



EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

GRAND CHAMBER

CASE OF LOPES DE SOUSA FERNANDES v. PORTUGAL

(Application no. 56080/13)

JUDGMENT

STRASBOURG

19 December 2017

This judgment is final but it may be subject to editorial revision.

In the case of Lopes de Sousa Fernandes v. Portugal,

The European Court of Human Rights, sitting as a Grand Chamber composed of:

Guido Raimondi, *President*,
Angelika Nußberger,
Linos-Alexandre Sicilianos,
Ganna Yudkivska,
Robert Spano,
Luis López Guerra,
Mirjana Lazarova Trajkovska,
Işıl Karakaş,
Nebojša Vučinić,
Paulo Pinto de Albuquerque,
Helen Keller,
Ksenija Turković,
Yonko Grozev,
Pere Pastor Vilanova,
Alena Poláčeková,
Pauliine Koskelo,
Georgios A. Serghides, *judges*,
and Roderick Liddell, *Registrar*,

Having deliberated in private on 16 November 2016 and on 20 September 2017,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case originated in an application (no. 56080/13) against the Portuguese Republic lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms (“the Convention”) by a Portuguese national, Ms Maria Isabel Lopes de Sousa Fernandes (“the applicant”), on 23 August 2013.

2. The applicant complained under Article 2 of the Convention about the death of her husband in hospital as a result of a hospital-acquired infection and of carelessness and medical negligence. She further complained that the authorities to which she had applied had failed to elucidate the precise cause of the sudden deterioration in her husband’s state of health. Relying on Articles 6 § 1 and 13 of the Convention, the applicant also complained about the duration and outcome of the domestic proceedings she had brought in that connection.

3. The application was allocated to the First Section and then to the Fourth Section of the Court (Rule 52 § 1). A Chamber of that Section composed of András Sajó, President, Vincent A. De Gaetano, Nona Tsotsoria, Paulo Pinto de Albuquerque, Krzysztof Wojtyczek, Iulia Antoanella Motoc and Gabriele Kucsko-Stadlmayer, judges, and Françoise Elens-Passos, Section Registrar, delivered a judgment on 15 December 2015. The Court unanimously declared the application admissible. It held, by a majority, that there had been a violation of the substantive aspect of Article 2 of the Convention. It concluded, unanimously, that there had been a violation of the procedural aspect of Article 2 of the Convention. The joint dissenting opinion of Judges Sajó and Tsotsoria was annexed to the judgment.

4. On 10 March 2016 the Government requested the referral of the case to the Grand Chamber under Article 43 of the Convention and Rule 73. On 2 May 2016 the panel of the Grand Chamber granted the request.

5. The composition of the Grand Chamber was determined according to the provisions of Article 26 §§ 4 and 5 of the Convention and Rule 24 of the Rules of Court.

6. By letter dated 2 June 2016 the applicant was invited to complete and return to the Registry by 23 June 2016 an authority form authorising an advocate to represent her in the proceedings before the Court, in accordance with Rule 36 §§ 2 and 4 of the Rules of Court. On 22 June 2016 the applicant submitted an authority form authorising Mr Sá Fernandes, a lawyer practising in Lisbon, to represent her in the proceedings before the Court. The applicant was granted legal aid on 8 December 2016.

7. The applicant and the Government each filed further written observations on the merits (Rule 59 § 1).

8. In addition, third-party comments were received from the United Kingdom and Irish Governments, which had been given leave by the President to intervene in the written procedure (Article 36 § 2 of the Convention and Rule 44 § 3).

9. A hearing took place in public in the Human Rights Building, Strasbourg, on 16 November 2016 (Rule 59 § 3).

There appeared before the Court:

(a) for the Government

Ms M.F. DA GRAÇA CARVALHO, Deputy Attorney-General,	Agent,
Ms A. GARCIA MARQUES, lawyer at the Office of the Agent,	
Ms M.E. SOUSA PINA, retired doctor from the National Health Service,	Advisers;

(b) *for the applicant*

Mr R. SÁ FERNANDES, lawyer,	<i>Counsel,</i>
Ms I. ROGEIRO, lawyer,	
Ms A. MARTINS, lawyer,	
Mr D. MACHADO, doctor,	<i>Advisers.</i>

The Court heard addresses by Mr Sá Fernandes and Ms da Graça Carvalho and their replies to the questions from judges.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

10. The applicant was born in 1969 and lives in Vila Nova de Gaia. The applicant's husband, Mr António Rui Calisto Fernandes, was born in 1957. He died on 8 March 1998 following a series of medical problems that occurred after he had undergone minor surgery for the removal of nasal polyps.

A. The sequence of events leading to the death of the applicant's husband

1. Treatment in Vila Nova de Gaia Hospital

11. On 26 November 1997 Mr Fernandes was admitted to the ear, nose and throat (ENT) department of Vila Nova de Gaia Hospital ("the CHVNG") for a nasal polypectomy. He underwent the operation on 27 November 1997 and was discharged from hospital on 28 November 1997 at 10 a.m.

12. On 29 November 1997, at 1 a.m., the applicant took her husband to the emergency department of the CHVNG because he was suffering from violent headaches and was in an agitated state. There he was examined by the doctors on duty, in particular by a neurologist. The doctors considered that Mr Fernandes was suffering from psychological problems and prescribed tranquilisers. The applicant claims that they recommended her husband's discharge but that she objected.

13. In the morning Mr Fernandes was examined by the new medical team on duty. At 10 a.m. he underwent a lumbar puncture which revealed that he had bacterial meningitis. He was transferred to the hospital's intensive care unit.

14. On 30 November 1997 a scan revealed a cerebral oedema. On 2 December 1997 another scan revealed that the cerebral oedema had diminished.

15. On 5 December 1997, following an improvement in his clinical condition, Mr Fernandes was transferred to the hospital's general D. ward, where he was under the care of Dr J.V. He was diagnosed with two duodenal ulcers on 10 December 1997.

16. Mr Fernandes was discharged from hospital on 13 December 1997 as his condition was considered to be stable. A follow-up scan as an outpatient was recommended.

17. On 18 December 1997 Mr Fernandes, who was suffering from vertigo and headaches, was admitted to the emergency department of the CHVNG. He was examined by Dr J.V., who kept him under observation because he had acute diarrhoea, abdominal pain and severe anaemia. Mr Fernandes received blood transfusions.

18. On 19 December 1997 an endoscopy was performed on Mr Fernandes, confirming that he had a gastroduodenal ulcer.

19. On 23 December 1997 Mr Fernandes was discharged from hospital. He was prescribed a special diet and medication. A medical appointment was fixed for 9 February 1998.

20. The applicant's husband continued to suffer from severe abdominal pain and diarrhoea. On 9 January 1998 he returned to the emergency department of the CHVNG. He was examined by Dr J.V., who did not consider it necessary to admit him. Mr Fernandes therefore returned home the same day.

21. On 25 January 1998 Mr Fernandes was readmitted to the CHVNG. A colonoscopy revealed infectious ulcerative colitis. Bacteriological tests showed the presence of the *Clostridium difficile* bacterium. Mr Fernandes was placed on a drip and treated with antibiotics.

22. At the request of the applicant and her husband, Dr J.V. discharged the latter on 3 February 1998. Dr J.V. prescribed oral treatment and referred Mr Fernandes for further treatment in the hospital's outpatient department.

2. Treatment in Santo António General Hospital in Oporto

23. On 17 February 1998 Mr Fernandes was admitted to Santo António General Hospital in Oporto after he was found to be suffering from chronic diarrhoea and microcytic anaemia. He underwent various examinations including a colonoscopy, an endoscopy and blood tests. The medical team considered several possible causes, including an infection with the *Clostridium difficile* bacterium, but all these possibilities were subsequently ruled out. However, a cytomegalovirus was detected and treatment was given.

24. On 5 March 1998 Mr Fernandes was examined by a doctor who judged the situation to be under control.

25. On 6 March 1998 Mr Fernandes's condition deteriorated. He was examined by a doctor who suspected a possible perforated viscus. An X-ray and an abdominal ultrasound were carried out. The latter showed ascites in the abdomen but did not confirm the initial diagnosis. At 5.30 p.m. the applicant's husband was examined by another doctor who detected some resistance to abdominal palpation. A gas analysis showed metabolic alkalosis, but there were no signs of hypocalcaemia. A sigmoidoscopy was performed which showed that the applicant's husband had rectocolitis.

26. On 7 March 1998 at 1 p.m. the applicant's husband was placed on oxygen because he had difficulty breathing. At 3 p.m. Mr Fernandes was examined by a general physician and subsequently by a surgeon. The latter decided that urgent surgery was needed as there was widespread peritonitis. Mr Fernandes was taken to the operating theatre at 4 p.m. and was brought out again a few minutes later in order to be prepared for surgery, in particular by being given a blood transfusion. He re-entered the operating theatre at 8 p.m. He died the following day at 2.55 a.m.

27. According to the death certificate issued by Santo António Hospital, the applicant's husband died from septicaemia caused by peritonitis and a perforated viscus.

B. Proceedings brought by the applicant

28. On 13 August 1998 the applicant wrote a joint letter to the Ministry of Health, the regional health authority for the North region and the Medical Association, stating that she had received no response from the hospitals to explain the sudden deterioration in her husband's health and his death.

1. Proceedings before the Inspectorate General for Health

29. On 30 October and 23 December 1998 the regional health authority for the North region sent the applicant copies of the reports drawn up by the CHVNG and Santo António Hospital on the basis of her husband's medical records.

30. On 30 May 2000 the applicant requested an update on progress in the proceedings from the regional health authority, stating that she had still received no clear explanations concerning the events preceding her husband's death. In a letter of 5 July 2000 the authority informed her that the file had been sent to the Inspectorate General for Health (*Inspeção-Geral da Saúde* – "the IGS") with a view to the opening of an investigation.

31. By an order of 20 September 2000 the Inspector General for Health ordered an investigation (*processo de averiguações*).

32. On 6 November 2001 an inspector was appointed to head the investigation.

33. On 7 February 2002 the IGS informed the applicant that evidence would be taken from the members of the medical team which had treated her husband and that an expert medical report would be prepared.

34. The applicant gave evidence on 3 April 2002.

35. On 23 September 2002 expert medical reports were requested. Reports prepared by experts in the fields of internal medicine, gastroenterology and general surgery were submitted in November 2002. According to the reports, in view of the deterioration in his state of health after the nasal polypectomy, it would not have been possible to save the applicant's husband's life.

36. The report of the investigation was submitted on 28 November 2002. It found, on the basis of the expert medical reports received, that the treatment administered to the applicant's husband had been appropriate.

37. In an order of 12 December 2002 the Inspector General for Health declared the investigation closed, finding that there had been no medical negligence and that there were no grounds for instituting disciplinary proceedings against the doctors who had treated the applicant's husband.

38. In a letter of 17 February 2003 the applicant appealed against the order. She argued that the final report had not answered her questions, complaining about areas of uncertainty and about the duration of the investigation and its findings.

39. On 28 March 2003 the Inspector General for Health informed the applicant that he had set aside the order of 12 December 2002 and ordered the reopening of the investigation.

40. On 26 September 2005, in view of the questions raised by the applicant, the medical experts were requested to provide additional information.

41. A new investigation report was submitted on 23 November 2005, clarifying the facts and taking account of the answers provided by the three medical experts. The report stated that there were no grounds for criticising the health-care personnel who had been involved in the care of the applicant's husband in the CHVNG and Santo António Hospital, as the patient had received proper and appropriate medical assistance in terms of his diagnosis, supervision and treatment. The report further noted that his discharge had been justified on each occasion in view of the improvement in his state of health. The report concluded as follows:

"The results of the investigation ... following the reopening of the proceedings and the fresh inquiries and medical reports do not indicate that there was any negligent or careless conduct in breach of good medical practice. There is therefore no need to take legal or disciplinary action against any persons involved in the [patient's] care ..."

42. Taking this report into account, the Inspector General for Health made a fresh order discontinuing the proceedings on 27 December 2005.

43. In a letter of 1 February 2006 the applicant appealed against that order, complaining of unclear points and omissions. She also raised the

possibility that the sudden deterioration in her husband's health and his eventual death might have been caused by bacteria present in the operating theatre on the day of the nasal polypectomy, that the diagnoses may have been made in haste and that there may have been negligence and carelessness in the medical treatment administered to her husband. She further complained that the internal medicine and gastroenterology reports had been prepared each time by the same experts. The applicant therefore requested the reopening of the investigation and the preparation of a fresh expert medical report.

44. The Inspector General for Health wrote to the applicant on 2 March 2006 informing her that he had set aside his previous order and ordered fresh expert assessments to be carried out by different experts in the fields of internal medicine and gastroenterology.

45. The applicant gave evidence again on 27 April 2006.

46. The medical experts submitted their reports on 20 May and 10 July 2006. The expert in gastroenterology stated that it was possible, albeit rare, for a nasal polypectomy to cause meningitis. He further considered that the applicant's husband had received appropriate treatment but that his discharge on 3 February 1998 may not have been wise in view of his clinical condition. The expert concluded that the applicant's husband had suffered a series of complications which were uncommon but could occur, and that he had received proper medical care at the CHVNG. As to the care in Santo António Hospital, the expert considered that the condition of the applicant's husband had been extremely complicated and had given rise to doubts as to the best way to proceed. In his report, the expert in internal medicine rejected the idea of a hospital-acquired infection on the grounds that, had that been the case, the antibiotics administered to the patient would have had no effect. In his view, the meningitis had developed unexpectedly. He further took the view that the applicant's husband's discharge on 3 February 1998 had been appropriate but that he should have continued to be monitored as an outpatient.

47. On 25 July 2006 a report was drawn up on completion of the investigation, which concluded as follows:

“...

The content of the most recent expert medical reports shows ... that there are no grounds for a finding of disciplinary liability for negligence against any of the health-care professionals involved in A.'s medical treatment...

... the decision by the assistant doctor [J.V.] to refer the patient for outpatient treatment was not appropriate and sufficient from a clinical viewpoint in so far as, in order to prevent a recurrence of the colitis caused by *Clostridium difficile* ..., the patient should have remained in hospital under close medical supervision ...

...

Hence, the doctor in question did not act with the necessary care and diligence, thereby incurring disciplinary liability on account of his negligent conduct in the medical assistance provided ... in D. ward of the CHVNG's medical department between 25 January and 3 February 1998.

The medical opinions make no criticisms of the assistance provided in the gastroenterology department of Santo António General Hospital in Oporto ...”

48. In the light of this report the Inspector General made an order on 26 July 2006 for the opening of disciplinary proceedings against Dr J.V.

49. By a letter dated 31 July 2006 the applicant was informed that the disciplinary proceedings initiated against Dr J.V. would be stayed pending the outcome of the criminal proceedings (see paragraphs 59-68 below).

2. Proceedings before the Medical Association

50. In the meantime, on 31 August 1998, the Medical Association acknowledged receipt of the applicant's letter of 13 August 1998, informing her that steps would be taken in response to it.

51. The case was referred to the Medical Association's regional disciplinary council for the North region. The latter obtained the patient's medical records and sought the opinions of four specialist panels: gastroenterology, infectious diseases, general surgery and ear, nose and throat (ENT).

52. In its report of 14 July 1999, the gastroenterology panel issued the following conclusions:

“ ...

A simple X-ray of the abdomen performed the day before the patient's death did not detect any dilatation or perforation of the colon.

The patient's death was caused by peritonitis as a result of the perforation of the duodenal ulcer. The difficulties in diagnosing the condition were understandable in view of the patient's serious clinical condition and the fact that his abdominal pains were explained by the inflammatory disease in the colon.

The role of the corticosteroids in aggravating or reactivating the peptic ulcer ... is not currently considered a risk factor ... However, given that the patient had already experienced one episode of intestinal bleeding, there would have been grounds for weighing up the use of these drugs.

...

The decisions to discharge the patient [from hospital] may have delayed the diagnosis or the commencement of treatment. Nevertheless, after examining the documents submitted to me, I am unable to confirm whether these discharge decisions adversely affected his diagnosis or programme of treatment.

...”

53. The conclusions of the report of 17 April 2000 by the infectious-diseases panel read as follows:

“1. In our opinion the diagnosis of meningitis, most likely resulting from the nasal polypectomy, was inexplicably delayed. The fact that there was no one on the medical team trained in this type of diagnosis (for example, a specialist in infectious diseases) may be regarded as the only explanation for such an incident. However, this was not the immediate cause of the patient’s death.

2. In our view, too long a period elapsed between the diagnosis of the perforation in the duodenal ulcer and surgery.

3. The procedure has been undermined to an incalculable extent by the fact that no autopsy was performed, although an autopsy is mandatory (*mandatória*) in cases of this type in order to shed light on the chain of events.”

In its report the panel further held as follows:

“The inhuman conditions described in this process, as regards how the patient was treated, are another example of the situation encountered on a daily basis in our hospitals; a reflection of the appalling structural and operational conditions which require urgent analysis and change.

This board of the Infectious-Diseases Panel of the Medical Association must have a fundamental role in advocating the rights of patients and doctors in order to create better conditions of care for the former and better working conditions for the latter.

We reiterate, once more, the need to consider the creation of infectious-diseases departments/units in hospitals of the same type as Vila Nova de Gaia Hospital, in order to improve the quality of care in this regard.”

54. In a report of 24 April 2001 the general-surgery panel found that there had been no negligence or medical malpractice in the hospitals concerned. The report read as follows:

“1. A perforated duodenal ulcer requires immediate surgery. In the present situation the perforated ulcer ... was difficult, if not impossible, to diagnose given the clinical context in which it occurred. Furthermore, in view of the seriousness of the patient’s clinical condition, the approach to surgery had to be given careful consideration and the patient had to be prepared by means of various measures.

...”

55. In a report dated 1 August 2001 the ENT panel concluded as follows:

“1. Meningitis following micro-endoscopic surgery for nasal polyps is described as one of the (major) complications of this type of surgery, estimated in the literature to occur in between 0.6% and 1% of cases. These figures will be higher in the event of a repeat operation, as in the present case (surgery was performed in 1993 as stated on page 314 of the file concerning the operation).

2. The post-operative CT scan of the brain carried out on 29 November 1997 does not show any discontinuity in the bones at the base of the skull ... which suggests that no invasive endocranial surgery was carried out.

3. The description of the surgery performed on the patient on 26 November 1997 (page 310 of the file) does not give any indication of clinical malpractice or negligence.

4. No ENT procedures were performed during any of the patient's subsequent stays in Vila Nova de Gaia Hospital or in Santo António Hospital."

56. In an order of 28 December 2001 the regional disciplinary council for the North region decided, after having examined the conclusions of the different specialist panels, to take no further action on the applicant's complaint, on the ground that there was no evidence of misconduct or medical negligence.

57. The disciplinary council observed the following:

(i) meningitis was a complication that could arise in between 0.6% and 1% of cases following a nasal polypectomy; the figures were liable to be higher for a repeat operation, as in the case in question;

(ii) the applicant's husband had received appropriate treatment during his various hospital stays;

(iii) the patient's bacterial meningitis (*Pseudomonas*) had been treated properly;

(iv) although the infectious-diseases panel had suggested that the presence of a specialist in that discipline might have enabled a diagnosis to be made sooner, this had not been a decisive factor in the development of the clinical situation;

(v) the perforation of the duodenal ulcer had been the cause of the peritonitis. This had been difficult to diagnose in view of the patient's serious clinical condition, a fact acknowledged by the gastroenterology and general-surgery panels;

(vi) although the infectious-diseases panel had considered that too long a period had elapsed between the diagnosis of the perforated duodenal ulcer and surgery, the time taken to prepare for the operation had been justified since the patient had been suffering from intestinal disease and had severe anaemia, sepsis and a fluid and electrolyte imbalance, as noted by the general-surgery panel.

58. On 29 April 2002 the applicant lodged an appeal against that order with the Medical Association's National Disciplinary Council. On 18 March 2003 the appeal was declared inadmissible as being out of time.

3. Criminal proceedings before the Vila Nova de Gaia District Court

59. On 29 April 2002 the applicant lodged a complaint for negligent homicide with the Oporto criminal investigation and prosecution department.

60. She gave evidence on 7 June 2002.

61. By order of the Criminal Investigation Court of 27 September 2002 the applicant was given leave to intervene in the proceedings as an assistant to the public prosecutor (*assistente*).

62. On 7 December 2007 the public prosecutor's office made its submissions, charging Dr J.V. with homicide by gross (*grosseira*) negligence. In support of their decision the prosecuting authorities referred to the report appended to the IGS order of 25 July 2006. They considered that Dr J.V. should not have discharged the applicant's husband on 3 February 1998 in so far as the patient's clinical condition had been problematic and he had been infected with the *Clostridium difficile* bacterium.

63. The case was referred to the Vila Nova de Gaia District Court. During the trial the court heard evidence from the applicant, the accused, eight doctors who had been involved in treating the applicant's husband in the CHVNG and in Santo António Hospital, and the five medical experts appointed in the context of the proceedings before the IGS. The court also sought the opinion of the Medical Association's Disciplinary Council.

64. On 15 January 2009 the District Court acquitted Dr J.V. of the charges against him. In particular, it took the view that the findings made by the IGS in its order of 26 July 2006 could not be taken into consideration as they had not been confirmed by the five medical experts who had given evidence during the trial.

65. As to the facts, the District Court considered, *inter alia*, the following to be established:

“The patient's hospitalisation on 18 December 1997 ... was not the result of a lack of medical supervision of his clinical condition ... since it was unconnected to the complications arising out of the meningitis. In fact, it resulted from acute anaemia caused by intestinal bleeding from a duodenal ulcer; ...

The decisions to discharge the patient on 13 and 23 December 1997 were appropriate, given that, in the former case, the problem of bacterial meningitis had been resolved, [the patient] had completed the course of antibiotics, he no longer had any symptoms or fever, had a slightly increased white-blood cell count, a falling neutrophil count and normal sedimentation rate, and was not complaining ... and, in the latter case, that is to say, the patient's hospitalisation from 18 to 23 December 1997, the patient was not complaining of abdominal pain, diarrhoea or bleeding ... with the result that it was possible to continue treating his ulcer with a dietary regime while monitoring him on an outpatient basis ...

When the patient was admitted to Santo António Hospital, laboratory tests were carried out for *Clostridium difficile*. The results were negative on two occasions.”

66. On the subject of the surgery preceding the death of the applicant's husband, the District Court observed as follows:

“... the patient was in a very serious clinical state, with septic shock and multiple organ dysfunction. For that reason, he was placed on artificial ventilation and vasoactive drugs and fluids were administered ..., together with hydrocortisone to deal with possible acute adrenal insufficiency (*falência supra-renal aguda*), and broad-spectrum antibiotics;

... in this medical context the patient's prospects of survival were very uncertain, in view of the septic shock and multiple organ dysfunction;

... a simple abdominal X-ray and an abdominal and pelvic ultrasound scan were therefore requested, which did not reveal a perforation of the intestine.”

