

# Human Rights in Patient Care

*A Practitioner Guide*

**GEORGIA**



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ISBN: 978-9941-0-3023-9

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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*

# ACKNOWLEDGEMENTS

Stemming from the genuine concern about urgent need to further enjoyment of human rights in patient care, this Guide is the joint product of a number of dedicated persons and organizations committed to making a difference. The aim of the Guide is to support the rights of healthcare providers and patients and particularly to assist lawyers to promote equal realization of rights and secure human dignity in the field of patient care.

Organizations supporting this project include the Open Society Georgia Foundation – Law, Media and Health Initiative, the Open Society Institute (OSI) Public Health Program Law and Health Initiative (LAHI), and the OSI Human Rights and Governance Grants Program (HRGGP). Much appreciation is owed to the individuals from these organizations who were most directly involved: **Nino Kiknadze** (OSI Foundation in Georgia); **Tamar Ezer** and **Jonathan Cohen** (LAHI), who, in addition to general oversight and editing responsibilities, co-authored the international and regional procedures chapter<sup>1</sup> and, with **Judith Overall**, co-authored the introduction; **Mariana Berbec Rostas** (HRGGP) for updating the regional procedures section; **Paul Silva** (OSI Communications Officer), for his advice and coordination of work on the Guide’s design, and **Tornike Lordkipanidze**, the designer.

Special thanks are owed to **Iain Byrne**, Senior Lawyer at INTERIGHTS, for writing the chapters on the international and regional framework for human rights in patient care and for preparing the glossary with **Judith Overall** and to **Eszter Csernus** for editorial review of the national chapters. Thanks are due as well to **Sara Abiola** for language and format editing of the international and regional framework chapters and to **Anna Kryukova** for preparing the ratification chart. Also deserving thanks are **Tamar Dekanosidze** for review and final edits, updates to the guide, and preparation of the national ratification chart and **Marina Kvachadze** for reviewing international legal instruments.

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

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

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<sup>1</sup> This chapter builds on material in *Health and Human Rights: A Resource Guide*, published by Open Society Institute and Equitas and edited by J. Cohen, T. Ezer, P. McAdams, and M. Miloff. An HTML version of this Resource Guide is available at: <http://equalpartners.info/>. The appendix to the international and regional procedures chapter is excerpted with permission from the Human Rights Center, University of Essex Publication, *Reported Killing as Human Rights Violations*, by Kate Thompson and Camille Giffard, pages 127-130.

- 1.1 **Introduction**
- 1.2 **Overview of the Guide**
- 1.3 **Table of Abbreviations**
- 1.4 **Table of Ratifications**

# 1

## Introduction

### 1.1 Introduction

This guide is part of a series published in cooperation with the Law and Health Initiative of the Open Society Institute (OSI) Public Health Program, OSI's Human Rights and Governance Grants Program, OSI's Russia Project, and the Soros 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 post-Soviet 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. These rights are universal and can be applied in the context of health care delivery just as they can be in any other context.

## 1.2 Overview of the Guide

Chapters 2 and 3 of the guide respectively cover the international and regional 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 Georgia; explains the country’s use of precedent; and includes a brief description of the legal and health systems. Chapter 6 deals with patient rights and responsibilities. The patient rights section is organized according to the rights in the European Charter of Patients’ Rights, with the addition of any country-specific rights not specifically covered by the charter. Drawn up in 2002 by the Active Citizenship Network—a European network of civic, consumer, and patient organizations—the European Charter of Patients’ Rights is not legally binding, but 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 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 Prosecutor, ombudspersons, ministries of internal affairs, ethics review committees, and inspectorates of health facilities. The chapter additionally contains an annex of sample forms and documents for lawyers to file.

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



## Uses of the Guide

The guide has been designed as a resource for both litigation and training. It may be particularly useful in clinical legal-education programs. Although designed for lawyers, the guide may additionally be of interest to medical professionals, 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](http://www.health-rights.org). The Georgian website is [www.healthrights.ge](http://www.healthrights.ge). 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 Georgia. 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 Georgia, 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 Table of Abbreviations

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

## 1.4 Table of Ratifications

| Documents  | Date of Accession / deposit | Date of Signature | Date of Ratification | Entry into Force | Applicable in country Legislation | Reservation Entered |
|--|-----------------------------|-------------------|----------------------|------------------|-----------------------------------|---------------------|
| <b>International</b>   |                             |                   |                      |                  |                                   |                     |
| International Covenant on Civil and Political Rights (ICCPR)   | 03.05.94                    |                   |                      | 03.08.94         | Applicable                        | None                |
| Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR – OP)   | 03.05.94                    |                   |                      | 03.08.94         | Applicable                        | None                |
| International Covenant on Economic, Social and Cultural Rights (ICESCR)  | 03.05.94                    |                   |                      | 03.08.94         | Applicable                        | None                |
| Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)   | 26.10.94                    |                   |                      | 25.11.94         | Applicable                        | None                |
| Convention for the Elimination of All Forms of Racial Discrimination (CERD)  | 26.10.94                    |                   |                      | 02.07.99         | Applicable                        | 1                   |
| Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment (CAT)   | 26.10.94                    |                   |                      | 25.11.94         | Applicable                        | 2                   |
| Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT – OP)   | 26.10.94                    |                   |                      | 22.06.06         | Applicable                        | None                |
| Convention on the Rights of the Child (CRC)  | 02.06.94                    |                   |                      | 02.07.94         | Applicable                        | None                |
| International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families (CMW)   | 02.06.94                    | -                 | -                    | -                | Applicable                        | None                |
| Convention on the Rights of Persons with Disabilities (DRC)  |                             | 10.07.09          | -                    | -                | -                                 | -                   |
| <b>European (Regional)</b>   |                             |                   |                      |                  |                                   |                     |
| 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                       | 22.11.00                    | 11.05.00          | 27.09.00             | 01.03.01         | Applicable                        | None                |
| 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 | 22.11.00                    | 11.05.00          | 27.09.00             | 01.03.01         | Applicable                        | None                |
| Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin   | 18.12.02                    | 25.03.02          | 27.09.02             | 01.05.06         | Applicable                        | None                |
| Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research  | -                           | 21.02.05          | 08.04.10             | 01.08.10         | Applicable                        | None                |
| Additional Protocol to the Convention on Human Rights and Biomedicine concerning Genetic Testing for Health Purposes   | -                           | -                 | -                    | -                | -                                 | -                   |
| Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights)   | -                           | 27.04.99          | 20.05.99             | 20.5.1999        | Applicable                        | None                |
| European Social Charter 1961   | -                           | -                 | -                    | -                | -                                 | -                   |
| European Social Charter 1996   | -                           | 30.06.00          | 22.08.05             | 01.10.00         | Applicable                        | 1                   |
| Framework Convention for the Protection of National Minorities 1995  | -                           | 21.01.00          | 22.12.05             | 01.04.06         | Applicable                        | None                |
| EU Charter of Fundamental Rights   |                             | -                 | -                    | -                | -                                 | -                   |

CHAPTER 1: INTRODUCTION

| Documents  | Date of Accession / deposit | Date of Signature | Date of Ratification | Entry into Force | Applicable in country Legislation | Reservation Entered |
|--|-----------------------------|-------------------|----------------------|------------------|-----------------------------------|---------------------|
| <b>Other treaties related to Health Law signed by country</b>  |                             |                   |                      |                  |                                   |                     |
| Declaration on Human Rights Protection   |                             |                   | 15.09.91             |                  | Applicable                        |                     |
| Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949.                   |                             |                   | 20.07.93             | 14.03.94         | Applicable                        | None                |
| Convention for the Amelioration of the Condition of the Wounded and Sick and Shipwrecked Members of Armed Forces at Sea. Geneva, 12 August 1949. |                             |                   | 20.07.93             | 14.03.94         | Applicable                        | None                |
| Convention relative to the Treatment of Prisoners of War. Geneva, 12 August 1949.  |                             |                   | 20.07.93             | 14.03.94         | Applicable                        | None                |
| Social Policy (Basic Aims and Standards) Convention, 1962  |                             |                   | 16.10.96             | 21.10.98         | Applicable                        |                     |
| UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances  |                             |                   | 28.05.97             | 08.04.98         | Applicable                        | None                |
| UN Organization's Convention on Psychotropic Substances  |                             |                   | 28.05.97             | 08.04.98         | Applicable                        | None                |
| Convention on Protection of Children and Co-Operation in Respect of Intercountry Adoption  |                             |                   | 01.08.99             | 01.08.99         | Applicable                        | None                |
| United Nations Convention on Narcotic Drugs.   |                             |                   | 23.02.00             | 26.04.00         | Applicable                        | None                |
| 4 <sup>th</sup> Protocol to the European Convention on Human Rights and Fundamental Freedoms   |                             |                   | 23.02.00             | 13. 04. 00       | Applicable                        | None                |
| 6 <sup>th</sup> Protocol to the European Convention on Human Rights and Fundamental Freedoms   |                             |                   | 23.02.00             | 01. 05. 00       | Applicable                        | None                |
| 7 <sup>th</sup> Protocol to the European Convention on Human Rights and Fundamental Freedoms   |                             |                   | 13.04.00             | 01. 07. 00       | Applicable                        | None                |
| The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment   |                             |                   | 20.06.00             | 01.10.00         | Applicable                        | 1                   |
| First additional protocol to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment              |                             |                   | 20.06.00             | 01.03.02         | Applicable                        | None                |
| Second additional protocol to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment             |                             |                   | 20.06.00             | 01.03.02         | Applicable                        | None                |
| 12 <sup>th</sup> Protocol to the European Convention on Human Rights and Fundamental Freedoms  |                             |                   | 15.06.01             | 01.04.05         | Applicable                        | 1                   |
| 1 <sup>st</sup> Protocol to the European Convention on Human Rights and Fundamental Freedoms   |                             |                   | 27.12.01             | 07.06.02         | Applicable                        | 2                   |
| Upon ratification of convention on ban of extreme forms of children's labor and immediate elimination activities.                                |                             |                   | 18.05.02             | 24.07.03         | Applicable                        | None                |
| Additional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict.                               |                             |                   | 21.06.02             |                  | Applicable                        |                     |
| Amendment to article 20, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women                          |                             |                   | 27.09.02             | 30.09.05         | Applicable                        | None                |
| Upon integration of additional protocol to convention on Trade, Prostitution, and Pornography of Children  |                             |                   | 27.09.02             | 28.07.05         | Applicable                        | None                |

| <b>Documents</b>   | <b>Date of Accession / deposit</b> | <b>Date of Signature</b> | <b>Date of Ratification</b> | <b>Entry into Force</b> | <b>Applicable in country Legislation</b> | <b>Reservation Entered</b> |
|--|------------------------------------|--------------------------|-----------------------------|-------------------------|--|----------------------------|
| Protocol No. 14 to the Convention for the Protection of Human Rights and Fundamental Freedoms, amending the control system of the Convention |                                    |                          | 10.11.04                    | 01.06.10                | Applicable                               | None                       |
| Convention on Political Rights of Women  |                                    |                          | 16.06.05                    | 04.07.05                | Applicable                               | None                       |
| Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data  |                                    |                          | 28.10.05                    | 01.04.06                | Applicable                               | None                       |
| WHO Framework Convention on Tobacco Control  |                                    |                          | 28.10.05                    | 15.05.06                | Applicable                               | None                       |

**2.1 INTRODUCTION**

**2.2 KEY SOURCES**

**2.3 PATIENTS ' RIGHTS**

**Right to liberty and security of the person**

**Right to privacy**

**Right to information**

**Right to bodily integrity**

**Right to life**

**Right to the highest attainable standard of health**

**Right to freedom from torture and cruel, inhuman, and degrading treatment**

**Right to participate in public policy**

**Right to nondiscrimination and equality**

**2.4 PROVIDERS' RIGHTS**

**Right to work in decent conditions**

**Right to freedom of association**

**Right to due process and related rights**

# 2

## International Framework for Human Rights in Patient Care

### 2.1 Introduction

This chapter presents the main standards that safeguard human rights in patient care internationally and examines how United Nations (UN) treaty-monitoring bodies have interpreted these standards. The chapter is divided into three parts. The first part describes the key international sources governing human rights in patient care. The second examines patients' rights, and the third focuses on the rights of providers. Each part includes subsections that discuss the standards and relevant interpretations connected to a particular right (e.g., the Right to Liberty and Security of the Person) and also provide some examples of potential violations. The standards addressed include binding treaties, such as the International Covenant on Civil and Political Rights (ICCPR), and nonbinding policies developed by the UN and nongovernmental organizations (NGOs), such as the World Medical Association's Declaration on Patients' Rights.

## 2.2 Key Sources

### UNITED NATIONS

#### Universal Declaration of Human Rights 1948 (UDHR)

The UDHR is not a treaty but it is highly authoritative. It has shaped the evolution of modern human rights law, and many of its provisions are effectively reproduced in international treaties (see below). Many of its provisions have also achieved the status of customary international law—they are universal and indisputable.

Key provisions include:

- Article 3 (right to life)
- Article 5 (prohibition on torture and cruel, inhuman, or degrading treatment)
- Article 7 (protection against discrimination)
- Article 12 (right to privacy)
- Article 19 (right to seek, receive, and impart information)
- Article 25 (right to medical care)

### TREATIES

All of the seven major international human rights treaties contain guarantees relating to the protection of human rights in patient care. While these treaties are binding on those states that have ratified them, their standards have strong moral and political force even for non-ratifying countries. Many, such as the two international covenants and the Convention on the Rights of the Child (CRC), have been widely (and, in the case of the latter, almost universally) ratified.<sup>1</sup>

The treaty-monitoring bodies have issued numerous General Comments (GCs) to serve as authoritative guides for the interpretation of treaty standards. For example, the Committee on Economic and Social Rights (CES CR) issued GC 14 on Article 12 of the International Covenant on Civil and Political Rights (ICES CR), interpreting the right to health as the right to control one's own health and body.

All of the treaty bodies monitor compliance through the consideration of periodic state reports and then issue concluding observations.<sup>2</sup> The majority—including the Human Rights Committee (HRC), Committee on the Elimination of Discrimination Against Women (CEDAW), Committee Against Tor-

1 Office of the UN High Commissioner for Human Rights (OHCHR). Status of the Ratifications of the Principle International Human Rights Treaties. <http://www2.ohchr.org/english/bodies/docs/status.pdf>. Accessed November 14, 2009.

2 Human Rights Bodies: Complaint Procedures. <http://www2.ohchr.org/english/bodies/petitions/index.htm>. Accessed November 14, 2009. The ICES CR will also have its own complaints mechanism in the near future, following adoption of an optional protocol by the UN in December 2008 and its opening for ratification on September 24, 2009.



ture (CAT), Committee on the Elimination of Racial Discrimination (CERD), and the Committee on the Rights of Persons with Disabilities (CRPD)—may now also consider individual complaints provided that, in most cases, the State has ratified the appropriate optional protocol to the treaty.<sup>3</sup> Together, these materials can be used to further interpret the standards

- ▶ **International Covenant on Civil and Political Rights (ICCPR)**<sup>4</sup> Together with the UDHR and the ICES CR, the ICCPR forms part of the International Bill of Rights. The ICCPR is monitored by the HRC.

Relevant provisions include:

- Article 2(1) (prohibition on discrimination)
- Article 6 (right to life)
- Article 7 (prohibition on torture)
- Article 9 (right to liberty and security)
- Article 10 (right to dignity for detainees)
- Article 17 (right to privacy)
- Article 19(2) (right to information)
- Article 26 (equality before the law)

- ▶ **International Covenant on Economic, Social and Cultural Rights (ICESCR)**<sup>5</sup>

The ICES CR is monitored by the CES CR.

Key provision:

- Article 12 (right to highest attainable standard of health) (See General Comment 14)<sup>6</sup>

The SR (currently, Anand Grover, who replaced Professor Paul Hunt in August 2008) is an independent expert who is mandated by the UN to investigate how the right to the highest attainable standard of health can be effectively realized. The SR conducts country visits, produces annual reports, and carries

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3 Human Rights Bodies: Complaint Procedures. <http://www2.ohchr.org/english/bodies/petitions/index.htm>. Accessed November 14, 2009. The ICES CR will also have its own complaints mechanism in the near future, following adoption of an optional protocol by the UN in December 2008 and its opening for ratification on September 24, 2009.

4 International Covenant on Civil and Political Rights (ICCPR). United Nations General Assembly Resolution 2200A [XXI]. December 16, 1966. <http://www2.ohchr.org/english/law/ccpr.htm>. Accessed November 14, 2009.

5 International Covenant on Economic, Social and Cultural Rights (ICESCR). United Nations General Assembly Resolution 2200A[XXI]. December 16, 1966. <http://www2.ohchr.org/english/law/cescr.htm>.

6 Official Documents Center of the United Nations. <http://daccessdds.un.org/doc/UN+DOC/GEN+/G00/439/34/PDF/G0043934.pdf?OpenElement>. Accessed November 14, 2009.

out in-depth studies into particular issues. For example, in September 2007, the SR produced draft guidelines for pharmaceutical companies on access to medicines.<sup>7</sup>

Other relevant provisions include:

- Article 2(1) (prohibition on discrimination)
- Article 10(3) (protection of children)
- Article 11 (adequate standard of living)

**Note: Special Rapporteur (SR) on the Right to Health<sup>8</sup>**

► **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)<sup>9</sup>**

Monitored by the Committee on the Elimination of Discrimination against Women.

Key provisions:

- Article 12 (elimination of discrimination against women in health care);
- Article 14(2)(b) (right of women in rural areas to have access to adequate health care facilities)

(See also General Recommendation 24 on Article 12 (women and health), a comprehensive analysis of women's health needs and recommendations for government action).<sup>10</sup>

► **Convention for the Elimination of All Forms of Racial Discrimination (CERD)<sup>11</sup>**

Monitored by the Committee on the Elimination of Racial Discrimination.

Key provision:

- Article 5(1)(e) (prohibition on race discrimination in public health and medical care)

► **Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment (CAT)<sup>12</sup>**

7 OHCHR. <http://www2.ohchr.org/english/issues/health/right/docs/draftguid.doc>

8 OHCHR. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. <http://www2.ohchr.org/english/issues/health/right/>. Accessed November 14, 2009.

9 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). United Nations General Assembly, December 18, 1979. <http://www2.ohchr.org/english/law/cedaw.htm>. Accessed November 14, 2009.

10 UN Committee on the Elimination of Discrimination against Women. CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health) <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24>.

11 International Convention for the Elimination of all Forms of Racial Discrimination (ICERD). UN General Assembly Resolution 2106 [XX], December 21, 1965. <http://www2.ohchr.org/english/law/cerd.htm> Accessed November 14, 2009.

12 Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. UN General Assembly Resolution 39/46, December 10, 1984. <http://www2.ohchr.org/english/law/cat.htm>. Accessed November 14, 2009.

Monitored by the Committee Against Torture, the CAT introduced a new optional protocol in 2002 that focuses on prevention of torture.<sup>13</sup>

▶ **Convention on the Right of Child (CRC)**<sup>14</sup>

Monitored by the Committee on the Rights of the Child, the CRC contains a comprehensive range of civil, political, economic, social, and cultural rights guarantees.

Key provision:

- Article 24 (right to highest attainable standard of health)

**International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families (CMW)**<sup>15</sup>

Monitored by the Committee on Migrant Workers, the CMW contains a comprehensive range of civil, political, economic, social, and cultural rights guarantees.

Key provisions:

- Article 28 (right to medical care)
- Articles 43 and 45(1)(c) (equal treatment in health care)

▶ **Convention on the Right of Persons with Disabilities (CRPD)**<sup>16</sup>

The CRPD applies to people with “long-term physical, mental, intellectual or sensory impairments,” and seeks to “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.” The CRPD contains a comprehensive range of civil, political, economic, social, and cultural rights guarantees. It was entered into force on May 12, 2008.

Key provision:

- Article 25 (health)

Other relevant provisions include:

- Article 5 (equality and nondiscrimination);

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13 Optional Protocol to the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. UN General Assembly Resolution A/RES /57/199. December 18, 2002. <http://www2.ohchr.org/english/law/cat-one.htm>. Accessed November 14, 2009.

14 Convention on the Rights of the Child (CRC). UN General Assembly Resolution 44/25. November 20, 1989. <http://www2.ohchr.org/english/law/crc.htm>, Accessed November 14, 2009.

15 International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families. UN General Assembly Resolution 45/158. December 18, 1990. <http://www2.ohchr.org/english/law/cmw.htm>. Accessed November 14, 2009.

16 Convention on the Rights of Persons with Disabilities (CRPD). UN General Assembly Resolution. December 13, 2006. <http://www2.ohchr.org/english/law/disabilities-convention.htm>. Accessed November 14, 2009.

- Articles 6 and 7 (women and children);
- Article 9 (access to medical facilities and services);
- Article 10 (right to life);
- Article 14 (liberty and security);
- Article 15 (freedom from torture, etc.)
- Article 16 (freedom from exploitation, violence, and abuse)
- Article 17 (protection of physical and mental integrity)
- Article 19 (independent living)
- Article 21 (access to information)
- Article 22 (respect for privacy)
- Article 26 (habilitation and rehabilitation)
- Article 29 (participation in public life)

### ***NONTREATY INSTRUMENTS***

- ▶ **UN Standard Minimum Rules for the Treatment of Prisoners<sup>17</sup>**
- ▶ **UN Body of Principles for the Protection of All Persons Under Any Form of Detention<sup>18</sup>**
- ▶ **UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care<sup>19</sup>**

### **ADDITIONAL INTERNATIONAL DOCUMENTS**

There are also a number of other important international consensus documents that do not have the binding force of a treaty but exert considerable political and moral force.

- ▶ **WHO Alma-Ata Declaration 1978<sup>20</sup>**

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17 Standard Minimum Rules for the Treatment of Prisoners. Economic and Social Council Resolution 663 C (XXIV). July 31, 1957. <http://www2.ohchr.org/english/law/treatmentprisoners.htm>. Accessed November 14, 2009.

18 Body of Principles for the Protection of All Persons Under Any Form of Detention. UN General Assembly Resolution 43/173. December 9, 1998. <http://www2.ohchr.org/english/law/bodyprinciples.htm>. Accessed November 14, 2009.

19 Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care. UN General Assembly Resolution 46/119. December 17, 1991. <http://www2.ohchr.org/english/law/principles.htm>. Accessed November 14, 2009. November 14, 2009.

20 Declaration of Alma-Ata. September 6, 1978. [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf). Accessed November 14, 2009.

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.

▶ **Charter on the Right to Health 2005 (International Union of Lawyers)**<sup>21</sup>

This charter addresses issues such as privacy and informed consent.

▶ **Declaration on the Rights of the Patients 2005 (revised) (World Medical Association (WMA))**<sup>22</sup>

This declaration addresses issues such as the rights to confidentiality, information, and informed consent. The following is an excerpt from the preamble:

*The relationship between physicians, their patients and broader society has undergone significant changes in recent times. While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice. The following Declaration represents some of the principal rights of the patient that the medical profession endorses and promotes.*

*Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.*

▶ **Declaration on the Patient-Centred Healthcare 2007, International Alliance of Patients' Organizations (IAPO)**<sup>23</sup>

This declaration was produced by IA PO as part of its effort to advocate internationally, with a strong voice for patients, on relevant aspects of health care policy, with the aim of influencing international, regional, and national health agendas and policies.

The document espouses five principles:

- *Respect:*

*Patients and caregivers have a fundamental right to patient-centred healthcare that respects their unique needs, preferences and values, as well as their autonomy and independence.*

- *Choice and empowerment:*

*Patients have a right and responsibility to participate, to their level of ability and preference, as a partner in making healthcare 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*

21 Charter on the Right to Health. International Union of Lawyers. UIA General Assembly. August 31, 2005. [www.uianet.org/documents/qquia/resolutions/Sante4GB.pdf](http://www.uianet.org/documents/qquia/resolutions/Sante4GB.pdf). Accessed November 15, 2009

22 Declaration on the Rights of the Patient. World Medical Association. WMA Assembly September/October 1981. <http://www.wma.net/en/30publications/10policies/I4/index.html>. Accessed November 15, 2009.

23 International Alliance of Patients' Organizations (IA PO). Declaration on Patient-Centred Healthcare. [www.patientsorganizations.org/](http://www.patientsorganizations.org/). Accessed November 15, 2009.

*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 healthcare choices.*

- *Patient involvement in health policy:*

*Patients and patients' organizations deserve to share the responsibility of healthcare 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 centre. This should not be restricted to healthcare policy but include, for example, social policy that will ultimately impact patients' lives.*

- *Access and support:*

*Patients must have access to the healthcare 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, healthcare must support patients' emotional requirements, and consider non-health factors such as education, employment and family issues which impact on their approach to healthcare choices and management.*

- *Information:*

*Accurate, relevant and comprehensive information is essential to enable patients and carers to make informed decisions about healthcare 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.*

- ▶ **Jakarta Declaration on Leading Health Promotion into the 21st Century (1997)<sup>24</sup>. 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.**
- ▶ **Position Statement: Nurses and Human Rights 1998, International Council of Nurses(ICN)<sup>25</sup>**

The ICN views health care as the right of all individuals, regardless of financial, political, geographic, racial, or religious considerations. This right includes the right to choose or decline care, including 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 the rights of both those seeking care and the providers. Nurses have an obligation to safeguard and actively promote people's health rights at all times and in all places. This obligation includes assuring that adequate care is provided within the scope of the available resources and in accordance with nursing ethics. In addition, the nurse is obliged to ensure that patients receive appropriate information in understandable language prior to giving their consent for treatment or procedures, including participation in research.

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<sup>24</sup> Jakarta Declaration on Leading Health Promotion into the 21st Century. World Health Organization (WHO). July 21–25, 1997. [www.who.int/hpr/NPH/docs/jakarta\\_declaration\\_en.pdf](http://www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf). Accessed November 15, 2009.

<sup>25</sup> Position Statement: Nurses and Human Rights. International Council of Nurses. [www.icn.ch/pshumrights.htm](http://www.icn.ch/pshumrights.htm). Accessed November 15, 2009.

## 2.3 Patients' Rights

This section explores international protection of nine critical patients' rights: the rights to liberty and security of the person; privacy and confidentiality; information; bodily integrity; life; highest attainable standard of health; freedom from torture, cruel, inhuman, and degrading treatment; participation in public policy; and nondiscrimination and equality for patients.

The CES CR has provided the most significant international legal commentary on the rights of patients. Its elaboration on UN General Comment 14 on the right to the highest attainable standard of health (under Article 12 of the ICES CR) has been particularly influential. In addition, the CES CR has frequently condemned governments for failing to devote adequate resources to health care and services for patients. At this writing, however, the lack of an individual complaint mechanism has hampered the ability of the CES CR to examine specific violations beyond the systemic failures identified in country reports. The expected introduction of such a mechanism should provide the CES CR with an opportunity to mirror the work of its sister body, the HRC, in developing significant case law on human rights in patient care.

Although the CES CR has elaborated on the right to health with the most detail, other UN monitoring bodies have also provided significant comments on patients' rights. The HRC has frequently cited Articles 9 and 10 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 of the ICCPR and has used the right to life under Article 6 of the ICCPR to safeguard medical treatment during pretrial detention. Additionally, as detailed below, UN bodies concerned with monitoring racial and sex discrimination have examined equal access to health care.

In addition to binding treaty provisions, other international standards, such as the Standard Minimum Rules for the Treatment of Prisoners, also provide significant reference points regarding patients' rights. Although these standards cannot be directly enforced against states, patients and their advocates can use them to progressively interpret treaty provisions.

### Right to liberty and security of the person

#### EXAMPLES OF POTENTIAL VIOLATIONS

- *A person is detained indefinitely on mental health grounds without any medical opinion being sought*
- *Residents of an institution are not informed about their right to apply to a court or tribunal to challenge their involuntary admission*
- *A female drug user is detained in hospital after giving birth and denied custody of her child*

#### HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- ▶ **Art 9(1) ICCPR:** *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.*

- The HRC has stated that treatment in a psychiatric institution against the will of the patient constitutes a form of deprivation of liberty that falls under the terms of article 9 of the ICCPR.<sup>26</sup> In this context, the HRC has considered a period of 14 days of detention for mental health reasons without review by a court incompatible with Art 9(1) of the ICCPR.<sup>27</sup>

In relation to arbitrary committal under mental health legislation where the victim was at the time considered to be legally capable of acting on her own behalf<sup>28</sup>.

*'[T]he State party has a particular obligation to protect vulnerable persons within its jurisdiction, including the mentally impaired. It considers that as the author suffered from diminished capacity that might have affected her ability to take part effectively in the proceedings herself, the court should have been in a position to ensure that she was assisted or represented in a way sufficient to safeguard her rights throughout the proceedings....The Committee acknowledges that circumstances may arise in which an individual's mental health is so impaired that so as to avoid harm to the individual or others, the issuance of a committal order, without assistance or representation sufficient to safeguard her rights, may be unavoidable. In the present case, no such special circumstances have been advanced. For these reasons, the Committee finds that the author's committal was arbitrary under article 9, paragraph 1, of the Covenant'*<sup>29</sup>

- ▶ **Art 25 CRC:** *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 14 DRC:**

*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. States 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.*

- ▶ **UN Body of Principles for the Protection of All Persons Under Any Form of Detention**

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<sup>26</sup> A. v. New Zealand, Communication No. 754/1997, Views adopted on 15 July 1999 and Fijalkovska v. Poland (1061/2002), ICCPR, A/60/40 vol. II (26 July 2005) 103 para 8.2

<sup>27</sup> Concluding observations (COs) on Estonia [CCPR/CO/77/EST (HRC, 2003), para. 10.

<sup>28</sup> HRC.Fijalkovska v. Poland (1061/2002), ICCPR, A/60/40 vol. II (26 July 2005)

<sup>29</sup> Ibid para 8.3



- ▶ **UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care**
- ▶ **Article 6 Charter on the Right to Health:** *No one may be deprived of liberty on the ground of medical danger to oneself or others unless this danger is certified by competent and independent physicians and by a judicial ruling made in accordance with the due process of law.*

## Right to Privacy

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A doctor discloses a patient's history of drug use or addiction without his or her consent*
- *Government requires disclosure of HIV status on certain forms*
- *Health care workers require young people to obtain parental consent as a condition of receiving sexual health services*
- *Residents of an institution have no place to keep their personal possessions*

### HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- ▶ **Art 17(1) ICCPR:** *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.*
- ▶ **Art 16(1) CRC:** *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.*
- ▶ **CESCR GC 14 para 12:** *Accessibility of information should not impair the right to have personal health data treated with confidentiality.*
- ▶ **CESCR GC 14 para 23:** *The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.*
- ▶ **Art 22 DRC:** *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. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.*
- ▶ **Article 8 Charter on the Right to Health:** *Physicians are bound by professional confidentiality to ensure due respect for patient privacy. This confidentiality...contributes to the effectiveness of medical care. Exceptions to medical confidentiality, strictly limited by law, may serve only the goals of protection of health, safety or public hygiene. Patients are not bound by medical confidentiality. Physicians may be relieved of their obligation to maintain professional confidentiality if they become aware of attacks on the dignity of the human person...*

## ► Principle 8 WMA Declaration on the Rights of the Patients

### *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.*

Clearly the need to protect the confidentiality of medical information can have an impact across a range of health issues. However, confidentiality is particularly vital in relation to sexual and reproductive health. Examinations by UN treaty bodies in the context of right to privacy have included (i) the 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<sup>30</sup>; (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 administering of anti-pregnancy drugs<sup>31</sup> 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.<sup>32</sup>

## Right to information

### EXAMPLES OF POTENTIAL VIOLATIONS

- **Government bans publications about drug use or harm reduction, claiming it promotes illegal activity**
- **Young people are deliberately denied information about STDs and the use of condoms**
- **Roma women lack access to information on sexual and reproductive health**

### HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- **Art 19(2) ICCPR:** *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.*

30 HRC COs on Chile, ICCPR, A/54/40 vol. I (1999) 44 at paras. 211 and 216 and Venezuela, ICCPR, A/56/40 vol. I (2001) 49 at para. 77(19) – need to end prohibition on abortions and protect confidential nature of medical information.

31 HRC COs on Mexico, ICCPR, A/54/40 vol. I (1999) 61 at para. 329 – requirement for women to have access to appropriate remedies where their equality and privacy rights had been violated.

32 CRC COs on Djibouti, CRC/C/97 (2000) 96 at para. 555.

- In the case of *Zheludkov v. Ukraine*<sup>33</sup> it was noted by a member of the HRC that:

*“A person’s right to have access to his or her medical records forms part of the right of all individuals to have access to personal information concerning them. The State has not given any reason to justify its refusal to permit such access, and the mere denial of the victim’s request for access to his medical records thus constitutes a violation of the State’s obligation to respect the right of all persons to be ‘treated with humanity and with respect for the inherent dignity of the human person,’ regardless of whether or not this refusal may have had consequences for the medical treatment of the victim.”*<sup>34</sup>

- ▶ **CESCR GC 14 para 12(b)(iv)** : *Health care accessibility “includes the right to seek, receive and impart information and ideas concerning health issues.*
- ▶ **CESCR GC 14 para 23**: *States Parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health behaviour choices they make.*
- ▶ **Art 17 CRC**<sup>35</sup>: *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.*
- ▶ **Art 21 DRC**: *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.*

▶ **Principle 7 WMA Declaration on the Rights of the Patients:**

- 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.*

33 (726/1996), ICCPR, A/58/40 vol. II (29 October 2002) 12 (CCPR/C/76/D/726/1996)

34 Individual Opinion by Ms. Cecilia Medina Quiroga (concurring)

35 See also CRC General Comment 4 (Thirty-third session, 2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child, A/59/41 (2004) 102 at paras. 9, 11, 33, 40 and 41(b).

- 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 5 IAPO Declaration on Patient-Centred Healthcare<sup>36</sup>:**

*Accurate, relevant, and comprehensive information is essential to enable patients and carers to make informed decisions about healthcare 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.*

**Note: Access to Sexual and Reproductive Health Information**

The provision of appropriate and timely information with respect to sexual and reproductive health is particularly crucial. UN treaty bodies have urged States to improve access in light of increasing teenage abortions<sup>37</sup> and sexually transmitted diseases including HIV/AIDS,<sup>38</sup> with such information also extending to children<sup>39</sup> and to people in areas with prevalent alcohol and tobacco use.<sup>40</sup>

## Right to bodily integrity

### EXAMPLES OF POTENTIAL VIOLATIONS

- ***A Roma woman is sterilized against her will***
- ***Doctors compel a drug-using pregnant woman to undergo an abortion***
- ***Treatment is routinely given to residents of an institution without their consent as they are assumed to lack the capacity to make decisions about their treatment and care***
- ***Patients at a psychiatric hospital are treated as part of a clinical medication trial without being informed that they are included in the research***
- ***Patients are given ECT (electro-convulsive therapy) having been told that this is "sleep therapy"***

### HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

The right to bodily integrity is not specifically recognized under the ICCPR or ICESCR, but has been interpreted to be part of the right to security of the person (ICCPR 9), the right to freedom from torture and cruel, inhuman, and degrading treatment (ICCPR 7), the right to privacy (ICCPR 17), and the right to the highest attainable standard of health (ICESCR 12).

36 See also IAPO Policy Statement on Health Literacy at <http://www.patientsorganizations.org/showarticle.pl?id=126&n=962>

37 CESCR Concluding Observations on Lithuania, E/2005/22 (2004) 18 at paras. 94 and 116; CEDAW COs on Costa Rica, CEDAW, A/58/38 part II (2003) 86 at paras. 68 and 69. See also COs on China (Hong Kong Special Administrative Region), E/2006/22 (2005) 34 at paras. 217 and 229.

38 ICESCR Concluding Observations on Chile, E/2005/22 (2004) 67 at paras. 553 and 580 and on Cameroon, E/2000/22 (1999) 56 at paras. 339 and 359 – state urged to review its family planning policies with a view to increasing access to information concerning contraceptives through educational programs. See also CEDAW COs on Ethiopia, CEDAW, A/59/38 part I (2004) 42 at paras. 257 and 258.

39 CRC COs on Mozambique, CRC/C/114 (2002) 65 at paras. 285, 286, 301 and 302 and Indonesia, CRC/C/137 (2004) 8 at paras. 78 and 79.

40 CESCR COs on Ukraine, E/2002/22 (2001) 78 at para. 512.

**Arts 12(1)CRC** – *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 39 CRC:** *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.*
- ▶ **Art 17 DRC:** *Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.*
- ▶ **Article 12 ICESCR:** *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.*
- **CESCR GC 14 para 8:** *the right to health includes “the right to be free from non-consensual medical treatment and experimentation.”*
- ▶ **International Ethical Guidelines for Biomedical Research involving Human Subjects<sup>41</sup>**
- ▶ **Article 5 Charter on the Right to Health:** *Consent of the patient must be required before any medical treatment, except in case of emergency only as strictly provided by law.*
- ▶ **Principles 2-6 WMA Declaration on the Rights of the Patients:**
  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.*
  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.*
  4. *The unconscious patient*

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<sup>41</sup> Contents of 2002 revised guidelines at [http://www.cioms.ch/frame\\_guidelines\\_nov\\_2002.htm](http://www.cioms.ch/frame_guidelines_nov_2002.htm)

- 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.*

#### 1. *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.*
2. *Procedures against the patient's will 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.*

#### Note: Genital Mutilation and the Right to Bodily Integrity

Treaty 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.<sup>42</sup>

## Right to life

### EXAMPLES OF POTENTIAL VIOLATIONS

- ***Doctors refuse to treat a person who is experiencing a drug overdose because drug use is illegal, thus resulting in the person's death***
- ***Drugs users die in locked hospital wards***
- ***Government places unjustified legal restrictions on access to life-saving HIV- prevention or treatment***

<sup>42</sup> CEDAW COs on Burkina Faso, A/55/38 part I (2000) 25 at para. 261 and Cameroon, A/55/38 part II (2000) 53 at para. 43.

- *The mortality rate of an institution is high particularly during the winter months due to the poor condition of the building, inadequate sanitation and heating, and poor quality of care*
- *A patient of a psychiatric hospital known to be at risk of suicide is not monitored adequately and subsequently takes her own life*

## HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- ▶ **Art 6(1) ICCPR:** *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.*
- ▶ **ICCPR GC 6 paras 1 and 5:** *the right to life “should not be interpreted narrowly” or “in a restrictive manner,” and its protection “requires that States adopt positive measures . . . to increase life expectancy.”*
  - The HRC, in finding a violation of Art 6 of the ICCPR (in addition to Art 10(1)) where a healthy young man who fell ill in a pre-trial detention center did not receive any medical treatment despite repeated requests for assistance and subsequently died, noted that:

*“It is incumbent on States to ensure the right to life of detainees, and not incumbent on the latter to request protection...it is up to the State party by organizing its detention facilities to know about the state of health of the detainees as far as may be reasonably be expected. Lack of financial means cannot reduce this responsibility.”<sup>43</sup>*

Because the detention center had a properly functioning medical service within and should have known about the dangerous change in the victim’s state of health, the state was required to take immediate steps to ensure that the conditions of detention were compatible with its obligations under Articles 6 and 10. Such obligations are retained even where private companies run such institutions.<sup>44</sup>

- While not explicitly recognizing the right to an abortion, the HRC has stated that States have a duty to take measures to ensure the right-to-life of pregnant women whose pregnancies are terminated thereby ending the blanket ban on the procedure.<sup>45</sup>

**Art 10 DRC:** *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.*

43 *Lantsova v The Russian Federation* (Comm No 763/1997), Views of 26 March 2002 para 9.2

44 HRC General Comment 20 on prohibition of torture under Art 7 ICCPR paras 1 and 13.

45 HRC COs on Chile, ICCPR, A/54/40 vol. I (1999) 44 at para. 216. See also CEDAW condemning both compulsory and criminalization of abortion in General Recommendation 19 paras 22 and 24(m)



## Right to the highest attainable standard of health

### EXAMPLES OF POTENTIAL VIOLATIONS

- *State fails to take progressive steps to ensure access to anti-retroviral drugs to prevent mother-to-child HIV transmission*
- *Doctors and health facilities are not located in close proximity to certain poor neighborhoods*
- *State fails to provide training in palliative care for its medical personnel*
- *A child in a social care home becomes bedridden due to malnutrition*
- *Adults and children are placed on the same wards in a psychiatric hospital*
- *Women with mental disabilities are treated as genderless and denied reproductive health services*

### HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- ▶ **Art 12 ICESCR:** *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.*
- **CESCR GC 14 paras 4, 11 and 12:** *The right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.*
- **CESCR GC 14 para 12:** Health care and services must be available, in sufficient quantity, accessible (ie physically and economically) to all without discrimination, culturally acceptable and of good quality.
- **CESCR GC 14 paras. 30-37:** In delivering such services states are under a duty to progressively realize the right to health<sup>46</sup> while ensuring that they respect people's own resources, protect them against the negative actions of third parties and fulfill or provide sufficient resources where there are none.
- **CESCR GC 14 paras. 46-52:** Violations of the right to health can be caused by deliberate acts or failures to act by the State.
- In the context of obligations under Article 12 ICESCR, the CESCR has frequently condemned states for failing to devote adequate resources to health care and services because of the obviously detrimental impact of that failure on patients.<sup>47</sup>

<sup>46</sup> Some obligations such as non discrimination are immediately realizable without qualification.

<sup>47</sup> COs on Uruguay, E/1998/22 (1997) 67 at para, 368 - 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 Congo, E/2001/22 (2000) 43 at para 206 – grave concern expressed at decline of standard of health due in part to ongoing financial crisis resulting in a serious shortage of funds for public health services; Mongolia, E/2001/22 (2000) 53 at para 271 - 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.



- The CESCR has required that states should introduce appropriate legislation to safeguard patient rights, including redress for medical errors.<sup>48</sup>
- ▶ **Art 3(3) CRC:** *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 CRC:** 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;..(d) To ensure appropriate pre-natal and post-natal health care for mothers.

In the context of the right to health, the Committee on the Rights of the Child has criticized the incompatibility of a proposed free trade agreement being negotiated by three Latin American countries and the United States and, in particular, the right to access low-cost drugs and social services by poor people.<sup>49</sup>

- ▶ **Art 25 DRC:** *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.*

48 Concluding observations on Russia (E/C.12/1/ADD.94 (CESCR, 2003) para. 32.

49 CRC. Concluding Observations of the Committee on Economic, Social and Cultural Rights: Russia, 2003. (E/C.12/1/ADD.94

## Right to Freedom from Torture and Cruel, Inhuman, and Degrading Treatment

### EXAMPLES OF POTENTIAL VIOLATIONS

- *Fearing prosecution by the state, a doctor refuses to prescribe morphine to relieve a patient's pain*
- *A prisoner suffering from cancer is denied treatment*
- *A drug user is denied mental health treatment while in detention*
- *Residents of an institution have no place to keep their personal possessions*
- *The medical records of residents are available to all staff, including those who are not involved in their care*
- *Residents of an institution are not allowed to keep their own clothes; all clothes are communal*
- *Female residents of an institution are required to have showers together, supervised by male staff*

### HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- ▶ **Art 7 ICCPR:** *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) ICCPR:** *All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.*
  - The HRC 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 prisons, hospitals—particularly psychiatric hospitals—detention camps or correctional institutions 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.<sup>50</sup>

The HRC has reaffirmed on a number of occasions that the obligation under Art 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<sup>51</sup> and, often in conjunction with Article 7, has gone on to find breaches of this obligation on numerous occasions.<sup>52</sup> Specifically, in relation to the

49 CRC. Concluding Observations of the Committee on Economic, Social and Cultural Rights: Russia, 2003. (E/C.12/1/ADD.94)

50 ICCPR General Comment 21 (Forty-fourth session, 1992): Article 10 replacing General Comment 9 Concerning Humane Treatment of Persons Deprived of Liberty, A/47/40 (1992) 195 at para. 2.

51 See, for example, Kelly v. Jamaica (253/1987), ICCPR, A/46/40 (8 April 1991) 241 (CCPR/C/41/D/253/1987) at para. 5.7 – breach of Art 10(1) where a prisoner contracted health problems as a result of a lack of basic medical care, and the fact that he was only allowed out of his cell for 30 minutes each day. Also Linton v. Jamaica (255/1987), ICCPR, A/48/40 vol. II (22 October 1992) 12 (CCPR/C/46/D/255/1987) at paras. 2.7 and 8.5 – denial of adequate medical treatment for injuries sustained during aborted escape attempt breached Articles 7 and 10(1). Also Bailey v. Jamaica (334/1988), ICCPR, A/48/40 vol. II (31 March 1993) 72 (CCPR/C/47/D/334/1988) at para. 9.3; Thomas v. Jamaica (321/1988), ICCPR, A/49/40 vol. II (19 October 1993) 1 (CCPR/C/49/D/321/1988) at paras. 9.2 and 11; Mika Miha v. Equatorial Guinea (414/1990), ICCPR, A/49/40 vol. II (8 July 1994) 96 (CCPR/C/51/D/414/1990) at para. 6.4; Colin Johnson v. Jamaica (653/1995), ICCPR, A/54/40 vol. II (20 October 1998) 135 (CCPR/C/64/D/653/1995) at para. 8.1 and Kalenga v. Zambia (326/1988), ICCPR, A/48/40 vol. II (27 July 1993) 68 (CCPR/C/48/D/326/1988) at para. 6.5.

52 See Whyte v. Jamaica (732/1997), ICCPR, A/53/40 vol. II (27 July 1998) 195 (CCPR/C/63/D/732/1997) at para. 9.4 – failure to treat asthma attacks and injuries sustained through beatings; Leslie v. Jamaica (564/1993), ICCPR, A/53/40 vol. II (31 July 1998) 21 (CCPR/C/63/D/564/1993) at paras. 3.2-3.5, 3.8 and 9.2 – lack of adequate medical treatment for beatings and stabbing on basis that it was pointless given that he was due to be executed imminently; Henry v. Jamaica (610/1995), ICCPR, A/54/40 vol. II (20 October 1998) 45 (CCPR/C/64/D/610/1995) at para. 7.3 - lack of medical treatment despite a recommendation from a doctor that prisoner be operated on. Also Pennant v. Jamaica (647/1995), ICCPR, A/54/40 vol. II (20 October 1998) 118 (CCPR/C/64/D/647/1995) at para. 8.3; Levy v. Jamaica (719/1996), ICCPR, A/54/40 vol. II (3 November 1998) 208 (CCPR/C/64/D/719/1996) at para. 7.4; Marshall v. Jamaica (730/1996), ICCPR, A/54/40 vol. II (3 November 1998) 228 (CCPR/C/64/D/730/1996) at para. 6.7; Morgan and Williams v. Jamaica (720/1996), ICCPR, A/54/40 vol. II (3 November 1998) 216 (CCPR/C/64/D/720/1996) at para. 7.2; Morrison v. Jamaica (663/1995), ICCPR, A/54/40 vol. II (3 November 1998) 148 (CCPR/C/64/D/663/1995) at para. 8.8; Brown v. Jamaica (775/1997), ICCPR, A/54/40 vol. II (23 March 1999) 260 (CCPR/C/65/D/775/1997) at paras. 3.2 and 6.5; Bennett v. Jamaica (590/1994), ICCPR, A/54/40 vol. II (25 March 1999) 12 (CCPR/C/65/D/590/1994) at paras. 10.7 and 10.8; Smith and Stewart v. Jamaica (668/1995), ICCPR, A/54/40 vol. II (8 April 1999) 163 (CCPR/C/65/D/668/1995) at para. 7.5.; Mulezi v. Democratic Republic of the Congo (962/2001), ICCPR, A/59/40 vol. II (6 July 2004) 159; Saidov v. Tajikistan (964/2001), ICCPR, A/59/40 vol. II (8 July 2004) 164

mentally ill in detention facilities (both in prisons and mental health institutions), the HRC has required improvements in hygienic Conditions and the provision of regular exercise and adequate treatment.<sup>53</sup> Failure to adequately treat a mental illness condition exacerbated by being on death row can also amount to a breach of Articles 7 and/or 10(1).<sup>54</sup>

In relation to Art 10(1) the HRC has found a violation where a prisoner on death row was denied medical treatment<sup>55</sup> and where severe overcrowding in a pre-trial detention center resulted in inhuman and unhealthy conditions leading eventually to the detainee's death.<sup>56</sup>

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<sup>57</sup>; while in another case 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 Arts 7 and 10(1).<sup>58</sup>

Denying a detainee direct access to his medical records, particularly where this may have consequences for his treatment, can constitute a breach of Art 10(1).<sup>59</sup>

Where a violation has occurred, the obligation to provide an effective remedy under Art 2(3)(a) of the ICCPR can include the provision of appropriate medical and psychiatric care.<sup>60</sup>

- ▶ **Article 1 CAT: (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.*

53 Concluding observations on Bosnia and Herzegovina (CCPR/C/BIH/CO/1 (HRC, 2006), para. 19.

54 Williams v. Jamaica (609/1995), ICCPR, A/53/40 vol. II (4 November 1997) 63 (CCPR/C/61/D/609/1995) at para. 6.5.

55 Lewis v Jamaica (Communication No. 527/1993, Views of 18 July 1996) – appointments to treat skin condition not kept over 2.5 years. See also Pinto v Trinidad & Tobago (232/1987), ICCPR, A/45/40 vol. II (20 July 1990) 69 at para. 12.7 where the HRC reaffirmed that, 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. See also Henry and Douglas v. Jamaica (571/1994), ICCPR, A/51/40 vol. II (25 July 1996) 155 (CCPR/C/57/D/571/1994) at para. 9.5 – keeping H in a cold cell after he was diagnosed for cancer breached Articles 7 and 10(1); Lee Hong v. Jamaica (613/1995), ICCPR, A/54/40 vol. II (13 July 1999) 52 (CCPR/C/66/D/613/1995) at paras. 3.11 and 9.2 – prisoner on death row only allowed to see a doctor once, despite having sustained beatings by warders and having requested medical attention.

56 Lantsova v Russian Federation (Comm No 763/1997, Views of 26 March 2002)

57 Setelich / Sentic v. Uruguay (R.14/63), ICCPR, A/37/40 (28 October 1981) 114 at para. 20.

58 Howell v. Jamaica (798/1998), ICCPR, A/59/40 vol. II (21 October 2003) 21 (CCPR/C/79/D/798/1998)

59 Zheludkov v. Ukraine (726/1996), ICCPR, A/58/40 vol. II (29 October 2002) 12 (CCPR/C/76/D/726/1996. See concurring opinion of Quiroga which states that the Committee's interpretation of Art 10(1) in relation to access to medical records is unduly narrow and that mere denial of records is sufficient to constitute a breach regardless of consequences

60 Sahadath v. Trinidad and Tobago (684/1996), ICCPR, A/57/40 vol. II (2 April 2002) 61 (CCPR/C/684/1996) at para 9.

**Article 2 CAT:** (1) Each State Party shall take effective legislative, administrative, judicial or circumstances whatsoever, whether a state of war or a threat of war, internal political in stability 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.

- ▶ **Article 4 CAT (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
- ▶ **Article 16 CAT (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.

The Committee Against Torture has identified overcrowding, inadequate living conditions, and lengthy confinement in psychiatric hospitals as “tantamount to inhuman or degrading treatment.”<sup>61</sup> 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<sup>62</sup> in addition to lack of medical attention.<sup>63</sup>

The committee has also emphasized that medical personnel who participate in acts of torture should be held accountable and punished.<sup>64</sup>

#### Note: Special Rapporteurs on Torture

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.<sup>65</sup> Some of the worst abuses include: failure to provide new detainees with access to a medical professional and with sanitary living conditions;<sup>66</sup> failure to segregate those with contagious diseases such as tuberculosis;<sup>67</sup> completely unacceptable quarantine procedures;<sup>68</sup> and insufficient provision of food, leading in some instances to conditions approaching starvation.<sup>69</sup>

61 Concluding observations on Russia (CAT/C/RUS/CO/4 (CAT, 2007), para. 18.

62 OHCHR. Concluding Observations: Cameroon. (CAT /C/CR/31/6).

63 OHCHR. Concluding Observations: Nepal. (CAT /C/NPL/CO/2). See also observations on Paraguay (CAT /C/SR.418) and Brazil (CAT /C/SR.471).

64 OHCHR. Concluding Observations: Argentina. (A/48/44).

65 M . Nowak. Report of the Special Rapporteur on Torture, mission to Jordan (addendum), 2007a. (UN doc. A/HRC/33/Add.3); T. van Boven. Report of the Special Rapporteur on torture, mission to Uzbekistan (addendum), 2003. (UN doc. E/CN.4/2003/68/ Add.2).

66 N . S. Rodley. Report of the Special Rapporteur on Torture, mission to the Russian Federation (addendum), 1994. (UN doc CN.4)

67 Rodley. Report of the Special Rapporteur on Torture, mission to Azerbaijan, 2000. (UN doc. E/CN.4/2001/66/Add.1).

68 Rodley. Report of the Special Rapporteur on Torture, mission to Azerbaijan, 2000. (UN doc. E/CN.4/2001/66/Add.1); Nowak. Report of the Special Rapporteur on Torture, mission to Moldova, 2009. (UN doc. A/HRC/10/44/Add.3).

69 Rodley. Report of the Special Rapporteur on Torture, mission to Kenya (addendum), 2000. (UN doc. E/CN.4/2000/9/Add.4).

Another issue repeatedly raised by UN Special Rapporteurs on Torture is the impact on the mental health of children who enter the justice system and the accompanying threats presented by inhuman and violent conditions.<sup>70</sup>

- ▶ **Article 37 CRC:** *States Parties shall ensure that: (a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.*
- ▶ **Article 39 CRC:** *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.*
- ▶ **Art 15 DRC:** *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.*
- ▶ **Code of Conduct for Law Enforcement Officials**
- ▶ **Article 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.*
- ▶ **Article 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.*
- ▶ **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 (1982).**
- ▶ **UN Body of Principles for the Protection of All Persons Under Any Form of Detention:**

**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.*

- ▶ **UN Standard Minimum Rules for Treatment of Prisoners**

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<sup>70</sup> Nowak. Report of the Special Rapporteur on Torture, mission to Nigeria, 2007. (UN doc. A/HRC/7/3/Add.4.0); Nowak. Report of the Special Rapporteur on Torture, mission to Moldova, 2009. (UN doc. A/HRC/10/44/Add.3); Rodley. Report of the Special Rapporteur on Torture, mission to Kenya (addendum), 2000. (UN doc. E/CN.4/2000/9/Add.4).

## Rules 22-26 on Medical Services

Rule 22(1) requires that every institution should have at least one qualified medical officer who has some knowledge of psychiatry. More generally, medical services should be organized in collaboration with the public health system and should include appropriate psychiatric services.

Rule 22(2) requires the transfer of sick prisoners to specialist institutions as appropriate while also ensuring that prison hospitals are properly equipped and staffed. Under Rule 22(3), the services of a qualified dental officer shall be available to every prisoner.

Rule 23 focuses on the provision of pre- and postnatal care and nursery care for women and their children and ensures that, whenever practicable, babies will be born in an external hospital.

Rule 24 requires that the medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view to diagnose any physical or mental illnesses and to segregate prisoners with infectious or contagious conditions.

Under Rule 25, the medical officer should see all sick prisoners on a daily basis and report to the prison director whenever he determines that a prisoner's physical or mental health is being adversely affected by his detention. In addition, in line with Rule 26, the medical officer shall regularly inspect and report upon prisoners' food, hygiene, sanitation, heating, lighting, clothing, and bedding. The director shall, after considering the reports, take immediate action as required.

### ► Physicians for Human Rights Principles on the Effective Investigation and Documentation of Torture: the Istanbul Protocol

## Right to participate in public policy

### EXAMPLES OF POTENTIAL VIOLATIONS

- *An indigenous group is denied any say in policy decisions affecting their health and well being on the grounds of their perceived lack of competence*
- *LGBT groups are deliberately excluded from participating in the development of policies on addressing HIV/AIDS*

### HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- **Art 25 ICCPR:** *Every citizen shall have the right and the opportunity, without . . . distinctions . . . (a) To take part in the conduct of public affairs, directly or through freely chosen representatives.*
- **Art 7 CEDAW:** *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) CEDAW:** *the right of rural women to participate in development planning.*



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

- ▶ **Principle 2 IAPO Declaration on Patient-Centered Healthcare: Choice and empowerment**

*Patients have a right and responsibility to participate, to their level of ability and preference, as a partner in making healthcare 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 healthcare choices.*

- ▶ **Principle 3 IAPO Declaration on Patient-Centered Healthcare<sup>71</sup>: Patient involvement in health policy:**

*Patients and patients' organizations deserve to share the responsibility of healthcare 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 healthcare policy but include, for example, social policy that will ultimately impact on patients' lives.*

- ▶ **Article 12 ICESCR:** 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.*
- ▶ **CESCR GC 14, paras. 43 and 54:** 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.”<sup>72</sup> In addition, “[p]romoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people’s participation is secured by States.”

## Right to Non-discrimination and Equality

### EXAMPLES OF POTENTIAL VIOLATIONS

- ***Asylum seekers are denied access to all health care apart from emergency treatment***
- ***Hospitals routinely place Roma women in separate maternity wards***
- ***Drug users are underrepresented in HIV treatment programs despite accounting for a majority of people living with HIV***
- ***A woman with a diagnosis of schizophrenia is told by nursing staff that her abdominal pains are “all in your mind;” she is later diagnosed as having ovarian cancer***

<sup>71</sup> See also IAPO’s Policy Statement on Patient Involvement at <http://www.patientsorganizations.org/showarticle.pl?id=590&n=962>

<sup>72</sup> CESCR GC 14, para. 43.

## HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- ▶ **Art 26 ICCPR:** *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*
  
- ▶ **Art 2(2) ICCPR; ICESCR:** *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.*

**CESCR GC 14, para. 12:** 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.*” 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.*” The CESCR has further 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.*”<sup>73</sup>

**CESCR GC 5, para. 15:** 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.*”<sup>74</sup> 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.*”<sup>75</sup>

To ensure equality between men and women in accessing health care, the CESCR has stated that it requires, at a minimum, the removal of legal and other obstacles that prevent men and women from accessing and benefiting from health care on a basis of equality. This 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.<sup>76</sup>

- ▶ **Article 5(e)(iv) CERD:** *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: Economic, social and cultural rights, in particular: The right to public health, medical care, social security and social services.*
  - 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 ad-

<sup>73</sup> CESCR GC 14, para 12.

<sup>74</sup> CESCR GC 5, para. 15

<sup>75</sup> CESCR GC 14, para 26

<sup>76</sup> CESCR General Comment 16 (Thirty-fourth session, 2005): Article 3: The Equal Right of Men and Women to the Enjoyment of all Economic, Social and Cultural Rights, E/2006/22 (2005) 116 at para. 29.



equate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services.<sup>77</sup>

- ▶ **Art 12 CEDAW:** *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) CEDAW:** *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.*
  
- ▶ **Art 23 CRC:** *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.*

The Committee on the Rights of the Child has criticized the incompatibility of a proposed free trade agreement being negotiated by three Latin American countries and the United States with respect to the right to health as protected by the CRC and in particular the right to access low costs drugs and social services by poor people.<sup>78</sup> It went on to recommend that a study on the impact of trade standards should be carried out.<sup>79</sup>

77 CERD General Recommendation XXX (Sixty-fifth session, 2004): Discrimination Against Non-Citizens, A/59/18 (2004) 93 at para. 36.

78 Observaciones Finales del Comité de Derechos del Niño: Ecuador. CRC/C/15/Add.262. Examen de los informes presentados por los Estados bajo el artículo 44 de la Convención Internacional de los Derechos del Niño (13/09/05)

79 In so doing the Committee was reiterating the recommendations issued by the CESCR in June 2004 (E/C.12/1/Add.100), which urged Ecuador to "conduct an evaluation of the effects of international trade standards on the right to health of all persons and to make ample use of the flexibility clauses allowed by the Agreement on Trade-Related Aspects of Intellectual Property of the World Trade Organization (WTO), so as to provide access to generic drugs and, more generally, to enable the universal enjoyment of the right to health in Ecuador."

- ▶ **Art 28 CMW:** *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 CMW:** *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) CMW:** *1. Members of the families of migrant workers shall, in the State of employment, enjoy equality of treatment with nationals of that State in relation to: Access to social and health services, provided that requirements for participation in the respective schemes are met;*
- ▶ **Art 1 CPRD:** *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 CPRD:** *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.*

**Article 25 CRPD:** 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.

▶ **Article 23 Convention Relating to the Status of Refugees**

*The Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals.*

- ▶ **Article 3 Charter on the Right to Health:** Duty of States to institute health services that are available, accessible and affordable for every individual.
- ▶ **Principle 1 WMA Declaration on the Rights of the Patients:** *Every person is entitled without discrimination to appropriate medical care.*
- ▶ **Principle 4 IAPO Declaration:**

Patients must have access to the healthcare 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, healthcare must support patients' emotional requirements, and consider non-health factors such as education, employment and family issues which impact on their approach to healthcare choices and management

► **Declaration on Medical Care for Refugees (World Medical Association)<sup>80</sup>**

*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.*

**Note: The right to nondiscrimination and equal access to medical services**

- UN treaty bodies have frequently condemned states for failing to ensure equal access to medical services (often due to a lack of sufficient resources) for marginalized and vulnerable groups. These groups have included indigenous people living in extreme poverty<sup>81</sup>; refugees of a particular nationality<sup>82</sup>; children, older persons, and persons with physical and mental disabilities<sup>83</sup>, those living in rural areas where the geographical distribution of health services and personnel shows a heavy urban bias.<sup>84</sup> In one country, the CESCR noted with regret that 90 percent of the population had no access to health services.<sup>85</sup> In another case, a state was criticized for inadequate medical care provided to low-income patients and was urged to subsidize expensive drugs required by chronically ill and mentally ill patients.<sup>86</sup>

Treaty 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.<sup>87</sup>

80 [www.wma.net/e/policy/m10.htm](http://www.wma.net/e/policy/m10.htm)

81 CERD COs on Bolivia, CERD, A/51/18 (1996) 41 at paras. 268 and 284. See also CESCR COs on Mexico, E/2000/22 (1999) 62 at paras. 404 where 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.

82 CERD COs on Japan, CERD, A/56/18 (2001) 34 at para. 177 – different standards of treatment applicable to Indochinese refugees compared to those from other nationalities

83 CESR. Concluding Observations: Nepal, 2001 (\*E/202/22).

84 CESCR COs on Mali, ICESCR, E/1995/22 (1994) 64 at para 350. See also Guatemala, ICESCR, E/1997/22 (1996) 29 at para. 134; Paraguay, ICESCR, E/1997/22 (1996) 22 at para. 78 – noting also the very small number of very small number of medical and paramedical personnel in the country as a whole. See also Mongolia, E/2001/22 (2000) 53 at para 273 – long term deterioration in health situation and need to improve access to health-care services in rural areas and for the poor.

85 COs on Nepal, ICESCR, E/2002/22 (2001) 83 at para 543 – the Committee went on to note that under the current national health plan for 1997-2017, the role of the State in the development of a national health care system, consistent with the structural adjustment programs, is minimized. It further noted that the mental health service was insufficient and that no community mental health program was available.

86 Concluding observations on China (E/C.12/1/ADD.107 (CESCR, 2005), para. 87. See also criticism of Russia for frequent failure of hospitals and clinics in poor regions to stock essential drugs (E/C.12/1/ADD.94 (CESCR, 2003), para. 31.

87 CEDAW COs on Guinea, A/56/38 part II (2001) 55 at para. 131 and ICESCR COs on Russian Federation, E/2004/22 (2003) 64 at para 504

Two groups which continue to suffer from unequal access to health services are women and young people, frequently resulting in high mortality rates.<sup>88</sup> Both groups, particularly women living in rural areas<sup>89</sup> as well as especially vulnerable groups of children such as girls, indigenous children and children living in poverty, will often experience multiple discrimination, requiring specific targeted measures and sufficient budgetary allocations.<sup>90</sup>

Treaty 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.

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## 2.4 Providers' Rights

Numerous international treaties and conventions include rights designed to protect workers and ensure safe and healthy work environments. The United Nations and its agencies, including the International Labor Organization, have developed some of these international labor standards and monitored their implementation. This section presents several standards and how they have been interpreted in relation to three key rights for health care and service providers. These include the right to (i) work in decent conditions (including fair pay); (ii) freedom of association (including trade unions and the right to strike) and (iii) due process and related rights such as fair hearing, 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, Part II discusses the right to freedom of association and Part III explores interpretation of the right to due process and related rights. Each section begins with a discussion of the significance of that particular right for providers, followed by examples of potential violations. Then the relevant labor standards from various UN treaties are reproduced, including those of general application and standards that make reference particular groups. Finally, key interpretative materials are summarized in bullet point format. Interpretive guidelines are drawn from the concluding observations, general comments and case law of official monitoring bodies.

### Right to Work in Decent Conditions

United Nations bodies have made it clear that there is no right to be provided with work or the occupation of one's choice. However, states must refrain from unduly hindering the ability of individuals to freely pursue

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88 Peru, ICESCR, E/1998/22 (1997) 33 at para. 152. See also Ukraine, ICESCR, E/2002/22 (2001) 78 at paras. 499 and 512 - deterioration in the health of the most vulnerable groups, especially women and children, and in the quality of health services. State urged 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 patients.

