human being by physicians and the State.

PATIENT SAFETY

Freedom from accidental injury due to medical care or medical errors (Institute of Medicine).

POSITIVE RIGHTS

Rights under which a State is obliged to do something for someone.

PRIMARY HEALTH CARE

1. General health services that are available in a community, located near the places where people live and work.

2. First level of contact that individuals and families have with the health system.

PROGRESSIVE REALIZATION

The requirement in Article 2 of the International Covenant on Economic, Social and Cultural Rights that governments move as expeditiously and effectively as possible toward the goal of realizing economic, social and cultural rights, and to ensure there are no regressive developments.

PROTOCOL

Refers to a section in a treaty that clarifies terms, adds additional text as amendments, or establishes new obligations. These new obligations can be quantitative targets for nations to achieve.

PUBLIC HEALTH

Collective actions of a society to ensure conditions in which people can be healthy (Institute of Medicine).

PUBLIC INTERNATIONAL LAW

Establishes the framework and the criteria for identifying states as the principal actors in the international legal system. Deals with the acquisition of territory, state immunity and the legal responsibility of states in their conduct with each other. Also concerned with the treatment of individuals within state boundaries including human rights, the treatment of aliens, the rights of refugees, international crimes and nationality. It further includes the maintenance of international peace and security, arms control, the pacific settlement of disputes and the regulation of the use of force in international relations. Branches, therefore, include international human rights law, international humanitarian law, refugee law and international criminal law.

Q

QUALITY

One of four criteria set out by the Committee on Economic, Social, and Cultural Rights by which to evaluate the right to the highest attainable standard of health. Quality: means that health facilities, goods, and services must be scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically-approved and unexpired drugs, and hospital equipment (Committee on Economic, Social and Cultural Rights, General Comment 14). *See also* "Acceptability," "Accountability," and "Availability."

R

RATIFICATION

The formal acceptance of the rights and obligations of a treaty. If the treaty has entered into force, the treaty thereafter becomes legally binding to parties that have ratified the treaty. Requires two steps: (a) the execution

of an instrument of ratification, acceptance or approval by the Head of State, Head of Government or Minister for Foreign Affairs, expressing the intent of the State to be bound by the relevant treaty; and (b) for multilateral treaties, the deposit of the instrument with the depositary; and for bilateral treaties, the exchange of the instruments between parties.

RESERVATION

A statement made by a State by which it purports to exclude or alter the legal effect of certain provisions of a treaty in their application to that State. A reservation may enable a State to participate in a multilateral treaty that it would otherwise be unable or unwilling to participate in. States can make reservations to a treaty when they sign, ratify, accept, approve or accede to it. When a State makes a reservation upon signing, it must confirm the reservation upon ratification, acceptance or approval. Since a reservation purports to modify the legal obligations of a State, it must be signed by the Head of State, Head of Government or Minister for Foreign Affairs. Reservations cannot be contrary to the object and purpose of the treaty. Some treaties prohibit reservations or only permit specified reservations.

RESPECT, PROTECT AND FULFILL

Governments' obligations with respect to rights. Respect: Government must not act directly counter to the human rights standard. Protect: Government must act to stop others from violating the human rights standard. Fulfill: Government has an affirmative duty to take appropriate measures to ensure that the human rights standard is attained.

RIGHT TO HEALTH

Right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of physical and mental health (Committee on Economic, Social and Cultural Rights, General Comment 14).

S

SECONDARY HEALTH CARE

General health services available in hospitals

SOCIAL RIGHTS IN HEALTH CARE

Category of rights that relate to the societal obligation undertaken or otherwise enforced by government and other public or private bodies to make reasonable provision of health care for the whole population. They also relate to equal access to health care for all those living in a country or other geopolitical area and the elimination of unjustified discriminatory barriers, whether financial, geographical, cultural or social and psychological. They are enjoyed collectively (Declaration on the Promotion of Patients' Rights in Europe, WHO, Amsterdam, 1994, Guiding Principles). *See also* "Individual Rights in Patient Care."

SELF-EXECUTING TREATY

A treaty that does not require implementing legislation for its provisions to have effect in domestic law.

SHADOW REPORT

An independent NGO submission to a treaty enforcement mechanism to help it assess a state's compliance with that treaty.

SIGNATORY

A party that has signed an agreement. In regards to a treaty, a signatory is not yet legally bound by the treaty. Instead, a signatory agrees to an obligation not to defeat the object and purpose of a signed treaty. *See also*

"Ratification."

SPECIAL RAPPORTEURS

Individuals appointed by the Human Rights Council to investigate human rights violations and present an annual report with recommendations for action. There are both country-specific and thematic special rapporteurs, including one on theright to the highest attainable standard of health.

T

TERMINAL CARE

Care given to a patient when it is no longer possible to improve the fatal prognosis of his or her illness/condition with available treatment methods, as well as care at the approach of death (Declaration on the Promotion of Patients' Rights in Europe, WHO, Amsterdam, 1994).

TERTIARY HEALTH CARE

Specialized health services available in hospitals.

TRANSFORMATION THEORY

A theory maintaining that international law only becomes part of domestic law after domestication and the incorporation of treaty provisions into domestic legislation.

TREATY

A formal agreement entered into by two or more nations which is binding upon them. A bilateral treaty is a treaty between two parties. A multilateral treaty is a treaty between more than two parties.

W

WORKING GROUPS

Small committees appointed by the Human Rights Council on a particular human rights issue. Working groups write governments about urgent cases and help prevent future violations by developing clarifying criteria on what constitutes a violation

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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CHPS CENTER FOR HEALTH POLICIES AND SERVICES