67. In the District Court’s view, it had not been demonstrated that the care provided to the applicant’s husband during his stay in hospital from 25 January to 3 February 1998 had not been in accordance with good medical practice, or that he should have been kept in hospital for longer. The court therefore concluded that there was no causal link between the treatment administered by Dr J.V. to the applicant’s husband in the CHVNG and his death, which had been caused by a perforated viscus that was unconnected to the colonic disease treated by the accused. It held:

“...there was no evidence to show that the treatment administered by the accused for the *Clostridium difficile* infection was incomplete, that the patient was discharged prematurely on 3 February 1998 or, in sum, that the accused was responsible for the death of the patient on 8 March 1998.”

68. The applicant did not appeal against that judgment.

4. *Proceedings before the Oporto Administrative and Fiscal Court*

69. On 6 March 2003 the applicant brought an action in the Oporto Administrative and Fiscal Court against the CHVNG, Santo António Hospital and the eight doctors who had been involved in treating her husband while he was in hospital, claiming compensation for the damage she had suffered on account of her husband’s death. She alleged, *inter alia*,

(i) that her husband’s meningitis had been caused by *Pseudomonas cepacia* bacteria which, she alleged, had been present in the operating theatre during the nasal polypectomy;

(ii) that the meningitis had been diagnosed too late, allowing the illness to become serious;

(iii) that the administering of excessive doses of medication and the lack of a suitable prophylactic had caused the duodenal ulcer which had led to her husband’s death.

70. In the context of these proceedings the applicant was granted legal aid in the form of exemption from payment of the court fees and the fees of a lawyer of her own choosing.

71. Between 4 and 24 April 2003 the eight doctors contested their standing to be sued (*ilegitimidade passiva*), relying on Article 2 of Legislative Decree no. 48051 of 21 November 1967.

72. On 16 April 2007 the court gave a preparatory decision (*despacho saneador*) specifying which facts were considered to be established and which remained to be established. In accordance with Article 2 of Legislative Decree no. 48051 of 21 November 1967 it further held that the doctors among the defendants did not have standing in so far as they had been sued only for negligent conduct. Accordingly, it declared the claim admissible only in respect of the hospitals.

73. On 17 January 2011 the applicant gave evidence.

74. During the three hearings the court heard evidence from the following witnesses:

(i) eleven doctors who had been involved in treating the applicant's husband during his various stays in the CHVNG and Santo António Hospital;

(ii) the general practitioner of the applicant's husband;

(iii) two doctors who were friends of the family;

(iv) the inspector who had written the final report on completion of the investigation within the IGS; and

(v) the medical experts in gastroenterology and internal medicine whose reports had formed the basis for the last IGS decision.

75. On 24 May 2011 the court made an order concerning the facts. Taking into account the medical records of the applicant's husband and the various statements made by the witnesses who had given evidence, the court considered it established, *inter alia*,

(i) that a polypectomy was a straightforward surgical operation which posed minimal risk and that the patient had been informed accordingly;

(ii) that the operating theatre had been aseptic and sterilised at the time of the polypectomy;

(iii) that the origin of the bacterium linked to the patient's meningitis had not been proven. The court dismissed the possibility of a hospital-acquired infection, pointing out that in that case the prescribed treatment would have had no effect;

(iv) that the medication prescribed in the CHVNG and Santo António Hospital could cause intestinal problems and hence could give rise to colitis;

(v) that the applicant's husband had been treated with drugs to protect his stomach in the CHVNG;

(vi) that the gastroduodenal perforation had not been detected until the operation was being performed; and

(vii) that the applicant's husband had died from septicaemia caused by peritonitis resulting from a perforated viscus.

76. On 23 January 2012 the Oporto Administrative and Fiscal Court delivered a judgment in which it dismissed the applicant's claims. On the facts, the judgment stated, *inter alia*, as follows:

"The *Pseudomonas* bacterium was resistant to the various antibiotics that were tried ...

When the patient attended Vila Nova de Gaia Hospital on 18 December 1997 he had completely recovered from his bacterial meningitis.

...

On 25 January 1998 the patient again attended Vila Nova de Gaia Hospital, where he was diagnosed with pseudomembranous colitis caused by *Clostridium difficile* ... The colitis was successfully treated in that hospital ...;

Throughout his stay in Vila Nova de Gaia Hospital he was given treatment to protect his stomach.

...

When he was admitted (to Santo António Hospital on 17 February 1998) he had chronic diarrhoea ... and was diagnosed with suspected inflammatory bowel disease. Medication was prescribed in keeping with that diagnosis.

...

While in Santo António Hospital he was kept under observation, received daily medication and underwent various tests.

...

On 6 March 1998 ... nothing had made it possible to predict the gastroduodenal perforation ... the tests carried out that day ... did not confirm the existence of any duodenal perforation such that the situation had to be kept under review;

...

It was not until 7 March 1998 that the patient's acute abdominal syndrome was diagnosed, calling for urgent surgery ... it was only during the operation that the patient was found to be suffering from a duodenal perforation;

...

The perforation had occurred 24 hours before surgery."

77. The judgment concluded as follows:

"... in view of the facts that have been established, it is not possible to determine at what point the defendants, by their actions or omissions, breached the rules of good medical practice ...

It is considered established that [Mr Fernandes's] death was caused by sepsis due to peritonitis resulting from the perforation of his duodenal ulcer...

No doubts persisted regarding the diagnosis of meningitis, the procedure adopted, the sequence of treatment and the resolution of the problem, as all the various after-effects were duly explained.

Hence there were no differences of opinion regarding the need to prescribe and use antibiotics in the context of [Mr Fernandes's] meningitis and other conditions, although it was explained that colitis is a bacterial imbalance caused by antibiotics (the very ones which have undesirable effects on intestinal flora).

Nevertheless, it was not possible to determine the agent or identify the cause of the bacterium linked to the meningitis and it could therefore not be established with certainty whether the sinus surgery was the source of the problem or was simply one factor causing the infection. The other factors and circumstances preceding the operation ... thus cease to be relevant.

It is nonetheless surprising that the death of the claimant's husband should have occurred ... given that he had been strong and in good health and that the microsurgery on his sinuses was a straightforward operation. However, it has not been demonstrated that the therapy or medication administered to [Mr Fernandes] at any point was unsuited to his clinical condition. There was therefore no breach of the rules of good medical practice (either by action or omission). Accordingly, one of the cumulative conditions for establishing civil liability, namely an unlawful act, is absent."

78. The applicant appealed against the judgment to the Supreme Administrative Court. She contested the facts deemed to be established, arguing that only by studying the circumstances before, during and after the operation would it be possible to understand what type of bacterium her husband had contracted. She further reiterated that her husband had contracted a hospital-acquired infection and had not received adequate treatment either in the CHVNG or in Santo António Hospital.

79. On 26 February 2013 the Supreme Administrative Court dismissed the applicant's claims, upholding the judgment of the Oporto Administrative and Fiscal Court. It first of all declined to review the facts considered by the lower court to have been established, on the grounds that the hearings had not been recorded and that no new documents had been submitted which could cast doubt on the evidence forming the basis for the court's decision. The Supreme Administrative Court summed up its judgment as follows:

"The lower court considered, in sum, that it had not been possible to identify the nature and origin of the bacterium that caused the meningitis and that it had not been demonstrated that the illnesses subsequent to [the patient's] treatment and recovery from that illness ... had been the consequence of incorrect diagnosis or treatment.

For that reason it found that no breach of the rules of good medical practice had been demonstrated that might have caused the patient's death.

The claimant takes a different view of the matter. However, she bases her arguments mainly on allegations that have not been proven, and in particular the allegation that the meningitis was caused by the *Pseudomonas* bacterium, allegedly acquired in hospital ... and that the patient did not receive appropriate prophylactic treatment to protect his stomach during his treatment with antibiotics.

Accordingly, these claims can be summed up as allegations of medical negligence which are unsupported by the established facts."

II. RELEVANT DOMESTIC LAW AND PRACTICE

A. Criminal law

80. The relevant provisions of the Criminal Code read as follows:

Article 137

"1. Anyone who kills another person through negligence shall be punishable by imprisonment for a period of up to three years or to a fine.

2. Gross negligence shall be punishable by imprisonment for up to five years."

Article 150

"...

2. Where the persons referred to in the previous paragraph, in pursuit of the aims indicated therein, perform surgery or provide treatment in a manner which breaches

the rules of good medical practice and thereby endangers a patient's life or health or creates a risk of serious bodily harm, their conduct shall be punishable by a period of imprisonment up to two years or by up to 24 day-fines, unless a heavier penalty has been imposed under another provision of the law."

81. The head of the relevant health-care establishment has a duty to inform the competent judicial authority of any suspicious death of a hospital patient, by forwarding the medical records so as to enable an investigation to be carried out to establish the circumstances of death (Article 51 of Legislative Decree no. 11/98 of 24 January 1998 on forensic medical matters). An autopsy is performed in cases of violent or unexplained deaths, except where the clinical data and other elements are sufficiently convincing to preclude any suspicion of a crime; in that case, no autopsy needs to be carried out (Article 54).

B. Civil and Administrative law

82. The relevant provision of the Civil Code reads as follows:

Article 487

"1. It is for the injured party to prove liability for damage through negligence (*culpa*), unless there is a legal presumption of it.

2. In the absence of any other legal criteria, negligence is assessed with reference to the diligence of the *bonus pater familias*, in view of the circumstances of the case."

83. At the material time the State's non-contractual liability was governed by Legislative Decree no. 48051 of 21 November 1967, Article 2 of which read as follows:

"1. The State and other public-law entities shall be liable in civil law *vis-à-vis* third parties for any acts infringing those parties' rights or the legal provisions designed to protect their interests, as the result of unlawful acts committed negligently by State or public agencies or officials in the performance of their duties or as a consequence thereof.

2. Where they have paid compensation under the terms of the preceding paragraph, the State and other public-law entities shall be entitled to claim reimbursement (*direito de regresso*) from those in charge of the agencies or the officials responsible, if these have not performed their duties with the requisite care and diligence."

84. Article 6 of the aforementioned Legislative Decree reads:

" For the purposes of the present Legislative Decree, legal acts which infringe the relevant legal and regulatory norms or general principles shall be deemed unlawful, as shall material acts which infringe the said norms or principles or the technical rules or principles of due caution which must be taken into account."

C. Relevant disciplinary provisions

85. Article 2 of the Disciplinary Regulations for Doctors defines a disciplinary offence as follows:

“A doctor who, by action or omission, fails, either intentionally or by negligence, to comply with one or more of the duties arising out of the Medical Association Statute, the Code of Ethics, the present Code, internal regulations, or any other applicable provision, shall be considered to have committed a disciplinary offence.”

86. The Disciplinary Regulations governing public officials and employees, in force at the material time, were contained in Legislative Decree no. 24/84 of 16 January 1984. Article 3 § 1 characterised a disciplinary offence as follows:

“A disciplinary offence consists in the failure, not exceeding the status of a fault, by a public official or employee to comply with one of the general or specific obligations attaching to his or her functions.”

87. The duty of diligence was defined in Article 3 § 6 as follows:

“The duty of diligence consists in being familiar with the relevant regulations and with the instructions from one’s hierarchical superiors, while possessing and perfecting the technical skills and working methods required to perform one’s duties correctly and efficiently.”

D. Regulatory framework in the field of health care

88. Article 64 of the Portuguese Constitution guarantees the right to health and to a national universal health-care service focused on providing free health care while taking account of citizens’ economic and social circumstances.

89. The Health Act, which was approved by virtue of Law no. 48/90 of 24 August 1990, establishes the principle whereby health care is dispensed by State services and establishments and by other public or private, profit-making or non-profit entities under State supervision (section I, paragraph 4).

90. Under Basic Principle XIV of the Act, the users of the health-care system have, among other rights, the right freely to choose their doctor and health-care establishment, the right to receive or refuse the treatment offered, the right to be treated in an appropriate and humane manner, promptly and with respect, the right to be informed of their situation, of possible alternative treatments and of the likely development of their condition, and the right to complain of the manner in which they have been treated and to receive compensation for any damage suffered.

91. The rules applying the framework Health Act are laid down by Legislative Decree no. 11/93 of 15 January 1993, which approved the National Health-care System Regulations (*Estatuto do sistema nacional de saúde*). Under Article 38, the State has the task of supervising health-care

establishments; the Ministry of Health is responsible for setting health-care standards, without prejudice to the functions assigned to the Medical Association and the Pharmacists' Association.

92. The Hospital Management Act, established by Legislative Decree no. 19/88 of 21 January 1988 and in force until 2002, stated in its preamble as follows:

“All citizens have the right to expect hospitals (institutions whose social purpose must never be forgotten) to provide treatment of a standard that can reasonably be expected having regard to the respect due to citizens and the human and material resources available. Assessment of the services provided in hospitals, in terms of cost-effectiveness but also and perhaps above all in terms of quality assurance, is an increasingly complex and essential task, one to which the authorities must give full attention and which must be addressed within the management of hospitals.”

93. Article 3 § 2 of the aforementioned Legislative Decree provided, in particular, for the Minister of Health to:

“... define standards and criteria for service provision in hospitals, establish guidelines to be followed by service provision plans and programmes, monitor their implementation and evaluate the results obtained and the quality of the health care provided to the population, and request any information and documentation needed for this purpose.”

94. The principles governing service provision, set out in Article 6 of that Legislative Decree, included: respect for patients' rights; promptness and quality of the assistance provided within the limits of the available resources; lawful and efficient use of those resources; deployment of best endeavours to provide the services, as far as possible, with the necessary organisational structures, personnel and equipment; and observance of professional ethics by all those working in hospitals.

95. Article 27 of Legislative Decree no. 73/90 of 6 March 1990 on Medical Careers lays down the duties of hospital doctors. It reads, *inter alia*, as follows:

“(a) Reception of patients, duly registered in the outpatient records, with recourse to hospitalisation where necessary, and provision of appropriate information to the patient's general practitioner in the form of a confidential written report.

(b) Diagnosis and treatment of patients, supported by an effective professional relationship with the patient's general practitioner and with the other doctors involved in his or her treatment outside the hospital.

(c) Reception in hospital emergency departments.

...”

96. Article 7 of Legislative Decree no. 373/79 of 8 September 1979 on the status of medical practitioners laid down the duties of health professionals, including ensuring continuous professional development and contributing to the establishment and preservation of sound technical and human working conditions, with a view to providing an effective service

and enhancing the prestige of the health-care service to which they belonged.

97. Relevant legislation concerning the health sector also includes the General Regulations on Hospitals, approved by Order no. 48358 of 27 April 1968, which lay down the forms of organisation and operation applicable to all hospitals, without prejudice to the fact that each establishment has its own local regulations.

98. At the relevant time, under Legislative Decree no. 291/93 of 24 August 1993, the Inspectorate General for Health was a department within the Ministry of Health with technical and administrative autonomy (Article 1) which was responsible, among other tasks, for supervising the activities and operation of health-care establishments (Article 3 § 1 (a)), and instituting disciplinary proceedings (Article 3 § 2 (b)). The IGS was headed by an Inspector General whose tasks included ordering the opening of investigative proceedings and issuing a decision when they had been completed (Article 5 (h)). Under the terms of Legislative Decree no. 275/2007 of 30 June 2007, the Inspectorate General for Health became the Inspectorate General for Health-Care Activities (IGAS). The IGAS has wider-ranging powers which extend to private bodies.

99. The Medical Association was governed at the material time by the Medical Association Statute, adopted by Legislative Decree no. 282/77 of 5 July 1977 as amended by Legislative Decree no. 217/94 of 20 August 1994. It is an independent body which is responsible for maintaining standards among members of the medical profession and ensuring observance of the Medical Code of Ethics. To be able to exercise their profession doctors must be registered with the Medical Association; in this context, emphasis is placed upon the need for them to observe the professional standards governing their profession.

100. The Medical Association also has disciplinary powers, although these do not preclude other disciplinary procedures provided for by law (Article 3 of the Disciplinary Regulations for Doctors, approved by Legislative Decree no. 217/94 of 20 August 1994). The regional disciplinary councils are responsible for instituting disciplinary proceedings against doctors in their region (Article 4). The decisions of the regional disciplinary councils are open to appeal before the National Disciplinary Council (*Conselho Nacional de Disciplina*) within an eight-day period (Articles 44 and 45).

101. The specialist panels (*Colégios de especialidades*) are bodies within the Medical Association composed of specialists in different branches of medicine (Article 87 of the Medical Association Statute). They are tasked, among other duties, with giving opinions to the Association's National Executive Council.

102. The Code of Ethics contains the rules of an ethical nature which doctors must observe and from which they must draw inspiration in the

course of their professional practice. According to the principle of independence of doctors, the latter, in the exercise of their profession, are “technically and ethically independent and accountable for their acts; they may not, in performing their clinical duties, receive technical or ethical directions from persons outside the medical profession”, a provision which “does not conflict with the existence of institutional technical hierarchies established by law or by contract; a doctor may in no circumstances be forced to perform acts against his or her will.”

103. In Portugal an Infectious-Diseases Control Plan (1988-98) was under way in late 1997. In the framework of this plan, a publication entitled *Livro da mão cor-de-rosa* (Book of the pink hand), containing a set of recommendations for the prevention and control of nosocomial infections acquired in health-care establishments, was issued in 1996.

104. In the introduction to the 1996 report reference was made to the following information:

“In 1988 the Infectious-Diseases Control Plan was initiated It was aimed at developing the methods to be used in the study of infections The first study concerning the prevalence of infection was carried out in 1988 with 10,177 patients from 71 hospitals; this was followed by a second study in 1993, with 9,331 patients from 65 hospitals. Other studies were also carried out with regard to the incidence of urinary-tract infections in patients with catheters, surgical infections, and nosocomial pneumonia in intensive care, for example. These studies show that, at any given time, approximately 30 % of hospital inpatients have an infection and one-third of them acquired the infection while in hospital.”

105. The report’s recommendations required each health-care establishment to define a comprehensive infectious-diseases control programme, which was to be coordinated and implemented by one of the interdisciplinary infectious-diseases control commissions created that same year under an instruction issued by the Directorate General for Health.

106. The infectious-diseases control commissions were established under an instruction issued by the Directorate General for Health on 23 October 1996. According to Article 4 of this instruction these commissions were required, among other tasks, to “define, implement and monitor a system of epidemiological surveillance addressing structures, processes and outcomes with regard to situations posing the gravest threats, propose recommendations and standards for the prevention and control of infectious diseases and the corresponding monitoring arrangements, carry out epidemiological inquiries and disseminate the information within the establishment, and contribute to training within the service and to other training actions undertaken by the establishment in the field of infection control.”

107. A working group dedicated to the issue of hospital-acquired infections was established in Vila Nova de Gaia Hospital in 1994. It published, from at least 1996 onwards, an information booklet on these issues and the procedures to be adopted.

108. In the meantime, the Council of Europe recommendations concerning the control of infectious diseases, and in particular Recommendation no. R (84) 20 (see paragraph 116 below), were circulated to public and private hospitals.

109. The aforementioned Plan (see paragraph 103 above) was replaced by the National Infectious-Diseases Control Programme adopted on 14 May 1999.

III. INTERNATIONAL LAW AND PRACTICE

A. United Nations

1. The International Covenant on Economic, Social and Cultural Rights

110. Article 12 of the International Covenant on Economic, Social and Cultural Rights provides:

“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 State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(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.”

111. In its General Comment No. 14 on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights (CESCR) held as follows:

“9. ... the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”

In this connection the CESCR required that the necessary public-health and health-care facilities should satisfy the following criteria: availability, accessibility, acceptability and quality.

The CESCR stressed that the obligations to protect included, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties, as well as to ensure that medical practitioners and other health professionals met appropriate standards of education, skill and ethical codes of conduct (paragraph 35).

It also required that any person or group that was the victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels (paragraph 59).

2. *The documents of the World Health Organisation (WHO)*

112. The relevant parts of the World Health Organisation’s Declaration on the Promotion of Patients’ Rights in Europe (1994) read as follows:

“5.1 Everyone has the right to receive such health care as is appropriate to his or her health needs, including preventive care and activities aimed at health promotion. Services should be continuously available and accessible to all equitably, without discrimination and according to the financial, human and material resources which can be made available in a given society.

...

6.5 ... Where patients feel that their rights have not been respected they should be enabled to lodge a complaint ... Patients have the right to have their complaints examined and dealt with in a thorough, just, effective and prompt way and to be informed about their outcome.”

113. The WHO has also adopted a number of technical medical guidelines relating to safe health care and surgical facilities, such as the WHO guidelines for safe surgery (2009), which provide checklists and set out ten objectives and recommendations, including the use of methods known to minimise the risk of surgical site infection and the establishment, by hospitals and public health systems, of routine surgical surveillance.

B. Council of Europe

1. *The European Social Charter*

114. Article 11 of the European Social Charter, 1961, entitled “The right to protection of health”, reads as follows:

“With a view to ensuring the effective exercise of the right to protection of health, the Contracting 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.”

2. *The Oviedo Convention on Human Rights and Biomedicine*

115. The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (known as the Oviedo Convention on Human Rights and Biomedicine),

which was adopted in 1997 and entered into force on 1 December 1999, has been ratified by twenty-nine of the Council of Europe member States. Its relevant provisions read as follows:

Article 3 – Equitable access to health care

“Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.”

Article 4 – Professional standards

“Any intervention in the health field, including research, must be carried out in accordance with relevant professional obligations and standards.”

Article 24 – Compensation for undue damage

“The person who has suffered undue damage resulting from an intervention is entitled to a fair compensation according to the conditions and procedures prescribed by law.”

Article 25 – Sanctions

“Parties shall provide for appropriate sanctions to be applied in the event of infringement of the provisions contained in this Convention.”

3. Recommendation Rec(84)20 on the prevention of hospital infections

116. The Committee of Ministers, in its Recommendation Rec(84)20 on the prevention of hospital infections, recommended to the Governments of member States that they promote the application of the strategy for the prevention of hospital infections described in detail in the Appendix to the Recommendation.

C. The Inter-American Court of Human Rights

117. The relevant provisions of the American Convention on Human Rights read as follows:

Article 4

“1. Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.

...”

Article 5

“1. Every person has the right to have his physical, mental, and moral integrity respected.

...”

118. In the case of *Suárez Peralta v. Ecuador* (Preliminary objections, merits, reparations and costs, Judgment of 21 May 2013, Series C No. 261), which concerned allegations of medical negligence, the Inter-American Court of Human Rights reiterated the obligation of the State to guarantee the right to personal integrity in the context of health, as follows:

“ 132. ... States must establish an adequate normative framework that regulates the provision of health care services, establishing quality standards for public and private institutions that allow any risk of the violation of personal integrity during the provision of these services to be avoided. In addition, the State must create official supervision and control mechanisms for health care facilities, as well as procedures for the administrative and judicial protection of victims, the effectiveness of which will evidently depend on the way these are implemented by the competent administration.”

IV. EUROPEAN UNION LAW

A. Charter of Fundamental Rights of the European Union

119. The relevant provisions of the Charter of Fundamental Rights of the European Union read as follows:

Article 2 – Right to life

“1. Everyone has the right to life.”