91 ICESCR. Concluding Observations of the Committee on Economic, Social and Cultural Rights: Peru, 1997. (E/1998/22)

92 CEDAW. Report of the Committee on the Elimination of Discrimination against Women: Burkina Faso, 2000 (A/55/38)

their chosen career. Furthermore, they are required to ensure the fair treatment of migrant workers. This is particularly relevant for medical professionals, who are often recruited from overseas to staff hospitals and clinics. The Convention on Migrant Workers emphasizes states' obligation to foreign-born employees.

United Nations treaty bodies have conducted non-exhaustive surveys of workers' pay and conditions and these investigations have resulted in specific reference to the treatment of healthcare personnel. The concern for medical professionals is driven in part by the poor levels of remuneration that they receive in some countries.

## Right to Work

### EXAMPLES OF POTENTIAL VIOLATION

- *All overseas migrant workers from country X, including a number employed as doctors and nurses, are summarily expelled after diplomatic relations are broken off following a trade dispute.*
- *Female employees are subject to frequent sexual harassment by other members of staff with no action taken to stop harassment.*
- *There is no regulation of working hours for medical staff that are frequently required to work in excess of 80 hours per week.*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ▶ **Article 23(1) Universal Declaration of Human Rights ('UDHR'):**

*Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment*

#### ▶ **Article 6(1) International Covenant on Economic, Social and Cultural Rights ('ICESCR'):**

*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.*

#### **Committee on Economic, Social and Cultural Rights ('CESCR') General Comment 18 on The Right to Work:**

##### **Para 1:**

*The right to work is essential for realizing other human rights and forms an inseparable and inherent part of human dignity. Every individual has the right to be able to work, allowing him/her to live in dignity. The right to work contributes at the same time to the survival of the individual and to that of his/her family, and insofar as work is freely chosen or accepted, to his/her development and recognition within the community*

##### **Para 4:**

*The right to work, as guaranteed in the ICESCR, affirms the obligation of States parties to assure individuals their right to freely chosen or accepted work, including the right not to be deprived of work*

*unfairly. This definition underlines the fact that respect for the individual and his dignity is expressed through the freedom of the individual regarding the choice to work, while emphasizing the importance of work for personal development as well as for social and economic inclusion.*

- CESCRC GC 18, paras. 6, 23, and 25: The right to work does not mean there is an absolute and unconditional right to obtain employment but that rather that the state should ensure that neither itself or others (such as private companies) do anything unreasonably or in a discriminatory way to prevent a person from earning a living or practicing their profession.
- CESCRC GC 16, para. 23: *Implementing article 3, in relation to article 6, requires inter alia, that in law and in practice, men and women have equal access to jobs at all levels and all occupations and that vocational training and guidance programmes, in both the public and private sectors, provide men and women with the skills, information and knowledge necessary for them to benefit equally from the right to work.*

In addition to frequent criticisms of states' high levels of unemployment, the CES CR has also condemned (a) the expulsion of HIV-positive foreign workers with valid work permits;<sup>93</sup> (b) the disproportionate number of women in low paid part time work;<sup>94</sup> and (c) the downsizing of the public sector with significant social repercussions.<sup>95</sup>

#### ► **International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)**

- The CERD has expressed concern on numerous occasions about the failure of states to address the lack of employment opportunities for ethnic minorities and migrant workers<sup>96</sup>.
- The CERD has held that the examination and quota system for doctors trained overseas did not breach a migrant worker's right, under Article 5(e)(i) of the ICERD. Article 5(e)(i) guarantees the right to work and freely choose employment without distinction as to race, color, or national or ethnic origin.<sup>97</sup>

Article 11 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 1998<sup>98</sup>: *Everyone has the right, individually and in association with others, to the lawful exercise of his or her occupation or profession. Everyone who, as a result of his or her profession, can affect the human dignity, human rights and fundamental freedoms of others should respect those rights and freedoms and comply with relevant national and international standards of occupational and professional conduct or ethics.*

93 ICESCR. Concluding Observations: United Kingdom of Great Britain and Northern Ireland, 1997. (E/1998/22), See also concluding observations on Ukraine, 1995 (E/1996/22)

94 ICESCR. Concluding Observations: Solomon Island, 1999. (E/2000/22)

95 CERD. Concluding Observations of the Committee on the Elimination of Racial Discrimination: Poland, 1997. (A/52/18)

96 CERD. Concluding Observations of the Committee on the Elimination of Racial Discrimination: Poland, 1997. (A/52/18). See also concluding observations Norway, 1994 (A/49/18); United Kingdom of Great Britain and Northern Ireland, 1991 (A/46/18); Israel, 1998 (A/53/18); The Netherlands, 1998 (A/53/18); Lebanon, 1998 (A/53/18); Azerbaijan, 1999 (A/54/18); Denmark, 2000 (A/55/18); Latvia, 2003 (A/58/18); Iceland, 2005 (A/60/18); and Turkmenistan, 2005 (A/60/18).

97 CERD. Opinion regarding B. M. S. v. Australia, 1996. (C/54/D/8/1996); Procedural Decisions, 1999. (A/54/18).

98 UN General Assembly Resolution 53/144. December 9, 1998.



## Standards related to women

- ▶ **Article 11(1) Convention on the Elimination of All Forms of Discrimination Against Women ('CEDAW'):**

*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;*

## Standards related to migrant workers

- ▶ **Article 51 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families**

*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.*

## Right to Fair Pay and Safe Working Conditions

### EXAMPLES OF POTENTIAL VIOLATIONS

- ***Nurses and ancillary staff are paid less than the national minimum wage;***
- ***A staff canteen remains open despite repeatedly failing to meet basic hygiene standards;***
- ***Medical staff in the X-ray department are frequently exposed to dangerously high levels of radiation due to faulty equipment that has not been checked or replaced;***
- ***A nurse is infected with HIV due to improperly sterilized medical equipment***

### HUMAN RIGHTS STANDARDS AND INTERPRETATIONS

- ▶ **Art 7 ICESCR:** *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.*

- ▶ **Article 12 ICESCR:** *(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 ... (b) [t]he improvement of all aspects of environmental and industrial hygiene. ...*

The CES CR has expressed concern about a range of working-condition issues, including: the need to harmonize the labor code with international standards, especially with regard to maternity leave;<sup>99</sup> disparities in pay and conditions between the private and public sectors (in teaching);<sup>100</sup> discrimination in employment on the grounds of political opinion;<sup>101</sup> the lack of a national minimum wage for public sector employees and the serious deterioration of some of those employees' (specifically, teachers') salaries in terms of purchasing power; the conflictual nature of relations between teachers and the state and the apparent ineffectiveness of the measures taken to remedy that situation;<sup>102</sup> ineffective campaigns to increase awareness of hygiene and safety in the workplace where they are frequently below established standards;<sup>103</sup> the fact that standards for the protection of workers concerning limits on the duration of the working day and weekly rest are not always fully met due to some areas of the private sector being dilatory in enforcing the relevant legislation; the lack of legislation to protect workers who are not covered by collective bargaining agreements in relation to a minimum wage, health and maternal benefits, and safe working conditions;<sup>104</sup> unsafe working conditions and lack of compensation for workplace injury;<sup>105</sup> the privatization of labor inspections and control systems;<sup>106</sup> legislation that favors individual negotiation with employers over collective bargaining;<sup>107</sup> the need for effective implementation of legislative provisions concerning job security;<sup>108</sup> and the allowance of excessive working hours in both the public and private sectors<sup>109</sup>.

### ▶ **International Convention on Civil and Political Rights (CCPR)**

- The UN Human Rights Council (HRC) has condemned sexual harassment in the workplace<sup>110</sup> and the lack of implementation of laws concerning labor standards. Laws concerning labor standards include those that call for adequate monitoring of working conditions and sufficient funding for labor inspection workforce.<sup>111</sup>

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99 ICES CR. Concluding Observations of the Committee on Economic, Social and Cultural Rights: Ecuador, 1990. (E/1991/23).

100 ICES CR. Concluding Observations: Spain, 1991. (E/1992/23); Concluding observations Columbia, 1991 (E/1992/23).

101 ICES CR. Concluding Observations: Germany, 1993. (E/1994/23).

102 ICES CR. Concluding Observations: Uruguay, 1994. (E/1995/22). See also concluding observations Finland, 1996. (E/1997/22).

103 ICES CR. Concluding Observations: Argentina, 1994. (E/1995/22).

104 ICES CR. Concluding Observations: Austria, 1994. (E/1995/22).

105 ICES CR. Concluding Observations: Suriname, 1995. (E/1996/22).

106 ICES CR. Concluding Observations: Argentina, 1999. (E/2000/22).

107 ICES CR. Concluding Observations: Australia, 2000. (E/2001/22).

108 ICES CR. Concluding Observations: Finland, 2000. (E/2001/22).

109 ICES CR. Concluding Observations: Japan, 2001. (E/2002/22).

110 ICCPR. Chile, 1999. (A/54/40 [vol. 1]). See also ICCPR. Trinidad and Tobago, 2001. (A/56/40 [vol. I]).

111 ICCPR. Dominican Republic, 1993. (A/48/40 [vol. I]). See also ICES CR. El Salvador, 1996. (E/1997/22).



- ▶ **Article 4 International Labor Organization (ILO) Occupation Safety and Health Convention No.155,1981**<sup>112</sup> *The state is under an obligation to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment with the aim of preventing accidents and injury to health arising out of, linked with or occurring in the course of work, by minimizing, so far as is reasonably practicable, the causes of hazards inherent in the working environment.*
- ▶ **Article 3(1) ILO Occupational Health Services Convention No.161,1985**<sup>113</sup>

States undertake to develop progressively occupational health services for all workers, including those in the public sector.

- ▶ **Article 2(1) ILO Promotional Framework for Occupational Safety and Health Convention No. 187, 2006:**<sup>114</sup> *States under a duty to 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.*

### Standards related to nursing staff

- ▶ **ILO Nursing Personnel Convention**<sup>115</sup> **No. 149, 1977**

**Article 1(2)** : *This Convention applies to all nursing personnel, wherever they work.*

**Article 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' organizations concerned, where such organizations exist. (4). This policy shall be co-ordinate with policies relating to other aspects of health care and to other workers in the field of health, in consultation with the employers' and workers' organizations concerned.*

**Article 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.*

112 International Labour Organization (ILO). Occupational Health Services Convention No. 155, 1981.[http://www.ilocarib.org.tt/projects/cariblex/conventions\\_19.shtml](http://www.ilocarib.org.tt/projects/cariblex/conventions_19.shtml).

113 ILO. Occupational Health Services Convention No. 161, 1985. <http://www.ilo.org/ilolex/cgi-lex/convde.pl?C161>.

114 ILO. Promotional Framework for Occupational Safety and Health Convention. <http://www.ilo.org/ilolex/cgi-lex/convde.pl?C187>

115 ILO. Table of ratifications. <http://www.ilo.org/ilolex/cgi-lex/ratific.pl?C149>.

**Article 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.*

#### Note: Working Conditions and Health care Professionals

UN treaty-monitoring bodies have made specific reference to health personnel on numerous occasions. There is general consensus about the need to take measures to increase the salaries of nurses.<sup>116</sup> The failure to pay medical staff their salaries for extended periods also presents an issue, as it leads many doctors to seek employment overseas. Monitoring bodies have also noted the pressing need to allocate funds to hospitals and health care services on a priority basis in order to restore health services to an operational level and to ensure those doctors, nurses, and other medical personnel are able to resume work as soon as possible. The low wages of the medical staff and the suboptimal living and working conditions in hospitals have also generated concern. Finally, the “brain drain” associated with the exodus of health professionals due to poor working conditions in the health sector in their home countries has been cited as problematic.<sup>117</sup>

#### Standards related to woman

- ▶ **Article 10(2) ICESCR:** *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.*
- ▶ **Article 7 ICESCR:** *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favorable 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.*

CESCR GC 16, para. 24: *Article 7 (a) of the Covenant requires States parties to recognize the right of everyone to enjoy just and favorable conditions of work and to ensure, among other things, fair wages and equal pay for work of equal value. Article 3, in relation to article 7 requires, inter alia, that the State party identify and eliminate the underlying causes of pay differentials, such as gender-based job evaluation or the perception that productivity differences between men and women exist. Furthermore, the State party should monitor compliance by the private sector with national legislation on working conditions through an effectively functioning labour inspectorate. The State party should adopt legislation that prescribes equal consideration in promotion, non-wage compensation and equal opportunity and support for vocational or professional development in the workplace. Finally, the State party should*

116 I CESCR. Concluding Observations of the Committee on Economic, Social and Cultural Rights: Uruguay, 1997. (E/1998/22).

117 ICESCR. Concluding Observations: Zambia, 2005. (E/2006/22).

*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.*

- ▶ **Article 11(1) Convention on the Elimination of All Forms of Discrimination Against Women ('CEDAW'):** *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.*
- CEDAW has offered frequent criticism of the disproportionate number of women occupying low-paid, low-skilled, and part-time work, including in the health sector.<sup>118</sup> The CEDAW committee has also highlighted the relative absence of women from high decision-making professional and administrative positions in both the public and private sectors (evidence of the so-called “glass-ceiling” phenomenon).<sup>119</sup>
- CEDAW has also condemned: the lack of regulations to penalize and remedy sexual harassment in the workplace in the private sector;<sup>120</sup> <sup>121</sup> the poor working conditions of women workers in both the private and the public sectors, particularly with respect to the non-implementation of minimum wage levels and the lack of social and health benefits;<sup>122</sup> discrimination against women on the grounds of pregnancy and maternity in spite of policies that prohibit this practice;<sup>123</sup> the lack of affordable childcare;<sup>124</sup> and the need to expand the number of crèches available for working mothers.<sup>125</sup>

### Standards related to race, noncitizens, and migrant workers

- ▶ **Article 5(e)(i) CERD:** *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, color, 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 favorable conditions of work, to protection against unemployment, to equal pay for equal work, to just and favorable remuneration.*

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118 CEDAW. Report of the Committee on the Elimination of Discrimination against Women: Belarus, 2004. (A/59/38 [part I]).

119 CEDAW. Report of the Committee: Finland, 1995. (A/50/38). See also reports of the committee on Ethiopia, 1996 (A/51/38) and Albania, 2003 (A/58/38 [part I]).

120 CEDAW. Report of the Committee: Argentina, 1997. (A/52/38/Rev. 1 [part II]). See also report of the committee on Cuba, 2000 (A/55/38 [part II]).

121 CEDAW. Report of the Committee: China, 1999. (A/54/38/Rev.1 [part I]).

122 CEDAW. Report of the Committee: Bangladesh, 1997. (A/52/38/Rev.1 [part II]).

123 CEDAW. Report of the Committee: Guyana, 2001. (A/56/38 [part II]). The committee recommended development of a national policy for the private and public sectors to include minimum mandatory and paid maternity and parental leave and also to include provisions for effective sanctions and remedies for violation of laws regarding maternity leave. It also recommended establishment of training programs for the staff of the labor office to facilitate prosecution and ensure the effective enforcement of existing laws for both the public and private sectors.

124 port of the Committee: Ireland, 2005. (A/60/38 [part II]).

125 CEDAW. Report of the Committee: Bangladesh, 2004. (A/59/38 [part II]).

**CERD GC 30, paras. 33–35:** *[The committee recommends] that the States parties to the Convention, as appropriate to their specific circumstances, adopt the following measures:...* (33) *Take measures to eliminate discrimination against non-citizens in relation to working conditions and work requirements, including employment rules and practices with discriminatory purposes or effects;* (34) *Take effective measures to prevent and redress the serious problems commonly faced by non-citizen workers, in particular by non-citizen domestic workers, including debt bondage, passport retention, illegal confinement, rape and physical assault;* (35) *Recognize that, while States parties may refuse to offer jobs to noncitizens without a work permit, all individuals are entitled to the enjoyment of labour and employment rights, including the freedom of assembly and association, once an employment relationship has been initiated until it is terminated.*

- ▶ **Article 25 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (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.*
- ▶ **Article 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 Freedom of Association

The ability of workers to be able to form, join and run associations without undue interference is critical to their ability to effectively defend their rights and to healthcare professionals enjoy the same collective action rights as other employees. Although the health sector provides an essential service, this would only preclude its members from collective action in certain exceptional circumstances. Moreover, 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 be also applied to professional associations or trade unions. The latter are also the subject of relevant International Labor Organization ('ILO') standards.

Certain provisions of the UN Human Rights Defenders Declaration emphasize the role of healthcare providers as human rights defenders who implement and protect social rights and fundamental civil rights, such as life and freedom from torture and inhuman or degrading treatment.<sup>126</sup>

<sup>126</sup> 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. (A/RES /53/144). [http://www.unhcr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.RES .53.144.En](http://www.unhcr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES .53.144.En).

## Right to Freedom of Association and Assembly

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A professional medical association is not approved by the Ministry of Health because its president is a leading member of an opposition political party*
- *Authorities prevent a rally for improved pay and conditions for health workers from taking place without any justification*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### General standards

- ▶ **Article 20 Universal Declaration of Human Rights (UDHR):** *(1) Everyone has the right to freedom of peaceful assembly and association. (2) No one may be compelled to belong to an association.*
- ▶ **Article 21 International Covenant on Civil and Political Rights (ICCPR):** *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 (order public), the protection of public health or morals or the protection of the rights and freedoms of others.*

Although freedom of assembly is not an absolute right, any restrictions on the ability of people to peacefully protest must be justified in line with the conditions explicitly stated in Article 21 of the ICCPR.<sup>127</sup>

**Article 21 ICCPR:** *(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 (order 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.*

- It is not clear whether Article 22 of the ICCPR also includes the freedom not to join an association, in which case trade union “closed shop” practices would amount to a breach, although it is probable that the article does include this freedom.<sup>128</sup>
- Procedural formalities for recognition of associations must not be so onerous as to amount to a substantive restriction on Article 22 of the ICCPR.<sup>129</sup>

127 S. Joseph, J. Schultz, and M. Castan. *The ICCPR: Cases, Materials and Commentary*. (Oxford: Oxford University Press, 2004), 569.

128 *Ibid.*, 582. See also HRC. *Gauthier v. Canada*. Communication No. 633/1995. Views adopted May 5, 1999.

129 HRC. *Concluding Observations of the Human Rights Committee: Belarus, 1997*. (CCPR/C/79/Add.); *Concluding Observations: Lithuania, 1997*. (CCPR/C/79/Add.87).

- Although legislation governing the incorporation and status of associations may be, on its face, compatible with Article 22, de facto state practice restricting the right to freedom of association through a process of prior licensing and control has been condemned.<sup>130</sup>
- ▶ Article 2 ILO Convention No. 87 on the Freedom of Association and Protection of the Right to Organise<sup>131</sup>: *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.*
- The right to establish and to join organizations for the promotion and defense of workers' interests without previous authorization is a fundamental right under Article 2 of ILO Convention No. 87 that should be enjoyed by all workers without any distinction whatsoever; hospital personnel are entitled to take full advantage of this right.<sup>132</sup>
- A law providing that the right of association is subject to authorization granted by a government department purely in its discretion is incompatible with the principle of freedom of association as guaranteed by ILO Convention No. 87<sup>133</sup>
- ▶ **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**<sup>134</sup>

**Article 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.*

**Article 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.*

## Standards Related To Women

### Article 5(d)(ix) CERD:

*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, color, 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.*

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130 HRC. Concluding Observations: Lebanon, 1997. (A/52/40 [vol. I]).

131 ILO. Table of ratifications. <http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?C087>.

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

133 ILO. Freedom of Association: Digest of Decisions and Principles, 2005; Digest of Decisions and Principles, 1996; and 332nd Report of the Freedom of Association Committee. Case No. 2225.

134 UN General Assembly Resolution 53/144. December 9, 1998. [http://www.unhcr.ch/huridocda/huridocda.nsf/\(Symbol\)/A.RES.53.144.En](http://www.unhcr.ch/huridocda/huridocda.nsf/(Symbol)/A.RES.53.144.En).



## Trade Unions and the Right to Strike

### EXAMPLES OF POTENTIAL VIOLATIONS

- **Health sector trade unions or professional associations have not been approved by the Ministry of Health to represent members;**
- **A nurse cannot work at a particular hospital unless she joins the only trade union recognized by the management, as part of a “closed shop” agreement;**
- **Some doctors and nurses are dismissed after taking collective action over their poor pay and conditions**

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ Article 22 ICCPR: *(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 Labor Organization 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.*
- Trade unions have specific protection under Article 22(1) of the ICCPR;<sup>135</sup> Article 22(3) emphasizes preexisting obligations under ILO Convention 87;
- The need for multiple trade unions to be lawfully guaranteed has been emphasized by both the HRC and the CES CR,<sup>136</sup> and the absence of enabling legislation has been condemned.<sup>137</sup>
- Workers’ rights—including collective bargaining, protection against reprisals for exercising free association rights, and freedom from unnecessary interference in trade union activities—have been reaffirmed by the HRC<sup>138</sup> and the CES CR<sup>139</sup> on numerous occasions;
- The HRC has found breaches of both Article 22 and 19 (free expression) for the unlawful detention of individuals because of their trade union activities.<sup>140</sup>

135 Article 22(1) of the ICCPR reads: 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.

136 I CCPR. Brazil, 1996. (A/51/40 [vol. I]); ICES CR. Rwanda, 1989. (E/1989/22).

137 I CCPR. Georgia, 1997. (A/52/40 [vol. I]).

138 I CCPR. Costa Rica, 1999. (A/54/40 [vol. I]). “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 Dominican Republic, 2001. (A/56/40 [vol. I]); Argentina, 1995. (A/50/40 [vol. I]); Guatemala, 1996. (A/51/40 [vol. I]); Nigeria, 1996. (A/51/40 [vol. I]); Bolivia, 1997. (A/52/40 [vol. I]); Venezuela, 2001. (A/56/40 [vol. I]).

139 ICES CR. Jamaica, 1990. (E/1990/23).

140 Burgos v. Uruguay. (R.12/52); ICCPR. A/36/40. July 29, 1981; Pietrarola v. Uruguay. (R.10/44); ICCPR. A/36/40. March 27, 1981; Weinberger v. Uruguay. (R.7/28); ICCPR. A/36/40. October 29, 1980; Sohn v. Republic of Korea. (518/1992); ICCPR. (A/50/40 [vol. II]). July 19, 1995. (CCPR/C/54/D/518/1992).

- Trade union protection includes ensuring that foreign workers are not barred from holding of-  
ficial positions and that unions are not dissolved by the executive;<sup>141</sup>
- Article 22(3) does not implicitly guarantee the right to strike;<sup>142</sup>
- The denial to civil servants of the right to form associations and to bargain collectively has been  
condemned as a violation of Article 22 of the ICCPR;<sup>143</sup>
- 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,” as defined by the ILO, may violate Article  
22 of the ICCPR<sup>144</sup>

▶ **Article 23(4) UDHR:**

*Everyone has the right to form and to join trade unions for the protection of his interests.*

▶ **Article 8 ICESCR:**

*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 Con-  
vention 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.*

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141 HRC. Concluding Observations of the Human Rights Committee: Senegal, 1997. (CCPR/C/79/Add.)

142 Majority view in *J. B. and Ors v. Canada*. (118/82). A sizeable minority of the committee dissented, however

143 HRC. Concluding Observations: Lebanon, 1997. (A/52/40 [vol. I]); ICCPR. Chile, 1999. (A/54/40 [vol. I]).

144 ICCPR. Germany, 1997. (A/52/40 [vol. I]).



► **ILO Convention 87 on the Freedom of Association and Protection of the Right to Organise<sup>145</sup>:**

**Article 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.*

**Article 3:** *1. Workers' and employers' organisations shall have the right to draw up their constitutions and rules, to elect their representatives in full freedom, to organise their administration and activities and to formulate their programmes.*

*2. The public authorities shall refrain from any interference which would restrict this right or impede the lawful exercise thereof.*

**Article 4:** *Workers' and employers' organisations shall not be liable to be dissolved or suspended by administrative authority.*

**Article 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 Convention 98 on Right to Organize and Collective Bargaining<sup>146</sup>:**

**Article 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.*

**Article 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.*

**Article 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.*

- Although there is no explicit recognition of the right to strike in any ILO convention or recommendation, the ILO's Freedom of Association Committee frequently states that the right to strike is a fundamental right of workers and of their organizations<sup>153</sup> and defines the limits within which it may be exercised. In addition, two resolutions of the International Labour Con-

<sup>145</sup> Table of ratifications at <http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?C087>

<sup>146</sup> Table of ratifications at <http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?C098>

ference, which provide guidelines for ILO policy, have emphasized recognition of the right to strike in member states in at least two resolutions.<sup>147</sup>

- Persons employed in public hospitals should enjoy the right to collective bargaining as guaranteed by ILO Convention No. 98.<sup>148</sup>
- Recognition of the principle of freedom of association in the case of public servants does not necessarily imply the right to strike.<sup>149</sup>
- The ILO Freedom of Association Committee has acknowledged that the right to strike can be restricted or even prohibited in the public service or in certain essential services when striking could cause serious hardship to the national community, provided that the limitations are accompanied by certain compensatory guarantees.<sup>150</sup>
- The ILO Committee has expressly stated that the hospital sector is considered an essential service for the purposes of prohibiting work stoppages.<sup>151</sup> More broadly, to determine situations in which a strike could be prohibited in an essential service, there must be a clear and imminent threat to the life, personal safety, or health of the whole or part of the population. Within those services considered essential, however, certain categories of employees, such as hospital laborers and gardeners, should not be deprived of the right to strike.

## RIGHT TO DUE PROCESS AND RELATED RIGHTS

This section outlines the relevant due process standards that healthcare providers enjoy when commencing or being the subject of civil proceedings, including disciplinary matters. It includes the related right to an effective remedy but does not deal with the rights of the accused in criminal proceedings.<sup>152</sup> The interpretation of what is meant by a ‘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.

As in previous sections, material that elaborates on the interpretation of standards in relation to health sector personnel has been highlighted. Relevant standards from the 1998 UN Human Rights Defenders Declaration underscore the fact that healthcare providers, as well as enjoying the same core rights as patients, are defenders of rights in their daily work. This section also details those standards that protect the privacy rights of healthcare providers in and outside the workplace, together with their honour and reputation.

In addition, there is brief discussion of standards that address the right to free expression and to impart information. These liberties are particularly important as they might offer protection to ‘whistleblowers’ that seek to place certain information in the public domain. This protection is important because public sector employees are often reluctant to disseminate information based on fear of adverse consequences.

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147 I CES CR. Russian Federation, 1997. (E/1998/22

148 ICES CR. Uruguay, 1994. (E/1995/22).

149 ICES CR. Belgium, 1994. (E/1995/22).

150 ILO. Table of ratifications. <http://www.ilo.org/ilolex/cgi-lex/ratifice.pl?C087>

151 ILO.Digest, 2005

152 The United Nations Human Rights Treaties. Rights of the accused in criminal proceedings.

## Right to a Fair Hearing

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A doctor facing disciplinary proceedings is unable to obtain access to all of the evidence presented against him in advance of the hearing;*
- *A nurse facing a medical negligence suit has still not been given a hearing date five years after commencement of the proceedings*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### Art 14(1) ICCPR: fair hearing (emphasis added)

*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. The press and the public may be excluded from all or part of a trial for reasons of morals, public order (*ordre public*) or national security in a democratic society, or when the interest of the private lives of the parties so requires, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice; but any judgment rendered in a criminal case or in a suit at law shall be made public except where the interest of juvenile persons otherwise requires or the proceedings concern matrimonial disputes or the guardianship of children.*

- The concept of “suit at law” under Article 14(1) of the ICCPR is based on the nature of the right in question rather than on the status of one of the parties (whether state or nonstate). The particular forum that the legal systems employ to adjudicate individual claims does not determine the nature of the right (an especially important condition in the case of common law systems).<sup>153</sup>
- The regulation of the activities of a professional body and the scrutiny of such regulations by the courts may raise issues under Article 14;<sup>154</sup>
- Purely administrative proceedings will fall outside the scope as not amounting to a determination of civil rights and obligations;<sup>155</sup>
- The notion of a “tribunal” in Article 14(1) refers to a body-regardless of denomination - that is a) established by law; b) independent of the executive and legislative branches of government; and c) in specific cases enjoys judicial independence in deciding legal matters in proceedings that are judicial in nature;<sup>156</sup>
- Determination of public law rights falls within the scope of Article 14(1) if, within the relevant municipal legal system, it is conducted by a court of law or if the administrative determination is subject to judicial review;

153 HRC. General Comment 32 of the Human Rights Committee; *Y. L. v. Canada*. (112/81). Applying this interpretation, claim for disability pension did amount to a “suit at law.” See also *Casanovas v. France*. (441/90). Covers procedure concerning employment dismissal; *Jansen-Gielsen v. The Netherlands*. (846/99). Tribunal proceedings to determine the psychiatric ability of people to perform their jobs amounted to “suit at law.”

154 *J. L. v. Australia*. (491/92).

155 *Kolanowski v. Poland*. (837/98). Challenge to the fact that denied promotion of police officer was not covered but dismissals from public service are (*Casanovas v. France* [441/90]). See also *Kazantzis v. Cyprus*. (972/01). Procedure for appointing public servants (in this case, judicial appointments) did not fall within scope of Article 14.

156 HRC. General Comment 32 of the Human Rights Committee, paras. 18 and 19

- Article 14 does not, however, appear to guarantee a right of judicial review of public law determinations by administrators or administrative tribunals and does not guarantee that any such review entails evaluation of the merits.
  - The right to a fair hearing in a civil suit encompasses:
    - ⇒ Equality before the courts:<sup>157</sup> This distinction is narrower than the right of equality before the law under Article 26 of the ICCPR as the latter applies to all organs involved in the administration of justice and not just to judicial power.<sup>158</sup>
    - ⇒ Access to courts:<sup>159</sup> Access includes the provision of legal aid.<sup>160</sup> Article 14 ICCPR requires that states provide for particular causes of action “in certain circumstances” and for competent courts to determine those causes of action, although it is not clear what those circumstances are.<sup>161</sup>
  - Article 14, in guaranteeing procedural equality, cannot be interpreted as guaranteeing equality of results or absences of error on the part of the competent tribunal<sup>162</sup>;
  - Elements of a fair hearing in a civil suit encompass equality of arms,<sup>163</sup> respect for the principle of adversarial proceedings, preclusion of ex officio worsening of an earlier verdict, and an expeditious procedure.<sup>164</sup>
  - Public hearings in civil suits have been explicitly recognized by the HRC, subject only to limited public interest exceptions.<sup>165</sup>
  - Placing the burden of proof on defendants in civil cases is permissible.<sup>166</sup>
  - Examples of breaches of Article 14 include: refusing to allow a complainant to attend the proceedings and to have the opportunity to brief legal representatives properly,<sup>167</sup> failing to inform the author of his appeal date until after it has taken place,<sup>168</sup> refusal of an administrative tribunal to admit crucial evidence,<sup>169</sup> and failure to permit one litigant to submit comments on the other side’s submissions.<sup>170</sup>
- ▶ **Article 26 ICCPR:** *All persons are equal before the law and are entitled without any discrimination to the equal protection of the law;*
- ▶ **Article 5(a) CERD:** *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.*
- ▶ **Article 15(1) CEDAW:** *states Parties shall accord to women equality with men before the law.*

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157 Ibid., paras. 3 and 7

158 Ibid., para. 65.

159 Ibid., paras. 8, 9, and 12.

160 Bahamonde v. Equatorial Guinea. (468/91); Avellanal v. Peru. (202/86); and HRC GC 32, para. 10.

161 Mahuika v New Zealand. (547/93).

162 HRC. GC 32, para. 26; B. D. B v. The Netherlands. (273/88).

163 HRC. GC 32, para. 13. See concurring individual opinion of Prafullachandra Natwarlal Bhagwati in Pezoldova v. The Czech Republic. (757/1997). “As 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. ...”

164 M orael v. France. (207/86). See also Fei v. Colombia. (514/92); HRC. GC 32, para. 27 on delay.

165 HRC. GC 32, paras. 28 and 29. See also van Meurs v. The Netherlands. (215/1986).

166 HRC. GC 32, para. 9.4

167 Wolf v. Panama. (289/88).

168 Thomas v. Jamaica. (272/88).

169 Jansen-Gielen v. The Netherlands. (846/99). Proceedings to determine psychiatric ability to perform job.

170 Arela and Anor v. Finland. (779/97).

## Right to an Effective Remedy<sup>171</sup>

### EXAMPLES OF POTENTIAL VIOLATIONS

- *No damages are awarded to a doctor after his reputation has been damaged following the appearance of unsubstantiated and false accusations of medical negligence in the media;*
- *A nurse is unable to appeal an employment tribunal decision to a court;*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ▶ Article 2(3) ICCPR:

*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.*

- There is a clear link between the right to an effective remedy and the right to a fair hearing and/or due process and, in general, this provision needs to be respected whenever any guarantee of Article 14 has been violated;<sup>172</sup>
- Remedies must be accessible and effective. 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.<sup>173</sup>
- States are required, as part of the obligation under Article 2(3)(a) of the ICCPR, to ensure determination of the right to a remedy by a competent judicial, administrative, or legislative authority,<sup>174</sup> a guarantee that would be void if it were not available in cases in which a violation of the ICCPR had not been established. The State is not obliged to make such procedures available, however, regardless of how unmeritorious the claim might be.<sup>175</sup>

#### ▶ Article 2(1) ICESCR

- 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

171 UN . Human Rights Defenders Declaration. Article 9.

172 HRC. General Comment 32 of the Human Rights Committee, para. 58.

173 HRC. General Comment 31 of the Human Rights Committee, paras. 15 and 16.

174 I bid., para. 15.

175 Kazantzis v. Cyprus. (972/01).

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.

- Administrative remedies will, in many cases, be adequate. Any such remedies should be accessible, affordable, timely, and effective. The ultimate right of judicial appeal from administrative procedures is also often appropriate, however. There are some obligations, such as (but by no means limited to) those concerning nondiscrimination, for which the provision of some form of judicial remedy is indispensable.<sup>176</sup>
- ▶ **Article 9 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) 1998**<sup>177</sup>

All human rights defenders have the right to an effective remedy and to protection in the event of the violation of their rights. This right includes the right to complain about the policies and actions of government bodies and officials. In turn, the state should conduct a prompt and impartial investigation or ensure that an inquiry takes place whenever there is reasonable ground to believe that a violation has occurred in any territory under its jurisdiction.

## Right to Protection of Privacy and Reputation

### EXAMPLES OF POTENTIAL VIOLATIONS

- *The phone of a hospital chief executive is bugged without any prior lawful authorization;*
- *A doctor involved in a civil suit against a hospital for unfair dismissal finds out that his correspondence has been routinely intercepted and read without his knowledge*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### Article 17 ICCPR : protection of privacy and reputation

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

#### HRC General Comment 16 : right to privacy

- *...The term “home” in English, “manzel” in Arabic, “zhùzhái” in Chinese, “domicile” in French, “zhilische” in Russian and “domicilio” in Spanish, as used in article 17 of the Covenant, is to be understood to indicate the place where a person resides or carries out his usual occupation ..*

<sup>176</sup> I CES CR, General Comment 9. (E/C.12/1998/24, CES CR). December 3, 1998

<sup>177</sup> UN General Assembly Resolution 53/144. December 9, 1998

- *Even with regard to interferences that conform to the Covenant, relevant legislation must specify in detail the precise circumstances in which such interferences may be permitted. A decision to make use of such authorized interference must be made only by the authority designated under the law, and on a case-by-case basis. Compliance with article 17 requires that the integrity and confidentiality of correspondence should be guaranteed de jure and de facto. Correspondence should be delivered to the addressee without interception and without being opened or otherwise read. Surveillance, whether electronic or otherwise, interceptions of telephonic, telegraphic and other forms of communication, wire-tapping and recording of conversations should be prohibited. Searches of a person's home should be restricted to a search for necessary evidence and should not be allowed to amount to harassment. So far as personal and body search is concerned, effective measures should ensure that such searches are carried out in a manner consistent with the dignity of the person who is being searched. Persons being subjected to body search by State officials, or medical personnel acting at the request of the State, should only be examined by persons of the same sex.*
- *The gathering and holding of personal information on computers, data banks and other devices, whether by public authorities or private individuals or bodies, must be regulated by law. Effective measures have to be taken by States to ensure that information concerning a person's private life does not reach the hands of persons who are not authorized by law to*

*receive, process and use it, and is never used for purposes incompatible with the Covenant. In order to have the most effective protection of his private life, every individual should have the right to ascertain in an intelligible form, whether, and if so, what personal data is stored in automatic data files, and for what purposes. Every individual should also be able to ascertain which public authorities or private individuals or bodies control or may control their files. If such files contain incorrect personal data or have been collected or processed contrary to the provisions of the law, every individual should have the right to request rectification or elimination;*

- *Article 17 affords protection to personal honour and reputation and States are under an obligation to provide adequate legislation to that end. Provision must also be made for everyone effectively to be able to protect himself against any unlawful attacks that do occur and to have an effective remedy against those responsible. States parties should indicate in their reports to what extent the honour or reputation of individuals is protected by law and how this protection is achieved according to their legal system.*

▶ **Article 19(3) ICCPR: limiting free expression to protect rights and reputation of others.**

*The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:*



- (a) For respect of the rights or reputations of others;
- (b) For the protection of national security or of public order (*ordre public*), or of public health or morals.

## Right to Free Expression and Information<sup>178</sup>

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A senior health service manager is dismissed after revealing that a hospital has been purchasing unlicensed drugs;*
- *State authorities intervene to prevent employees from learning that their hospital contains dangerously high levels of radiation*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ▶ Article 19(2) ICCPR : right to information

*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.*

- ▶ **Article 5(d)(viii) The right to freedom of opinion and expression** *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) 1998<sup>179</sup>**

- ▶ **Article 6** *Everyone has the right, individually and in association with others:*

*(a) To know, seek, obtain, receive and hold information about all human rights and fundamental freedoms, including having access to information as to how those rights and freedoms are given effect in domestic legislative, judicial or administrative systems;*

*(b) As provided for in human rights and other applicable international instruments, freely to publish, impart or disseminate to others views, information and knowledge on all human rights and fundamental freedoms;*

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<sup>178</sup> Laptsevich v. Belarus. (780/97).

<sup>179</sup> UN General Assembly Resolution 53/144; 9 December 1998



*(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.*

**3.1 INTRODUCTION**

**3.2 KEY SOURCES**

**3.3 PATIENTS' RIGHTS**

**Right to liberty and security of the person**

**Right to privacy**

**Right to information**

**Right to bodily integrity**

**Right to life**

**Right to the highest attainable standard of health**

**Right to freedom from torture and cruel, inhuman, and degrading treatment**

**Right to participate in public policy**

**Right to nondiscrimination and equality**

**3.4 PROVIDERS' RIGHTS**

**Right to work in decent conditions**

**Right to freedom of association**

**Right to due process and related rights**

# 3

## Regional Framework for Human Rights in Patient Care

### 3.1 Introduction

This chapter elaborates on the main standards that safeguard human rights in patient care within Europe (as defined geographically by the Council of Europe [COE]) and examines how they have been interpreted by supranational bodies, most notably 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 parts that describe key regional sources governing human rights in patient care and also examine patients' and providers' rights. Each part includes subsections that discuss the standards and relevant interpretations connected to a particular right (for example, the right to liberty and security of the person) and also provide some examples of potential violations. The standards addressed include binding treaties, such as the [European] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights [ECHR]), the European Social Charter (ES C), and other standards developed by the COE and civil society, such as the highly significant European Charter of Patients Rights.

## 3.2 Key Sources

### 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)<sup>1</sup>**

This 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.”<sup>2</sup> It is binding on ratifying states.

Key provisions include:

- Equitable access to health care (Article 3)
- Protection of consent (Chapter II , Articles 5–9)
- Private life and right to information (Chapter III , Article 10)

- ▶ **European Convention on Human Rights (ECHR)<sup>3</sup>**

The ECHR is the leading regional human rights instrument and it has been ratified by all Council of Europe member states. It is enforced by the ECtHR, which hands down binding decisions that frequently involve monetary compensation for victims.

Relevant provisions include:

- Article 2 (right to life)
- Article 3 (protection against torture and cruel, inhuman or degrading treatment)
- Article 5 (right to liberty and security of person)
- Article 6 (access to a fair hearing)
- Article 8 (right to privacy)
- Article 13 (right to effective remedies)
- Article 14 (prohibition of discrimination)

- ▶ **European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment**

Article 1 establishes the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which monitors compliance with the treaty through regular monitoring visits to places of detention. The rest of the treaty sets out the membership and working methods of the committee.

<sup>1</sup> Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine. <http://conventions.coe.int/Treaty/EN/Treaties/Html/164.htm>.

<sup>2</sup> Subsequent additional protocols have been produced on prohibition of cloning (Treaty No. 168), transplantation of organs and tissues (Treaty No. 186), and biomedical research (Treaty No. 195)

<sup>3</sup> E European Convention on Human Rights. <http://www.hri.org/docs/ECHR50.html>

▶ European Social Charter 1961 and 1996 (ESC)<sup>4</sup>

The ES C 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 ES C was significantly revised in 1996, although some states have not ratified the later version and has the option as to which provisions they 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.

Relevant provisions include:

- Article 11 (right to protection of health)
- Article 13 (right to social and medical assistance)
- Article 14 (right to benefit from social welfare services)
- Article 15 (right of persons with disabilities to independence, social integration and participation in the life of the community)
- Article 16 (right of the family to social, legal and economic protection)
- Article 17 (right of children and young persons to appropriate social, legal and economic protection)
- Article 19 (right of migrant workers and their families to protection and assistance)
- Article 23 (right of elderly persons to social protection)

The ECSR has stated that rights related to health in the ES C are inextricably linked to their counterpart guarantees in the ECHR because "human dignity is the fundamental value and indeed the core of positive European human rights law—and health care is a prerequisite for the preservation of human dignity."<sup>5</sup>

▶ Framework Convention for the Protection of National Minorities 1995<sup>6</sup>

This binding treaty guarantees equal treatment for all ethnic and other minorities.

Relevant provisions include:

- Article 4(2) (adoption of adequate measures to promote, in all areas of economic, social, political, and cultural life, full and effective equality for persons belonging to a national minority, taking due account of the specific conditions of the persons belonging to national minorities)
- ▶ 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 decisionmaking process affecting health care<sup>7</sup>

4 Council of Europe (COE). European Social Charter. [http://www.coe.int/T/E/Human\\_Rights/Esc/](http://www.coe.int/T/E/Human_Rights/Esc/).

5 International Federation of Human Rights Leagues (FIDH) v. France. (14/2003).

6 Framework Convention for the Protection of National Minorities. <http://conventions.coe.int/treaty/en/Treaties/Html/157.htm>.

7 COE. Recommendation Rec No. R (2000) 5. <https://wcd.coe.int/ViewDoc.jsp?id=340437&BackColorInternet=9999CC&BackColorIntranet=FFBB55&BackColorLogged=FFAC75>.

Although not binding, this recommendation possesses strong political and moral authority. 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.

## EUROPEAN UNION

### ► EU Charter of Fundamental Rights<sup>8</sup>

Signed in Nice, France, on November 7, 2000, this charter sets out in a single text, for the first time in the history of the European Union (EU), the whole range of civil, political, economic, and social rights belonging to European citizens and all persons resident in the EU. The charter was incorporated as part two of the treaty establishing a constitution for Europe on June 18, 2004. After the rejection of the proposed EU constitution, an adapted version of this charter was retained and proclaimed in Strasbourg on December 12, 2007, before the signing of the Treaty of Lisbon, which makes it legally binding.

The charter's full implications for EU member states remain unclear, but it will be an important reference point even for countries outside of the EU, especially with respect to those in the process of accession.

Key provision:

Article 35 (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,” specifying that the EU must guarantee “a high level of protection of human health”)

Other relevant provisions include:

- Article 1 (the inviolability of human dignity)
- Article 2 (the right to life)
- Article 3 (the right to the integrity of the person)
- Article 6 (the right to security)
- Article 8 (the right to the protection of personal data)
- Article 21 (the right to non-discrimination)
- Article 24 (the rights of the child)
- Article 25 (the rights of the elderly)
- Article 34 (the right to social security and social assistance)
- Article 37 (the right to environmental protection)
- Article 38 (the right to consumer protection)

### ► Proposed EU Directive on Patients' Rights in Cross Border Health Care<sup>9</sup>

After repeated delays, the European Commission released this proposed directive, together with a communication on improving cooperation between member states in this area, on July 2, 2008. The

<sup>8</sup> Charter of Fundamental Rights of the European Union. [http://www.europarl.europa.eu/charter/default\\_en.htm](http://www.europarl.europa.eu/charter/default_en.htm).

<sup>9</sup> The draft directive, along with other key documents, communication from the commission, and press releases are available at [http://ec.europa.eu/health/ph\\_overview/co\\_operation/healthcare/cross-border\\_healthcare\\_en.htm](http://ec.europa.eu/health/ph_overview/co_operation/healthcare/cross-border_healthcare_en.htm).

aim of the directive is to create legal certainty on the issue, thereby avoiding potential court cases, as the EU treaty grants individuals the right to seek health care in other member states, a principle confirmed by several clear rulings by the European Court of Justice.

Under the treaty's major provisions:

- **Patients** have the right to seek health care abroad and to be reimbursed the same amount that they would have received if they had sought care in their home country. The directive will provide clarity as to how these rights can be exercised, including the limits that member states can place on cross-border health care and the level of financial coverage provided for it.
- **Member states** are responsible for health care provided on their territory. Patients should be confident that the quality and safety standards of the treatment they will receive in another member state are regularly monitored and based on sound medical practices.

In its press release, the commission stated that the directive “provides a solid basis to unlock the huge potential for European cooperation to help improve the efficiency and effectiveness of all EU health systems.”<sup>10</sup>

The European Public Health Alliance (EPHA) has expressed some concerns about the draft directive, including in relation to patients’ rights and whether it can really resolve the existing significant differences concerning access to and quality of health care between member states. The EPHA goes on to warn that the directive may merely lead to financial savings for the tiny minority who can already afford “health care tourism” as opposed to equal access for all.

## ***NONTREATY INSTRUMENTS***

### ▶ The European Charter of Patients’ Rights<sup>11</sup>

*“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.”<sup>12</sup>*

Drawn up in 2002 by the Active Citizenship Network, a European network of civic, consumer, and patient organizations, this charter provides a clear, comprehensive statement of patients’ rights. The 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.<sup>13</sup>

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10 European Commission. “Commission Adopts Proposal for Directive on Patients’ Rights in Cross-Border Healthcare.” July 2, 2008. (IP/08/1080).

11 European Charter of Patients’ Rights. [http://www.activecitizenship.net/health/european\\_charter.pdf](http://www.activecitizenship.net/health/european_charter.pdf).

12 I *bid.*, preamble.

13 The pharmaceutical company Merck & Co., Inc., also provided funding for this movement

The charter 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 the charter 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.<sup>14</sup> The charter has also been used as a reference point to monitor and evaluate health care systems across Europe.

- ▶ **WHO Declaration on the Promotion of Patients' Rights in Europe: European Consultation on the Rights of Patients, Amsterdam<sup>15</sup>**

*"In its scope and focus, this document seeks to reflect and express people's aspirations not only for improvements in their health care but also for fuller recognition of their rights as patients. In so doing, it keeps in mind the perspectives of health care providers as well as of patients. This implies the complementary nature of rights and responsibilities: 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. There is a basic assumption in the text that the articulation of patients' rights will in turn make people more conscious of their responsibilities when seeking and receiving or providing health care, and that this will ensure that patient/provider relationships are marked by mutual support and respect."<sup>15</sup>*

This nonbinding declaration was issued by the WHO Regional Office for Europe in 1994 and has become a significant reference point. Taking as its conceptual foundation the International Bill of Rights, the ECHR, and the ES C, the declaration focuses on rights to information, consent, confidentiality and privacy and care and treatment.

- ▶ **The WHO Ljubljana Charter on Reforming Health Care 1996<sup>16</sup>**

This charter 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."<sup>17</sup> Specifically, it recommends that health care systems be people-centric and calls for patient participation in shaping improvements.

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<sup>14</sup> 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.



### 3.3 Patients' Rights

Just as in the preceding chapter on the international framework, this section is structured around nine critical patient rights: 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; and nondiscrimination and equality for patients.

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 some patients' rights issues. 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 has outlawed 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 ES C, the ES CR 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.

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 only considered one right to healthcare case, concerning denial of medical assistance to poor illegal immigrants.

Therefore, there is great potential for development of the ECSR's case law further 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 referred to when arguing claims under binding treaties, such as the ECHR and the ES C, in order to better interpret the treaties' own provisions. In turn, increased references to nonbinding documents such as the European Charter of Patients' Rights will help them gain further credibility and strength so that, over time, some of their provisions might attain customary international law status.<sup>18</sup>

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15 | *bid*

16 Ljubljana Charter on Reforming Health Care. <http://www.bmj.com/cgi/content/full/312/7047/1664>.

17 | *bid*.

18 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.

## Right to Liberty and Security of the Person

### EXAMPLES OF POTENTIAL VIOLATIONS

- **A person is detained indefinitely on mental health grounds without efforts to seek any medical opinion;**
- **Residents of an institution are not informed about their right to apply to a court or tribunal to challenge their involuntary admission;**
- **A female drug user is detained in hospital after giving birth and is denied custody of her child**

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ▶ Article 5(1)(e) ECHR

*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: ... 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. ...*

- The ECtHR has not defined the phrase “unsound mind” on the basis that its meaning is continually evolving.<sup>19</sup> It has established, however, that there must be objective expert medical evidence that the person at the relevant time is of unsound mind (other than in emergencies).<sup>20</sup> Therefore, detention pursuant to the order of a prosecutor, without obtaining a medical opinion, will breach Article 5(1)(e), even if the purpose of the detention is to obtain such an opinion.<sup>21</sup>
- The ECtHR has established a number of procedural guarantees in relation to the application of Article 5(1)(e):
- Committing somebody 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.<sup>22</sup>
- Any commitment must be subject to a speedy periodic legal review that incorporates the essential elements of due process.<sup>23</sup>
- 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).<sup>24</sup>
- Detention under Article 5(1)(e) can be justified both in the interests of the individual and on public safety grounds.<sup>26</sup> A relevant factor in determining the legality of detention is whether the detention occurs in a hospital, clinic, or other appropriate authorized institution. The fact that detention may be in a suitable institution has no bearing on the appropriateness of the

19 *Litwa v. Poland*. (33 EHRR 53). Providing definition of alcoholism for purposes of Article 5(1)(e).

20 *Herz v. Germany*. (44672/98); *Rakevich v. Russia*. (No 58973/00).

21 *Varbanov v. Bulgaria*. (31365/96).

22 *Winterwerp v. The Netherlands*. (6301/73). See also *HL v. UK* (45508/99). System of detaining “informal patients” in psychiatric institutions did not incorporate sufficient procedural safeguards in order to prevent arbitrary deprivations of liberty.

23 *X v. United Kingdom*. (7215/75).

24 *Gajcsi v. Hungary*. (34503/03). Patient unlawfully detained for three years in a Hungarian psychiatric hospital, where the commitment procedure was superficial and insufficient to show dangerous conduct. 26. *Litwa v. Poland*. (33 EHRR 53). See also *Hutchinson Reid v. UK*. (37 EHRR 9). 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 his condition was not susceptible to medical treatment.

patient's treatment or conditions under which he or she is detained.<sup>25</sup> A violation of Article 5(1)(e) was found where a person was detained as a person infected with HIV—after having transmitted the virus to another man as a result of sexual activity—on the grounds that a fair balance had not been struck between the need to ensure that the virus did not spread and the individual's right to liberty.<sup>26</sup>

## Right to Privacy

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A doctor discloses a patient's history of drug use or addiction without their consent*
- *Government requires disclosure of HIV status on certain forms*
- *Health care workers require young people to obtain parental consent as a condition of receiving sexual health services*
- *Residents of an institution have no place to keep their personal possessions*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ▶ Article 8(1) ECHR

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 ... Respecting the confidentiality of health data is a vital principle in the legal systems of [State] Parties. ... It is crucial not only to respect the sense of privacy of the patient but also to preserve his or her confidence in the medical profession and in the health services in general.”*<sup>27</sup>

The reasons for such protection are clear: without it, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community.<sup>28</sup>

The ECtHR has gone on to note that the disclosure of health data *“may dramatically affect a person's private and family life, as well as social and employment situation, by exposing him or her to opprobrium and the risk of ostracism.”*<sup>29</sup> Disclosure is clearly particularly damaging in case of HIV infection. Therefore sufficient safeguards in domestic law must be in place.

A person's body concerns the most intimate aspect of one's private life<sup>30</sup> so there are clear links between the right to privacy and the right to bodily integrity.<sup>31</sup>

25 *A shingdane v. UK*. (7 EHRR 528)

26 *E nhorn v. Sweden*. (56529/00).

27 *M. S. v. Sweden*. (27/08/1997); *Z v. Finland*. (25 EHRR 371).

28 *Z v. Finland*. (25 EHRR 371).

29 *I bid*.

30 *Y. F. v. Turkey*. (24209/94). A forced gynecological exam conducted on woman in police custody breached Article 8 of the ECHR

31 *G lass v. UK*. (39 EHRR 15). The practice of administering diamorphine to a severely mentally and physically ill child against the clearly expressed wishes of the mother breached Article 8 of the ECHR.

▶ **Article 10(1) European Convention on Human Rights and Biomedicine:**

*Everyone has the right to respect for private life in relation to information about his or her health.*

- ▶ **Article 13(1) COE Recommendation No. R (2004) 10:** *All personal data relating to a person with 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.*
- ▶ **Article 6 European Charter of Patients' Rights:** *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.*
- ▶ **Article 4(1) and (8) Declaration on the Promotion of Patients' Rights in Europe:** *All information about a patient's health status ... must be kept confidential, even after death. ... Patients admitted to health care establishments have the right to expect physical facilities which ensure privacy.*
- ▶ **Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data**<sup>32</sup> Provides additional safeguards to protect a person's privacy with respect to the automatic processing of personal data (i.e., data protection).
- ▶ **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 7: Data security:** *Appropriate security measures shall be taken for the protection of personal data stored in automated data files against accidental or unauthorised destruction or accidental loss as well as against unauthorised access, alteration or dissemination.*
- ▶ **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.*

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<sup>32</sup> Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data. <http://conventions.coe.int/treaty/EN/Treaties/Html/108.htm>.

## Right to Information

### EXAMPLES OF POTENTIAL VIOLATIONS

- *Government bans publications about drug use or harm reduction, claiming they promote illegal activity;*
- *Young people are deliberately denied information about ST Ds and the use of condoms;*
- *Roma women do not have access to information about sexual and reproductive health*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ Article 8(1) ECHR - *Everyone has the right to respect for his private and family life, his home and his correspondence.*

The ECtHR has held that there is a positive obligation for the state to provide information to those whose right to respect for family and private life, under Article 8, is threatened by environmental pollution,<sup>33</sup> suggesting that any claim to the right to information in relation to health protection will have more prospects for success under Article 8 than Article 10.

- ▶ **Article 10(1) ECHR:** *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.*

The ECtHR has narrowly interpreted Article 10 of the ECHR as only prohibiting authorities from restricting a person from receiving information that others wish to impart and *not imposing* a positive obligation on the state to collect and disseminate information on its own motion.<sup>34</sup>

- ▶ **Article 3 European Charter of Patients' Rights:** *Every individual has the right to access to all kind of information regarding their state of health, the health services and how to use them, and all that scientific research and technological innovation makes available.*
- ▶ 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

## II. INFORMATION

*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.*

<sup>33</sup> I bid. See also McGinley and Egan v. UK. (27 EHRR 1). Positive obligation could arise under Article 8 in relation to provision of information about risks of exposure to radiation.

<sup>34</sup> Guerra v. Italy. (26 EHRR 357).

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).

- ▶ **Article 10(2) European Convention on Human Rights and Biomedicine:** *Everyone has the right to know any information collected about his or her health.*
- ▶ **Article 2(2) and (6) Declaration on the Promotion of Patients' Rights in Europe:** *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 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. [Moreover, patients] have the right to choose who, if any one, should be informed on their behalf.*

## Right to Bodily Integrity

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A Roma woman is sterilized against her will*
- *Doctors compel a drug-using pregnant woman to undergo an abortion*
- *Treatment is routinely given to residents of an institution without their consent as they are assumed to lack the capacity to make decisions about their treatment and care*
- *Patients at a psychiatric hospital are treated as part of a clinical medication trial without being informed that they are included in the research*
- *Patients are given ECT (electroconvulsive therapy) but are told that it is "sleep therapy"*
- *HIV tests are routinely administered without informed consent*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ **Article 5 – European Convention on Human Rights and Biomedicine:** *An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.*
- ▶ **Article 18 COE Recommendation No. R (2004) 10:** Council of Europe guidelines concerning the protection of the human rights and dignity of persons with mental disorder. A person should be subject to involuntary treatment for a mental disorder only if: the individual has a mental disorder which "represents a significant risk of serious harm to his or her health or to other persons;" less intrusive means of providing appropriate care are not available; and "the opinion of the person concerned has been taken into consideration."
- ▶ **Articles 4 and 5 European Charter of Patients' Rights:** *A patient has the right to refuse a treatment or a medical intervention and to change his or her mind during the treatment, refusing its continuation ... [and] the right to freely choose from different treatment procedures and providers on the basis of adequate information.*
- ▶ **Articles 3(1) and (2) Declaration on the Promotion of Patients' Rights in Europe:** *[T]he*



*informed consent of the patient is a prerequisite for any medical intervention [and] [a] patient has the right to refuse or halt a medical intervention.*

- ▶ **Article 3 EU Charter of Fundamental Rights:** *(1) Everyone has the right to respect for his or her physical and mental integrity. (2) In the fields of medicine and biology, the following must be respected in particular: (a) the free and informed consent of the person concerned, according to the procedures laid down by law; (b) the prohibition of eugenic practices, in particular those aiming at the selection of persons; (c) the prohibition on making the human body and its parts as such a source of financial gain; (d) the prohibition of the reproductive cloning of human beings.*

#### **Note: ECHR and the Right to Bodily Integrity**

The right to bodily integrity is not specifically recognized under the ECHR, but it has been interpreted to be part of the right to security of the person (ECHR 5), the right to freedom from torture and cruel, inhuman, and degrading treatment (ECHR 3), the right to privacy (ECHR 8), and the right to the highest attainable standard of health (ES C 11).

The ECtHR has found in relation to Article 8 of the ECHR that a person's body concerns the most intimate aspect of one's private life.<sup>35</sup> It has gone on to hold that a breach of physical<sup>35</sup>. *Y. F. v. Turkey*. (24209/94). and moral integrity occurred when dimorphine was administered to a son against his mother's wishes and a DNR (Do Not Resuscitate) order was placed in his records without his mother's knowledge.<sup>36</sup>

English courts have considered whether the compulsory treatment of a mentally competent patient has the potential to breach Articles 8 and 3 of the ECHR (even if the proposed treatment complies with the legislative requirements). Relevant factors include the consequences of the patient's not receiving the proposed treatment, the treatment's possible side effects, and the potential for less invasive options.<sup>37</sup>

- ▶ **European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment**

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has stated that every competent patient should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and should only relate to clearly and strictly defined exceptional circumstances.

<sup>35</sup> *Y. F. v. Turkey*. (24209/94).

<sup>36</sup> *G lass v. United Kingdom*. (61827/00).

<sup>37</sup> *R (on the application of PS) v. (1) Responsible Medical Officer (Dr. G) and (2) Second Opinion Appointed Doctor (Dr. W)*. (EWHC 2335 [Admin.]).



## Right to Life

### EXAMPLES OF POTENTIAL VIOLATIONS

- *No one calls 911 in the case of a drug overdose due to fear of arrest, and the person subsequently dies*
- *Drugs users die in locked hospital wards*
- *Government places unjustified legal restrictions on access to lifesaving HIV prevention or treatment*
- *The mortality rate of an institution is particularly high during the winter months due to the poor condition of the building, inadequate sanitation and heating, and poor quality of care*
- *A patient of a psychiatric hospital known to be at risk of suicide is not monitored adequately and subsequently takes her own life*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ **Article 2(1) ECHR:** *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.*

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, it is likely that a breach of Article 2 for denial of health care will only be found in exceptional cases.<sup>38</sup>

*“[I]t cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2. However, where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, it cannot accept that matters such as error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life.”<sup>39</sup>*

The ECtHR has held that an issue may arise under Article 2 “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”<sup>40</sup>—in other words, where there are preexisting obligations; these must not be applied in a discriminatory manner.

The ECtHR has held that the right to life can impose a duty to protect those in custody, including in cases in which the risk derives from self-harm.<sup>41</sup> 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.”

38 In *Nitecki v. Poland* (65653/01), no breach of Article 2 was found where the authorities only paid 70 percent of the cost of lifesaving drugs prescribed to a patient, with the latter expected to pay the remainder.

39 *Powell v. UK*. (No 45305/99). 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.

40 *Cyprus v. Turkey*. (35 EHRR 731).

41 *Keenan v. United Kingdom*. (33 EHRR 913).

In relation to medically caused deaths, states are required under Article 2 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"<sup>42</sup> 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.<sup>43</sup>

- To date, there has been no substantive decision on euthanasia, apart from the determination by the ECtHR that the right to life does not mean the right to die.<sup>44</sup>
- The ECtHR has also left open the possibility that Article 2 could be engaged in a situation in which sending a terminally ill person back to their country of origin could seriously shorten their life span or could amount to cruel and inhuman treatment due to inadequate medical facilities.<sup>45</sup>

## Right to the Highest Attainable Standard of Health

### EXAMPLES OF POTENTIAL VIOLATIONS

- *State fails to take progressive steps to ensure access to antiretroviral drugs to prevent mother-to-child HIV transmission*
- *Doctors and health facilities are not located in close proximity to certain poor neighborhoods*
- *State fails to provide any training in palliative care for its medical personnel*
- *A child in a social care home becomes bedridden due to malnutrition*
- *A hospital is unable to provide the appropriate specialist pediatric services for children who instead have to be treated with adult patients*
- *Women with mental disabilities are denied reproductive health services*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ **Article 11 ESC:** *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 organisations, 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*
- The ES CR has stated that Article 11 includes physical and mental well-being in accordance with the definition of health in the WHO Constitution.<sup>46</sup>

42 I bid.

43 Calvelli and Ciglio v. Italy. (32967/96). 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.

44 Pretty v. UK. (35 EHRR 1).

45 D v. UK. (24 EHRR 423). Issues under Article 2 were indistinguishable from those raised under Article 3.

46 COE. Conclusions of the European Committee of Social Rights. (XVII -2); Conclusions 2005. Statement of interpretation of Article

- 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.<sup>47</sup>
  - The health care system must be accessible to everyone (see the section on right to nondiscrimination and equality). Arrangements for access must not lead to unnecessary delays in provision. Access to treatment must be based on transparent criteria, agreed upon at national level, taking into account the risk of deterioration in either clinical condition or quality of life.<sup>48</sup>
  - 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.<sup>49</sup> In relation to advisory and educational facilities, the ES CR 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.<sup>50</sup>
- ▶ Articles 8–10 The European Charter of Patients’ Rights: The charter refers to the right to “the observance of quality standards,” “safety,” and “innovation.”
  - ▶ Article 5(3) WHO Declaration on the Promotion of Patients’ Rights in Europe: *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 provider.*
  - ▶ Article 35 EU Charter on Fundamental Rights: *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.*

#### Note: ECHR and Detainees’ Right to Health

The ECtHR has ruled that states have a duty to protect the health of detainees and that lack of treatment may amount to a violation of Article 3, which prohibits torture and cruel, inhuman, and degrading treatment or punishment<sup>51</sup>

47 COE. Conclusions: Denmark. (XV-2).

48 COE. Conclusions: United Kingdom. (XV-2).

49 COE. Conclusions: Denmark. (XV-2).

50 COE. The Right to Health and the European Social Charter. [http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/FactsheetHealth\\_en.pdf](http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/FactsheetHealth_en.pdf).

51 *Hurtado v. Switzerland*. (280-A); *Ilhan v. Turkey*. (34 EHRR 36).

## Right to Freedom from Torture and Cruel, Inhuman, and Degrading Treatment

### EXAMPLES OF POTENTIAL VIOLATIONS

- *Fearing prosecution by the state, a doctor refuses to prescribe morphine to relieve a patient's pain*
- *A prisoner suffering from cancer is denied treatment*
- *A drug user is denied mental health treatment while in detention*
- *Residents of an institution are not allowed to keep their own clothes as all clothes are communal*
- *Female residents of an institution are required to have showers together, supervised by male staff*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ **Article 3 ECHR:** *No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*
  - The former European Commission on Human Rights has 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.”<sup>52</sup>
  - 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. 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.<sup>55</sup> Breaches will tend to amount to inhuman and degrading treatment rather than torture.
  - Article 3 cannot be construed as laying down a general obligation to release detainees on health grounds, however. 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.”<sup>53</sup>
  - In relation to prisoners’ health and well-being, this condition includes the provision of requisite medical assistance.<sup>54</sup> Where the lack of this 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.<sup>55</sup> However, even when these results do not occur, a finding of degrading treatment may still be made if the humiliation caused to the victim by the stress and anxiety that he suffers due to the lack of assistance is severe enough.<sup>56</sup> For example, this finding was made in a case in which lack of medical treatment for the applicant’s various illnesses, including TB, contracted in prison, caused him considerable mental suffering, thereby diminishing his human dignity.<sup>57</sup>

52 *Tanko v. Finland*. (23634/94).