Article 35 –Healthcare

“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 Union policies and activities.”

B. Council Recommendation on patient safety, including the prevention and control of healthcare associated infections

120. On 9 June 2009 Council Recommendation on patient safety, including the prevention and control of healthcare associated infections (2009/C 151/01) was adopted. In particular, the text recommends that Member States:

“I. 1. ...

(d) [regularly review and update] safety standards and/or best practices applicable to healthcare provided on their territory;

...

(f) [include] a specific approach to promote safe practices to prevent the most commonly occurring adverse events such as medication-related events, healthcare associated infections and complications during or after surgical intervention.”

8.

...

(a) implement prevention and control measures at national or regional level to support the containment of healthcare associated infections and in particular:

...

(iii) to make guidelines and recommendations available at national level.”

121. The text also recommends informing patients about:

“I. 2. (b) (iii) complaints procedures and available remedies and redress and the terms and conditions applicable;”

V. COMPARATIVE LAW

122. It transpires from the materials available to the Court on the legislation of member States of the Council of Europe that all of the thirty-one member States surveyed offer a civil remedy with the possibility to claim compensation for medical negligence in either the civil or the administrative courts. In the majority of countries, liability can be both contractual and extra-contractual (for instance, in Austria, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Germany, Italy, Luxembourg, Monaco, Poland, Spain and Switzerland). Tort liability is the exclusive or main form of liability in Lithuania, Malta, Moldova, Serbia, Russia, Ukraine and the United Kingdom.

123. It is also a common feature of all countries that medical negligence can amount to a criminal offence, either as manslaughter or as unintentional bodily injury or another offence against health (such as failure to provide assistance). In several countries, medical negligence constitutes a distinct offence (for instance, in Armenia, Bosnia and Herzegovina, Croatia, Slovenia, the former Yugoslav Republic of Macedonia and Ukraine).

124. The great majority of the countries surveyed have professional bodies (that is, medical councils, chambers, associations) with the power to impose disciplinary sanctions. In the absence of such bodies sanctions may be imposed by the head of the health establishment concerned or the Ministry of Health (for example, in Armenia and Russia). In certain countries, even if disciplinary proceedings exist, they appear to play no role in medical negligence cases, or only a very limited one (for example, Azerbaijan and Estonia).

125. Administrative complaints to various State supervisory bodies (such as the Ministry of Health, the Health Inspectorate, the Health Board, and so on) are possible in some countries including Bulgaria, Croatia, Estonia and Hungary. In Azerbaijan, Russia, Spain and Ukraine a breach of

the rules and regulations relating to health care constitutes an administrative offence.

126. Finally, apart from contentious proceedings, several countries provide for a system of settlement, mediation or no-fault compensation schemes (for example, Austria, Belgium, France, Germany, Poland and the United Kingdom).

THE LAW

I. PRELIMINARY ISSUES

A. Compliance with the six-month rule

127. The Court reiterates that the Grand Chamber is not precluded from examining, where appropriate, questions concerning the admissibility of an application under Article 35 § 4 of the Convention, as that provision enables the Court to dismiss applications it considers inadmissible “at any stage of the proceedings”. Therefore, even at the merits stage and subject to Rule 55, the Court may reconsider a decision to declare an application admissible where it concludes that it should have been declared inadmissible for one of the reasons given in the first three paragraphs of Article 35 of the Convention (see, for example, *Muršić v. Croatia* [GC], no. 7334/13, § 69, ECHR 2016).

128. Although the respondent State did not raise any objection before the Grand Chamber based on the six-month time limit as it had done previously before the Chamber, this issue, as a public policy rule, calls for consideration by the Court of its own motion (see *Sabri Güneş v. Turkey* [GC], no. 27396/06, § 29, 29 June 2012).

129. The Court reiterates that the object of the six-month time-limit under Article 35 § 1 is to promote legal certainty, by ensuring that cases raising issues under the Convention are dealt with in a reasonable time and that past decisions are not continually open to challenge. It marks out the temporal limits of supervision carried out by the organs of the Convention and signals to both individuals and State authorities the period beyond which such supervision is no longer possible (*ibid.*, §§ 39 and 40).

130. In this regard the Court emphasises that the requirements contained in Article 35 § 1 concerning the exhaustion of domestic remedies and the six-month period are closely interrelated (see *Jeronovičs v. Latvia* [GC], no. 44898/10, § 75, ECHR 2016), since they are not only combined in the same Article, but also expressed in a single sentence whose grammatical construction implies such a correlation (see *Gregačević v. Croatia*, no. 58331/09, § 35, 10 July 2012, and the references cited therein).

131. Thus, as a rule, the six-month period runs from the date of the final decision in the process of exhaustion of domestic remedies (see *Blokhin v. Russia* [GC], no. 47152/06, § 106, ECHR 2016). Article 35 § 1 cannot therefore be interpreted in a manner which would require an applicant to inform the Court of his complaint before his position in connection with the matter has been finally settled at the domestic level, otherwise the principle of subsidiarity would be breached (see *Mocanu and Others v. Romania* [GC], nos. 10865/09, 45886/07 and 32431/08, § 260, ECHR 2014 (extracts)).

132. However, this provision allows only remedies which are normal and effective to be taken into account as an applicant cannot extend the strict time-limit imposed under the Convention by seeking to make inappropriate or misconceived applications to bodies or institutions which have no power or competence to offer effective redress for the complaint in issue under the Convention (see, for example, *Fernie v. the United Kingdom* (dec.), no. 14881/04, 5 January 2006; *Beiere v. Latvia*, no. 30954/05, § 38, 29 November 2011; and, *a contrario*, *Hizb ut-tahrir and Others v. Germany* (dec.), no. 31098/08, §§ 58-59, 12 June 2012, and *Petrović v. Serbia*, no. 40485/08, § 60, 15 July 2014).

133. The Court observes that in the Chamber judgment the Government's objection as regards the six-month time limit was dismissed because the application had been lodged on 23 August 2013, that is, within six months following the final domestic decision, namely the Supreme Administrative Court judgment delivered on 26 February 2013 following the proceedings for civil liability.

134. At the outset, the Court stresses that determining whether a domestic procedure constitutes an effective remedy within the meaning of Article 35 § 1, which an applicant must exhaust and which should therefore be taken into account for the purposes of the six-month time-limit, depends on a number of factors, notably the applicant's complaint, the scope of the obligations of the State under that particular Convention provision, the available remedies in the respondent State and the specific circumstances of the case.

135. For example, the Court has held that, in the area of unlawful use of force by State agents – and not mere fault, omission or negligence – civil or administrative proceedings aimed solely at awarding damages, rather than ensuring the identification and punishment of those responsible, were not adequate and effective remedies capable of providing redress for complaints based on the substantive aspect of Articles 2 and 3 of the Convention (see *Jeronovičs*, § 76, and *Mocanu and Others*, § 227, both cited above). It has further held that the Contracting Parties' obligation under Articles 2 and 3 of the Convention to conduct an investigation capable of leading to the identification and punishment of those responsible in cases of assault could be rendered illusory if, in respect of complaints under those Articles, an

applicant were required to bring an action leading only to an award of damages (see *Jeronovičs*, cited above, § 77).

136. In cases such as these, therefore, the Court considered that any subsequent civil proceedings undertaken by the applicant were not an adequate and effective remedy within the meaning of Article 35 § 1 which the applicants had to exhaust and which should therefore be taken into account for the purposes of the six-month time-limit. Accordingly, the Court dismissed those cases as having been lodged out of time (see, among others, *Jørgensen and Others v. Denmark* (dec.), no. 30173/12, § 63, 28 June 2016; *Narin v. Turkey*, no. 18907/02, § 49, 15 December 2009; and *Bedir v. Turkey* (dec.), no. 25070/02, 2 October 2007).

137. By contrast, in medical negligence cases the Court has considered that the procedural obligation imposed by Article 2, which concerns the requirement to set up an effective judicial system, will be satisfied if the legal system affords victims a remedy in the civil courts, either alone or in conjunction with a remedy in the criminal courts, enabling any responsibility of the doctors concerned to be established and any appropriate civil redress to be obtained. It has also accepted that disciplinary measures may also be envisaged (see *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 51, ECHR 2002-I, and *Vo v. France* [GC], no. 53924/00, § 90, ECHR 2004-VIII). In such cases, therefore, the Court, having regard to the particular features of a respondent State's legal system, has required the applicants to exhaust the legal avenues whereby they could have their complaints duly considered. This is because of the rebuttable presumption that any of those procedures, notably civil redress, are in principle apt to satisfy the State's obligation under Article 2 of the Convention to provide an effective judicial system.

138. In the present case, the applicant used all the avenues of redress that were available to her in the Portuguese legal system. The Court finds that none of the proceedings instituted by her can be regarded as inappropriate or misconceived applications to bodies or institutions with no power or competence to offer effective redress for the complaint in issue under the Convention. Nor has it been demonstrated that, at the time when the applicant brought an action for compensation – the most appropriate avenue for establishing any alleged causal link between the initial surgery and Mr Fernandes's tragic death three months later and for shedding light on the extent of the doctors' alleged responsibility for his death – it was obvious that these proceedings would be bound to fail from the outset and hence should not be taken into account for the calculation of the six-month period (see, for example, *Musayeva and Others v. Russia* (dec.), no. 74239/01, 1 June 2006, and *Rezgui v. France* (dec.), no. 49859/99, ECHR 2000-XI).

139. In the light of the above the Court considers, like the Chamber (see paragraph 133 above), that the application was not lodged out of time.

B. Government’s preliminary objection

140. The Government asked the Court to declare the application inadmissible as being manifestly ill-founded (see paragraph 213 below).

141. The applicant did not specifically comment on this issue.

142. The Court considers that the preliminary objection raised by the Government is so closely linked to the substance of the applicant’s complaint that it must be joined to the merits of the application (see, for example, *O’Keeffe v. Ireland* [GC], no. 35810/09, § 121, ECHR 2014 (extracts)).

II. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

143. The applicant alleged a breach of her husband’s right to life. She claimed that her husband had been the victim of a hospital-acquired infection and that the medical personnel had been careless and negligent in their diagnoses and treatment and in discharging her husband from hospital. In particular, she complained of delays in providing him with treatment and of the administration of medication in excessive doses. She did not, however, call into question her husband’s discharge from hospital authorised by Dr J.V. on 3 February 1998, that decision having been taken with her assent and that of her husband. She further complained that the authorities to which she had applied had failed to elucidate the precise cause of the sudden deterioration in the health of her husband, who had previously been perfectly fit. She also complained about the length of the domestic proceedings and the fact that she had not been informed of the exact cause of her husband’s death.

144. The applicant relied on Articles 2, 6 § 1 and 13 of the Convention, the first of which reads as follows:

“1. Everyone’s right to life shall be protected by law.”

145. Reiterating that the Court was master of the characterisation to be given in law to the facts of the case and finding that these complaints covered the same ground, the Chamber found it appropriate to examine the applicant’s allegations solely under Article 2 of the Convention. The Grand Chamber agrees with this approach. It will therefore proceed in the same manner (see *Bouyid v. Belgium* [GC], no. 23380/09, § 55, ECHR 2015).

A. The substantive aspect

1. The Chamber judgment

146. The Chamber held that there had been a violation of the substantive aspect of Article 2 of the Convention. It noted that the second gastroenterology expert who gave evidence before the IGS, and also the

ENT and infectious-diseases panels in the proceedings before the Medical Association, had all indicated that meningitis was a complication that could arise in exceptional cases after a polypectomy. The Chamber further noted that doubts had been expressed by the infectious-diseases panel in the Medical Association proceedings as to the promptness with which the patient's meningitis had been diagnosed.

147. The Chamber held the view that the mere fact that the patient had undergone a surgical operation presenting a risk of infectious meningitis should have warranted immediate medical intervention in conformity with the medical protocol on post-operative supervision. However, this had not been done. Without wishing to speculate on the chances of survival of the applicant's husband if his meningitis had been diagnosed earlier, it considered that the lack of coordination between the ENT department and the emergency unit at the hospital disclosed failings in the public hospital service, depriving the patient of the possibility of accessing appropriate emergency care. This fact was considered sufficient to find that the State had failed in its obligation to protect the physical integrity of Mr Fernandes.

2. The parties' submissions

(a) The applicant

148. The applicant submitted that, according to the more recent understanding of Article 2 of the Convention (she referred to *Dodov v. Bulgaria*, no. 59548/00, 17 January 2008; *Mehmet Şentürk and Bekir Şentürk v. Turkey*, no. 13423/09, ECHR 2013; *Arskaya v. Ukraine*, no. 45076/05, 5 December 2013; *Asiye Genç v. Turkey*, no. 24109/07, 27 January 2015; and *Elena Cojocaru v. Romania*, no. 74114/12, 22 March 2016), for the Court to find that there had been a violation of Article 2 under its substantive limb, it had to be established that in concrete terms the promptness and diligence which could reasonably have been expected in the circumstances of the case had been lacking and, further, that this failing had contributed to putting the victim's life at risk. The applicant noted that in the aforementioned cases the factor which had weighed most heavily in the Court's judgment was the absence of the timely medical treatment which, in the circumstances of each case, could reasonably have been expected and whose absence had contributed significantly to the chain of events which put at risk the life of patients who, in the end, had died. She stressed that in these various situations the Court had emphasised that there was no call to speculate on what the victims' chances of survival might have been if the failings identified had not occurred; what counted was the unreasonable risk to which, in the circumstances of each case, the patient had been exposed and which had contributed to the chain of events leading to his or her death. The applicant observed that, in determining the relevant facts, the Court had applied the "beyond reasonable doubt" test, according to which the requisite

proof could follow from a sufficiently persuasive combination of inferences and presumptions. She submitted, contrary to the Portuguese Government's view, that the Chamber judgment provided a concrete application of these principles to the facts of the case. The applicant emphasised in this connection that the Court had subsequently applied the same principles in the *Elena Cojocaru* case, cited above.

149. The applicant agreed with the facts as laid down in the Chamber judgment as well as the reasoning adopted in finding a substantive violation of Article 2 of the Convention. She further submitted that the Court should also take into account at least one other aggravating factor. In this connection the applicant argued that, irrespective of the origin of the bacterium which caused the meningitis, the treatment had not been administered as promptly as the situation demanded. The emergency team which had taken charge of the applicant's husband at the CHNVG had been entirely unaware of, or else had disregarded, the fact that a nasal polypectomy had been performed two days earlier in the same hospital, and instead had treated the patient on the assumption that he was suffering from psychological problems. The applicant contended that the patient had not received any treatment between his arrival at the emergency department at about 1.30 a.m., and 10 a.m., when the lumbar puncture had been performed.

150. The applicant submitted that while the bacterial meningitis had not been the immediate cause of her husband's death, it was undeniable that this event had given rise to the succession of clinical complications which had continued up to his death on 8 March 1998 as a direct result of septicaemia caused by peritonitis. She argued that the clinical complications from which her husband had suffered between 29 November 1997 and 8 March 1998 could not be viewed in isolation from each other, as though there was no connection between them. Relying on the report which formed the basis for the final report of the IGS, the applicant submitted that, in the present case, there had been a series of clinical complications (opportunistic infections, ulcers and other illnesses or pathological symptoms), each of which could be attributed to a greater or lesser extent to a previous event in the chain. She emphasised that the starting-point in this chain of events had been an occurrence of meningitis, attributable to a hospital-acquired bacterium, which had not been treated with the promptness the situation demanded, with the consequent need to intensify the antibiotic treatment, resulting in a worsening of the victim's state of health. This had contributed to the appearance of complications – and in particular of opportunistic infections and ulcers – which, occurring in succession, had resulted in the patient's death.

151. The applicant further submitted that there had been other instances of medical negligence, such as the four occasions on which her husband had been imprudently discharged from hospital (13 December 1997,

23 December 1997, 9 January 1998 and 3 February 1998). In addition, she argued that the direct cause of her husband's death on 8 March 1998 undeniably amounted to medical negligence. She alleged that there had been an inexplicable delay in performing surgery, which should have taken place on 6 March but had in fact not been performed until 7 March at 8 p.m., by which time it had been too late to cure the peritonitis which had set in. In this connection she contended that it was undisputed that peritonitis, attributable in her husband's case to a duodenal ulcer and the resulting perforated viscus, called for urgent surgery in order to avoid the onset of uncontrollable septicaemia, as in the present case. There was thus no reasonable explanation for the fact that the surgery had not been performed until 8 p.m. the following day. To that extent, the applicant submitted that this circumstance formed part of the series of unjustifiable delays in the delivery of appropriate medical treatment to her husband, which had deprived him of the possibility of access to such care. This constituted a further violation of the substantive limb of Article 2 of the Convention. In this connection she argued that even if the need for surgery had not become apparent until 7 March, this still did not explain why a surgeon had not been called until 3 p.m., thus leaving the patient without effective assistance until that time, and why he had been taken to the operating theatre without the necessary preparation, with the result that he had to be taken out of the theatre and then returned there around 8 p.m., by which time he had been in a very serious condition, between life and death.

(b) The Government

152. The Government submitted at the outset that the validity of the contention underpinning the applicant's complaint – that the entire course of her deceased husband's clinical treatment had been marked by a series of interconnected shortcomings and errors – had not been demonstrated in any of the proceedings at domestic level. It had never been proven that the death of the applicant's husband was attributable to medical negligence. They argued that the Chamber judgment had accepted that no medical negligence had been established and that the death of the applicant's husband had not been caused by an event occurring on 29 November 1997, an event identified and characterised by the Chamber as a lack of coordination between the ENT department and the emergency department of the first hospital. This, according to the Chamber, attested to "failings in the public hospital service" and had "deprived the patient of the possibility of access to appropriate emergency care". Notwithstanding the absence of medical negligence and of a causal link the Chamber had deemed this finding to be "sufficient for the Court to consider that the State failed in its obligation to protect his physical integrity" in breach of the substantive aspect of Article 2 of the Convention.

153. The Government, referring to the Court’s case-law (*Byrzykowski v. Poland*, no. 11562/05, § 104, 27 June 2006; *Eugenia Lazăr v. Romania*, no. 32146/05, §§ 68-72, 16 February 2010; *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], no. 47848/08, § 130, ECHR 2014; and *Powell v. the United Kingdom* (dec.), no. 45305/99, ECHR 2000-V), maintained that in the area of health care the positive obligation arising for the Contracting States under Article 2 of the Convention with a view to preventing death caused by medical negligence was essentially of a procedural nature and involved a duty to put in place a regulatory structure requiring that hospitals, be they private or public, take appropriate steps to ensure that patients’ lives were protected. In view of the facts of the case and the Court’s case-law, the Government submitted that the conclusion of the Chamber judgment raised serious doubts in that regard.

154. In the Government’s submission, the health-care system in Portugal at the material time was supported by a comprehensive and appropriate regulatory scheme; patients were covered by a charter which included their rights and obligations, and could present and formally lodge complaints; doctors were subject to ethical rules and, in the performance of their duties, were required to comply with good medical practice and apply technical and scientific knowledge in accordance with best practice and the relevant clinical protocols. Moreover, all hospital activity was subjected to a system of supervision and doctors who failed to comply with the duty of diligence or the ethical rules were liable to disciplinary measures; in the event of an allegation of negligence resulting in the death of a patient, criminal proceedings for the crime of negligent homicide could be instituted and an action for civil liability could be brought.

155. They noted that no expert opinions, documents or other evidence submitted at the domestic level had confirmed the allegations made by the applicant. The latter, in the Government’s view, had disputed the diagnoses made, the medications prescribed, the timing of the operation and the discharge decisions, with the exception of the discharge granted on 3 February 1998 which she and her husband had themselves requested. However, the Government stressed that the conclusion reached by the various domestic bodies, which had heard evidence from a great number of doctors and other experts, was that the assistance which the doctors concerned had provided to the patient had disclosed no negligent conduct, and no errors had been committed. The Government further asserted that all necessary care and treatment had been provided to the applicant’s husband; in particular, there had been no manifest failure to provide essential care or refusal to admit and attend to the patient. Having regard to the regulatory framework, they considered that the circumstances of the present case did not reveal any failure on the part of the Portuguese authorities to comply

with the positive obligation imposed upon them by virtue of Article 2 of the Convention.

156. The Government reiterated that the Chamber judgment had been insufficiently reasoned and that it had departed from the Court's existing line of case-law in an area of fundamental importance, thereby creating legal uncertainty for the State. They argued that in finding a violation of the right to life under the substantive limb of Article 2, in the absence of medical negligence, of any established causal link with the patient's death, or of any failure to provide treatment by refusing to admit or attend to the patient, but simply on the basis of a possible lack of coordination between hospital services that had no consequences for the value protected by the rule, the Chamber had acted as a fourth instance and had expanded the Court's area of competence to include the assessment *in abstracto* of the functioning of domestic health-care services. This should not be its role.

3. *The third-party interveners*

(a) **The United Kingdom Government**

157. The United Kingdom Government noted that the present case raised questions as to the extent to which a Contracting State could be in breach of the substantive aspect of Article 2 of the Convention as a result of deficiencies in the provision of medical treatment. In this regard they submitted that Contracting States had a positive obligation under Article 2 § 1 to make regulations compelling hospitals to adopt appropriate measures for the protection of their patients' lives. A failure to discharge that obligation to regulate medical treatment could amount to a breach of the substantive aspect of Article 2, where that failure led to the death of a person within the Contracting State's jurisdiction. However, in the view of the United Kingdom Government, deficiencies in the provision of medical treatment by health-care professionals and hospital staff did not engage the responsibility of the Contracting State under the substantive aspect of Article 2, but could only engage the procedural aspect of Article 2. The United Kingdom Government, referring to a number of cases determined by this Court, emphasised that previous cases had been decided consistently with these general principles.

158. As to the substantive aspect of Article 2 in connection with a failure to provide health care, the United Kingdom Government emphasised that the Convention contained no express provision recognising a right to the provision of any kind of health care, nor a right to be provided with health care of any particular standard. In this connection they submitted that the Court, in *Mehmet Şentürk and Bekir Şentürk and Asiye Genç*, both cited above, had relied on an *obiter dictum* in *Cyprus v. Turkey* ([GC], no. 25781/94, ECHR 2001-IV), which concerned a claim of denial of medical treatment to a whole section of a population. They further

considered that in any event the circumstances in the aforementioned cases had been particular and severe. The United Kingdom Government further noted that in these cases, and also in the case of *Aydoğdu v. Turkey* (no. 40448/06, 30 August 2016), the Court had applied the *Osman* line of case-law (see *Osman v. the United Kingdom*, 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII). They maintained that this case-law could not be extended to cases where medical treatment had been provided to a person but had been provided deficiently (for example, because there had been medical negligence). Finally, the United Kingdom Government observed that the Turkish cases referred to above and the case of *Elena Cojocaru*, cited above, suggested that there could be a breach of the substantive aspect of Article 2 where there was a dysfunction in the health-care system. However, they were of the view that a dysfunction in the management of a particular hospital or hospital department, or dysfunctional coordination between two different hospitals, would not of itself be sufficient to engage the Contracting State's obligations under the substantive aspect of Article 2, unless it was established that the dysfunction was the result of a failure by the Contracting State to meet its regulatory obligations referred to above.

(b) The Government of Ireland

159. The Government of Ireland provided the Court with a detailed account of the regulation of medical practice in Ireland. They submitted that Ireland had made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients. The Chamber judgment appeared to suggest however that, notwithstanding this, a Contracting State might still be found to be in breach of Article 2 by reason of an error of judgment on the part of a health professional. The Government of Ireland submitted that the Chamber judgment further suggested that, even where a case had been rigorously examined by an adequate national system and no error identified, the Court might nevertheless substitute its own reasoning for that of the national courts and tribunals. In this regard they submitted that the Chamber judgment in this case represented a departure from established jurisprudence.

160. Analysing the medical negligence and health-care cases dealt with by the Court over the last sixteen years, the Government of Ireland submitted that there was a consistent approach by the Court in relation to the application of Article 2 in both its substantive and procedural aspects. According to them, the principles which emerged were as follows: (1) where a Contracting State had made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in

the treatment of a particular patient were not 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; (2) there might be an exception where the negligence attributable to that hospital's medical staff went beyond a mere error or medical negligence. These circumstances seemed to occur where the domestic courts found the relevant staff in a hospital setting responsible and liable for more than negligence and/or where there was a denial of care/medical treatment simpliciter, resulting in the patient's life being put in danger.

161. The Government of Ireland submitted that no such exception had existed in the facts of the present case. They underlined the pertinence of the dissenting opinions annexed to the Chamber judgment, as well as Judge Sajó's dissent in the case of *Elena Cojocaru*, cited above. In conclusion, the Government of Ireland submitted that the existing line of reasoning established in the case-law prior to the current case should be adopted and continued in the case at hand. In their view any departure from this case-law would lead to legal uncertainty in the application of obligations under Article 2 and would undermine the validity of domestic efforts and authorities involved in the regulation of health care, especially in circumstances where there was no causation between an alleged breach of duty and an injury or death.

4. The Court's assessment

(a) Summary of the relevant case-law

162. The Court is frequently called upon to rule on complaints alleging a violation of Article 2 of the Convention in the context of health care. A considerable number of these cases concern allegations of negligence occurring in the context of medical treatment in hospitals. In this regard the Court considers that the present case provides an opportunity to reaffirm and clarify the scope of the substantive positive obligations of States in such cases.

163. The Court would emphasise at the outset that different considerations arise in certain other contexts, in particular with regard to the medical treatment of persons deprived of their liberty or of particularly vulnerable persons under the care of the State, where the State has direct responsibility for the welfare of these individuals (see, for example, *Slimani v. France*, no. 57671/00, ECHR 2004-IX (extracts), and *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, §§ 143-44). Such circumstances are not in issue in the present case.

(i) General principles

164. The Court reiterates that the first sentence of Article 2, which ranks as one of the most fundamental provisions in the Convention and also

enshrines one of the basic values of the democratic societies making up the Council of Europe, requires the State not only to refrain from the “intentional” taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction (see *Calvelli and Ciglio*, § 48, and *Vo*, § 88, both cited above).

165. The Court has stressed many times that, although the right to health – recognised in numerous international instruments – is not as such among the rights guaranteed under the Convention and its Protocols (see *Vasileva v. Bulgaria*, no. 23796/10, § 63, 17 March 2016), the aforementioned positive obligation must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake (see *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, § 130), including in the public-health sphere.

166. In the particular context of health care the Court has interpreted the substantive positive obligation of the State as requiring the latter to make regulations compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients’ lives (see, among many other authorities, *Oyal v. Turkey*, no. 4864/05, § 54, 23 March 2010, and *Lambert and Others v. France* [GC], no. 46043/14, § 140, ECHR 2015 (extracts)).

167. However, it has not excluded the possibility that the acts and omissions of the authorities in the context of public health policies, may, in certain circumstances, engage the Contracting Parties’ responsibility under the substantive limb of Article 2 (see *Powell*, cited above).

(ii) *Case-law on medical negligence*

168. In cases where allegations of medical negligence were made in the context of the treatment of a patient, the Court has consistently emphasised that, where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are not 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 (see, among many other authorities, *Powell*, cited above, and *Sevim Güngör v. Turkey* (dec.), no. 75173/01, 14 April 2009).

169. To date, in cases concerning medical negligence, the Court has rarely found deficiencies in the regulatory framework of member States as such (see *Arskaya*, cited above, § 91, and, *a contrario*, *Z v. Poland*, no. 46132/08, §§ 110-12, 13 November 2012; see also *Altuğ and Others v. Turkey*, no. 32086/07, § 73, 30 June 2015; *Glass v. the United Kingdom*, (dec.), no. 61827/00, 18 March 2003; and *Sevim Güngör*, cited above).

170. In the case of *Arskaya v. Ukraine*, cited above, the applicant alleged that her son, who had been hospitalised for pneumonia and tuberculosis, had died as a result of medical negligence on account of inadequate health-care regulations concerning patients refusing to consent to treatment. The Court, when finding a substantive violation of Article 2, noted that the local regulations governing patients' admission to intensive care were inadequate. It further found that there was a lack of appropriate rules for establishing patients' decision-making capacity, including their informed consent to treatment. It considered therefore that the authorities had not taken sufficient steps to put in place a regulatory framework ensuring that the life of the applicant's son was properly protected by law as required by Article 2 of the Convention (ibid. §§ 84-91).

171. In a number of cases the Court has also addressed the substance of the applicants' medical negligence claims. However, in all those cases, such claims were considered unfounded on the facts because no medical negligence had been established at the domestic level, notably by medical experts (see, for example, *Skraskowski v. Poland* (dec.), no. 36420/97, 6 April 2000; *Sieminska v. Poland*, no. 37602/97, 29 March 2001; *Buksa v. Poland* (dec.), no. 75749/13, § 13, 31 May 2016; and *Mihu v. Romania*, no. 36903/13, § 67, 1 March 2016). The Court reiterates that it is not for it to speculate, on the basis of the medical information submitted to it, on whether the conclusions of the medical experts on which domestic court decisions were founded were correct (see *Sayan v. Turkey*, no. 81277/12, § 112, 11 October 2016, and *Balcı v. Turkey* (dec.), no. 58194/10, § 45, 20 October 2015, and the cases cited therein).

172. The Court has usually reviewed such factual issues under the procedural limb, considering that the events leading to the death of the patient and the responsibility of the health professionals involved were matters which must be addressed from the angle of the adequacy of the mechanisms that were in place for shedding light on the course of those events, allowing the facts of the case to be exposed to public scrutiny, not least for the benefit of the applicants (see, for example, *Trzepalko v. Poland* (dec.), no. 25124/09, § 24, 13 September 2011; *Oyal*, cited above; *Eugenia Lazăr*, cited above, §§ 69-70; *Rinkūnienė v. Lithuania* (dec.), no. 55779/08, 1 December 2009; and *Zafer Öztürk v. Turkey*, no. 25774/09, § 46, 21 July 2015).

(iii) *Case-law on denial of health care*

173. The Court has further held that an issue may arise under Article 2 where it is shown that the authorities of a Contracting State have put an individual's life at risk through the denial of the health care which they have undertaken to make available to the population generally (see *Cyprus v. Turkey*, cited above, § 219).

174. Until recently, the type of cases which were examined by the Court with reference to the aforementioned principle concerned applicants who were claiming that the State should pay for a particular form of conventional treatment because they were unable to meet the costs it entailed (see, for example, *Nitecki v. Poland* (dec.), no. 65653/01, 21 March 2002; *Pentiacova and Others v. Moldova* (dec.), no. 14462/03, ECHR 2005-I; *Gheorghe v. Romania* (dec.), no. 19215/04, 22 September 2005; and *Wiater v. Poland* (dec.), no. 42290/08, 15 May 2012) or that they should have access to unauthorised medicinal products for medical treatment (see *Hristozov and Others v. Bulgaria*, nos. 47039/11 and 358/12, ECHR 2012 (extracts)). The Court did not find a breach of Article 2 in any of these cases, either because it considered that sufficient medical treatment and facilities had been provided to the applicants on an equal footing with other persons in a similar situation (see *Nitecki* and *Gheorghe*, both cited above) or because the applicants had failed to adduce any evidence that their lives had been put at risk (see *Pentiacova and Others*, cited above). In *Hristozov and Others*, cited above, the Court did not find fault with the regulations governing access to unauthorised medicinal products in situations where conventional forms of medical treatment appeared insufficient, and considered that Article 2 of the Convention could not be interpreted as requiring access to unauthorised medicinal products for terminally-ill patients to be regulated in a particular way (ibid. § 108).

175. In this connection the Court reiterates that issues such as the allocation of public funds in the area of health care are not a matter on which the Court should take a stand and that it is for the competent authorities of the Contracting States to consider and decide how their limited resources should be allocated, as those authorities are better placed than the Court to evaluate the relevant demands in view of the scarce resources and to take responsibility for the difficult choices which have to be made between worthy needs (see *Wiater*, § 39, *Pentiacova and Others* and *Gheorghe*, all cited above).

176. The Court found a procedural violation in the case of *Panaiteescu v. Romania* (no. 30909/06, 10 April 2012) where it considered that the State had failed to prevent the applicant's life from being avoidably put at risk by not providing him with the appropriate health care as ordered by the national courts. This was a very exceptional case which concerned the refusal of the domestic authorities to provide the patient with a particular, costly cancer drug free of charge, in circumstances where the domestic courts had found that the individual in question had such an entitlement.

(iv) *Recent case-law developments*

177. The Court observes that the parties, in their submissions, focused on some recent cases concerning a failure to provide emergency medical care in the context of pre- or post-natal care.

178. A substantive violation of Article 2 was found in the context of denial of health care in *Mehmet Şentürk and Bekir Şentürk*, cited above, where the first applicant's wife, who was pregnant, died in an ambulance because of the doctors' refusal to carry out an urgent operation owing to her inability to pay medical fees. In this connection the Court held that it was not disputed that the patient had arrived at the hospital in a serious condition and that she required emergency surgery, failing which there were likely to be extremely grave consequences. While the Court did not want to speculate on the chances of survival of the first applicant's wife had she received medical treatment, it considered that the medical staff had been fully aware that transferring the patient to another hospital would put her life at risk. In this regard it took note that domestic law did not have any provisions in this area capable of preventing the failure to give the patient the medical treatment she had required on account of her condition. The Court therefore considered that the first applicant's wife, victim of a flagrant malfunctioning of the relevant hospital departments, had been deprived of the possibility of access to appropriate emergency care (ibid. §§ 96-97).

179. In the case of *Asiye Genç*, cited above, the applicant's new-born baby died in an ambulance after being refused admission to a number of public hospitals owing to a lack of space or adequate equipment in their neonatal units. The Court, considering that the State had not sufficiently ensured the proper organisation and functioning of the public hospital service, or more generally its health protection system, held that the applicant's son had been the victim of a dysfunction in the hospital services, as he had been deprived of access to appropriate emergency treatment. It emphasised that the baby had not died because there had been negligence or an error of judgment in his medical care, but because no treatment whatsoever had been offered. The Court therefore concluded that there had been a refusal to provide medical treatment, resulting in the patient's life being put in danger (ibid. §§ 80-82).

180. In *Elena Cojocarui*, cited above, the applicant's pregnant daughter, who was suffering from a serious pre-natal condition, died after a doctor at the public hospital had refused to perform an emergency C-section and she was transferred to another hospital, 150 km away, without a doctor's supervision. The new-born baby died two days later. The Court found that the circumstances in that case constituted a failure to provide adequate emergency treatment (ibid. § 125) since, irrespective of the reason, the patient's transfer had delayed the emergency treatment she needed. The apparent lack of coordination of the medical services and the delay in administering the appropriate emergency treatment attested to a dysfunction in public hospital services (ibid. § 111).

181. The case of *Aydoğdu*, cited above, concerned the death of a premature baby due to a combination of circumstances, notably on account of a dysfunction in the health system in a particular region of Turkey (ibid.

§§ 55 and 76). In that case the Court considered that the authorities responsible for health care must have been aware at the time of the events that there was a real risk to the lives of multiple patients, including the applicant's baby, owing to a chronic state of affairs which was common knowledge, and yet had failed to take any of the steps that could reasonably have been expected of them to avert that risk. The Court noted that the Government had not explained why taking such steps would have constituted an impossible or disproportionate burden for them, bearing in mind the operational choices that needed to be made in terms of priorities and resources (ibid. § 87). It therefore held that Turkey had not taken sufficient care to ensure the proper organisation and functioning of the public hospital service in this region of the country, in particular because of the lack of a regulatory framework laying down rules for hospitals to ensure protection of the lives of premature babies. The Court, noting that, apart from the negligent behaviour of the medical staff, there was a causal link between the baby's death and the above-mentioned structural problems, held that the baby had been the victim of negligence and structural deficiencies. This had effectively prevented her from receiving appropriate emergency treatment and amounted to a refusal to provide medical treatment, resulting in the patient's life being put in danger (ibid. § 88).

182. The predominant features which stand out in the aforementioned cases - apart from the case of *Elena Cojocaru* which follows the line taken in the Chamber judgment in the present case - clearly demonstrate that the Court has distinguished these cases, where there is an arguable claim of a denial of immediate emergency care, from cases which concern allegations of mere medical negligence (see *Mehmet Şentürk and Bekir Şentürk*, §§ 85, 104 and 105; *Aydoğdu*, §§ 62, 76 and 80; and *Asiye Genç*, §§ 73, 76 and 82, all cited above; see also *M. v. Turkey*, no. 4050/10 (dec), 15 October 2013, and *Sayan*, cited above, §§ 111-12, where the applicants were unable to substantiate the alleged denial of health care). Thus, the approach adopted in those cases cannot be transposed to cases where the allegations concern mere medical negligence.

183. These cases are, in the Court's view, exceptional ones in which the fault attributable to the health-care providers went beyond a mere error or medical negligence. They concerned circumstances where the medical staff, in breach of their professional obligations, failed to provide emergency medical treatment despite being fully aware that a person's life would be put at risk if that treatment was not given (see *Mehmet Şentürk and Bekir Şentürk*, cited above, § 104).

184. Moreover, as observed by the United Kingdom Government, the Court's approach, particularly in the case of *Aydoğdu*, cited above, is akin to the test which it applies when examining the substantive positive obligation of the State to undertake preventive operational measures to protect an individual whose life is imminently at real risk (see, for general principles,

Osman, cited above, §§ 115-16). In *Aydoğdu* the failure to provide emergency medical treatment resulted from a dysfunction in the hospital services in that particular region, a situation of which the authorities were or ought to have been aware but which they had failed to address by undertaking the necessary measures to prevent the lives of patients being put at risk. In this regard the Court emphasises that the dysfunctioning of the hospital services referred to in *Aydoğdu* and *Asiye Genç*, both cited above, did not concern negligent coordination between different hospital services or between different hospitals *vis-à-vis* a particular patient. It concerned a structural issue linked to the deficiencies in the regulatory framework (see *Aydoğdu*, cited above, § 87).

(b) The Court's approach

185. Having regard to its case-law summarised above, the Court considers that the approach adopted hitherto should be clarified.

186. In this regard the Court reaffirms that in the context of alleged medical negligence, the States' substantive positive obligations relating to medical treatment are limited to a duty to regulate, that is to say, a duty to put in place an effective regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives.

187. Even in cases where medical negligence was established, the Court would normally find a substantive violation of Article 2 only if the relevant regulatory framework failed to ensure proper protection of the patient's life. The Court reaffirms that where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient cannot be considered 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 (see, among many other authorities, *Powell* and *Sevim Güngör*, both cited above).

188. For the Court's examination of a particular case, the question whether there has been a failure by the State in its regulatory duties calls for a concrete assessment of the alleged deficiencies rather than an abstract one. In this regard, the Court reiterates that its task is not normally to review the relevant law and practice *in abstracto*, but to determine whether the manner in which they were applied to, or affected, the applicant gave rise to a violation of the Convention (see *Roman Zakharov v. Russia* [GC], no. 47143/06, § 164, ECHR 2015 and the cases cited therein). Therefore, the mere fact that the regulatory framework may be deficient in some respect is not sufficient in itself to raise an issue under Article 2 of the Convention. It must be shown to have operated to the patient's detriment (compare and

contrast *Z v. Poland*, cited above, §§ 110-12, and *Arskaya*, cited above, §§ 84-91).

189. It must, moreover, be emphasised that the States' obligation to regulate must be understood in a broader sense which includes the duty to ensure the effective functioning of that regulatory framework. The regulatory duties thus encompass necessary measures to ensure implementation, including supervision and enforcement.

190. On the basis of this broader understanding of the States' obligation to provide a regulatory framework, the Court has accepted that, in the very exceptional circumstances described below, the responsibility of the State under the substantive limb of Article 2 of the Convention may be engaged in respect of the acts and omissions of health-care providers.

191. The first type of exceptional circumstances concerns a specific situation where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment (see, for example, *Mehmet Şentürk and Bekir Şentürk*, and, by contrast, *Sayan*, both cited above). It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment.

192. The second type of exceptional circumstances arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger (see, for example, *Asiye Genç* and *Aydoğdu*, both cited above).

193. The Court is aware that on the facts it may sometimes not be easy to distinguish between cases involving mere medical negligence and those where there is a denial of access to life-saving emergency treatment, particularly since there may be a combination of factors which contribute to a patient's death.

194. However, the Court reiterates at this juncture that, for a case to fall into the latter category, the following factors, taken cumulatively, must be met. Firstly, the acts and omissions of the health-care providers must go beyond a mere error or medical negligence, in so far as those health-care providers, in breach of their professional obligations, deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given (see *Mehmet Şentürk and Bekir Şentürk*, cited above, § 104).

195. Secondly, the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the State authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong

or functioning badly (see, in particular, *Aydoğdu*, cited above, § 87, and, by contrast, *Eugenia Lazăr*, cited above, §§ 69-70).

196. Thirdly, there must be a link between the dysfunction complained of and the harm which the patient sustained. Finally, the dysfunction at issue must have resulted from the failure of the State to meet its obligation to provide a regulatory framework in the broader sense indicated above (see paragraph 189 above and, for example, *Mehmet Şentürk and Bekir Şentürk*, cited above, § 96, and *Aydoğdu*, cited above, §§ 87-88).

(c) Application of those criteria to the present case

197. The Court observes that, in the instant case, the applicant did not allege or imply that her husband's death had been caused intentionally. She submitted that her husband had lost his life as a result of a hospital-acquired infection and of various instances of medical negligence which occurred throughout his treatment, and that the doctors in charge of treating him had failed to undertake the necessary measures to save her husband's life. In particular, she claimed that her husband had been infected at the hospital by the *Pseudomonas cepacia* bacterium, which had caused her husband's meningitis; that a serious error of diagnosis had been made when her husband had attended the emergency department of the CHVNG on 29 November 1997; that this delay in diagnosis had allowed a life-threatening infection to develop, which had then had to be treated with very high doses of medication with extremely damaging gastrointestinal side-effects; that the decision to discharge her husband from the CHVNG on various dates had not been accompanied by the requisite medical follow-up; and that the perforated duodenal ulcer had been diagnosed well before the surgery performed on 7 March 1998.

198. At the outset, the Court emphasises that it is not for the Court to call into question the medical professionals' assessment of the health status of the now deceased patient, or their decisions regarding how he should have been treated (see *Glass*, cited above). Those clinical assessments and decisions were made against the background of the patient's state of health at the time and the conclusions of the medical staff as to what steps needed to be taken for his treatment. In this connection the Court observes that the medical treatment provided to the applicant's husband was subjected to domestic scrutiny and that none of the judicial or disciplinary bodies which examined the applicant's allegations ultimately found any fault with his medical treatment. Moreover, while some experts voiced concerns or criticism with regard to certain aspects of his treatment, none of the medical expert evidence conclusively established the existence of medical negligence in the treatment of the applicant's husband.

199. The Court reiterates in this regard that, except in cases of manifest arbitrariness or error, it is not the Court's function to call into question the findings of fact made by the domestic authorities, particularly when it

comes to scientific expert assessments, which by definition call for specific and detailed knowledge of the subject (see *Počkajevs v. Latvia* (dec.), no. 76774/01, 21 October 2004). It follows that the examination of the circumstances leading to the death of the applicant's husband and the alleged responsibility of the health professionals involved are matters which must be addressed from the angle of the adequacy of the mechanisms in place for shedding light on the course of those events. These aspects fall to be examined under the procedural obligation of the State as addressed below (see, among other authorities, *Eugenia Lazăr*, § 70; *Powell* (dec.); *Sevim Güngör* (dec.); and *Mihu*, § 68, all cited above).

200. The Court observes that in the present case the applicant did not complain that her husband had been denied access to medical treatment in general or emergency treatment in particular. Nor is there any information in the case file which would suggest such an issue in the present case. Rather, the applicant complained that the medical treatment provided to her husband had been deficient because of the negligence of the doctors who had treated him. In the Court's view, an alleged error in diagnosis leading to a delay in the administration of proper treatment, or an alleged delay in performing a particular medical intervention, cannot in themselves constitute a basis for considering the facts of this case on a par with those concerning denial of healthcare.

201. Moreover, the Court considers that no sufficient evidence has been adduced in the present case to demonstrate that there existed, at the material time, any systemic or structural dysfunction affecting the hospitals where the applicant's husband was treated, which the authorities knew or ought to have known about and in respect of which they failed to undertake the necessary preventive measures, and that such a deficiency contributed decisively to the death of the applicant's husband (compare *Asiye Genç*, § 80, and *Aydoğdu*, § 87, both cited above). In this respect, while the Court does not disregard the critical remarks which were made by the infectious-diseases panel (see paragraph 53 above), it observes, firstly, that this panel neither mentioned any supporting evidence for these general remarks nor considered that this alleged deficiency contributed decisively to the death of the applicant's husband. Secondly, these views were not endorsed by the Medical Association's regional disciplinary council for the North region in its decision, which was given after having examined the conclusions of five different specialist panels, including that of the infectious-diseases panel. Finally, no similar views were mentioned by any other experts who gave evidence in the different proceedings at the national level.

202. It has not been demonstrated, either, that the alleged fault attributable to the health-care professionals went beyond a mere error or medical negligence or that the health-care professionals involved in the treatment of the applicant's husband failed, in breach of their professional

obligations, to provide emergency medical treatment to him despite being fully aware that his life was at risk if that treatment was not given. In this regard the Court, contrary to the Chamber's finding, considers that the alleged lack of coordination between the ENT department of the CHVNG and the hospital's emergency department does not, by itself, amount to a dysfunction in hospital services capable of engaging the State's responsibility under Article 2. In the present case, the Court does not have at its disposal any evidence or other elements that would enable it to make any findings or reach any conclusions establishing a situation of structural or systemic dysfunctions in the health-care services in question.