53 *Mouisel v. France*. (38 EHRR).

54 *Kudla v. Poland*. (30210/96).

55 *McGlinchey v. UK*. (37 EHRR 821).

56 *Sarban v. Moldova*. (3456/05).

57 *Hummatov v. Azerbaijan*. (9852/03) and (13413/04).

- Should a prisoner’s state of health require adequate medical assistance and treatment beyond that available in prison, he should be released subject to appropriate restrictions in the public interest?<sup>58</sup>
- 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.<sup>59</sup>
- Examples of breaches of Article 3 include: the continued detention of a cancer sufferer, causing “particularly acute hardship;”<sup>60</sup> significant defects in the medical care provided to a mentally ill prisoner known to be suicide risk;<sup>61</sup> and systematic failings in relation to the death of a heroin addict in prison.<sup>62</sup>
- In a recent case against Ukraine, the ECtHR found a breach of Article 3 both in terms of the conditions of detention in a pretrial detention center (overcrowding, sleep deprivation, and lack of natural light and air) and the failure to provide timely and appropriate medical assistance to the applicant for his HIV and tuberculosis infections.<sup>63</sup>
- If an individual suffers from multiple illnesses, the risks associated with any illness he suffers during his detention may increase and 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.<sup>64</sup>
- 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.<sup>65</sup> 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.<sup>66</sup>
- The combined and cumulative impact on a detainee of both the conditions of detention and a lack of adequate medical assistance may result in a breach of Article 3.<sup>67</sup>
- 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.<sup>68</sup>
- The authorities must also ensure that there is a comprehensive record concerning the detainee’s state of health and the treatment he underwent while in detention<sup>69</sup> and that the

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58 *Wedler v. Poland*. (44115/98). See also *Mouiel v. France*. (38 EHRR 34).

59 *Keenan v. UK*. (33 EHRR 48). The treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 with regard to the protection of fundamental human dignity, even though the person may not be able to point to any specific ill effects.

60 *Mouiel v. France*. (38 EHRR 34). Finding the detention amounted to inhuman and degrading treatment.

61 *Keenan v. UK*. (33 EHRR 48). Finding failure to refer to psychiatrist and lack of medical notes.

62 *M cGlinchey and Ors v. UK*. (37 EHRR 821). Finding inadequate facilities to record weight loss, gaps in monitoring, failure to take further steps including admission to hospital.

63 *Yakovenko v. Ukraine*. (15825/06). See also *Hurtado v. Switzerland (A 280-A)*. An X-ray, which revealed a fractured rib, was only ordered after a delay of six days.

64 *Khudobin v. Russia*. (59696/00).

65 *Jalloh v. Germany*. (44 EHRR 667).

66 68. *Jalloh v. Germany*. (44 EHRR 667).

67 *Popov v. Russia*. (26853/04); *Lind v. Russia*. (25664/05); *Kalashnikov v. Russia*. (47095/99) and (ECHR 2002-VI).

68 *Hummatov v. Azerbaijan*. (9852/03) and (13413/04); *Malenko v. Ukraine*. (18660/03).

69 *Khudobin v. Russia*. (59696/00).

diagnoses and care are prompt and accurate.<sup>70</sup> The medical record should contain sufficient information, specifying the kind of treatment the patient was prescribed, the treatment he actually received, who administered the treatment and when, how the applicant's state of health was monitored, etc. In the absence of such information, the court may draw appropriate inferences.<sup>71</sup> Contradictions in medical records have been held to amount to a breach of Article 3.<sup>72</sup>

- Experimental medical treatment may amount to inhuman treatment in the absence of consent.<sup>73</sup> During the drafting of the convention, compulsory sterilization was considered to amount to a breach.<sup>74</sup>
  - Medical negligence that does not cause a level of suffering/stress/anxiety in excess of the minimal level of humiliation, as defined by the ECtHR, will not involve a breach of Article 3.
- ▶ European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment The convention's monitoring mechanism, the European Committee for the Prevention of Torture (CPT), monitors compliance with Article 3 of the European Convention on Human Rights 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.<sup>75</sup> The CPT has emphasized the impact of overcrowding on prisoners' health.<sup>79</sup> 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.
  - ▶ Article 11 European Charter of Patients' Rights: *Each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness. The health services must commit themselves to taking all measures useful to this end, like providing palliative care treatment and simplifying patients' access to them.*
  - ▶ Articles 5(10) and (11) Declaration on the Promotion of Patients' Rights in Europe: *Patients have the right to relief of their suffering according to the current state of knowledge. ... Patients have the right to humane terminal care and to die in dignity.*

The ECSR has stated in relation to Article 11 of the ES C that conditions of stay in hospital, including psychiatric hospitals, must be satisfactory and compatible with human dignity.<sup>76</sup>

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70 A Ileksanyan v. Russia. (46468/06).

71 Hummatov v. Azerbaijan. (9852/03) and (13413/04); Melnik v. Ukraine. (72286/01). See also Holomiov v. Moldova. (30649/05).

72 Radu v. Romania. (34022/05).

73 X v. Denmark. (32 DR 282).

74 COE. Travaux préparatoires of the European Convention on Human Rights. Volume 1.

75 COE. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The CPT Standards. (CPT/Inf/E [2002, rev. 2006]).

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

## Right to Participate in Public Policy

### EXAMPLES OF POTENTIAL VIOLATIONS

- *An indigenous group is denied any meaningful participation in decisions regarding the design of appropriate systems to meet their health care needs*
- *LGBT groups are deliberately excluded from developing policies on addressing HIV/AIDS*
- *Civil society organizations are excluded from government deliberations to prepare applications for funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria*
- *The government negotiates a large-scale clinical trial without consulting or requiring researchers to consult affected communities*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ► Article 5.3 Fundamental Principles of the Ljubljana Charter on Reforming Health

**Care:** *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.*

- Part III European Charter of Patients' Rights: Section on the Rights of Active Citizenship: Citizens have the "right to participate in the definition, implementation and evaluation of public policies relating to the protection of health care rights."
- 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<sup>77</sup>

#### **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.

<sup>77</sup> COE. Recommendation No. R (2000) 5. <https://wcd.coe.int/ViewDoc.jsp?id=340437&Site=CM&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383>.



▶ **Committee of Ministers Recommendation No. R (2006) 18 to member states on health services in a multicultural society**<sup>78</sup>

5.1. Patient training programmes should be developed and implemented to increase their participation in the decision-making process regarding treatment and to improve outcomes of care in multicultural populations.

5.2. Culturally appropriate health promotion and disease prevention programmes have to be developed and implemented as they are indispensable to improve health literacy in ethnic minority groups in terms of health care.

5.3. Ethnic minority groups should be encouraged to participate actively in the planning of health care services (assessment of ethnic minorities' health needs, programme development), their implementation and evaluation.

## Right to Nondiscrimination and Equality

### EXAMPLES OF POTENTIAL VIOLATIONS

- *Asylum seekers are denied access to all health care apart from emergency treatment*
- *Hospitals routinely place Roma women in separate maternity wards*
- *Drug users are underrepresented in HIV-treatment programs despite fact that they account for a majority of people living with HIV*
- *A woman with a diagnosis of schizophrenia is told by nursing staff that her abdominal pains are “all in your mind” and is later diagnosed as having ovarian cancer*
- *A person with intellectual disabilities is not provided with the appropriate community care support to effectively socially integrate in the community*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ **Article 14** ECHR: Prohibition of Discrimination: *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.*
- ▶ Article 14 is not a stand-alone provision—in other words, it must be argued in conjunction with one of the substantive provisions of the ECHR.<sup>84</sup> 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.
  - To date, there have been no significant Article 14 decisions in relation to health care. Because Article 14 case law has increased during the last decade in areas such as racial discrimination and sexual orientation, it is likely that this circumstance will change in the future.
  - The main principles for considering an Article 14 claim are: evidence that there has been a difference of treatment on one of the non-permitted categories (although this condition is not exhaustive); and, if so, the existence of an objective and reasonable justification for such difference.<sup>79</sup>
  - The court has also recently accepted the use of statistics to prove indirect discrimination,<sup>80</sup> a practice that in itself may not amount to impermissible discrimination but that disproportionately affects members of a particular group.

78 COE. Committee of Ministers Recommendation No. R (2006) 18. <https://wcd.coe.int/ViewDoc.jsp?id=1062769&BackColorIntranet=9999CC&BackColorIntranet>.

79 Rasmussen v. Denmark. (7 EHRR 371).

- ▶ **Article 11 ESC (taken together with Article E of the charter guaranteeing nondiscrimination)**  
*With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation 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.*
  
- ▶ **Article 15 ESC: Rights of persons with disabilities to vocational training, rehabilitation and social resettlement**  
*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 specialised 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 specialised 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.*
  
- The ECSR has stated that the health care system must be accessible to everyone and that restrictions on the application of Article 11 ES C must not be interpreted in such a way as to impede disadvantaged groups' exercise of their right to health.<sup>81</sup>
- Specifically, the right of access to care requires that care must not represent an excessively heavy cost for the individual, and steps must be taken to reduce the financial burden on patients from the most disadvantaged sections of the community.<sup>82</sup>
- The ES CR, in considering a claim brought against France that it had violated (a) the right to medical assistance of poor illegal immigrants on very low incomes under Article 1389 of the Revised European Social Charter<sup>83</sup> by ending their exemption from charges for medical and hospital treatment<sup>84</sup> and (b) the rights of children of immigrants to protection under Article 17 of the revised charter<sup>85</sup> by a 2002 legislative reform that restricted their access to medical services for children, upheld the claim of the children but not of the adults. With regard to Article 13, the ES CR did find,

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80 D. H. v. Czech Republic. (57325/00).

81 COE. Conclusions of the European Committee of Social Rights. (XVII -2); Conclusions 2005. Statement of interpretation of Article

82 COE. Conclusions: Portugal. (XVII -2).

83 The Revised Social Charter of 1996 (ETS No. 163) embodies in one instrument all the rights guaranteed by the original charter of 1961 (ETS No. 035) and its additional protocol of 1988 (ETS No. 128) and adds new rights and amendments adopted by the parties. The revised charter is gradually replacing the initial, 1961 treaty.

84 I nternational Federation of Human Rights Leagues (FIDH) v. France. (13/2003).

85 A rticle 17: With a view to ensuring the effective exercise of the right of children and young persons to grow up in an environment which encourages the full development of their personality and of their physical and mental capacities, the Parties undertake, either directly or in co-operation with public and private organisations, to take all appropriate and necessary measures designed: (1) (a) to ensure that children and young persons, taking account of the rights and duties of their parents, have the care, the assistance, the education and the training they need, in particular by providing for the establishment or maintenance of institutions and services sufficient and adequate for this purpose; (b) to protect children and young persons against negligence, violence or exploitation; (c) to provide protection and special aid from the state for children and young persons temporarily or definitively deprived of their family's support; (2) to provide to children and young persons a free primary and secondary education as well as to encourage regular attendance at schools.'

based on a purposive interpretation of the ES C 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 ES C rights). This finding is highly significant in relation to the protection afforded to such marginalized groups within Europe. On the facts, however, by a majority of nine to four, the ES CR found no violation of Article 13 as illegal immigrants could access some forms of medical assistance after three months of residence, and all foreign nationals could, at any time, obtain treatment for “emergencies and life threatening conditions.” By contrast, the ES CR found a violation of Article 17 (the right of children to protection), even though the affected children had similar access to health care as adults, because Article 17 was considered more expansive than the right to medical assistance. In response to the decision, the government of France changed its policy in relation to migrant children.<sup>86</sup>

- ▶ **Article 3 European Convention on Human Rights and Biomedicine<sup>87</sup>*Equitable access to health care***
- ▶ **Article 23 Convention Relating to the Status of Stateless Persons.** The contracting states shall accord to stateless persons lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals.
- ▶ **Article 4 Framework Convention for the Protection of National Minorities**

*The Parties undertake to guarantee to persons belonging to national minorities the right of equality before the law and of equal protection of the law. In this respect, any discrimination based on belonging to a national minority shall be prohibited. The Parties undertake to adopt, where necessary, adequate measures in order 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. In this respect, they shall take due account of the specific conditions of the persons belonging to national minorities. The measures adopted in accordance with paragraph 2 shall not be considered to be an act of discrimination.*

- ▶ **Committee of Ministers Recommendation No. R (2006) 18 to member states on health services in a multicultural society**

This recommendation includes a number of strategies for promoting health and health care for multicultural populations, including: nondiscrimination and respect for patient rights; equal access to health care; overcoming language barriers; sensitivity to health and socioeconomic needs of minorities; empowerment; and greater participation and development of appropriate knowledge base of the health needs of multicultural populations.

- ▶ **Paragraph 4 COE Parliamentary Assembly Recommendation 1626 (2003) on the Reform of Health Care Systems in Europe: Reconciling equity, equality and efficiency<sup>88</sup>**

<sup>86</sup> The government issued a circular on March 16, 2005, which provided that “all care and treatment dispensed to minors resident in France who are not effectively beneficiaries under the State medical assistance scheme is designed to meet the urgency requirement.” (CIRCULAR DHOS/DSS /DGAS ).

<sup>87</sup> Convention on Human Rights and Biomedicine. <http://conventions.coe.int/Treaty/en/Treaties/Word/164.doc>

<sup>88</sup> COE. Parliamentary Assembly Recommendation 1626 (2003). <http://assembly.coe.int/Documents/AdoptedText/TA 03/ EREC1626.htm>.

*Member states should take as their main criterion for judging the success of health system reforms the existence of effective access to health care for all, without discrimination, as a basic human right.*

► **Article 2 European Charter of Patients Rights: Right of Access**

*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.*

### 3.4 Providers' Rights

This section presents relevant European regional standards as they appear in the European Convention on Human Rights and the European Social Charter. It also explains how these standards have been interpreted in relation to three key rights for health care and service providers: (i) work-related rights, including the right to work and to equal opportunity based on sex; (ii) freedom of association, including the right to form trade unions and the right to strike; and (iii) due process and related rights to a fair hearing, effective remedy, protection of privacy and reputation, and freedom of expression and information.

The chapter is divided into three major sections. Part I discusses the right to work in decent conditions; Part II discusses freedom of association; and Part III discusses due process and related rights. Each section outlines the significance of the right for health providers and gives examples of potential violations. The relevant standards from the Council of Europe treaties are then presented. Finally, key interpretative guidelines based on case law and concluding observations of state reports issued by the monitoring bodies are summarized.

#### Right to Work in Decent Conditions

The right to work and rights in work are governed by the European Social Charter (ES C). Although they are not the focus of this section, relevant ECHR standards may 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.

The European Committee of Social Rights (ES CR) has provided extensive interpretation of the right to work in decent conditions in the ES C, particularly in the following four areas: the right to work (article 1[2]) and to equal opportunity based on sex (article 20); the right to reasonable daily and weekly working hours (article 2[1]); the right to safe and healthy working conditions (article 3); and the right to a fair remuneration.<sup>89</sup> Each of these is discussed in turn in this section. Although there is little or no direct reference to health sector personnel, they enjoy the same level of protection as other workers.

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<sup>89</sup> A digest of the case law of the ECSR is regularly updated and available at [http://www.coe.int/t/dghl/monitoring/socialcharter/Digest/DigestIndex\\_en.asp](http://www.coe.int/t/dghl/monitoring/socialcharter/Digest/DigestIndex_en.asp).

## Right to Work and to Equal Opportunity Based on Sex

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A female doctor is constantly passed over for promotion despite having more relevant experience and better qualifications than male colleagues*
- *All nationals from a country are banned from taking jobs in the health sector following a territorial dispute subsequently referred to the International Court of Justice*
- *Female employees are subject to frequent sexual harassment by other members of staff, and no action is taken to stop harassment*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ Article 5.3 1(2) ESC: *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.*
- ▶ Article 1(2) of the ES C, ensuring the effective exercise of the right to work, is further divided into three separate issues:

a) the prohibition of all forms of discrimination in employment (which overlaps with the right to equal opportunity based on sex);

b) the prohibition of any practice that might interfere with a worker's right to earn a living in an occupation freely entered upon;<sup>90</sup>

c) the prohibition of forced or compulsory labor.

The first two of these issues are discussed below, with an emphasis on the definition and scope of discrimination. Acceptable domestic policies to combat discriminatory practices that limit enjoyment of the right to work, as set forth in Article 1, are also outlined.

#### *Prohibition of all forms of discrimination in employment*

- The ES C defines discrimination as the different treatment of persons in comparable situations where such treatment does not pursue a legitimate aim, is not based on objective and reasonable grounds, or is not proportionate to the aim pursued.<sup>91</sup> The assessment of whether a difference in treatment pursues a legitimate aim and is proportionate takes into account Article G,99 the limitation provision of the ES C.100
- Under Article 1(2), legislation should prohibit any discrimination in employment on grounds of, inter alia, sex, race, ethnic origin, religion, disability, age, sexual orientation, and political opinion.<sup>92</sup> This provision is inherently linked to other provisions of the ESC, in particular to Article 20 (the right to equal opportunities and equal treatment in matters of employment and occupation without discrimination on grounds of sex) and Article 15(2) (the right of persons

90 COE. Conclusions of the European Committee of Social Rights. Conclusions (II and XVI-1). Statements of interpretation of Article 1§2.

91 Syndicat national des Professions du Tourisme v. France. (6/1999). Decision on the merits of 10 October 2000.

92 COE. Conclusions: Iceland. (XVIII -1); Conclusions 2006 (Albania).

- with disabilities to employment).
- Legislation should prohibit both direct and indirect discrimination.<sup>93</sup>
  - Indirect discrimination 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.<sup>94</sup>
  - Discrimination may also result from the failing to take positive account of all relevant differences or failing to take adequate steps to ensure that the rights and collective advantages that are open to all are genuinely accessible to and by all.<sup>95</sup>
  - The discriminatory acts and provisions prohibited by this provision are ones that may occur in connection with recruitment or with employment conditions in general. Remuneration, training, promotion, transfer, and dismissal or other detrimental action are especially important.<sup>96</sup>
  - In order to make the prohibition of discrimination effective, domestic law must at least provide for:
    - ✓ the power to set aside, rescind, 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;<sup>97</sup>
    - ✓ protection against dismissal or other retaliatory action by the employer against an employee who has lodged a complaint or taken legal action;<sup>107</sup>
    - ✓ appropriate and effective remedies that are adequate and proportionate and available to victims in the event of an allegation of discrimination. The imposition of predefined upper limits to compensation that may be awarded are not in conformity with Article 1(2).<sup>98</sup>
    - ✓ Domestic law should also provide for an alleviation of the burden of proof that rests with the plaintiff in discrimination cases.

The following measures also contribute to combating discrimination in accordance with Article 1(2) of the ESC:

- ✓ Recognizing the right of trade unions to take action in cases of employment discrimination, including action on behalf of individuals<sup>99</sup>
- ✓ The right to challenge discriminatory practices that violate the right to take collective action
- ✓ Establishing a special, independent body to promote equal treatment, particularly by providing discrimination victims with the support they need to take proceedings
- ✓ States parties to the ES C may make foreign nationals' access to employment while in their territories subject to possession of a work permit. They cannot, however, in general, ban nationals of other states from occupying jobs for reasons other than those set out in Article G. The only jobs from which foreigners may be banned are those that are inherently connected with the protection of the public interest or national security and involve the exercise of public authority.<sup>100</sup>
- ✓ Exclusion of individuals from functions on grounds of previous political activities, either in the form of refusal to recruit or dismissal, is prohibited, unless the job relates to law and order and national security or to functions involving such responsibilities.<sup>101</sup>

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93 COE. Conclusions: Austria. (XVIII -1).

94 David Harris et al. *Law of the European Convention on Human Rights*. (Oxford: Oxford University Press, 2009), 607.

95 *Association Internationale Autisme-Europe (AIAE) v. France*. (13/2002). Decision on the merits of 4 November 2003

96 COE. Conclusions: Austria. (XVI-1).

97 COE. Conclusions: Iceland. (XVI-1).

98 COE. Conclusions 2006: Albania.

99 COE. Conclusions: Iceland. (XVI-1).

100 COE. Conclusions 2006: Albania.

101 COE. Conclusions 2006: Lithuania.



- ✓ The ECSR has offered limited interpretation of the following standard: “Prohibition of any practice that might interfere with workers’ right to earn their living in an occupation freely entered upon.”

Practices that could violate this standard include:

- The lack of adequate legal safeguards against discrimination in respect to part-time work. In particular, there must be rules to prevent non declared work through overtime and equal pay, in all its aspects, between part-time and full-time employees;<sup>102</sup>
- Undue interference in employees’ private or personal lives associated with or arising from their employment situation, in particular through electronic communication and data collection techniques.<sup>103</sup>

▶ **Article 20 ESC: Equal opportunity based on sex**

*All workers have 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 recognize 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.*

## Right to Reasonable Daily and Weekly Working Hours

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A doctor regularly works 100 hour weeks including, on occasion, 18-hour shifts*
- *A nurse is forced to work overtime without prior agreement*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ **Article 2(1) ESC: Reasonable working hours to ensure 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.*

- Article 2(1) ES C guarantees workers the right to reasonable limits on daily and weekly working hours, including overtime. This right must be guaranteed through legislation, regulations, collective agreements, or any other binding means. In order to ensure that the limits are re-

102 COE. Conclusions: Austria. (XVI-1).

103 COE. Conclusions: Norway. (XIV-2).



spected in practice, an appropriate authority must supervise whether the limits are being respected.

- The ES C does not expressly define what constitutes reasonable working hours, instead it assesses situations on a case-by-case basis: extremely long working hours (more than 16 hours in any one day<sup>103</sup> or, under certain conditions, more than 60 hours in one week<sup>117</sup> are unreasonable and therefore contrary to the ESC.
- 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.<sup>104</sup>
- Article 2(1) also provides for the progressive reduction of weekly working hours, to the extent permitted by productivity increases and other relevant factors. These “relevant factors” may include the nature of the work to be performed and the safety and health risks to which workers are exposed.<sup>105</sup>
- Periods of “on call” duty during which the employee has not been required to perform work for the employer do constitute effective working time and cannot be regarded as rest periods, in the meaning of Article 2 of the ES C, except in the framework of certain occupations or particular circumstances and pursuant to appropriate procedures. The absence of effective work cannot constitute an adequate criterion for regarding such a period as a period of rest.<sup>106</sup>

## Right to Safe and Healthy Working Conditions

### EXAMPLES OF POTENTIAL VIOLATIONS

- **Medical staff in the X-ray department are frequently exposed to dangerously high levels of radiation due to faulty equipment that has not been checked or replaced**
- **A nurse is infected with HIV after medical equipment is not properly sterilized**
- **A staff canteen remains open despite repeatedly failing basic hygiene standards**

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- ▶ **Article 3 ESC: 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: 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 minimizing the causes of hazards inherent in the working environment; (1) to issue safety and health regulations; (2) to provide for the enforcement of such regulations by measures of supervision; (3) to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions.*
- The right of every worker to a safe and healthy working environment is a “widely recognized principle, stemming directly from the right to personal integrity, one of the fundamental principles of human rights.”<sup>107</sup>

104 COE. Conclusions: The Netherlands. (XIV-2).

105 I bid.

106 Confédération Française de l’Encadrement CFE-CGC v. France. (16/2003). Decision on the merits of 12 October 2004.

107 COE. Conclusions I. Statement of Interpretation on Article 3.

- The purpose of Article 3 ES C is thus directly related to that of Article 2 of the European Convention on Human Rights, which recognizes the right to life.<sup>108</sup>
- Article 3 ES C applies to both the public and private sectors.<sup>109</sup>
- Occupational risk prevention must be a priority. It must 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.).<sup>110</sup> The policy and strategies adopted must be 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).<sup>111</sup>
- The ES C does not actually define the risks to be regulated. Supervision takes an indirect form, referring to international technical occupational health and safety standards, such as the ILO conventions and European Community Directives on health and safety at work.
- Domestic law must include framework legislation (often, the Labour Code) that sets out employers' responsibilities, workers' rights and duties, and specific regulations. The risks that the ECSR currently highlights include:
  - establishment, alteration, and upkeep of workplaces (equipment, hygiene);
  - hazardous agents and substances;
  - risks connected with certain sectors (the health sector is not expressly mentioned).
- Most of the risks listed above have to be covered by a specific regulation, i.e., they must set out rules in sufficient detail for them to be applied properly and efficiently.<sup>112</sup> Accordingly, the ECSR does not consider that states are required to introduce specific insurance for occupational diseases and accidents to comply with Article 3(2).<sup>113</sup>
  - All workers, all workplaces, and all sectors of activity must be covered by occupational health and safety regulations.<sup>114</sup>
  - There is a need for regular inspections and effective penalties for breaches.

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108 COE. Conclusions. (XIV-2). Statement of Interpretation on Article 3.

109 COE. Conclusions II . Statement of Interpretation on Article 3.

110 COE. Conclusions 2005: Lithuania.

111 COE. Conclusions 2003: Bulgaria.

112 COE: Conclusions: Norway. (XIV-2).

113 M arangopoulos Foundation for Human Rights (MFHR) v. Greece. (30/2005). Decision on the merits of 6 December 2006.

114 COE. Conclusions 2005: Estonia.

## Right to a Fair Remuneration

### EXAMPLES OF POTENTIAL VIOLATIONS

- *Some health staff are only paid the equivalent of 40 percent of the national average wage, and ancillary staff are paid less than the national minimum wage*
- *A nurse working overtime receives the same wage that she is normally paid*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ■ Article 4 ESC: The right to fair remuneration

*With a view to ensuring the effective exercise of the right to a fair remuneration, the Parties undertake: (1) to recognize the right of workers to a remuneration such as will give them and their families a decent standard of living; (2) to recognize the right of workers to an increased rate of remuneration for overtime work, subject to exceptions in particular cases; (3) to recognize the right of men and women workers to equal pay for work of equal value; (4) to recognize 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.*

- To be considered fair within the meaning of Article 4(1) of the ESC, wages must be above the poverty line in a given country—in other words, 50 percent of the national average wage. In addition, a wage must not fall too far short of the national average wage. The threshold adopted by the ESCR is 60 percent.<sup>115</sup>
- Employees who work overtime must be paid at a higher rate than the normal wage rate.<sup>116</sup> Article 4(2) permits granting an employee leave to compensate for overtime, provided that the leave is longer than the overtime hours worked. It is not sufficient, therefore, to offer employees leave of equal length to the number of overtime hours worked.<sup>117</sup> Exceptions to Article 4(2) may be authorized in certain specific cases. These “special cases” have been defined by the ECSR as “state employees, management executives, etc.”<sup>118</sup> With respect to state employees, confining exceptions to “senior officials” is compatible with Article 4(2).<sup>119</sup> Exceptions to receipt of a higher rate of overtime pay cannot, however, be applied to all state employees or public officials, irrespective of their level of responsibility.<sup>120</sup> Exceptions may be applied to all senior managers. The ECSR has ruled that certain limits must apply, however, particularly on the number of hours of overtime not paid at a higher rate.<sup>121</sup>

115 COE. Conclusions. (XIV-2). Statement of Interpretation on Article 4§1. The committee’s calculations are based on net amounts, (after deduction of taxes and social security contributions). Social transfers (for example, social security allowances or benefits) are taken into account only when they have a direct link to the wage.

116 COE. Conclusions I. Statement of Interpretation on Article 4§2.

117 COE. Conclusions: Belgium. (XIV-2).

118 COE. Conclusions: Ireland. (IX-2).

119 COE. Conclusions: Ireland. (X-2).

120 COE. Conclusions: Poland. (XV-2).

121 Confédération Française de l’Encadrement CFE-CGC v. France. (9/2000). Decision on the merits of 16 November 2001.

- Women and men are entitled to “equal pay for work of equal value,” and this right must be expressly provided for in legislation.<sup>122</sup> The equal pay principle should apply to all jobs performed by both women and men. The principle of equality should cover all the elements of pay, including minimum wages or salary plus all other benefits paid directly or indirectly in cash or in kind by the employer to the worker.<sup>123</sup> It must also apply to full-time and part-time employees, covering the calculation of hourly wages, pay increases, and the components of pay.<sup>124</sup>
- Domestic law must provide for appropriate and effective remedies in the event of alleged wage discrimination.<sup>125</sup> Employees who claim that they have suffered discrimination must be able to take their cases to court.
- Domestic law should provide for an alleviation of the burden of proof in favor of the plaintiff in discrimination cases. Anyone who suffers wage discrimination on grounds of sex must be entitled to adequate compensation, sufficient to make good the damage suffered by the victim and to act as a deterrent to the offender.<sup>126</sup> In cases of unequal pay, any compensation must, at minimum, cover the difference in pay.<sup>127</sup>

## Right to Freedom of Association

Freedom of association is recognized under Article 11 of the ECHR. Although the European Court of Human Rights has only examined this right in a limited number of cases, it has confirmed that it 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.<sup>128</sup>

The most comprehensive analysis of the right to strike has been made under the ES C. The ECtHR has engaged in a more limited exploration of trade unions, which includes upholding workers’ right to strike.

This section covers two aspects of freedom of association: the freedom of association and assembly, found in Article 11 of the ECHR, and the right to form trade unions and to strike, addressed by Articles 5, 6, 21, and 22 of the ESC.

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122 COE. Conclusions: Slovak Republic. (XV-2, addendum).

123 COE. Conclusions I. Statement of Interpretation on Article 4§3.

124 COE. Conclusions: Portugal. (XVI-2).

125 COE. Conclusions I. Statement of Interpretation on Article 4§3.

126 COE. Conclusions. (XIII -5). Statement of Interpretation on Article 1 of the Additional Protocol.

127 COE. Conclusions: Malta. (XVI-2).

128 See also International Centre for the Protection of Legal Rights. INTE RIG HTS Manual for Lawyers. Article 11 of the European Convention of Human Rights: Freedom of Assembly and Association. <http://www.interights.org/view-document/index.htm?id=520>. Provides information on how the ECtHR has interpreted Article 11 of the ECHR.

## Right to Freedom of Association and Assembly

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A professional medical association is not approved by the Ministry of Health because its president is a leading member of an opposition political party*
- *Without any justification, authorities prevent a rally for improved pay and conditions for health workers from taking place*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- **Article 11 ECHR** (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.*
- Under Article 11, “association” is an autonomous concept that is not dependent on the classification adopted under domestic law. This factor is relevant but not decisive.<sup>129</sup>
- The right to freedom of association under Article 11 applies to private law bodies only. Public law bodies (i.e., those established under legislation) are not considered to be “associations” within the meaning of Article 11. This limited scope of the right may be particularly relevant for health professionals and the compulsory membership of their national professional bodies.<sup>130</sup>
- The right also includes the freedom not to join an association or trade union.<sup>131</sup>
- Article 11(2) permits “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.”<sup>132</sup> The latter term should be narrowly interpreted, however; the ECtHR left open whether it should apply to teachers.<sup>133</sup>

<sup>129</sup> Chassagnou and Ors v. France. (29 EHRR 615). Hunters’ associations in France are held to be “associations” for purposes of Article 11 even though government argued that they were public law institutions.

<sup>130</sup> Le Compte v. Belgium. (4 EHRR 1). After being suspended by the regulatory body for their profession, doctors unsuccessfully complained about their compulsory membership in it and their subjection to the jurisdiction of its disciplinary organs. Given the regulatory body’s public law status—it was integrated with the structure of the state, and judges were appointed to most of its organs by the state—its functions of regulating medical practice and maintaining the register of practitioners, and its administrative, rule making, and disciplinary powers, the court held that it was also relevant that there were no restrictions on practitioners establishing or joining their own professional associations. See also the subsequent cases of Albert and Le Compte v. Belgium (7299/75, etc.) as regards medical doctors; Revert and Legallais v. France (14331/88 and 14332/88) as regards architects; A. and others v. Spain (13750/88) as regards bar associations; and Barthold v. Germany (8734/79) as regards veterinary surgeons. See also O. VR. v. Russia (44139/98) and A v. Spain (6 DR 188).

<sup>131</sup> Young and Ors v. UK. (4 EHRR 38). “Closed shop,” compulsory membership of the rail trade union breached Article 11. See also Sigurjonsson v. Iceland. (A264).

<sup>132</sup> This approach has been endorsed by ES CR 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.”

<sup>133</sup> Vogt v. Germany. (21 EHRR 205). The court has left open whether teachers are members of the “administration of the state,”

## Trade Unions and the Right to Strike

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A nurse is refused a promotion on the grounds that she has been “causing problems” for the management through her trade union activities*
- *A collective agreement between a trade union and health authority management ensures that 30 percent of the vacant posts will be reserved for the union’s members*
- *There is a blanket ban on all health sector workers, prohibiting them from taking any form of industrial action*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ▶ Article 5 ESC 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.*

- Article 5 of the ES C applies both to the public and to the private sector.<sup>134</sup> Domestic law must guarantee the right of workers to join a trade union and include effective punishments and remedies when this right is not respected.
- Under Article 5, workers must be free to join and free not to join a trade union. Any form of compulsory trade union membership imposed by law is incompatible with Article 5.<sup>135</sup>
- Domestic law must clearly prohibit all preentry or postentry “closed shop” clauses and all union security clauses (automatic deductions from wages).<sup>136</sup> 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 of Article 5.<sup>137</sup>
- Trade union members must be protected 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.<sup>138</sup>

<sup>134</sup> COE. Conclusions I. Statement of Interpretation on Article 5.

<sup>135</sup> COE. Conclusions III . Statement of Interpretation on Article 5..

<sup>136</sup> COE. Conclusions VIII . Statement of Interpretation on Article 5.

<sup>137</sup> COE. Conclusions: Denmark. (XV-1).

<sup>138</sup> COE. Conclusions 2004: Bulgaria.

- Trade unions and employers’ organizations must be independent from excessive state interference in relation to their infrastructure or effective functioning.<sup>139</sup> For example, trade unions are entitled to choose their own members and representatives, and there should be not excessive limits on the reasons for which a trade union may take disciplinary action against a member.<sup>140</sup> Further, trade union officials must have access to the workplace, and union members must be able to hold meetings at work, subject to the requirements of the employer.<sup>141</sup>
  - Trade unions and employer organizations must be free to organize without prior authorization, and initial formalities, such as declaration and registration, must be simple and easy to apply. If fees are charged for the registration or establishment of an organization, they must be reasonable and designed only to cover strictly necessary administrative costs.<sup>142</sup>
  - Registration requirements as to the minimum number of members comply with Article 5 if the number is reasonable and presents no obstacle to the founding of organizations.<sup>143</sup>
  - Domestic law may restrict participation in various consultation and collective bargaining procedures to certain representative trade unions, subject to certain criteria being met.<sup>144</sup>
  - The right to strike may be restricted, provided that any restriction satisfies the conditions laid down in Article G, which outlines the circumstances that can justify limitation of rights guaranteed by the charter. Any limitation must serve a legitimate purpose and be necessary in a democratic society for the protection of the rights and freedoms of others or for the protection of public interest, national security, public health, or morals.<sup>145</sup>
  - 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 Article 6(4).<sup>146</sup>
- ▶ **Article 19(4) ESC: The right of migrant workers and their families to protection and assistance**

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<sup>139</sup> COE. Conclusions: Germany. (XII -2).

<sup>140</sup> COE. Conclusions: United Kingdom. (XVII ).

<sup>141</sup> COE. Conclusions: France. (XV-1).

<sup>142</sup> COE. Conclusions: United Kingdom. (XV-1).

<sup>143</sup> COE. Conclusions: Portugal. (XIII -5).

<sup>144</sup> COE. Conclusions: Belgium. (XV-1); Conclusions: France. (XV-1).

<sup>145</sup> COE. Conclusions: Norway. (X-1). Regarding Article 31 of the charter.

<sup>146</sup> COE. Conclusions I. Statement of Interpretation on Article 6§4; Confederation of Independent Trade Unions in Bulgaria, Confederation of Labour “Podkrepa” and European Trade Union Confederation v. Bulgaria. (32/2005). Decision on the merits of 16 October 2006.



*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 much matters are regulated by law or regulations or are subject to the control of administrative authorities, treatment not less favorable than that of their own nationals in respect of the following matters: ... (b) membership of trade unions and enjoyment of the benefits of collective bargaining.*

#### ▶ **Article 6 ESC: 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 recognize: (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.*

- Public officials enjoy the right to strike under Article 6(4). Prohibiting all such officials from exercising the right to strike is not permissible. The right of certain categories of public officials to strike may be restricted, however. Under Article G, these restrictions should be limited to public officials whose duties and functions, given their nature or level of responsibility, are directly related to national security or to the general public interest.
- A strike should not be considered a violation of the contractual obligations of the striking employees, constituting a breach of their employment contract; participation should be accompanied by a prohibition of dismissal. If strikers are fully reinstated when the strike has ended and their previously acquired entitlements (for example, pensions, holidays, and seniority) are not affected, then formal termination of the employment contract does not violate Article 6(4).<sup>147</sup> Any deduction from strikers' wages should not exceed the proportion of their wage that would be attributable to the duration of their strike participation.<sup>148</sup> Workers who are not members of the striking trade union but participate in the strike are entitled to the same protection as the trade union members.

#### ▶ **Article 21 ESC: The right to information and consultation**

*With a view to ensuring the effective exercise of the right of workers to be informed and consulted within the undertaking, the Parties undertake to adopt or encourage measures enabling workers or their representatives, in accordance with national legislation and practice: (a) to be informed regularly or at the appropriate time and in a comprehensible way about the economic and financial situation of the undertaking employing them, on the understanding that the disclosure of certain information which could be prejudicial to the undertaking may be refused or subject to confidentiality; and (b) to be consulted in good time on proposed decisions which could substantially affect the interests of workers, particularly on those decisions which could have an important impact on the employment situation in*

<sup>147</sup> COE. Conclusions I. Statement of Interpretation on Article 6§4.

<sup>148</sup> COE. Conclusions: France. (XIII -1); Confédération Française de l'Encadrement (CFE CGC) v. France. (16/2003). Decision on the merits of 12.11.2004

*the undertaking.*

► **Article 22 ESC: 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.*

► **Article 11 ECHR: Freedom of assembly and association**

*(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.*

- The right to form and join trade unions is a subdivision of freedom of association and is not a special and independent right under Article 11.<sup>149</sup>
- Article 11 does not explicitly guarantee any particular treatment of trade unions, such as the right to be consulted by the government or to strike.<sup>150</sup> Trade unions, however, should be heard and should be permitted to take action to protect the occupational interests of their members.<sup>151</sup>
- This protection can include the right to strike, which may only be limited under certain circumstances.<sup>152</sup>

## Right to Due Process and Related Rights

Health providers have rights to due process when complaints about 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. It is clear that this right covers matters such as licensing and medical negligence suits against a hospital.

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.

This section discusses four aspects of due process and related rights: the interpretation of the right to a fair hearing in Article 6(1) of the ECHR; the guarantee of effective remedy articulated in Article 13 of the ECHR; the protection of privacy and reputation in Article 8 of the ECHR; and the protection of

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149 National Union of Belgian Police v. Belgium. (1 EHRR 578).

150 Schmidt and Dahlstrom v. Sweden. (1 EHRR 632).

151 National Union of Belgian Police v. Belgium. (1 EHRR 578).

152 Wilson and Ors v. UK. (35 EHRR 20). Court found violation of Article 11 where law permitted an employer to derecognize trade unions for collective bargaining purposes and to offer inducements to employees to relinquish some of their union rights.

freedom of expression and information in Article 10 of the ECHR.

It should be noted that there is no explicit right to information under the ECHR, and Article 10 (freedom of expression) offers only very limited protection in relation to information. There is no right to impart information, and the right to receive has been narrowly interpreted.

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.

## Right to a Fair Hearing

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A doctor facing a disciplinary hearing is denied the opportunity to contest the allegations made against him*
- *A disciplinary body decides, without explanation, that all of its hearings should take place in private*
- *A nurse's disciplinary hearing takes more than three years to complete, during which time she is suspended*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

- **Article 6(1) ECHR:**

*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.*

- Article 6(1) of the ECHR applies to the determination of civil rights or criminal charges. It also covers all related proceedings between the state and the individual or between private parties, the result of which is “decisive” for civil rights and obligations.<sup>153</sup>
- In *Konig v. Federal Republic of Germany*, the court found: “Whether or not a right is to be regarded as civil ... must be determined by reference to the substantive contents and effects of the right—and not its legal classification—under the domestic law of the State concerned.”<sup>154</sup>

153 *Ringeisen v. Austria*. (1 EHRR 466).

154 *Konig v. Federal Republic of Germany*. (2 EHRR 170).

155 *Fayed v. UK*. (18 EHRR 393).

156 *173. B rennan v. UK*. (34 EHRR 50).

157 *Konig v. Germany*. (2 EHRR 170). Disciplinary proceedings led to the withdrawal of the applicant’s licence to run a medical clinic.

158 *Konig v. Germany*. (2 EHRR 170). Concerning the revocation of the applicant’s permission to practice as a doctor in proceedings before the Tribunal for the Medical Profession; *Wickramsinghe v. UK*. (31503/96).

- A merely investigative procedure will not engage Article 6(1),<sup>155</sup> even though pretrial proceedings may be determinative of civil rights and obligations under certain circumstances.<sup>156</sup>
- The ECtHR has confirmed that civil rights and obligations are implicated in disciplinary proceedings that determine the right to practice a profession. The ECtHR was ruling on claims brought by medical professionals in these cases.<sup>157</sup> Licensing decisions are also covered.<sup>158</sup>
- Article 6(1) will usually apply where an individual claims compensation from a public authority for an unlawful act provided there is a right to such compensation. Medical negligence proceedings against a hospital have been held to be covered.<sup>159</sup>
- Disputes relating to private law relations between private employers and employees fall within the scope of Article 6(1).<sup>160</sup> As a general rule, however, disputes relating to the employment of public servants fall outside of it.<sup>161</sup>

In civil proceedings, a litigant has the right to:

- ✓ real and effective access to a court;
  - ✓ notice of the time and place of the proceedings;<sup>162</sup>
  - ✓ a real opportunity to present his/her case;
  - ✓ 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.<sup>163</sup>
  - Entitlement to present one's case effectively is not as strong in the civil context as it is in the criminal context. There is no automatic requirement to be present and to have an oral hearing. The principle of the "equality of arms" does apply, however,<sup>164</sup> and can be violated by mere procedural inequality.<sup>165</sup>
  - The same principle applies to the submissions of nonparties to the proceedings.<sup>166</sup>
  - Both parties have a right to be informed of the other's submissions and other written material and have a right to reply.<sup>167</sup> Disclosure is crucial for a fair hearing.<sup>168</sup>

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159 H v. France. (12 EHRR 74).

160 Obermeier v. Austria. (13 EHRR 290).

161 Lombardo v. Italy. (21 EHRR 188).

163 De La Pradelle v. France. (A 253-B).

164 Airey v. Ireland. (2 EHRR 305); P and Ors v. UK. (35 EHRR 31).

164 Ruiz-Martin v. Spain. (16 EHRR 505).

165 Fischer v. Austria. (ECHR 33382/96).

166 Van Orshoven v. Belgium. (26 EHRR 55). Breach of Article 6(1), where applicant, who had been struck off the medical register following disciplinary proceedings, was given no prior notice of submission by the advocate-general intended to advise the court.

167 Dombo Beheer B. V. v. The Netherlands. (18 EHRR 213).

168 Ruiz Torija v. Spain. (19 EHRR 55).

169 H v. France. (12 EHRR 74).

170 Mantovanelli v. France. (24 EHRR 370). Claimants in medical negligence case had not been given an opportunity to give instruction to court-appointed expert.

171 Helle v. Finland. (26 EHRR 159).

- Although there is no obligation on a court to obtain an expert report merely because one party seeks it,<sup>169</sup> where an expert is appointed, there must be compliance with the equality of arms principle.<sup>170</sup>
- In order to comply with the obligation to give a reasoned decision, the court or tribunal does not need to provide a detailed answer to every argument, but needs to address the essential issues in the case.<sup>171</sup>
- A decision-making disciplinary or administrative process does not need to comply with Article 6 at all stages, provided it is subject to appeal and/or judicial review.<sup>172</sup>
- Similarly, even where an adjudicatory body is not impartial and independent, it will not breach Article 6(1) if its deliberations are subject to control by a body that has the power to quash its decision.<sup>173</sup>
- The right to a public hearing includes disciplinary hearings of professionals.<sup>174</sup>
- Determining whether a hearing has been held within a reasonable time will depend upon a number of relevant factors, including the complexity of the case, the applicant's conduct, and the importance of what is at stake for the applicant.<sup>175</sup> The time period begins at the moment when proceedings are instituted<sup>176</sup> and does not end until all matters—including appeals and determination of costs—have been completed.<sup>177</sup>

## Right to an Effective Remedy

### EXAMPLES OF POTENTIAL VIOLATIONS

- *No damages are awarded to a doctor after his reputation is damaged by unsubstantiated and false accusations of medical negligence that appear in the media*
- *A nurse is unable to appeal an employment tribunal decision to a court*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ▶ Article 13 ECHR: Right to an effective remedy

*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*

172 *Le Compte v. Belgium*. (5 EHRR 533). The Court of Cassation's review of a medical disciplinary body was insufficient for Article 6(1) as the court did not "take cognisance" of the merits of the case, as many aspects fell outside of its jurisdiction

173 *Kingsley v. UK*. (35 EHRR 10).

174 *Diennet v. France*. (21 EHRR 554). Concluding that misconduct hearing of a general practitioner should have been in public, except in the event that a confidential private or professional matter arose in the proceedings.

175 *Gast and Popp v. Germany*. (33 EHRR 37).

176 *Scopelliti v. Italy*. (17 EHRR 493); *Darnell v. UK* (18 EHRR 205). The total period of nine years—for the determination of the dismissal of the applicant from a health authority following several judicial review applications, an industrial tribunal hearing, and an Employment Appeal Tribunal hearing—was considered unreasonable.

177 *Somjee v. UK*. (36 EHRR 16).

178 *Silver v. UK*. (5 EHRR 347).

179 *Peck v. UK*. (36 EHRR 41).

*acting in an official capacity.*

- According to the terms of Article 13, the availability of a remedy must include the determination of the claim and the possibility of redress.<sup>195</sup> All procedures, including judicial and non judicial, will be examined.<sup>178</sup>
- Formal remedies that prevent examination of the merits of the claim, including judicial review, may not comply with Article 13.<sup>179</sup>
- The nature of the remedy required to satisfy the obligation under Article 13 will depend 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.<sup>180</sup>
- The authority with the ability to provide the remedy must be independent of the body alleged to have committed the breach.<sup>181</sup>

## Right to Protection of Privacy and Reputation

### EXAMPLES OF POTENTIAL VIOLATIONS

- ***The phone of a hospital’s chief executive is bugged without any prior lawful authorization***
- ***A doctor involved in a civil suit against a hospital for unfair dismissal finds out that his correspondence has been routinely intercepted and read without his knowledge***

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

#### ▶ Article 8 ECHR: Privacy and reputation

*(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.*

-The term “private life,” within the context of Article 8 of the ECHR can extend to an individual’s office, offering protection, for example, against the unlawful bugging of telephone calls.<sup>182</sup> 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.<sup>183</sup> It has been held, however, that private life is not engaged by “real time” closed-circuit television if no images are recorded, although once a systematic record is made or the image is processed in some way, it will be engaged.<sup>184</sup>

<sup>180</sup> Aksoy v. Turkey. (23 EHRR 553).

<sup>181</sup> Khan v. UK. (31 EHRR 45); Taylor-Sabori v. UK. (36 EHRR 17).

<sup>182</sup> Halford v. UK. (20605/92). Concluding that bugging of private telephone calls made to an office telephone could constitute a breach of Article 8.

<sup>183</sup> Von Hannover v. Germany. (43 EHRR 7).

<sup>184</sup> Peck v. UK. (36 EHRR 41).

▶ **Article 10(2) ECHR: Limiting free expression to protect rights and reputation of others.**

*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.*

## Right to Freedom of Expression and Information

### EXAMPLES OF POTENTIAL VIOLATIONS

- *A senior health service manager is dismissed after revealing that a hospital has been purchasing unlicensed drugs*
- *State authorities intervene to prevent employees from receiving information that their hospital contains dangerously high levels of radiation*
- *A senior health services manager is dismissed after revealing that a hospital has been purchasing unlicensed drugs*

### HUMAN RIGHTS STANDARDS AND RELEVANT INTERPRETATIONS

▶ **Article 10 ECHR: Freedom of expression including information**

*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.*

- There is no right to impart information under Article 10 of the ECHR. The right to receive information has been narrowly interpreted as prohibiting the authorities from restricting a person from receiving information that others may wish to impart. The state has no positive obligation to collect and disseminate information on its own motion.<sup>185</sup>
- 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.<sup>186</sup>

185 Guerra and Ors v. Italy. (26 EHRR 357).

186 Yankov v. Bulgaria. (39084/97).



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- 4.1 **INTRODUCTION**
  - 4.2 **THE INTERNATIONAL SYSTEM**
  - 4.3 **THE EUROPEAN SYSTEM**
  - 4.4 **COMPLAINT PROCEDURE: EUROPEAN CONVENTION ON HUMAN RIGHTS**

# 4

## International and Regional Procedures

### 4.1 Introduction

International and regional human rights mechanisms play an important role in the implementation of rights. These mechanisms were established to enforce governments' compliance with the international and regional human rights treaties they have ratified. These treaties make up the so-called "hard law" of international human rights, and the interpretations of the treaty mechanisms make up "soft law" that is not directly binding on governments. There are two main types of enforcement mechanisms:

- ✓ Courts, which act in a judicial capacity and issue rulings that are binding on governments in the traditional sense; and
- ✓ Committees, which examine reports submitted by governments on their compliance with human rights treaties and, in some cases, examine individual complaints of human rights violations.

## 4.2 The International System

### The Human Rights Committee

#### MANDATE

The Human Rights Committee (HRC) oversees government compliance with the International Covenant on Civil and Political Rights (ICCPR). The HRC has two mandates: to monitor country progress on the ICCPR by examining periodic reports submitted by governments and to examine individual complaints of human rights violations under the Optional Protocol to the ICCPR.

#### CIVIL SOCIETY PARTICIPATION

Civil society participation NGOs can submit “shadow reports” to the HRC on any aspect of a government’s compliance with the ICCPR. Shadow reports should be submitted through the HRC Secretariat based at the Office of the High Commissioner for Human Rights (OHCHR) in Geneva, which also keeps a calendar of when governments come before the committee. The HRC meets three times a year. Individuals and NGOs can also submit complaints to the HRC under the Optional Protocol.

#### Contact

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 Web: <http://www2.ohchr.org/english/bodies/hrc/index.htm>

### Committee on Economic, Social, and Cultural Rights

#### MANDATE

The Committee on Economic, Social, and Cultural Rights (CES CR) oversees government compliance with the International Covenant on Economic, Social, and Cultural Rights (ICES CR). The CES CR monitors country progress on the ICES CR by examining periodic reports submitted by governments.

#### CIVIL SOCIETY PARTICIPATION

Civil society participation NGOs can submit “shadow reports” to the CES CR on any aspect of a government’s compliance with the ICES CR. Shadow reports should be submitted through the CES CR Secretariat based at the Office of the High Commissioner for Human Rights (OHCHR) in Geneva, which also keeps a calendar of when governments come before the committee. The CES CR meets twice a year.

#### Contact

Wan-Hea Lee  
 CES CR Secretary  
 Office 1-025, Palais Wilson, Palais des Nations  
 8–14 Avenue de la Paix  
 CH 1211 Geneva 10, Switzerland  
 Tel: +41 22 917 9321; Fax: +41 22 917 9046  
 Email: [wlee@ohchr.org](mailto:wlee@ohchr.org)  
 Web: <http://www2.ohchr.org/english/bodies/cescr/index.htm>

## Committee on the Elimination of Racial Discrimination

### MANDATE

The Committee on the Elimination of Racial Discrimination (CERD) is the body of independent experts that monitors implementation of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) by states. It monitors country progress on ICERD by examining periodic reports submitted by governments. The committee then addresses its concerns and recommendations to the country in the form of “concluding observations.” Besides commenting on country reports, CERD monitors state compliance through an early-warning procedure and through the examination of interstate and individual complaints.

### CIVIL SOCIETY PARTICIPATION

NGOs can submit “shadow reports” to the CERD on any aspect of a government’s compliance with the ICERD. Shadow reports should be submitted through the CERD Secretariat based at the Office of the High Commissioner for Human Rights (OHCHR) in Geneva, which also keeps a calendar of when governments come before the committee. CERD meets twice a year.

#### Contact

Nathalie Prouvez

Secretary of the Committee on the Elimination of Racial Discrimination  
Treaties and Commission Branch

Office of the High Commissioner for Human Rights, Palais Wilson

52 rue des Pâquis CH 1201 Geneva 10, Switzerland ,Mailing address: UN OG-OHCHR, CH 1211 Geneva 10, Switzerland

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Email: [nprouvez@ohchr.org](mailto:nprouvez@ohchr.org)

<http://www2.ohchr.org/english/bodies/cerd/>

## International Labour Organization

### MANDATE

The International Labour Organization (ILO), located within the United Nations, is primarily concerned with respect for human rights in the field of labor. In 1989, they adopted the Convention concerning Indigenous and Tribal Peoples in Independent Countries. States must provide periodic reports on their compliance with the convention to the ILO and to national employers’ and workers’ associations. National employers’ and workers’ associations may submit comments on these reports to the ILO. The ILO Committee of Experts (CE) evaluates the reports and may send “Direct Requests” to governments for additional information. The CE then publishes its “observations” in a report, which is presented at the International Labour Conference. On the basis of this report, the Conference Committee on the Application of Standards may decide to more carefully analyze certain individual cases and publishes its conclusions. Additionally, an association of workers or employers may submit a representation to the ILO alleging that a member state has failed to comply with the convention, and a member state may file a complaint against another member state.

### CIVIL SOCIETY PARTICIPATION

The convention encourages governments to consult indigenous peoples in preparing their reports. Indigenous peoples may also affiliate with a workers’ association or form their own workers’ association

in order to more directly communicate with the ILO. The CE meets in November and December of each year, and the International Labour Conference is held in June.

### Contact

Office Relations Branch  
4 rue des Morillons  
CH 1211 Geneva 22, Switzerland  
Tel. +41.22.799.7732; Fax: +41.22.799.8944  
Email: RELOFF@ilo.org  
Web: [www.ilo.org/public/english/index.htm](http://www.ilo.org/public/english/index.htm)

## Committee on the Elimination of All Forms of Discrimination Against Women

### MANDATE

The Committee on the Elimination of All Forms of Discrimination Against Women oversees government compliance with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

The committee has three mandates: to monitor country progress on CEDAW by examining periodic reports submitted by governments, to examine individual complaints of violations of women's rights under the Optional Protocol to CEDAW, and to conduct missions to state parties in the context of concerns about systematic or grave violations of treaty rights.

### CIVIL SOCIETY PARTICIPATION

NGOs can submit "shadow reports" to the committee on any aspect of a government's compliance with CEDAW. Shadow reports should be submitted through the Division for the Advancement of Women in New York, which also keeps a calendar of when governments come before the committee. The committee meets twice a year. Individuals and NGOs can also submit complaints to the committee under the Optional Protocol or they can encourage the committee to undertake country missions as part of its inquiry procedure.

### Contact

Tsu-Wei Chang  
Coordination and Outreach Unit, Division for the Advancement of Women Department of Economic and Social Affairs  
Two UN Plaza  
Room DC2, 12th Floor  
New York, NY 10017  
Tel: +1 (212) 963-8070; Fax: +1 (212) 963-3463  
Email: [changt@un.org](mailto:changt@un.org)  
Web: <http://www.un.org/womenwatch/daw/cedaw/cedaw38/NGOnote.pdf>

## Committee on the Rights of the Child

### MANDATE

The Committee on the Rights of the Child oversees government compliance with the Convention on the Rights of the Child (CRC). It monitors country progress on the CRC by examining periodic reports submitted by governments.

## CIVIL SOCIETY PARTICIPATION

NGOs can submit “shadow reports” to the committee on any aspect of a government’s compliance with the convention. Shadow reports should be submitted through the CRC Secretariat based at the Office of the High Commissioner for Human Rights (OHCHR) in Geneva, which also keeps a calendar of when governments come before the committee.

### Contact

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CRC Secretary, 8–14 Avenue de la Paix, CH 1211 Geneva 10, Switzerland Tel: +41 22 917 9000; Fax: +41 22 917 9022

Email: [mandrijasevic@ohchr.org](mailto:mandrijasevic@ohchr.org)

[www2.ohchr.org/english/bodies/crc/index.htm](http://www2.ohchr.org/english/bodies/crc/index.htm)

## UN Charter Bodies

In addition to the treaty bodies listed above, there are a number of bodies created for the protection and promotion of human rights under the Charter of the United Nations.

The principal charter body is the Human Rights Council (HRC), which replaced the Commission on Human Rights (CHR) in 2006. The HRC is a subsidiary organ of the United Nations General Assembly with a mandate “to address situations of violations of human rights, including gross and systematic violations.”

The responsibilities of the HRC include: the Universal Periodic Review (UPR), the Special Procedures, the Human Rights Council Advisory Committee (formerly the Sub-Commission on the Promotion and Protection of Human Rights), and the Complaints Procedure. These responsibilities are summarized at <http://www2.ohchr.org/english/bodies/hrcouncil/>.

## UNIVERSAL PERIOD IC REVIEW (UPR)

Beginning in 2008, the HRC will periodically review the human rights obligations and commitments of all countries. All UN member states will be reviewed for the first time within four years. A working group will meet for two weeks, three times a year, to carry out the review. The review will take into account a report from the state concerned, recommendations from the Special Procedures and Treaty Bodies, and information from nongovernmental organizations and national human rights institutions.

## 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 HRC to address specific country situations or thematic issues throughout the world. The HRC currently includes 28 thematic and 10 country Special Procedures.

Special Procedures activities include responding to individual complaints, conducting studies, providing advice on technical cooperation at the country level, and engaging in general promotional activities. The Special Procedures are considered “the most effective, flexible, and responsive mechanisms within the UN system.”

Special Procedures cited in this practitioner guide include:

- Working Group on Arbitrary Detention
- Special Rapporteur on Extrajudicial, Summary, or Arbitrary Executions
- Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health
- Special Rapporteur on Violence against Women, Its Causes and Consequences
- For more information about the Special Procedures, see <http://www.ohchr.org/english/bodies/chr/special/index.htm>.

## **HUMAN RIGHTS COUNCIL ADVISORY COMMITTEE**

The Human Rights Council Advisory Committee functions like a think tank, providing expertise and advice and conducting substantive research and studies on issues of thematic interest to the HRC at its request.

The committee is made up of 18 experts who serve in their personal capacity for a period of three years.

## **COMPLAINTS PROCEDURE**

This confidential complaints procedure allows individuals or organizations to bring complaints about “gross and reliably attested violations of human rights” to the attention of the HRC. The procedure is intended to be “victims oriented” and is expected to conduct investigations in a timely manner. Complaints are reviewed by two working groups that meet for five days at least twice a year.

## **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.

The 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. Information about NGOs with consultative status can be found at <http://www.un.org/esa/coordination/ngo/>.

ECOSOC agencies and commissions that may be cited in or that may be relevant to this practitioner guide include the following:

- Commission on the Status of Women
- Commission on Narcotic Drugs
- Commission on Crime Prevention and Criminal Justice
- Committee on Economic, Social and Cultural Rights
- International Narcotics Control Board



## 4.3 The European System

### European Court of Human Rights

#### MANDATE

The European Court of Human Rights (ECtHR), a body of the Council of Europe (COE), enforces the provisions of the European Convention on Human Rights (ECHR). The ECtHR adjudicates both disputes between states and complaints of individual human rights violations. The Committee of Ministers of the Council of Europe is responsible for monitoring the implementation of judgments made by the ECtHR. (See note on Committee of Ministers below.)

#### CIVIL SOCIETY PARTICIPATION

Any individual or government can lodge a complaint directly with the ECtHR alleging a violation of one of the rights guaranteed under the convention, provided they have exercised all other options available to them domestically. An application form may be obtained from the ECtHR website ([www.echr.coe.int/echr/](http://www.echr.coe.int/echr/)).

The COE has established a legal aid scheme for complainants who cannot afford legal representation. NGOs can file briefs on particular cases either at the invitation of the president of the court or 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.

#### Contact

European Court of Human Rights  
Council of Europe  
F-67075 Strasbourg-Cedex, France  
Tel: +33 3 88 41 20 18; Fax: + 33 3 88 41 27 30  
Web: [www.echr.coe.int](http://www.echr.coe.int)

### European Committee of Social Rights

#### MANDATE

The European Committee of Social Rights (ECSR), also a body of the COE, conducts regular legal assessments of government compliance with provisions of the European Social Charter (ESC). These assessments are based on reports submitted by governments at regular two- to four-year intervals, known as supervision cycles. The governmental committee and the Committee of Ministers of the Council of Europe also evaluate government reports under the ECSR. (See note on Committee of Ministers below.)

#### CIVIL SOCIETY PARTICIPATION

Reports submitted by governments under the ESC are public and may be commented upon by individuals or NGOs. International NGOs with consultative status with the COE and national NGOs autho-

rized by their government may also submit collective complaints to the COE alleging violations of the charter.

### Contact

Web: [www.humanrights.coe.int/cseweb/GB/index.htm](http://www.humanrights.coe.int/cseweb/GB/index.htm)

## Committee of Ministers

The Committee of Ministers ([www.coe.int/cm](http://www.coe.int/cm)) is the decision-making body of the COE. It is composed of the foreign ministers of all COE member states (or their permanent representatives). In addition to supervising judgments of the ECtHR and evaluating reports under the ECSR, the Committee of Ministers also makes separate recommendations to member states on matters for which the committee 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 ([www.assembly.coe.int](http://www.assembly.coe.int)), which is a consultative body, composed of representatives of the parliaments of member states.

## Advisory Committee

### MANDATE

The Advisory Committee (AC) assists the Committee of Ministers in monitoring compliance with the Framework Convention for the Protection of National Minorities (FCNM). It monitors country progress on the FCNM by examining periodic reports submitted by governments. Besides examining these reports, the AC may hold meetings with governments and request additional information from other sources. The AC then prepares an opinion, which is submitted to the Committee of Ministers. Based on this opinion, the Committee of Ministers issues conclusions concerning the adequacy of measures taken by each state party. The AC may be involved by the Committee of Ministers in the monitoring of the follow-up to the conclusions and recommendations.

### Contact

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

Email: [minorities.fcnm@coe.int](mailto:minorities.fcnm@coe.int)

Web: [www.coe.int/minorities](http://www.coe.int/minorities) Civil society participation NGOs can submit “shadow reports” to the AC on any aspect of a government’s compliance with the FCNM.

Shadow reports should be submitted through the FCNM Secretariat. ([http://www.coe.int/t/dghl/monitoring/minorities/2\\_Monitoring/NGO\\_Intro\\_en.asp](http://www.coe.int/t/dghl/monitoring/minorities/2_Monitoring/NGO_Intro_en.asp))

## 4.4 Complaint Procedure: European Convention on Human Rights

This section excerpts and updates information from the publication *Reported Killing as Human Rights Violations* by Kate Thompson and Camille Giffard (published by the Human Rights Centre, University of Essex).