203. In view of the above considerations, the Court takes the view that the present case concerns allegations of medical negligence. In these circumstances Portugal's substantive positive obligations are limited to the setting-up of an adequate regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives (see paragraphs 186 and 189 above).

204. Having regard to the detailed rules and standards laid down in the domestic law and practice of the respondent State in the area under consideration (see paragraphs 88-109 above), the Court considers that the relevant regulatory framework does not disclose any shortcomings as regards the State's obligation to protect the right to life of the applicant's husband. Nor has the applicant argued otherwise.

205. Therefore, the Court finds that there has been no violation of Article 2 of the Convention in its substantive aspect.

B. The procedural aspect

1. The Chamber judgment

206. The Chamber found that there had been a violation of the procedural aspect of Article 2 of the Convention. It considered at the outset that the Portuguese legal system provided citizens with means which, theoretically, met the requirements of Article 2 of the Convention.

207. With regard, however, to the effectiveness of the mechanisms the Chamber noted, firstly, the excessive length of the domestic proceedings before the IGS, the Vila Nova de Gaia District Court and the Oporto Administrative and Fiscal Court, which did not meet the requirement of promptness under the procedural limb of Article 2 of the Convention. Secondly, it considered that none of the decisions taken, nor any of the experts' assessments presented, had addressed satisfactorily the question of the possible causal link between the various illnesses suffered by the patient two days after the surgery. The Chamber observed that in each set of proceedings the events had been described in chronological order in isolation from each other. Finally, the Chamber considered that if

meningitis was a possible complication following this type of surgery, then the issue as to whether the applicant's husband had been duly informed of the risks he faced so that he could give his informed consent had to be addressed by the domestic courts. No explanation had been provided in the domestic proceedings regarding the pre- and post-operative medical protocol for this surgery. The Chamber therefore considered that the domestic authorities had not dealt with the applicant's case concerning her husband's death in a manner compatible with the procedural requirements of Article 2 of the Convention.

2. The parties' submissions

(a) The applicant

208. The applicant submitted that where a death occurred in a hospital without the cause being clarified, there was in principle an obligation to establish an appropriate procedural mechanism for determining that cause, for holding any persons at fault to account and for correcting any shortcomings in the functioning of the system. In this regard she stressed that she had consistently set in motion the appropriate mechanisms at the domestic level. According to the Court's case-law, compliance with the procedural obligation under Article 2 required: (i) that effective legal mechanisms exist for establishing the facts and the responsibility of those at fault; (ii) that the task of establishing such facts and responsibilities be assumed by impartial persons; (iii) that the procedures concerned be set in motion and carried through in good time and with suitable promptness, without unnecessary or unjustified delays; and (iv) that any specific steps required by the circumstances be taken.

209. In this regard the applicant did not contest that the first two requirements had been satisfied in the circumstances of the present case. However, she claimed that the national authorities had failed to react to the situation with the necessary promptness, responsiveness and diligence, as established in paragraphs 132-37 of the Chamber judgment, with which she agreed. She further considered that there had been a number of failings which had compromised the decision-making process. Firstly, as the Chamber had noted, no comprehensive, thorough and satisfactory assessment had been made by the domestic authorities. Secondly, as the Chamber had likewise emphasised, the risks attendant on the intended surgery had not been made clear to the patient. Thirdly, the authorities had not even tried to determine the origin of the bacterium which had caused the meningitis and, fourthly, in the absence of a properly substantiated explanation for the chain of events in question an autopsy should have been mandatory.

(b) The Government

210. The Government submitted that the death of a patient in hospital could not be compared to the death of someone who was under the control of the authorities or the deaths of vulnerable persons in the care of public services. They considered that the death of a patient following a medical procedure in hospital did not require the automatic institution of an inquiry, particularly where the death did not give rise to doubts as to its cause or raise suspicions as to the existence of an intentional act or medical negligence. In the Government's view an examination of all the circumstances was, however, necessary in order to determine the cause of death, with the performance of an autopsy being required only where it had not been possible to determine that cause. The Government submitted that, in the present case, there was no evidence or indication of medical negligence, and the cause of death was known. They stated that, pursuant to Article 54 of Legislative Decree no. 11/98 of 24 January 1998, autopsies were undertaken in the event of violent death or where the cause of death was unknown.

211. They noted, nonetheless, that when the applicant had made her allegations, a number of proceedings of a different nature had been initiated and had gone on to run their full course; all the actions that were requested had been carried out, as had all the appropriate steps that had been necessary in order to help establish the facts and determine possible responsibilities. The Government provided a detailed description of the steps taken in the course of each set of proceedings. They maintained that the courts and the disciplinary bodies involved in the present case had had a clear and detailed set of facts at their disposal concerning, in particular, the causes of death, which had allowed them to conclude without any doubt that there had been no medical negligence. In this connection the Government stressed that the applicant had at every stage participated in the proceedings, presented her arguments and evidence in full adversarial proceedings, lodged complaints and appealed against decisions. Moreover, the judicial proceedings had taken place before independent and impartial judges and the hearings had been public.

212. The Government conceded that the proceedings had been lengthy. However, they considered that this had not stood in the way of effective observance of the procedural obligation. They argued that the length of the criminal and civil proceedings and those before the IGS could be attributed precisely to the efforts made by the competent authorities to address with rigour all the facts of the case and all the doubts expressed by the applicant. In such circumstances, the Government considered that the duration of the proceedings could not be a ground for finding a violation of the procedural obligation under Article 2 of the Convention. At most, they argued, the lengthy proceedings might breach Article 6 § 1 of the Convention, which was incidentally the complaint lodged by the applicant.

213. The Government reiterated that, in accordance with the Court's case-law, the obligation deriving from the procedural limb of Article 2 was one of means and not of result. In this regard, if some doubts had persisted concerning the events surrounding the applicant's husband's death, this was simply because there were always situations in which medical science was unable to predict, diagnose or explain. However, this was not in any way attributable to a lack of effort on the part of the domestic authorities. The Government therefore considered that the procedural obligations deriving from Article 2 of the Convention had been fulfilled in the present case. Accordingly, they called for the application to be rejected as inadmissible under Article 35 § 4 of the Convention, on the ground that it was manifestly ill-founded.

3. *The Court's assessment*

(a) **General principles**

214. The Court has interpreted the procedural obligation of Article 2 in the context of health care as requiring States to set up an effective and independent judicial system so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable (see, among other authorities, *Šilih v. Slovenia* [GC], no. 71463/01, § 192, 9 April 2009, and the cases cited therein).

215. While, in some exceptional situations, where the fault attributable to the health-care providers went beyond a mere error or medical negligence, the Court has considered that compliance with the procedural obligation must include recourse to criminal law (see, for example, *Mehmet Şentürk and Bekir Şentürk*, §§ 104-105, and *Asiye Genç*, § 73, both cited above), in all other cases where the infringement of the right to life or to personal integrity is not caused intentionally, the procedural obligation imposed by Article 2 to set up an effective and independent judicial system does not necessarily require the provision of a criminal-law remedy (see paragraph 137 above; see also *Cevrioğlu v. Turkey*, no. 69546/12, § 54, 4 October 2016).

216. The Court reiterates that the choice of means for ensuring the positive obligations under Article 2 is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues for ensuring Convention rights, and even if the State has failed to apply one particular measure provided by domestic law, it may still fulfil its positive duty by other means (see *Cevrioğlu*, cited above, § 55). However, for this obligation to be satisfied, such proceedings must not only exist in theory but also operate effectively in practice (see, for example, *Byrzykowski*, cited above, § 105, and *Spyra and Kranczkowski v. Poland*, no. 19764/07, § 88, 25 September 2012).

217. A requirement of independence of the domestic system set up to determine the cause of death of patients in the care of the medical profession is implicit in this context. This requires not only a lack of hierarchical or institutional connection but also that all parties tasked with conducting an assessment in the proceedings for determining the cause of death of patients enjoy formal and *de facto* independence from those implicated in the events (see *Bajić v. Croatia*, no. 41108/10, § 90, 13 November 2012). This requirement is particularly important when obtaining medical reports from expert witnesses (see *Karpisiewicz v. Poland* (dec.), no. 14730/09, 11 December 2012), as the medical reports of expert witnesses are very likely to carry crucial weight in a court's assessment of the highly complex issues of medical negligence, which gives them a particularly important role in the proceedings (see *Bajić*, cited above, § 95).

218. Likewise, the procedural obligation under Article 2 in the context of health care requires, *inter alia*, that the proceedings be completed within a reasonable time (see *Šilih*, cited above, § 196). In that connection the Court emphasises that, apart from the concern for the respect of the rights inherent in Article 2 of the Convention in each individual case, more general considerations also call for a prompt examination of cases concerning medical negligence in a hospital setting. Knowledge of the facts and of possible errors committed in the course of medical care is essential to enable the institutions and medical staff concerned to remedy the potential deficiencies and prevent similar errors. The prompt examination of such cases is therefore important for the safety of all users of health-care services (see *Oyal*, cited above, § 76).

219. This is why the Court has held that, in Article 2 cases, particularly in those concerning proceedings instituted to elucidate the circumstances of an individual's death in a hospital setting, the lengthiness of proceedings is a strong indication that the proceedings were defective to the point of constituting a violation of the respondent State's positive obligations under the Convention, unless the State has provided highly convincing and plausible reasons to justify the length of the proceedings (see, for example, *Bilbija and Blažević v. Croatia*, no. 62870/13, § 107, 12 January 2016).

220. Unlike in cases concerning the lethal use of force by State agents, where the competent authorities must of their own motion initiate investigations, in cases concerning medical negligence where the death is caused unintentionally, the States' procedural obligations may come into play upon the institution of proceedings by the deceased's relatives (see *Šilih*, cited above, § 156).

221. Finally, the Court stresses that this procedural obligation is not an obligation of result but of means only (*ibid.*, § 193). Thus, the mere fact that proceedings concerning medical negligence have ended unfavourably for the person concerned does not in itself mean that the respondent State has

failed in its positive obligation under Article 2 of the Convention (see *Besen v. Turkey* (dec.), no. 48915/09, § 38 *in fine*, 19 June 2012, and *E.M. and Others v. Romania* (dec.), no. 20192/07, § 50, 3 June 2014).

(b) Application of these principles to the present case

222. The Court observes that the applicant's husband, who had been in good health, underwent a routine operation in hospital and ended up suffering from bacterial meningitis, ulcers, colitis and other medical complications which led to his death three months later from septicaemia caused by peritonitis and a perforated viscus. In view of the aforementioned sequence of events, the Court considers that the applicant had arguable grounds to suspect that her husband's death could have been the result of medical negligence. The respondent State's duty to ensure compliance with the procedural obligations arising under Article 2, in the proceedings instituted with regard to her husband's death, is therefore engaged in the present case (see *Şilih*, cited above, § 197). This obligation came into play upon the institution of proceedings by the applicant (*ibid.*, § 156).

223. The Court notes that in cases of medical negligence Portuguese law provides, in addition to the possibility of criminal proceedings, for the option of bringing proceedings for civil liability in the administrative courts against public hospitals. The hospitals may in turn be entitled to claim reimbursement of the damages payable from the officials who acted in breach of their professional duty. Furthermore, an application may be made to the Ministry of Health and the Medical Association seeking to establish disciplinary liability on the part of members of the health-care profession.

224. On this basis the Court concludes that the Portuguese legal system offers litigants remedies which, in theory, meet the requirements of the procedural obligations under Article 2. The applicant has not argued otherwise.

225. In the instant case, the applicant made use of all of the procedures mentioned above. The question is therefore whether, in the concrete circumstances of the case, given the fundamental importance of the right to life guaranteed under Article 2 of the Convention and the particular weight the Court has attached to the procedural requirement under that provision, the legal system as a whole dealt adequately with the case at hand (see *Dodov*, cited above, § 86; *Arskaya*, cited above, § 66; and *Kudra v. Croatia*, no. 13904/07, § 107, 18 December 2012).

226. At the outset the Court observes that the applicant did not contest the independence and impartiality of the domestic authorities or the experts who gave evidence in the various proceedings. It further considers that the applicant did have the possibility to participate actively in the different proceedings and availed herself of her procedural rights to influence their course. There is nothing in the case file to demonstrate – nor has the applicant argued before the Grand Chamber – that she was placed at a

procedural disadvantage *vis-à-vis* the medical institutions or doctors in any of these proceedings. It therefore remains to be ascertained whether the domestic proceedings were effective in terms of being thorough, prompt and concluded within a reasonable time.

227. As regards the thoroughness, the Court finds it appropriate to respond first to the specific complaints raised by the applicant in her written submissions regarding the lack of an autopsy and of her husband's consent to his operation (see paragraph 209 above). As regards the first of these issues, the Court agrees with the Chamber's view that the cause of the applicant's husband's death had not raised any doubts which would have required an autopsy to be performed under the statutory provisions in that regard. As to the second issue, in the absence of a specific substantive complaint on the matter, the Court finds that the domestic judicial and other bodies cannot be faulted for not delving into that issue in depth (see, for example, *Vasileva*, cited above, § 76).

228. The Court will now proceed with the examination of the manner in which the domestic proceedings were conducted.

229. As regards the proceedings before the IGS the Court observes, firstly, that it took the IGS two years to order the opening of an investigation, and a further year to appoint an inspector to head the investigation. Secondly, evidence was heard from the applicant for the first time almost three years and six months after she had contacted the authorities. The investigation before this body therefore lacked promptness. The Court further observes that the proceedings before the IGS had already lasted for slightly more than seven years and ten months before the applicant was informed that the disciplinary proceedings initiated against Dr J.V. would be stayed pending the outcome of the criminal proceedings. During this period the Inspector's report was set aside twice by the Inspector General for Health in order to obtain additional information or to order fresh expert assessments to be carried out by different experts in the fields of internal medicine and gastroenterology. The successive adoption of such decisions within one set of proceedings disclosed, in the particular circumstances of the present case, a deficiency in the manner in which the Inspector General investigated the case.

230. As to the proceedings before the Medical Association, the Court observes that the latter responded promptly to the applicant's request by seeking the opinions of five of its specialist panels immediately after receiving the patient's medical records, and that the overall length of the proceedings before the Medical Association was approximately four years and five months at two levels. This cannot be considered *per se* as unreasonable. However, the Court cannot lose sight of the fact that the proceedings before this specialised body consisted merely in examining the patient's medical records and the opinions of the specialist panels. The proceedings were written and no evidence was heard. Seen from this angle

and in the absence of any explanation from the Government, the duration of these proceedings was also unreasonable.

231. In view of the above, the Court considers that the disciplinary proceedings in the present case can hardly be regarded as effective for the purposes of Article 2. It is further necessary to examine the effectiveness of the criminal proceedings.

232. In this connection the Court notes that, in the instant case, there is nothing to indicate that the death of the applicant's husband was caused intentionally, and the circumstances in which it occurred were not such as to raise suspicions in that regard. Therefore, Article 2 did not necessarily require a criminal-law remedy. However, if deemed effective, such proceedings would by themselves be capable of satisfying the procedural obligation of Article 2 (see *Šilih*, cited above, § 202).

233. The Court observes, firstly, that the prosecuting authorities initiated criminal proceedings against Dr J.V. merely on the basis of the report adopted by the Inspector in the proceedings before the IGS, without conducting any further investigation (see paragraph 62 above). As a result the criminal proceedings were concerned only with the narrow issue set out in the charges that had been brought, and did not deal with any of the other instances of alleged medical negligence complained of by the applicant. This in itself is sufficient to consider that they were deficient. Having regard to the limited scope of the criminal proceedings, the applicant could not be faulted for not appealing against the court's judgment. Secondly, the proceedings were neither prompt nor was their overall duration reasonable. No significant procedural steps – save for those mentioned in paragraphs 60 and 61 above – were undertaken by the prosecuting authorities between 29 April 2002 and 7 December 2007, a period of almost five years and seven months. The proceedings in total lasted for six years, eight months and nineteen days.

234. In view of the above shortcomings, the Court considers that the criminal proceedings in the present case were also ineffective for the purposes of Article 2. The Court further finds it necessary to examine the effectiveness of the action for compensation brought by the applicant before the administrative courts.

235. As mentioned above (see paragraph 138 above), in the Court's view those proceedings were, in principle, capable of providing the most appropriate redress in relation to the death of the applicant's husband. However, the Court does not consider that they did so in the instant case, for the following reasons.

236. The Court observes that the first striking feature of these proceedings is their considerable length. It notes that the compensation proceedings before the Oporto Administrative and Fiscal Court commenced on 6 March 2003 and ended on 26 February 2013. They therefore lasted for nine years, eleven months and twenty-five days over two levels of

jurisdiction. Contrary to the Government's assertion, the case file does not suggest that such lengthy proceedings were justified by the circumstances of the case. In particular, the Court stresses that the Oporto Administrative and Fiscal Court took more than four years to give a preliminary decision, and a further four years to arrange the hearings. The Court considers that such a lengthy time prolongs the ordeal of uncertainty not only for the claimants but also for the medical professionals concerned.

237. Secondly, the Court considers that, for the purposes of the procedural obligation of Article 2, the scope of an investigation faced with complex issues arising in a medical context cannot be interpreted as being limited to the time and direct cause of the individual's death. The Court cannot speculate on the reasons why the origin of the bacterium which caused the applicant's husband to contract meningitis could not be established at domestic level. It finds however that, where there is a *prima facie* arguable claim of a chain of events possibly triggered by an allegedly negligent act that may have contributed to the death of a patient, in particular if an allegation of a hospital-acquired infection is concerned, the authorities may be expected to conduct a thorough examination into the matter. The Court considers that no such examination was conducted in the instant case, in which the domestic courts, instead of carrying out an overall assessment, approached the chain of events as a succession of medical incidents, without paying particular attention to how they may have related to each other.

238. In sum, the Court considers that the domestic system as a whole, when faced with an arguable case of medical negligence resulting in the death of the applicant's husband, failed to provide an adequate and timely response consonant with the State's obligation under Article 2. Accordingly, there has been a violation of the procedural aspect of that provision.

C. Conclusion

239. The Court reiterates that there has been no violation of the substantive limb of Article 2 of the Convention and that there has been a violation of the procedural limb of Article 2 of the Convention. The Court therefore dismisses the Government's preliminary objection that the application is manifestly ill-founded.

III. APPLICATION OF ARTICLE 41 OF THE CONVENTION

240. Article 41 of the Convention provides:

"If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Damage

241. In the proceedings before the Chamber, the applicant claimed 174,580 euros (EUR) and EUR 100,000 respectively by way of pecuniary and non-pecuniary damage.

242. With regard to the sum claimed in respect of pecuniary damage, the Chamber found, besides the lack of evidence in support of the claim, no causal link between the violation found and the alleged pecuniary damage. Accordingly, it rejected that claim. By contrast, it considered that just satisfaction should be awarded on account of the fact that the violation of the substantive and procedural aspects of Article 2 had caused the applicant non-pecuniary damage by placing her in a position of distress and frustration. It awarded the applicant EUR 39,000 under that head.

243. Before the Grand Chamber, in her observations of 31 August 2016, the applicant did not make any specific claims for just satisfaction. However, at the hearing before the Grand Chamber the applicant's representative referred to her claim before the Chamber and emphasised that the applicant accepted the decision made by the latter with regard to just satisfaction.

244. The Government did not comment on the question of just satisfaction after it was raised by the applicant's representative at the hearing before the Grand Chamber.

245. The Court reiterates that Article 41 empowers it to afford the injured party such satisfaction as appears to it to be appropriate (see *Karácsony and Others v. Hungary* [GC], no. 42461/13, § 179, ECHR 2016 (extracts)).

246. It observes in this regard that there is no doubt that a claim for just satisfaction was duly made during the communication procedure before the Chamber, within the required time-limits (see, *a contrario*, *Schatschaschwili v. Germany* [GC], no. 9154/10, § 167, ECHR 2015, and *Nagmetov v. Russia* [GC], no. 35589/08, § 62, 30 March 2017), leading to an award of compensation to the applicant in respect of non-pecuniary damage.

247. The Court further notes that, while the applicant did not make any fresh claim for just satisfaction within the required time-limit in the proceedings before the Grand Chamber, she subsequently referred to her claim before the Chamber and affirmed that she accepted the decision made by the latter with regard to just satisfaction. The Government, who had the opportunity to respond to this claim at the hearing, did not object.

248. In view of the above, the Court is satisfied that a "claim" for just satisfaction has been made before the Court in the present case.

249. Like the Chamber, the Court does not discern any causal link between the violation found and the unsubstantiated pecuniary damage alleged, and dismisses this claim.

250. As regards non-pecuniary damage, the Court observes that the State was not found liable for the death of the applicant's husband. Nevertheless, it considers that the applicant must have experienced severe distress and frustration on account of the inadequacy and protracted nature of the proceedings initiated by her in order to elucidate the circumstances surrounding the death of her husband. Ruling in equity, as required under Article 41, the Court awards her EUR 23,000 under this head.

B. Costs and expenses

251. As the applicant, who was granted legal aid for the proceedings before the Grand Chamber, submitted no claim for costs and expenses, the Court makes no award under this head (see *Perdigão v. Portugal* [GC], no. 24768/06, § 87, 16 November 2010).

C. Default interest

252. The Court considers it appropriate that the default interest rate should be based on the marginal lending rate of the European Central Bank, to which should be added three percentage points.

FOR THESE REASONS, THE COURT

1. *Joins to the merits*, unanimously, the Government's preliminary objection that the application is manifestly ill-founded and *dismisses* it;
2. *Holds*, by fifteen votes to two, that there has been no violation of the substantive limb of Article 2 of the Convention;
3. *Holds*, unanimously, that there has been a violation of the procedural limb of Article 2 of the Convention;
4. *Holds*, by fifteen votes to two,
 - (a) that the respondent State is to pay the applicant, within three months, the sum of EUR 23,000 (twenty-three thousand euros), plus any tax that may be chargeable on that amount, in respect of non-pecuniary damage;
 - (b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amount at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;

5. *Dismisses*, by fifteen votes to two, the remainder of the applicant's claim for just satisfaction.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 19 December 2017.

Roderick Liddell
Registrar

Guido Raimondi
President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following separate opinions are annexed to this judgment:

- (a) Partly concurring, partly dissenting opinion of Judge Pinto de Albuquerque;
- (b) Partly dissenting opinion of Judge Serghides.

G.R.
R.L.

PARTLY CONCURRING, PARTLY DISSENTING OPINION OF JUDGE PINTO DE ALBUQUERQUE

Table of contents

I. Introduction (§§ 1-2)	59
First part – The origins of the right to health care (§§ 3-59)	60
II. The right to health care in international law (§§ 3-28)	60
A. Universal standards (§§ 3-15).....	60
1. The foundational statements (§§ 3-4)	60
2. The general international instruments (§§ 5-10).....	61
3. The group-specific international instruments (§§ 11-15)	66
B. Regional standards (§§ 16-26)	68
1. Outside Europe (§§ 16-19).....	68
2. Within the European Union (§§ 20-22)	70
3. Within the Council of Europe (§§ 23-26).....	71
C. Preliminary conclusion (§§ 27-28)	73
III. The right to health care under the Convention (§§ 29-59)	74
A. The right of specific groups (§§ 29-43).....	74
1. Detainees and servicemen (§§ 29-38).....	74
2. Children and persons with disabilities (§§ 39-41)	79
3. Migrants (§§ 42-43).....	81
B. The emerging right of the general population (§§ 44-53).....	81
1. Health-related incidents in the outside environment (§§ 44-46)	81
2. Health-related incidents in the workplace (§§ 47-48).....	83
3. Health-related incidents in hospital or other health-service facilities (§§ 49-53).....	85
C. Preliminary conclusion (§§ 54-59)	89
Second part – Taking the right to health care seriously (§§ 60-91).....	93
IV. Conceptualising a <i>pro persona</i> approach to the right to health care under the Convention (§§ 60-72)	93
A. The substantive obligations (§§ 60-66)	93
1. The obligation to respect (§§ 60-61).....	93
2. The obligation to safeguard (§§ 62-66)	95
B. The procedural obligations (§§ 67-70).....	98
1. The obligations to account for and explain (§§ 67-68).....	98
2. The obligations to investigate and prosecute (§§ 69-70).....	99

C. Preliminary conclusion (§§ 71-72)	100
V. The application of a <i>pro persona</i> approach to the present case (§§ 73-91).....	101
A. Critique of the majority’s ideological approach (§§ 73-81)	101
1. Narrowing the Court’s case-law (§§ 73-78)	101
2. Rewriting history (§§ 79-81)	104
B. A human rights-based approach to the present case (§§ 82-89)	106
1. The “appalling structural and operational conditions” of treatment (§§ 82-85).....	106
2. Drawing consequences from history (§§ 86-89).....	107
C. Preliminary conclusion (§§ 90-91)	109
VI. Conclusion (§§ 92-94).....	109

I. Introduction (§§ 1-2)

1. I agree with the majority that there has been a procedural violation of Article 2 of the European Convention on Human Rights (“the Convention”), because the respondent State failed to provide a reasonable explanation for the death of the applicant’s husband and an adequate and timely response to an arguable case of medical malpractice. I regret that the majority do not address the implications of this failure for the substantive limb of Article 2. Furthermore, I disagree with the majority’s strict standard for the international-law responsibility of the Contracting Parties in cases of medical malpractice, which is not in line with the previous case-law of the European Court of Human Rights (“the Court”) and the standards set by international law and particularly by the Council of Europe. I also diverge from the majority’s iniquitous assessment of the evidence in the file, which neglected the crystal-clear, authoritative evidence of a systemic or structural failure in the health care provided at the relevant time.

2. This opinion has two parts. In the first part I deal with the origins of the right to health care¹, both in international law in general and under the Convention. Particular attention is accorded to an analysis of the Court’s case-law on the right to health care of certain groups of the population and on the emergent right to health care of the general population. On the basis of this study, the second part of the opinion seeks to conceptualise a *pro persona* approach to the right to health care under the Convention. This

1. In this opinion, the expression health care is understood as in paragraph 24 of the Explanatory Report to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, ETS No. 164 (the Oviedo Convention). Article 10 of the (revised) European Code of Social Security, 1990, ETS No. 139, further classifies medical care as including general practitioners and specialist care, pharmaceutical, dental and hospital care, medical rehabilitation and medical transportation.

purposive (*effet utile*) and principled reading of the Convention aims to establish that there is a substantive right to health care under the Convention and that this right entails an obligation to respect and to safeguard health which incorporates a reasonableness standard into a core obligations-consistent framework. In the case of death or ill-treatment, the Contracting Parties have an obligation to provide a convincing explanation as to the circumstances of what happened and, for that purpose, to investigate the facts and prosecute the persons responsible. Once this has been made clear, I feel myself not merely authorised but required to draw all the necessary legal inferences for the case at hand, and finally to conclude that there has also been a violation of the substantive limb of Article 2 of the Convention.

First part – The origins of the right to health care (§§ 3-59)

II. The right to health care in international law (§§ 3-28)

A. Universal standards (§§ 3-15)

1. The foundational statements (§§ 3-4)

3. In modern times, the right to enjoy the highest attainable standard of health was first stated in the Preamble to the 1946 Constitution of the World Health Organization (WHO), which defined health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and considered “unequal development in different countries in the promotion of health and control of disease, especially communicable disease, as a common danger”². On the basis of these far-reaching legal principles, the WHO Constitution sought to create a true “Magna Carta of health”³, which “represent[s] the broadest and most liberal concept of international responsibility for health ever officially promulgated”⁴. Two years later, Article 25 (1) of the Universal Declaration of Human Rights laid the foundations for the international legal framework governing the right to health care, affirming the right of everyone, and not only of citizens or nationals, to a “standard of living adequate for the health and well-being of himself and of his family”, including medical care⁵. This

2. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 July, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100), entry into force 7 April 1948.

3. “Magna Carta of health”, 36 *American Journal of Public Health* (1946), p. 1041.

4. Allen, “World Health and World Politics”, 4 *International Organization* (1950), p. 30.

5. On health as a global issue and global health law, see Meier and Onzivu, “The evolution of human rights in World Health Organization policy and the future of human

right has been reiterated in a number of WHO declarations, foremost amongst them the 1978 Alma-Ata Declaration on Primary Health Care and the 1998 World Health Declaration⁶. By adopting the expression “health care” rather than “medical care”, the WHO acknowledged that the full development of health requires not only medical treatment and medicine, but also more generally some underlying practical conditions such as adequate nutrition.

4. Concomitantly with these grand statements of principle, Article 5(e) (iv) of the 1965 International Convention on the Elimination of All Forms of Racial Discrimination (CERD)⁷ prohibited any form of racial discrimination in access to health care and established a general clause of equal access to public health and medical care. This type of clause would be replicated in several other group-specific international instruments.

2. The general international instruments (§§ 5-10)

5. It was only in 1966 that the international community enunciated the content of the right to health care⁸. According to Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR)⁹, “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”. This requires, as “necessary” steps, the reduction of the stillbirth rate and of infant mortality and provision for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic,

rights through global health governance”, 128 *Public Health* (2014), 179-187; Meier, “Global health governance and the contentious politics of human rights: mainstreaming the right to health for public health advancement”, 46 *Stanford Journal of International Law* (2010), 1-50; Meier, “The World Health Organization, the Evolution of Human Rights, and the Failure to Achieve Health for All”, in Harrington and Stuttford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives*, New York: Routledge, 2010, 168-189; Gruskin et al., “History, Principles, and Practice of Health and Human Rights”, 370 *Lancet* (2007), 449-455; Gostin and Taylor, “Global Health Law: A Definition and Grand Challenges”, 1 *Public Health Ethics* (2008), 53-63; Szlezák et al., “The Global Health System: Actors, Norms, and Expectations in Transition”, 7 *PLOS Medicine* (2010); Lee, *Globalization and health: an introduction*, Palgrave: Macmillan, 2003.

6. Some of these standards have been converted into treaty law by the International Labour Organisation (ILO), for example in its Conventions No. 155 on Occupational Safety and Health, 1981; No. 161 on Occupational Health Services, 1985; No. 169 concerning Indigenous and Tribal Peoples in Independent Countries, 1989; and No. 182 on the Worst Forms of Child Labour, 1999.

7. Adopted and opened for signature and ratification by General Assembly resolution 2106 (XX) of 21 December 1965; entry into force 4 January 1969, in accordance with Article 19.

8. This opinion does not take in account the international instruments for health protection in armed conflicts.

9. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966; entry into force 3 January 1976, in accordance with article 27.

endemic, occupational and other diseases; and the creation of conditions which would assure to all medical service and medical attention in the event of sickness¹⁰. A narrow biomedical model of health was thus rejected.

6. The Committee on Economic, Social and Cultural Rights (CESCR), in its General Comment No.14 on the right to the highest attainable standard of health, affirmed that: “[h]ealth is a fundamental human right indispensable for the exercise of other human rights”¹¹. With regard to its scope the CESCR held that “the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health”¹². In this regard, the CESCR required the necessary public health and health-care facilities to possess the so-called AAAQ features: Availability¹³, Accessibility¹⁴, Acceptability¹⁵ and Quality¹⁶. Since State

10. On health care as a human rights issue, see Tobin, *The Right to Health in International Law*, Oxford: Oxford University Press, 2012; San Giorgi, *The Human Right to Equal Access to Health Care*, Cambridge: Intersentia, 2012; Meier et al., “Conceptualizing a Human Right to Prevention in Global HIV/AIDS Policy”, *Public Health Ethics* (2012) 263-282; Hessler and Buchanan, “Specifying the content of the Human Right to Health Care”, in Buchanan (ed.), *Justice and Health Care: Selected Essays*, Oxford: Oxford University Press, 2009; Yamin, “Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care”, 10 *Health & Human Rights* (2008), 45-63; Riedel, “The International Protection of the Right to Health”, in Rüdiger Wolfrum et al. (eds.), *Max Planck Encyclopedia of Public International Law*, Oxford: Oxford University Press, 2008, vol. IV, 764-776; London, “What Is a Human-Rights Based Approach to Health and Does It Matter?”, in 10 *Health & Human Rights* (2008) (1), 65-80; Meier and Mori, “The Highest Attainable Standard: Advancing a Collective Human Right to Public Health”, 37 *Columbia Human Rights Law Review*, 101 (2005), 101-147; Yamin, “The Right to Health Under International Law and Its Relevance to the United States”, 95 *American Journal of Public Health* (2005), 1156-1161; Gruskin and Tarantola, “Health and Human Rights”, in Detels et al. (eds), *Oxford Textbook of Public Health* 311 (2015); Oppenheimer et al., “Health and Human Rights: Old Wine in New Bottles”, 30 *Journal of Law Medicine & Ethics* (2002), 522-532; Kinney, “The International Human Right to Health: What Does This Mean for Our Nation and World?”, 34 *Indiana Law Review* (2001), 1457-1475; Farmer, “Pathologies of Power: Rethinking Health and Human Rights”, 89 *American Journal of Public Health* (1999), 1486-1496; Mann et al. (eds), *Health and Human Rights: A Reader*, London: Routledge, 1999; Toebe, *The Right to Health as a Human Right in International Law*, Antwerp: Intersentia, 1999; and Mann, “Health and Human Rights: If Not Now, When?”, 2 *Health & Human Rights* (1997), 113-120.

11. CESCR, General Comment No. 14: The right to the highest attainable standard of health (Article 12), 11 August 2000, paragraph 1. On the standard-setting work of the CESCR in the field of the right to health, see Saul et al., *The International Covenant on Economic, Social and Cultural Rights Commentary, Cases and Materials*, Oxford: Oxford University Press, 2012, 1025-1029; and Riedel, “New Bearings to the State Reporting Procedure: Practical Ways to Operationalize Economic, Social and Cultural Rights – the Example of the Right to Health”, in von Schorlemer (ed.), *Praxishandbuch UNO*, Berlin: Springer, 2003, 345-358.

12. CESCR, General Comment No. 14, cited above, paragraph 9.

obligations under the ICESCR were limited to progressive realisation to the maximum of available resources, and Article 12 did not specify what minimum level of health care satisfied these requirements, the CESCR defined “a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care”¹⁷. These minimum core obligations are not subject either to progressive realisation or to resource limitations and *a fortiori* do not vary from country to country depending on available resources¹⁸. No derogation clause applies to the rights enshrined in the Covenant¹⁹, but only a clause contained in Article 4 concerning limitations, which must “be compatible with the nature of these rights”. Hence, the fulfilment of minimum essential levels of the right ensures a universally applicable “floor” of essential health care²⁰. This involves at least access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups, and access to essential drugs (applicable to most chronic and acute diseases), as defined from time

13. CESCR requires that facilities, services and goods, as well as the underlying determinants of health such as safe and potable drinking water, adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel and essential drugs, be available in sufficient quantity. See examples of the CESCR practice in Tobin, cited above, p. 161.

14. Accessibility means that facilities, services and goods and health-related information have to be physically and economically accessible without discrimination, especially to vulnerable or marginalised populations. See examples of the CESCR practice in Tobin, cited above, 168-172.

15. CESCR opines that facilities, services and goods must respect medical ethics, respect confidentiality and improve the health status of those concerned.

16. Quality requires facilities, services and goods to be scientifically and medically appropriate and of good quality which, according to the Committee, requires, *inter alia*, skilled health-care staff, scientifically approved and unexpired drugs and equipment, safe and potable water and adequate sanitation.

17. CESCR, General Comment No. 14, cited above, paragraph 43. See also in the literature, Young, “The minimum core of economic and social rights: a concept in search of content”, in 33 *Yale Journal of International Law* (2008), 113-175; Riedel, “The Human Right to Health: Conceptual Foundations”, in Clapham et al. (eds), *Realizing the Right to Health*, Zürich: Rüffer und Rub, 2009, 21-39; Forman et al. “Conceptualizing minimum core obligations under the right to health: How should we define and implement the ‘morality of the depths’?”, 20 *International Journal of Human Rights* (2016), 531-548; Forman et al., “What do core obligations under the right to health bring to universal health coverage?”, 18 *Health and Human Rights Journal* (2016), 23-34; and Forman, “Can Minimum Core Obligations Survive a Reasonableness Standard of Review Under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights?”, *Ottawa Law Review*, Vol. 47, No. 2, 2016, 557-573. The word “core” is used in these texts interchangeably with the words “essence” or “substance”.

18. See Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 22-26 January 1997, paragraph 9.

19. General Comment No. 14, cited above, paragraph 47.

20. General Comment No. 14, cited above, paragraphs 9 and 12.

to time under the WHO Action Programme on Essential Drugs²¹. Put differently, this means that the focus of the core obligations of the right to health is not exclusively on processes (such as plans of action), but also on outcomes. The CESCR further indicated that this interpretation of the ICESCR was drawn from the Declaration of Alma-Ata²², read in conjunction with the Programme of Action of the International Conference on Population and Development.

7. Furthermore, the CESCR emphasised that the obligation to respect the right to health includes refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services. The obligation to protect includes the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties as well as to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. The obligation to fulfil includes the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion of, and support for, the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country, as

21. See “The Use of Essential Drugs: Ninth Report of the WHO Expert Committee”, 2000. Although the WHO stresses that exactly which drugs are regarded as essential remains a national responsibility, it defines a Model List of Essential Drugs. See also CESCR, Concluding Observations on Angola, E/C.12/AGO/CO/3, paragraph 37, Kenya, E/C.12/KEN/CO/1, paragraph 32, and Tajikistan, E/C.12/TJK/CO/1, paragraph 70; Human Rights Council of the United Nations, “Access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, 11 June 2013, A/HRC/23/L.10/Rev. 1; and Commission on Human Rights, Resolution 2003/29, “Access to medications in the context of pandemics such as HIV/AIDS, tuberculosis and malaria”, 22 April 2003. In the literature, see Yamin, “Not Just a Tragedy: Access to Medications as a Right Under International Law”, 21 *Boston University International Law Journal* (2003), 302-371; Joseph, “Pharmaceutical Corporations and Access to Drugs: The ‘Fourth Wave’ of Corporate Human Rights Scrutiny”, 25 (2) *Human Rights Quarterly* (2003), 425-452; Rubenstein, “Human Rights and Fair Access to Medication”, 17 *Emory International Law Review* (2003) 525; Marks, “Access to essential medicines as a component of the right to health”, in Clapham et al. (eds), *Realizing the Right to Health*, cited above, 82-101; Perehudoff, *Health, Essential Medicines, Human Rights & National Constitutions*, Vrije Universiteit Amsterdam, 2008; Hogerzeil and Mirza, *The World Medicines Situation 2011: Access to Essential Medicines as Part of the Right to Health*, WHO/EMP/MIE/2011.2.10; and Saul et al., *The International Covenant on Economic, Social and Cultural Rights: Commentary, Cases and Materials*, cited above, p. 1018.

22. The Declaration adopted at the International Conference on Primary Health Care, Alma-Ata, 1978, highlighted the central function played by primary health care in a country’s health system (Article VI). By including the provision of essential drugs as one of the eight listed components of primary health care (Article VII.3), the Declaration established the link between the goal of the highest possible level of health and access to essential medicines.

well as an obligation to fulfil a specific right contained in the ICESCR when individuals or a group are unable, for reasons beyond their control, to realise that right themselves by the means at their disposal. Moreover, the private business sector also has responsibilities regarding the realisation of the right to health²³. Finally, the CESCR held that any person or group that had been a victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.

8. Although the right to health is not directly protected under the 1966 International Covenant on Civil and Political Rights (ICCPR), Article 6 thereof protects the right to life, under which the right to health has often been asserted. Regarding the fulfilment of the State's duty to ensure the right to life under Article 6(1), the Human Rights Committee (HRC) stated that "the protection of this right requires that States adopt positive measures"²⁴. In the field of public health, the Committee included malnutrition and life-threatening illness in the scope of protection of the right to life. The Committee considered that it would be desirable for States Parties to take all possible measures to reduce infant mortality and to increase life expectancy, notably with regard to access to HIV treatment²⁵.

9. According to the High Commissioner for Human Rights and the WHO, the right to health contains certain entitlements, including entitlement to a minimum level of access to health care and essential medicines. As the High Commissioner explained:

"Notwithstanding resource constraints, some obligations have an immediate effect, such as the undertaking to guarantee the right to health in a non-discriminatory manner, to develop specific legislation and plans of action, or other similar steps towards the full realization of this right, as is the case with any other human right. States also have to ensure a minimum level of access to the essential material components of the right to health, such as the provision of essential drugs and maternal and child health services"²⁶.

10. In a similar vein, the Special Rapporteur on the right to the highest standard of health has stressed as follows:

"Although subject to progressive realization and resource constraints, the right to health imposes various obligations of immediate effect. These immediate obligations include the guarantees of non-discrimination and equal treatment, as well as the

23. General Comment No. 14, cited above, paragraph 42.

24. Human Rights Committee, General Comment 6, Article 6 (Sixteenth session, 1982), HRI/GEN/1/Rev.1 at 6 (1994), paragraph 5. See also Commission on Human Rights Resolutions 2002/31 and 2003/28 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

25. For example, on lack of access to antiretroviral medication, see Concluding Observations on Uganda (2004), CCPR/CO/80/UGA, paragraph 14; and on Kenya (2005), CCPR/CO/83/KEN, paragraph 15.

26. Office of the United Nations High Commissioner for Human Rights, The right to health, Fact sheet no. 31, 2008, page 5.

obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health, such as the preparation of a national public health strategy and plan of action. Progressive realization means that States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health”²⁷.

3. The group-specific international instruments (§§ 11-15)

11. The innovative Article 12 of the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) establishes an obligation of result (“shall ensure”) with regard to certain health services in connection with pregnancy, confinement and the post-natal period²⁸, in addition to an obligation of means (“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. The Committee on the Elimination of Discrimination against Women has further required States Parties to ensure that women have appropriate services in connection with pregnancy, childbirth and the post-natal period, including emergency obstetric care²⁹. Meanwhile, the Committee has also noted “that the State is directly responsible for the action of private institutions when it outsources its medical services and that furthermore, the State always maintains the duty to regulate and monitor private health-care institutions”³⁰.

12. Article 24 of the 1989 Convention on the Rights of the Child³¹ recognises the right of the child to the enjoyment of “the highest attainable standard of health” and to facilities for the treatment of illness and

27. See the site of the Special Rapporteur (consulted on 30 October 2017) and Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/4/28, 17 January 2007, paragraph 63. In the same vein, see other more recent Reports, such as A/72/137, 14 July 2017, paragraph 24, and A/71/304, 5 August 2016, paragraph 27. Regarding access to essential drugs, see in particular the reports on access to medicines, 1 May 2013, A/HRC/23/42; guidelines for pharmaceutical companies, 11 August 2008, A/63/263; the responsibilities of pharmaceutical companies, 13 September 2006, A/61/338; and intellectual property and access to medicines, E/CN.4/2004/49/Add.1.

28. Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979; entry into force 3 September 1981, in accordance with article 27(1). See also Articles 11 (1) (f), and 14 (2) (b) of the CEDAW.

29. See especially the Committee on the Elimination of Discrimination against Women General Recommendation No. 24 on women and health, 1999, A/54/38/Rev.1, paragraphs 14 and 17; and Freeman et al., *The UN Convention on the Elimination of All Forms of Discrimination against Women, A Commentary*, Oxford: Oxford University Press, 2012, 329-332.

30. CEDAW, *Alyne da Silva Pimentel v. Brazil*, 10 August 2011, CEDAW/C/49/D/17/2008, paragraph 7.5.

31. Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989; entry into force 2 September 1990, in accordance with article 49.

rehabilitation of health, but imposes on States Parties an obligation of means (“shall strive to ensure”) so that no child is deprived of his or her right of access to such health-care services. This general obligation is given material form in certain specific, more concrete obligations of result, such as the obligation to ensure the provision of necessary medical assistance and health care to all children, with emphasis on the development of primary health care, and the obligation to ensure appropriate pre-natal and post-natal health care for mothers³². The Committee on the Rights of the Child has held that States have core obligations to ensure universal coverage of high-quality primary health services, including prevention, health promotion, care and treatment, and essential drugs³³. Such core obligations should not be dependent on the availability of resources³⁴.

13. Article 4 of the Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal³⁵ imposes an obligation of means (“shall take the appropriate measures”) to prevent pollution due to hazardous wastes and other wastes arising from such management and, if such pollution occurs, to minimise the consequences thereof for human health and the environment.

14. Article 28 of the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families³⁶ establishes a right to equal access of migrant workers and members of their families to any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health, independently of any irregularity with regard to their stay or employment.

15. More recently, Article 25 of the 2006 Convention on the Rights of Persons with Disabilities (CRPD)³⁷ focuses on non-discriminatory access to health care. Additionally, it sets an obligation of result (“shall provide”) to provide health services needed by persons with disabilities specifically

32. Articles 3 (3), 17, 23, 25, 32 and 28 contain protections for especially vulnerable groups of children.

33. Committee on the Rights of the Child, General Comment No. 15, The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24), 17 April 2013, CRC/C/GC/15, paragraph 73. See also its General Comment No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child, 1 July 2003, CRC/GC/2003/4.

34. Committee on the Rights of the Child report on the Forty-Sixth session, CRC/C/46/3, 22 April 2008, chapter VII, paragraph 89.

35. Adopted on 22 March 1989 by the Conference of Plenipotentiaries in Basel, Switzerland; entered into force in 1992.

36. Adopted by General Assembly resolution 45/158 of 18 December 1990; entered into force on 1 July 2003. See also Articles 43 (e) and 45 (c).

37. Adopted on 13 December 2006; entered into force on 3 May 2008. See also Declaration on the Rights of Disabled Persons (1975); Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare (1991); Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993); and the CESCR General Comment No. 5 on persons with disabilities, 9 December 1994, E/1995/22.

because of their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities, including among children and older persons³⁸. In one instance, the Committee on the Rights of the Persons with Disabilities ruled that Sweden’s refusal to grant permission for the construction of an indoor hydrotherapy pool at home for the rehabilitation of a person with disabilities violated the above-mentioned Article 25³⁹.