**TABLE: BASIC FACTS ON THE EUROPEAN COURT OF HUMAN RIGHTS**

| <b>Origin:</b>                  |  |
|---------------------------------|--|
| How was it created?             | By the 1950 European Convention on Human Rights, revised by Protocol 11 to that convention, 1994 |
| When did it become operational? | In 1998, under the revised system  |

### **Composition:**

|   |  |
|---|--|
| How many persons is it composed of?                             | As many judges as there are states parties to the convention |
| Are these persons independent experts or state representatives? | Independent experts  |

| <b>Origin:</b>    |   |
|-------------------|---|
| General objective | To examine complaints of violation of the ECHR  |
| Function          | Interstate complaints (compulsory) (Article 33, ECHR)   |
|                   | Individual complaints (compulsory) (Article 34, ECHR)   |
|                   | Fact finding (in the context of individual complaints only and an optional step in the procedure) |

## 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;
- 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 ineffective or unreasonably prolonged

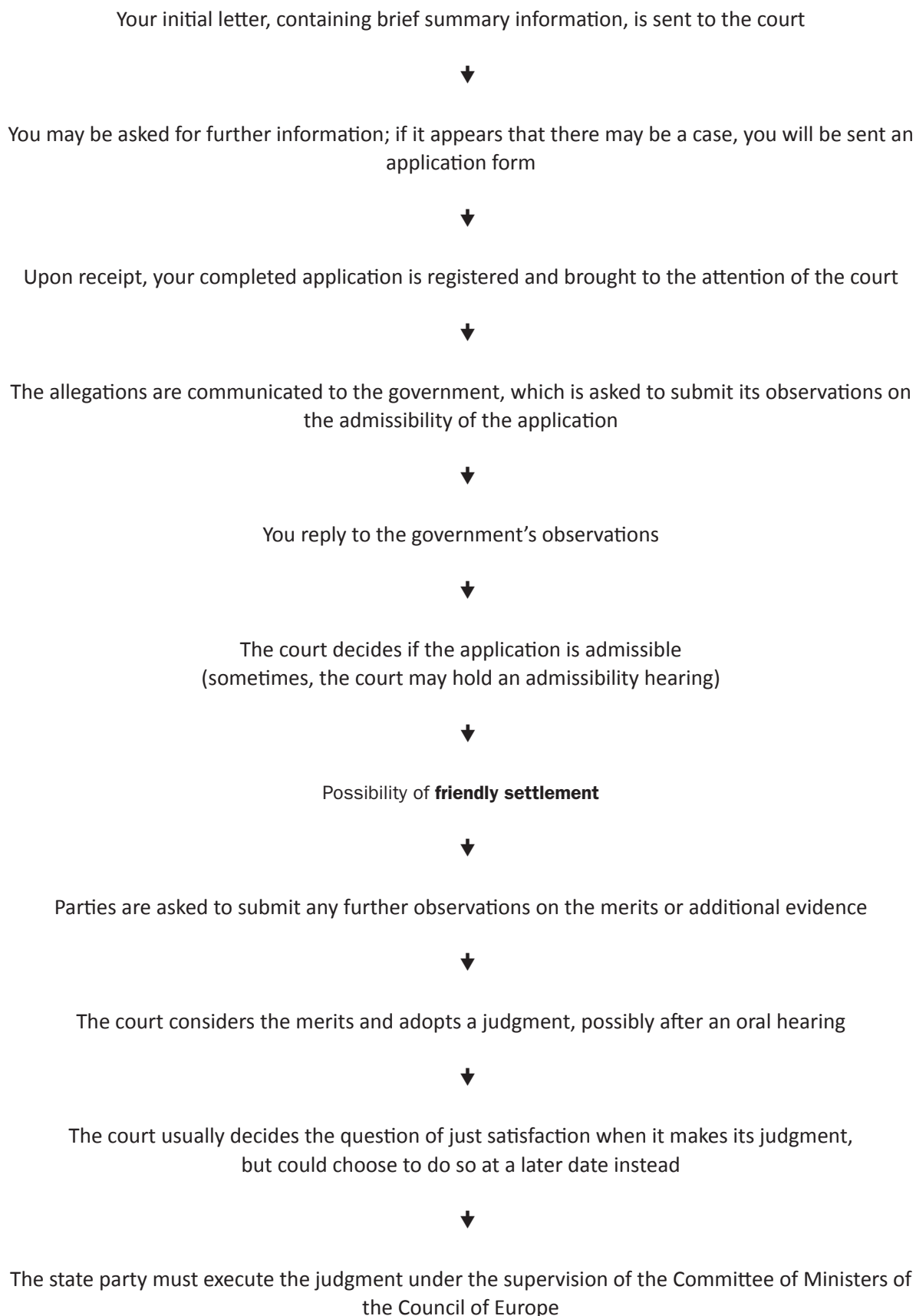
As of June 1, 2010, in accordance with Protocol 14 to the ECHR (Council of Europe Treaty Series No. 194), a new admissibility requirement allows the court to declare inadmissible applications where the applicant has not suffered a significant disadvantage, unless respect for human rights requires an examination of the application on the merits and provided that no case may be rejected on this ground that has not been duly considered by a domestic tribunal (Article 12 of Protocol 14, amending Article 35 of the ECHR). In order to avoid rejection of cases warranting an examination on the merits, single-judge formations and committees will not be able to apply this new criterion for the first two years after the entry into force of Protocol 14 (Article 20 of the protocol).

## WHAT SHOULD YOUR APPLICATION CONTAIN?

Your initial letter should contain:

- a brief summary of your complaints;
- an indication of which convention rights you think have been violated;
- an indication of the remedies you have used;
- a list of the official decisions in your case, including the date of each decision, who it was made by, and an indication of what it said (attach a copy of each of these decisions).

If you later receive an application form, you should follow the instructions on that form and in the accompanying letter.

**TABLE: BASIC CHRONOLOGY OF INDIVIDUAL COMPLAINT PROCEDURE TO THE ECHR**

**TABLE: BASIC FACTS ON THE EUROPEAN COURT OF HUMAN RIGHTS**

|   |   |
|---|---|
| Who can bring a case under this procedure?  | Individuals, NG Os, 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 government; 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 mechanism take to assist the court in reaching a decision?   | Fact-finding hearings, expert evidence, written pleadings, and 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)                                   |

## HELPFUL GUIDELINES

- Under the original procedure, which was replaced in 1998, the initial stages of the case took place before the European Commission on Human Rights. If you are researching a particular topic under the convention case law, remember to search for reports by the commission and also for court judgments.
- If the six-month period within which an application must be submitted is about to expire, and there is no time to prepare a full application, you can send a “stop the clock” application with a short summary of your complaint, which should be followed by the complete application as soon as possible.
- For the purpose of respecting the deadlines set by the court, keep in mind that the court considers the date of posting—not the date of receipt—as determinative. It is advisable, however, to notify the court on the day of the deadline that the submission has been posted, either via email or telephone or by faxing a copy of the application cover letter.
- The court may, on its own initiative or at the request of one of the parties, obtain any evidence it considers useful to the case, including by holding fact-finding hearings. Where such measures are requested by one of the parties, that party will normally be expected to bear the resulting costs, although the chamber may decide otherwise. If you do not wish to bear such costs, it is advisable to word your letter carefully—for example, suggest to the court that it might wish to exercise its discretion to take measures to obtain evidence.
- The court carries out most of its regular work in chambers of seven judges. Where a case is considered to raise a serious issue or might involve a change in the views of the court in relation to a particular subject, it can be referred to a grand chamber of 17 judges. Where a case has been considered by a chamber and a judgment delivered, it is possible, in exceptional cases, to request within three months of the judgment that the case be referred to the grand chamber for reconsideration (Rule 73 of the Rules of Court).
- As of June 1, 2010, in accordance with Protocol 14 to the ECHR (Article 6), the court will carry out its regular work in the following structures: (1) *A single-judge formation*, assisted by a non judicial rapporteur from the registry, will be able to declare inadmissible or strike out an individual application in clear-cut cases, where the inadmissibility of the application is manifest from the outset (Article 7 of Protocol 14 of the ECHR, which will become Article 27); (2) *Three-judge committees* will rule, in a simplified procedure, on both the admissibility and the merits of an application in cases where the underlying question falls under the already well-established case law of the court, that is, those cases consistently applied by a chamber (Article 8 of Protocol 14, which will become Article 28 of the ECHR); (3) *Seven-judge chambers* will rule, through joint decisions, on both the admissibility and merits of individual applications that have not been considered under Articles 27 or 28 (Article 9 of the Protocol 14, amending current Article 29 of the ECHR); (4) *A seventeen-judge grand chamber* will rule on cases referred by one chamber and raising a serious question about the interpretation of the convention or its protocols, or where the resolution of a question before the chamber might have a result inconsistent with a judgment previously delivered by the court (Articles 30 and 31 of the ECHR).
- In accordance with Protocol 14 to the ECHR, the Council of Europe Commissioner for Human Rights may submit written comments and take part in hearings in all cases before a chamber or the grand chamber (Article 13, amending Article 31 of the ECHR). This factor becomes significant in cases where the commissioner’s experience may help the court by highlighting structural or systemic weaknesses in the respondent or other high-contracting parties (Article 13 of the protocol).
- It is possible to request the interpretation of a judgment within one year of its delivery (Rule 79 of the Rules of Court). It is also possible to request, within six months of the discovery, the revision of a judgment if important new facts are discovered that would have influenced the court’s findings (Rule 80 of the Rules of Court).



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- 5.1 **STATUS OF INTERNATIONAL AND REGIONAL LAW**
  - 5.2 **STATUS OF PRECEDENT**
  - 5.3 **LEGAL & HEALTH SYSTEMS**

# 5

## Country-Specific Notes

### 5.1 Status of International and Regional Law

The process of the development of patients' rights legislation in Georgia has been greatly influenced by the extensive movement for health care reform in Europe. Particularly significant intergovernmental instruments were developed by authoritative international organizations such as the UN, the World Health Organization (WHO), UNESCO, the Council of Europe, the World Medical Association, etc. Furthermore, specific acts on patients' rights were introduced in several European countries.<sup>1</sup>

Health and human rights principles and provisions of variously binding levels, as well as soft legal instruments,<sup>2</sup> have been incorporated into national law. Strategies and principles developed by the afore-mentioned international organizations have significantly influenced patient's rights legislation in Georgia. International research data and conclusions, as well as the experience of various countries possessing specific legislation on the rights of patients have also been taken into account. The documents that played a major role in promoting the process of drafting patients' rights legislation in Georgia were the "Declaration on the Promotion of Patients' Rights in Europe"<sup>3</sup> and the "Convention on Human Rights and Biomedicine".<sup>4</sup> Later, Georgia also signed and ratified the Convention and its three protocols.<sup>5</sup>

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1 The first to adopt a separate patients' rights act was Finland, in 1992.

2 Declarations and Guidelines of the World Medical Association, Council of International Organizations on Medical Sciences, etc.

3 WHO 1994.

4 Council of Europe; the document was opened for signature in Oviedo in 1997.

5 See the Table of Ratifications in Chapter I – Introduction.

Below is the list of major documents (binding as well as non-binding) comprising the conceptual foundations of the national legislation of Georgia on the rights of patients as well as the obligations and rights of health care providers:

- The Universal Declaration of Human Rights (1948);
- Convention for the Protection of Human Rights and Fundamental Freedoms (1950);
- European Social Charter (1961);
- International Covenant on Civil and Political Rights (1966);
- International Covenant on Economic, Social and Cultural Rights (1966);
- The Convention on the Rights of the Child (1989);
- Convention on Human Rights and Biomedicine (CHRB)
- Additional Protocol to the CHRB on the Prohibition of Cloning Human Beings (1998);
- Additional Protocol to the CHRB concerning Transplantation of Organs and Tissues of Human Origin (2001);
- Additional Protocol to the CHRB Protocol concerning Biomedical Research (2005);
- Universal Declaration on the Human Genome and Human Rights; UNESCO (1997);
- Declaration Of Helsinki: Recommendations Guiding Physicians In Biomedical Research Involving Human Subjects; World Medical Association
- Principles of Medical Ethics; United Nations (1982);
- International Ethical Guidelines for Biomedical Research Involving Human Subjects (1982, 1992)
- International Guidelines for Ethical Review of Epidemiological Studies (CIOMS; 1991, 2002);
- A Declaration on the Promotion of Patients' Rights in Europe (WHO; 1994).
- Convention on Human Rights and Biomedicine (CHRB; Council of Europe; 1997);
- Various Resolutions and Recommendations of Parliamentary Assembly of the Council of Europe and Committee of Ministers of the Council of Europe; e.g.:

**Recommendation of Parliamentary Assembly No1418 (1999)** on the protection of the human rights and dignity of the terminally ill and the dying.

**Recommendation No. Rec(2003)24** of the Committee of Ministers to Member States on the Organization of Palliative Care;

**Recommendation No. Rec(2004)10** of the Committee of Ministers to Member States concerning the Protection of Human Rights and Dignity of Persons with Mental Disorder.

Additionally, Georgia has signed and ratified most of the international and regional (European) legal instruments related to health, biomedicine and human rights. The list of these instruments and dates of their ratification are presented in the Table of Ratifications.<sup>6</sup>

## 5.2 Status of Precedent

Unlike common law countries, power of precedent is not granted to the court. Thus, they have little significance for interpreting existing practices. However, one of the key objectives of the current court reform is to develop uniform court practice.

On February 5, 2007, the Standing Commission on the Study and Generalization of Court Practice in Criminal Law and Development of Guidelines for General Court Judges was established. As a result of active and intensive work, the Commission drew up guidelines that considered all possible circumstances that might arise in relation to the specific articles of the Criminal Code and provided details as to which punishment the judge shall impose on a person convicted under any article in the presence or absence of adequate circumstances that are necessary to qualify for a crime. The guidelines are meant not only to help judges deal with cases more quickly and effectively, but to also make prosecutors, solicitors and their defendants aware of the prospect and progress of their position (complaint) from the beginning.

Moreover, a new initiative approved in February 2006 calls for the organization of regular meetings of judges from all courts to be held in the Supreme Court of Georgia. The meetings aim to consider and analyze issues relevant to court practice, summarize different views expressed by judges of different courts, and develop a common interpretation for specific norms. Meeting results are recorded and sent in the form of recommendations to all judges nationwide.

The meetings have resulted in developing recommendations on the uniform application of norms of Criminal Law on quite a few controversial issues. Recommendations are short and simple. They clearly express the essence of the subject. The ultimate goal of this is to develop a single approach to the majority of norms, which will contribute to the speedy administration of justice.

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<sup>6</sup> See Chapter I – Introduction.

## 5.3 Legal & Health Systems

### Judicial System and Reform

The structure of Judicial Power in Georgia is defined and outlined in the Constitution adopted by Parliament in 1995. Chapter Five of the Constitution deals specifically and solely with Judicial Power. It identifies all the judicial bodies that implement justice in the country (the constitutional court, courts of general jurisdiction and military courts within the system of the courts of general justice in time of war). Under the Constitution, the Public Prosecutor's office is a body of Judicial Power and its authority, competence and some procedural rules are also defined in the relevant paragraphs of Chapter Five.

In order to guarantee human rights and uphold the rule of law, the Constitution prohibits the establishment of ad hoc courts, i.e. no courts can be established other than those identified in the Constitution.

**It also lays down some general principles:**

- ✓ The independence and inviolability of Judicial Power;
- ✓ The independence, immunity and security of judges;
- ✓ Transparency of court proceedings;
- ✓ The authority and competence of the Constitutional Court and the rules governing its establishment;
- ✓ The authority and competence of the Supreme Court and the rules governing its establishment.

Health care disputes fall under the competence of the civil branch of the court system, or under the competence of the Constitutional Court, authorized to rule on the conformity to the Constitution of statutes and other legal acts.<sup>7</sup>

**District/City Court:** Institutional reorganization of the court system, i.e. establishment of a smooth, functionally balanced system, and correspondingly, provision of the principle of sequential order of instances, represents one of the main directions of the reform. Therefore, the reform envisages modernizing district (city) courts with regard to the cases that fall under their jurisdiction and to the specialization of judges. District Courts became first instance courts of the general jurisdiction and hear all of the controversies not subjected to the direct competence of the courts of appeal. They have been specialized into three divisions: administrative, civil and criminal.

**Magistrate Judges:** For ensuring accessibility – one of the main principles of justice - the institute of magistrate judges will be established. It will constitute part of the district (city) court and implement judicial power in the administrative-territorial unit where the enlarged district (city) court is not present. For example, an enlarged district court will be established in Zestaponi, and its jurisdiction will cover the districts of Sachkhere, Chiatura, Kharagauli, Terjola and Tkibuli, and a magistrate judge will be appointed in each of these districts. Each magistrate judge hears cases single-handedly.

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<sup>7</sup> See Chapter VIII on National Procedures.

In order to avoid the impediment of the administration of justice, the chairman of the district (city) court can order the magistrate judge to hear a case out of his/her area – in another administrative-territorial unit of the district (city) court, if necessary. Cases of less complexity fall under the jurisdiction of magistrate judges. Namely, according to Article 14 of the Civil Proceedings Code of Georgia, the magistrate judges hear the following civil cases by the rule of the first instance:

- ✓ Property disputes, if the value of the claim does not exceed 2,000 GEL;
- ✓ Indisputable and simple cases, except adoption; cases of payment orders<sup>8</sup> and declaring abeyance of property, if the value of the claim or the property exceeds 2,000 GEL;
- ✓ Disputes on the grounds of family relationships, except those of adoption, deprivation of parental rights, establishment of paternity and divorce, and rights for rearing a child;
- ✓ Employment disputes.

Magistrate judges, according to Article 6 of the Administrative Proceedings Code of Georgia, hear the following administrative cases by the rule of the first instance:

- ✓ Related to the village, community, town and city within the district; cases of legitimacy of the administrative-legal acts issued by the representative and executive bodies;
- ✓ Of the legitimacy of the individual administrative-legal acts made in reference to the administrative offences (this norm has been effective since January 1, 2006);
- ✓ Issues of social state protection;
- ✓ Disputes about the execution of the court decision that has entered into the legal force;
- ✓ Disputes on the grounds of labor relationships in the public service;
- ✓ On the grounds of issuing an order for inspecting the entrepreneur's activity, as based on the mediation of a controlling body.

Magistrate judges, according to Article 46 of the Criminal Proceedings Code of Georgia, hear the petitions about applying and changing the means of proceedings and legal duress by the rule of the first instance. This means that an individual in a legal proceeding who believes that court procedural measures are not conducted in accordance with the law and/or that the measures of duress used are not legal, can petition the Magistrate judge.

**Court of Appeal:** From the viewpoint of institutional changes, the reform envisages to establish the institution of a pure appeals court in Georgia. According to the legislative amendments implemented in the first half of 2005, the appeals court was put into practice on November 1, 2005. This has completely changed the existing model of district courts in the unified system of common courts. According to the previously functioning system, the court of the so-called second instance, i.e. the district

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<sup>8</sup> Cases related to human rights in patient care may fall under this category.

court, was not a pure appeals court. There were relevant panels for hearing cases that were brought under their jurisdiction by the rule of the first instance. After the reform changes were introduced, the essence of court instances was clearly differentiated, in which the principle of ‘Instanzenzug’<sup>9</sup>, which is predominant in the West, has been observed precisely.

**Court of Cassation / Supreme Court:** The Supreme Court of Georgia has been established as the court of pure cassation. Courts of Cassation are courts of limited power, hearing and judging over the legality of the appellate court and district court decisions. Cases are admitted to courts of cassation based on relevance and the importance of pending court practices. They are heard in open or closed hearings upon judicial discretion. The Georgian Supreme Court (Court of Cassation) is mandated to control both procedural and substantive groundings of the cases. The panel for hearing criminal cases, which used to hear the cases of grave crimes in first instance, has been cancelled at the Supreme Court.

Envisaging the fundamentals of revision established in democratic countries, the ongoing reform defined that a complaint will necessarily be discussed by the Court of Cassation if the case has been discussed at the Court of Appeals with substantial violation(s) of rules of procedure, and in case the violations affected, or could have affected, the final outcome of the case. It is worth mentioning that in civil law, the cassation appeals related to property disputes can be accepted unconditionally if the value of the dispute subject exceeds 50,000 GEL; for non-property disputes, the appeals related to disputes on the grounds of freedom of speech and expression can be accepted.

The Supreme Court is also entitled to develop common guidelines and uniform court practice.<sup>10</sup> Although Georgia is not a common law country, where the court decisions have prejudicial and obligatory power and are therefore used as precedent, the establishment of a common judicial practice, and its generalization, is still of great significance in European continental law countries as well, from the viewpoint of correlation and explanation of legal norms. With the changes mentioned above, the Supreme Court is in fact becoming a doctrinal court that can more effectively develop justice and establish common judicial practices through founded explanation and correlation of judicial norms. This will guarantee the quick and balanced functioning of the court system in general. Additionally, these changes will result in a significant eradication of case protraction problems in the court system, in that at least 35-40% of the cases that are accepted for hearing will not be admitted in the Supreme Court. Correspondingly, the decisions made by the appeal courts for the same number of cases will remain the final decisions for those cases and will not be admitted by the Supreme Court for consideration.

**The Constitutional Court of Georgia**, established in 1996, is the judicial body of constitutional review, having the greatest significance in the country, with the view of securing constitutional provisions, separa-

tion of powers and its accomplishment within the constitutional framework, protecting human rights and freedoms, recognized and guaranteed by the Constitution, and enhancing public stability in the country. It consists of nine judges who serve 10-year terms. The Constitutional Court, among other tasks, adjudicates upon conformity with the Constitution of Georgia with the following: the constitutional agreement; the laws of Georgia; the normative resolutions of the Parliament of Georgia; the normative acts of the President of Georgia, of the higher state bodies of Abkhazia, and of the Autonomous Republic of Ajaria. The Court considers constitutionality of international treaties and agreements as well; and considers a submission of a court of general jurisdiction. For example, a submission is lodged with the Constitutional Court,

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<sup>9</sup> The order of instances.

<sup>10</sup> See section on the Status of Precedent above.



when considering a particular case, the court of general jurisdiction concludes that there is a sufficient ground to deem the law or other normative act applicable by the court while adjudicating upon the case, fully or partially incompatible with the Constitution.

In the Georgia legal system, the Constitutional Court is not a part of the regular court system in the sense that there is no possibility to appeal a lower court decision to the Constitutional Court. Although judges from regular courts can turn to the Constitutional Court and suspend the regular court procedure, they are only one group of persons who can petition the Court. However, in regard to Human Rights in Patient Care, the Constitutional Court can be a very important tool, as it is the only independent body that has the authority and power to interpret the Constitution and to determine whether a law, bylaw, etc., is constitutional; and its decisions are binding.

### **High Council of Justice of Georgia**

One of the most important priorities of the reform was to reform the High Council of Justice by increasing the number of judges and by strengthening the ‘voices’ of judges, in general. This body is made up of great authority in judicial law, and its duty is to draw up the judiciary budget, provide and control the material and technical resources, nominate the judiciary candidates to the President, submit proposals to the President regarding the dismissal or promotion of judges, initiate the disciplinary administration of justice against judges, and to employ court personnel. The reform has greatly modified the representation of judges in the High Council. As a result of these changes, judges will possess a sufficient number of votes to effectively implement the tasks listed above.

### **Disciplinary Administration of Justice**

Another particularly important target of reform was the existing model of disciplinary administration of justice. The mechanism defined by the Law on “Disciplinary Responsibilities and Disciplinary Administration of Justice against Judges of the Common Courts of Georgia” is in fact the only mechanism of internal monitoring of the court system. Offences committed by judges are to be examined by the relevant independent and competent body. According to Article 8 of the law, the validity of the complaint about the disciplinary responsibility is examined by the Head of the Supreme Court, Head of the Court of Appeal, Secretary of the High Council of Justice or a member of the High Council of Justice. According to Article 17, the decision to impose disciplinary responsibility is taken at the meeting of the High Council of Justice, which is presided over by the Head of the Supreme Court. The examination shall take place within a reasonable period of time, and it shall not be delayed. This is the main approach of the ongoing reform. This approach is expected to ensure the promptness and effectiveness of the disciplinary administration of justice.

## The Health System

The health care system of the country is still in the process of reforming, beginning in 1995. Despite considerable improvements in terms of financing, planning and statistics, the country still faces problems in terms of accessibility and quality of services. Although moving away from the extremely centralized Soviet model (the “Semashko” model), contours of the new health care system are still not well formed. This is mostly related to the roles and responsibilities of the State and private sector in terms of financing and delivering health care services, as well as defining volume and quality of these services. The role of private health insurance companies is being increased. In addition to their own programs, these companies are involved in implementing State-financed health programs (e.g. program for people below the poverty line). On the other hand, the number of the uncovered/uninsured population is still considerable and the rate of out-of-pocket payments in the health sector is still high.

It is important that there is a statutory system of licensing and certification of health care institutions and health care professionals. This exists in Georgia, although the recertification requirements of health care professionals were changed. Those professionals no longer are required to participate in continuing education for purposes of proving competence and extending or renewing the validity of their State Certificates for the next 5 years. State certification is issued once and is valid unless it is suspended or withdrawn. Recently, clinical practice guidelines have been defined as important instruments in the process of quality assurance; and according to Georgian legislation, national guidelines are approved by The National Council on Elaboration and Establishment of the National Clinical Practice Recommendations (guidelines) and Disease Management Standards, a competent body. Existence of such guidelines makes health care services more transparent and provides a basis upon which to judge how professional standards are followed.

**The Legislation of Georgia related to health and human rights** comprises of texts which regulate various aspects of medicine/health care: rights of patients and research subjects (including vulnerable groups, such as minors, persons with mental disorders, patients with HIV/AIDS, etc.), duties and responsibilities of health care professionals and institutions, human organ transplantation, assisted reproductive technologies, public health issues etc.

Legislation of Georgia in the field of Health and Human Rights comprises the Constitution of Georgia, international agreements and treaties to which Georgia is a party, national laws and other legislative and regulatory texts.

The list of national laws related to health, biomedicine and human rights are given in the table below.

|  | ADOPTED           | LAST UPDATE  |
|--|-------------------|--------------|
| The Law on Health Care   | 1997 (10.12)      | 2008 (21.03) |
| The Law on the Rights of Patient   | 2000 (05.05)      | 2007 (08.05) |
| The Law on Doctor’s Professional Activity  | 2001 (08.06)      | 2008 (21.03) |
| The Law on Public Health   | 2007 (27.06)      | no updates   |
| The Law on HIV Infection/AIDS  | 2009 (17.11)      | no updates   |
| The Law on Psychiatric Care  | 2006 (14.07)      | 2008 (01.11) |
| The Law on Blood Donors and Blood Components   | 1997 (30.04)      | 2006 (29.12) |
| The Law on Human Organ Transplantation   | 2000 (23.02)      | 2006 (23.06) |
| The Law on Drug and Pharmaceutical Activity  | 1996 (25.12)      | 2008 (18.06) |
| The Law on Narcotic Drugs, Psychotropic Substances, Their Precursors and Narcologic Care | 2002 (05.12)      | 2007 (08.05) |
| The Law on Protection and Promotion of Infant Natural Feeding                            | 1999 (09.09)      | 2000 (09.06) |
| The Law on Medical and Social Expertise  | 2001 (07.12)      | 2007 (16.03) |
| The Law on Tobacco Control in Georgia  | 2003 (06.06)      |              |
| The Law on Biomedical Research Involving Human Subjects                                  | Before Parliament |              |
| The Law on Reproductive Health and Reproductive Rights                                   | Before Government |              |

From these laws, the “**Law of Georgia on Health Care**” is considered to be the general framework law, which determines the priorities and sets out fundamental principles of health care legislation of Georgia.

The “**Law on the Rights of Patients**” is the specific law that defines all major principles of patients’ rights protection. Such rights are enforceable through the court.

The “**Law on Doctor’s Professional Activity**” defines the responsibilities of doctors towards patients and also regulates all major aspects of doctors’ training, professional development and activity. Defining legal duties of doctors in relation to patient’s rights creates the possibility to introduce disciplinary sanctions in case a doctor fails to fulfill their duties.

The “**Law on Public Health**” is related to the rights of patients, as far as it defines rules of interrelation between individuals and the public health system; and in a few, very specific cases, it restricts the rights of individuals for the sake of public interest. Other laws regulate patients’ rights issues in the context of various specific fields of medicine, such as psychiatry, human organ transplants, HIV/Aids etc.

As one of the major roles of health legislation is to define legal responsibilities and rights of **health-care providers**, it is important to know which professionals are understood to be included under the

term “Healthcare Providers.” Quite often this term is vague and difficult to interpret for the interested parties. The **Law on Health Care** defines health care professionals or healthcare personnel as follows (**Article 3.c'**): *“Persons with medical and non-medical education who carry out medical activity”*. The term “medical activity” is further defined by the same law as follows (**Article 3ch**): *“Activity which is related to disease prevention, diagnosis, treatment, rehabilitation and palliative care and corresponds to professional and ethical standards established in the country.”*

Knowing that **ratified international documents** are not only part of Georgian legislation, but are also higher in the legal norms hierarchy than national laws (except for the Constitution), and taking into consideration the importance of Council of Europe instruments in the European region, the authors/ Working Group decided to present the Convention on Human Rights and Biomedicine and its additional protocols under the rights and responsibilities of patients and of providers, whenever appropriate, in the sub-section “Other Relevant Sources” of this Practitioner Guide.

**The Code of Ethics of Physicians of Georgia** is an important, though not legally-binding, instrument aimed at implementing the highest ethical standards in the everyday practice of physicians in Georgia. The document was endorsed by the Congress of Georgian Physicians in April 2003. The code was developed by the Georgian Health Law and Bioethics Society (a non-governmental organization – NGO) and the Health Legislation and Bioethics Department of the National Institute of Health (a department under the Ministry of Labour, Health and Social Affairs at the time, but now no longer exists).

The first version of the Code was discussed by the participants of the Congress and was submitted for further considerations to the National Council on Bioethics. The latter considered the document during its three different sittings and published the final text of the Code, which was adopted at the last session of the First Congress of Physicians of Georgia (2003). However, this was not a formal procedure (e.g. there was no formal voting or signing of the document). It was rather a ceremonial announcement and the text of the Code was distributed among several thousand doctors.

The Code includes a preamble, general provisions and specific chapters on a doctor’s relation to patients, colleagues and towards society. The whole text is quite general; it mostly defines general principles and attitudes rather than detailed instructions for each specific case.

No sanctions may be applied in the case of an eventual breach of the provisions of the Code itself. However, most of the provisions of the Code are based on principles already laid down in health-related laws (such as the Law on Health Care, the Law on Doctor’s Professional Activity, the Law on the Rights of Patients etc.). Therefore, there is good reason to follow the provisions of the Code, as they are mostly based on existing legislation.

The Ethics Code of Physicians of Georgia is the first national code of ethics in the sphere of biomedicine. The first international document outlining ethical principles for physicians acknowledged by Georgia was the World Medical Association Declaration of Geneva – Physician’s Oath. This document has been recognized as the official text for the oath of physicians in Georgia (Law of Georgia on Health Care, 1997).

Finally, a new, more detailed instrument is being developed, the so-called “Rules of Doctor’s Conduct,” by a few professional associations and the above-mentioned NGO “Georgian Health Law and Bioethics Society.” The document is intended to be an instrument of professional associations to regulate the conduct of their members. However, there are still ongoing discussions on whether to make these

rules binding through legislation. The work is planned to be finalized before the end of 2010.

There is no code of ethics yet for nurses or other health care providers in Georgia.

**Bylaws of medical institutions** are other instruments regulating the conduct of medical personnel, their rights and responsibilities, as well as the rights and responsibilities of the patients. These bylaws shall correspond to the existing legislation. However, if this is not the case and certain provisions of the bylaw contradict the law, such provisions shall be considered invalid, according to existing hierarchy of legislation established by the Law on Normative Acts (2009: 1876-IIS)

## **6.1 PATIENTS' RIGHTS**

- Right to Preventive Measures**
- Right of Access**
- Right to Information**
- Right to Consent**
- Right to Free Choice**
- Right to Privacy and Confidentiality**
- Right to Respect for Patients' Time**
- Right to Observance of Quality Standards**
- Right to Safety**
- Right to Innovation**
- Right to Avoid Unnecessary Suffering and Pain**
- Right to Personalized Treatment**
- Right to Complain**
- Right to Compensation**
- Right to Make Advanced Will**
- Right of Persons Deprived of Liberty**
- Right Related to Genetics**

## **6.2 PATIENTS' RESPONSIBILITIES**

- Responsibility to Undergo Medical Intervention**
- Responsibility to Provide Information**
- Responsibility to Receive Information**

# 6

## National Patients' Rights and Responsibilities

### 6.1 Patients' Rights

#### Right to Preventive Measures

According to the Law of Georgia on the Rights of Patients, a *patient* is considered to be any person independent of his health situation that receives, or needs, or is going to use health care services.

##### **a) Right 1 as Stated in the European Charter of Patients' Rights (ECPR)**

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

Georgian legislation does not specifically mention the “right to preventive measures” or the “right to preventive medical services.” However, several provisions could be interpreted as being indirectly applicable to the right to prevention, particularly the provisions concerning the rights to healthy living conditions/environment and to healthcare/medical services. In the first case, measures which are essential to achieve and maintain a “*healthy environment*” should be considered as preventive measures; and in the second case, “*medical services*” in general include various types of preventive measures as well. The explanations below are based on the above interpretation of health environment and of medical/healthcare services.

## b) Right as Stated in Country Constitution/Legislation

### Constitution of Georgia

There is no direct provision on the right to preventive measures in the Constitution, as there is no direct provision on the right to health as such.<sup>1</sup> However, **Article 37.3**, which states that “*Everyone shall have the right to live in a healthy environment ...*” may be interpreted as having relation to one specific aspect of prevention, such as preventing diseases through establishing and/or maintaining a healthy environment (e.g. an environment free of tobacco smoke, human parasites, animals transmitting diseases etc.).

The general provision of the Constitution on the accessibility to health care (particularly health care insurance) is also relevant (*See the section on Right to Access in this chapter.*)

### Legislation

#### Law on Health Care

The law is mostly focused on the responsibility of the State to provide certain services and to ensure the quality of services, rather than on the rights of patients to such services. According to the Law, “*It is the duty of the State to ensure a safe environment for health.*” (**Article 70**).

The law also states that the “*Ministry of Labour, Health and Social Affairs (...) works out large-scale programs of their epidemiological study, **prevention** and treatment of these diseases, and leads the implementation of these programs.*” (**Article 74**).

One more provision related to the obligations of the State in the sphere of preventive services is specifically focused on vaccination (**Article 78**):

*“The Georgian Ministry of Labour, Health and Social Affairs works out and approves the national timetable for preventive vaccination and the medical program necessary for its implementation.”*

The law is very specific with regard prevention of goiter in high mountain regions; particularly, it grants free preventive services to the population of such regions (**Article 64**):

*“In high mountainous regions the State is directly funding programs for prevention and treatment of goiter and other endocrinal diseases.”*

Such specific focus on thyroidal problem is explained by the fact that in some mountain regions of Georgia, goiter has an endemic character.

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<sup>1</sup> Article 37: “1. Everyone shall have the right to enjoy health insurance as a means of accessible medical aid. In the cases determined in accordance with a procedure prescribed by law, free medical aid shall be provided. 2. The State shall control all institutions of health protection and the production and trade of medicines. 3. Everyone shall have the right to live in healthy environment and enjoy natural and cultural surroundings. Everyone shall be obliged to care for natural and cultural environment. 4. With the view of ensuring safe environment, in accordance with ecological and economic interests of society, with due regard to the interests of the current and future generations the state shall guarantee the protection of environment and the rational use of nature. 5. A person shall have the right to receive complete, objective and timely information as to the state of his/her working and living environment.



The law also recognizes the right of the population to “radiation security” and defines the responsibility of the State to carry out relevant measures to ensure the above right is implemented (**Article 71**).

Finally, according to the Law on Health Care, the State shall provide “the population with universal and equal accessibility to medical care within the frames of state-funded medical programs” (**Article 4**).

Although the term “medical care” is not defined in the Law, it defines the term “medical activity,” which has the following definition: “activity, which is related to **prevention**, diagnosis, treatment and rehabilitation of a disease and corresponds to professional and ethical standards recognized in the country.”

It is important to highlight that the right to access to services is limited only to State-funded programs, which are approved by the Parliament of the country as part of the **Law on State Budget**. Therefore, the rights of citizens to health care services are limited to State medical programs, which vary from year to year.

### Law on the Rights of Patients

The law defines medical service as “any intervention or procedure having diagnostic, therapeutic, **preventive** or rehabilitative purpose and carried out by a healthcare provider.” (**Article 4**). Later, in **Article 5**, the law grants citizens of Georgia the right “to receive from any healthcare provider medical service in accordance with the professional and service standards, acknowledged and established in Georgia.” Therefore, this right indirectly includes the right to preventive services that are of an adequate quality.

Like the law on Health Care, the Law on the Rights of Patients limits the right to healthcare to the services included in state medical programs (see comments above on the Law on Health Care). **Article 11** of the Law on the Rights of Patients states the following:

*“Equal access to medical Services is ensured through State Medical Programs.”*

### Law on HIV Infection/AIDS

The State has the responsibility to develop and implement measures aimed at preventing the spread of HIV/AIDS. Such measures include the development of universally accessible services, including counseling and lab testing for HIV/AIDS. According to the Law, everyone “*shall have the right to undergo voluntary counseling and testing for HIV infection, including tests conducted anonymously and confidentially*” (**Article 6, paragraph 1**).

The Law defines the principles of the State policy in the field of HIV infection (Article 5), which include provisions related to prevention of HIV/AIDS:

- ✓ Development and implementation of the State programs aiming at the prevention and treatment of HIV infection / AIDS;
- ✓ Informing individuals about voluntary HIV testing;
- ✓ Informing persons through media and/or individually upon request, about HIV / AIDS prevention;
- ✓ Facilitation of ensuring universal access to HIV voluntary counseling and testing, also prevention;

- ✓ Facilitation of implementation of the HIV/AIDS prevention, diagnostics, treatment, care and support, as well as harm reduction programs in penitentiary institutions;
- ✓ Introduction of the post-exposure prophylaxis of HIV infection.

Health care institutions which provide services to persons with HIV/AIDS are required to offer pre-test and post-test counseling on HIV infection to all patients accessing them for services (**Article 8, paragraph 4**).

Such institutions are also required to supply information on the applicable preventive measures to the person concerned, in order to ensure the safety of others (**Article 8, paragraph 3**).

### Law on Public Health

The purposes of this law include: promotion of healthy lifestyles and protection of the population's health; provision of an environment that is safe to human health; protection of reproductive health of families; prevention of contagious and non-contagious diseases. The government must ensure preventive measures for averting threats related to public health.

The Law explicitly states the obligations of the State and of the Ministry of Labour, Health and Social Affairs to organize and carry out vaccinations, and to ensure the adequate quality of vaccines and vaccination procedures. It also states that vaccinations that are defined by the National Preventive Vaccination Calendar must be accessible for every person in the territory of the country (**Articles 6 and 7**).

According to **Article 5 (paragraph 2)** of the Law, every person in Georgia has the right to:

*"a) Be protected in all medical healthcare providing facilities from being exposed to communicable diseases.*

*b) Refuse to participate in preventive activities if there is no threat of an epidemic or pandemic. People whose activities are associated with a high risk of spreading communicable diseases cannot refuse the participation in preventive activities.*

*c) Live in a safe environment.*

*d) Receive complete, timely and accurate information about the meaning and necessity of preventive vaccination, expected clinical results, the risks associated with it, and in case of refusing the vaccination, about the possible results."*

The Law states also that the population shall have access to free vaccines according to the National Preventive Vaccination Calendar.

### Other Laws

According to state health care programs that are approved every year, according to the **Law on State Budget**, the population shall have access to free vaccines in accordance with the National Preventive Vaccination Calendar. The selection of the manufacturer, along with the purchase and the transporta-

tion of the vaccines, is the responsibility of the State. Therefore, only vaccines purchased by the State are free. However, if a patient prefers to have a vaccine from a different, yet authorized manufacturer, they must pay for such a vaccine. In any case, the health care institution responsible for vaccinations shall first offer free vaccines, which are provided by the State program.

In any case the health care institution responsible for vaccinations shall inform the patient and/or their representative about all existing alternatives (**Law on the Rights of Patients, Article 18.1**), i.e. about vaccines available free of charge within the State program and about “commercial” vaccines.

### c) Supporting Regulations/Bylaws/Orders

Minister of Labour, Health and Social Affairs No 122/nof 4.06.2003 on “Approval of National Preventive Vaccination Calendar” legitimizes the detailed schedule, methods of vaccinations and safety measures for the population of Georgia. The document defines the schedule of vaccination based on the age of the patient, while it also identifies the criteria and methods for vaccination based on epidemiological indications (e.g. for tularemia, brucellosis, yellow fever, hepatitis A and B, etc.).

Order of the Minister of Labour, Health and Social Affairs No215/n of 11.07.2007 on “Approval of Cases and Rules for Mandatory Health Examination of Employees to be Financed by Employer” defines diseases/diagnoses which are contraindicated for certain jobs. The regular check-up of these employees contributes to the prevention of illness, which is a form of prevention, while regular check-ups of health care workers contribute to keeping a healthy environment in health care facilities, an indirect form of prevention as well.

### d) Provider Codes of Ethics

The **Code of Ethics of Physicians of Georgia** (approved by the 1<sup>st</sup> Congress of Georgian Doctors) does not include a specific provision on prevention. However it states that the doctor shall do his/her best to inform society about circumstances that could contribute to, or cause the deterioration of the health of all society, or of its particular groups; and the doctor himself/herself shall participate in the process of changing such conditions/circumstances.

### e) Other Relevant Sources

According to the Council of Europe Convention on Human Rights and Biomedicine,<sup>2</sup> the State, while considering existing needs and available resources, shall ensure “*equitable access to health care of appropriate quality*”(Article 3). This is supposed to include preventive services as well. According to the Explanatory Report of the Convention, “*Health care*” means the services offering diagnostic, preventive, therapeutic and rehabilitative interventions, designed to maintain or improve a person’s state of health or alleviate a person’s suffering”(Item 24 of the Explanatory Report).

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<sup>2</sup> Entered into force in Georgia on 01.03.2001.

## f) Practical Examples

### 1. Example(s) of Compliance

- Children received scheduled vaccinations according to the National Preventive Vaccination Calendar. The vaccine was given free of charge (*Example taken from everyday reality*).
- Parents decided to get their daughter vaccinated against an infection that was not part of any of the State-funded prevention programs. Accordingly, they paid for the additional vaccine that was not listed in the National Preventive Vaccination Calendar (*Example taken from everyday reality*).

### 2. Example(s) of Violation

A doctor required the patient to pay for a vaccination that was envisaged by the National Preventive Vaccination Calendar. The doctor said that the vaccine was commercial. (*Reported by the "Health Care Ombudsman Office"<sup>3</sup>*)

### 3. Actual Cases

No actual legal cases were available as examples for this section.

## g) Practice Notes for Lawyers

- To claim the violation of some of the rights guaranteed by Article 37 of the Constitution (which includes the right to live in a healthy environment, and the right to health insurance, as well as to free medical aid in certain circumstances), lawyers should seek expert medical opinions proving that the medical treatment a person received did not conform with medical standards established by the State. As a rule, lawyers should refer to the instructions and guidance issued by the Ministry of Labour, Health and Social Affairs. However, where there are no such instructions/guidance, and even when they are at hand, it is the Court's prerogative to establish the reliability of opinions provided by every expert.
- Concrete facts of the case must be taken into account to claim that the right to free medical treatment guaranteed by Article 37.1 was violated<sup>4</sup>. The burden of proof rests on the patient (complainant) or his/her representative to prove the concrete facts. Expert opinion should only be sought to determine if a person, given their health conditions at a given time, could qualify as an individual entitled to free medical treatment.
- Proving the violation of the right guaranteed by Article 37.3 might be achieved, as the constitutional provision is of a general character, stemming from the obligations of the State under international law. In addition, according to Georgian national legislation, a person must have suffered damages to seek a remedy. This impedes the work of NGOs concerned with the protection of

<sup>3</sup> Case from the office of the "Healthcare Ombudsman," which existed from 2001 to 2007 at NGO "Georgian Health Law and Bioethics Society"

<sup>4</sup> Free medical treatment is guaranteed through State programs, and has several prevention components.

environment and health, as often the damage is to entire communities, and Georgian legislation does not allow filing collective claims. Thus, practical advice for lawyers might always be having an injured person for the Court to accept the claim. The State does not have the right to conceal the information about the existence (or non-existence) of environmental factors harmful to the health of the population, i.e. the State must inform the population in a timely manner. To claim that the State has violated such obligations, it must be ascertained that the State organs were themselves aware of the threat factors. The State can only be held responsible if the State (or its organs) was informed about the threat factors detrimental to the health of the population. Considering the afore-mentioned, proving the violation by the State might be impeded. However, it is still possible to make the State liable for violating its positive obligations. Two important sources on this issue include the following: (1) Constitution of Georgia, Article 37.5: *“A person shall have the right to receive complete, objective and timely information as to the state of his/her working and living environment,”* and (2) the Law on the Rights of Patients, Article 16: *“1. Every citizen of Georgia shall have the right to receive comprehensive, objective and timely information on factors which improve or have a negative influence on health,” and “2. The State shall provide citizens with the information specified in paragraph 1 of this article via mass media or individually, upon request, in accordance with existing regulations.”*

## **h) Cross-referencing Relevant International and Regional Rights**

Please find a discussion of international and regional standards relevant to the Right to Preventative Measures under the Right to the Highest Attainable Standard of Health in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## **Right of Access**

### **a) Right 2 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.***

According to authoritative interpretations of the “right to the highest attainable standard of health,” the right of access has many dimensions. Undoubtedly, the most important constituent of this right

in Georgia is financial accessibility. However, geographical accessibility, elimination of discrimination, and ensuring adequate quality of services are of great importance as well, as their existence contribute to making the access effective.

Ensuring adequate quality of services needs particular attention because ensuring access to services without ensuring adequate quality of those services does not help patients. Therefore, the right of access and the right to adequate quality of services are closely interrelated.

An example of the importance of such a link between accessibility and quality of services is when approximately 10 years ago, the Tbilisi municipality decided to make ambulance services free of charge throughout the city. However, ambulances were not adequately equipped, and the staff was not appropriately trained to offer real, effective emergency services to the population – they did not have ECG machines, defibrillators, cervical spine collars, immobilizing boards, laryngoscopes, catheters, etc. As a result, the team could not deal with real medical emergencies, such as myocardial infarction (heart attack), arrhythmia, trauma, etc. So, there was almost no real benefit from having free access to ambulance services (Conclusion of the National Council on Bioethics of Georgia, April 24, 2002).

Based on the above discussion and considerations, there are a lot of cross-references between these two rights in the Guide (under the current section, **Right of Access**, as well as under the section entitled **Rights to Observance of Quality Standards**).

The right of access to health services is supported by Georgian legislation. However, the legislation is general and does not include detailed financial guarantees. Financial accessibility to health services is connected to the provision of State medical programs, which in turn, are defined by the Law on State Budget, subject to annual approval by Parliament for the given year.

On the other hand, legislation of Georgia includes concrete provisions against discrimination and the right to quality services. The latter is not always translated into the language of patients' rights. In many cases, this issue is dealt with through the language of obligations on the part of State and/or health care providers, who have to ensure adequate quality of health services.

## b) Right as Stated in Country Constitution/Legislation

### Constitution of Georgia

**Article 37** of the Constitution applies to health, health services and the rights of citizens in this field. According to **paragraph 1** of this article:

*“Everyone shall have the right to enjoy health insurance as a means of accessible medical aid. In the cases determined in accordance with a procedure prescribed by law, free medical aid shall be provided.”*

The Constitution specifically mentions the right to *health insurance*, yet not the right to *health*, meaning that health insurance must be equally available for those fitting the same criteria, meeting the same (including monetary) requirements. In certain circumstances (to be defined by law), it also grants the right to free medical services.

The respect of the right of access implies that the access is free from any kind of discrimination. The Constitution provides against any type of discrimination in spheres of life – social, economic, cultural and political life. Particularly, it states (**Article 14, and Article 38, paragraph 1**):

*“Everyone is free by birth and is equal before the law regardless of race, color, language, sex, religion, political and other opinions, national, ethnic and social belonging, origin, property and title, place of residence.”*

*“Citizens of Georgia shall be equal in social, economic, cultural and political life irrespective of their national, ethnic, religious or linguistic belonging. In accordance with universally -recognized principles and rules of international law, they shall have the right to develop freely, without any discrimination and interference, their culture, to use their mother tongue in private and in public.”*

## Legislation

### Law on Health Care

The Law on Health Care connects the right to health/medical services to State medical programs, stating that citizens have the right only to those medical services that are included in the State medical programs. Particularly, **Article 5** of the law states the following:

*“Georgian citizens have the right to enjoy the medical care envisaged by the state healthcare programs, which are approved under existing rules.”*

As mentioned above, such programs are approved for each year separately, according to the **Law on State Budget**. The volume and terms of services within such programs change from year to year.

The Law on Health Care also prohibits any type of discrimination against patients; particularly, it states that (**Article 6**):

*“Discrimination against a patient because of his/her race, skin color, sex, religious convictions, political and other views, ethnic and social origination, property or title status, place of residence, disease, sexual orientation or negative personal attitude is prohibited.”*

The Law (second paragraph of the same article) specifically prohibits discrimination against patients who are in detention or imprisoned.

Finally, the Law on Health Care requires the State to be responsible for the general quality of health services (**Articles 4 and 16**). However, healthcare institutions are obliged to follow the standards, rules and norms regulating medical and pharmaceutical activity and the requirements determined by the system of quality control (**Article 53**).

It should be highlighted that, in addition to licensing institutions and certifying doctors, the Law has identified the development and approval of **clinical practice guidelines and protocols** as an important tool for quality control/assurance (**Article 16**). These tools (clinical practice guidelines and protocols) could be very important in judging the quality of services when the quality is questionable and/or a patient is dissatisfied with the services. Based on the aforementioned article, the Ministry of Labour, Health and Social Affairs set up a special body – “The National Council on Elaboration, Evaluation and Establishment of the National Clinical Practice Recommendations (Guidelines) and Disease Management Standards,” which is in charge of monitoring guideline development and approval. As of this writing, more than 100 clinical guidelines have been approved by individual (not normative) orders of the Minister.



## Law on the Rights of Patients

The Law on the Rights of Patients is similar to the Law on Health Care in defining rights to health services. According to **Article 5** of the Law on the Rights of Patients, *“Every citizen of Georgia has the right to receive from any healthcare provider medical services in accordance with the professional and service standards, acknowledged and established in Georgia.”*

This article is mostly related to quality aspects of healthcare services and stresses the importance of professional standards and the elimination of inequality between different regions, providers etc.

More specifically, equity in terms of accessibility to health services is ensured by **Article 11**: *“Equal access to medical services is ensured through State Medical Programs.”* As it is clear from this provision, equity is granted only within State medical programs, financed by the government. Therefore, although non-discrimination provisions apply to private and public sectors, financial accessibility and equity can be guaranteed only within State medical programs,<sup>5</sup> financed from the State budget.

The Law, similarly to the Law on Health Care, prohibits any type of discrimination. However, it includes an additional ground for possible discrimination: *“genetic heritage”* (**Article 6**).

**Article 12** of the Law on the Rights of Patients specifically mentions **the right to emergency medical care**:

*“The State protects the right of patients to medical services, without immediate providing of which the death or disability or serious deterioration of health is inevitable”* (Article 12.1).

This right clearly implies a legal obligation of the State. However, more detailed provisions on how to enforce this right have not yet been developed by the legislature. The only concrete provision is related to the obligation of the health care provider to inform the patient, or relatives of the patient, of where they can receive relevant emergency care when the provider is not in a position to provide such care itself.

Finally, there is one specificity deserving attention in Georgian legislation related to the right to health and the State's obligations in this field. The Law on Patients' Rights provides for mobilizing resources to address needs of the patients with rare, uncommon diseases. The argument in favor of such an approach was the supposition that patients with rare diseases will never fall under the scope of interests of private medical or insurance companies. Even if the State would pay for the treatment of such patients, healthcare providers would not be interested in broadening their services to target a very small group of patients. Taking into consideration such reality, **Article 13** of the Law states the following:

*“1. Government shall ensure that patients with rare, uncommon diseases are able to receive appropriate medical services in accordance with the professional and service standards, acknowledged and established in Georgia.*

*2. The Ministry of Labour, Health and Social Affairs elaborates the list of rare, uncommon diseases.”*

Currently, the list of such diseases is approved by the Order of the Minister of Labour, Health and Social Affairs.

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<sup>5</sup> Patients entitled to these programs can access them either in private or in public institutions, as the State program could be run by private as well as by State institutions.



## Criminal Code

Provisions of the Criminal Code against discrimination apply to the field of health care, in both private and public sectors. According to **Article 142** of the Criminal Code, violation of the equality of persons due to their race, color, language, sex, religious belonging or profession, political or other belief, national, ethnic, social rank or public affiliation, origin, place of residence, or property status that has substantially infringed human rights shall be punishable by fine or by corrective labor for the term not exceeding one year, or by imprisonment for up to two years in length.

According to the second part of the Article, the same action either committed through the abuse of one's official position or resulting in a grave consequence shall be punishable by fine or by corrective labor for up to one year in length, with or without deprivation of the right to occupy the position he/she occupied at the time of the action or to pursue a particular activity that he/she pursued for up to three years.

It should nevertheless be stressed that, according to **Article 142**, violation of the equality of persons is considered a criminal offence if this action has essentially infringed the person's right. In that case, importance is granted to determination of the fact of whether or not the violation of equality resulted in essential infringement of the person's right. The criminal responsibility of the person (the alleged violator) may arise only when proving the essential infringement.

**Article 142.1** of the Criminal Code is no less important. According to it, racial discrimination, i.e. action committed for the purpose of inciting national or racial hatred or conflict for humiliating the national honor and dignity, as well as direct or indirect restriction of human rights on the basis of race, color, social belonging, national or ethnic origin, and/or granting preferential treatment to a person based on the same grounds, shall be punishable by imprisonment.

**Article 142.2** is of particular importance as well, as it defines that a restriction, on the grounds of disability, of the rights granted by law and/or international treaty to a disabled person, resulting in the substantial infringement of his/her right, shall be punishable. This action shall be subject to fine or imprisonment for up to 3 years. The second part of this Article defines that the same action committed repeatedly, through the abuse of official position, with violence or threat of violence, or which caused grave consequences, shall be punishable by fine or imprisonment for up to 5 years.

### c) Supporting Regulations/Bylaws/Orders

Based on Article 13 of the Law on the Rights of Patients, the Order of the Minister of Labour, Health and Social Affairs No 199/n of 14.05.2001 on "Approving List of Rare Diseases" was adopted. After an amendment in 2004, the list includes 23 diseases and health conditions.

### d) Provider Codes of Ethics

The **Code of Ethics of Physicians of Georgia** includes several provisions relevant to the issue of health care accessibility. These provisions concern equal care of patients, obligation to provide emergency care in all circumstances, ensuring adequate quality of services, and trying to improve accessibility to healthcare services for the population. Below are quoted corresponding provisions of the code:

*"A physician always cares for every patient with equal compassion" (Chapter "Physician and Patient," Paragraph 2);*

*"In case of emergency or life threatening condition, a physician assists any person within his/her ability, even in a non-working environment" (Chapter "Physician and Patient," Paragraph 5);*

*"During his medical practice a physician shall be guided only by professional standards and universally recognized ethical norms" (Chapter "General Provisions," Paragraph 2);*

*"A physician shall try to create working conditions that are necessary for providing adequate medical care to the patient" (Chapter "Physician and Patient," Paragraph 8);*

*"A physician responds to the problem of healthcare accessibility and within his/her ability makes efforts to reduce obstacles in obtaining medical care" (Chapter "Physician and Society," Paragraph 2).*

## e) Other Relevant Sources

According to the Council of Europe Convention on Human Rights and Biomedicine<sup>6</sup>, the State shall ensure *"equitable access to health care of appropriate quality"*; however, local health needs and available resources are to be taken into consideration (**Article 3 - Equitable Access to Health Care**).

## f) Practical Examples

### 1. Example(s) of Compliance

Patient was admitted to the hospital due to "acute abdomen" (strangulated hernia). The patient was operated on immediately, after the essential investigations. Before being discharged, the patient was requested by the hospital to pay only 25% of the total cost of the treatment, as defined by the State program on emergency in-patient care (**Example taken from everyday life**).

### 2. Example(s) of Violation

- After an automobile accident, patient J was admitted to the hospital, in need of an urgent operation. The patient was not operated on because the hospital requested the patient to cover 100% of the operation costs and the family could not pay for the operation immediately. Consequently, the patient died because treatment was refused. (**Hypothetical example**)
- Having burnt his house, a mentally ill person, G, was living in the street. G, not once, but several times, asked one of the mental hospitals to admit him for treatment. The hospital refused on the basis that G's symptoms did not meet the threshold for admission. G's condition deteriorated over time, and finally he was given treatment in another mental hospital. However, G died two weeks later, as he received the treatment too late. (**Example collected by the authors**)

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<sup>6</sup> Entered into force in Georgia on 01.03.2001.

### 3. Actual Cases

- Citizen A was arrested and charged with acting against public order. During the trial, it was determined that A was a chronic drug user, and going without intravenous narcotics caused unbearable suffering. He was acting against public order because he was trying to procure drugs. Due to his social situation, A could not afford treatment in expensive clinics. At the same time, the State did not fulfill its obligations under national legislation to provide free treatment for drug addiction at least once in every drug user's lifetime<sup>7</sup>. The fact that the State does not provide accessible health-care indirectly pushes these people to violate public order, i.e. to commit illegal acts in order to get drugs. The Center for Protection of Constitutional Rights pointed out that A's conditions were equal to torture, inhuman and degrading treatment, as the State did not provide a cure for his severe opiate craving. The first instance court charged A, not for purchasing drugs, but for using drugs, and did not take into account the mentioned circumstances. The decision of the first instance court was appealed in the Court of Appeals, and the case is still pending. **(Reported by the NGO Center for the Protection of Constitutional Rights<sup>8</sup>)**
- Ms S, living below the poverty level, had health insurance through the State insurance program. She was physically impaired and was using a wheelchair. The polyclinic to which Ms. S was assigned for receiving treatment was 3 kilometers from her house and the doctor's cabinet was on the third floor. The building did not have special facilities for the disabled. Consequently, Ms. S was unable to go to the polyclinics to receive treatment. Nor did the doctor visit her apartment to provide treatment. The patient applied to the Public Defender's Office, asking to receive treatment in the polyclinic near her home. Due to involvement of the Public Defender's Office, the doctor is currently treating the patient in her residence. **(Public Defender's Office Reports, 20099)**
- Mr. G was injured in an automobile accident and needed an urgent operation. The insurance agency refused to cover the costs, as Mr. G's domicile was an old people's asylum in Gurjaani and he requested the operation to be performed in Tbilisi. Through the efforts of the Public Defender's Office, Mr. G was operated on in Tbilisi. **(Public Defender's Office Reports, 200910)**
- NGO Center for the Protection of Constitutional Rights received an appeal from citizen M, residing in Ksani Prison. Mr. M claimed that he was suffering from a poor health condition and was not provided with appropriate medical care. The patient was in need of urgent treatment for his endocrinological problem. However, the prison medical department continually ignored his condition. The Center for the Protection of Constitutional Rights forwarded the appeal to the prison medical department, claiming that court action would be pursued in case of non-compliance. The department operated on Mr. M, and the patient's rights were restored. **(Reported by the NGO Center for the Protection of Constitutional Rights<sup>11</sup>)**

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<sup>7</sup> Standards of the Ministry of Labor, Health and Social Affairs, based on Article 40.2 of the Law on Narcotic and Psychotropic Substances, their precursors and Narcologic Care: "When undergoing voluntary treatment, the person suffering with drug addiction, has a right to keep anonymity as defined by Law at his/her own expense, and at least once in his/her life to undergo full course of treatment at the State's expense."

<sup>8</sup> <http://www.cpcr.ge/?lan=eng&cat=1>

<sup>9</sup> <http://www.ombudsman.ge/>

<sup>10</sup> <http://www.ombudsman.ge/>

<sup>11</sup> <http://www.cpcr.ge/?lan=eng&cat=1>

### **g) Practice Notes for Lawyers**

To claim the violation of some of the rights guaranteed by Article 37 of the Constitution (which includes the right to live in a healthy environment, and the right to health insurance, as well as to free medical aid in certain circumstances), lawyers should seek expert medical opinions proving that the medical treatment a person received was not in conformity with medical standards established by the State. As a rule, lawyers should refer to the instructions and guidance provided by Controlling Agencies under the Ministry of Labor, Health and Social Affairs. However, where there are no such instructions/guidance, and even when they are at hand, it is the Court's prerogative to establish the reliability of opinions provided by every expert.

Concrete facts of the case must be taken into account to claim that the right to free medical treatment guaranteed by Article 37.1 was violated. The burden of proof rests on the establishment of concrete facts only. Expert opinion should only be sought to determine if a person, given his/her health conditions at a given time, could qualify as an individual entitled to free medical treatment.

When representing the individual claimant, the lawyer should first deliberate whether the client's status and conditions qualify him/her as a beneficiary to special State programs.

### **h) Cross-referencing Relevant International and Regional Rights**

Please find a discussion of international and regional standards relevant to the Right of Access under the Right to Nondiscrimination and Equality in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## Right to Information

### a) Right 3 as Stated in the European Charter of Patients' Rights (ECPR)

*Every individual has the right to access all kinds of information regarding their state of health, the health services and how to use them, and to all that scientific research and technological innovation makes available.*

Georgian legislation is quite specific on this issue. This right is enforced in “general legislation” in the Law on Health Care and the Law on the Rights of Patients; moreover, provisions ensuring citizens’ right to information relevant to their health are included in specific laws on Psychiatric Care, on HIV/AIDS Prevention, on Human Organ Transplants etc. Finally, the Law on Doctor’s Professional Activity defines duties to provide patients and/or their relatives with information about the health status, and proposed care, of the patient.

### b) Right as Stated in Country Constitution/Legislation

#### Constitution of Georgia

The Constitution of Georgia does not specifically mention the right to information related to health. However, it includes two provisions, which are relevant to health.

In the first case, the Constitution grants the right to citizens to receive information about their working and living conditions. This must be understood in relation to health, in so far as living and working conditions influence health. Also, this provision is included in **Article 37**, which is devoted to health and healthcare. Particularly, according to **paragraph 5 of Article 37** of the Constitution:

*“A person shall have the right to receive complete, objective and timely information as to a state of his/her working and living environment.”*

Another article (**Article 41, paragraph 1**) of the Constitution is related to the right to information contained in official documents, or documents stored in State institutions. This information could be relevant to health. In the past, it could apply to health information more directly because most of the health institutions were public ones. However, only a few hospitals and out-patient clinics are owned by the State nowadays. Below is the relevant provision of the Constitution:

*“Every citizen of Georgia shall have the right to become acquainted, in accordance with a procedure prescribed by law, with the information about him/her stored in State institutions as well as official documents existing there unless they contain state, professional or commercial secrets.”*

#### Legislation

##### Law on Health Care

The Law on Health Care addresses the right to information in the field of health in many ways by outlining rights of patients to information, obligations and policy of the State, and obligations of health care providers to provide information. Particularly, the Law covers the following issues:

- ✓ Right of citizens to receive correct, comprehensive, understandable information about their health **(Article 7)**;
- ✓ Right to seek a second opinion on their health **(Article 7)**;
- ✓ Right of citizens and their legal representatives (when severe health condition prevents patients from receiving information) to receive information related to health when a patient is in critical condition **(Article 146)**;
- ✓ Obligation of doctors to provide a patient with full information on his/her health condition **(Article 41)**;
- ✓ State policy to provide the population with full information on all existing forms of medical care, and the ways to access those services **(Article 4)**;
- ✓ Duties of employers to inform employees about the factors existing in the working place that may contribute to the development of occupational diseases; also about methods to avoid/diminish influence of those factors **(Article 96)**.

So, the Law on Health Care grants citizens the right to information, which is relevant to their health **(Article 7)**, and also articulates responsibilities of health care providers, employers, and the State, to provide the patients and population with such information **(Article 41)**.

In addition, the specific right of patients to seek second opinions on their health must be highlighted.<sup>12</sup> The right to a second opinion should be considered as an important tool to strengthen patients' positions and give them an opportunity to satisfy their need for information and clarifications concerning their health and care. This is particularly so in cases when they are dissatisfied with the information and explanations they receive from their health care provider, or when they are uncertain about the quality of services offered due to possible questionable competence of the providers, or due to any other reasons. The Law on Health Care defines the term “*second opinion*” in the following way **(Article 3.L)**:

*“The opinion on diagnosis, prognosis, and optimal method of treatment of the disease provided by the medical specialist, whom the patient addresses, bypassing his/her doctor in the case when the patient is not sure of the accuracy of the diagnosis and medical treatment, or intended medical treatment may cause serious results for the patient (e.g. mutilation due to operation).”*

## Law on the Rights of Patients

While the Law on the Rights of Patients addresses all the issues concerning the rights of patients to information on health and health care services, which have been discussed under the Law on Health Care, this specific law regulates many additional aspects of the right to information, such as: clarity, comprehensiveness, impartiality and timeliness of the information provided to the patient; the right of the patient to refuse to receive information; conditions for withholding or limiting information given to the patient; etc.

According to **Article 18**, the patient has the right to information about his/her own health as well as issues related to medical services; the patient should be aware of the available resources of the medical institution and the diagnostic and treatment methods applied; and the patient has the right to obtain the information about the prices of services and methods of payment of these services in advance,

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<sup>12</sup> See also section on the Right to Free Choice, later in this Chapter.

when services are being offered. Particularly, **Section 1 of Article 18** states that a patient has the right to the following information:

- “a) Available resources of healthcare services, the methods of accessing these services, as well as the tariffs and methods of payment;
- b) The rights and responsibilities of the patient stipulated by legislation of Georgia and bylaws of the medical institution;
- c) Proposed preventive, diagnostic, therapeutic and rehabilitation procedures the patient will be subjected to and the potential risks and benefits of each procedure;
- d) Results of medical investigation;
- e) Alternatives to the proposed medical procedures and the potential risks and benefits of alternative procedures;
- f) Possible results of refusal of proposed medical procedure;
- g) Diagnosis, prognosis and ongoing treatment;
- h) The identity, status and professional experience of healthcare provider.”

When the patient, due to age or health condition, lacks decision-making capacity, the relative(s) or legal representative of that patient is entitled to receive the above information (**Article 18.4**).

While providing information to the patient or to the family members of the patient, the capacity of the people receiving the information to understand shall be considered; specific medical terminology shall be avoided and used as rarely as possible, in order to ensure that the patient and/or his/her relatives do not fail to understand all details related to the patient’s health and the care offered. This is clearly provided in the **Article 19** of the same law:

*“When information is provided to the patient or his/her relative or legal representative, his/her capacity to understand shall be taken into consideration. Specific terminology shall be minimized when explanations are given.”*

The Law on the Rights of Patients sets out the conditions for withholding information from the parents or legal representatives of an adolescent between the ages of 14 and 18 upon his/her request (*See “Right to Privacy and Confidentiality”*).