B. Regional standards (§§ 16-26)

1. Outside Europe (§§ 16-19)

16. Several regional instruments protect the right to health, both directly and indirectly. Article 4 of the 1969 American Convention on Human Rights protects the right to life. Article 5 protects the right to physical integrity in paragraph 1, and the right not to be subjected to torture and other degrading treatments in paragraph 2⁴⁰. Based on the rights enumerated by these Articles, the Inter-American Commission on Human Rights has successfully provided immediate relief to individuals living with HIV/AIDS⁴¹.

17. The case-law of the Inter-American Court has evolved significantly. In the *Case of Albán-Cornejo et al v. Ecuador*⁴², the Inter-American Court did not find sufficient evidence to attribute international responsibility to the State for the death of Laura Albán under Article 4 of the American Convention. However, the State was found to be liable on account of a violation of the right to humane treatment, on the grounds of the lack of supervision and regulation of the rendering of services of public interest, such as health, by private or public entities⁴³. In the *Case of the Xákmok Kásek Indigenous Community v. Paraguay*⁴⁴, the Court attributed the death

38. On the right to health care of this group, see Perlin, “International Human Rights Law and Comparative Mental Disability Law: The Universal Factors”, 34 *Syracuse Journal of International Law & Commerce* (2006-2007), 333-357; Gable and Gostin, “Mental Health as a Human Right”, in Clapham et al. (eds), *Realizing the right to health*, cited above, III, 249-261; Mégret, “The Disabilities Convention: Human Rights of Persons With Disabilities or Disability Rights?”, 30 *Human Rights Quarterly* (2008), 494-516; Gostin and Gable, “The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health”, 63 *Maryland Law Review* (2004), 20-121.

39. Committee on the Rights of Persons with Disabilities, Communication No. 3/2011, CRPD/C/7/D/3/2011, 21 May 2012, paragraph 8.8.

40. Adopted at the Inter-American Specialized Conference on Human Rights, San José, Costa Rica, 22 November 1969.

41. Inter-American Commission, *Jorge Odir Miranda Cortez et al. v. El Salvador*, Report No. 29/11, Case 12.249, admissibility decision, 7 March 2001.

42. Inter-American Court, *Case of Albán Cornejo et al v. Ecuador* (Merits, Reparations and Costs), Judgment of 22 November 2007, Series C No. 171.

43. *Ibid.*, § 119.

of certain persons to the lack of adequate health care, including assistance by personnel who were adequately trained to deal with births, and adequate pre-natal and post-partum care⁴⁵. In the *Case of Suarez Peralta v. Ecuador*⁴⁶, the Court also found a violation of the obligation to monitor and supervise the provision of health-care services, in view of the medical care received from an unauthorised professional and in a clinic that was not being supervised by the State⁴⁷. In the *Case of Gonzales Lluy et al v. Ecuador*⁴⁸, the Inter-American Court explicitly recognised a right of access to essential medicine⁴⁹ and found a violation of the right to life and the right to personal integrity on account of a breach of the obligation to monitor and supervise the provision of blood transfusion, after blood was delivered that had not undergone the most basic safety testing, such as for HIV⁵⁰.

18. Article 10 of the 1988 Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights⁵¹ enshrines the right to health, understood to mean the enjoyment of “the highest level of physical, mental and social well-being”, and sets out several obligations of result (“to ensure”), including primary health care, that is, essential health care made available to all individuals and families in the community. In *Jorge Odir Miranda Cortez v. El Salvador*, the Inter-American Commission on Human Rights held that, while it was not competent to determine whether El Salvador had violated Article 10 of the Protocol of San Salvador, it would “take into account the provisions related to the right to health in its analysis of the merits of the case”⁵².

19. Article 16 of the 1981 African Charter on Human and Peoples’ Rights⁵³ is less demanding than its American counterpart. It recognises the right to enjoy “the best attainable state of physical and mental health”, but only establishes a general obligation of means (“shall take the necessary measures”) to implement it and a concrete obligation of result “to ensure” that people receive medical attention “when they are sick.” Article 18(4) provides for the right of the aged and disabled to special measures of

44. Inter-American Court, *Case of the Xákmok Kásek Indigenous Community v. Paraguay* (Merits, Reparations, and Costs), Judgment of 24 August 2010.

45. Ibid., §§ 231-234.

46. Inter-American Court, *Case of Suarez Peralta v. Ecuador* (Preliminary Objections, Merits, Reparations and Costs), Judgment of 21 May 2013.

47. Ibid., §§ 152 and 153.

48. Inter-American Court, *Case of Gonzales Lluy et al v. Ecuador* (Preliminary Objections, Merits, Reparations and Costs), Judgment of 1 September 2015.

49. Ibid., §§ 194 and 197.

50. Ibid., § 189.

51. Adopted in San Salvador on 17 November 1988; entered into force on 16 November 1999.

52. *Jorge Odir Miranda Cortez v. El Salvador*, cited above, § 47.

53. Concluded at Nairobi on 27 June 1981. See also Article 14 of the African Charter on the rights and welfare of the child.

protection in keeping with their physical or moral needs. Article 14(1) of the African Charter on the Rights and Welfare of the Child⁵⁴ protects the right to the enjoyment of “the highest level of physical, mental and spiritual health” and sets out a general obligation of means to implement it (“shall undertake to pursue the full implementation”) and various specific obligations of means (“shall take measures to”), including “to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care”. The African Commission on Human and Peoples’ Rights has found a violation of the right to enjoy the best attainable standard of physical and mental health on several occasions, including for failure to provide adequate medicine⁵⁵.

2. Within the European Union (§§ 20-22)

20. The scope of European Union (EU) action on health policy is set out in Article 168 of the Treaty on the Functioning of the European Union (TFEU). Health is a matter of “complementary” competence, in which the Union may “carry out actions to support, coordinate or supplement the actions of the Member States”, according to Article 2(5) TFEU. It is up to national governments to organise health care and ensure that it is provided, while the EU’s role is to complement national policies by promoting cooperation between Member States, adopting incentive measures, providing funds, and so forth.

21. The issue of health is also addressed in Article 35 of the Charter of Fundamental Rights, which guarantees the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices⁵⁶. The provision sets an aspirational goal, stating that “[a] high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”. For example, according to Article 15 of Council Directive No 2003/9/EC⁵⁷, Member States must ensure that asylum seekers receive the necessary health care, including emergency care and essential treatment of illness, and provide the necessary medical or other assistance to applicants who have special needs.

22. The EU has achieved a high degree of normative uniformity in health-care standards, especially in the field of patient safety. The main

54. Adopted by the Organisation of African Unity in 1990; entered into force in 1999.

55. *Free legal assistance Group et al v. Zaire*, Communication No. 25/89, 47/90, 56/91, 100/93. See also *SERAC and CESR v. Nigeria*, Communication No. 155/96, Fifteenth Annual Activity Report 2001-2002, annex V, and *Purohit and Moore v. the Gambia*, Communication No. 241/2001, Sixteenth Activity Report 2002-2003, annex VII.

56. McHale, “Fundamental rights and health care”, in Mossialos et al., *Health Systems Governance in Europe – The Role of European Union Law and Policy*, Cambridge: Cambridge University Press, 2010, 282-314.

57. Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers.

piece of legislation is the Council Recommendation of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections (HAI)⁵⁸. The European Parliament also adopted a Resolution in October 2013⁵⁹ calling for greater prioritisation of patient safety at EU and national level. Several guidance documents and reports to support Member States have also been produced by the European Centre for Disease Prevention and Control. In addition to these guidelines and reports which relate directly to the issues of patient safety and HAIs, the EU has also legislated in areas indirectly related to patient safety. According to Article 168(5) TFEU, the EU may adopt legislation in the field of serious cross-border health threats, excluding any harmonisation of the laws and regulations of the Member States. In this area it is worth noting the adoption by the European Parliament and the Council of Decision No 1082/2013/EU on serious cross-border threats to health⁶⁰. In the field of patient mobility inside the EU, Directive 2011/24/EU on the application of patients' rights in cross-border healthcare⁶¹ establishes the “general principle” whereby the home Member State must reimburse the costs of patients receiving cross-border health care.

3. Within the Council of Europe (§§ 23-26)

23. Article 11 of the European Social Charter (ESC) explicitly recognises the right to protection of health. States are required to take appropriate measures to remove the causes of ill-health and to provide facilities to prevent diseases. The ESC also recognises the right to social and medical assistance (Article 13).

24. The European Committee of Social Rights (ECSR) has emphasised that Article 11 of the ESC complements Articles 2 and 3 of the Convention and that the rights relating to health embodied in these provisions are inextricably linked, since “human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention of Human Rights – and health care is a prerequisite for the preservation of human

58. Council Recommendation (2009/C 151/01) of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections.

59. European Parliament resolution of 22 October 2013 on the report from the Commission to the Council on the basis of Member States' reports on the implementation of the Council Recommendation (2009/C 151/01) on patient safety, including the prevention and control of healthcare associated infections (2013/2022(INI)).

60. Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 setting up a network for the epidemiological surveillance and control of communicable diseases in the Community.

61. Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare.

dignity”⁶². The ECSR has further held that States must ensure the best possible state of health for the population according to existing knowledge and that their health care systems must respond appropriately to avoidable health risks, that is, ones that can be controlled by human action, and that they must be accessible to everyone. Furthermore, restrictions on the application of Article 11 may not be interpreted in such a way as to impede disadvantaged groups’ exercise of their right to health. The ECSR considered the conditions governing access to care taking into account Parliamentary Assembly Recommendation 1626 (2003) on “the reform of health care systems in Europe: reconciling equity, quality and efficiency”, which invited member States to take as their main criterion for judging the success of health-system reforms effective access to health care for all, without discrimination, as a basic human right. The right of access to health care requires that the cost of health care should be borne, at least in part, by the community as a whole and must not represent an excessively heavy burden for the individual. Steps must therefore be taken to reduce the financial burden on patients from the most disadvantaged sections of the community. Access to treatment must be based on transparent criteria, agreed at national level, taking into account the risk of deterioration in either clinical condition or quality of life. A derogation clause may apply, under the terms of Article F. The ECSR has found several States in breach of these obligations⁶³, including for failing to provide primary care and drugs⁶⁴.

25. Article 3 of the Oviedo Convention guarantees equitable access to health care of appropriate quality. This is an obligation of means (“shall take appropriate measures with a view to”), which takes into account health needs and available resources. The purpose of this provision, according to the Explanatory Report, is not to create an individual right on which each person may rely in legal proceedings against the State, but rather to prompt the latter to adopt the requisite measures as part of its social policy in order to ensure equitable access to health care.

62. Digest of the case-law of the European Committee of Social Rights, 2008, pp. 81-89.

63. See for example *European Roma and Travelers Forum (ERTF) v. the Czech Republic*, collective complaint No. 104/2014, on inadequate access to health care by the Roma; *Conference of European Churches (CEC) v. the Netherlands*, collective complaint No. 90/2013, 10 November 2014, on the need to provide all persons staying in the Netherlands in an irregular manner with necessary medical care; *Defence for Children International (DCI) v. Belgium*, collective complaint No. 69/2011, 23 October 2012, on ill-health among accompanied foreign minors; *European Roma Rights Centre (ERRC) v Bulgaria*, collective complaint No. 46/2007, 3 December 2008, on the problems encountered by many Roma in accessing health-care services; and *International Federation of Human Rights League (FIDH) v. France*, collective complaint no. 14/2003, 3 November 2004, on denial of immediate medical assistance to children of illegal immigrants.

64. *European Roma Rights Centre (ERRC)*, cited above, paragraph 44.

26. Finally, the “Declaration on the Promotion of Patients’ Rights in Europe” was the outcome of a consultation meeting with experts held in Amsterdam in 1994 under the auspices of the WHO’s Regional Office for Europe. It is the first comprehensive international legal instrument dealing with patients’ rights. The Declaration provides a picture of the different rights enjoyed by patients, namely the right to information, to consent, to confidentiality and privacy, to care and treatment, to lodge complaints and to compensation, that is, the ability to be compensated for harm caused by treatment. Having remarked that vulnerable and marginalised groups in societies tend to bear an undue proportion of health problems, the WHO enlarged the AAAQ principles in order to include the principle of accountability, according to which States and other duty-bearers are answerable for the observance of human rights, and the principle of universality, according to which human rights, including the right to health care, are universal and inalienable⁶⁵.

C. Preliminary conclusion (§§ 27-28)

27. In view of the wide, and in some cases universal, ratification of the international instruments mentioned above, as well as the consolidation of an immense array of both supporting and developing soft-law instruments during the last sixty years, which highlights the existence of a consistent *opinio iuris*, it can be said that the right to health care has gained the status of a customary international norm⁶⁶. This norm also corresponds to a growing body of constitutional law⁶⁷. As it emerges from international and constitutional law, the right to health care has a core which encompasses the right of access to adequate health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups, and to urgent and primary medical treatment and essential drugs. Such was also the initial perspective of the CESCR in 1993, which confined the core-obligations concept to primary health care⁶⁸. Article 24 of the

65. WHO, Health and human rights, Fact sheet No. 323, December 2015. See also Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, Open Society Institute, Public Health Programme, University of Essex, Human Rights Centre, 2008.

66. Riedel, “The Human Right to Health”, cited above, 32.

67. Among those arguing that there is growing recognition of a right to health in constitutional law, see den Exter, “The right to health care under European law”, *Diametros* 51 (2017): 173–195; Saul et al., *The International Covenant on Economic, Social and Cultural Rights: Commentary, Cases and Materials*, cited above, 1061-1070; Tobin, cited above, 202-208; Perchudoff, *Health, Essential Medicines, Human Rights & National Constitutions*, cited above; and Kinney and Clark, “Provisions for Health and Health Care in the Constitutions of the Countries of the World”, 37 *Cornell International Law Journal* (2004), 285-305.

68. CESCR, General Comment No. 3, The Nature of States Parties’ Obligations (Art. 2, par. 1 of the Covenant) UN Doc. E/1991/23, 1990, paragraph 10, and CESCR, An

universally ratified CRC confirmed that understanding, in so far as it required the protection of primary health care for children⁶⁹. There is no reason to distinguish adults from children, since “the rights to life and humane treatment are directly and immediately linked to health care”⁷⁰.

28. The core of the right is not subject to the progressive realisation clause or to resource limitations. Hence, it constitutes a binding, universal State obligation of result. This means three things. Firstly, any violation of core obligations can be established and censured by the courts. Secondly, all States are bound to provide such health care, regardless of whether or not they have ratified the international instruments and whether they are the addressees of the soft-law instruments mentioned above. Thirdly, all States have to provide such health care to everyone, irrespective of the nationality of the person in need. In this context, it is pertinent to recall the interdependence and indivisibility that exist between civil and political rights and economic, social and cultural rights, because they should be understood as a whole as human rights, without any order of precedence, and as being enforceable in both cases by the competent authorities⁷¹.

III. The right to health care under the Convention (§§ 29-59)

A. The right of specific groups (§§ 29-43)

1. Detainees and servicemen (§§ 29-38)

29. The right to health care is not as such among the rights guaranteed under the Convention or its Protocols⁷². It is however an implied right that emerges from several Articles. The first sentence of Article 2 enjoins the State to refrain from the intentional and unlawful taking of life and to take appropriate steps to safeguard the lives of those within its jurisdiction⁷³. Nonetheless, the Court has considered that the positive obligation to “take

evaluation of the Obligation to Take Steps to the “Maximum of Available Resources” under an Optional Protocol to the Covenant, 10 May 2007, UN Doc. E/C.12/2007/1, paragraph 6. But I do not share the view that this core obligation should be confined to a weak, rebuttable presumption, dependent on State discretion over scarce resources.

69. See, for example, the CRC Report on Belarus, CRC/C/15/Add.17, paragraph 14.

70. *Case of Albán Cornejo et al. v. Ecuador*, cited above, § 117; *Case of Suárez Peralta v. Ecuador*, cited above, § 130; and *Case of Llyu et al. v. Ecuador*, cited above, § 171.

71. *Airey v. Ireland*, 9 October 1979, § 26, Series A no. 32; *Case of Acevedo Buendía et al. (“Discharged and Retired Employees of the Comptroller’s Office”) v. Peru* (Preliminary objection, Merits, Reparations and Costs), Judgment of July 1, 2009, Series C No. 198, § 101; *Case of Suárez Peralta v. Ecuador*, cited above, § 131; *Case of Llyu et al. v. Ecuador*, cited above, § 172; and CESCR, General comment No. 9: The domestic application of the Covenant, E/C.12/1998/24, 3 December 1998, paragraph 10.

72. *Vasileva v. Bulgaria*, no. 23796/10, § 63, 17 March 2016 and the cases cited therein.

73. *L.C.B. v. the United Kingdom*, 9 June 1998, § 36, *Reports of Judgments and Decisions* 1998-III, and *Jasińska v. Poland*, no. 28326/05, § 57, 1 June 2010.

appropriate steps” to protect life must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake, including in the public-health sphere⁷⁴. In this context, the Court has been confronted with a rich plethora of health-related issues under Articles 2, 3 and 8 of the Convention. The first cases related to the health situation of detainees.

30. The Court has held, unequivocally, that the national authorities have an obligation to protect the health and well-being of persons who have been deprived of their liberty⁷⁵. The obligation to protect the life of individuals in custody also implies an obligation for the authorities to provide them with the medical care necessary to safeguard their life⁷⁶. When establishing these obligations, and in a spirit of coherence with the standards set by other Council of Europe bodies and organs, the Court refers frequently to soft-law materials which enshrine a right to health care in prison⁷⁷, as well as to the work of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health⁷⁸ and the WHO Guidelines on public health⁷⁹.

31. In the light of these soft-law sources the Court has held that a lack of appropriate medical care may thus amount to treatment contrary to Article 3 of the Convention⁸⁰. The Court considers that the “adequacy” of medical assistance remains the most difficult element to determine. When assessing it, the Court considers that medical assistance is not automatically found to be adequate any time a detainee is seen by a doctor and prescribed a certain form of treatment⁸¹. The authorities must also keep a comprehensive record

74. *Vo v. France* [GC], no. 53924/00, § 89, ECHR 2004-VIII, and *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], no. 47848/08, § 130, ECHR 2014.

75. *Kalashnikov v. Russia*, no. 47095/99, §§ 95 and 100, ECHR 2002-VI; *Khudobin v. Russia*, no. 59696/00, § 96, ECHR 2006-XII (extracts); *Naumenko v. Ukraine*, no. 42023/98, § 112, 10 February 2004; *Dzieciak v. Poland*, no. 77766/01, § 91, 9 December 2008; and *Karpylenko v. Ukraine*, no. 15509/12, § 79, 11 February 2016.

76. *Tais v. France*, no. 39922/03, § 98, 1 June 2006; *Huyllu v. Turkey*, no. 52955/99, § 58, 16 November 2006; and *Jasinskis v. Latvia*, no. 45744/08, § 60, 21 December 2010.

77. For example, Recommendation No. R (98) 7 of the Committee of Ministers of the Council of Europe to the member States concerning the ethical and organisational aspects of health care in prison, and Recommendation Rec(2006)2 of the Committee of Ministers to member States on the European Prison Rules. Noting the “importance” of these recommendations, see for example *Murray v. the Netherlands* [GC], no. 10511/10, § 66, ECHR 2016, and *Slawomir Musiał v. Poland*, no. 28300/06, §§ 62, 63, and 96, 20 January 2009.

78. *Hiller v. Austria*, no. 1967/14, § 37, 22 November 2016.

79. *Kozhokar v. Russia*, no. 33099/08, §§ 77-79 and 108, 16 December 2010, and *Fedosejevs v. Latvia* (dec.), no. 37546/06, §§ 60-61 and 73-75, 19 November 2013.

80. *Hummatov v. Azerbaijan*, nos. 9852/03 and 13413/04, 29 November 2007; *Ukhan v. Ukraine*, no. 30628/02, 18 December 2008; *Petukhov v. Ukraine*, no. 43374/02, 21 October 2010; and *Sergey Antonov v. Ukraine*, no. 40512/13, §§ 72-74, 22 October 2015.

concerning the detainee’s state of health and the treatment he or she undergoes while in detention⁸², and ensure that diagnosis and care are delivered promptly and accurately⁸³ and that supervision is regular, systematic and involves a comprehensive treatment strategy, where such a strategy is necessitated by the nature of a medical condition⁸⁴. The authorities must also show that the necessary conditions were created for the prescribed treatment to be actually followed through⁸⁵. At the same time the State’s obligation to cure a seriously ill detainee is one as to means, not as to result (due diligence test)⁸⁶. For example, in *Mustafayev*⁸⁷, the Court criticised the delay in the treatment of a critically ill detainee. With regard to the Government’s assertion that there was no link between the death of the applicant’s son and his belated transfer to hospital, the Court most notably replied that the object of its examination was solely “whether or not the domestic authorities fulfilled their duty to safeguard the life of the applicant’s son by providing him with proper medical treatment in a timely manner”⁸⁸.

Although the Court has held that medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the State authorities have committed themselves to providing to the population as a whole, this does not, however, mean that every detainee must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities⁸⁹. The Court has been “prepared to accept that in principle the resources of medical facilities within the penitentiary system are limited compared to those of civil[ian] clinics”⁹⁰.

32. The quality of medical assistance is called into question when necessary medicines are unavailable, especially if such a shortage has a direct and harmful impact on the applicant’s state of health⁹¹. For example,

81. *Hummatov*, cited above, § 116.

82. *Khudobin*, cited above, § 83.

83. *Melnik v. Ukraine*, no. 72286/01, §§ 104-106, 28 March 2006, and *Hummatov*, cited above, § 115.

84. *Popov v. Russia*, no. 26853/04, § 211, 13 July 2006, and *Hummatov*, cited above, §§ 109 and 114.

85. *Holomiov v. Moldova*, no. 30649/05, § 117, 7 November 2006, and *Hummatov*, cited above, § 116.

86. *Goginashvili v. Georgia*, no. 47729/08, § 71, 4 October 2011, and *Jashi v. Georgia*, no. 10799/06, 8 January 2013.

87. *Mustafayev v. Azerbaijan*, no. 47095/09, 4 May 2017. The situation was compared to *Anguelova v. Bulgaria*, no. 38361/97, §§ 127-130, ECHR 2002-IV; *Tais*, cited above, §§ 99-102; *Huyllu*, cited above, §§ 61-68; and *Jasinskis*, cited above, §§ 62-67.

88. *Ibid.*, § 65.

89. *Mirilashvili v. Russia* (dec.), no. 6293/04, 10 July 2007, and *Blokhin v. Russia* [GC], no. 47152/06, § 137, ECHR 2016.