There is a strong and long-lasting tradition in Georgia to “protect” patients from receiving “bad news” or harmful information about their health, even among health care providers. However, as specified above, the law clearly provides for informing the patient. The same Law, as an exception, defines conditions for withholding information or part of the information from the patient. Such exception is saved for the cases when there is well-grounded supposition that the provision of information may be harmful for the patient. However, despite the assumptions of the doctor, if the patient explicitly asks for the information, he/she is entitled to receive complete information about his/her health condition (**Article 18, paragraph 2**):



*“Information on the patient’s health status may only be withheld or limited, if there is valid assumption that complete information would seriously harm the patient. The Patient shall receive information if he/she expressly requires information.”*

It is important to highlight that the doctor cannot decide on withholding information from the patient independently. Such a decision must be authorized by the Medical Ethics Committee. If such a committee does not exist at the medical institution where a doctor practices, the decision of the doctor must be supported by another doctor. In any case, “the decision about withholding or limiting the patient’s information shall be entered in the medical record of the patient” (**Article 18, paragraph 3**).

The law also acknowledges the right of the patient not to be informed; however, this right also has exceptions. Particularly, **Article 20** of the Law on the Rights of the Patients says the following:

*“A Patient shall have the right to refuse to receive information specified in paragraph “1” of Article “18”, with the exception of cases when withholding information may cause serious damage to the patient or to a third party.”*

Very often, health care providers in Georgia still speak to the relatives or people closely related to the patient about his/her health and care without clear consent of the patient. This tradition contradicts current legislation. Particularly, the Law on the Rights of Patients explicitly requires that it should be the patient, who makes decisions regarding who is to be informed about his/her health and care.<sup>13</sup>

Similar to the Law on Health Care, the Law on the Rights of Patients also grants patients the right to a second opinion. Patients are entitled to “freely apply to another physician or healthcare institution to seek a second opinion” (**Article 7**).

The Law on the Rights of Patients also defines the right of the patient and/or his/her representative (if patient lacks decision-making capacity) to **access information contained in medical records** of the patient (**Article 17**). Particularly, they have the right:

*“a) To access information included in medical records and to require the amending of information about the patient. Medical records shall contain the amended information entered by patient, his/her relative or legal representative as well as the information that existed in the file before amendment was made.*

*b) To require the receiving of copies of any part of the medical records.”*

The request about accessing medical records and/or about receiving copies from medical records shall be presented in written form (**Article 17.2** of the same Law).

To conclude, the Law on the Rights of Patients regulates practically all aspects of the right to information, including the right not to be informed and the very strict conditions for withholding information from the patient in his/her own health interests.

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<sup>13</sup>Except the cases when he/she does not wish to be informed, and his/her wish can be honoured.

See also the section on the Right to Privacy and Confidentiality, later in this Chapter.



## Law on Doctor's Professional Activity

The Law on Doctor's Professional Activity establishes the duties of Doctors to inform patients and/or their representatives about the health condition of the patient and about proposed care. These duties are based on the rights of patients to receive information as outlined in the Law on the Rights of Patients. Therefore, the wording that specifies duties of doctors in the Law on Doctor's Professional Activity (**Articles 39-43**) almost coincides with the wording defining patients' rights in the Law on the Rights of Patients. These duties are further specified in the Chapter "National Provider Rights and Responsibilities" (See section "Responsibility to inform patients and/or their representatives") of this Practitioner Guide.

## Law on Public Health

In the Law on Public Health the right to information is mentioned in the context of vaccination; specifically, the law stipulates that everyone has the right to receive information about vaccination and related issues such as purpose, expected outcomes, risks etc. (**Article 5.2.d**).

## Law on HIV Infection/AIDS

According to the new Law on HIV/AIDS (adopted in 2009), a person who has been tested for HIV infection must be provided "with complete information on his/her health status, if he/she does not refuse to obtain this information" (**Article 8.2**). The exception to this rule (withholding information) is regulated by the Law on the Rights of Patients (See above).

These persons shall also be provided with information on the applicable preventive measures in order to ensure the safety of others, the disobedience of which results in relevant legal responsibility (punishment) under the Georgian Legislation (**Article 8.3**). According to the Criminal Code of Georgia, transmitting HIV by intent, or transmitting of HIV by negligence (when carrying out professional duties) or constituting threat of HIV transmission by intent is punishable (**Article 131**). The punishment is imprisonment for 8 years in the first case and for 5 years in the last two cases.

## Law on Psychiatric Care

There are specific provisions in the law granting the right to information to patients with psychiatric disorders. These provisions are very similar to corresponding provisions included in the Law on the Rights of Patients. Particularly, the Law on Psychiatric Care provides for the following:

- ✓ The patient has a right to receive complete, objective, timely and understandable information about his/her health and planned psychiatric care. If the patient is not able to make an informed decision, then the legal representative shall be provided with the above information. In the absence of a legal representative, the patient's relative must be informed (**Article 5.1.g**).
- ✓ The patient has a right to access his/her medical records. However, according to the same Law, the doctor defines the volume of the information in the record and the method of communication to the patient (**Article 5.1.d**).

- ✓ The doctor may withhold the information completely or partly, due to the particular interests of the patient. However, this shall be recorded in the patient's medical records (**Article 9.1**).
- ✓ The person who, while implementing professional duties, receives information about a psychiatric disorder of another person and intentionally or accidentally uses such information to the detriment of this or a third person shall be punished according to the law (**Article 26.1**). The Law on Psychiatric Care does not specify what the punishment is.
- ✓ Information may be provided to third parties only upon consent of the patient or his/her legal representative, or upon the decision of the court (**Article 26.3**). In addition the information may be also disclosed if the patient or third parties face any danger (**Article 26.4**).

### c) Supporting Regulations/Bylaws/Orders

Order of the Minister of Labour, Health and Social Affairs No 198/n of 17.06.2002 on "Keeping Medical Records at Medical Institutions" regulates the rules for keeping medical records at health care institutions, including length of time and rules on how to access these records and to ask for copies. The order was developed based on Article 56 of the Law on Doctor's Professional Activity.

The length of time required for record keeping is different for different types of documents. Patient records are kept at the archive of each medical institution: at a hospital, patient records are kept for 15 years, and at out-patient institutions, for 5 years. After the time has expired, records are assessed by the Expert Commission of Medical Institution (established at each institution) and they are either destroyed or transferred to the State Archive.

### d) Provider Codes of Ethics

According to the **Ethics Code of Georgian Physicians**, a physician shall respect patients' rights to participate in decision-making concerning their health. Furthermore, the Code says that informed consent is a fundamental principle in the relationship with the patient. These provisions of the Code imply that patients have to be informed about their health condition and the care being offered or provided to them.

### e) Other Relevant Sources

#### International Treaties

The Council of Europe Convention on Human Rights and Biomedicine<sup>14</sup> and its additional Protocols concerning Transplantation of Organs and Tissues of Human Origin<sup>15</sup> and concerning Biomedical Research<sup>16</sup>

The Convention and its protocols explicitly require that a patient has the right "to know any information collected about his or her health. However, the wishes of individuals not to be so informed shall be observed" (**Convention on Human Rights and Biomedicine, Article 10.2**).

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<sup>14</sup> Entered into force in Georgia on 01.03.2001.

<sup>15</sup> Entered into force in Georgia on 01.05.2006.

<sup>16</sup> Entered into force in Georgia on 01.08.2010.

The Convention stipulates that national legislation may place restrictions on the afore-mentioned rights in the interest of the patient (**Article 10.3**). This implies the possibility, as an exception, to withhold information from the patient or to provide information to the patient against his/her will.

Furthermore, the **Protocol concerning Transplantation of Organs and Tissues of Human Origin** provides for giving the recipient as well as the donor the appropriate information about the purpose, risks and alternatives of the intervention proposed (**Articles 5 and 12**).

In addition, donors *“shall also be informed of the rights and the safeguards prescribed by law for the protection of the donor”* (Article 12).

The **Protocol concerning Biomedical Research** stipulates for providing potential research subjects with comprehensible and adequate information, which shall be documented (**Articles 13**). According to the second paragraph of the same Article, this information shall include *“the purpose, the overall plan and the possible risks and benefits of the research project,”* also the opinion of the research ethics committee that considered the research project. Furthermore, the potential research subject also must be informed:

- “i. Of the nature, extent and duration of the procedures involved, in particular, details of any burden imposed by the research project;
- ii. Of available preventive, diagnostic and therapeutic procedures;
- iii. Of the arrangements for responding to adverse events or the concerns of research participants;
- iv. Of arrangements to ensure respect for private life and ensure the confidentiality of personal data;
- v. Of arrangements for access to information relevant to the participant arising from the research and to its overall results;
- vi. Of the arrangements for fair compensation in the case of damage;
- vii. Of any potentially foreseen further uses, including commercial uses, of the research results, data or biological materials;
- viii. Of the source of funding of the research project.”

## f) Practical Examples

### 1. Examples of Compliance

- The surgeon Dr. A offers the patient Mr. J a surgical procedure to cure his health problem (which is not an acute condition). The patient finds it difficult to agree on the operation, and wants to obtain a second opinion from Doctor B. Therefore, Mr. J asks Dr. A to provide him with his medical records. Patient J’s request is refused on the grounds that the medical documents are the property of the hospital. However, the patient was provided with the copies of all relevant parts of his medical records. (Example collected by the authors)
- Patient Mrs. K is diagnosed as having colon cancer with metastasis to adjacent as well as distant organs. She seems to be frightened while expecting news from her attending doctor, Dr. G. The latter thinks that the patient has a “fragile” state of mind, and decides not to tell her about the diagnosis. Dr. G discusses the case with his colleague Dr. H. They agree that it is in the best interest of Mrs. K for her not to be informed about the diagnosis; and they decide that Dr. G will tell the patient that she has a chronic condition of her large intestine, with exacerbation

tions and remissions, which needs long-term treatment. The decision is documented in the medical records of the patient. When Dr. G informs Mrs. K about her health condition, she has doubts concerning the diagnosis, and says that she is sure she has cancer. The patient asks Dr. G to give her the opportunity to look into her medical records. Dr. G promises that he will see the patient again in half an hour. Dr. G consults again with Dr. H. They decide to provide the patient with true information, as she has full decision-making capacity, and explicitly requires full information about her health. (Example collected by the authors)

## 2. Examples of Violation:

The surgeon **Dr. A** offers the patient **Mr. J** a surgical procedure due to his health problem (which is not an acute condition). The patient finds it difficult to agree on the operation and wants to obtain a second opinion from **Dr. B**. Therefore, Mr. J asks **Dr. A** to provide him with copy of his medical records. **Dr. A** refuses to give the copy saying that the medical documents are the property of the hospital, and that they have been created to be used by health care professionals. After involvement of the health care ombudsman (functioning at the office of Georgian Health Law and Bioethics Society) **Dr. A** provided the patient with the copy of his medical records. (Example reported by the “Health Care Ombudsman Office”<sup>17</sup>)

Patient **Mrs. K** is diagnosed as having colon cancer with metastasis to adjacent as well as distant organs. She seems to be frightened while expecting news from her attending doctor **Dr. G**. The latter thinks that the patient has a “fragile” state of mind, and decides not tell the patient about the diagnosis. **Dr. G** discusses the case with his colleague **Dr. H**. They agree that it is in the best interest of **Mrs. K** not to be informed about the diagnosis; and they decide that **Dr. G** will tell the patient that she has a chronic condition of her large intestine, with exacerbations and remissions, which needs long-term treatment. The decision is documented in the medical records of the patient. When **Dr. G** informs **Mrs. K** about her health condition, she has doubts concerning the diagnosis, and says that she is sure she has cancer. The patient asks **Dr. G** to give her the opportunity to look into her medical records. **Mrs. K**'s request is refused. However, later, after consulting with the patient's husband, medical personnel creates a duplicate of **Mrs. K**'s medical records, in which the diagnosis is specified to be inflammatory bowel disease. After reading the document, the patient seems to be suspicious. However, she does not contest it anymore, and seems convinced that she does not have cancer.

## 3. Actual Cases

No actual legal cases were available as examples for this section.

### g) Practice Notes for Lawyers

- While doctors have a responsibility to explicitly inform patients about their health conditions, prognoses and possible treatment, they have a right to withhold information in exceptional cases. Such a decision is based on the principle of “do no harm,” i.e. if a doctor has valid grounds that the true information may harm the patient, the doctor can withhold information (e.g. about severe diagnosis or prognosis). However, the law requires that the doctor consult

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<sup>17</sup> “Health Care Ombudsman office” was functioning from 2001 to 2007 at the NGO “Georgian Health Law and Bioethics Society”.

with the medical ethics committee of the institution or, if such committee does not exist, with another colleague/doctor (who agrees with doctor's decision to withhold after hearing all of the information). In any case such a decision should be documented in the patient's medical record. Lastly, if a competent patient explicitly requires information, he/she shall be informed completely regardless of the doctor's views. The patient has a right to initiate legal action against the doctor who does not tell the true information to the patient once the patient learns about this. In such a case, if the patient had not explicitly required information, the doctor's action could be justified if the doctor:

- Had sound reasons for not informing the patient;
  - Has consulted with ethics committee or another colleague/doctor; and
  - Has documented all this information in the medical records of the patient (information about reasons for withholding information, that the patient does not explicitly require information, the fact that the committee or colleague/doctor has been consulted and their consent has been obtained).
- In many cases, a patient's right to information is intermingled with the right to free choice. For the right to free choice to exist, healthcare providers must guarantee that the patient was actually given the opportunity to choose from different providers offering essentially the same services for essentially the same cost. The lawyer must not only rely on the document issued by the Ministry of Labour, Health and Social Affairs as proof that the patient was provided with appropriate and comprehensive information about alternative medical institutions and medical professionals that could offer similar treatment.
  - The State does not have the right to conceal information about the existence (or non-existence) of an environment harmful to the health of population, i.e. the State must provide information to the population in a "timely" manner. However, there is no definition included of "timely." To claim that the State has violated such obligations, it must be ascertained that the State organs were themselves aware of the threat factors. The State can only be held responsible if the State (or its organs) were informed about the threat factors detrimental to the health of the population. Considering the above-mentioned, proving the violation by the State might be impeded. However, it is still possible to make the State liable for violating its positive obligations. Two important sources on this issue include the following: (1) Constitution of Georgia, Article 37.5: "A person shall have the right to receive complete, objective and timely information as to the state of his/her working and living environment," and (2) the Law on the Rights of Patients, Article 16: "1. Every citizen of Georgia shall have the right to receive comprehensive, objective and timely information on factors which improve or have a negative influence on health," and "2. The State shall provide citizens with the information specified in paragraph 1 of this article via mass media or individually, upon request, in accordance with existing regulations."

#### **h) Cross-referencing Relevant International and Regional Rights**

Please find a discussion of international and regional standards relevant to the Right to Information in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## Right to Consent

### a) Right 4 as Stated 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 right to consent is the core of patient's rights, and is based, or is derived from, the principle of respect of the *autonomy of the patient*, and, in a broader sense, from the principle of *respect for persons and the dignity of individuals*. The right to consent (informed consent) in general terms is explicitly outlined in the Law on Health Care, and is further specified in the Law on the Rights of Patients, and a number of specific laws regulating different branches of medicine (transplantation, HIV/AIDS, psychiatry etc.).

### b) Right as Stated in Country Constitution/Legislation

#### Constitution of Georgia

There is no specific provision on the right to consent in the context of health care in the Constitution of Georgia. However, the Constitution stipulates the inviolability of "*honor and dignity of an individual*" (**Article 17.1**). According to the second paragraph of this Article, treatment "*infringing upon honor and dignity shall be impermissible.*" Inviolability of honor and dignity of an individual in the context of health care is to be implemented by respecting the autonomy of the patients, and giving them the possibility to participate in the decision-making process concerning their own health care. This means that patients have to be asked for informed consent before carrying out any medical intervention on them.

#### Legislation

##### Law on Health Care

Principles of the State policy in the field of health care are set out in **Article 4** of the Law on Health Care. One of the main principles of the State policy requires that dignity, honor and autonomy of patients are recognized:

a) "The principles of the state policy in the field of health care are the following:  
(...)

b) To provide the protection of human rights and freedoms in the field of health care, the recognition of patient's dignity, honor and autonomy.  
(...)"

Further, the law defines respect for a person's dignity and honor as ethical values, which should guide doctors, particularly according to **Article 30** of the Law:

“During the accomplishment of medical activity, medical personnel should be guided by ethics values - principles of respect for a person’s dignity, honor, justice (...)”

The Law on Health Care is the first Georgian Law which introduces and defines the term “*informed consent*” and establishes informed consent (written or oral) as an essential prerequisite for participation of the patient in any health care procedure (**Article 8.1**). The list of medical interventions requiring written consent is specified in the Law on the Rights of Patients (*See below*).

The law also requires that patients are asked for consent before involving them in education/teaching of medical students and trainees. According to **paragraph 3 of Article 8**, “*verbal informed consent is the necessary condition for a patient’s participation in the medical educational process.*”

Patients have the right to refuse to undergo any kind of medical treatment/intervention (**Article 9**). Exceptions are to be established by legislation, and these are mostly exceptions established in the interest of public health (e.g. **Article 75** of the Law on Health Care – immunization, quarantine measures, curative and preventive measures taken for citizens with high risk of development of communicable diseases). Further, **Article 76** obliges citizens to carry out all necessary examinations “*to confirm the substantiated suspicion on the existence of particularly dangerous contagious disease.*” It is important to highlight that the exceptions from the rule of informed consent can only be established by legislation, so that nobody could carry out any medical intervention without the patient’s informed decision, if such an exception is not stipulated by law.

The Law on Health Care provides also for the possibility to make advanced wills about end-of-life care, which may include resuscitation, life sustaining and/or palliative care.<sup>18</sup> Particularly, according to **Article 10**, “*all capable persons have the right to express in advance in written form their will on conduction of resuscitation, life sustaining or palliative treatment at a terminal stage of the incurable disease.*”

The same Law requires that such advanced wills (if they exist) are taken into consideration by health care providers when they provide care to, or carry out research or education activities involving incapable or mentally disabled patients. If such a document does not exist, consent for care or for involvement of the patient in research or education is obtained from the patient’s relative and/or legal representative (**Article 11**).

Detailed criteria for involvement of patients in biomedical research are outlined in **Articles 105-112 (Chapter XIX Biomedical Research)**. According to **Article 109**, biomedical research “*should not be performed without a written informed consent of the person participating in the research,*” and before obtaining such consent, research participants (research subjects) shall be fully informed about “*goals, methods, expected results of research, (...) risk of research, and possible inconvenience related to this research.*” The Law gives research subjects the right to refuse to participate in the research project, or to withdraw prior consent. It is required that all participants are informed in advance about the above-mentioned right (**Article 109**).

For involvement of an incapable person in research, consent of his/her legal representative is required. In addition, “*if an incapable person has the ability of understanding, his/her consent is also required*”

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<sup>18</sup> See also section on the Right to Make Advanced Will, later in this Chapter.



(**Article 110**). There are additional conditions for carrying out research on incapable persons (also, for pregnant and breastfeeding women), which are outlined in **Article 111**.

The only situation defined by law when medical care can be carried out *without a patient's consent* or authorization from patient's legal representative is that of a clinical emergency. In such cases, the decision on medical care shall be made according to patient's best interest (**Article 12**). As already mentioned, advanced wills (when they exist) have to be taken into consideration (**Article 11**).

### Law on the Rights of Patients

According to the Law on the Rights of Patients, informed consent is defined as consent to medical services given by the patient, or in case of the patient's incapacity, by his/her legal representative, after the patient is provided with information about the nature and need of the medical service, its expected results, the risks that the service entails for the patient's health and life, the alternative types of services and the expected results and risks related to the alternative intervention, the consequence of refusal to treatment, and finally, about the financial and social aspects related to treatment or non-treatment (**Article 4.b**).

Informed consent is an obligatory prerequisite for any medical intervention, and informed consent shall be obtained before medical service is carried out (**Article 22.1**). There is no further specification on how early consent must be obtained.

It is important that the Law on the Rights of Patients specifically grants the right to competent patients to refuse, or to stop the process of medical care at any stage. However, the Law requires that the patient be *"thoroughly informed about the expected outcomes of refusal or cessation of medical services"* (**Article 23.1**).

The law prohibits any medical intervention against the will of a competent patient with decision-making capacity, except in cases defined by Law (**Article 23.2**). One such case is defined by the same Law: according to **Article 36.2**, *"A woman in labor shall not have the right to refuse medical intervention which is necessary for the birth of a living fetus, and which bears minimal risk to the health and life of the woman in labor."* Among other exceptions are the those defined by the Law on Health Care (**Articles 9 and 75**), and by the Law on Public Health (**Articles 5.2.b and 10.3**).

The list of services for which *written informed consent* must be obtained includes the following (**Article 22.2**): surgery, except minor surgery; abortion; contraception surgery – sterilization; central blood vessels catheterization; hemodialysis and peritoneal dialysis; extra-corporal fertilization; genetic tests, gene therapy; radiotherapy; chemotherapy for malignancies. The same article gives the right to a healthcare provider to ask for and obtain written consent when he/she considers it necessary. Such a provision is very important, as it is practically impossible to develop an exhaustive list of services that carry risks that require written informed consent to be given.

If the patient is not competent, informed consent must be obtained from the patient's relative/legal representative (**Article 22**), and such consent/authorization must be given in writing (**Article 22.3**). However, in emergency clinical situations, when an incompetent patient, or a patient who lacks decision-making capacity (e.g. patient in coma) urgently needs medical care because of a severe health condition (which may cause disability, serious deterioration of health, or death), health care providers



are entitled to decide about the medical care of the patient in accordance with the patient's health interests, without consent/authorization (**Article 25.2**). Advanced wills have to be taken into consideration; however, an advanced will can be related only to care at the end stage of an incurable disease, or to a disease or condition which eventually will cause severe disability (**Article 24.1** of the same Law, and **Articles 10-11 of the Law on Health Care**).

The Law also includes provisions that regulate situations in which decisions of the patient's legal representative are against the health interest of the patient. In such circumstances, the Law envisages two possibilities: (a) if time allows, the health care provider can appeal to court and ask for authorization of the treatment/intervention that is in the best interest of the patient (**Article 25.3**); or (b) if it is a clinical emergency and the legal representative does not consent to life-saving care, the health care provider is entitled to "*make the decision in accordance with patient's health interests*" (**Article 25.3**).

The law defines cases when a patient who, due to his/her age is not fully competent according to Georgian legislation (i.e. is under 18), can independently give informed consent. This includes the following situations:

- Patients between 16 and 18 have the right to give informed consent or to refuse medical care if, in the opinion of the healthcare provider, the patient has the capacity to understand his/her health status. In such cases, a relative or legal representative of the patient must be informed about the patient's decision; however, they cannot oppose it, as their consent is not required (**Article 41.3**).
- Patients between 14 and 18 have the right to give informed consent, or to refuse medical care related to sexually-transmitted disease, or drug abuse, or non-surgical methods of contraception or abortion, if, in the opinion of the healthcare provider, the patient has the capacity to understand his/her health status (Article 41.1). In such cases, the request of the patient not to inform his/her parents or legal representative shall be honored by the health care provider.<sup>19</sup>

Like the Law on Health Care, the Law on the Rights of Patients envisages the right to express advanced wishes in writing about resuscitation, life-saving treatment and/or palliative care. However, according to the Law on the Rights of Patients, such wishes apply to two different situations (**Article 24.1**):

- a) Terminal stage of incurable disease; or
- b) Disease or condition, which will eventually cause severe disability.

Therefore, in addition to the terminal stage of incurable disease as defined by the Law on Health Care (Articles 10-11), the Law on the Rights of Patients envisages one more medical situation for which advanced wishes may be expressed: a condition that could lead to severe disability. Because the Law on the Rights of Patients is more recent than the Law on Health Care, the Law on Patients' Rights prevails; and cases in which advanced wills can be made are broader than in the definition given by the Law on Health Care.

In addition, citizens are entitled to **appoint another person in advance** who will make decisions about their health care in the afore-mentioned situations (**Article 24.2**). If the patient has not

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<sup>19</sup> For more details, see section on the Right to Privacy and Confidentiality, later in this Chapter.

appointed anyone in advance, and is not in a position to make informed decisions, their relatives are entitled to make decisions on his/her behalf, according to an order fixed by law.<sup>20</sup> (In case the patient has a legal representative, it is the legal representative who is entitled to make decisions on behalf of the patient.)

The Law on the Rights of Patients requires that informed consent is obtained before a patient is involved in medical education/teaching (**Article 26.1**). However, consent is not required when a patient's data or biological materials are used for education/teaching in such a way that identification of the patient is not possible (**Article 26.2**).

### The Law on Doctor's Professional Activity

The law on Doctor's Professional Activity enforces the same rights of patients related to consent; however, it does so using the "language" of obligations.<sup>21</sup> This gives the possibility to introduce disciplinary sanctions against doctors if they fail to fulfill their obligation to obtain informed consent, or to correctly identify situations when they can carry out medical intervention without consent or authorization.<sup>22</sup>

### Law on Public Health

The right to consent or refuse to undergo medical interventions in the context of public health has specific limitations. According to the Law on Public Health, a person whose professional activity is associated with a high risk of dissemination of communicable diseases cannot refuse to undergo preventive measures (**Article 5.2.b**). Also, if a person is proven to be infected with a communicable disease, they can be requested to undergo a medical examination and/or medical treatment, and/or receive medical counseling (**Article 10.3**).

Public health services personnel make the decision about isolating a person, or applying quarantine measures to a person, without prejudice to the principles of the European Convention on Human Rights and Fundamental Freedoms (**Article 11.3**). The person can appeal to court against such a decision (**Article 11.2**).<sup>23</sup> In a state of emergency, decisions about an individual's isolation or about applying quarantine measures to individuals are implemented by the Department for Management of Emergency Situations of the Ministry of Internal Affairs (**Article 11.1**).

### Law on HIV Infection/AIDS

The recent Law on HIV Infection/AIDS provides for voluntary testing of HIV. Particularly, it states that, "*HIV testing of individuals shall only be conducted after the person concerned has given voluntary and informed consent to it*" (**Article 6.2**). On the other hand, the law defines a few cases when the person does not have the right to refuse HIV testing, i.e. when HIV testing is obligatory. Particularly, HIV testing is obligatory for the following persons (**Article 6.3**):

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<sup>20</sup> As the list of heirs at law can be found in the Civil Code, see connected paragraph under the sub-section Other Relevant Sources below.

<sup>21</sup> See section on the Responsibility to Obtain Informed Consent in Chapter VII.

<sup>22</sup> For more details, see Chapter VIII on National Procedures.

<sup>23</sup> In this case, court procedure will be faster than a usual procedure.

- “Blood donors and donors of products of blood;
- Donors of organs and parts of organs;
- Donors of tissues; and
- Donors of ovum and sperm.”

These individuals can refuse to be donors, and consequently, they will not be obliged to undergo HIV testing. However, if they decide to be donors (of blood, organs, etc.), they have to undergo HIV testing.

According to **Article 6.5**, other cases in which HIV testing is mandatory shall only be defined by law. That means that no one can issue an order about involuntary HIV testing, if such specific case is not stipulated by law.

### Law on Human Organ Transplantation

The Law on Human Organ Transplantation requires that written informed consent is obtained prior to obtaining an organ from an “alive” competent donor; however, the law defines other safeguarding criteria as well (**Article 18**). Explanations given before consent shall include the following (**Article 21**):

- “The kind of surgical intervention required for the taking of an organ, its complexity, risk to life accompanying this operation, possible immediate and remote, direct and indirect impacts of the operation on the donor’s health;
- Expected results from transplantation of the organ taken from a living donor, including success and failure possibilities;
- All possible circumstances that can affect the donor’s decision.”

The law permits obtaining bone marrow for transplantation from a person who, due to age, *is not fully competent* only if the bone marrow shall be transplanted to a blood relative (i.e. for a sibling) of the first or second order and the following conditions are met (**Article 20**):

- ✓ “No other therapeutic option exists for the recipient;
- ✓ Taking of bone marrow will not affect the health of the donor; this shall be confirmed by two independent duly-certified (licensed) physicians;
- ✓ The personal attitude of a potential donor (minor) towards the procedure allows medical intervention;
- ✓ Informed consent from parent(s) has been obtained; or, in case the minor has no parents, informed consent/authorization from a legal representative has been obtained; in the latter case consent “shall be attested by the respective body in charge of guardianship and care.”

The law establishes a so-called “opt in” system of “donorship”, which means that any competent person has the right to voluntarily declare his/her consent or refuse to take his/her organ post mortem. Such a decision must be made in writing, confirmed by the medical institution, and sent to the Transplantation Information Center, which runs the donors’ register (**Article 4-6**).

So, organs from a deceased person can be obtained for the purpose of transplantation only if his/her advanced consent, as defined by law, exists; or if an advanced will does not exist, the following two conditions are met (**Article 8**):

It is clear that organ donation “does not contradict the religious beliefs and ethical principles of the deceased”; and

A relative gives consent to take an organ from the deceased.

The list of relatives according to priority of who can give consent for or refuse organ removal is articulated in **Article 9** of the same Law.

### **Civil Code**

**Article 1336** of the Civil Code contains the list of those entitled to make decisions on behalf of a patient who has not appointed a surrogate decision-maker in advance, and who is not in a position to make their own decisions. The list of heirs at law identifies five grades or lines of heirs:

- ✓ “Line I: children, spouse, parents; grandchildren;
- ✓ Line II: sisters and brothers; their children;
- ✓ Line III: grandparents; their parents;
- ✓ Line IV: uncles, aunts;
- ✓ Line V: nephews, nieces.”

### **c) Supporting Regulations/Bylaws/Orders**

Based on the Law on Human Organ Transplantation, the joint Order of the Ministry of Labour, Health and Social Affairs and the Ministry of Justice No 463 was issued on 30.11.2001, which approves the rules for registering the will regarding organ donation. It outlines detailed procedures and includes various forms, such as the informed consent form of a donor.

### **d) Provider Codes of Ethics**

According to the **Ethics Code of Georgian Physicians**, a physician in Georgia “*respects a patient’s individuality, culture, spiritual and moral values.*” Further, the Code requires that a physician recognize a patient’s right to participate in the decision-making process concerning his or her own health. Moreover, it states “*informed consent is a fundamental principle in relationship with the patient*” (**Chapter “Physician and Patient,” paragraphs 1 and 3**).

## e) Other Relevant Source

### International Treaties

The Council of Europe Convention on Human Rights and Biomedicine<sup>24</sup> and its additional Protocols concerning Transplantation of Organs and Tissues of Human Origin<sup>25</sup> and concerning Biomedical Research<sup>26</sup>

These international treaties explicitly require that informed consent is obtained prior to medical intervention or prior to involvement of persons in biomedical research (**Article 5** of the Convention, **Article 13** of the Protocol concerning Transplantation of Organs and Tissues of Human Origin and **Article 14** of the Protocol concerning Biomedical Research).

## f) Practical Examples

### Example(s) of Compliance

- The patient Mr. D needs a surgical operation due to acute appendicitis. His doctor, Dr. J, concludes that the patient is in a condition to understand all relevant information, has a clear mind, and is able to make an informed decision. He asks if the patient wishes to discuss his situation in the presence of his wife. Mr. D answers positively, so his wife is invited to join them. Then Dr. J discusses with the couple Mr. D's health situation, and gives them all the information about the diagnosis, the treatment needed, the risks and benefits associated with the proposed operation, as well as the financial aspects, and the expected results of non-treatment. After answering some questions, and clarifying issues related to anesthesia and post-surgery care, Mr. D gives his consent in written form. **(Example collected by the authors)**
- The parents of a 2-year-old child refuse lumbar puncture, which is urgently needed to initiate adequate treatment and save the life of the child. The parents are given detailed information about the consequences of refusal. However, they still do not agree. Then parents are informed that health care providers are entitled to carry out urgent interventions to save the life of the child, even against the will of parents, and the hospital administration initiates the contacting of the hospital guard and police station because the parents were trying to prevent health care personnel from carrying out lumbar puncture. Parents finally agree to the intervention, which was carried out successfully.<sup>27</sup> **(Example collected by the authors)**

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<sup>24</sup> Entered into force in Georgia on 01.03.2001.

<sup>25</sup> Entered into force in Georgia on 01.05.2006.

<sup>26</sup> Entered into force in Georgia on 01.08.2010.

<sup>27</sup> In cases in which an intervention, due to the fact that there is a life indication, could be performed by the health care providers without parental consent, it is still recommended, if time allows, to proceed as follows: first, to give clear information to the parents that doctors have the right to proceed without parental consent in such cases, as the intervention (examination, treatment, operation etc.) is needed in order to save their child's life; and second, to perform the necessary intervention even if the parents refused to give their consent. Although health care providers are not bound by legislation to convince the parents and get their consent, most of the parents would be convinced under such circumstances, and such a scenario is much better both for the health care professionals involved, and the parents and child (whose situation is difficult enough already because of the child's health problem).

## 2. Example(s) of Violation

- The patient **Mr. D** needs a surgical operation due to acute appendicitis. **Dr. J** concludes that the patient has a clear mind and is in a condition to understand all the relevant information. However, he decides not to bother the patient, and discusses the situation separately with the patient's wife. He gives her all information about her husband's health condition, the treatment needed, its associated risks and benefits, the financial aspects, as well as the expected results of non-treatment. The wife of the patient agrees to the operation and signs the informed consent form. **(Hypothetical example)**
- **Mrs. H** experienced serious health problems while being pregnant, and arrived to the hospital in a critical condition. **Dr. G** examined her and discovered that the fetus was no longer alive and informed Mrs. H that an operation was needed immediately in order to save her life. **Mrs. H** gave her consent to the operation in written form. While performing the operation, **Dr. G** decided not only to remove the dead fetus, but also to sterilize Mrs. H in order to prevent her from getting into a similar situation in the future, although there were no signs that similar difficulties would arise in case of a future pregnancy. When **Mrs. H** discovered what happened and complained, **Dr. G** argued that she should be grateful that she had to undergo only one operation instead of two (first, because of the dead fetus in her womb, and second, to be sterilized).

## 3. Actual Cases

No actual legal cases were available as examples for this section.

### g) Practice Notes for Lawyers

- In case of a conflict **between surrogate decision-makers**, i.e. heirs- at- law of the same line that would take different decisions on the behalf of the same patient, the legislation does not provide direct guidance. If time allows, the most appropriate action would be to apply to court; yet if there is an emergency, health care providers are entitled by law to do whatever is in the best interest of the patient. This approach is based on the extrapolation of the articles of the Law on the Rights of Patients that are related to situations when health care providers think that the decision of the proxies are against the interests of the patient, or when the proxies could not be contacted in time (Law on Patients' Rights, Article 25).
- **Right to Consent in the Context of Blood Transfusion for Treatment to Jehovah's Witnesses**

The doctrine of informed consent and the right to refuse any treatment can be clearly described using the example of blood transfusions for treatment purposes to Jehovah's Witnesses.

### Problem Description

It is well known that Jehovah's Witnesses (a religious denomination) reject blood transfusion even when this type of medical assistance is vital for saving the patient's life.

In such instances medical personnel face a dilemma: on one hand, their duty is to assist the patient; on the other hand, the patient, his/her family member, or legal representative does not allow medical personnel to perform their duty. Rendering medical assistance (blood transfusion) in such cases will be definitely linked to violence and coercion, which is also unacceptable in the relations between a doctor and a patient.

From the perspective of legal and medical ethics, this dilemma is based on the conflict between the **principle of patient's autonomy** (duty of the doctor to respect patient's choices) recognized universally, including in Georgian legislation, and the **principle of beneficence** (duty of the doctor to assist the patient).

### Interpreting Georgian Legislation

Health care legislation of Georgia (laws on "Health Care", on "the Rights of Patients" and on "Doctor's Professional Activity") straightforwardly stipulates that a patient who is legally capable and able to make a conscious decision enjoys the right to decide on allowing or rejecting medical intervention. In that case, the patient's decision is final. Medical personnel do not have the right to carry out medical intervention, which the patient is against, except in cases established by law.

This means that medical personnel do not have the right to transfuse blood to competent Jehovah's Witnesses having conscious decision-making capacity, if the patient is against blood transfusion.

Different rules are established in case the patient is incompetent (a minor or one recognized by the court as incompetent due to mental disease or imbecility) and requires urgent medical care, or is in a dangerous life condition. In such cases the decision must be made according only to the health interests of the patient (**Law on Health Care: Article 12 and the Law on the Rights of Patient: Article 25, Paragraph 2**). This also applies to the situations when legal representatives (e.g. parents of the minor) are against lifesaving intervention (**Law on the Rights of Patient: Article 25, Paragraph 3**).

Hence, if the Jehovah's Witness is a minor and his/her life is in a dangerous condition or requires urgent medical care, without which death is imminent, medical personnel are authorized to transfuse blood to them, even if the medical personnel cannot contact the patient's relative or legal representative or even if the relative or legal representative are against medical intervention.

Rejection by the Jehovah's Witnesses of blood transfusion gives rise to yet another problem: rejection of blood transfusion by a delivering woman. There are instances when blood transfusion to a delivering mother is the only way to save both the life of a woman and fetus. In such cases, there is a conflict between the mother's autonomy and the life of a fetus.

Under the legislation of Georgia, delivering woman cannot reject medical care which saves the life of a fetus and does not expose the mother's health and life to any danger (**Law on the Rights of Patients, Article 36, paragraph 2**).

Thus, by recognizing, on the one hand, the supremacy of the principle of patient's autonomy, Georgian legislation allows competent persons having conscious decision-making capacity to decide whether or not to undergo medical intervention, including blood transfusion. On the other hand, the law protects incom-



petent persons, including minors, and even a fetus not yet born, from the decisions of their relatives, legal representative, or the woman in labor carrying the fetus, which expose their life to danger (e.g. through refusal of blood transfusion). The **Law on the Rights of Patients (Article 36.2)** states, for example, that “Women in labor shall not have the right to refuse medical intervention which is necessary for the birth of a living fetus and which bears minimal risk to the health and life of a woman in labor.

## **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

## **Right to Free Choice**

### **a) Right 5 as Stated in the European Charter of Patients’ Rights (ECPR)**

*Each individual has the right to freely choose from among different treatment procedures and providers on the basis of adequate information.*

The right to free choice could be interpreted in two ways with regard to the legislation of Georgia:

The right to freely choose from among different treatment procedures is linked to the broader rights to receive information and give informed consent to one of the treatments offered; and the right to choose or change health care institution or health care professional (e.g. attending doctor, general practitioner).

### **b) Right as Stated in Country Constitution/Legislation**

#### **Constitution of Georgia**

There is no specific provision on the right to choose among different treatments in the Constitution of Georgia.

#### **Legislation**

Cases in which the right to freely choose among different treatments is implied under the right to give informed consent have been extensively discussed in the sections “Right to Information” and “Right to Consent” of this chapter of the Guide. Particularly, according to the **Law on the Rights of Patients**, before providing informed consent, a patient shall receive comprehensive information about the proposed inter-

vention, as well as “*the alternative types of services and the expected results and risks related to the alternative intervention*” and about “*the consequence of refusal of treatment*” (**Article 4.b**).

In another case, the law provides that citizens of Georgia have the right “to choose or change the medical personnel and/or medical institution in correspondence with the conditions of the insurance agreement;” and an insurance agreement (plan) should provide the possibility of such a choice (**Article 14, Law on Health Care**). The same right is granted to patients by the **Law on the Rights of Patients (Article 8)**. There is one possibility to restrict this right: according to **Article 47** of the same law, “the administration of a detention institution or prison shall have the right to restrict the right of a person in detention or held in custody to choose a healthcare provider.” Such decisions of detention institution administrations may be challenged in court (**Article 47**).

Finally, patients are entitled to “*freely apply to another physician or healthcare institution to seek a second opinion*” (**Article 7, Law on the Rights of Patients**). The right to a second opinion gives the possibility to a patient to make an informed decision considering a broader spectrum of choices of treatments.

c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular right.

d) Provider Codes of Ethics

There are no provisions in existing codes of ethics on this matter.

e) Other Relevant Sources

There are no other relevant sources on this matter.

## f) Practical Examples

### 1. Example(s) of Compliance

Patient **Mrs. G** is offered a tonsillectomy by her attending doctor, **Dr. M**, who provides her with comprehensive and understandable information about the need for the operation. **Dr. M** also describes the possibility to proceed without the operation; but in this case, the patient may need long-term treatment with various medications and procedures having different success rates. The patient decides to have the operation. (**Example collected by the authors**)

### 2. Example(s) of Violation

Patient **Ms. K** is recommended a resection of her gallbladder using abdominal surgery due to gallstones. Her attending doctor, **Dr. L** provides the patient with comprehensive and understandable information about the need for the operation, the risks associated with it, as well as the financial issues of such treatment. However, **Dr. L** does not inform the patient about the possibility to cut out the gallbladder using an endoscopic procedure, which is less traumatic and, as a result, patients usually recover sooner. (**Hypothetical example**)

### 3. Actual Cases

Underage, disabled patient **D** was receiving treatment in the Jvania Children's Clinic. Her parents wanted to transfer **D** to Iashvili Children's Central Hospital. For some uncertain reasons, Jvania Children's Clinic objected to the patient's moving to Iashvili Hospital. The parents applied to the Public Defender's Office, and legal action was going to be taken with their support, but ultimately, **D** was transferred to Iashvili Children's Central Hospital. Therefore, the parents withdrew their complaint. (**Public Defender's Office Reports, 2008<sup>28</sup>**)

#### g) Practice Notes for Lawyers

See notes for the Right to Information.

#### h) Cross-referencing Relevant International and Regional Rights

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

- Right to Liberty and Security of the Person in Chapter 2 and Chapter 3.
- Right to Privacy in Chapter 2 and Chapter 3.
- Right to Freedom from Torture and Cruel, Inhuman, and Degrading Treatment in Chapter 2 and Chapter 3.
- Right to Bodily Integrity in Chapter 2 and Chapter 3.
- Right to the Highest Attainable Standard of Health in Chapter 2 and Chapter 3.

## Right to Privacy and Confidentiality

### a) Right 6 as Stated in the European Charter of Patients' Rights (ECPR)

***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.***

The right of patients to privacy and confidentiality is regulated by various laws in the field of health care.<sup>29</sup> As in the case of other patients' rights, the Law on Health Care is more general, while the Law on the Rights of Patients is more specific in defining rights. The Law on Doctor's Professional Activity defines the duties of doctors to respect privacy and maintain confidentiality; and other specific laws regulate issues of privacy and confidentiality in specific circumstances (laws on HIV Infection/AIDS, on Human Organ Transplantation, on Psychiatric Care etc.).

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<sup>29</sup> There are no general data protection laws in Georgia.

## b) Right as Stated in Country Constitution/Legislation

### Constitution of Georgia

The Constitution of Georgia provides for inviolability of private life in general. **Article 20.1** of the Constitution states:

*“Everyone’s private life, place of personal activity, personal records, correspondence, communication by telephone or other technical means, as well as messages received through technical means shall be inviolable. Restriction of the aforementioned rights shall be permissible by a court decision or also without such decision in the case of the urgent necessity provided for by law.”*

On the other hand, **Article 41.2** of the Constitution is specifically mentions that *“the information existing on official papers pertaining to an individual’s health”* shall not be accessible to anyone without the consent of the person concerned. Apparently, the aforementioned information should be considered to include information on patients contained in medical records. Particularly, the above article (Article 41, Paragraph 2) provides for the following:

*“The information existing on official papers pertaining to an individual’s health, his/her finances or other private matters, shall not be accessible to anyone without the consent of the individual in question except in the cases determined by law, when it is necessary for ensuring the state security or public safety, for the protection of health, rights and freedoms of others”.*

### Legislation

#### Law on Health Care

The Law includes the definition of **“medical secrecy”** with the following interpretation (**Article 4**):

*“The information on a patient’s physical, psychological condition, business and social activity, his/her personal or family life, received by doctor or other medical personnel during professional activity. This includes the fact of visiting a doctor and circumstances of death.”*

The term **“medical personnel”** includes professionals with or without medical education whose professional activity is related to disease prevention, diagnosis, treatment, rehabilitation and palliative care (**Article 3**).

Medical personnel of healthcare institutions have an obligation to maintain medical secrecy, which may be disclosed only if *“confidential information is necessary for public safety, protection of the rights and freedoms of others,”* or upon the request of judicial or investigatory establishments, as defined by law (**Article 42**).

Furthermore, according to **Article 152**, medical records and related documents of a deceased person are subject to medical secrecy except in cases envisaged by the above article (**Article 42**) of the Law on Health Care.

## Law on the Rights of Patients

The Law on the Rights of Patients requires that information about a patient is kept confidentially, even after the patient's death (**Article 27**).

However, there are exceptions to this rule defined by the same law. Exceptions include the following situations (**Article 28.1**):

- Patient's informed consent to disclosing confidential information is obtained;
- Nondisclosure of information will endanger the life and/or health of a third person;
- Georgian legislation provides for such an exception.

Finally, cases in which information about the patient is used for the purpose of scientific research or medical training/education and the information is presented in a manner that makes identification of the patient impossible are not considered a breach of confidentiality, and the use of such information is permitted by the same Article (**Article 28.1**).

In general, parents or legal representatives are entitled to receive information about the health of their children under 18 (**Article 40.1**). However, information about the health of a person under 18 does not have to be provided to parents or legal representatives if the patient is against the information provision, and he/she is considered either to be legally competent (i.e. is married); or is aged 14-18, and has accessed the doctor for consultation related to treatment of sexually-transmitted disease, drug abuse, non-surgical methods of contraception or termination of pregnancy (**Article 40.2**).

The law also envisages situations in which health care professionals involved in medical care of the same patient have to exchange/share information about the patient for that patient's own interest. In such cases a patient's consent to the disclosure of confidential information is presumed (**Article 28.2**). Therefore a physician can share information with other colleagues who participate in a patient's treatment and who need such information in order to provide adequate care.

Intervention into "*private and family life of the patient*" is prohibited (**Article 29**). However, the Law also establishes exceptions for this rule. Intervention into private and family life of the patient would be justified and allowed if it is necessary for (**Article 29**):

- Provision of adequate medical care to the patient concerned (i.e. for establishing diagnosis or for carrying out certain types of medical interventions);
- Protection of the health and/or life of patient's family members.

In the first case, informed consent of the competent patient is absolutely necessary; in the second case, such consent is not required by law (**Article 29**). However, in everyday practice, physicians would ask for such permission (although this is not obligatory), which helps maintain a good doctor-patient communication and relationship.

The Law on the Rights of Patients protects the privacy of patients also by establishing who can attend medical procedures provided to the patient. According to **Article 30**, "*only persons who directly participate in the providing of medical services shall attend the medical procedure.*" According to the same article, others may be invited to attend a procedure only upon the patient's consent (e.g. students), or if the patient explicitly requests the presence of these other persons (e.g. spouse or sibling). So, in order to let students observe a medical procedure, the patient must be asked for permission in advance.

It already has been mentioned in the section on the “Right to Information” that often health care providers in Georgia discuss issues that relate to the health and care of the patient with relatives or people in close relations with the patient, without clear consent of that patient. However, this is against the law, as the Law on the Rights of Patients explicitly requires that the patient makes decisions concerning who can be informed about his/her health and care. Particularly, according to **Article 21**:

*“The patient shall have the right to make the decision of whether any person can receive information about his/her health status. If the patient agrees, he/she should name the person who should be informed. Information about the decision of the patient, as well as the identity of the person named shall be entered in the medical record of the patient.”*

### **Law on Doctor’s Professional Activity**

The right of patients to privacy and confidentiality is also enforced by the Law on Doctor’s Professional Activity by obliging doctors to keep information about the patient’s health condition and private life confidential (**Chapter VII, 2.5: “Responsibility to Keep Confidentiality and Respect Patient’s Privacy”**).

### **Law on HIV Infection / AIDS**

The Law permits testing for HIV infection and respective counseling anonymously (**Article 6**). This means that citizens applying for HIV testing do not have to specify their personal data (name, date of birth, etc.). Further, **Article 9** explicitly provides for maintaining confidentiality of patients who are HIV positive. Particularly, according to the first paragraph of this article:

“A Service Providing Institution which provides HIV-infected individuals with diagnostic, preventive, treatment services and support, as well as any legal and natural person who possesses the information about a person being HIV positive, shall be responsible to maintain the confidentiality of such information in a manner established by Law”.

This obligation is binding “throughout the lifetime of the said individual as well as after his/her death” (**Article 9.2**).

There are a few exceptions defined by the Law in which the institution concerned can disclose confidential information (**Article 9.3**):

- When an informed consent for disclosing information is obtained from the HIV- infected individual;
- When there exists advanced written consent of the infected individual allowing disclosure of the information after his/her death;
- In other cases envisaged by Georgian Legislation.<sup>30</sup>

Like the Law on the Rights of Patients, the Law on HIV/AIDS allows the disclosure of information for the purpose of education/training or scientific purposes only, if this information is presented in a way that the person concerned cannot be identified (**Article 9.4**).

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<sup>30</sup> Such as Article 42 of the Law on Health Care, Article 28.1 of the Law on the Rights of Patients, and Article 48.2 of the Law on Doctor’s Professional Activity. See description of these articles in the previous and the subsequent paragraphs.

The patient can name the person or persons to whom health care providers can provide information about the patient's HIV status (**Article 9.5**). So, e.g. if a patient's family members ask for the information about HIV status of the patient, this can only be provided upon the patient's approval.

### **Law on Psychiatric Care**

The Law requires that confidential information about a patient's mental state is accessible only by people who are directly involved in the process of treatment and care of this patient (**Article 26.2**). That information may be provided to third persons if the patient or his/her legal representative (in the case when the patient is incompetent) gives consent, or a court decision provides for it (**Article 26.3**).

Finally, breach of confidentiality is admissible when it is necessary to protect the life and/or health interests of the patient, or of a third person. In such cases, the decision on disclosure is made *"by the administration of the psychiatric institution, and this information shall be issued only to the legal representative of the patient, or, in case of absence of the latter – a relative"* (**Article 26.4**).

### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular right.

### **d) Provider Codes of Ethics**

The **Ethics Code of Georgian Physicians** requires that a physician in Georgia keep "confidentiality of the facts concerning a patient's health and private life, even in case of a patient's death, unless the law obligates him/her to disclose information." If law requires the disclosing of information, the doctor "shall inform the patient (or his/her relatives) of the intention to disclose the secret" (**Chapter "Physician and Patient," paragraph 4**).

### **e) Other Relevant Sources**

There are no other relevant sources on this matter.

### **f) Practical Examples**

#### **1. Example(s) of Compliance**

16-year-old patient **K** consulted a doctor regarding her reproductive health issues without letting her parents know about it. K's mother, having heard about her daughter's visit to the medical institution, asked the doctor about K's pregnancy. The doctor did not reveal any medical information on the basis of the rule of confidentiality. (**Hypothetical example**)



## 2. Example(s) of Violation

According to the Public Defender's Office, all meetings between a prisoner and a doctor are attended by the prison supervisor or an attendant, without any respect to the patients' privacy, confidentiality and inviolability of his medical data. (**Public Defender's Office Reports, 2009**<sup>31</sup>)

## 3. Actual Cases

**Ms. A** applied to the Public Defender's Office, claiming that doctors compelled her and other women to abandon their disabled infants in the maternity hospitals. The Public Defender's Office forwarded the notice to the Agency of Medical Regulation. In the formal letter sent by the Office, it was indicated that the notice included confidential information. However, on the third day, the scanned version of **Ms. A's** letter to the Public Defender's Office was published in Alia Newspaper. Legal action was taken against the newspaper. The case is still pending. No action has been taken against the Agency of Medical Regulation. (**Public Defender's Office Reports, 2008**<sup>32</sup>)

### g) Practice Notes for Lawyers

With regard to the Right to Privacy and Confidentiality, national legislation is to directly stipulate that the information is confidential, irrespective of the fact that disclosure of such information does or does not entail sanctions. In the absence of provisions imposing sanctions, violating the principle of confidentiality imposes the obligation to pay damages in accordance with the Civil Code of Georgia. As the basis of imposing civil liability is the existence of a civil wrong, factual circumstances are needed to ascertain whether disclosure was an intentional or negligent act.

### h) Cross-referencing of Relevant International and Regional Rights

Please find a discussion of international and regional standards relevant to the Right to Privacy and Confidentiality in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## Right to Respect for Patients' Time

### a) Right 7 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.*

**This right is not specifically mentioned in Georgian legislation.** Particularly, there are no provisions about waiting lists, as the responsibility of the State in financing services is very limited.

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<sup>31</sup> <http://www.ombudsman.ge/>

<sup>32</sup> [www.ombudsman.ge](http://www.ombudsman.ge/)

However, legislation does stipulate that medical care is initiated without delay in clinical emergencies, even without consent of the patient (e.g. when a patient is in coma) and the consent of his/her legal representative (when the legal representative could not be contacted due to time constraints).

Health laws provide also for informing patients about various aspects of care. This definitely requires (from the doctor and other health care professionals) enough time to be devoted to information provision and explanations.

Finally, respect for patient's time can be understood as not having to wait for hours, especially if the patient was previously given an appointment.

## **b) Right as Stated in Country Constitution/Legislation**

### **Constitution of Georgia**

**Article 17** of the Constitution declares that:

*“Honor and dignity of an individual is **inviolable**.”*

The Right to Respect for Patient's Time can be linked to the right to respect for patient, or more generally, in the right to respect for individuals.

### **Legislation**

#### **Law on Health Care**

The Law on Health Care envisages situations in which, due to a clinical emergency, medical care shall be initiated without delay in accordance with the health interests of the patient who has no capacity to consent (**Article 12**).<sup>33</sup>

#### **Law on the Rights of Patients**

The Law on the Rights of Patients (**Article 12**) specifically mentions the right to emergency medical care (*“services, without immediate providing of which the death or disability or serious deterioration of health is inevitable”*); however, this right is not specified further. The only straightforward provision is related to the obligation of the health care provider to inform the patient, or the relatives of the patient, where he/she can receive relevant emergency care if the provider is not in a position to provide it.

However, according to the same Law, a health care provider may initiate medical care of an incompetent patient without delay even without the consent/authorization of the patient's legal representative in the following two circumstances:

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<sup>33</sup> See also corresponding articles about information provision described in the section on the Right to Information, earlier in this Chapter.

- An incompetent patient, or a patient who lacks decision-making capacity, urgently needs medical care without which death or disability or serious deterioration of health is inevitable, and there is no possibility to contact the patient’s representative (**Article 25.2**); or
- “An incompetent patient or patient who lacks decision making capacity urgently needs medical service without which death is imminent, but the patient’s relative or legal representative refuses medical service” (**Article 25.3**).<sup>34</sup>

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular right.

### d) Provider Codes of Ethics

According to the **Ethics Code of Georgian Physicians**, in clinical emergencies, a physician must assist “any person within his/her ability, even being in a non-working environment” (**Chapter “Physician and Patient,”** paragraph 5).

### e) Other Relevant Sources

There are no other relevant sources on this matter.

### f) Practical Examples

#### 1. Example(s) of Compliance

**Citizen J** lives below the poverty line and is entitled to free medical treatment due to a special government program. Three months ago, he was diagnosed with severe forms of urinal disease, causing suffering and pain and making it difficult to urinate. Because of his conditions, **Citizen J** was given priority over other patients on the hospital waiting list and was operated on a few days after he was registered. (**Hypothetical example**)

#### 2. Example(s) of Violation

**Citizen M** lives below the poverty line and is entitled to free medical care. Two months ago, he applied to the state hospital for an operation for an ulcer. **M** was registered on the waiting list, and even though his disease required urgent response and the hospital had free capacity, he has not yet received any treatment. (**Hypothetical example**)

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<sup>34</sup> also corresponding articles about information provision described in the section on the Right to Information, earlier in this Chapter.

### 3. Actual Cases

On March 18, 2003, the condition of **Patient V** – admitted to Caspi (rayon) hospital with body injuries from a domestic accident – worsened significantly. Having failed in improving the rapidly-worsening condition of the patient, on March 23, around 05:00pm, the surgeon **Dr. I** assumed that the injury of abdominal cavity organs (parenchymal organs) was the reason for the aggravation and decided that emergency operative intervention was necessary. Despite the situation described, the surgeon did not perform the operation himself and tried to postpone it till the arrival of the head of the department, who had been informed by **Dr. I** by phone.

The head of the department arrived late to the hospital – at 08:10pm – which meant that an urgency for operative intervention caused by bleeding from the spleen and left lung started 5-6 hours later. As a result of these circumstances, the patient **V** died.

Legal action was taken against the doctor. The Supreme Court of Georgia imposed criminal responsibility on the doctor and held that timely diagnosing and operative intervention would have significantly increased the patient's chances of survival. (**Supreme Court of Georgia Archives**<sup>35</sup>)

#### g) Practice Notes for Lawyers

According to Georgian legislation, the Right to Respect for Patients' Time intertwines with the obligation to provide timely and adequate treatment. If the State violates the mentioned medical standard, an affidavit from a competent medical expert must be obtained to establish what damages or losses resulted from the delay in medical treatment and whether the delay increased the risk of injury. Collecting evidence to establish subjective elements – intent or negligence – is of equal importance.

#### h) Cross-referencing Relevant International and Regional Rights

Please find a discussion of international and regional standards relevant to the Right to Privacy and Confidentiality in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## Right to Observance of Quality Standards

### a) Right 8 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.***

This right was partially discussed under the Right of Access. Accessibility of services implies adequate quality of services as well. Otherwise, if the services were accessible but were not of appropriate quality, patients could not exercise their right to care, because such services would not be able to improve

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<sup>35</sup> [http://www.supremecourt.ge/default.aspx?sec\\_id=133&lang=1](http://www.supremecourt.ge/default.aspx?sec_id=133&lang=1)

and/or to maintain their health.

Georgian legislation mostly addresses the right to observance of quality standards through the language of obligations (contained basically in the Law on Health Care, and the Law on Doctor's Professional Activity).

## **b) Right as Stated in Country Constitution/Legislation**

### **Constitution of Georgia**

According to **paragraph 2 of Article 37** of the Constitution:

“The state shall control all institutions of health protection and the production and trade of medicines.”

This is understood as a measure to ensure adequate quality of health services and medicines (Authors' opinion).

### **Legislation**

#### **Law on Health Care**

The Law on Health Care identifies *the State* to be responsible for the general quality of health services (**Articles 4 and 16**).<sup>36</sup> The Ministry of Labour, Health and Social Affairs is in charge of the “*control over the quality of medical activity of medical institutions in accordance with the established rule*” (**Article 63**).

On the other hand, *healthcare institutions* are obliged to follow the standards, rules and norms regulating medical and pharmaceutical activity, and requirements as determined by the system of quality control (**Article 53**).

The specific instruments for ensuring adequate quality of services are *licensing of institutions and doctors and development and approval of clinical practice guidelines and protocols* (**Article 16, Articles 23-33, and Articles 53-63**).

It is prohibited for medical institutions to offer services without a proper license (**Article 56**). The list of services and activities subject to licensing is defined by the **Law on Licenses and Permissions**<sup>37</sup> (**Article 6, paragraphs 42-84**).

Clinical practice guidelines and protocols are very important tools, to be used in judging the quality of services when the quality is questionable and/or the patient is dissatisfied with the services. The Ministry of Labour, Health and Social Affairs approves the National Clinical Practice Guidelines (**Article 16**). In Article 16 it is specified that the Ministry of Labour, Health and Social Affairs set up a special body – “The National Council on Elaboration, Evaluation and Establishment of the National Clinical Practice Recommendations (Guidelines) and Disease Management Standards,” which is in charge of monitoring the

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<sup>36</sup> Although the law does not expressly state it, the responsibility of the State in assuring general quality of health services is the same in the cases of private and public institutions. This can be understood from the fact that the law gives only one definition of health services; i.e. health services (and their quality) are to be understood in the same way in both private and public health care institutions.

<sup>37</sup> Adopted in 2005.

guideline development and approval. Until now, more than 100 clinical guidelines have been approved by the individual (not normative) order of the Minister of Labour, Health and Social Affairs. Guidelines can be viewed/downloaded from the official page of the Ministry – [www.moh.gov.ge](http://www.moh.gov.ge).

Finally, the law provides for establishing ethics committees at health care institutions for promoting and implementing patient's rights and norms of medical ethics (**Article 62**). Roles and functions of medical ethics committees (as well as other types of ethics committees) are discussed in Chapter 8 on National Procedures.

### **Law on the Rights of Patients**

**Article 5** of the Law stipulates that every citizen of Georgia has “the right to receive from any healthcare provider medical service in accordance with the professional and service standards, acknowledged and established in Georgia.” “Professional and service standards” imply the adequate quality of services. Thus, citizens of the country are entitled to receive services of adequate quality from any provider.

### **Law on Doctor's Professional Activity**

The right of patients to the observance of quality standards by doctors is further ensured by establishing legal obligations for doctors to ensure adequate quality of medical care<sup>38</sup>.

### **Law on Human Organ Transplantation**

The quality of services in the sphere of organ transplantation has particular importance, as organ removal and transplantation is associated with quite high risks for donors (living donors) and recipients. According to **Article 27**, the Ministry of Labour, Health and Social Affairs:

- Elaborates standards for organ locating, removal, transportation, storage and transplantation; and elaborates also criteria for selecting and testing of donors and recipients;
- Defines quality control standards for organs;
- Controls how rules and procedures for organ removal, transportation and storage are followed; also, controls organ quality and procedures for defining histological compatibility.
- Checks the quality of medical services provided by institutions involved in transplantation, including transplantation banks, and, in case of necessity, suspends or withdraws the license.

### **c) Supporting Regulations/Bylaws/Orders**

Based on the Law on Human Organ Transplantation, the Order of the Minister of Labour, Health and Social Affairs No 419/n of 29.11.2001 “on approval of length for keeping organs in quarantine, criteria for defining high risk groups for dangerous infections among donors, criteria for selecting and testing donors and recipients, standards for organ allocation, removal, keeping and transplantation, standards for human organ quality control and rules on destruction of human organs” was issued, which approves instruments of quality control in the field of human organ transplantation.

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<sup>38</sup> For more details, see section on the Responsibility to Ensure Quality of Care, in Chapter VII.

#### d) Provider Codes of Ethics

The **Code of Ethics of Georgian Physicians** addresses the issue of quality through the following provisions:

- A doctor shall try to create working conditions that are necessary for providing adequate medical care to the patient (**Chapter “Physician and Patient,” paragraph 8**);
- During their medical practice, physicians shall be guided only by professional standards and universally-recognized ethical norms (**Chapter “General Provisions,” paragraph 2**);
- A physician shall get into the habit to daily update and improve his/her knowledge, and master proper skills in the course of his/her medical practice (**Chapter “General Provisions,” paragraph 8**);
- A physician shall make all efforts within his/her ability to assist other physicians in fulfilling professional duties (**Chapter “Physician and Colleague,” paragraph 2**);
- A physician shall be aware of his/her own professional abilities. If a physician lacks adequate professional knowledge and experience, he/she invites other physicians for help (**Chapter “Physician and Colleague,” paragraph 3**);
- A physician refers a patient to a colleague only if he/she is confident in the professional competence of the latter. Furthermore, before consulting, he/she provides the colleague with all relevant information about the patient’s medical care (**Chapter “Physician and Colleague,” paragraph 4**);
- Finally, when the patient refuses to participate in the teaching process, this shall not influence the quality of healthcare offered by physician, or the physician’s attitude towards the patient (**Chapter “Physician – Teacher,” paragraph 2**).

#### e) Other Relevant Sources

The Council of Europe Convention on Human Rights and Biomedicine<sup>39</sup> and its additional Protocols concerning Transplantation of Organs and Tissues of Human Origin<sup>40</sup> and concerning Biomedical Research<sup>41</sup>

Quality and professional standards are specifically mentioned in all the above instruments of the Council of Europe. Particularly, signatory States are required to ensure “*equitable access to health care of appropriate quality*,” and to ensure that all interventions in the health field, including research, are carried out in accordance with relevant professional obligations and standards.

| Council of Europe Instrument  | Relevant articles  |
|---|--|
| Convention on Human Rights and Biomedicine                                | Articles 3 and 4: request for quality and for observance of professional obligations and standards.  |
| Protocol concerning Transplantation of Organs and Tissues of Human Origin | Articles 3 and 4: request for quality and for observance of professional obligations and standards.  |
| Protocol concerning Biomedical Research                                   | Articles 23 and 24: request for non-interference with medically necessary preventive, diagnostic or therapeutic procedures in the context of biomedical research |

<sup>39</sup> Entered into force in Georgia on 01.03.2001.

<sup>40</sup> Entered into force in Georgia on 01.05.2006.

<sup>41</sup> Entered into force in Georgia on 01.08.2010.

## f) Practical Examples

### 1. Example(s) of Compliance

**Mr. T**, who is 55 years old, has been diagnosed with essential hypertension during his last three visits to his family doctor, **Doctor E**. The doctor prescribes an ECG and lab studies including a comparatively expensive analysis – lipid profile. The representative of **Mr. T's insurance company** suggests to not order this study, which will not be covered by the company. However, **Doctor E** explains that the lipid profile, according to the national practice guideline, is included on the list of routine lab studies for the assessment of patients with hypertension. Finally, the analysis is done, and its expenses are covered by the insurance policy. **(Hypothetical example)**

### 2. Example(s) of Violation

- **K** is the mother of a disabled child who received medical treatment at a children's hospital in Tbilisi. During the treatment, doctors and nurses did not take the special needs of the child into consideration; therefore, the treatment provided was not of a proper quality for that particular child. **K** applied to the Ministry of Labour, Health and Social Affairs, claiming that, considering the needs of her child, the treatment he received failed to comply with quality standards. After the Ministry's intervention, the hospital provided appropriate treatment considering the special needs of the child **(Hypothetical example)**.
- **K and C** – the parents – and their **child M**, had proper health insurance. The child was undergoing medical treatment in a health care institution. The insurance expired 2 weeks after the treatment started and the patient's health did not improve because the treatment provided was not of an adequate quality. Later, the parents moved the child to another medical institution, and **M** convalesced soon. However, the parents had to pay for the treatment in the second institution. If **M** would have received adequate quality treatment from the beginning, **K and C** would not have had to pay for it, as their health insurance was still valid at that time. No legal action was taken. **(Public Defender's Office Reports, 2008<sup>42</sup>)**
- In Tbilisi prisons, 154 persons have been diagnosed with diabetes. The prisons have not provided the patients with proper dietary meals. As a result, every medical effort to cure them has been a failure. There has been only one case when a diabetes patient was consulted by an endocrinologist. **(Public Defender's Report to the Parliament for the 1st Half of 2009<sup>43</sup>)**

### 3. Actual Case(s)

In the case '*Ghvtadze vs. Georgia*', the European Court of Human Rights (ECHR) reprimanded the Georgian Government because an ill prisoner was returned to the penitentiary institution before his full recovery, or before the treatment became possible outside the medical institution. The ECHR declared that this attitude is equivalent to inhumane treatment and torture and violates Article 3 of the European Convention on Human Rights. The Court notes in its decision that the fact that the prisoner was returned to the prison does not represent in itself a violation of Article 3. The main point is to define, or ascertain whether the prisoner received adequate medical treatment before he was re-

42 [www.ombudsman.ge](http://www.ombudsman.ge)

43 [www.ombudsman.ge/uploads/reports/saxalxo\\_damcvelis\\_angarishi\\_\\_2009\\_\\_I\\_\\_naxevari.pdf](http://www.ombudsman.ge/uploads/reports/saxalxo_damcvelis_angarishi__2009__I__naxevari.pdf)



turned to the prison; whether it was justified that, based on his health condition, he was returned to prison; and whether he was under medical observation once he was back in prison. With regard to the guarantees of protection of prisoners' health and wellbeing, the Court held that prisoners' health and wellbeing should be ensured adequately, including through provision of proper medical treatment. Thus, non-existence of adequate medical treatment and, more broadly, keeping an ill prisoner in inadequate conditions could represent ill-treatment, which is against **Article 3. (European Court of Human Rights<sup>44</sup>)**.

### g) Practice Notes for Lawyers

- To establish whether a medical service was of adequate quality or not, both parties (applicant and defendant) have to obtain affidavits from medical experts and/or expert medical opinions (provided during trial) on what specific medical standards are to be met in certain territorial units.<sup>45</sup> Namely, the standards are to establish what criteria qualify medical treatment as being a quality one. Ultimately, the court considers evidence (expert opinions) obtained by the parties and decides if, in the disputed case, medical treatment was in compliance with quality standards.
- The best source of information about the adequacy of treatment for specific conditions is national clinical practice guidelines, which are approved by Ministry of Labour, Health and Social Affairs. These guidelines could be used when dealing with complaints on the quality of care, also with complaints against insurance companies that do not cover costs of certain types of services.
- It is not explicitly stated in the law that insurance companies are required to cover costs of services (investigations, lab studies) that are included in the national practice guidelines. However, such a conclusion could be drawn from various provisions of the law concerning the right of patient to get adequate care and provisions stating that clinical practice guidelines are approved by Ministry of Labour, Health and Social Affairs.
- Lawyers should not only check whether treatment provided by a physician was in line with the latest guidelines, but also whether there were special circumstances, specific to the patient that could explain and legitimize the treatment that differed from the instructions of the relevant guidelines.<sup>46</sup>
- See also Practice Notes under the Right of Access.

### 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 Chapter 3 and under the Right to Life in Chapter 2 and Chapter 3.

44 The full case is available in Georgian at the website of the Ministry of Justice: [http://www.justice.gov.ge/files/Documents/adam/Ghavantdze\\_sakartvelos\\_cinaagmdeg.pdf](http://www.justice.gov.ge/files/Documents/adam/Ghavantdze_sakartvelos_cinaagmdeg.pdf); and in French (only) – “Affaire Ghavtadze c. Géorgie” – at the website of the European Court of Human Rights: <http://cmiskp.echr.coe.int/tkp197/view.asp?item=36&portal=hbkm&action=html&source=tkp&highlight=G%C9ORGIE&sessionid=57303760&skin=hudoc-fr>. The decision became definitive on June 06, 2009.

45 Medical expert opinions and/or affidavits can be obtained by contracting state or private agencies providing expert services.

46 See section on the Right to Personalized Treatment, later in this Chapter.

## Right to Safety

### a) Right 9 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.*

Safety of patients is ensured through ensuring adequate quality of services. However, ensuring safety could be considered an absolutely-required minimal standard of care. Therefore, this right can be linked to one of the four principles of modern medical ethics/bioethics – *nonmaleficence* (“do not harm”).

In many cases, relevant legislation of Georgia specifically concerns the issue of patients' safety, particularly the following: safety of medical services, safety of medical equipment and technologies, safety of blood and blood products, safety of medicines and vaccines, safety of environment (including radiation and biological safety), control of nosocomial infections etc. It also specifically regulates safety of patients and health volunteers participating in biomedical research.

Although not specified in health care legislation, the right to patient safety shall also be understood as a right to be free from physical assaults while in a health care institution. Obviously, all the general legislation provisions protecting individuals' life and physical integrity are to be respected in health care settings as well.

### Right as Stated in Country Constitution/Legislation

#### Constitution of Georgia

The Constitution does not contain any specific provisions on safety of health care services; yet constitutional provisions protect individual's safety in general (**Article 15.1**):

*“Everyone has the inviolable right to life and this right shall be protected by law.”*

#### Legislation

#### Law on Health Care

Provisions of the law related to quality of care<sup>47</sup> are indirectly linked to the right to safety. In addition, the Law on Health Care concretely mentions safety standards in connection with medical devices and technologies, and identifies the Ministry of Labour, Health and Social Affairs, together with other branches of the executive government, to be responsible for elaborating and implementing quality and safety standards for medical-technical devices, and medical technologies (**Article 67**).

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<sup>47</sup> See sections on the Right to Observance of Quality Care (earlier in this Chapter), and on the Responsibility to Ensure Quality of Care (in Chapter VII).

According to **Article 16.4** of the Law on Health Care, one of the mechanisms of the State management of healthcare is *“the control over medicines, regulating pharmacy and the pharmaceutical industry.”* By regulating medicines and the overall pharmaceutical industry, the State tries to ensure adequate quality of medicines and safety of the patients using these medicines.

The same Law also stresses the general responsibility of the State to ensure a safe environment, to develop sanitary and hygienic norms and standards and measures for epidemic control, and to monitor implementation of those norms, standards and measures (**Articles 70-79**).

The Law also includes a separate chapter aiming at protecting research subjects and ensuring their safety (**Chapter XIX**).

### **Law on the Rights of Patients**

Please see section on the Right to Observance of Quality Standards.<sup>48</sup>

### **Law on Doctor’s Professional Activity**

Safety of medical care is specifically mentioned only in the context of assigning a patient’s care to a different health care professional. In this case, the Law requires that safety of medical care is ensured (**Article 49**).

However, provisions of the current law discussed under the section on the Right to Observance of Quality Standards are relevant to the issue of patient safety as well.

### **Law on Human Organ Transplantation**

Please see the section on the Right to Observance of Quality Standards.

### **Law on Public Health**

The Law addresses various issues related to safety of environment (**Chapter 6**), biosafety (**Chapter 5**), and safety of vaccines (**Article 7**). The law also prescribes prevention and control of nosocomial infections (**Article 8**), and specifically mentions the right of every individual in the territory of Georgia to be protected from infectious diseases at medical institutions (**Article 5.2**). The Law also specifies that the State has responsibility for the safety of blood and blood products (**Article 15.2**).

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<sup>48</sup> Earlier in this Chapter.

### **Law on Drug and Pharmaceutical Activity**

The primary purpose of the Law is to create a basis for ensuring the safety and quality of prescription drugs. It regulates the activity of institutions and personnel involved in drug supply and usage, and it regulates the development and clinical testing of new drugs as well.

### **Law on Psychiatric Care**

The Law provides for ensuring a safe environment for the doctor when carrying out primary psychiatric assessment of the patient (**Article 13**). The Law also specifies circumstances when the rights of patient with psychiatric disorders can be restricted in order to ensure safety of others (**Articles 16, 18, 19**).

### **Law on Blood and Blood Products Donorship**

The Law includes provisions on quality of blood and blood products (such as fresh frozen plasma or packed red blood cells).

### **c) Supporting Regulations/Bylaws/Orders**

Order of the Minister of Labour, Health and Social Affairs No215/n of 11.07.2007 on "Approval of Cases and Rules for Mandatory Health Examination of Employees to be Financed by Employer" defines diseases/diagnoses which are contraindicated for certain jobs.

See also sub-section Supporting Regulations/Bylaws/Orders in the section on the Right to Observance of Quality Standards.

### **d) Provider Codes of Ethics**

See the section on the Right to Observance of Quality Standards.

### **e) Other Relevant Sources**

See the section on the Right to Observance of Quality Standards.

### **f) Practical Examples**

See also examples and actual cases under the Right to Observance of Quality Standards in addition to those below.

#### **1. Example(s) of Compliance**

**Dr. A** made a mistake in prescribing medicine to the patient Miss J because two kinds of medication had very similar names. The pharmacist K realized the doctor's error and phoned him. The problem

was solved by the doctor, and the patient was given proper medication. (**Example collected by the authors**)

## 2. Example(s) of Violation

- The Public Defender's Office reports that medical records often do not follow the standards established by the Ministry of Labour, Health and Social Affairs. Resulting errors in medical treatment infringe upon patients' right to safety and have a detrimental effect on patients' health. (**Public Defender's Office Reports, 2nd Half of 2009<sup>49</sup>**)
- In penitentiaries, there is no proper monitoring of nutrition provided to a prisoner. Doctors try to cure the results of food poisoning and health problems stemming from the consumption of often inedible food by giving medications to prisoners. They do not indicate that sickness is caused by poor food quality, however. (**Public Defender's Office Reports, 1st Half of 2009<sup>50</sup>**)

## 3. Actual Cases

**Dr. V**, who was employed in the Diagnostic Center Ltd as an obstetrician-gynecologist, was discharged from the position on the basis that he had not passed state certification exams and had no certificate. Having ignored the mentioned decree, **Dr. V** kept working in the Obstetrical Department and kept undertaking illegal medical activity. In August 2006, he performed an abortion on **Ms. X** without comprehensive investigation of the patient's condition. As a result, **Dr. V** failed to recognize abdominal extra uterine pregnancy and wrongly evaluated the woman's condition as a pregnancy of 9-10 weeks. Instead of performing an operation in order to avoid further extreme complications, **Dr. V** artificially aborted (curettement of uterus cavity) **Ms. X**. Despite the fact that the patient still felt sick, she was discharged from the hospital immediately on the day of the operation. Later on, her condition became graver and she began bleeding. **Ms. X** applied again to **Dr. V**, the physician who performed the scraping.

A recurrent incorrect treatment performed by **Dr. V** further worsened the state of the patient, as reflected by the development of peritonitis. On August 24, 2005, **Ms. X** was moved for further treatment to Chachava Institute for Perinatal Medicine and Gynecologic Scientific Research, where, as a result of another operation carried out by **Dr. V**, the excision of the uterus (womb) along with right ovary and left Fallopian tube was performed. This operation appeared to be harmful for the patient's health. The Supreme Court of Georgia imposed criminal responsibility on **Dr. V**, as well as the responsibility to pay damages. (**Supreme Court of Georgia archives<sup>51</sup>**)

### g) Practice Notes for Lawyers

The precondition of any medical intervention is preventing injury and damage to the health of the patient. Considering that precondition, in order to ascertain that the patient's right to safety was violated, it is vital to obtain expert medical opinion to prove the existence of methods and instruments of

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49 [www.ombudsman.ge/files/downloads/ge/vobeapyzfolshjmcllybl.pdf](http://www.ombudsman.ge/files/downloads/ge/vobeapyzfolshjmcllybl.pdf)

50 [www.ombudsman.ge/uploads/reports/saxalxo\\_damcvelis\\_angarishi\\_\\_2009\\_I\\_\\_naxevari.pdf](http://www.ombudsman.ge/uploads/reports/saxalxo_damcvelis_angarishi__2009_I__naxevari.pdf)

51 [www.supremecourt.ge](http://www.supremecourt.ge)

safe treatment that could have been used, and to prove that these were accessible in the given area and period but were not used.

## **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 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## **Right to Innovation**

### **a) Right 11 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.*

Although there is no specific mention of the right to innovation in Georgian legislation, the law does provide for the availability of appropriate care for patients with rare, uncommon diseases (Law on the Rights of Patients). Legislation also deals with biomedical research on human beings (Law on Health Care, and Law on Drug and Pharmaceutical Activity). Finally, the right to innovation is indirectly linked to the continuing education and professional development of health care personnel, which provides them with the possibility to offer up-to-date care.

### **b) Right as Stated in Country Constitution/Legislation**

#### **Constitution of Georgia**

No specific provisions on this issue.

#### **Legislation**

##### **Law on Health Care**

The law does not specifically recognize the right to innovation.

According to **Article 16**, one of the mechanisms for the management of the health care system by the State is the promotion of development and implementation of innovative treatment methods and technologies.

A specific chapter of the Law (**Chapter XIX**) regulates biomedical research, including research on human beings (**Articles 105-112**).

The State must develop relevant mechanisms to ensure improvement of professional knowledge of health care personnel (**Article 48**).

## Law on the Rights of Patients

The Law on the Rights of Patients provides for mobilizing resources to address the needs of patients with rare, uncommon diseases (**Article 13**). The argument in favor of such an approach was the supposition that patients with rare diseases would never fall under the scope of private medical or insurance companies' interests. Even if the State paid for the treatment of such patients, healthcare providers would not be interested in broadening their services for such very small groups of patients. Taking into consideration such a reality, **Article 13** states the following:

*"1. Government shall ensure that patients with rare, uncommon diseases are able to receive appropriate medical services in accordance with the professional and service standards acknowledged and established in Georgia.*

*2. The Ministry of Labour, Health and Social Affairs elaborates the list of rare, uncommon diseases."*

The list of such diseases has been approved by the order of the Minister of Labour, Health and Social Affairs (See section "Supporting Regulations/Bylaws/Orders").

## Law on Doctor's Professional Activity

According to **Article 29** of the Law, doctors can participate in continuing professional development, which gives them the possibility to bring their practices closer to the most recent achievements in medicine. The purpose of continuing professional development is to ensure that the knowledge and practice of doctors are relevant to the latest developments and technologies in medicine. It should be mentioned that from 2001 (when the Law on Doctor's Professional Activity was approved) up to

2007, continuing professional development was mandatory for doctors in Georgia. However, in 2007, amendments were made to the above Law, which made the system of continuing professional development of doctors voluntary.

### c) Supporting Regulations/Bylaws/Orders

Based on Article 13 of the Law on the Rights of Patients, the Order of the Minister of Labour, Health and Social Affairs No 199/n of 14.05.2001 on "Approving List of Rare Diseases" was adopted. After an amendment made in 2004, the list includes 23 diseases and health conditions.

### d) Provider Codes of Ethics

The following provisions of the **Ethics Code of Georgian Physicians** address issues associated with biomedical research involving human subjects (**Chapter "Physician – Researcher"**):

*"1. Scientific research is one of the important parts of a physician's professional activity and an important tool for professional development. In the process of planning and carrying out research, a physician relies on universally recognized scientific principles. In conducting the research and publishing its results, a physician shall be objective;*

*2. The patient's interests are supreme in scientific research on human beings. The research goals and its possible outcomes shall never interfere with the main mission of a physician – to serve for patient's health and life".*

## e) Relevant Sources

The Additional Protocol to the Council of Europe Convention on Human Rights and Biomedicine concerning Biomedical Research<sup>52</sup> provides comprehensive and specific regulation of research activities on human beings. Currently, the protocol is far more specific than corresponding provisions of Georgian legislation, particularly the Law on Health Care, and the Law on Drug and Pharmaceutical Activity.

It is expected that Parliament will start to consider the new draft Law on Biomedical Research involving Human Beings, which if adopted, is expected to be the most specific law in the field of biomedical research in Georgia. The draft law is before Parliament at the time of this writing

## f) Practical Examples

### 1. Example(s) of Compliance

A 67-year-old pensioner **Mr. P** needed to undergo modern procedures for his cardiac disease. The treatment cost 200 GEL, which Mr. P was unable to afford. However, due to government programs targeted to the retired population, Mr. P incurred only 45 GEL, and his heart disease was relieved by the application of innovative procedures. **(Example collected by the authors)**

### 2. Example(s) of Violation

People living below the poverty line whose health is insured by private insurance companies<sup>53</sup> are not afforded innovative diagnostic procedures due to the high costs of these procedures. **(Example taken from everyday life)**

### 3. Actual Cases

As this field of law is still developing, no real cases were available as examples for this section.

## g) Practice Notes for Lawyers

The given right is directly connected to the patients' right to equality and to prohibition of discrimination of any kind. The lawyer must prove that in the same circumstances and existence of a similar medical necessity, the treatment that was provided to other patients was illegally denied to the com-

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<sup>52</sup> Entered into force in Georgia on 01.08.2010.

<sup>53</sup> The insurance is purchased for them by the Government, through a State program targeting people living below the poverty line.



plainant. In the conditions of limited State resources, a complaint regarding legal acts regulating the issue can be filed in general courts applying administrative procedural rules, as well as in the Constitutional Court.

## **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 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## **Right to Avoid Unnecessary Suffering and Pain**

### **a) Right 10 as Stated in the European Charter of Patients' Rights (ECPR)**

*Each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness.*

In Georgian health legislation, there are no specific provisions on the right to avoid unnecessary suffering and pain. However, avoiding and alleviating suffering and pain is the main objective of **palliative care**, which is specifically mentioned in Georgian laws (*See below*). Provisions regulating involuntary placement, seclusion and restraint of patients with psychiatric disorders are closely connected to this right; and abuses in prison and in psychiatric facilities fall under its scope as well. Finally, this right is linked to the Right of Access<sup>54</sup>, the Right to Observance of Quality Standards, the Right to Safety, and to the Right to Free Choice.<sup>55</sup>

### **b) Right as Stated in Country Constitution/Legislation**

#### **Constitution of Georgia**

The provisions of **Article 17** of the Constitution can be connected with the right to avoid unnecessary suffering and pain:

*“1. A person’s honor and dignity are inviolable.*

*2. Torture, inhumane, brutal or degrading treatment or punishment is impermissible.”*

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<sup>54</sup> I.e. the right of access to pain relief.

<sup>55</sup> For more details, see relevant sections, earlier in this Chapter.

## Legislation

### Law on Health Care

The law on Health Care defines **Palliative Care** as “active, multidisciplinary care, which has as its primary objective to alleviate pain and other pathological symptoms, and to offer social and psychological support to patients. It covers patients with incurable diseases; such care can improve the quality of life of patients and their families.”

All provisions of the Law related to patients' rights in the process of health care provision apply to palliative care as well (e.g. **Articles 8, 147**).

In some circumstances, palliative care is specifically mentioned. Particularly, the Law on Health Care provides for the possibility to make advanced directives about end-of-life care. Such care may only include resuscitation, life sustaining and/or *palliative care*. According to **Article 10**, “All capable persons have the right to express in advance in a written form their will on conduction of resuscitation, life sustaining or palliative treatment at a terminal stage of an incurable disease.” A patient's will not to be “treated” (i.e. end-of-life care) must be taken into consideration by health care professionals when caring for such patients (**Article 149**).

Finally, the Law instructs the Ministry of Labour, Health and Social Affairs to prepare a special instruction/guideline for palliative care of patients with chronic incurable diseases (**Article 154**).

### Law on the Rights of Patients

The Law on the Rights of Patients also grants citizens *the right to express advanced wishes about resuscitation, life-saving treatment and/or palliative care*. However, such wishes may apply only to the following two situations (**Article 24.1**):

- a) *When patient is in the terminal stage of incurable disease;*
- b) *The patient has a disease which will inevitably cause serious disability.*

### Law on Doctor's Professional Activity

The Law on Doctor's Professional Activity considers *palliative care* as one of the forms of medical care. Palliative care is mentioned in **Article 39** (information provision to the patient) and **Article 49** (intervention in private life of the patient).

### Law on Narcotic and Psychotropic Substances, their Precursors and Narcologic Care”

Substitution methadone therapy for drug dependence helps to avoid suffering and pain when quitting a narcotic. So, accessibility to methadone therapy could be considered as an important aspect of the right to avoid unnecessary suffering and pain. The Law on “Narcotic and Psychotropic Substances, their Precursors and Narcologic Care” considers special substitution programs as a

legitimate method for the treatment of drug dependence (**Article 38.3**). The methods of substitution therapy have to be defined by the normative act of the Ministry of Labour, Health and Social Affairs (**Article 38.4**).

### c) Supporting Regulations/Bylaws/Orders

In accordance with Article 154 of the Law on Health Care, special Order of the Minister of Labour, Health and Social Affairs No 157/n of 10.07.2008 concerning approval of “Instruction for palliative care of patients with chronic incurable diseases” was issued.

The above instruction approved by the Ministerial Order is in fact the guideline on various aspects of palliative care. It includes pure clinical guidelines, as well as guidelines on communication with patients with incurable and terminal diseases, and many other aspects of palliative care.

In addition to the approval of instructions, the same Order of the Minister of Labour, Health and Social Affairs sets out the most important provisions for using narcotic analgesics (opiates) for pain management in palliative care. These provisions include the following:

- ✓ One prescription for a patient with chronic incurable disease may include enough doses of narcotic analgesic for 7 days of treatment;
- ✓ The doctor who issues the prescription and the administrator of the medical institution (or the person appointed by the administrator) are responsible for proper dosing and prescription of narcotic drugs;
- ✓ If the condition of the patient changes that may require changing the drug, its form or dosage, a new prescription must be issued;
- ✓ The narcotic drug must be dispensed within 5 days after the prescription is issued; after this deadline a new prescription must be issued;
- ✓ While submitting the annual quota to The International Narcotics Control Board (INCB) for the country, and during state purchase, the Government must consider WHO recommendations about narcotic drugs, their forms and also the correlation or ratio between those forms.

These new conditions, while improving accessibility to adequate doses of narcotic analgesics, will also contribute to the better management of pain among patients with chronic, incurable conditions, and are additionally expected to considerably improve the state of patients suffering from pain, as well as the conditions of their family members.

The methods of substitution therapy must be defined by the normative act of the Ministry of Labour, Health and Social Affairs (**Article 38.4**). The relevant normative act was issued in 2005, and amended in 2006 – Order of the Minister of Labour, Health and Social Affairs No 302/n of 24.11.2005 on “The Methodology of implementation of Pilot Projects on Methadone Substitution Therapy.”

### d) Provider Codes of Ethics

The **Ethics Code of Georgian Physicians** expects the doctor to continue to provide medical care and spiritual support to dying patients suffering from incurable diseases until the end of their lives (**Chapter “General Provisions,” paragraph 4**).

### e) Other Relevant Sources

There are no other relevant sources on this matter.

### f) Practical Examples

#### 1. Example(s) of Compliance

- **Mr. V**, a 43-year-old man, was suffering from a severe form of lung cancer, which had spread to his lymph nodes and bones. A large tumor growing into his chest and diaphragm made it difficult for him even to take short breaths. Mr. V realized he was dying slowly. He was living his final days in a cancer treatment center, far from his family. His only relief was 50mg of morphine a day. A few hours following his dose, Mr. V's excruciating pain returned. Although the Government regulations on morphine would not have allowed it, his doctor decided to make the necessary change in dosage to relieve Mr. V's pain, and the patient was given an extra dose of morphine.<sup>56</sup>**(Hypothetical example)**.
- **Ms. D** has a lethal disease in its terminal stage and is experiencing serious pain. Although there is no hope of recovery for her, she is receiving adequate medicines to relieve her pain and to ameliorate her quality of life. **(Example taken from everyday life)**

#### 2. Example(s) of Violation

- Disabled patient **Mr. J** injured his leg and his conditions deteriorated during the healing process. The patient suffered from severe pains because of the lack of medication. Being disabled, Mr. J had the right to get free medicines from the Government to ease his pain. However, the Government failed to fulfill its obligation, and Mr. J ultimately received medications from a humanitarian organization. **(Example reported by the staff of the Public Defender's Office)**
- **Ms. A** has a history of drug addiction. Two years ago, she was diagnosed as a cancer patient. However, she has constantly been denied pain relief (including for surgical anesthesia) out of fear that she will resume dependence on illicit opiates. **(Example collected by the authors)**
- **Mr. V**, a 43-year-old man, was suffering from a severe form of lung cancer, which had spread to his lymph nodes and bones. A large tumor growing into his chest and diaphragm made it difficult for him even to take short breaths. Mr. V realized he was dying slowly. He was living his final days in

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<sup>57</sup> See related piece of advice under the sub-section Practice Notes below.

a cancer treatment center, far from his family. His only relief was 50mg of morphine a day. A few hours following his dose, Mr. V's excruciating pain returned. His cries of agony and pleas for relief were ignored by the medical staff. The doctor informed Mr. V that nothing could be done because of the Government regulations on morphine<sup>57</sup> (Hypothetical example.) As in the similar example of compliance above, the doctor remains in a situation of potential conflict between human rights/ethical norms and the law (Government regulations), although the doctor would not be in danger of reprimand or sanctions, as he/she did not violate the legal regulations.

### 3. Actual Cases

No actual legal cases were available as examples for this section.

#### g) Practice Notes for Lawyers

- The Patient's Right to Avoid Unnecessary Suffering and Pain is linked to the Right to Observance of Quality Standards, the Right of Access, the Right to Free Choice, and the Right to Safety. Relying on competent expert medical opinion, lawyers should ascertain the existence of circumstances according to which methods and means of alternative treatment having equal effect<sup>58</sup> were at hand. In the above example of violation, however, the client/patient was not provided with procedures relieving unnecessary suffering and pain. In cases related to the patient's right discussed in this section, it is most probable for the healthcare provider to be imposed responsibility for moral damage (Article 10 of the Law on the Rights of Patients).
- In practice, health care professionals willing to respect the right to avoid unnecessary suffering and pain can face a serious dual loyalty dilemma when the possibility to administer adequate pain killers is impaired by the relevant Government regulations, or by other administrative barriers, such as transmission of inappropriate estimates of required opioids to the International Narcotics Control Board. Health care professionals have to choose between respecting the regulations in force, and providing their patients with effective methods of pain relief, according to the imperatives of the right to avoid unnecessary suffering and pain.

#### h) Cross-referencing Relevant International and Regional Rights

Please find a discussion of international and regional standards relevant to the Right to Avoid Unnecessary Suffering and Pain under the Right to the Highest Attainable Standard of Health in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

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<sup>57</sup> See related piece of advice under the sub-section Practice Notes below.

<sup>58</sup> I.e. other, less painful treatment that could have been used as an alternative to the one that was actually, used.

## Right to Personalized Treatment

### a) Right 12 as Stated in the European Charter of Patients' Rights (ECPR)

*Each individual has the right to diagnostic or therapeutic programs tailored as much as possible to his or her personal needs.*

Although any health care system should be aimed at offering citizens personalized treatment and care, it often is hardly achievable under existing constraints in terms of financing and other resources.

Georgian legislation addresses this by calling for respecting a patient's dignity and honor and what is more, for respecting a patient's culture, religious convictions and personal values. Also, this right is linked to the Right to Privacy.

### b) Right as Stated in Country Constitution/Legislation

#### Constitution

There are no specific provisions on this issue in the Constitution of Georgia. However, **Article 17.1** does provide for the inviolability of the honor and dignity of individuals and the health care context is not an exception from this rule.

#### Legislation

##### Law on Health Care

In carrying out professional activity, medical personnel should be guided by ethical values and principles of respect for a person's dignity and honor, and by justice and compassion. The law also requires that medical personnel act only *"in accord with the patient's interest"* (**Article 30**).

The rights of patients to be informed, to give consent and to make choices, as well as the obligations of medical personnel to acknowledge these rights, contribute to individualized care of patients (**Articles 7-14, 36-44**).

##### Law on the Rights of Patients

Like the Law on Health Care, the Law on the Rights of Patients promotes personalized care by granting rights to be informed, to give free informed consent, and to choose among different services, health-care professionals and institutions, as well as by granting the right to private life and confidentiality (e.g. **Articles 16-30**).

However, the Law on the Rights of Patients specifically entitles patients "to request from the health-care provider to be treated with dignity and to respect his/her culture, religious convictions and personal values" (**Article 15**).

## Law on Doctor's Professional Activity

The Law requires that doctors, during everyday activities, *respect patients' dignity, religious convictions and traditions*" and consider maximally the health interests of the patient (**Article 38**).

The Law also calls for respect of all other rights of patients – right to information, right to give consent, rights to privacy and confidentiality (**Articles 38-49**).

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular right.

### Relevant Provisions of Provider Code of Ethics

The **Ethics Code of Georgian Physicians** explicitly calls for respecting *"patient's individuality, culture, spiritual and moral values;"* and also states that a physician *"always cares for every patient with equal compassion"*

(**Chapter "Physician and Patient", paragraphs 1 and 2**).

The Code emphasizes even more the special attention physicians have to pay while examining and treating certain categories of patients (**Chapter "General Provisions," paragraph 3**):

*"A physician shall take special care of unprotected, vulnerable people – children, mentally ill, elderly, lonely, handicapped, homeless, prisoners, captives;"*

*and especially (Chapter "Physician and Patient," paragraph 6):*

*"A physician tries to safeguard a child and surround him/her with comfortable, quiet surroundings while providing medical care to a minor within his/her ability; benevolently listens to the child making him/her a partner."*

### c) Other Relevant Sources

The Council of Europe Convention on Human Rights and Biomedicine<sup>59</sup> and its additional Protocols concerning Transplantation of Organs and Tissues of Human Origin<sup>60</sup> and concerning Biomedical Research<sup>61</sup>

All of these explicitly require the protection of the dignity and identity of all human beings and respect for their integrity and other rights and fundamental freedoms in the context of biology and medicine.

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59 Entered into force in Georgia on 01.03.2001.

60 Entered into force in Georgia on 01.05.2006.

61 Entered into force in Georgia on 01.08.2010.

## d) Practical Examples

### 1. Example(s) of Compliance

- Before injecting painkillers, the physician consulted his patient to find out if she had any allergy to the medicine components and explained to her the possible side effects of the painkiller he was about to inject. **(Hypothetical example)**
- As a 2-year-old, D has already experienced febrile seizure (convulsions linked to high fever) in the past. The family doctor recommended the parents use acetaminophen (Paracetamol) as soon as the temperature of their daughter reaches 37.5 C. Although the usual recommendation is to let the temperature (fever) play its role and help the immune system combat infections (meaning that anti-fever medication must be taken only if the temperature reaches 38-38.5 C), in order to prevent the recurrence of a seizure, the family doctor has specifically given advice tailored to D's health conditions. **(Hypothetical example)**
- Before traveling to the region of the Amazons, Mr. J wants to get vaccinated against yellow fever. His family doctor, knowing that Mr. J is allergic to eggs, recommends a skin test before the vaccine, as chicken embryos (eggs) have been used to develop the vaccine that may contain components to which Mr. J is allergic. Although undergoing a skin test is not the usual way of proceeding, in the case and special needs of Mr. J, the doctor must overwrite the general guidelines in order to safeguard his patient's health. **(Hypothetical example)**

### 2. Example(s) of Violation

**Mr. J**, of Muslim religion, is undergoing long-term leukemia treatment at Iashvili Hospital. Observing his religion, Mr. J has to get up every morning at 5 am to say his morning prayers. The medical staff does not allow him to have electricity on in the ward so early in the morning. **(Hypothetical example)**

### 3. Actual Cases

No real cases were available as examples for this section.

## g) Practice Notes for Lawyers

The foundation of this right lies in the principle of “do not harm” – one of the major statements in Hippocrates’ Oath – as taking into account a patient’s personal and special needs is a prerequisite to provide him/her a treatment that would not harm his/her health. In practice, this means that preventive measures during medical care must not be generalized to the extent that such generalization is against individual needs, and is a detriment to the conditions of a specific patient. Violation of the right to personalized treatment might take the form of giving medicine or providing treatment without prior diagnosis, or in cases when adequate procedures are not used while diagnosing. In order for the complaint to succeed in court, competent expert medical opinion should be obtained in advance.

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62 For more details, see Chapter VIII on National Procedures.



## 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.

## Right to Complain

### a) Right 13 as Stated in the European Charter of Patients' Rights (ECPR)

*Each individual has the right to complain whenever he or she has suffered harm and the right to receive a response or other feedback.*

The right to complain and/or appeal to court is defined by common legislation.<sup>62</sup> However, this right is specifically articulated in the context of health care as well.

### b) Right as Stated in Country Constitution/Legislation

#### Constitution of Georgia

The Constitution grants everyone the right to “*apply to court for the protection of his/her rights and freedoms*” (**Article 42, Paragraph 1**). This right can certainly be exercised in the context of health care as well.

There are no other provisions on this issue in the Constitution. However, the institution of the Public Defender (established by **Article 43** of the Constitution) is supposed to help reveal facts regarding human rights and freedoms violations. The Public Defender is entitled to report such facts to the “*corresponding bodies and officials.*”

Similarly, the Constitutional Court can help safeguard human rights in health care (as well as in other fields), based especially on the **Article 89** of the Constitution.

#### Legislation

##### Law on Health Care

The Law on Health Care outlines the possibilities for patients and their legal representatives to complain. A patient or his/her legal representative can complain against a physician, a nurse, or any other health care professional, as well as against the health care institution itself. The complaint shall be lodged to the administration of the institution, to the health care management institution<sup>63</sup>, to the court, or to other arbitral bodies<sup>64</sup> (**Article 104**).

63 Such as the Ministry of Labour, Health and Social Affairs, and the municipal bodies responsible for health care (e.g. the Civil Service of Culture and Social Protection of Tbilisi Municipality).

64 When the Law on Health Care was promulgated in 1997, it was not yet clear what kind of complaint systems will be established in the country. There is, therefore, no specific interpretation for this term.

These general provisions of the law are not further strengthened by appropriate regulations and structures, except for situations in which the complaint is made in court. There is no well-developed alternative system of complaint management.

### Law on the Rights of Patients

According to this Law, a patient can apply to court (**Article 10**). The purposes for applying to court may be diverse. The patient or his/her legal representative may wish to:

- ✓ Get compensation for financial and non-financial damages;
- ✓ Achieve suspension or revoke a health care personnel's license/certificate;
- ✓ Change State medical standards or sanitary norms.

As already described under the section on the Right to Consent, according to the Law on the Rights of Patients, a healthcare provider has the right to appeal to court when they think that the decision of a patient's relative or legal representative contradicts the health interests of the patient (**Article 25.1**). When applying to court, the health care provider competes with the patient's relative or legal representative and tries to prove that his approach is in the best interest of the patient, rather than the decision taken by the patient's relative or legal representative. In any case, the right of health care personnel to appeal to court is established to safeguard a patient's health and life.

### Law on Doctor's Professional Activity

Similar provisions are included in the Law on Doctor's Professional Activity. Particularly, according to **Article 45.4**, if the patient's representative's decision does not conform to the patient's health interests, the physician may appeal in court against such a decision and request permission to provide the patient with appropriate medical care.

### Law on Public Defender

The Law on Public Defender<sup>65</sup> is an organic law based on the provisions of Article 43 of the Constitution.

According to the Law, citizens, foreigners, and stateless persons can equally submit complaints to the Public Defender when they think that their rights and/or freedoms (established by the Constitution, national legislation or international treaties) have been violated (**Article 13**). It goes without saying that such complaints may concern human rights violations within the healthcare system as well.

The process of considering a citizen's complaint by the Public Defender shall not create any obstacle for consideration of the same complaint within a corresponding international organization (**Article 14.3**); i.e. the Public Defender's procedure is not considered an internal remedy that must be exhausted first.

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<sup>65</sup> Adopted in 1997.

<sup>66</sup> Georgian Citizenship, Basic Rights and Freedoms of Individual.

<sup>67</sup> For more details, see Chapter VIII on National Procedures.

No fees can be imposed on a complaint or letter submitted to the Public Defender, and the services of the Public Defender are free of any charges (**Article 16**).

Based on the complaint submitted, the Public Defender initiates a process of evaluation, and informs the complainant about this, as well as the organization or official person concerned. The Public Defender is obliged to inform the complainant about the potential outcomes of consideration of the complaint (**Article 17**).

### **Law on the Constitutional Court**

Any natural person is entitled to lodge a constitutional complaint if he/she feels that his/her rights granted in Chapter Two of the Constitution of Georgia<sup>66</sup> have been violated by a normative act. Similarly, general courts can also turn to the Constitutional Court if they have a doubt on the conformity to the Constitution of the normative act upon which they are to base their judgment.<sup>67</sup>

### **Criminal Procedure Code**

For persons deprived of liberty, the Criminal Procedure Code provides further complaint mechanisms. For more details, see sub-section Other Relevant Sources under the Rights of Persons Deprived of Liberty.

#### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular right.

#### **d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

#### **e) Other Relevant Sources**

European Court of Human Rights and European Convention on Human Rights and Fundamental Freedoms:

Complaints can be lodged to the European Court of Human Rights based on the European Convention on Human Rights and Fundamental Freedoms, which was ratified by Georgia on 12.05.1999 (when Georgia became member of the Council of Europe).

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<sup>68</sup> For more detailed rules, see Chapter IV on International and Regional Procedures.

According to **Article 34** of the Convention, *“the Court may receive applications from any person, non-governmental organization or group of individuals claiming to be the victim of a violation by one of the High Contracting Parties of the rights set forth in the Convention or the protocols thereto. The High Contracting Parties undertake not to hinder in any way the effective exercise of this right.”*

Admissibility or inadmissibility of the complaint must be determined by the Court based on **Article 35** of the Convention. The relevant provisions of this article are given below:

- The Court may only deal with the matter after all domestic remedies have been exhausted, according to the generally- recognized rules of international law.
- The Court may only deal with the matter if it is submitted to the Court within a period of six months after exhaustion of domestic remedies.
- The Court shall not deal with any application that “is substantially the same” as a matter that has already been examined by the Court or has already been submitted to another procedure of international investigation or settlement and contains no relevant new information.
- The Court shall declare inadmissible any application submitted under Article 34 that is “anonymous” or which it considers “incompatible with the provisions of the Convention or the protocols thereto, manifestly ill-founded, or an abuse of the right of application.”<sup>68</sup>

## f) Practical Examples

### 1. Example(s) of Compliance

**Mr. M**, residing in Ksani prison, claimed that he was suffering from poor health conditions and was not provided with appropriate medical care. The patient was in need of urgent endocrinological treatment; however, the prison medical department constantly ignored his condition. The prison hospital informed Mr. M that he had the right to file a complaint and to seek redress. A human rights' NGO received a request from citizen M to represent him in court. (**Hypothetical example**)

### 2. Example(s) of Violation

Taking advantage of patients' lack of knowledge in legal procedures, the staff of medical facilities often assures patients that their rights can only be recovered through the courts and that their complaints are not subject to addressing by any administrative entity. This is how medical institutions attempt to reduce the number of patient complaints against them. (**Example taken from everyday life; authors' opinion**)

### 3. Actual Cases

No real cases were available as examples for this section.

## g) Practice Notes for Lawyers

The constitutional right to file a complaint in order to seek remedy is reflected in the current legislation. Therefore, prior analysis of the effectiveness of the diverse complaint procedures and alternative

means of restoring rights is vital, together with being acquainted with existing court cases on different forms of claiming damages. Besides filing a complaint in court, there exist administrative procedures, such as applying to supervisory and controlling agencies within the system of the Ministry of Labour, Health and Social Affairs. After consulting with clients and deliberating upon clients' interests, the lawyer should decide which methods and procedures respond best to the clients' needs. These court and alternative procedures are further developed in Chapter VIII on the National Procedures.

## **h) Cross Referencing Relevant International and Regional Rights**

Please find a discussion of international and regional standards relevant to the Right to Complain in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## **Right to Compensation**

### **a) Right 14 as Stated in the European Charter of Patients' Rights (ECPR)**

*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.*

Georgian Law envisages the right of patients to seek compensation for the harm caused to them within the health care system. However, the only possibility (well-established system) to be compensated is through the court.

### **b) Right as Stated in Country Constitution/Legislation**

#### **Constitution of Georgia**

According to **paragraph 9 of the Article 42** of Georgian Constitution,

*“Everyone has sustained illegal damage by the State. Self-government bodies and officials shall be guaranteed to receive complete compensation from state funds through the court proceedings.”*

#### **Legislation**

##### **Law on Health Care**

A physician is responsible for medical malpractice in accordance with the rule established by the legislation. A physician has a right to insurance in case of a medical malpractice suit (**Article 50**). However, there is no mention of who pays for this malpractice insurance. As this area is slowly developing, it is more and more common that private insurance companies offer malpractice insurance options.

A medical (healthcare) institution may establish a foundation for malpractice cases in which a complaint is lodged against medical personnel of the institution. Fees for the foundation may be collected from medical personnel and other means permitted by the Law (**Article 58**). Further details on how these foundations are supposed to function (e.g. who decides about payments from the foundation) have not been developed; and in reality, such foundations are quite uncommon. Because there are no further details about these foundations in the law, it is difficult to implement this provision on foundations for malpractice cases.

The Law on Health Care defines **malpractice** as “*diagnostic and therapeutic measures carried out improperly for the patient’s condition, which has become a direct cause of inflicted harm*” (**Article 3**).

### **Law on the Rights of Patients**

As already mentioned, according to **Article 10** of the Law on the Rights of Patients, a patient and his/her legal representative have a right to apply to court for compensation of financial and non-financial damages, which could be the result of:

- ✓ Infringement of the patient’s rights as outlined in the law;
- ✓ Medical error/malpractice;
- ✓ Other types of malfunctioning of healthcare institution;
- ✓ Inadequate supervision or control by State.

### **Civil Code of Georgia**

According to **Article 992** of the Civil Code of Georgia, if a person intentionally or negligently causes losses to another person in violation of laws, he/she must compensate for the damages incurred. Breach of a law is a necessary precondition for compensating for the damages caused by the professional activity of doctor or other healthcare personnel.

**Article 1007** defines that damages suffered by a patient while treated in a hospital (due to wrong surgery or wrong diagnosis, etc.) are to be compensated subject to general regulation. Defendant (hospital) has the burden of proof and if it is proven that the hospital is not guilty in causing damages, the defendant is released from responsibility to pay compensation.

The Civil Code establishes time limitations for any claim to be 3 years, beginning from the moment when the complainant became aware of harm or of a party who could be in charge of compensation (**Article 1008**).

### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular right.

### **d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

## e) Other Relevant Sources

There are no other relevant sources on this matter.

## f) Practical Examples

### 1. Example(s) of Compliance

**Mr. S**, 70, applied to a dentist for a removable partial denture to have replacement teeth for functional reasons. After paying 400 GEL for the artificial device, Mr. S realized that the denture kept falling off during food consumption. In addition, the dentist had removed 4 healthy teeth in order to make the denture to fit well. The dentist refunded Mr. S's money. In addition, Mr. S. received compensation for the loss of his healthy molars. **(Hypothetical example)**

### 2. Example(s) of Violation

**Mr. S** was confined in a mental health institution without having any psychiatric problems. The treatment inflicted bodily harm on him, and Mr. S lost the capacity to move his legs. Later, Mr. S was dismissed from the institution on the grounds of not having mental health problems. He claimed compensation. However, the court refused to examine his claim, stating that somebody confined in mental health institution had no right to ask for any kind of compensation. **(Hypothetical example)**

### 3. Actual Cases

**Citizen K's legal representative G** filed a complaint against the Ministry of Labour, Health and Social Affairs, as well as against "Berna Biotech Korea Corporation" (the pharmaceutical company that produces the vaccine given to Citizen K), in the Administrative Chamber of Tbilisi Civil Court and claimed compensation for non-pecuniary damages resulting from the health injury Citizen K experienced.

The first instance court confirmed that K's illness was caused by hepatitis B vaccine causing acute post-vaccine encephalomyelitis and awarded compensation to the complainant.

After the above ruling, **G** filed a complaint to the Court of Appeal. The applicant claimed that the lower instance court did not provide full remedy in regard to the compensation, as it did not take into account the non-pecuniary damages suffered by the party. According to Article 413.2 of the Georgian Civil Code, in case of health or bodily injury, the injured party can claim pecuniary, as well as non-pecuniary, damages. The Court of Appeal upheld the decision of the lower instance court.

The Supreme Court of Georgia reaffirmed the existence of the pecuniary damage and the defendant's culpability. Furthermore, non-material damages suffered by K, as well as his parents, were demonstrated by mental suffering and psychological disorder.

The Supreme Court of Georgia ordered Ltd. "Berna Biotech Korea Corporation" and the Ministry of Labour, Health and Social Affairs liable to pay 75000 GEL and 15000 GEL, respectively, as compensation

for both pecuniary and non-pecuniary damages suffered by K. (**Supreme Court of Georgia Archives, 2006<sup>69</sup>**)

### **g) Practice Notes for Lawyers**

See practice notes under the Right to Complain.

### **h) Cross-referencing Relevant International and Regional Rights**

Please find a discussion of international and regional standards relevant to the Right to Compensation in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## **Right to Make Advanced Will**

### **a) This right is not dealt with separately in the European Charter of Patients' Rights (ECPR)**

### **b) Right as Stated in Country Constitution/Legislation**

#### **Constitution**

**Article 17.1** of the Constitution states that “[a] *person’s honor and dignity are inviolable.*” Having the right to make advanced decisions about one’s own health is closely linked to the right to dignity, as these advanced wills are very often motivated by the desire to be able to live, or die, with dignity.<sup>70</sup>

#### **Legislation**

##### **Law on Health Care**

All legally competent persons have the right to express in advance, in written form, their will in regards to possible treatment/care at the end of life, or at a terminal stage of incurable disease. Such a will may concern resuscitation, life- sustaining or palliative treatment/care (**Article 10**).

In cases when, after expressing his/her advanced will (in writing), the person loses decision-making capacity, the will must be considered while making decisions about medical care of this person or about his/her involvement in the process of education or scientific research (**Article 11**).

A similar provision is included in **Article 149**, which provides for considering advanced wishes concerning resuscitation, life-saving or palliative treatment, while treating unconscious patients.

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<sup>69</sup> [www.supremecourt.ge](http://www.supremecourt.ge)

<sup>70</sup> See also constitutional analysis under the Right to Consent, earlier in this Chapter.



## Law on the Rights of Patients

According to the Law on the Rights of Patients, citizens have the right to express advanced wishes about resuscitation, life-saving treatment and/or palliative care. However, in this connection, the Law on the Rights of Patients is more specific than the Law on Health Care. Particularly, the Law on the Rights of Patients requires that advance wishes concern only the two following specific situations (**Article 24.1**):

- a) Final stage of terminal illness; or
- b) Disease or condition, which eventually will cause severe disability.

Therefore, advance wills cannot be made about other clinical situations.

In addition, according to the same Law, citizens are entitled to **appoint another person** in advance who will make decisions about their health care in the above-mentioned situations (**Article 24.2**).

There are no further details in the legislation about implementing advanced wills.

## Law on Human Organ Transplantation

According to the Law, any competent person has the right to voluntarily declare his/her wish in advance on donating his/her organ(s) after death. Such a wish must be made in writing, confirmed by the medical institution, and sent to the Transplantation Information Center, which runs the donors' register (**Article 4-6**).

Further details on this subject, including the role of relatives and their consent, are covered in the section on the Right to Informed Consent, earlier in this Chapter.

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular right.

### d) Provider Codes of Ethics

There are no provisions in existing codes of ethics on this matter.

### e) Other Relevant Sources

There are no other relevant sources on this matter.

### f) Practical Examples

#### 1. Example(s) of Compliance

**Citizen K**, in a final stage terminal illness, has appointed in advance his girlfriend, who will make decisions about his health when needed. (**Hypothetical example**)

## 2. Example(s) of Violation

**Mrs. G**, with full decision-making capacity, expressed in advance and in a written form her refusal of resuscitation if her disease reached a terminal stage. However, Mrs. G was ultimately resuscitated due to the demand of her spouse. (**Hypothetical example**)

## 3. Actual Cases

As this area of law is still developing, no real cases were available as examples for this section.

### g) Practice Notes for Lawyers

As there have been no real cases on advanced wills, experience is lacking on this matter. Surely, traditions and culture have to be taken into consideration: as usual, a patient's family members are strongly involved in the decision-making process about the care of the patient. It is expected that, even if there exists an advanced will of the patient, family members would be asked about the decision. Perhaps, it will take some time until advanced wills are accepted and implemented in the country by the system and society at large. Nevertheless, the law explicitly states that advanced wills must be taken into consideration; therefore, health care providers have to keep this in mind and share this responsibility with relatives.

### h) Cross-referencing Relevant International and Regional Rights

Please find a discussion of international and regional standards relevant to the Right to Make Advanced Will under the Freedom of Choice and Freedom of Expression in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## Rights of Persons Deprived of Liberty

### a) This rights is not dealt with separately in the European Charter of Patients' Rights (ECPR)

The rights of persons deprived of liberty are a sensitive issue; therefore, Georgian health legislation contains some specific provisions about them.

### b) Right as Stated in Country Constitution/Legislation

#### Constitution

According the Constitution, all kinds of mental or physical coercion of persons deprived of liberty is prohibited. Particularly, the **Article 15.4** of the Constitution states:

*“Physical or mental coercion of an arrested or a person otherwise restricted in his/her liberty shall be impermissible.”*

General constitutional provisions on torture etc. (**Article 17**) are valid for persons deprived of liberty as well:

*“1. Honor and dignity of an individual is inviolable.*

*2. Torture, inhuman, cruel treatment and punishment or treatment and punishment infringing upon honor and dignity shall be impermissible.”*

## Legislation

### Law on Health Care

In addition to prohibiting any type of discrimination in the field of health care, **Article 6.2** specifically declares that the *“discrimination of a patient in detention and in a penitential place during medical care is inadmissible.”*

The right to consent, as well as other rights of patients, is also specifically articulated for patients in the penitential system. Particularly, according to **Article 13**, *“the medical care for the patient in penitential or a detention place, including the cases of hunger strike, is allowed only upon informed consent of the patient. Medical care will be carried out in accordance with the rules stipulated by the present law.”*

Further, **Article 44** reiterates the obligation of physicians to acknowledge the above rights and provide medical care to “a person in detention or held in custody only after informed consent is obtained from this person, except of the cases of emergency or grave danger for life when the consent is not available due to the patient’s severe condition.” A physician is also obliged to refuse to carry out any medical intervention, which contradicts the norms of ethics and medicine.

The Law also prohibits taking blood and blood components from the person placed in detention or held in custody (**Article 129**).

Finally, the Law on Health Care, in addition to general provisions (contained in **Articles 108 and 109**), establishes specific protective conditions for involvement of prisoners in biomedical research. Particularly, the Law permits involvement of the persons in penitential places in biomedical researches only if *“expected results of the research will be directly and significantly beneficial to the health of these persons”* (**Article 112**).

### Law on the Rights of Patients

**Chapter X** of the Law is devoted to the rights of patients who are in detention or are held in custody. Such persons shall enjoy all rights stipulated by the Law on the Rights of Patients (**Article 46**). The only exception, when the administrations of the detention institutions and prisons can restrict the rights of

patients in their institutions, is related to the right to choose a healthcare provider. However, a person in detention or in custody may place such a decision of the administration in court (**Article 47**).

According to **Article 45**, “a person shall have the right to require an appropriate medical examination, independent medical expertise and medical treatment if necessary as soon as he/she is held in custody.”

### Law on Doctor’s Professional Activity

Duties of doctors while providing care to persons deprived of liberty are outlined in **Chapter VI** of the Law – “**Duties of a Physician while Providing Medical Care to Prisoners, Detainees and Captives.**”

While caring for the patients from the above mentioned target group, a doctor shall ensure that the quality and standards of care are the same as in cases when care is offered to persons who are not deprived of liberty (**Article 53**).

In aiming to protect the rights and safety of persons deprived of liberty, **Article 54** introduces specific prohibitions. Particularly, doctors are prohibited from:

- “Any direct or indirect relation to actions linked to participation, co-participation in, instigation of, or attempted torture or other brutal, savage, inhumane and degrading treatment or punishment, or the presence at such actions;
- Any professional relation with a person deprived of liberty if the sole purpose of the doctor is not assessing, protecting or improving the physical or mental health of such persons, or that purpose prejudices principles of ethics;
- Using his/her knowledge and skills to promote interrogation of a prisoner, a detainee or a captive by such methods which will adversely affect the physical or mental health or condition of such persons;
- Using his/her knowledge and skills or giving out any instrument or substance to promote the torture (of) or any other inhumane or degrading treatment to a person deprived of liberty, or to weaken the resistance of such persons against such practices;
- Imposing any restrictions on a prisoner, detainee or captive if such a restriction is not based on medical indications or it is not necessary for the protection of the health of the person concerned, or for ensuring the safety of another prisoner, detainee or captive, or convoy.”

The above prohibitions shall apply even during emergencies, including military conflicts and civil unrest.

Finally, the Law sets out specific provisions regulating actions of doctors in cases when a person deprived of liberty is on a hunger strike (**Article 55**). According to this article:

- “A physician shall be prohibited from forced feeding a person deprived of liberty when he/she refuses to eat food and he/she, in the physician’s opinion, has the ability to independently and adequately evaluate the consequences of voluntary discontinuance of feeding. This opinion must be confirmed by at least one other independent physician. However, a physician may provide medical care to the patient unless the latter objects to it.
- In case a prisoner or a detainee declares a hunger-strike, the physician shall explain to such a prisoner or detainee the consequences of refusal to receive food and inform such person whether the physician will provide medical care or not, should any unconscious condition develop as a result of the hunger-strike.

- If a prisoner or a detainee falls into any unconscious condition as a result of a voluntary hunger strike, the physician may act in the best interests of the patient's life and health despite the patient's hitherto declared will; the decision shall be made by the physician. The decision-making must not be affected by opinions of any third persons for whom the patient's well-being is not essential.
- In case the hunger-striker, who is able to make a reasonable decision, refuses medical intervention, the physician shall bear no responsibility for the hunger-strike consequences."

## Code of Criminal Procedure of Georgia

According to **Part 1, subparagraph "f" of Article 73** of the Code of Criminal Procedure, the suspected individual, at the moment of detention or after the decision upon his/her accusation is delivered, has the right to require a free of charge medical examination and a written report of the results of such examination. He/she has also the right to require the appointment of a medical expert for investigating his/her health status. The suspect is not obliged to present any kind of proof (document) about his/her health status, or to prove the necessity of the medical examination and expertise requested in any other form.

At the moment of detention or upon final conviction, the suspected individual can require a medical examination free of charge and written conclusions, or appointment of medical expertise without any reasoning. In such cases, intermediation shall be immediately satisfied.

In case the above right is violated, an appeal against the denial can be filed to regional court according to the location of the investigation, where the appeal will be discussed within 24 hours. The decision of the regional court can be appealed in a court at a higher stage.

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular right.

### d) Provider Codes of Ethics

A physician shall take special care of unprotected, vulnerable people – children, mentally ill, elderly, lonely, handicapped, homeless, *prisoners* and *captives* (**Ethics Code of Georgian Physician, Chapter "General Provisions," paragraph 3**).

### e) Other Relevant Sources

There are no other relevant sources on this matter.

### f) Practical Examples

#### 1. Example(s) of Compliance

**Mr. A**, imprisoned in Rustavi, had a severe form of pneumonia. The prison's medical staff was not qual-

ified to provide adequate treatment. After a few days of being in unbearable conditions, and as the treatment provided on-site had no effects, the prison administration requested a doctor from Tbilisi Republic Hospital. The prisoner convalesced after the treatment. **(Hypothetical example)**

## 2. Example(s) of Violation

- It has been 4 years and **Mr. Z** has never left his prison cell because he is physically disabled - the prison never provided him with a wheelchair for movement. **(Public Defender's Office Reports, the first half of 2009<sup>71</sup>)**
- On March 19, 2010, representatives of the Public Defender visited convict B., who was placed in the Anesthesia/Reanimation and Intensive Therapy Unit of the prison medical department. On March 23, 2010, experts of the Department of Prevention and Monitoring at the Public Defender's Office also visited the patient. As a result of the examination, it was discovered that the patient had been diagnosed with tubercular meningitis. At the time of the monitoring, the patient was not cared for adequately. Hospital sanitary standards had been violated in relation to the patient. In particular, the bed in the hospital room was placed with the head to the window, where a draft of cold air blew down toward the head of the patient. The Public Defender addressed the Minister of Corrections, Probation and Legal Assistance to ensure the transfer of convict B. to continue treatment in a specialized hospital, in particular, in the National Center for Tuberculosis, due to the specific nature of his disease. **(Public Defender's News Archive<sup>72</sup>)**

## 3. Actual Cases

- **Citizen O** is imprisoned in Rustavi Prison N6. A few months after imprisonment, his health conditions began to deteriorate significantly. Day by day, his eyesight became worse. O applied to the Medical Department of the Penitentiary Institution several times to request treatment, but did not receive adequate medical aid. As a sign of protest, O started a hunger strike, after which he was removed to the medical department to investigate his health. He was diagnosed with severe health problems, but was not provided with any treatment. In addition to his deteriorating eyesight, O suffers from severe neurosis headaches and needs surgery immediately. O applied to the Center for Protection of Constitutional Rights for help. The Center applied to the Prison Medical Department, but the Department has made no comments regarding the issue. The Center the applied to the Minister for Probation and Legal Aid. The claim was registered on September 14, 2009. The Ministry has not taken any measures yet. **(NGO Center for Protection of Constitutional Rights<sup>73</sup>)**.
- The Public Defender received an application from the lawyer of convict A.Ch. According to the lawyer, the convict was in need of qualified medical assistance and examinations, which are impossible to administer in the institution where he is detained. The application was accompanied by an examination report of Vector LLC, an independent forensic examination center, which states that "the health condition of A. Ch. requires attention; he has a chronic and predictably serious illness, without prospects for full recovery." In the expert's opinion, in order to select adequate surgical intervention, coronary angiography and ventriculography should

71 [www.ombudsman.ge](http://www.ombudsman.ge)

72 <http://www.ombudsman.ge/index.php?page=1001&lang=1&id=1193>

73 [www.cpcr.ge](http://www.cpcr.ge)

have been administered to A.Ch. It was only possible to conduct the aforementioned examinations and treatment in a specialized cardiology clinic. The examination report also states that “without the appropriate qualified medical monitoring and, accordingly, adequate treatment, it is expected that complications dangerous to life in the form of myocardial infarction, stroke or sudden death will occur.” On December 17, 2009, the Public Defender addressed the Acting Minister of Corrections, Probation and Legal Assistance, and the Head of the Penitentiary Department with a recommendation to transfer convict A.Ch. to a medical institution of the corresponding specialization and administer adequate treatment to him. On February 3, 2010, the Penitentiary Department notified the Public Defender that on January 27, 2010, the convict A.Ch. had been transferred to the “Guli” cardiology clinic. **(Public Defender’s News Archive<sup>74</sup>)**

### g) Practice Notes for Lawyers

- Although several complaint options exist in order to seek redress in cases when patients’ rights of a person deprived of liberty have been violated, experience reveals that the most effective method is to apply to the Public Defender’s Office. The Public Defender’s recommendations are not binding; however, their moral impact often brings results much faster than a court procedure would. This is due to the following: the fact that the Office has the possibility to send experts directly to examine the state of health and conditions of the complainant; that there are regular meetings between the Public Defender and the Minister of Corrections, Probation and Legal Assistance; and that the Public Defender uses the power of publicity to give weight to his recommendations.
- It should be noted, however, that the procedure of the Public Defender is helpful mostly in cases in which action is needed to be taken urgently (i.e. cases in which a convict is in a critical health condition and needs to be provided with adequate care within a short period of time). In order to seek redress for patients’ rights violations that cannot be solved by simply stopping the violation (such as, for example, malpractice cases), one shall apply to regular courts, as only courts have the power to award compensation.

### h) Cross-referencing Relevant International and Regional Rights

Please find a discussion of international and regional standards relevant to the Right to Persons Deprived of Liberty under the Right to Non-discrimination and Equality, Right to receive Treatment, Right to Bodily Integrity, Right to Observance of Quality Standards, Freedom from Torture and Other Cruel, Inhuman and Degrading Treatment and Punishment, Right to Physical and Mental Health, Right to Free Choice and Right to Require Free Medical Examination in Chapter 2 and Chapter 3.

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74 [www.ombudsman.ge/index.php?page=1001&lang=1&id=1163](http://www.ombudsman.ge/index.php?page=1001&lang=1&id=1163)

## Rights Related to Genetics

### a) These rights is not dealt with separately in the European Charter of Patients' Rights (ECPR)

Clinical genetics is a field of comparatively new development within the health care systems, and it poses considerable risks to the dignity of individuals in terms of possible discrimination and infringement into private life.

### b) Rights as Stated in Country Constitution/Legislation

#### Constitution

The following articles of the Constitution shall be examined in connection with the rights related to genetics:

- *"1. Honor and dignity of an individual is inviolable." (Article 17.1)*
- *"Everyone is free by birth and is equal before law regardless of race, color, language, sex, religion, political and other opinions, national, ethnic and social belonging, origin, property and title, place of residence." (Article 14)*
  
- *"1. Everyone's private life, place of personal activity, personal records, correspondence, communication by telephone or other technical means, as well as messages received through technical means shall be inviolable. Restriction of the aforementioned rights shall be permissible by a court decision or also without such decision in the case of the urgent necessity provided for by law." (Article 20.1)*

#### Legislation

##### Law on Health Care

The Law on Health Care is the first piece of legislation regulating genetic therapy and human cloning.

**Article 52** of the Law defines specific conditions for carrying out genetic therapy:

- The purpose of genetic therapy is to diagnose and treat fatal diseases;
- There are no less dangerous methods of treatment, as an alternative;
- Written informed consent of the patient, and/or patient's legal representative (in case of patient's incapacity), has been obtained;
- The current level of development of science allows determining that the treatment will not cause undesirable change of the genome of descendants.

**Article 142.1** of the Law prohibits human cloning. Actually the Law on Health Care (adopted in December 10, 1997) was influenced by the Protocol on the Prohibition of Cloning of Human Beings of the Council of Europe even before the Protocol was opened for signature (January 12, 1998). The above-mentioned article, which introduces prohibition on human cloning, was influenced by the debates within the Council of Europe around the draft protocol in 1997. So, Georgia is probably one of the first countries that prohibited human cloning by law,



although the text of the relevant article is not close enough to the language of the protocol.

The anti-cloning protocol itself entered into force in Georgia in 01.03.2001, as in the 4 other countries that had ratified it earlier. Georgia was the 5<sup>th</sup> country to ratify the Additional Protocol on the Prohibition of Cloning of Human Beings, and thus, the minimum number of ratifications needed for the Protocol to enter into force was reached.

### **Law on the Rights of Patients**

The Law on the Rights of Patients includes a separate chapter on this subject – **Chapter VI. “Rights in the Field of Genetic Counseling and Gene Therapy.”**

Provisions of this chapter are closely in line with the corresponding provision of the Council of Europe Convention on Human Rights and Biomedicine (*See further specific provisions of the Convention under section “Other Relevant Sources”*).

The Law on the Rights of Patients prohibits discrimination against a person on grounds of his/her genetic heritage (**Article 31**).

**Article 32** defines two possible purposes of genetic testing, which serve to identify a gene responsible for a disease or to detect a genetic predisposition to a disease (so-called predictive genetic tests). Such tests can only be carried out for the purpose of a patient’s health care and for scientific research, which is linked to health purposes.

The law does permit interventions seeking to modify human genome only for diagnostic, therapeutic or preventive purposes. However, it does not allow modification of the genome of patient’s descendants (**Article 33**).

Finally, the Law specifically prohibits sex selection during medically-assisted procreation, except cases “*when hereditary sex-related disease is to be avoided*” (**Article 34**).

### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for these particular rights.

### **d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

### **e) Other Relevant Sources**

The Convention on Human Rights and Biomedicine prohibits any form of discrimination against a person on grounds of his or her genetic heritage (**Article 11**).

Predictive genetic tests can be carried out only for health purposes. The only exception is scientific research, which must be linked to health purposes as well. So, the Convention does not allow predictive genetic tests to be performed for any other purposes than health (**Article 12**). The same article requires that such genetic tests are subject to appropriate genetic counseling.

**Article 13** requires that “an intervention seeking to modify the human genome may only be undertaken for preventive, diagnostic or therapeutic purposes and only if its aim is not to introduce any modification in the genome of any descendants.”

Finally, the Convention provides for non-selection of sex when using techniques of medically assisted procreation. The only exception could be cases “*where serious hereditary sex-related disease is to be avoided*” (**Article 14**).

As discussed above, another instrument of the Council of Europe – the Additional Protocol on the Prohibition of Cloning of Human Beings – entered into force in Georgia on 01.03.2001.

## **f) Practical Examples**

### **1. Example(s) of Compliance**

Spouses **Mr. L and Mrs. M** decided to go through medically-assisted procreation. After thorough medical examinations, it was revealed that there was a chance that the child would possess a hereditary disease if it were a girl. Even though the Law on the Rights of Patients specifically prohibits sex selection during medically-assisted procreation, Article 34 of the Law makes an exception regarding cases in which hereditary sex-related disease is to be avoided. Thus, in compliance with the law, the doctor allowed the parents to choose the sex of the child. (**Hypothetical example**)

### **2. Example(s) of Violation**

A private insurance company has made it mandatory for its clients to undergo a genetic test that serves as a basis for the insurance contract. The pricing of the insurance is defined based on the health risks identified in the test results. Those who refuse to undergo the test are automatically ranked in the highest-risk category and have to pay the highest price for their insurance. (**Hypothetical example**)

### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

## **g) Practice Notes for Lawyers**

Genetics is an intensively developing branch of medicine and poses a considerable number of ethical and legal problems for patients and health care providers (e.g. problems related to confidentiality and/or using results of genetic testing for insurance or employment purposes, which could lead to discrimination or other problems). Although genetic testing is already being offered to patients

in Georgia, ethical and legal consequences have not been widely discussed. Step by step, cases of violations in this sphere will likely come to light. However, it would be better to prevent such cases through awareness-raising activities, and through the introduction of relevant guidelines into the practice of the health care providers working in the field of genetics.

### **h) Cross-referencing Relevant International and Regional Rights**

Please find a discussion of international and regional standards relevant to the Rights Related to Genetics under Right of Consent, Right to Non-discrimination and Equality and Right to Health in Chapter 2 on international standards of human rights in patient care and Chapter 3 on regional standards of human rights in patient care.

## **6.2 Patient Responsibilities**

There are few cases when responsibilities of patients are explicitly regulated in Georgian legislation. Mostly, these are exceptions defined for some specific rights of patients (e.g. exception for the right not to be informed, or exception from the right to refuse treatment). Responsibilities related to treatment in health care institutions are mostly defined further in institutional bylaws. However, these bylaws cannot contradict laws and regulations.

### **Responsibility to Undergo Medical Intervention**

**a) Responsibility to undergo medical treatment is not usually specified in Georgian legislation and such; it is rather defined as an exception from the right to refuse medical intervention.**

**b) Responsibility as Stated in Country Constitution/Legislation**

#### **Constitution**

There is no specific provision on this issue in the Constitution of Georgia.

#### **Legislation**

##### **Law on Health Care**

The responsibility to undergo medical intervention is linked to the right to refuse treatment. Particularly, the Law on Health Care (**Article 9**) allows exception from the right of the patient to refuse medical intervention, if the law provides for this. According to the same article, such an exception could be related to immunization, quarantine measures, curative and preventive measures taken for the citizens with high risk of development of communicable diseases.

### Law on the Rights of Patients

According to **Article 23** of the Law, cases when medical intervention can be carried out against the will of a competent patient with decision-making capacity, can be defined only by law (**Article 23**). The Law on the Rights of Patients identifies one specific case when the patient cannot refuse medical treatment: a woman in labor cannot refuse medical intervention which is necessary for the birth of her living fetus, and which bears minimal risk to the health and life of the pregnant woman (**Article 36.2**).

### Law on Public Health

The Law does not specifically mention responsibility of the patient/citizen to undergo medical intervention, but rather establishes exceptions from the right to refuse treatment (like other law discussed above). Particularly, the person whose professional activity is associated with high risk of dissemination of communicable diseases cannot refuse preventive measures (**Article 5.2.b**). According to the same article, such restrictions on the right to refuse treatment could be placed in case of epidemics and pandemics.

On the other hand, health care providers and public health services are entitled to request a person who is proved to be infected with a communicable disease to undergo medical examination and/or medical treatment and/or to receive medical counseling (**Article 10.3**).

Specific rights are granted to the State Committee on Emergency Situations for controlling epidemics and pandemics (**Article 12**). This committee is entitled to request individuals in the region of epidemics to undergo medical examination.

Decision about isolating a person or applying quarantine measures to a person is made by public health services without prejudice to the principles of the European Convention on Human Rights and Fundamental Freedoms (**Article 11.3**). The person can appeal to court against the decision (**Article 11.2**). In a state of emergency, decisions about an individual's isolation or about applying quarantine measures to an individual are implemented by the Department for Management of Emergency Situations, Ministry of Internal Affairs (**Article 11.1**).

### Law on HIV Infection/AIDS

The Law on HIV Infection/AIDS (of 17 November, 2009) establishes specific cases when HIV testing is obligatory (**Article 6.3**); particularly, HIV testing is obligatory for the following persons:

- ✓ Blood donors and donors of products of blood;
- ✓ Donors of organs and parts of organs;
- ✓ Donors of tissues; and
- ✓ Donors of ovum and sperm.

Such an obligation is conveyed by a citizen's decision of to be a donor (of blood, organs etc.). As soon as one decides not to be a donor they are no longer obliged to undergo HIV testing.

According to **Article 6.5** other cases when HIV testing is mandatory can only be defined by law. That means that no one can issue an order about involuntary HIV testing, if such a specific case is not stipulated by law.

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular responsibility.

### d) Provider Codes of Ethics

There are no provisions in existing codes of ethics on this matter.

### e) Other Relevant Sources

The Council of Europe Convention on Human Rights and Biomedicine<sup>75</sup> in general, allows for placing restrictions on the exercise of rights specified in the convention (including right to consent) only if they are *“prescribed by law and are necessary in a democratic society in the interest of public safety, for the prevention of crime, for the protection of public health or for the protection of the rights and freedoms of others”* (**Article 26 – Restrictions on the Exercise of Rights**).

### f) Practical Examples

#### 1. Examples of Compliance

The blood donor has agreed to undergo HIV testing before donating his blood for transfusion upon the request of the health care provider. (**Example taken from everyday life**)

#### 2. Examples of Violation

**Mrs. J**, who happened to travel to a region defined by the Governmental Committee on Emergency Situations as a region of pandemic, refused at her return to undergo a medical examination upon the request of the above-mentioned committee. (**Hypothetical example**)

#### 3. Actual Cases

No real cases were available as examples for this section.

### g) Practice Notes for Lawyers

As the experience in this matter is lacking, no notes were available as practical advice for this section.

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<sup>75</sup> Entered into force in Georgia on 01.03.2001.

## Responsibility to Provide Information

a) Responsibility of the patient to provide information about his/her health is primarily aimed at protecting the health of others.

b) Responsibility as Stated in Country Constitution/Legislation

### Legislation

#### Law on HIV Infection/AIDS

A person with HIV/AIDS, who is aware of his/her HIV positive status, is obliged to inform his/her spouse or sexual partners that he/she is infected with HIV (**Article 11.2**).

According to **Articles 8.7 and 11.2**, if the HIV-positive person does not fulfill his/her obligation to inform those who can be potentially infected by him/her, the healthcare provider must inform these people (i.e. spouse or sexual partners) according to the relevant rules, provided that their identity is known to him/her. These rules are not further specified in the Law, except for the following (**Article 8.6**):

*“A Service Providing Institution which carries out diagnostic, preventive, treatment, care and support activities to HIV infected individuals is responsible to request from the HIV infected person the information about those individuals with whom he / she has had a risk-involving contact from the epidemiological point of view.”*

The legislation does not impose any penalty upon the patient for not having informed his/her spouse or sexual partner; however, **Article 131.1 of the Criminal Code** imposes sanctions (imprisonment for 5 years) for causing the threat of infecting with intent with HIV another person.<sup>76</sup>

c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular responsibility

d) Provider Codes of Ethics

There are no provisions in existing codes of ethics on this matter.

e) Other Relevant Sources

There are no other relevant sources on this matter.

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<sup>76</sup> As regards to causing the threat of infecting another person with an extremely harmful disease, the existence of intent is not required by the Criminal Code (article 132.1).

## f) Practical Examples

### 1. Examples of Compliance

**Mr. S** found out that he was HIV-positive. Fearing the social stigma, he decided not to reveal the information to his close friends and co-workers. However, fulfilling his obligation, and willing to prevent her from getting infected, Mr. S informed his wife about his status immediately. (**Hypothetical example**)

### 2. Examples of Violation

**Mr. P** was aware that he was HIV-positive. However, fearing his girlfriend's reaction, he decided not to inform her about it. After several months, it was revealed that her boyfriend had infected her. (**Hypothetical example**)

### 3. Actual Cases

As this area of law is still developing, no real cases were available as examples for this section.

## g) Practice Notes for Lawyers

As the experience on this matter is lacking, no notes were available as practical advice for this section.

## Responsibility to Receive Information

a) Responsibility to receive information is defined as an exception from the right not to be informed.

### b) Responsibility as Stated in Country Constitution/Legislation

#### Constitution

There is no specific provision on this issue in the Constitution of Georgia.

#### Legislation

##### Law on the Rights of Patients

According to **Article 20** of the Law on the Rights of Patients, restriction can be placed on the right of a patient not to be informed about his/her health, medical care and related issues, if *“withholding information may cause serious damage to the patient or to a third party.”*

So the patient must receive the above-mentioned information as it is essential to prevent harm to the

patient and/or other individuals (an example might be the patient is a driver or pilot with a specific type of epilepsy that is characterized by so-called “absences” in which the patient cannot see or hear anything, i.e. he/she is isolated from the outer world. In such cases, the patient shall be informed about the disease to avoid harming others).

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular responsibility.

### d) Provider Codes of Ethics

There are no provisions in existing codes of ethics on this matter.

### e) Other Relevant Sources

According to **Article 10.3** of the Council of Europe Convention on Human Rights and Biomedicine,<sup>77</sup> restrictions can be placed on the right of individuals to refuse receiving “*information collected about his or her health.*” Therefore, in exceptional cases a patient can be informed against his/her wish not to be informed.

### f) Practical Examples

#### 1. Examples of Compliance

**Mr. A** had serious doubts whether or not he had hepatitis B and decided to undergo a medical examination. He was too scared to learn about his health condition so at the very last moment, he did not apply to the medical institution to find out about the results of the testing. The doctor explained to A that his refusal to receive information could seriously damage the health of third parties. Finally, A agreed to cooperate with the doctor. **(Hypothetical example)**

#### 2. Examples of Violation

**Mrs. D** has undergone a free and anonymous HIV testing offered at an open-air festival. When the doctor informed her that she was HIV-positive, Mrs. D became so upset that she rudely questioned the doctor’s professional abilities, and left the facility without accepting to hear anything more about her infection. Although the doctor tried to argue that she had the duty to listen, he could not inform Mrs. D about ways the virus is transmitted, or about safety measures to prevent third people from getting infected. Therefore, Mrs. D violated her obligation to receive information. **(Hypothetical example)**

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<sup>77</sup> Entered into force in Georgia on 01.03.2001.



### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

#### **g) Practice Notes for Lawyers**

Although it is crucial for people to know about threats to their health, it is vital to mention that people infected with HIV or with other transmittable diseases shall not be considered ‘public enemies.’ Human rights of all people, whether infected or not, shall be respected in all circumstances; this is an absolute prerequisite of an effective cooperation between those concerned. Therefore, defending people against prosecution for not knowing, or for disclosing their status shall be a priority of all health care professionals involved, together with awareness-raising (in the general population) about ways of transmission and effective means of prevention of diverse infectious diseases.

## **7.1 PROVIDERS' RIGHTS**

**Right to Work in Decent Conditions**

**Right to Freedom of Association**

**Right to Due Process**

**Right to Undertake Professional Activities**

## **7.2 PROVIDERS' RESPONSIBILITIES**

**Responsibility to Consider Patients' Interests**

**Responsibility to Provide Care**

**Responsibility to Ensure Quality of Care**

**Responsibility to Inform Patients and/or Their Representatives**

**Responsibility to Obtain Informed Consent**

**Responsibility to Maintain Confidentiality and Respect Patients' Privacy**

**Responsibility to Keep Medical Records**

**Responsibility to Submit Report/Information**

**Responsibility Related to Care of Persons Who Are in Detention or in Prison**

**Responsibility and Duties Before Colleagues and Profession**

# 7

## National Providers' Rights and Responsibilities

The term **“Health Care Provider”** should be understood in a broad sense, and it usually includes health care professionals as well as health care institutions. In the **Law on Health Care**, the term **“Health Care Provider”** is mentioned in the context of health care financing, and it includes only health care institutions (**Article 19**). The law does not include any definition of the term **“Health Care Provider.”**

For health care professionals, the term **“Medical Personnel”** is used in the same Law. The term is defined as “individuals with medical or non-medical education who provide care to patients” (**Article 3**).

The **Law on the Rights of Patients** defines the term **“Health Care Service Provider”** as (**Article 3**): “A person who provides medical services in accordance with the rules set out by the Legislation of Georgia.”

In this Chapter, under the term **“Health Care Provider,”** are included health care professionals – in most cases doctors, then nurses and other personnel. Rights and duties of doctors only are outlined separately in the Law on Doctor’s Professional Activity.

According to Georgian legislation, the above health service providers are entitled to practice medicine independently, if they have completed relevant medical education and, as prescribed by law, received state certificate in an approved medical specialty (**Law on Health Care, Article 28**).

## 7.1 Providers' Rights

This section focuses on provider 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. This recognizes the interdependence of patient and provider rights. Health workers are unable to provide patients with good care unless their rights are also respected, and they can work under safe and respectful conditions. For each right, there is a brief explanation of how it relates to health providers; an examination of its basis in country legislation, regulations, and ethical codes; examples of compliance and violation; and practical notes for lawyers on taking cases protecting provider rights.

There has been a long-standing discussion in Georgian society, especially among health care providers, about the rights of health care providers. In such debates, health care providers request their rights, such as the right to adequate working conditions and remuneration, as well as other social rights, to be specifically articulated in the legislation. On the other hand, those who are against such an approach suppose that the above rights are general social rights which are common for everyone in every profession.

As a result, the rights of health care providers can be found partly in general legislation (as part of a wide range of social and political rights), and partly in specific health care laws.

### 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.**

Working in decent working conditions is an important prerequisite for provision of high quality services by health care providers. Georgian legislation grants certified doctors the right to request adequate working environments from their employers. Furthermore, general legislation obliges all employers to guarantee safe working environments to their employees.

**b) Right as Stated in Country Constitution/Legislation**

#### Constitution

According to **paragraph 4 of Article 30** of the Georgian Constitution, “the protection of labor rights, fair remuneration of labor and safe, healthy working conditions and the working conditions of minors and women shall be determined by law.” The right to decent working conditions is further articulated in health care legislation (See below).

## Legislation

### Law on Doctor's Professional Activity

A certified doctor has the right to request his/her employer to create working conditions that are adequate for the professional activity he/she (the doctor) carries out (**Article 93.1**).

### Labor Code of Georgia

Provisions of the Labor Code of Georgia are applicable to all employees, including health care professionals. Employers are obliged to ensure their employees have a working environment which is the safest for their life and health (**Article 35.1**), and to provide employees within a reasonable time with complete, objective and understandable information about the factors related to the workplace that influence their health and life (**Article 35.2**). Employers must establish preventive measures for labor safety and inform employees about such measures, as well as about safe methods of working with dangerous equipment. Employers must also provide employees with protective equipment and make sure that, in light of technical progress, dangerous equipment is replaced with safe or less dangerous equipment (**Article 35.4**).

An employee has the right to refuse to carry out tasks or instructions which, due to inobservance of safety measures, pose obvious and considerable risk to his/her own, or to a third person's health and life (**Article 35.3**).

Finally, employers are obliged to compensate their employees for any health damages inflicted at the work place, as well as to reimburse for treatment costs related to them (**Article 35.6**).

The law provides for establishing a list of jobs that are harmful and hazardous and for defining cases when employees have to undergo mandatory regular health examinations, which must be paid for by employers (**Article 54.1.b**). The list and cases can be found in the Order of the Minister of Labour, Health and Social Affairs.<sup>1</sup>

### Law on Health Care

According to **Article 96** of the Law, employers must provide employees with comprehensive information on the risks of development of occupational diseases in the enterprise and/or institution, information on the existence of harmful factors, and the measures to be taken against their influence.

### c) Supporting Regulations/Bylaws/Orders

The Order of the Minister of Labour Health and Social Affairs No 215/n of 11.07.2007,<sup>2</sup> based on the Labor Code of Georgia (Article 54.1.b), defines the list of cases when employees have to undergo regular medical examinations, which are financed by their employers. This list includes doctors and nurses of all specialties (*See Appendix 1 to the above Order, Paragraph 1.e.*).

<sup>1</sup> See sub-section Supporting Regulations/Bylaws/Orders below.

<sup>2</sup> Title of the order: "on establishing list of cases and rules for mandatory regular medical examination of employees to be covered by employer".

#### **d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

#### **e) Other Relevant Sources**

There are no other sources on this matter.

#### **f) Practical Examples**

##### **1. Examples of Compliance**

Equipment in the X-ray departments of state polyclinics is frequently checked and replaced to ensure appropriate functioning and to protect medical staff from high levels of radiation, which could harm their health. (**Hypothetical example**)

##### **2. Examples of Violation**

In Georgian prisons, the prevalence of communicable diseases is much higher than in civil clinics. When lacking extra-protection, medical personnel are under an increased risk of being infected, which hinders them in fulfilling their duties (**Public Defender's Office Reports to Parliament, 1<sup>st</sup> Half of 2009<sup>3</sup>**)

##### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

#### **g) Practice Notes for Lawyers**

Medical activity is subject to licensing, and conditions of licensing are, among other things, aimed at preventing injury to patients during high-risk medical manipulations. To hold the State responsible together with the medical institution, lawyers should ascertain that inadequate control was conducted by the State Regulatory Agency for Medical Activity<sup>4</sup> when granting a license to the medical institution. In addition, according to the Law on Licenses and Permissions, and to the bylaws of the Agency, the Agency is responsible for monitoring whether the institution satisfies the conditions of the license. This is done based on annual reports and selective assessment of institutions (not more than once per year). Whether the Agency may be held liable for inadequate monitoring is another legal question, but is not clearly answered. The Law on Licenses and Permissions states that "responsibility for violating this law" is defined by Georgian Legislation, but it does not include such a definition (**Law on Licenses and Permissions, Article 37**).

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<sup>3</sup> <http://www.ombudsman.ge/>

<sup>4</sup> For more details on the State Regulatory Agency for Medical Activity, see Chapter VIII on National Procedures.

## h) Cross-referencing Relevant International and Regional Rights

See sections on the Right to Work in Decent Conditions in Chapter II on International Framework for Human Rights in Patient Care, and in Chapter III on Regional Framework for Human Rights in Patient Care.

## 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.**

The right to form and to join associations is a general right of every citizen of Georgia. There are various provisions in health care legislation that enforce the role of professional associations in setting standards, certifying health care professionals, and ensuring quality of health care.

### b) Right as Stated in Country Constitution/Legislation

#### Constitution

There is a general provision in the Constitution on the right to form associations. Particularly, according to **paragraph 1 of Article 26** of Georgian Constitution:

“Everyone shall have the right to form and to join public associations, including trade unions.”

#### Legislation

##### Law on Health Care

Professional associations<sup>5</sup>, as other organizations (e.g. academies, private or State organizations) are entitled to participate in the process of management of the health care system of the country (**Article 18**)<sup>6</sup>:

“Professional associations, academies and other public organizations as well as State and private medical institutions participate in the state management of the health care system within the frame of Georgian legislation.”

<sup>5</sup> Apart from the diverse professional associations of doctors, nurses also have their professional association. The Association of Nurses of Georgia is involved in policy making, and in several training programs, yet the fact that there is currently no licensing system for nurses makes the role and possibilities of the Association of Nurses different from the doctors' professional associations' ones.

<sup>6</sup> In practice, doctors' professional associations are involved in this process in the following ways: they take part in the development of postgraduate (residency) training programs and the elaboration of related examination systems; their conclusions are requested before the approval of any relevant postgraduate or continuing professional education program; the representative of the Medical Association of Georgia takes part in the work of the Professional Development Council (PDC); foreign specialists are invited by the PDC and the State Regulatory Agency for Medical Activity (SRAMA) only after the proposal about inviting the specialist has been submitted for consideration to relevant professional associations; the PDC and the SRAMA always submit cases related to quality of care, or patient complaints, to the relevant professional association.

According to **Article 49**, physicians have the right to attend, and to participate in, professional meetings allowed by the legislation, irrespective of the venue of the meeting.

### **Law on Doctor's Professional Activity**

The Law envisages participation of professional associations of doctors in the process of regulating/running the profession. Particularly, the role of professional associations of doctors is specified in the following contexts:

- ✓ Postgraduate education/training and certification of doctors (**Articles 12, 20, 37**);
- ✓ Monitoring professional activity of doctors (**Article 66**);
- ✓ Professional responsibility of doctors (**Article 94**);
- ✓ Inviting specialists from other countries (**Article 11**).

### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular right.

### **d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

### **e) Other Relevant Sources**

There are no other sources on this matter.

### **f) Practical Examples**

#### **1. Example(s) of Compliance**

**Doctor B**, living in Kobuleti, is a member of a doctors' professional organization conducting its weekly meetings in Tbilisi. Because of the long distance, B cannot travel to Tbilisi to attend the meetings. However, he is still involved in all the deliberations of the organization by conference call. (**Hypothetical example**)

#### **2. Example(s) of Violation**

Even though professional associations of doctors are entitled to participate in the State management of the healthcare system, some organizations are deprived of this opportunity because of administrative obstacles, as administrative procedures can sometimes be very lengthy and complicated. (**Hypothetical example**)



### 3. Actual Cases

As this area of law is still developing, no real cases were available as examples for this section.

#### g) Practice Notes for Lawyers

The right to freedom of association is important for medical society because it makes it possible to observe the principle of self-regulation and excludes any prohibited form of State intervention. In other words, apart from matters and objectives regulated by law (e.g. licensing of doctors), joining associations is aimed at a professional self-regulation of doctors; and operation of such organizations must not be limited. The right to freedom of association would normally imply the right of doctors to strike. For more details on this issue, see the section below on the Right to Strike.

#### h) Cross-referencing Relevant International and Regional Rights

See sections on Freedom of Association in Chapter II on International Framework of Human Rights in Patient Care, and in Chapter III on Regional Framework of Human Rights in Patient Care.

## Right to Strike

**a) Strike is a temporary, voluntary refusal of the employee, in case of a dispute, to perform fully or partially the commitments imposed by the employment agreement.**

#### b) Right as Stated in Country Constitution/Legislation

##### Constitution

According to **Article 33** of the Constitution of Georgia, “The right to strike shall be recognized. The Procedure for exercising this right shall be determined by law. The law shall also establish the guarantees for the functioning of services of vital importance.”

##### Legislation

##### Labor Code of Georgia

The Labor Code of Georgia recognizes the right to strike. **Article 49** of the Code defines “*strike*” and states that, “*persons identified by Georgian legislation are not authorized to participate in the strike.*”

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<sup>7</sup> See definition in the textbox above.

According to **Article 51** of the Code, “it is prohibited to apply the right to strike or lockout<sup>8</sup> in the work process by those employees who are engaged in activities dealing with human health and life security, i.e. due to its technological nature it is impossible to suspend such activity.”

### **Law of Georgia on the Procedure of the Settlement of Collective Labor Disputes**

The Law of Georgia on the Procedure of the Settlement of Collective Labor Disputes guarantees the right to strike against the employer. Participation in the strike is voluntary. Any pressure against the enjoyment of this right leads to responsibility under the law (**Article 11**). However, the Article does not identify or define specific “responsibility under the law.”

#### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular right.

#### **d) Provider Codes of Ethics**

There are no provisions in existing code of ethics on this matter.

#### **e) Other Relevant Sources**

The right to strike is stipulated in **Article 11** of the **European Convention on Human Rights**, constituting directly-acting national law for the member states, and thus, for Georgia. According to Article 11: *“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.”*

The Convention emphasizes also that 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.”

#### **f) Practical Examples**

According to actual labor legislation, health care professionals do not have a right to strike, therefore, examples of compliance, or of violation, could not be provided. For similar reasons, no real (actual) cases were available either.

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<sup>8</sup> Article 49.2: “Lockout is the temporary voluntary refusal of the employer in case of dispute to perform fully or partially commitments imposed by the employment agreement”

### g) Practice Notes for Lawyers

- Although the Constitution of Georgia guarantees the right to strike in general for every profession, it indicates the only possible limitation is in the provision-functioning of services of vital importance. The legislature decided to entirely forbid the striking of health care workers (in case they are employees), police staff, and even teachers (in case they are employees as well).
- In the opinion of the authors of Commentary to the Constitution of Georgia, Human Rights and Freedoms<sup>9</sup>, these provisions are unconstitutional. However, to the knowledge of the authors of this Practitioner Guide, none of these provisions have been challenged at the Constitutional Court so far.

### h) Cross-referencing Relevant International and Regional Rights

Please find a discussion of international and regional standards relevant to the Right to Strike in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

## 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. Georgian health care legislation provides the right to due process and a fair hearing to medical doctors.<sup>10</sup>**

### b) Right as Stated in Country Constitution/Legislation

#### Constitution

There is no specific provision in the Constitution that would give the right to due process specifically to health care providers.

However, general due process guarantees have been defined in the Constitution: presumption of innocence (**Article 40<sup>11</sup>**); access to court, right to defense, principle of *Nullum crimen sine lege, nulla poena sine lege* – no one shall be held responsible on account of an action which did not constitute a criminal offence at the time it was committed – and principle of *Ne bis in idem* – no one shall be convicted twice for the same crime (**Article 42**); prohibition of arbitrary restriction of personal liberty (**Article 18**); and prohibition of creation of either extraordinary or special courts (**Article 83.4**).

<sup>9</sup> By Levan Izoria, Konstantine Korkelia, Konstantine Kublashvili and Giorgi Khubua; Meridiani, Tbilisi, 2005.

<sup>10</sup> The Law on Doctor's Professional Activity relates only to doctors; and there are no similar provisions within health care laws that would concern other health care professionals.

<sup>11</sup> 1.) An individual shall be presumed innocent until the commission of an offence by him/her is proved in accordance with the procedure prescribed by law and under a final judgment of conviction. 2.) No one shall be obliged to prove his innocence. A burden of proof shall rest with the prosecutor. 3.) A resolution on preceding a person as an accused, a bill of indictment and a judgment of conviction shall be based only on the evidence beyond a reasonable doubt. An accused shall be given the benefit of doubt in any event.

## Legislation

### Law on Doctor's Professional Activity

Doctors' professional activity is subject to supervision and quality control. This could be accomplished through various activities, including review of medical records. Doctors have the right to participate in the process of supervision / quality control, and they shall be involved in the preparation and discussion of the documents summarizing the results of the assessment of their professional activity. Moreover, doctors are entitled to provide comments and explanations to documents reflecting assessment results, and such comments will be attached to the aforementioned documents (**Article 68**).

The Ministry of Labour, Health and Social Affairs, and particularly the State Regulatory Agency for Medical Activity, is in charge of supervision and quality control of health care provider activity in general, including doctors, other health care professionals, and legal entities.<sup>12</sup>

In addition, patients, their representatives, employers, and colleagues are entitled to submit complaints or reports or information that could be a basis for sanction against a certified doctor to the Professional Development Council. Finally, the Council imposes sanctions if violation of the law and professional misconduct is proven (**Articles 75-79**).<sup>13</sup>

When a complaint or note or information on professional misconduct of a doctor is submitted to the Professional Development Council, the doctor is entitled to be informed of this fact, and a copy of such document will be sent to him/her (**Article 84**). The doctor can give oral or written comments on the document containing the complaint or note about his/her professional misconduct.

The doctor, as well as the opposing party/complainant, is entitled to attend the decision-making process about the professional misconduct (**Article 87**).

Certified doctors can be imposed the following sanctions for professional misconduct (**Article 74.1**): written warning; suspension of license; withdrawal of license; restriction of the right to prescribe narcotics, psychotropic drugs or medications containing alcohol; other measures of professional liability envisaged by the legislation of Georgia.

Doctors can appeal to the first instance court against any sanction mentioned above, as well as against any decision about their professional misconduct (**Articles 74.3, 77.4, 80 and 89**).

### c) Supporting Regulations/Bylaws/Orders

The establishment, functions and procedures of the Professional Development Council are established by the Order of the Minister of Labour, Health and Social Affairs No122/n of 16.05.2008 on "Establishment of the Professional Development Council at the Minister of Labour, Health and Social Affairs and Approval of its Bylaw."<sup>14</sup>

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<sup>12</sup> For more details, see Chapter VIII on National Procedures.

<sup>13</sup> Reasons and conditions for sanctions described in Article 74.1 (presented below) are described in the sub-section on the Professional Development Council in Chapter VIII on National Procedures.

<sup>14</sup> The bylaw includes 6 Articles: Article 1 – General Provisions; Article 2 – Functions and Authorities of the Council; Article 3 – Working Methods of the Council; Article 4 – State Certificate; Article 5 – State Certification Examination; Article 6 – Transitional Provisions.

This order abolished two different bodies – “State Certifying Council” and “Postgraduate and Continuing Medical Education Council” – and established a new body – “Professional Development Council,” which is in charge of managing postgraduate education, certification, continuing medical education and professional development of health care professionals, monitoring their professional activity and implementing relevant actions. This is done through accreditation, certification, monitoring and quality assurance, and also by implementing sanctions, if necessary.

The Order of the Minister of Labour, Health and Social Affairs No24/n of 30.01.2005 regulates the statute of the State Regulatory Agency on Medical Activity. It defines the Agency as the controlling body that supervises the medical activity of all legal entities and natural persons on the territory of Georgia.

#### **d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

#### **e) Other Relevant Sources**

There are no other sources on this particular right.

#### **f) Practical Examples**

##### **1. Example(s) of Compliance**

**Doctor J** was sued in court for medical negligence while performing an abortion. J was immediately informed about this fact, and written documentation was sent to his home, as well as to his work address. The court proceedings were conducted observing fair trial standards, and doctor J was acquitted as a result. **(Hypothetical example)**

##### **2. Example(s) of Violation**

A complaint was filed in a court of law against **Physician C** on charges of performing an abortion without the patient’s consent. In violation of the Law on Doctor’s Professional Activity, Dr. C was not informed about the submission of such complaint, and no copy of the document was sent to him. As a result, Dr. C was not given the opportunity to comment on the complaint, or to get prepared before the trial. **(Hypothetical example)**

##### **3. Actual Cases**

As, generally, due process is respected in court complaints filed against physicians, no real cases were available as examples for this section.

### g) Practice Notes for Lawyers

For medical institutions, the right to due process is of utmost importance, as these institutions are potential defendants of numerous complaints. From the health law prospective, the right to due process pertains to the existence of transparent, speedy and effective procedures, which exclude admissibility of non-legally-based claims and the provision of remedy for such claims. Any kind of infringement upon the right to due process is considered as a violation of Article 6 of the European Convention on Human Rights. In this case, lawyers should assess whether the procedures established by national legislation respond to the procedural criteria in free, impartial and regularly-constituted courts. Those criteria are set out in the case law of the European Court of Human Rights.

### h) Cross-referencing Relevant International and Regional Rights

See sections on the Right to Due Process and Related Rights in Chapter II on International Framework for Human Rights in Patient Care and in Chapter III on Regional Framework for Human Rights in Patient Care.

## Right to Fair Remuneration

### a) Health care providers are entitled to fair remuneration.

### b) Right as Stated in Country Constitution/Legislation

#### Constitution

According to **paragraph 4 of Article 30** of the Georgian Constitution, *“the protection of labor rights, fair remuneration of labor (...) shall be determined by law.”*

#### Legislation

##### Law on Health Care

Doctors have the right to receive adequate remuneration from their employers if they (doctors) are not paid directly (legally) by patients or their representatives. The system of doctors' payment is to be developed through participation of public organizations protecting physicians' interests, the Ministry of Labour, Health and Social Affairs, and the Ministry of Finances (**Article 46**). Bonuses are envisaged for doctors and other healthcare professionals working in specific specialties and/or regions (**Article 47**).

##### Law on Doctor's Professional Activity

Certified doctors have a right to request from the employer adequate remuneration which corresponds to their work (**Article 93.2**).

Moreover, doctors working in certain specific fields and/or specific regions of the country (as defined by the President of Georgia) are entitled to receive additional remuneration and other benefits, including accommodation and means of communication (**Article 95**). These include regions in the high mountains and near the state border and conflict regions. Every year additional funding of healthcare institutions and personnel in those regions is defined by the Order of the Minister of Labour, Health and Social Affairs regarding implementation of State medical programs based on the Law on the State Budget.

### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular right.

### **d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

### **e) Other Relevant Sources**

There are no other sources on this matter.

### **f) Practical Examples**

#### **1. Example(s) of Compliance**

**Doctor N**, working full time at Tbilisi N2 Polyclinics received \$50 per month as remuneration. The amount of her salary was not an adequate remuneration for the work she was performing and the number of working hours spent at the polyclinic. Last year, due to a related State program, her salary was doubled, which is considered more or less fair by Georgian minimum wages standards. **(Example collected by the authors)**

#### **2. Example(s) of Violation**

All over Georgia the salary of prison medical staff is so meager that it discourages physicians to fulfill their obligations towards imprisoned patients in an appropriate manner. **(Report of the Public Defender of Georgia Regarding the State of the Protection of Human Rights and Freedoms in Georgia, July-December 2008)**

#### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

### **g) Practice Notes for Lawyers**

As the experience on this matter is lacking, no notes were available as practical advice for this section.

### **h) Cross-referencing Relevant International and Regional Rights**

See sub-section on the Right to Fair Pay and Safe Working Conditions in Chapter II on International Framework for Human Rights in Patient Care, and sub-section on the Right to a Fair Remuneration in Chapter III on Regional Framework for Human Rights in Patient Care.

## **Right to Independent Professional Judgment**

**a) The right to independent professional judgment gives health care professionals the possibility to make independent, free of any undue influence, health care decisions in the best interests of the patient.**

### **b) Right as Stated in Country Constitution/Legislation**

#### **Constitution of Georgia**

There is no specific provision on this issue in the Constitution of Georgia.

#### **Legislation**

##### **Law on Health Care**

While caring for patients, doctors and other health care professionals are to be guided by the interests of patients and to be independent and free in making decisions about a patient's care (**Article 30**).

The law acknowledges the doctor's profession to be a "free profession." In no circumstances can either an official or private person, despite his/her position, demand a physician to act against professional ethics and principles defined in the law. Any activity impeding the accomplishment of professional duties by medical personnel is punishable under the law (**Article 34**).

Finally, doctors are entitled to prescribe any medication and method of treatment that is in the best interest of the patient (**Article 51**).<sup>15</sup>

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<sup>15</sup> However, according to the Law on Drug and Pharmaceutical Activity, only drugs authorized by the State can be sold and circulated on the market, and thus, used for treating patients.



## Law on Doctor's Professional Activity

Doctors shall be independent and free when making professional decisions (**Articles 6 and 38**). No one can demand or order a doctor to act against professional standards and ethics (**Article 6**).<sup>16</sup>

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular responsibility.

### d) Provider Codes of Ethics

There are no provisions in existing codes of ethics on this matter.

### e) Other Relevant Sources

There are no other sources on this matter.

## f) Practical Examples

### 1. Examples of Compliance

A doctor orders an expensive additional test based on the national clinical practice guideline to confirm the diagnosis and prescribe a relevant treatment to his patient, irrespective of the request of the insurance company not to order such tests. Such a case could be discussed by the Health Insurance Medication Service, which can help settle the case and instruct the insurance company to reimburse expenses.

### 2. Examples of Violation

- On the request of the government, **Physician A** has assessed prisoner J's fitness to withstand torture. (**Hypothetical example of dual violation by the State and the physician**)
- **Mr. K** has been treated in a mental hospital. Every time he was unwilling to take the medicines prescribed by his doctor, he was severely beaten by nurses. In order to protect the hospital's "renomé," the physician in charge never documented any of these injuries in Mr. K's medical records. (**Hypothetical example**)

### 3. Actual Cases

No real cases were available as examples for this section.

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<sup>16</sup> Naturally, as professionals standards and ethics imply respect for patients' autonomy, this rule does not impede patients' right to consent or right to free choice.

### **g) Practice Notes for Lawyers**

As the experience on this matter is lacking, no notes were available as practical advice for this section.

### **h) Cross-referencing Relevant International and Regional Rights**

See sections on the Right to Bodily Integrity, the Right to Non-discrimination and Equality, and the Right to Due Process in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

## **Right to Refuse to Provide Treatment**

### **a) Physicians have the right to refuse to provide patients with treatment in certain cases.**

This right is limited to cases in which there is no emergency and it is possible to ensure continuity of care, or when there would be considerable risk to health and life of the provider during health care provision.

### **b) Right as Stated in Country Constitution/Legislation**

#### **Constitution**

There is no specific provision on this issue in the Constitution of Georgia.

#### **Legislation**

##### **Law on Health Care**

According to **Article 37**, the doctor has the right to refuse provision of medical care to a patient only when the continuity of medical care for the patient could be ensured in some other way and there is no need for emergency/urgent medical care. Paragraph "b" of the Article deals with the rare situation when the provision of care would pose a real risk to the life of the doctor; in these cases, the doctor is entitled not to provide care. Examples of such high-risk situations include risks from fire or at an accident scene in which a high power line (electricity) prevents the doctor from touching the patient.

### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular right.

#### **d) Provider Codes of Ethics**

A physician may refuse to perform medical intervention if it is against his/her moral and cultural values only in cases when medical service can be provided to the patient by another physician. The physician must notify the patient about his decision and provide the reasons behind it (**Code of Ethics of Physicians of Georgia, Chapter “Physician and Patient,” paragraph 7**).

#### **e) Other Relevant Sources**

There are no other sources on this matter.

#### **f) Practical Examples**

##### **1. Example(s) of Compliance**

**Dr. G** refuses to perform an abortion because of his moral and religious beliefs. After informing his patient about this, he directs her to his colleague, **Dr. J**, who has experience in performing such interventions. (**Example collected by the authors**)

##### **2. Example(s) of Violation**

Even though there exists no real threat to the health of the prison medical staff, physicians often refuse to treat prisoners during outbreaks of communicable diseases. (**Public Defender’s Office Reports in the First Half of 2009<sup>17</sup>**)

##### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

#### **g) Practice Notes for Lawyers**

As the experience on this matter is lacking, no notes were available as practical advice for this section.

#### **Cross-referencing Relevant International and Regional Rights**

No references for this section were found.

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<sup>17</sup> <http://www.ombudsman.ge/>

## 7.2 Provider Responsibilities

Health care providers' responsibilities may be divided into the following groups:

- ✓ Responsibilities linked to a corresponding right of patients;
- ✓ Responsibilities connected to other colleagues and their professional activity; and
- ✓ Responsibilities to the State and/or society.

More information about the rights of patients, which correspond to specific obligations of doctors, can be found in Chapter 6 on National Patient Rights and Responsibilities.

### Responsibility to Consider Patients' Interests

**a) When providing health care, health care professionals must take into consideration patients' interest. This responsibility is set out in Georgian legislation as one of the basic principles of professional activity of health care personnel.**

#### **b) Responsibility as Stated in Country Constitution/Legislation**

##### **Constitution**

There is no specific provision on this issue in the Constitution of Georgia.

##### **Legislation<sup>18</sup>**

##### **Law on Health Care**

Acting in accordance with a patient's interests is considered to be one of the basic constituents of professional ethics of health care personnel in Georgia (**Article 30**).

##### **Law on Doctor's Professional Activity**

Doctors shall consider the health interests of the patient as much as possible (**Article 38**).

#### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular responsibility.

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<sup>18</sup> See also section on the Right to Consent in Chapter VI on National Patients' Rights and Responsibilities, especially the part on the Law on the Rights of Patients.

#### **d) Provider Codes of Ethics**

“A Patient’s interests are supreme in scientific research on a human being. The research goals and its possible outcomes never interfere with the main mission of a physician – to serve for the patient’s health and life” (**Code of Ethics of Physicians of Georgia, Chapter “Physician – Researcher,” paragraph 2**).

#### **e) Other Relevant Sources**

There are no other sources on this matter.

#### **f) Practical Examples**

##### **1. Example(s) of Compliance**

From two alternatives, **Physician K** gives her patient medicine that does not have side effects for that particular patient, considering his individual needs. (**Hypothetical example**)

##### **2. Example(s) of Violation**

**Dentist Z** performs a teeth-whitening procedure without taking into consideration that the procedure makes the teeth of his patient too sensitive and fragile. (**Hypothetical example**)

##### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

#### **g) Practice Notes for Lawyers**

As the experience on this matter is lacking, no notes were available as practical advice for this section.

#### **h) Cross-referencing Relevant International and Regional Rights**

See sections on the Right to Bodily Integrity, the Right to Life, and the Right to the Highest Attainable Standard of Health in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

## Responsibility to Provide Care

**a) Doctors are responsible to provide care to their patients. They can refuse to provide care only in exceptional cases defined by law.**

See also section on the Right of Access in Chapter VI on National Patients' Rights and Responsibilities.

### **b) Responsibility as Stated in Country Constitution/Legislation**

#### **Constitution**

There is no specific provision on this issue in the Constitution of Georgia.

#### **Legislation**

##### **Law on Health Care**

A doctor at his/her practice is obliged to provide appropriate medical care to the patient who is in a life-threatening condition, or when the patient needs emergency care. The same duty exists in all cases when there is an official contract or agreement concluded on provision of care (**Article 38**).

When a doctor is away from the work place (non-working hours), the obligation to provide emergency care to a patient rests on a doctor to the same extent as on any other person. In such circumstances, a doctor cannot claim remuneration (**Article 39**).

**Article 94** of the same Law says that in case of natural and technical catastrophes, the costs of health care provided to the citizens are assumed by the State.

Finally, when making decisions about prioritizing care to be provided to various patients (i.e. decision about who should receive care first), a doctor shall base his/her decision only on medical indications (**Article 40**).

### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular responsibility.

### **d) Provider Codes of Ethics**

According to the **Code of Ethics of Georgian Physicians**, a doctor should assist any person in case of emergency or life threatening condition, within his/her ability, even if the doctor is out of his/her practice (**Chapter "Physician and Patient," paragraph 5**).

## e) Other Relevant Sources

With regard to emergencies, **Article 129 of the Criminal Code** could be mentioned. According to this article, non-provision of help to a person whose life is under threat is punishable; however, the provision of help should not pose a risk to the life of the person or to the life of third parties.

## f) Practical Examples

### 1. Example(s) of Compliance

**Mr. G** was severely injured in a car accident on his way from Lagodekhi to Tbilisi. An urgent operation was needed to keep him alive. The operation cost 300 GEL. Even though G's family was unable to pay in advance, the physician performed the operation, and saved Mr. G's life. **(Example collected by the authors)**

### 2. Example(s) of Violation

**Mr. T**, 46, had a blood circulation disorder in his brain and was placed in Tkibuli Hospital. As Mr. T was in a life-threatening condition, he needed to be transferred to Kutaisi hospital immediately to receive special treatment there. The patient and his family waited for an ambulance for 8 hours. The patient eventually died. Currently, Mr. T's family is demanding a criminal investigation against the doctors from Kutaisi Hospital, accusing them of violating the responsibility to provide care. **(Reported by Rustavi 2 News Program "Kurieri", January, 2010<sup>19</sup>)**

### 3. Actual Cases:

On March 18, 2003, **Mr. V** was admitted to hospital with a body injury from a domestic accident. Considering the severity of the patient's trauma, it was necessary to control his condition in dynamics; but the attending **physician X**, assuming his duties inappropriately, did not provide adequate and consistent treatment to the patient. Within the period from March 19 to March 23, the physician did not perform a complete blood count (CBC) to identify the blood content. This would have prepared the ground for examining the abdomen cavity through echoscopy (ultrasound examination). The fact that the examination was not carried out led to a failure to set a precise diagnosis. Bleeding caused by a sub-capsular split of the spleen and wounds on the left lung was not detected and led to inadequate treatment that caused the death of the patient. The court imposed criminal responsibility on the doctor, and held that diagnostics and timely operative intervention would have increased the chances of saving the patient's life. **(Archive of Supreme Court of Georgia<sup>20</sup>)**

## g) Practice Notes for Lawyers

As the experience on this matter is lacking, no notes were available as practical advice for this section.

<sup>19</sup> <http://www.rustavi2.com/>

<sup>20</sup> [http://www.supremecourt.ge/default.aspx?sec\\_id=39&lang=1](http://www.supremecourt.ge/default.aspx?sec_id=39&lang=1)

## h) Cross-referencing relevant international and regional rights

See sections on the Right to Life in Chapter 2 on International Framework for Human Rights in Patient Care, and Chapter 3 on Regional Framework for Human Rights in Patient Care.

## Responsibility to Ensure Quality of Care

### a) Doctors are responsible to provide care of adequate quality

### b) Responsibility as Stated in Country Constitution/Legislation

#### Constitution

There is no specific provision on this issue in the Constitution of Georgia.

#### Legislation

##### Law on Doctor's Professional Activity

Continuing quality improvement is considered to be part of doctor's continuing professional development (**Article 29**).

The Law establishes a system of doctors' education, training and licensing, which is essential for ensuring the adequacy of services offered by doctors (**Articles 7-37.5**). According to **Article 7**, only a doctor possessing a State Certificate<sup>21</sup> in an approved specialty is allowed to practice medicine independently. His/her professional activity must be limited to the specialty specified in the State Certificate. The Professional Development Council is responsible for issuing the State License (**Article 20**), and it is also the body entitled to safeguard quality of care by examining and deciding on complaints about, or applications concerning, doctors' professional activities.<sup>22</sup>

The quality of services is also specifically mentioned in the Law on Doctor's Professional Activity in the context of transferring a patient's care to a different health care professional. In such cases the Law requires that *"due quality of medical care has been ensured"* (**Article 49**).

Finally, the doctor must ensure that the quality of medical services provided to prisoners is of the same quality as the services that are offered to individuals who are not prisoners or detainees (**Article 53**).

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21 A State Certificate can be issued only if the following documents are submitted (Article 21): written request of the person seeking State Certificate; copy of the diploma confirming completion of higher medical education; certificate confirming completion of postgraduate training program (residency program) in relevant medical specialty; recommendation from the director of residency program or head of the medical institution where the person worked; certificate confirming that the State Certification Examination in relevant specialty has been successfully passed; health certificate (the form is defined by the MoLHSA); service record; and description of the clinical work carried out by the person during the last 2 years.

22 For more details, see section on the Right to Due Process, earlier in this Chapter.



See also sections on the Right to Observance of Quality Standards, on the Right to Personalized Treatment, and on the Right to Innovation in Chapter VI on National Patients' Rights and Responsibilities.

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular responsibility.

### d) Provider Codes of Ethics

A physician shall get into the habit to daily update and improve his/her knowledge, master proper skills in the course of his/her medical practice (**Code of Ethics of Physicians of Georgia, Chapter "General Provisions," paragraph 8**).

### e) Other Relevant Sources

There are no other sources on this matter.

### f) Practical Examples

#### 1. Example(s) of Compliance

As **Mrs. D** needed a special operation that could not be performed in the prison medical facilities, the prison administration authorized her transfer to an adequate civil hospital. (**Hypothetical example**)

#### 2. Example(s) of Violation

The treatment provided by mental health institutions, particularly Asatiani and Gldani hospitals, is of low quality, and sometimes leads to the deterioration of patients' health. (**Public Defender's Office Reports in the First Half of 2009<sup>23</sup>**)

#### 3. Actual Cases

As this area of law is still developing, no real cases were available as examples for this section.

### g) Practice Notes for Lawyers

Quality in the context of health care is a "perpetual question;" quality is very hard to define. In Georgian legislation, the term "*professional standards and ethical norms*" is often used in connection with quality of care; however, an official definition for *quality of care* does not exist.

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<sup>23</sup> <http://www.ombudsman.ge/files/downloads/ge/mrdgeisbslxrlgajxhkx.pdf>

Article 68 of the Law on Doctor's Medical Activity states that the Ministry of Labour, Health and Social Affairs (MoLSHA) assesses periodically, at least annually, medical records and quality of care provided by doctors. A doctor has the right to take part at any stage in the quality assessment process of his/her professional activity; and he/she has the right to submit written comments / explanations to the medical records that are being assessed.

Within the MoLSHA, the State Regulatory Agency for Medical Activity is in charge of quality supervision. Cases in which the quality of care is questionable are submitted by the Agency to experts for their conclusions. The relevant documents (medical records) are submitted to experts from relevant professional associations and also to experts in forensic medicine. If the Agency finds that the quality of care was not adequate, the Agency prepares a report and sends it to the Council on Professional Development to decide upon sanctions (suspending or withdrawing the State Certificate, for example).

### **h) Cross-referencing Relevant International and Regional Rights**

See sections on the Right to the Highest Attainable Standard of Health and the Right to Non-discrimination and Equality in Chapter 2 on International Framework for Human Rights in Patient Care, and Chapter 3 on Regional Framework for Human Rights in Patient Care.

## **Responsibility to Inform Patients and/or Their Representatives**

**a) This responsibility of health care providers to inform patients is linked to the right of patients to receive information (right to information).**

### **b) Responsibility as Stated in Country Constitution//Legislation**

#### **Constitution**

There is no specific provision on this issue in the Constitution of Georgia.

#### **Legislation**

##### **Law on Health Care**

According to **Article 41**, a physician is obliged to provide a patient with full information on his/her health condition. Exceptions from this duty are regulated by another law, the Law on Doctor's Professional Activity.

##### **Law on Doctor's Professional Activity**

Doctors are obliged to provide patients and/or their relatives/legal representatives (if patient is not

competent, or is not in a position to receive information, or if a patient wishes or agrees that the relative/legal representative receives the information) with information about patient's health and care.

Particularly, doctors have the duty:

- To provide the patient with understandable, exhaustive, objective and clear information about his/her health, proposed care, its benefits and associated risks, possible alternatives etc.; also, about the fees for services offered and methods of payment **(Article 39.1)**;
- To respect a patient's right to refuse receiving information (except in cases of not receiving information "*may cause serious damage to the health and/or the life of the patient and/or of third person*" **(Article 39.2)**)
- To withhold information from the patient in specific cases when it is in the best interest of the patient. Particularly, the doctor can withhold information from the patient if there is a reasonable assumption to believe that this information would substantially affect the health of the patient. Such a decision must be confirmed by the ethics committee of the medical institution or by another doctor (if there is no ethics committee at the medical institution). However, this right is not absolute, and ends at the point when a competent patient explicitly requests information about his/her health and care **(Articles 39.3)**;
- To allow the patient or to the patient's authorized representative access to information included in medical records to **(Article 41.1)**
- To inform the patient about his/her (as a doctor's) identity and professional status **(Article 43)**.

All these duties are linked to corresponding rights of patients. (See section on the Right to Information in Chapter VI on National Patients' Rights and Responsibilities).

### Law on the Rights of Patients

There is a general duty to consider the information recipients' capacity to understand. While providing information to the patient, or to the family members of the patient, specific medical terminology shall be avoided, or used as rarely as possible, in order to ensure that the patient and/or his/her relatives understand all details related to the patient's health and care **(Article 19)**.

### Law on HIV/AIDS

According to the new Law on HIV/AIDS, health care service-providing institutions are obliged to provide an individual who has been tested for HIV infection with complete information on his/her health status **(Article 8.2)**. In addition, those persons shall also be informed on the applicable preventive measures, in order to ensure the safety of others **(Article 8.3)**. Finally, the above institutions are responsible to offer the person concerned, and upon his/her consent, provide pre-test and post-test counseling on HIV infection **(Article 8.3)**. Exceptions to the rule to inform the patient are regulated by the Law on the Rights of Patients.<sup>24</sup>

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular responsibility.

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<sup>24</sup> See section on the Right to Information in Chapter VI on National Patients' Rights and Responsibilities.

#### d) Provider Codes of Ethics

**Paragraph 3 of Chapter “Physician and Patient”** of the **Code of Ethics of Physicians of Georgia** implies the responsibility to inform: *“Informed consent is a fundamental principle in relationship with the patient.”*

#### e) Other Relevant Sources

There are no other sources on this matter.

#### f) Practical Examples<sup>25</sup>

##### 1. Example(s) of Compliance

- Underage **citizen K** was undergoing psychiatric treatment without being informed that she had mental health problems. When K turned 18, her consent was required to proceed with some medical treatments. K’s parents compelled the physician not to ask K for her informed consent and tried to make the decision on their daughter’s behalf. Realizing that K was a fully-capable person, and despite the parents’ request, the physician informed K about her health conditions. **(Example collected by the authors)**
- **Mr. S** hates hearing bad news about his own health and has always asked his physician, **Dr. G**, not to go into details about any of his ailments. Taking the medicines that his physician prescribed was enough for Mr. S; he did not even want to know what health problems he had. Dr. G has always respected Mr. S’s request, yet recently it appeared that Mr. S had epilepsy. Knowing that Mr. S was working as a pilot at an airline company, Dr. G had no choice other than to inform his patient, as this disease could endanger the health or life of third persons. **(Hypothetical example)**

##### 2. Example(s) of Violation

In Georgian prisons, patients are poorly informed about their health conditions, and prisoners’ comments on how they feel are almost never included in medical records. **(Public Defender’s Office Report to Parliament in the first half of 2009<sup>26</sup>)**

##### 3. Actual Cases

As this area of law is still developing, no real cases were available as examples for this section.

#### g) Practice Notes for Lawyers

As the experience on this matter is lacking, no notes were available as practical advice for this section.

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<sup>25</sup> See also examples in section on the Right to Information, in Chapter VI on National Patients’ Rights and Responsibilities.

<sup>26</sup> <http://www.ombudsman.ge/files/downloads/ge/mrdgeisbslxrlgajxhkx.pdf>

## h) Cross-referencing relevant international and regional rights

See sections on the Right to Information in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

## Responsibility to Obtain Informed Consent

**a) Providers' responsibility to obtain informed consent is linked to the right of patients to make choices about their own health care: to consent to it, to refuse it, or to choose among its various options.**

See also sections on the Right to Consent and on the Right to Free Choice, in Chapter VI on National Patients' Rights and Responsibilities.

## b) Responsibility as Stated in Country Constitution/Legislation

### Constitution

There is no specific provision on this issue in the Constitution of Georgia.

### Legislation

#### Law on Health Care

The obligation to obtain informed consent is specifically stressed in the context of service provision to persons in detention or held in custody (**Article 44**).

#### Law on Doctor's Professional Activity

Doctors are obliged to obtain informed consent from a patient before any medical intervention (**Article 44**).

If a patient refuses, or asks to terminate ongoing medical care, the doctor is obliged to provide his/her patient with complete information about the possible consequences of withholding or withdrawing the treatment. The patient makes the final decision (**Article 46.1**).

If the patient is incompetent, the doctor can start medical care only after informed consent of the patient's legal representative is obtained (**Article 45.1**). However, the doctor shall initiate medical care of an incompetent patient without consent of the patient's legal representative if: (a) due to a life-threatening condition, the patient urgently needs medical care, and the legal representative cannot be contacted; or (b) due to a similar condition, the patient requires emergency medical care, and the patient's medical representative objects to such care (**Article 45.2-3**).

A doctor can appeal to court against the decision of the legal representative of an incompetent patient if the patient's representative's decision contradicts the health interests of the patient (**Article 45.4**).

The law requires that the doctor to obtain informed consent before involving the patient in any educational/teaching process (oral consent), or in biomedical research (written consent) (**Article 47.1**).

### **c) Supporting Regulations/Bylaws/Orders**

There are no relevant supporting regulations for this particular responsibility.

### **d) Provider Codes of Ethics**

The Code requires that a physician recognize a patient's right to participate in the decision-making process concerning his/her own health, and informed consent is considered as a fundamental principle of the doctor-patient relationship (**Code of Ethics of Physicians of Georgia, Chapter "Physician and Patient," paragraph 3**).

In the process of teaching, a physician shall discuss with the patient the teaching objectives and methods, and obtain consent in advance (**Code of Ethics of Physicians of Georgia, Chapter "Physician – Teacher," paragraph 2**).

### **e) Other Relevant Sources**

There are no other sources on this matter.

### **f) Practical Examples**

#### **1-2. Examples of compliance-violation**

See examples in sections on the Right to Consent and on the Right to Free Choice, in Chapter VI on National Patients' Rights and Responsibilities; and examples in the section on the Responsibility to Inform Patients and/or their Representatives (linked to patients' Right to Information, Chapter VI), earlier in this Chapter.

#### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

### **g) Practice Notes for Lawyers**

As the experience on this matter is lacking, no notes were available as practical advice for this section.

## h) Cross-referencing relevant international and regional rights

See sections on the Right to Bodily Integrity in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

## Responsibility to Maintain Confidentiality and Respect Patients' Privacy

### a) The providers' responsibility to maintain confidentiality and respect patients' privacy is linked to the right of patients to privacy and confidentiality.

See also the section on the Right to Privacy and Confidentiality in Chapter VI on National Patients' Rights and Responsibilities.

### b) Responsibility as Stated in Country Constitution//Legislation

#### Constitution

There is no specific provision on this issue in the Constitution of Georgia.

#### Legislation

##### Law on Health Care

All personnel of healthcare institutions are legally obliged to maintain medical secrecy, which may be disclosed only if "*confidential information is necessary for public safety, protection of the rights and freedoms of others,*" or upon the request of judicial or investigatory establishments as defined by law (**Article 42**).

Furthermore, according to **Article 152**, medical records and related documents of a deceased person are attributed to medical secrecy, except the cases envisaged by the above article (Article 42) of the Law on Health Care.

##### Law on Doctor's Professional Activity

The law obliges doctors to keep information about the patient's health condition and private life confidential while the doctor practices medicine and after they have retired. This obligation lasts after the patient's death as well (**Article 48.1**).

The Law on Doctor's Professional Activity explicitly articulates situations when the doctor can disclose confidential information (**Article 48.2**). Below is the complete /exhaustive list of such situations:

- The patient authorizes disclosure of the information;
- Non-disclosure of the information endangers the life and/or health of a third person;
- There is a reasonable ground to suspect existence of a disease subject to mandatory registration;
- The information is provided to other medical personnel participating in the medical care of the given patient;
- Doing so is necessary for the purposes of forensic medicine;
- Information is requested by law enforcement authorities upon court decision;
- The information is provided to State authorities in order to establish social privileges for the patient. In such cases, the patient's consent to disclose information shall be a necessary precondition;
- The information is used for education and research purposes if the information is presented so that the person cannot be identified.

Finally, the Law on Doctor's Professional Activity is coherent with the Law on the Rights of Patients in establishing exceptions for the rule concerning protection of private life. According to **Article 49** of the Law on Doctor's Professional Activity, the doctor can *"intervene into the patient's family and private life if:*

*a) Intervention is necessary for diagnosis, treatment and care of the patient. The patient's consent shall be a necessary precondition for intervention;*

*b) In cases of non-intervention, the health and lives of the patient's family members come under serious threat."*

### **Law on the Rights of Patients**

According to **Article 27**, healthcare providers have a duty to keep information about the patient confidential even after the patient's death. **Article 28.1** of the same Law defines exceptions to this rule, according to which a health care provider can disclose confidential information if the patient's consent had been previously obtained, or if disclosure is in the interest of the life and/or health of a third person, or if the information has been anonymized (information is introduced in a way that identification of the patient is impossible). Finally, *"consent of the patient shall be presumed for the disclosure of confidential information by a healthcare provider to other healthcare providers who take part in the process of medical care of that patient."* (**Article 28.2**)

### **Law on HIV Infection/AIDS**

The Law provides for maintaining the confidentiality of patients who are HIV positive. Particularly, according to the first paragraph of **Article 9**:

*"A Service-Providing Institution which provides HIV-infected individuals with diagnostic, preventive, treatment services and support, as well as any legal and natural person who possesses information about a person being HIV positive, shall be responsible to maintain the confidentiality of such information in a manner established by Law."*



This obligation is binding “throughout the lifetime of the said individual as well as after his/her death” (**Article 9.2**).

There are exceptions defined by law, when the institution concerned<sup>27</sup> can disclose confidential information (**Article 9.3**):

- When informed consent for disclosing information is obtained from the HIV infected individual;
- When there exists advanced written consent of the infected individual allowing disclosure of the information after his/her death;
- In other cases envisaged by Georgian Legislation.

The Law allows the use of information for the purpose of education/training or scientific purposes only if the information is presented in a way that the person concerned cannot be identified (**Article 9.4**).

### Law on Psychiatric Care

The Law requires that confidential information about a patient’s mental state is accessible only by people who are directly involved in the process of treatment and care of the patient (**Article 26.2**). The aforementioned information may be provided to third persons if the patient or his/her legal representative (when the patient is incompetent) gives his/her consent, or when a court decision provides for it (**Article 26.3**).

Finally, breach of confidentiality is admissible when it is necessary for the life and/or health interests of the patient or of a third person. In such cases, the decision on disclosure is made *“by the administration of the psychiatric institution, and this information shall be issued only to the legal representative of the patient, or, in case of the absence of the latter – to a relative”* (**Article 26.4**).

### c) Supporting Regulations/Bylaws/Orders

The Order of the Minister of Labour, Health and Social Affairs No217/o of 23.07.2010 on the Approval of Recommendations for Routine Supervision of HIV/Aids includes a special article on data protection and confidentiality (**Article 11**).

### d) Provider Codes of Ethics

The **Code of Ethics of Georgian Physicians** requires that a physician in Georgia keep “confidentiality of the facts concerning a patient’s health and private life, even in case of a patient’s death, unless the law obligates him/her to disclose information.” If a law requires disclosing information, the doctor “shall inform the patient (or his/her relative) of the doctor’s intention to disclose the secret” (**Chapter “Physician and Patient,” paragraph 4**).

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<sup>27</sup> The Law on HIV Infection/AIDS defines Service Providing Institution as follows: “a legal entity which provides medical services in accordance with the requirements of the legislation: services include diagnostics, prevention, treatment, care and support of People Living with HIV.” (Article 3, “e”)

### **e) Other Relevant Sources**

There are no other sources on this matter.

### **f) Practical Examples**

#### **1. Example(s) of Compliance**

See examples in the section on the Right to Privacy and Confidentiality in Chapter VI on National Patients' Rights and Responsibilities.

#### **2. Example(s) of Violation<sup>28</sup>**

When underage patients enter a children's polyclinic to undergo medical examination, they are asked to take off their clothes in the presence of other child-patients of both sexes, who are examined at the same time. In addition, the door is often kept open; therefore people walking in the corridor can easily observe what is going on in the doctor's cabinet. Thus, the children's right to privacy is violated. This happens frequently in polyclinics in general in Georgia. **(Example collected by the authors)**

#### **3. Actual Cases**

See actual cases in section on the Right to Privacy and Confidentiality in Chapter VI on National Patients' Rights and Responsibilities.

### **g) Practice Notes for Lawyers**

See practice notes in the section on the Right to Privacy and Confidentiality in Chapter VI on National Patients' Rights and Responsibilities.

### **h) Cross-referencing Relevant International and Regional Rights**

See sections on the Right to Privacy in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

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<sup>28</sup> See examples in section on the Right to Privacy and Confidentiality in Chapter VI on National Patients' Rights and Responsibilities.

## Responsibility to Keep Medical Records

a) Health care providers shall keep medical records according to existing rules. This duty is linked, among others, to patients' right to information.<sup>29</sup>

### b) Responsibility as Stated in Country Constitution/Legislation

#### Constitution

There is no specific provision on this issue in the Constitution of Georgia.

#### Legislation

##### Law on Health Care

Doctors and other health care professionals shall keep medical records according to existing rules. In cases when medical care has been provided outside of the workplace of the doctor's practice, health care professionals shall describe the care provided in a written form and transfer it to relevant personnel in charge of the patient's care in order to ensure continuity of care (**Article 43**).

##### Law on Doctor's Professional Activity and Law on the Rights of Patients

Doctors are obliged to keep medical records on each patient (**The Law on Doctor's Professional Activity, Article 56.1**). Such records have to be written clearly in an understandable manner and in a State language. Records of invited foreign specialists have to be translated into a State language.

Medical records shall be made in "due time;" however, the meaning of the term is not specified in the law. Sometimes it is defined by internal regulations of a health care institution (within 24 hours, for example). Records must be comprehensive and complete and cover all aspects of the patient's medical care. All new entries into medical records have to be confirmed by the doctor's signature (**The Law on Doctor's Professional Activity, Article 56.2**).

The law requires medical doctors to enter information regarding the decision to withhold information from the patient into medical records (**The Law on Doctor's Professional Activity, Article 39.4**).

Doctors are obliged to modify or append information upon the patient's or his/her legal representative's request (**The Law on Doctor's Professional Activity, Articles 42.1-42.2**). However, the doctor is entitled not to follow the request of the patient or his/her legal representative if they ask for modification of information which must be specified and kept in medical records as required by law (**The Law on Doctor's Professional Activity, Article 42.3**).

More precise provisions on how to enter information modified upon a patient's request in the records is described in the **Law on the Rights of Patients**. Particularly, according to **Article 17.1.a**, both original data and information amended as requested by the patient (or his/her legal representative) shall be retained in the medical records.

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<sup>29</sup> See relevant section in Chapter VI on National Patients' Rights and Responsibilities.

### **c) Supporting Regulations/Bylaws/Orders**

The Order of the Minister of Labour, Health and Social Affairs No198/n of 17.07.2002 on “The Rules of Storing Medical Records at Medical Institutions” regulates how long and in what conditions medical records have to be stored in medical institutions, when and how to transfer them to archives, how to run archives, etc. Medical documents are to be stored for 5 years, 15 years, or permanently, depending on the type and importance of the documentation (details are specified in the Order).

### **d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

### **e) Other Relevant Sources**

There are no other sources on this matter.

### **f) Practical Examples**

#### **1. Example(s) of Compliance**

When a patient is transferred from one state polyclinic to another, the original polyclinic shares a copy of relevant information with the new polyclinic but keeps all the original medical records related to the patient’s health. **(Example taken from everyday life)**

#### **2. Example(s) of Violation**

In penitentiary institutions, medical records are not stored as prescribed by the relevant regulation of the Ministry of Labour, Health and Social Affairs.<sup>30</sup> The doctors are not competent on what to do with the medical information when a prisoner is released or transferred to another institution. Usually, there are no records on prisoner injuries. Even if such records exist, the information is incomplete, and does not give a clear picture of prisoners’ conditions. **(Public Defender’s Office Report to Parliament in the First Half of 2009<sup>31</sup>)**

#### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

### **g) Practice Notes for Lawyers**

As the experience on this matter is lacking, no notes were available as practical advice for this section.

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<sup>30</sup> See “Supporting Regulations/Bylaws/Orders” above.

<sup>31</sup> <http://www.ombudsman.ge/files/downloads/ge/mrdgeisbslxrlgajxhkx.pdf>

## **h) Cross-referencing Relevant International and Regional Rights**

See sub-sections on the patient Right to Receive Treatment and sections on the Right to Information in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

## **Responsibility to Submit Report/Information**

**a) Health care providers have to submit appropriate reports and information to the administration of health care institutions, or to relevant bodies in charge of managing the health care system.**

### **b) Responsibility as Stated in Country Constitution/Legislation**

#### **Constitution**

There is no specific provision on such responsibility of health care providers in the Constitution of Georgia.

#### **Legislation**

##### **Law on Health Care**

Health care providers have to submit to the Ministry of Labour, Health and Social Affairs medical statistical information according to established rules (**Article 20.2**).

##### **Law on Doctor's Professional Activity**

Often damages inflicted to the patient or risks to patient health existing in a health care institution are not apparent and transparent for patients and the administration of the health care institution. Health care providers are in the best position to reveal, and report on such damages and risks. Doctors are requested to report to the administration of the medical institution if, during the provision of medical care, any damage was inflicted to the patient's health, or the risk of such damage has been revealed (**Article 51**).

##### **Law on Public Health**

Health care providers must submit statistical reports on communicable diseases according to the rules established by the Ministry of Labour, Health and Social Affairs (**Article 8**). Health care providers are also obliged to inform public health services about all new cases of communicable diseases (**Article 10**).

In order to be able to fulfill the above duties, the Law also grants health institutions and health care providers the right to request individuals affected with communicable disease to name the persons

who have been (or still are) in contact with them during the period when the disease could have been transmitted to others (**Article 10.3**).<sup>32</sup>

### **Law on HIV Infection/AIDS**

Service-Providing Institutions are responsible to keep records in a manner established by the Legislation (**Article 8.5**) and to request from the HIV-infected person information about those individuals with whom he/she has had risk-involving contact from the epidemiological point of view (**Article 8.6**).

### **c) Supporting Regulations/Bylaws/Orders**

The Order of the Minister of Labour, Health and Social Affairs No. 101/n of 5.04. 2005 “on the Management and Submittal of Medical Statistical Information” approves forms and methods of monthly, quarterly and annual statistical reports of medical institutions.

The Order of the Minister of Labour, Health and Social Affairs No 122/n of 4.06.2003 “on the Approval of the National Preventive Vaccination Calendar” includes provisions about reporting and submitting statistical data on vaccination.

The Order of the Minister of Labour, Health and Social Affairs No217/o of 23.07.2010 “on the Approval of Recommendations for Routine Supervision of HIV/Aids” defines which cases related to HIV/AIDS shall be reported, how they shall be reported (procedures) and by whom. The Order also includes a special article on data protection and confidentiality (Article 11).

### **d) Provider Codes of Ethics**

The **Code of Ethics of Georgian Physicians** calls physicians to inform society about the circumstances which may aggravate the health of all society or certain groups of the population (**Chapter “Physician and Society,” paragraph 1**).

### **e) Other Relevant Sources**

There are no other sources on this matter.

### **f) Practical Examples**

#### **1. Example(s) of Compliance**

- Physicians from the region of Batumi, heavily hit by an epidemic of tuberculosis, report every

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<sup>32</sup> Thus, this right is limited to the cases when the information requested is needed for public health interest, and/or for the health interests of third persons.

week to the National Center for Disease Control and Public Health, the relevant agency of the Ministry of Labour, Health and Social Affairs, on the number of new cases, the categories of patients (age, sex, etc.), and the actions taken. **(Hypothetical example)**

- Healthcare providers take timely measures with regard to gathering information on individuals affected by influenza to avoid an outbreak of an epidemic in the general population. **(Hypothetical example)**

## 2. Example(s) of Violation

- Information submitted by prison medical institutions is not full or accurate and does not realistically reflect damages inflicted to the patients during treatment. **(Public Defender's Office Reports in the First Half of 2009<sup>33</sup>)**
- Even though there is an emergency, no action is taken by medical staff to identify and cure persons with Hepatitis A or to vaccinate people who were in contact with the infected persons. **(Hypothetical example)**

## 3. Actual Cases

As this area of law is still developing, no real cases were available as examples for this section.

### g) Practice Notes for Lawyers

As the experience on this matter is lacking, no notes were available as practical advice for this section.

### h) Cross-referencing Relevant International and Regional Rights

See sections on the Right to Information and the Right to the Highest Attainable Standard of Health in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

## Responsibilities Related to Care of Persons Who Are in Detention or in Prison

**a) Patients in detention or prison are particularly vulnerable. Therefore, obligations of doctors providing care to persons who are in detention or imprisoned are specifically regulated.**

**b) Responsibility as Stated in Country Constitution/Legislation**

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<sup>33</sup> <http://www.ombudsman.ge/files/downloads/ge/mrdgeisbslxrlgajxhkx.pdf>

## Constitution

There is no specific provision on the responsibilities of health care providers related to the care of persons who are in detention or prison in the Constitution of Georgia.

However, provisions of the Constitution prohibiting torture, inhuman and cruel treatment in general (**Article 17**), as well as specific provisions about prohibiting physical or mental coercion of arrested persons (**Article 18**) apply to the treatment and care of such persons. Constitutional provisions prohibiting any type of discrimination (**Articles 14 and 38**) shall also be considered when caring for persons who are in detention or prison.

## Legislation

### Law on Health Care

The law specifically prohibits any form of discrimination against patients who are in detention or imprisoned (**Article 6.2**). Further, the law obliges physicians to provide medical care to such patients only after informed consent is obtained, *“except in the cases of emergency or grave danger for life when the consent is not available due to the patient’s severe condition.”* A physician is also obliged to refuse to carry out any medical intervention that contradicts norms of ethics and the medical profession (**Article 44**).

### Law on Doctor’s Professional Activity

Duties of doctors while providing care to persons deprived of liberty are outlined in **Chapter VI** of the Law – **“Duties of a Physician while Providing Medical Care to Prisoners, Detainees and Captives”**.

While caring for patients from the above-mentioned target group, a doctor shall ensure that the quality and standards of care are the same as in cases when care is offered to persons who are not deprived of liberty (**Article 53**).

In aiming to protect the rights and safety of persons deprived of liberty, **Article 54** introduces specific prohibitions. Particularly, doctors are prohibited from:

- ✓ “Any direct or indirect relation to actions linked to participation, co-participation in, instigation of, or attempted torture or other brutal, savage, inhumane and degrading treatment or punishment, or presence at such actions;
- ✓ Any professional relation with a person deprived of liberty if the sole purpose of the doctor is not assessing, protecting or improving the physical or mental health of such persons, or that purpose prejudices principles of ethics;
- ✓ Using his/her knowledge and skills to promote interrogation of a prisoner, a detainee or a captive by such methods which will adversely affect the physical or mental health or condition of such persons;
- ✓ Using his/her knowledge and skills or giving out any instrument or substance to promote the torture (of) or any other inhumane or degrading treatment to a person deprived of liberty, or to weaken the resistance of such persons against such practices;
- ✓ Imposing any restrictions to a prisoner, a detainee or a captive if such restriction is not based on



medical indications or it is not necessary for the protection of the health of the person concerned, or for ensuring the safety of other prisoner, detainee or captive, or convoy.”

The above prohibitions shall apply even during emergency, including military conflicts and civil unrest.

Finally, the Law sets out specific provisions regulating actions of doctors in cases when a person deprived of liberty is on a hunger strike (**Article 55**). According to this article:

- A physician shall be prohibited from forced feeding a person deprived of liberty when he/she refuses to eat food and he/she, in the physician’s opinion, has the ability to independently and adequately evaluate the consequences of voluntary discontinuance of feeding. This opinion must be confirmed by at least one other independent physician. However, a physician may provide medical care to the patient unless the latter objects.
- In case a prisoner or a detainee declares a hunger strike, the physician shall explain to such prisoner or detainee the consequences of refusal to receive food, and inform such person whether the physician will provide medical care or not, should any unconscious condition develop as a result of the hunger-strike.
- If a prisoner or a detainee falls into any unconscious condition as a result of a voluntary hunger-strike, the physician may act in the best interests of the patient’s life and health despite the patient’s hitherto declared will; the decision shall be made by the physician. The decision-making must not be affected by the opinions of any third persons for whom the patient’s well-being is not essential.
- In the case when a hunger-striker is able to make a reasonable decision to refuse medical intervention, the physician shall bear no responsibility for the hunger-strike consequences.

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular responsibility.

### d) Provider Codes of Ethics

The **Code of Ethics of Georgian Physicians** instructs doctors to offer special care to unprotected, vulnerable people, including prisoners and captives (**Chapter “General Provisions,” paragraph 3**). The following general rules also apply in case of health care provision to detainees or prisoners:

“During their medical practice physicians shall be guided only by professional standards and universally recognized ethical norms” (**Chapter “General Provisions,” paragraph 2**);

“It is inadmissible for a physician to use professional knowledge and position for inhuman purposes” (**Chapter “General Provisions,” paragraph 6**).

### e) Other Relevant Sources

There are no other sources on this matter.

## f) Practical Examples

### 1. Examples of Compliance

**Citizen J** had a heart attack two weeks after being imprisoned. As the prison was not able to provide emergency treatment of appropriate quality, J was transferred to a civil hospital. After several days of treatment, J was taken back to his cell. **(Reported by Rustavi 2 News Program "Kurier" <sup>34</sup>)**

### 2. Examples of Violation

The Georgian legislation envisages that every penitentiary institution must have a medical facility. According to data from 2009, 5 institutions out of 18 did not have such facilities. Three of the institutions have never possessed such structures; and in two of the institutions, the medical facilities could not be used because of lengthy reconstruction work. In some of the institutions, doctors do not provide treatment on weekends or during non-working hours. Quality standards are not attainable. Equipment is insufficient and outdated. None of the penitentiary institutions (apart from the medical institution for convicted persons and those on detention) possesses equipment for urgent medical aid. Sanitary and hygienic conditions are more than alarming. **(Reported by Public Defender's Office to Parliament in the 1<sup>st</sup> Half of 2009 <sup>35</sup>)**

### 3. Actual Cases

See cases in section on the Rights of Persons Deprived of Liberty, in Chapter VI on National Patients' Rights and Responsibilities.

## g) Practice Notes for Lawyers

As the experience on this matter is lacking, no notes were available as practical advice for this section.

## h) Cross-referencing Relevant International and Regional Rights

See sections on the Right to the Highest Attainable Standard of Health, the Right to Bodily Integrity, the Right to Life, the Right to Freedom from Torture and Cruel, Inhuman and Degrading Treatment, and the Right to Non-discrimination and Equality in Chapter 2 on International Framework for Human Rights in Patient Care, and in Chapter 3 on Regional Framework for Human Rights in Patient Care.

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<sup>34</sup> <http://www.rustavi2.com/>

<sup>35</sup> <http://www.ombudsman.ge/files/downloads/ge/mrdgeisbslxlrgajxhkx.pdf>

## Responsibilities and Duties before Colleagues and Profession

a) Integrity of the medical profession and reputation of health care professionals is of high importance and great value for the society. Groundless and undue criticism can damage these values. Georgian legislation, as well as professional code of ethics, provides for respecting the profession and its integrity.

### b) Responsibility as Stated in Country Constitution/Legislation

#### Constitution

There is no specific provision on this issue in the Constitution of Georgia.

#### Legislation

##### Law on Health Care

Health care professionals are obliged to act towards increasing the prestige of the medical profession; they shall treat colleagues and superiors with respect. They shall not use their professional knowledge and experience against principles of humanity (**Article 53**).

##### Law on Doctor's Professional Activity

Doctors shall act in compliance with norms of professional ethics. They shall care about the prestige of the profession and shall contribute to establishing an atmosphere of mutual respect among colleagues (**Article 57**). They must provide maximum support and care to colleagues who apply to them for medical care (**Article 58**).

When providing care to patients of colleagues, a doctor must consider the following principles (**Article 59**):

- A doctor must do his/her best to convince the patient and/or his/her legal representative (as required by law) to inform the colleague, who had formerly been responsible for that patient's medical care. The aim of this provision is to establish respectful relations between health care providers and to prevent doctors from appropriating patients from each other. In any case, a patient's wish is the decisive factor.
- After completing the treatment of the patient referred by a colleague, the doctor shall refer the patient back to the same colleague if any further supervision or care is needed (in such cases, patient's consent is required).
- If a doctor has provided the patient (who is under the supervision of another colleague) with emergency medical care, he/she (doctor) must inform the patient's usual doctor as soon as possible and refer the patient back to him/her for further evaluation and care (upon patient's consent).

- The physician shall provide needed medical care to a patient who is supervised by a colleague working in the same establishment if the latter, for any reason, fails to perform medical care.

While assessing the professional conduct of a colleague (as part of continuing professional development process), a doctor must be unprejudiced and act in good faith (**Article 63**). Senior doctors are obliged to be ensured that their subordinates are part of the continuing professional development (**Article 64**).

The Law establishes specific prohibitions aimed at establishing fair and respectful inter-colleague relationship (**Article 65**); particularly, doctors are prohibited from:

- Criticizing a colleague's professional conduct without having grounds to do so, or to issue expressions abusing the personal qualities thereof;
- Hindering a colleague from accomplishing his/her professional tasks, or to expulse, or attempt to expulse, the colleague from practice due to competition;
- Undertaking medical practice in the territory (region, populated area or part thereof) of a physician with whom he/she worked as an associate or assistant. The doctor can start practice in the aforementioned region only upon the consent of the colleague concerned, or after 2 years elapsed.
- Taking advantage of the condition of an unemployed colleague and sign a labor contract there-with to pay compensation at rates lower than prescribed under legislation;
- Accepting compensation for referring a patient to a colleague or another medical institution, or for sending specimens to another laboratory; also, to paying compensation in the case when a patient is referred to him/her from another colleague.

### c) Supporting Regulations/Bylaws/Orders

There are no relevant supporting regulations for this particular responsibility.

### d) Provider Codes of Ethics

There is a specific chapter in the **Code of Ethics of Physicians of Georgia** entitled "**Physician and Colleague**" devoted to relationship between colleagues. The Code calls upon doctors to:

- ✓ Safeguard the professional reputation, as well as existing confidence between patients and doctors;
- ✓ Care for the prestige of the profession while running a medical practice;
- ✓ Openly share their views with a colleague about the colleague's professional deficiency and unethical behavior;
- ✓ Discuss a colleague's professional deficiency in the colleagues' circle as well, if needed;
- ✓ Not discuss a colleague's medical errors publicly, unless it is required by law;
- ✓ Make all efforts within his/her ability to assist another physician to fulfill professional duties;
- ✓ Observe and judge his/her own professional abilities and ask other physicians for help, if he/she lacks adequate professional knowledge and experience;
- ✓ Refer a patient to a colleague only if the physician of the patient is confident in the professional competence of that colleague;

- ✓ Provide the colleague to whom the patient is referred with all relevant information about the patient's medical care;
- ✓ Give detailed information and conclusions to the colleague who has referred the patient to him/her;
- ✓ Assist colleagues who try to act according to the supreme principles of professional ethics and who are forced to disregard the mentioned principles (such as the instance in which a doctor practicing in the penitentiary system is instructed to participate in torture or to issue a health certificate to a prisoner who is to be sent to the punishment cell / "sweat box").

### **e) Other Relevant Sources**

There are no other sources on this matter.

### **f) Practical Examples**

#### **1. Example(s) of Compliance**

**Dr. J** made a medical error: he prescribed the wrong medicine to patient C, who was suffering from pneumonia. On the same day, Dr. J found out about his mistake and changed the prescription before patient C had taken the wrong pill. Finding out about Dr. J's error, **Dr. K** talked to Dr. J, but did not discuss Dr. J's professional deficiency either in public, or among colleagues. **(Example collected by the authors)**

#### **2. Example(s) of Violation**

In order to have more patients, **Dr. P** spread a false rumor that his colleague, Dr. G has become too old to perform operations safely. **(Hypothetical example)**

#### **3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

### **g) Practice Notes for Lawyers**

As the experience on this matter is lacking, no notes were available as practical advice for this section.

### **h) Cross-referencing Relevant International and Regional Rights**

No references have been found for this responsibility.

## Responsibility to Undergo Medical Examination

a) In certain cases health care providers are obliged to undergo medical examination. This responsibility is established to ensure that the health condition of a healthcare provider allows him/her to provide adequate care to patients. It is also linked to working conditions that could be harmful or hazardous to healthcare providers with certain diseases.

### b) Responsibility as Stated in Country Constitution/Legislation

#### Constitution

There is no specific provision on such responsibility of health care providers in the Constitution of Georgia.

#### Legislation

##### Labor Code of Georgia

This law requires that certain professionals undergo regular medical examinations. In such cases, the cost of the examination is covered by the employer (**Article 54.1.b**). Doctors and nurses are included in the list of such professions according to the relevant order of the Minister of Labour, Health and Social Affairs<sup>36</sup>.

##### Law on Doctor's Professional Activity

The doctor is also obliged to undergo medical examination for evaluation of his/her health status upon the request of the Ministry of Labour, Health and Social Affairs (**Articles 70.1-70.2**). The Ministry will issue such a request if there is a reasonable cause to believe that, due to his/her health conditions, the doctor is no longer able to adequately perform his/her professional activity.

If a doctor refuses to undergo the above-mentioned medical examination, the Continuing Professional Development Council at the Ministry of Labour, Health and Social Affairs can suspend the doctor's certificate and his/her right to practice medicine independently (**Articles 71**).

### c) Supporting Regulations/Bylaws/Orders

Order of the Minister of Labour Health and Social Affairs No 215/n of 11.07 on "Establishing the list of cases and rules for mandatory regular medical examination of employees to be covered by employer" defines the list of situations in which employees have to undergo regular medical examinations, which are financed by their employers. This list includes doctors and nurses of various specialties (Appendix 1, Paragraph 1.e.).

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<sup>36</sup> See sub-section Supporting Regulations/Bylaws/Orders in this section.

**d) Provider Codes of Ethics**

There are no provisions in existing codes of ethics on this matter.

**e) Other Relevant Sources**

There are no other sources on this matter.

**f) Practical Examples****1. Example(s) of Compliance**

**Dr. A** made two medical errors during surgery. The Ministry of Labour, Health and Social Affairs requested him to undergo a medical examination to evaluate his health status. The physician agreed. The examination found Dr. A in good health, capable to pursue his medical activities. As a result, the Continuing Professional Development Council did not suspend Dr. A's certificate, at least not upon the basis of health status. **(Hypothetical example)**

**2. Example(s) of Violation**

A doctor provided false documents to avoid having to go through a medical examination prescribed by law. **(Hypothetical example)**

**3. Actual Cases**

As this area of law is still developing, no real cases were available as examples for this section.

**g) Practice Notes for Lawyers**

As the experience on this matter is lacking, no notes were available as practical advice for this section.

**h) Cross-referencing Relevant International and Regional Rights**

No references have been found for this responsibility

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- 8.1 **MECHANISMS TO PROTECT/ENFORCE RIGHTS AND RESPONSIBILITIES IN COURT**
  - 8.2 **ADMINISTRATIVE PROCEDURE**
  - 8.3 **CIVIL PROCEDURE**
  - 8.4 **CRIMINAL PROCEDURE**
  - 8.5 **ALTERNATIVE MECHANISMS TO PROTECT/ENFORCE RIGHTS AND RESPONSIBILITIES**
  - 8.6 **APPENDIX: CIVIL COMPLAINT FORM**

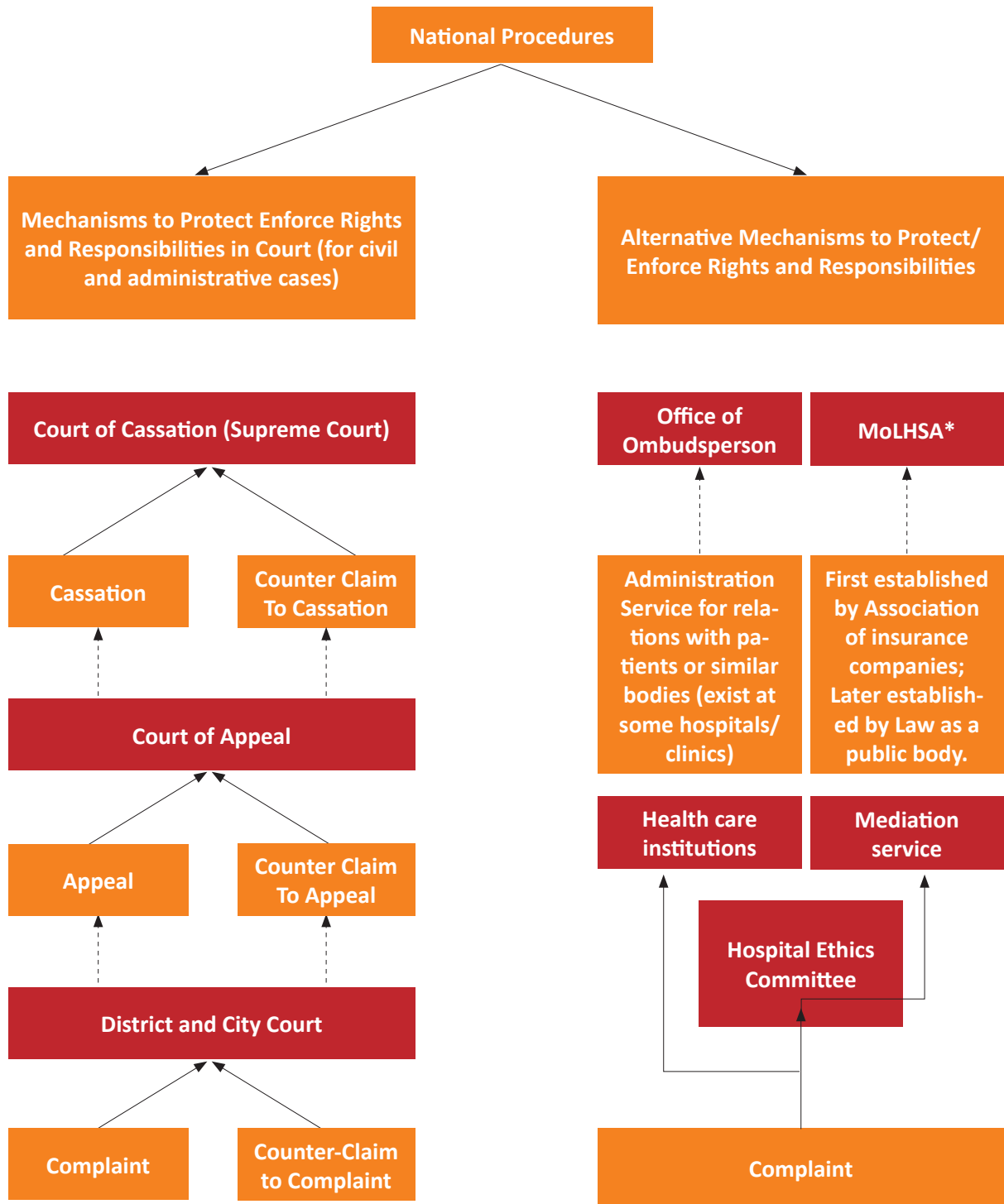


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## **National Procedures and Appendixes**

## National Procedures



\* MoLHSA – Ministry of Labour, Health and Social Affairs

## 8.1 Mechanisms to Protect/Enforce Rights & Responsibilities in Court

### Levels (instances) of Judiciary System of Georgia

The Judiciary System of Georgia consists of three instances:

- District/City Court;
- Court of Appeal;
- Court of Cassation (Supreme Court).

All patients' rights cases must be filed in district/city courts, and can proceed up to the Supreme Court, consistent with the requirements of Civil and/or Administrative Codes of Procedure. If, however, a patient dies because of the criminal intent of a doctor, for example, the case is no longer a patient's rights case; instead it is an ordinary crime under the Criminal Code (the key being the criminal intent).

The forms of complaint, appeal, cassation and counter-claim on Civil and Administrative cases were approved by the decision of January 16, 2008, No1/6 of the Council of Justice. To appeal at court, it is necessary to use the above-mentioned forms in Civil and Administrative cases.<sup>1</sup>

Complaint (statement), appeal, cassation and counter-claim must be done in written, printed form, and must correspond to established requirements pursuant to the Civil Procedural Code of Georgia<sup>2</sup> and the model forms approved by the Council of Justice of Georgia.

Court forms for civil cases are: complaint, counter-claim, appeal, counter-claim of appeal, cassation, counter-claim of cassation.

Court forms on administrative cases are: complaint, counter-claim, appeal, counter-claim of appeal, cassation, and counter-claim of cassation.<sup>3</sup>

The court reform that has been underway in Georgia since the beginning of 2005 is broad-scaled and covers all the issues related to the arrangement of the court system and to its balanced functioning. Roughly all the major steps of the reform are substantially interrelated, and it is necessary to implement them comprehensively and gradually to achieve the goal - the creation of an independent court system.

### District (City) Court

The structure of the district (city) court is being established in a new manner: the enlarged district (city) courts are established for hearing the criminal, civil and administrative cases that fall under their jurisdiction by the rule of the first instance. After the reform, fifteen enlarged district (city) courts will be established in all the regions of Georgia, among them in Kutaisi, Batumi, Rustavi, Marneuli, Telavi, Sighnaghi, Ambrolauri, Zestaponi, etc. The main advantage of this system is that the judges will be specialized in the district (city) courts. It is also significant that all the cases (except those under the jurisdiction of magistrate judges), regardless of their complexity or subject, will be heard by the specialized judges of the district (city) courts.

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<sup>1</sup> See the forms in the Appendix.

<sup>2</sup> See articles 177, 178, 201, 367, 368, 395, 396 and 400.

<sup>3</sup> For more details please visit: [www.supremecourt.ge](http://www.supremecourt.ge).

## Magistrate Judges

Complaints (claims) and petitions concerning the civil and administrative cases that fall under the jurisdiction of magistrate judges are taken to the court according to the location of the magistrate judge. Definite categories of civil and administrative cases, such as appeals against procedure rules violations and complaints of undue influence by law enforcement officials brought by individuals, fall under the jurisdiction of Magistrate Judges. If, for example, an individual believes that the court's procedural measures are not conducted in accordance with the law and/or that there were illegal measures of duress, he/she can petition the magistrate judge. The cases subordinated to magistrate judges include: claims of value not exceeding 2,000 GEL; payment orders and other straightforward disputes, except adoption; cases for declaring the abeyance of property, if the value of the claim or the property exceeds 2,000 GEL. Magistrates also serve as a family court, except for cases of adoption, deprivation of parental rights, establishment of paternity and divorce, and spousal disputes over the right for rearing the child. Magistrates can hear employment cases as well.

## Court of Appeal

Panels at the appeal courts that heard cases in the first instance in the past no longer exist, and the Court of Appeal only hears all cases by the rule of appeal. Courts of appeal, as opposed to courts of cassation, are competent to overrule the decisions of the lower instance (district/city) courts on both legal and factual grounds. Courts of Appeal hear cases based upon principles of reciprocity. They try cases from District (City) Courts and Magistrate Judges, including actual court hearings with witnesses et al. With the purpose of executing prompt and effective justice, disputes about something with the value of not more than 1,000 GEL in case of civil disputes cannot be appealed. As for the criminal cases, verdicts on crimes not subject to imprisonment cannot be appealed. However, the exception can be considered from the viewpoint of protection of fundamental human rights; namely, a person has the right to appeal and require acquittal from the charge. The complainant may also appeal the decision of the lower court (district/city court) that found that the accused was not guilty of the violation of his/her (complainant's) human rights (a non-incriminatory verdict).

## Supreme Court (Court of Cassation)

The Supreme Court of Georgia represents the court of the highest and final instance for justice administration in the country. It was established in 2005 as a purely cassation instance court. The Supreme Court's competence as the cassation court is the review of the consistency of appealed judicial decisions with acting legislative norms and uniform court practices. The Court is authorized to declare the appeals inadmissible if the appeals do not state that the appealed decisions are in contradiction with the existing court practices.

It oversees the administration of justice at common courts of Georgia, and its activities are guided by the principles of legality, equality of parties, and competitiveness; as well as inviolability and independence of justices/judges.

Presently, the Supreme Court hears cassation appeals only. This means that the factual circumstances of the case are neither investigated nor assessed in this instance. The criteria for eligibility for cassation are identical to all three spheres of justice (criminal, administrative and civil). This also means that

the Supreme Court considers the eligible case and accepts it for hearing only if the case is significant for the development of justice and for the establishment of the common judicial practice, or if the decision of the Court of Appeal is substantially different from the practice at the Supreme Court in reference to similar cases.

The principle of the so-called sequential order of instances – that represents the significant mechanism for control within the Government – will more effectively be guaranteed in the reformed court system. According to this principle, the appeal courts and the cassation court (Supreme Court) supervise the proceedings of the lower courts by using the proceedings forms defined for the decisions of the courts of the first instances – first by appealing, and then by cassation. In other words, the decisions are verified; the court proceedings in appellate and cassation courts are used to supervise/check how the proceedings were conducted in the first instance courts. Such verification represents the most important mechanism for revealing offences by first instance judges within the court system. If judges are constantly controlled by such proceedings, then they are less likely to be involved in corruption.

The rules of procedure tailored for first instance court hearings is the law for higher instances of appeal and cassation with exception procedures and additions specially drafted to their functions. The Supreme Court is authorized to identify and verify the cases most important for the development of court practices that serve the purpose of revealing the decisions subject to overruling. This mechanism will become more instrumental after some time, as the common practice of the Supreme Court related to all the norms of justice will be established and identified little by little. Although the decisions made by the Supreme Court will not have the decisional, obligatory power on future decisions (unlike in *common law* systems), a court of lower instance will have to strongly justify a decision that would be different from the practice of the Supreme Court, in order to give it a chance to be discussed at the Supreme Court without facing the risk of cancellation in the very beginning.

## Constitutional Court

The Constitutional Court of Georgia is the judicial body of constitutional review and has the greatest significance in the country, with the view of securing constitutional provisions, separation of powers and its accomplishment within the constitutional framework, protecting human rights and freedoms recognized and guaranteed by the Constitution, and enhancing public stability in the country.

The Constitutional Court was established in 1996. The legal basis of its organization and activity is the Constitution of Georgia, the Organic Law of Georgia “On the Constitutional Court of Georgia”, the Law of Georgia “On the Constitutional Legal Proceedings” and the Rules of the Constitutional Court—amended in 2002.

The Constitutional Court of Georgia consists of nine judges – the members of the Constitutional Court. To ensure its independence, all three branches of State powers participate in the formation of the Constitutional Court on an equal basis – three members are appointed by the President of Georgia, three members are elected by the Parliament by not less than three fifths of the number of members of Parliament on the current nominal list, and three members are appointed by the Supreme Court. The term of office of a member of the Constitutional Court is ten years.

Those entitled to lodge a constitutional claim or a constitutional submission with the Constitutional Court are: the President of Georgia; not less than one fifth of the members of the Parliament of Georgia; a court of general jurisdiction; the higher representative bodies of Abkhazia and of the Autonomous Republic of Ajar; the Public Defender; legal entities of Georgia, as well as foreign legal entities; and any natural person (citizens of Georgia, citizens of foreign states, stateless persons, regardless of their place of residence).<sup>4</sup>

The Plenum of the Constitutional Court, among other tasks, adjudicates upon conformity with the Constitution of Georgia of the following: the constitutional agreement; the laws of Georgia; the normative resolutions of the Parliament of Georgia; the normative acts of the President of Georgia, of the higher state bodies of Abkhazia, and of the Autonomous Republic of Ajar. The composition of the Plenum shall include all nine members of the Constitutional Court, and its sittings shall be presided over by the President of the Constitutional Court (Organic Law of Georgia on the Constitutional Court of Georgia, Articles 11.1 and 11.2).

The Court considers the constitutionality of international treaties and agreements as well; and it considers a submission from a court of general jurisdiction. A submission is lodged with the Constitutional Court when considering a particular case, the court of general jurisdiction concludes there is sufficient ground to deem the law or other normative act applicable by the court while adjudicating upon the case, fully or partially incompatible with the Constitution.

A Board of the Constitutional Court considers, among others, the constitutionality of the normative acts adopted in terms of Chapter Two of the Constitution of Georgia (Georgian Citizenship, Basic Rights and Freedoms of Individual). The composition of each Board shall include four members of the Constitutional Court (Organic Law of Georgia on the Constitutional Court, Articles 11.1 and 11.3)

The Constitutional Court may also be asked to decide on the conformity or nonconformity of the normative acts or the part questioned with respect to the Constitution of Georgia, Constitutional Law of Georgia on the Status of the Autonomous Republic of Ajar, Constitutional Agreement, international treaties and agreements, and the Laws of Georgia.

As a result of the examination of the constitutional submission, the Court can decide to uphold fully or partially the claim, or to reject it, i.e. it must state the constitutionality or unconstitutionality of the impugned norms. Unconstitutional norms shall be considered invalid.

The Constitutional Court of Georgia performs its activity based on the principles of legality, co-collegiality, openness, equality of parties and adversarial nature of the proceedings, independence, immunity and tenure of the members of the Constitutional Court.

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<sup>4</sup> The circle of those who have the right to apply to the Constitutional Court has recently been widened: <http://www.ombudsman.ge/index.php?page=1001&lang=1&id=1296>.

## 8.2 Administrative Procedures

### 1. Health Care Institution

The **Law on Health Care** outlines the possibilities for patients and their legal representatives to complain. The patient or his/her legal representative can complain against a physician, a nurse, or any other health care professional, as well as against the health care institution itself. The complaint shall be lodged to the administration of the institution, to the health care management institution<sup>5</sup>, to the court, or to other arbitral bodies<sup>6</sup> (**Article 104**).

As these general provisions of the law have not been further strengthened by appropriate regulations and structures<sup>7</sup>, except for situations in which the complaint is made to court, rules of the health care institution administration or of the health care management institution procedures cannot be further detailed.

Some hospitals and clinics have created a Patient Relations Service (or similar body), but these services do not exist in every health care institution and are set up at the discretion of the health care institution. Health care legislation does not specify their role or power. They should rather be seen as a “patient-friendly” way of gathering complaints to the administration of the health care institution, in the opinion of the authors of this Guide.

### 2. Ministry of Labour, Health and Social Affairs and its Relevant Bodies

The Ministry of Labor, Health and Social Affairs accepts citizen applications and complaints. According to the Statute of the Ministry, approved by the Decree of the Government of Georgia of 31.12.2005 No249, the Minister’s Office is responsible for public relations, accepting citizen complaints, and organizing a hotline for citizens.

Within the Ministry, applications and complaints are usually considered by the following bodies:

- The State Regulatory Agency for Medical Activity (SRAMA);
- The Professional Development Council (PDC) – however, issues that are submitted to it are preliminarily studied by SRAMA;
- The Office of Public Relations.

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<sup>5</sup> Such as the Ministry of Labour, Health and Social Affairs, and the municipal bodies responsible for health care (e.g. the Civil Service of Culture and Social Protection of Tbilisi Municipality).

<sup>6</sup> When the Law on Health Care was promulgated in 1997, it was not yet clear what kind of complaint systems would be established in the country. There is, therefore, no specific interpretation for this term.

<sup>7</sup> E.g. deadlines, mechanisms of appeal, possible sanctions etc.

## State Regulatory Agency for Medical Activity

The Statute of the Agency has been approved by the Order of the Minister of Labour, Health and Social Affairs No24/n of 30.01.2005. According to the Statute, the Agency is a controlling body, and supervises (regulates) the medical activity of all legal entities<sup>8</sup> and natural persons<sup>9</sup> on the territory of Georgia.

The duties and activities of the Agency include:

- ✓ “Providing organizational support for issuing licenses and permissions in the field of health care; issuing relevant licenses and permissions, and keeping a register a register of those licenses and permissions;
- ✓ Cooperating with all stakeholders to ensure that postgraduate and continuing professional development programs are developed and run appropriately;
- ✓ Ensuring that institutions participating in postgraduate programs comply with requirements established by law;
- ✓ Ensuring that the competences gained as a result of postgraduate and continuing professional development programs are relevant to acknowledged international and high quality standards;
- ✓ Ensuring organizational support of certification of medical and pharmaceutical personnel and keeping all data and the register;
- ✓ Ensuring quality control of health services provided to patients by legal entities and individuals;
- ✓ Considering individual complaints within the competence of the Agency based on existing legislation;
- ✓ Checking compliance of existing conditions to licensing requirements on site;
- ✓ Ensuring quality control of services provided within state medical programs;
- ✓ Revealing cases of illegal medical activity and carrying out measures established by law;
- ✓ Participating in the process of establishing licensing conditions for health care institutions;
- ✓ Completing the relevant protocol on violation of administrative procedures according to the Administrative Proceedings Code of Georgia (Article 239, Section 38).
- ✓ Implementing instructions of the Minister.”

SRAMA accepts complaints from anyone who uses the services within the health care system. As the Agency is in charge of the supervision and quality control of the professional activity of doctors and other health care professionals, its main focus is the quality of care, and it deals mainly with complaints linked to the quality of care.<sup>10</sup> In practice, this means that SRAMA considers mostly cases in which the patient or his/her representative was dissatisfied with the medical care received (they are concerned with poor results or high costs incurred as a result of the poor quality of care). The Agency bases its judgments on expert reviews of medical records, as the examination of medical records is the only reliable tool at its disposal. If SRAMA experts find problems, they invite external experts, mostly from professional associations.

SRAMA also provides organizational and technical support to the Professional Development Council.

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8 I.e. both private and public institutions.

9 I.e. citizens, foreigners and stateless persons.



## Professional Development Council (PDC)

The Council was established by the Order of the Minister of Labour, Health and Social Affairs No122/n of 16.05.2008.

According to the Law on Doctor's Professional Activity, only a doctor possessing a State Certificate in a relevant specialty is allowed to practice medicine independently. His professional activity must be limited to the specialty specified in the State Certificate (**Article 7**). Based on this Certificate, and other documents, it is the Professional Development Council that is responsible for issuing the State License (**Article 20**).

According to **Article 75**, complaints or applications about a doctor's professional activity, which could be the basis for reprimand, can be submitted by:

- ✓ The patient or his/her legal representative;
- ✓ The employer of the doctor;
- ✓ Two colleagues from the same institution where the implicated doctor works or worked; the application/complaint must be signed by the head of the institution as well.

**Chapter 11** of the Law on Doctor's Professional Activity sets out procedures for submitting a complaint to the Council against a doctor. After accepting the complaint, the Council is obliged to inform that doctor about the complaint and to send him/her a copy of the document containing the complaint (**Article 84**). The doctor shall provide a written opinion on the complaint filed against him/her, except in cases when the Council considers that oral explanation is enough (**Article 85**). If the doctor agrees to it, or requests it, relevant professional associations may take part in the discussion of the case in question (**Article 86.3**). Both parties (complainant and doctor) have a right to take part in the discussions on the complaint organized by the Council (**Article 87**). Once the PDC procedure is closed,<sup>11</sup> the doctor can apply to court and appeal the decision of the Council (**Articles 74.3, 80 and 89**).

The right of a patient to appeal the decision is not included in this law. However, the patient also can appeal to the court, according to **Article 104 of the Law on Health Care**, as stated above at the beginning of this section on Administrative Procedures (Section B.1).

Sanctions for inadequately carrying out professional activity could be (**Article 74.1**):

- ✓ Written reprimand;
- ✓ Suspension of the certificate (license);
- ✓ Withdrawal of the license;
- ✓ Restricting the right to prescribe narcotics, psychotropic drugs and medications containing alcohol;
- ✓ Other means envisaged by the legislation of Georgia.

The Certificate can be suspended (**Article 77**) if a doctor:

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<sup>10</sup> However, the Agency has its system of quality supervision as well: particularly, the SRAMA assesses quality of care and of medical records on its own initiative.

<sup>11</sup> The doctor has to be informed about the decision of the Council within one week.

- Violated the law regulating independent medical practice of doctors, or conditions defined by his/her Certificate; or
- Received a written reprimand 3 times within one year.

A Certificate cannot be suspended for longer than 6 months.

A decision on withdrawal of the Certificate can be taken if (**Article 79**):

- ✓ His/her health conditions do not allow the doctor to fulfill his/her professional duties;
- ✓ The doctor carries out activities that are out of the scope defined by his/her Certificate;
- ✓ If the doctor failed to remove the reasons of suspension, and to comply with the conditions established by the PDC, after the time of suspension of the Certificate expires;
- ✓ If the doctor violated professional standards, ethical norms, rules defined by law, systematically or once; if in the latter case the violation caused significant deterioration of the health condition, or death of the patient, or damage to the property of the patient;
- ✓ If there is a court decision about imprisonment or dismissal of the doctor from his/her current position;
- ✓ If it became known that a doctor submitted falsified documents to obtain a State License.

The Council can only apply sanctions against health care professionals; it does not consider issues related to compensation to be paid to patients.

### 3. National Center for Disease Control and Public Health (NCDC)

**Chapter 9 of the Law on Public Health** defines competences of various parties in the field of public health. These parties are: the Ministry of Labour, Health and Social Affairs (**Article 31**), the Government of Georgia (**Article 32**), the Ministry of Agriculture (**Article 33**), the Ministry of Environment and Natural Resources (**Article 34**), other ministries (**Article 35**), and local authorities (**Article 36**).

The central agency being in charge of public health issues in the country is the National Center for Disease Control and Public Health (NCDC). The NCDC is a legal entity under Public Law, and it reports to the Minister of Labour, Health and Social Affairs.

The main responsibilities of the NCDC include:

- Surveillance on communicable and non-communicable diseases;
- Control and prevention of public health diseases;
- Outbreak investigations;
- National IHR<sup>12</sup> Focal Point;
- National Immunization Program;
- National Referral Laboratories;
- National Repository of EDP's (Especially Dangerous Pathogens);
- Medical statistics;
- Health promotion;
- Training and continuing education;
- Ensuring biosecurity and biosafety.

For more details, see [http://www.ncdc.ge/W2/Page1\\_en.htm](http://www.ncdc.ge/W2/Page1_en.htm).

As part of the decentralization process, local/municipal governments established Centers of Public Health (CPH). These Centers implement surveillance, routine disease control measures, immunization programs, and coordinate other prevention activities at the local level. They cooperate with NCDC and they are obliged to send specific reports to NCDC, according to the Order of the Ministry of Labour, Health and Social Affairs No 101/n of 5.04.2005 “on the Rules of Managing and Submitting Statistical Informatics.”

#### 4. Health Insurance Mediation Service (HIMS)

The Health Insurance Mediation Service (HIMS) was first established in 2008 by insurance companies involved in the health sector. It was a non-commercial, non-governmental body which aimed at resolving disputes (conflicts) among subjects of health insurance-disputes between the patient/insured and the insurance company or a provider that is financed through an insurance scheme. Establishment of the mediation service was supported by grants from various donors.

In 2010, the HIMS moved from the insurance sector to the state sector. Based on the Edict of the President of Georgia of 7.06.2010 No386, the Service has been established as a legal entity under Public Law. Its Statute was approved by the Order of the Minister of Labour, Health and Social Affairs No192/n of 30.06.2010. Although the HIMS is an independent legal entity with its own budget, it has been established under the Ministry of Labour, Health and Social Affairs, and reports to the Ministry.

The objectives of the Service are as follows:

- ✓ To play the role of mediator between parties/subjects of insurance within State healthcare programs;
- ✓ To prepare proposals on the quality of implementation of State healthcare programs, based on the information received from the parties of insurance; it prepares proposals on how the implementation of the State healthcare programs could be improved and submits those proposals to the Government, i.e. the Ministry of Labour, Health and Social Affairs;
- ✓ To gather information and prepare proposals about cases of violation of conditions defined by insurance vouchers;
- ✓ To promote and support implementation of State healthcare programs;
- ✓ To protect the interests of insurers and insured persons within State healthcare programs;
- ✓ To contribute to the establishment of adequate communication between the insured and the healthcare providers selected by the insurance companies.

## 8.3 Alternative Mechanisms to Protect/Enforce Rights & Responsibilities

### 1. Public Defender (Ombudsperson)

The Public Defender of Georgia is a national human rights institution. The Office of Public Defender was established in 1997, based on a law adopted by the Parliament of Georgia. The Public Defender is elected for a 5-year term by majority vote of the total members of the Parliament of Georgia. In his activities, the Public Defender shall follow the Constitution of Georgia and the present Law of Georgia on the Public Defender, as well as the universally-recognized principles and rules of international law, international treaties and agreements concluded by Georgia.

The Public Defender supervises the protection of human rights and fundamental freedoms on the territory of Georgia, elicits the facts of violation of human rights, and assists in the redress of infringed rights.

The Public Defender can be addressed directly by any individual (citizens, foreigners, and stateless persons equally) in case he/she feels that his/her human rights have been violated; patients' and providers' (human) rights are naturally, not an exception. No fees can be imposed on a complaint or letter submitted to the Public Defender and the services of the Public Defender are free of any charges.

The Public Defender is authorized by law to address the respective governmental agencies by recommendations concerning a certain violation, or to request information related to a concrete complaint. Based on the complaint submitted, the Public Defender initiates a process of evaluation, and informs the complainant, as well as the organization or official person concerned. The Public Defender is obliged to inform the complainant about the outcomes of the consideration of the complaint.

Addresses and petitions of the Public Defender are subject to mandatory observation guaranteed by administrative and criminal legislation.

The process of considering a citizen's complaint by the Public Defender shall not create any obstacle for consideration of the same complaint within a corresponding international organization; i.e. the Public Defender's procedure is not considered as an internal remedy that must be exhausted before turning to international/regional human rights bodies.

The Public Defender supervises the activities of public authorities, national or local public officials and legal persons, evaluates all acts passed by them, and gives recommendations and proposals. The Public Defender annually addresses Parliament with his report on human rights violations – including rights of individuals subjected to medical treatment – committed in the previous calendar year.

## 2. Ethics Committees

Ethics Committees in Georgia have existed for little more than a decade.

The table below briefly describes the three types of ethics committees (EC) in Georgia and the legal basis for their establishment and function.

| Title of the Committee        | Task of the committee   | Legal bases (Laws, decrees, etc)   |
|-------------------------------|---|--|
| National Council on Bioethics | To advise the Minister of Labor, Health and Social Affairs on the ethical aspects of healthcare and biomedicine | Presidents Decree No15 of 12 January 98.<br>Order No57/m of the Minister of Health and Social Affairs<br>Regulation for the National Council on Bioethics enacted by the Order No 157/0, of 5 July 2000 of the Minister of Labour, Health and Social Affairs |
| Research Ethics Committees    | Ethical review of research protocols  | Law on Health Care (1997)<br>Law on Drug and Pharmaceutical Activity (1995)<br>Law on Biomedical Research Involving Human Subjects (before government)   |
| Medical Ethics Committees     | Ethics education and consultation for healthcare professionals, patients and their family members               | Law on Health Care (1997)<br>Regulation for the Institutional Medical Ethics Committees enacted by the Order No 128/n, of 2 October 2000 of the Minister of Labour, Health and Social Affairs  |

### Medical Ethics Committees

Medical ethics committees (MECs) have been designed to help in the implementation of ethical principles and legal requirements reflected in Georgian patients' rights legislation.

The first push towards the establishment of medical ethics committees was the enforcement of the Law on Health Care (1997). **Article 62** of the Law envisages that health establishments set up ethics committees (Hospital or Clinical Ethics Committee)<sup>13</sup> to ensure that the rights of patients are respected and the principles of medical ethics are considered:

*“In order to ensure protection and promotion of the patient’s rights and the norms of medical ethics, medical institutions create medical ethics committees. The basis of creation of the commission is determined by Georgian legislation.”*

The Charter adopted by the Minister of Labour, Health and Social Affairs on 2 October 2000 (which is partly obligatory, but has mostly educational/recommendatory character) defines the purpose and priorities of the committees. The Charter states that the purpose of establishing medical ethics committees is *“the humanization of the medical practice, the promotion of patients’ rights, and the protection of patients’ dignity and autonomy.”* The main functions of the ethics committee may be accom-

plished by “educating health care personnel, identifying the ethical issues related to medical care, and by analyzing these issues, and providing recommendations.”

The Charter outlines the procedures for submitting cases to the committee, the organization of committee meetings, the reporting of regulations, and other organizational issues. The Charter details the functions of institutional medical ethics committees as follows:

*“a) Education of medical personnel, patients, patients’ families and the community about the ethical dimensions of contemporary medical practice.*

*b) Development of policies and guidelines that will help medical personnel address the complex ethical problems that arise in the process of providing care to patients (e.g. policy for the cessation of futile cardiopulmonary resuscitation, do not resuscitate orders, guidelines for how to deal with previously-expressed patient wishes regarding the withholding or withdrawing of life-sustaining procedures if they should have a terminal condition –“living wills,” etc.).*

*c) Counseling medical staff members, patients and their families on the ethical aspects of particular clinical cases.*

*d) Retrospective review/analysis of ethical questions, which arise in the decision-making process related to the care of individual patients.”*

It appears from the above that MECs are primarily consultative bodies for health care personnel, intended to help them in making difficult decisions. When there is a specific case on the care of a particular patient, the local committee is accessed by the attending doctor, or by other personnel of the same institution who think(s) that the case should be considered by the MEC. (In the latter case, the attending doctor must be informed that the case has been submitted to the MEC.) In both cases, the informed consent of the patient, or his/her representative (if the patient does not have decision-making capacity), must be obtained.

The committee may refuse to accept the case, but it must provide adequate justification of the refusal to the healthcare personnel who submitted the case. The MEC can invite the patient or his/her representative to participate in its meeting. However, before adopting its final recommendations, the MEC may ask the patient (or his/her representative) to leave the committee meeting.

The MEC members shall ensure confidentiality of the information they get about the particular case. The chair of the committee prepares the conclusions, which include the following information: date of the meeting, participants, the reason/purpose of the meeting, what information MEC members received, and the recommendation itself. Information about the MEC meeting and the recommendation developed shall be entered in the medical records of the patient. However, the recommendation is not mandatory for health care personnel, or for the patient or his/her legal representative.

Although there are several legal developments related to the establishment and the development of MECs in Georgia, including an Article in the Law on Health Care and the Charter of MECs approved by the Order of the Ministry of Labour, Health and Social Affairs, very few committees have been established so far. It is not clear what the views of health care professionals and ad-

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<sup>13</sup> However, setting up ethics committees is not an obligation.

ministrations of health care institutions (basically hospitals) are about the value of MECs. Several projects are on their way to implementation, aimed at intensifying the clinical/medical ethics committee movement in Georgia. However, it is too early to make any serious conclusions about the fate of MECs in this country.

### Research Ethics Committees

Research ethics committees are designed to prevent unethical research and to protect research subjects from all types of abuse.

Today, almost all international, national and legal texts include the aforementioned requirement to subject every research protocol to an independent ethical review to be carried out by ethics committees.

The Law of Georgia on Healthcare lays down the legal basis for the establishment of the research ethics committees, which shall carry out an ethical review of all research protocols (not only research protocols related to drug testing). So, currently *“a scientific research plan shall be considered and reviewed ...by the ethics committee”* (**Article 107 of the Law on Health Care**).

About 15 research ethics committees have been established during the last 8-10 years, 10 of which still function presently. They have been created at institutions that used to participate in multi-center trans-national drug trials. Without having such committees, these institutions would have not been able to take part in such trials. Only a few of them have their own regulations/bylaws. The number of members varies from 5 to 11 (their number is mostly 5, as defined by the **Law on Drug and Pharmaceutical Activity**).

One of the most active research ethics committees is the Biomedical Research Ethics Committee of the Tbilisi State Medical University (TSMU), established in 2007 by a decision of the Academic Council of the University for the purpose of implementing research protocols at TSMU. The committee holds regular monthly meetings, and reviews several research protocols during each meeting. The possible conclusions of the committee on research protocols are as follows: (a) approved without changes, (b) approved with conditions (protocol is approved in principle, but the researcher must make minor changes to the protocol and/or accompanying documents), (c) refusal until the next meeting (the protocol will be discussed at the next meeting after the researcher amends the protocol according to the comments of the committee and/or provide explanations to the questions of the committee), and (d) final refusal (researcher must substantially change the research protocol; then it may be re-submitted to the committee).

Finally, the National Council on Bioethics especially reviews those research protocols that reflect international multi-central biomedical research, because there is still no central research ethics committee in Georgia in charge of carrying out ethical reviews of multi-central studies.

Although research ethics committees are extremely important in protecting patients' (research subjects') rights, patients themselves do not have access to the committees. Research ethics committees are accessed by researchers who submit their research protocols for ethical review. Thus, from the point of view of patients' rights protection, the role of the committees is an indirect, preventive role.



### **National Council on Bioethics (NCB)**

The National Council on Bioethics (NCB) was established according to the President's Decree No15 of 12 January 98, and the related Order No57/m of the Minister of Labour, Health and Social Affairs. The Department of Health Law and Bioethics at the National Health Management Center (within Ministry of Labour, Health and Social Affairs) and the NGO Georgian Health, Law and Bioethics Society prepared the regulation for this body.

The purpose of establishing the National Council on Bioethics is to highlight and study ethical issues related to biomedicine, and to elaborate appropriate recommendations. The Council is the advisory body to the Ministry of Labor, Health and Social Affairs. However, it can be accessed by other state executive bodies as well. According to the Statute of the Council, its priority is to promote the protection of the rights, dignity and autonomy of the persons in the process of medical care and biomedical research.

Therefore, the NCB plays an important role in the protection of human rights in the field of biomedicine through popularization among health care professionals of the principles of modern medical ethics/bioethics, as well as by providing advice and recommendations to State executive bodies.

It should be emphasized that the National Council on Bioethics is a consultative body; it expects very specific cases and is not responsible to review particular cases. According to the Bylaw of the Council, the Council shall promote the establishment of the most appropriate environment for the protection of human rights related to health and biomedicine.

In certain circumstances, the Council initiates the process of consideration of various problematic issues in the field of bioethics. Exceptionally, the Council considers ethical aspects of cases of (patients', research subjects') human rights violations and/or of professional misconduct.<sup>14</sup> These cases are submitted to the Council, mostly by the Ministry of Labour, Health and Social Affairs (by the minister or by the heads of the various departments or agencies within the Ministry).

The NCB also carries out ethical evaluation of research protocols upon the request of researchers in cases when the research project is multi-central, international or involves high risk interventions (this could be physical risk or risk to private life and confidentiality as well), or when research ethics committee does not exist in the institution where the research is to be carried out.



## 8.4 Appendix: Civil Complaint Form

### Appendix of Documents and Forms Complaint<sup>15</sup> (Civil Case)

.....  
Name of the Court where the Complaint is filed

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#### Claimant:

1

.....  
First Name, Last Name (Legal Name) Current Address

.....  
Alternate Address Work Tel. Home Tel. Cell Phone e-mail address  
Number Number

.....  
Work place and address Fax Most suitable time for  
delivering warrant

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#### Legal Representative of the Claimant (If applicable):

1

.....  
First Name, Last Name (Legal Name) Current Address

.....  
Alternate Address Work Tel. Home Tel. Cell Phone e-mail address  
Number Number

.....  
Work place and address Fax Most suitable time for  
delivering warrant

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#### Respondent:

1

.....  
.....

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<sup>14</sup> For example, the Council has recently considered some aspects of end-of-life care. The question was whether or not health care providers were right when they terminated the intensive care of patients whose death was imminent due to a fatal disease (while keeping these patients on ventilation and tube feeding), and whether or not their conduct was appropriate when they did not provide cardiopulmonary resuscitation when the heartbeat of these patients stopped. In response, the NCB elaborated specific recommendations on the given case, and general recommendations aimed at educating society about medical, ethical and legal aspects of end-of-life care (Recommendation of the NCB No13, 28.07.2010.).

|                                    |                  |                  |            |   |
|------------------------------------|------------------|------------------|------------|---|
| First Name, Last Name (Legal Name) |                  | Current Address  |            |   |
| Alternate Address                  | Work Tel. Number | Home Tel. Number | Cell Phone | e-mail address                            |
| Work place and address             |                  |                  | Fax        | Most suitable time for delivering warrant |

**Contact Information of Contact Person:**

1

|                                    |                  |                  |            |     |                |
|------------------------------------|------------------|------------------|------------|-----|----------------|
| First Name, Last Name (Legal Name) | Work Tel. Number | Home Tel. Number | Cell Phone | Fax | e-mail address |
|------------------------------------|------------------|------------------|------------|-----|----------------|

**Note:** Providing all the requested information is necessary to ensure a speedy and effective administration of justice. The claimant (legal representative) is obligated to provide accurate information. Copies of the complaint and accompanying documents shall be equal to the number of defendants. If the claimant has legal representative at the time of filing the complaint, the claimant must provide contact information of the representative together with his/her and defendant’s contact information.

**List of Persons to be Called on the Court**

Witnesses, experts, specialists and interpreters might be called on the court.

1

|                                      |                  |                  |            |   |
|--------------------------------------|------------------|------------------|------------|---|
| Status of Person Called in the Court |                  |                  |            |   |
| First Name, Last Name (Legal Name)   |                  | Current Address  |            |   |
| Alternate Address                    | Work Tel. Number | Home Tel. Number | Cell Phone | e-mail address                            |
| Work place and address               |                  |                  | Fax        | Most suitable time for delivering warrant |

**Note:** If you would like the court to call on certain person as witness in the case, you must indicate which substantial circumstances of the case the person can affirm. The **Claimant (legal representative) is obligated to provide accurate information regarding the person to be called on the court.**

15 This form is used for any civil complaint in any court.

## Cause of Action

### Legal Claim

The claimant must state which legal rights he/she aims to restore via court action.

### Short review of the cause of action

Here the claimant must indicate which events have led to his/her complaint, what the respondent did or did not do and the date(s) of the conduct the claimant is complaining about.

### Concrete Facts and Circumstances, on which the Claimants Bases his/her Claim and Evidence Affirming these Facts and Circumstances

The claimant indicates concrete facts and circumstances which he/she considers important for the outcome of the case and which he/she purports to be the subject of the discussion in court.

Facts and circumstances of the case must be indicated one by one, numbered by Arabic symbols.

Circumstances of the case must be stated clearly and concisely. In case of interrelated circumstances, when separate reference might alter the meaning of these circumstances, they may be indicated in one paragraph.

The claimant must himself/herself indicate which facts to refer to as basis of his/her claim.

The claimant must not indicate facts and circumstances that have no direct connection to the cause of action and cannot impact the outcome of the case;

The claimant is authorized to request a reasonable time for filing a claim.

**Cost of the Complaint** ..... **Lari**

**The Amount of State Tax** ..... **Lari**

The amount of state tax is indicated in Article 39 of the Civil Procedure Code of Georgia and the Law of Georgia on State Tax. In the first instance court, the amount of tax must not exceed 3000 Lari with regard to natural persons and 5000 Lari with regard to juridical persons. The claimant must attach the receipt of payment to the complaint. In case the requirement is not fulfilled, the court will not hear the dispute, except cases when the law exempts the claimant from paying the tax. If the claimant withdraws the complaint, he/she is exempt from tax.

**List of Attachments to the Complaint**

**After each attachment, the number of pages must be indicated. After the list, the total number of attached pages must be specified. The list must be numbered using Arabic symbols.**

**Do You Give Your Consent to the Court’s considering the Case without Oral Hearing?**

In this section the claimant must specify his/her opinion about resolving the case without an oral hearing.

Yes

No

**Do You Authorize the Court to Send the Documents on Your E-mail Address?**

In this section the claimant must explain his/her opinion about receiving court documents via e-mail. In case of consent, the court sends all the relevant documents via electronic address.

Yes

No

Hereby I confirm that the information provided is complete and accurate to the best of my knowledge. I realize the legal obligation of claimant and his/her representative to notify the court immediately in case of changing the current home address during the court hearings. I am obligated not to hinder the court to consider the case promptly and in due dates. I realize that my non-appearance will not stop the court from resolving the case.

.....  
Claimant's signature

.....  
Signature of claimant's representative

“ ..... “ ..... “ ..... 20 ..... “



# GLOSSARY

## International

### 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. *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 (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 (q.v.). 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 (q.v.) or ratification (q.v.), without further domestication (q.v.).

**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 programs, 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 (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 (q.v.) 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 (q.v.). 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* (q.v.) 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 (q.v.), 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).

### **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 issued 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 infirmity (World Health Organization).

**Health Care or Patient Care**

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 embraces all the goods and services designed to promote health, including preventive, curative, and palliative interventions, whether directed to individuals or populations (World Health Organization).

**Health Care Establishment**

Any health care facility such as a hospital, nursing home, or establishment for disabled persons (World Health Organization)

**Health Care Providers**

Physicians, nurses, dentists, or other health professionals (World Health Organization)

**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 against which interfere 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” approved in 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”

**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**

Rights more readily expressed in absolute terms than are social rights in health care. When made operational, these can be made enforceable on behalf of an individual patient (Declaration on the Promotion of Patients' Rights in Europe, WHO EURO, 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 by 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 a 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 (q.v.) and private international law. Sources are (a) custom; (b) treaties; (c) general principles of law and (d) judicial decisions and juristic writings (see Art 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 provisions of ICESCR, Article 2, obliging governments to devote 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 (WHO)

**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 receives 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 (see article 2(1) (g) of the Vienna Convention 1969).

**Patient**

A person who is waiting for, is receiving, or has received health care services.

User(s) of health care services, whether healthy or sick (World Health Organization).

**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-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**

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.

Specific patient rights have been codified in regional and international instruments (e.g., European Charter of Patient Rights; Declaration on the Promotion of Patients' Rights in Europe) as well as in national charters and legislation. *See also "Individual Rights in Patient Care" and "Social Rights in Health Care."*

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**

General health services available in the community near places where people live and work; the first level of contact that individuals and families have with the health system.

**Progressive Realization**

The requirement 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 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 (q.v.), international humanitarian law, refugee law and international criminal law.

**Q****Quality**

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. 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 (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 health.

**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 geographical 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 EURO, Amsterdam 1994, Guiding Principles). *See also "Individual Rights in Patient Care" and "Patients' Rights."*

**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 ratification (q.v.).*

**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 the right to the highest attainable standard of health.

## T

### **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 (q.v.) and the incorporation of treaty provisions into domestic legislation.

### **Treaty**

A formal agreement entered into by two or more nations which are 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.

## Country-specific

### E

#### **Epidemic**

Substantial raise of the disease incidence comparing to the background disease on the given territory or among the specific group of the population in any given period of time.

#### **Epidemic Outbreak**

Sharp increase of the number of new cases of the contagious disease among the limited number of people during the short period of time.

### G

#### **Genome**

The total set of chromosomes comprising hereditary factors (genes).

### H

#### **Healthcare provider**

Person who provides medical service in accordance with the rules, set out by Legislation of Georgia.

All legal and physical entities providing healthcare that have the State Certificate or Appropriate Medical License for performing the independent medical service

### I

#### **Informed Consent**

The consent of the patient, or in the case of his/her incapacity, consent of next of kin or legal representative, to medical services, after the doctor has provided information about:

- b.1) The nature and need of the medical service;
- b.2) The expected results of medical service;
- b.3) The risks that the service entails for the patient's health and life;
- b.4) The alternative types of services and the expected results and risks related to the alternative intervention;
- b.5) The consequence of refusal to treatment;
- b.6) The financial and social aspects related to the issues mentioned in sections "b.1"- "b.5". (The Law of Georgia on Healthcare, Art. 3)

## L

### **Legal Representative**

Patient's guardian or trustee.

## M

### **Medical Service**

Any intervention or procedure having diagnostic, therapeutic, prophylactic or rehabilitative purpose and carried out by healthcare provider

### **Medical records**

Information that is entered on the paper or personal computer/electronic record of a patient by a healthcare provider, and is related to the medical service provided to the patient.

## N

### **Next of Kin**

Person who according to the legislation of Georgia has priority to participate in making decision about the patient's medical care or issues, related to patient's death.

## P

### **Palliative Care**

An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (WHO)

### **Public Health Care**

Unity of measures designed for the improvement of the population's health, disease prevention and control.

## T

### **Terminal state**

End stage of incurable disease.