90. *Grishin v. Russia*, no. 30983/02, § 76, 15 November 2007.

in *Makharadze and Sikharulidze*⁹², the Court considered that “the State failed to ensure timely access to the relevant susceptibility laboratory tests, which were indispensable for early and accurate diagnosis and planning of a drug regimen necessary for effective treatment of the applicant’s type of mycobacterium”.

33. At this juncture it is important to note that, under Rule 39 of the Rules of Court, the Court has previously ordered that an applicant who was staying in the new prison hospital be placed in a specialised medical establishment capable of dispensing appropriate anti-tuberculosis treatment. The Court has found that, when a detainee’s health condition is critical, there may be a direct requirement under the Convention to have recourse to a specialised medical facility in the civil sector if no comparable medical assistance is available in the penitentiary sector⁹³. Most notably, the Court has previously indicated, under Article 46 of the Convention, that the State had an obligation to admit a patient to a specialised medical facility where he would remain under constant medical supervision and would be provided with adequate medical services corresponding to his needs⁹⁴, to provide free and full medical cover to an applicant during his lifetime⁹⁵, and to take the necessary measures as a matter of urgency in order to secure appropriate conditions of detention and adequate medical treatment, in particular, for prisoners, like the applicant, in need of special care owing to their state of health⁹⁶.

34. Moreover, the Court has held that the State authorities must account for the treatment of persons deprived of their liberty. A sharp deterioration in a person’s state of health in detention facilities inevitably raises serious doubts as to the adequacy of medical treatment there⁹⁷. Thus, “where a detainee dies as a result of a health problem, the State must offer an explanation as to the cause of death and the treatment administered to the person concerned prior to his or her death”⁹⁸. If the applicant’s medical file for the relevant period of time does not contain any records, the Government will be found to have failed in discharging their burden of

91. *Makharadze and Sikharulidze v. Georgia*, no. 35254/07, § 80, 22 November 2011; *Pitalev v. Russia*, no. 34393/03, § 57, 30 July 2009; and *Mirilashvili*, cited above.

92. *Makharadze and Sikharulidze*, cited above, § 90.

93. *Aleksanyan v. Russia*, no. 46468/06, §§ 155-157, 22 December 2008, and *Akhmetov v. Russia*, no. 37463/04, § 81, 1 April 2010.

94. *Amirov v. Russia*, no. 51857/13, § 118, 27 November 2014.

95. *Oyal v. Turkey*, no. 4864/05, 23 March 2010.

96. *Dybeku v. Albania*, no. 41153/06, § 64, 18 December 2007.

97. *Farbtuhs v. Latvia*, no. 4672/02, § 57, 2 December 2004, and *Khudobin*, cited above, § 84.

98. *Kats and Others v. Ukraine*, no. 29971/04, § 104, 18 December 2008.

proof concerning the availability of adequate medical supervision and treatment for the applicant in prison⁹⁹.

35. On the other hand, the Court has held that “Article 3 cannot be interpreted as requiring a prisoner’s every wish and preference regarding medical treatment to be accommodated”¹⁰⁰. Accordingly, the State may not be held responsible for delays caused by the applicant’s own refusals to undergo medical examinations or accept treatment, where the materials available to the Court show that qualified medical assistance was made available to the applicant but that he or she voluntarily refused it¹⁰¹.

36. Finally, Article 3 of the Convention cannot be construed as laying down a general obligation to release detainees on health grounds. Rather, the compatibility of a detainee’s state of health with his or her continued detention, even if he or she is seriously ill, is contingent on the State’s ability to provide relevant treatment of the requisite quality in prison¹⁰². When the prison authority is able to cope with the detained person’s health problems by having him treated in a prison hospital and providing medical supervision of a regular and systematic nature and a truly comprehensive therapeutic strategy, the issue of release is redundant¹⁰³. That was not the case in *Kats and Others*¹⁰⁴, where the prison authorities refused “basic” medical treatment to a detainee suffering from various chronic illnesses and also delayed the release of the detainee.

37. State authorities that decide to place a person with disabilities in detention should demonstrate special care in guaranteeing conditions that account for the special needs resulting from the detainee’s disability¹⁰⁵. The same applies to persons who are placed involuntarily in psychiatric institutions. In the case of mentally ill patients, consideration must be given to their particular vulnerability¹⁰⁶. For example, in *Slawomir Musiał*, the Court found that “the failure of the authorities to hold the applicant ... in a suitable psychiatric hospital or a detention facility with a specialised psychiatric ward has unnecessarily exposed him to a risk to his health”¹⁰⁷.

99. *Malenko v. Ukraine*, no. 18660/03, §§ 55-58, 19 February 2009; *Ashot Harutyunyan v. Armenia*, no. 34334/04, § 112, 15 June 2010; *Irakli Mindadze v. Georgia*, no. 17012/09, § 47, 11 December 2012; and, *a contrario*, *Goginashvili*, cited above, § 72.

100. *Mathew v. the Netherlands*, no. 24919/03, § 186, ECHR 2005-IX.

101. *Knyazev v. Russia*, no. 25948/05, § 103, 8 November 2007.

102. *Rozhkov v. Russia*, no. 64140/00, § 104, 19 July 2007.

103. Compare with *Sarban v. Moldova*, no. 3456/05, § 79, 4 October 2005, and *Popov*, cited above, § 211.

104. *Kats and Others*, cited above, § 104.

105. *Jasinskis*, cited above, § 59; *Price v. the United Kingdom*, no. 33394/96, § 30, ECHR 2001-VII; *Farbuhs*, cited above, § 56; and the international law sources mentioned in paragraphs 39 to 41 above.

106. See, *mutatis mutandis*, *Keenan v. the United Kingdom*, no. 27229/95, § 111, ECHR 2001-III; *Rivière v. France*, no. 33834/03, § 63, 11 July 2006; and *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, § 131.

107. *Slawomir Musiał*, cited above, § 96.

38. Noting the salient parallels between the situation of persons in custody and conscripts doing their compulsory military service, the Court has held that conscripts are also entirely in the hands of the State and that the Contracting Parties bear the burden of providing a plausible explanation for any injuries and deaths that may occur in the armed forces¹⁰⁸ and showing that they complied with their positive obligation to provide the conscript with prompt and adequate medical treatment for his health problem¹⁰⁹. In *Metin Gültekin and Others*¹¹⁰, the Court concluded that the respondent Government had not satisfactorily discharged this burden. Since the military authorities were given ample indications that the conscript might have contracted hepatitis, they knew or ought to have known of the real risks to his life. When the conscript's condition deteriorated and his symptoms became impossible to misinterpret or ignore, a military doctor at the regiment's infirmary referred him to hospital with suspected hepatitis. Nevertheless, that decision was also not acted upon until the following day. A violation of Article 2 was found on account of the Government's failure to comply with their positive obligation to protect Toğay Gültekin's right to life.

2. Children and persons with disabilities (§§ 39-41)

39. According to the judgment in *İlbeyi Kemaloğlu and Meriye Kemaloğlu*¹¹¹, it is incumbent on teachers to protect the health and well-being of pupils, in particular young children who are especially vulnerable and are under their exclusive control. Hence, the State was found to be responsible for the death of a seven-year boy when he was trying to return home alone after the early dismissal of classes due to bad weather conditions. This obligation is no less binding when the child's conduct is highly imprudent, as in the case of *Iliya Petrov*¹¹². In spite of the child's adventurous conduct playing with an electric transformer, the Court criticised the State for not putting in place a system to monitor the correct application of security rules in the operation of an electricity sub-station placed in a children's playground in the vicinity of a residential neighbourhood, which caused the child's electrocution¹¹³. In *Oruk*¹¹⁴, the Court noted the particular vulnerability of the six children who had been killed by the explosion of ammunition near a military firing range, which they had taken to be harmless toys. Consequently, the Court found a

108. *Beker v. Turkey*, no. 27866/03, §§ 41-43, 24 March 2009.

109. *Metin Gültekin and Others v. Turkey*, no. 17081/06, § 48, 6 October 2015.

110. *Ibid.*

111. *İlbeyi Kemaloğlu and Meriye Kemaloğlu v. Turkey*, no. 19986/06, § 35, 10 April 2012.

112. *Iliya Petrov v. Bulgaria*, no. 19202/03, §§ 62 and 63, 24 April 2012.

113. But, differently, *Fedina v. Ukraine*, no. 17185/02, § 54, 2 September 2010.

114. *Oruk v. Turkey*, no. 33647/04, § 64, 4 February 2014.

substantive violation of Article 2 of the Convention, since no measures had been taken to protect the residents and especially the children living close to the firing range from the real risk posed by non-exploded ammunition, of which the military authorities had had “precise knowledge”¹¹⁵.

40. In *Cevrioğlu*¹¹⁶, the applicant’s ten-year-old son died as a result of falling into a large water-filled hole outside a private building under construction in a residential area. In spite of the absence of an imminent risk, the respondent State in the present context had a more compelling responsibility towards the members of the public who had to live with the very real dangers posed by construction work on their doorstep. The Court reiterated that its task was not to establish individual liability but rather to determine whether the State had fulfilled its obligation to protect the right to life through the adoption and effective implementation of an adequate regulatory framework, including a mechanism of inspection. In *Nencheva and Others*¹¹⁷, the Court took into consideration the fact that the children’s death in a social care home was not a sudden event, in so far as the authorities had already been aware of the appalling living conditions in the social care home and of the increase in the mortality rate in the months prior to the relevant time. In *Câmpeanu*¹¹⁸, similarly, the domestic authorities’ response to the generally difficult situation at the Poiana Mare Neuropsychiatric Hospital (“the PMH”) at the relevant time was found to be inadequate, seeing that the authorities had been fully aware of the fact that the lack of heating and appropriate food and the shortage of medical staff and medical resources, including medication, had led to an increase in the number of deaths during the winter of 2003. By deciding to place Mr Câmpeanu in the PMH, notwithstanding his several disabilities and already heightened state of vulnerability, the domestic authorities had unreasonably put his life in danger. The continuous failure of the medical staff to provide Mr Câmpeanu with appropriate care and treatment had been yet another decisive factor leading to his untimely death. By not providing the requisite standard of protection for Mr Câmpeanu’s life, the State had violated the substantive limb of Article 2.

41. The previous examples highlight the Court’s uncertain treatment of Article 2. While in some cases the Court requires the presence of causality and a subjective link between the action or omission of the State agents and the harm caused, in another set of cases the Court does not require such a connection. In some instances the Court has taken a much broader and more abstract view of the State’s responsibilities and focused primarily on general safety rules and obligations.

115. *Ibid.*, § 65 (“*connaissance précise des risques réels*”).

116. *Cevrioğlu v. Turkey*, no. 69546/12, 4 October 2016.

117. *Nencheva and Others v. Bulgaria*, no. 48609/06, 18 June 2013.

118. *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above.

3. Migrants (§§ 42-43)

42. Health-care needs have been invoked as a shield against the removal or expulsion of aliens and migrants, and the Court has rarely been sympathetic to their applications¹¹⁹. In extreme cases, the Court has admitted that these cases may engage Article 3 of the Convention¹²⁰.

43. The Court unfortunately set a very low bar in *N. v. the United Kingdom*¹²¹, a case that dealt with the expulsion of a HIV patient to Uganda, where her access to appropriate medical treatment was uncertain. In that case the Court held that the applicant's expulsion would not amount to a violation of Article 3. The reason was quite clear: placing an obligation on States to provide health care to aliens without a right to stay would put too great a budgetary burden on them and promote Europe as the sick-bay of the world. In other words, the Court was driven by the concern not to open up the floodgates to medical immigration. The same sub-standard of protection led the Court in *Bensaid*¹²² to hold that the expulsion of a person suffering from schizophrenia would not amount to a violation of either Article 3 or Article 8, despite the alleged risk of deterioration due to the lack of adequate care in the country of destination.

B. The emerging right of the general population (§§ 44-53)

1. Health-related incidents in the outside environment (§§ 44-46)

44. Breaches of the right to respect for the home are not confined to concrete or physical breaches, such as unauthorised entry into a person's home, but also include those that are not concrete or physical, such as noise, emissions, smells or other forms of interference¹²³. In the leading case of *López Ostra*¹²⁴, which concerned the pollution caused by the noise and odours generated by a waste-treatment plant, the Court held that "severe environmental pollution may affect individuals' well-being and prevent them from enjoying their homes in such a way as to affect their private and family life adversely, without, however, seriously endangering their health". This view was subsequently confirmed in *Guerra and Others*¹²⁵, where the

119. *Arcila Henao v. the Netherlands* (dec.), no. 13669/03, 24 June 2003; *Karagoz v. France* (dec.), no. 47531/99, 15 November 2001; *Ndangoya v. Sweden* (dec.), no. 17868/03, 22 June 2004; and *Salkic and Others v. Sweden* (dec.), no. 7702/04, 29 June 2004.

120. *D. v. the United Kingdom*, 2 May 1997, *Reports* 1997-III.

121. *N. v. the United Kingdom* [GC], no. 26565/05, ECHR 2008. See my separate opinion on this case-law, joined to *S.J. v. Belgium* [GC], no. 70055/10, 19 March 2015.

122. *Bensaid v. the United Kingdom*, no. 44599/98, *Reports* 2001-1.

123. *Hatton and Others v. the United Kingdom* [GC], no. 36022/97, § 96, ECHR 2003-VIII.

124. *López Ostra v. Spain*, 9 December 1994, § 51, Series A no. 303-C.

125. *Guerra and Others v. Italy*, 19 February 1998, § 57, *Reports* 1998-I.

Court observed that “[t]he direct effect of the toxic emissions on the applicants’ right to respect for their private and family life means that Article 8 is applicable”. In *Tătar*¹²⁶, the applicants – a father and his son – alleged that the son’s asthma had deteriorated because of exposure to sodium cyanide coming from a gold mine situated near their home. Although the applicants could not prove a causal link between exposure to sodium cyanide and their son’s asthma, the Court found that the national authorities had failed to assess the risks related to the company’s activity and take the necessary measures to protect people’s right to a healthy and safe environment. In *Öneryıldız*¹²⁷, the Grand Chamber consolidated the previous case-law, concluding that the positive obligation to take all appropriate steps to safeguard life for the purposes of Article 2 applied to dangerous activities, which had to be governed by rules on the licensing, setting-up, operation, security and supervision of the activity. In that case, the lack of such security rules regarding the immediate and known risk posed by household refuse tips had resulted in a fatal explosion. In addition, the Court elaborated on the appropriate general policy choice in the case at hand¹²⁸. Finally, the Court recognised that in the context of dangerous activities the scope of positive obligations under Article 2 largely overlapped with those under Article 8¹²⁹. Consequently, the principles developed in the Court’s case-law relating to planning and environmental matters affecting private life, home and health may also be relied on for the protection of the right to life.

45. After discussing cases of dangerous activities of a man-made nature¹³⁰, the Court turned to natural hazards. The judgment in *Budayeva and Others*¹³¹ marked a turning-point in the Court’s jurisprudence. In the first case of its kind, the Court was called on to assess a mudslide which had killed eight people, including the first applicant’s husband, and the lack of State action in the face of an imminent natural hazard which had been clearly identifiable and which concerned a recurring calamity affecting an area developed for human habitation or use. The Court found that there was a causal link between the serious administrative flaws that had impeded the implementation of land-planning and emergency relief policies, and the death of Vladimir Budayev and the injuries sustained by the first and second applicants and the members of their family. Similarly, in *Kolyadenko and Others*¹³², the applicants complained that the authorities had put their lives

126. *Tătar v. Romania*, no. 67021/01, 27 January 2009.

127. *Öneryıldız v. Turkey* [GC], no. 48939/99, § 93, ECHR 2004-XII.

128. *Ibid.*, § 107.

129. *Ibid.*, §§ 90 and 160. See also *Giacomelli v. Italy*, no. 59909/00, ECHR 2006-XII.

130. See also *Flamenbaum and Others v. France*, no. 3675/04 and 23264/04, 13 December 2012; *Deés v. Hungary*, no. 2345/06, 9 November 2010; *Grimovskaya v. Ukraine*, no. 38182/03, 21 July 2011; and *Bor v. Hungary*, no. 50474/08, 18 June 2013.

131. *Budayeva and Others v. Russia*, nos. 15339/02 and 4 others, § 146, ECHR 2008 (extracts).

at risk by releasing a large amount of water, without any prior warning, from the Pionerskoye reservoir into a river which for years they had failed to maintain in a proper state of repair, causing a flash flood in the area around the reservoir where the applicants lived. The Court held that the authorities had disregarded technical and safety requirements and therefore potential risks, including risk to human lives, by failing to reflect them in legal acts and regulations and allowing urban development in the area downstream from the Pionerskoye reservoir. Since the authorities could reasonably have been expected to acknowledge the increased risk of grave consequences in the event of flooding, the Court found for the applicants. In *Georgel and Georgeta Stoicescu*¹³³, the Court embarked on a direct critique of the lack of general and preventive measures in order to protect public health from the attacks of stray dogs on the streets of Bucharest, regardless of the fact that the authorities had had no knowledge of a real, immediate and individual risk to the applicant.

46. As these previous examples suggest, the Court has been willing to find violations of Articles 2 and 8 of the Convention when an authority's action or inaction has created or allowed the creation of an unsafe environment that has subsequently caused harm to an individual's life or health, and also when no such causal link could be established. The objective situation of risk to life and health may be imminent or not. The Court's requirement as regards the authority's knowledge of the danger also varies widely, ranging from direct knowledge of the risk to a mere assumption of that same knowledge.

2. Health-related incidents in the workplace (§§ 47-48)

47. The Court has asserted that the Contracting Parties have due diligence obligations to ensure that individuals' health is not put at risk by the State during their employment. It has further held that a State has a positive obligation to safeguard the life and health of its citizens, and also to provide adequate information and warning about dangers associated with their employment. The Court has, however, failed to provide a coherent approach to causality and the subjective link between the authorities' conduct and the harm to life and health, assessing sometimes both requirements, or at least one of them, and sometimes neither.

In *L.C.B.*¹³⁴, where the applicant suffered from leukaemia allegedly resulting from her father's exposure to dangerous radiation while stationed as a serviceman on Christmas Island, the Court held that, as matter of principle, States have the obligation not only to refrain from the intentional taking of life, but also to take all appropriate steps to safeguard the lives of

132. *Kolyadenko and Others v. Russia*, nos. 17423/05 and 5 others, 28 February 2012.

133. *Georgel and Georgeta Stoicescu v. Romania*, no. 9718/03, 26 July 2011.

134. *L.C.B. v. the United Kingdom*, cited above, § 36, and *Keenan*, cited above, § 89.

those within their jurisdiction. However, the Court rejected on the facts of the case any causal link between the father’s possible radiation and the applicant’s illness. In *Roche*¹³⁵, the Court went a step further and imposed on the respondent State the obligation to provide all relevant information enabling the applicant to assess the health risks associated with his work. Since the respondent State had not established a mechanism that would have enabled the applicant to assess the health risk caused by his exposure to mustard and nerve gas during tests carried out on him in the 1960s while serving in the British army, the Court found a violation of Article 8. In *Binişan*¹³⁶, the applicant claimed that his accident had been the result of a failure on the part of the National Railway Company to take steps to ensure safe working conditions. The Court concluded, after reassessing the available evidence, that “the domestic authorities did not display due diligence in protecting the applicant’s right to life”¹³⁷. In *Brincat and Others*¹³⁸, the Court criticised the lack of legislation and other practical measures (other than distributing masks) to avoid the risk posed by exposure to asbestos in the workplace, although the medical certificates produced by the applicants did not establish a direct link between their medical complaints and the fact that they were employed in the shipbuilding or ship repair industry. Nonetheless, the Court considered as established, on the basis of its own assessment of the available scientific evidence, that the Maltese Government knew or ought to have known of the dangers arising from exposure to asbestos at least from the early 1970s onwards and that no tests had ever been carried out in the workrooms (or elsewhere) where the applicants, like the other employees, had been exposed to asbestos. In other words, the Court assumed the existence of causality on the basis of far-reaching, putative governmental knowledge of the danger.

48. Yet Article 2 of the Convention cannot be interpreted as guaranteeing to every individual an absolute level of security in any activity in which the right to life may be at stake, in particular when the person concerned bears a degree of responsibility for the accident having exposed him or her to unjustified danger¹³⁹. Hence, the negligent conduct of the victims is one important factor in the Court’s assessment of the State’s responsibility, especially when the victim faced an obvious risk which an average person would be expected to appreciate and to avoid. For example, in *Prilutskiy v. Ukraine*¹⁴⁰, the Court rejected a “paternalistic” interpretation

135. *Roche v. the United Kingdom* [GC], no. 32555/96, ECHR 2005-X.

136. *Binişan v. Romania*, no. 39438/05, 20 May 2014.

137. *Ibid.*, § 90.

138. *Brincat and Others v. Malta*, nos. 60908/11 and 4 others, 24 July 2014.

139. *Bone v. France* (dec.), no. 69869/01, 1 March 2005; *Kalender v. Turkey*, no. 4314/02, § 49, 15 December 2009; *Fedina*, cited above, § 65; and *Gökdemir v. Turkey* (dec.), no. 66309/09, 19 May 2015.

140. *Prilutskiy v. Ukraine*, no. 40429/08, § 32-35, 26 February 2015. The Court is very reluctant to criticise States under the substantive limb of Article 2 in cases involving the

of the State's positive obligations arising out of dangerous activities by invoking the notion of personal autonomy. The applicant's son took part in a privately organised driving game, during which he died. Since the danger emanating from this game was no different from an inherent danger of road traffic, no special regulation was required. The Court held that there had therefore been no violation of Article 2 in this regard. By contrast, in *Kalender v. Turkey*¹⁴¹ the negligent conduct of the victims, who had been run over by a train, was not considered as the "decisive factor" in view of the various serious shortcomings in the observance of the safety rules by the national authorities.

3. Health-related incidents in hospital or other health-service facilities (§§ 49-53)

49. Although the Court has, on occasion, established States' obligation of due diligence with regard to health-related incidents in hospitals, it has mostly relied on the procedural limb of Article 2 of the Convention and has rarely departed from the findings of the domestic courts and experts. In *Erikson*¹⁴², the Court held that Article 2 included the requirement for "hospitals to have regulations for the protection of their patients' lives and also the obligation to establish an effective judicial system for establishing the cause of a death which occurs in hospital and any liability on the part of the medical practitioners concerned"¹⁴³. While *Calvelli and Ciglio* concerned medical doctors' errors, in *Dodov* the negligent act that endangered Mrs Stoyanova's life was apparently committed by a medical orderly. The Court affirmed that the requirement to regulate the activities of public health institutions and afford remedies in cases of negligence should encompass such staff, whose acts might also put the life of patients at risk¹⁴⁴. However, where a Contracting State has made adequate provision to ensure that those requirements are met, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals are insufficient of themselves to find that a State has breached

victims of sports accidents (*Furdík v. Slovakia* (dec.), no. 42994/05, 2 December 2008; *Molie v. Romania* (dec.), no. 13754/02, 1 September 2009; *Vrábel v. Slovakia* (dec.), no. 77928/01, 19 January 2010; *Koceski v. the Former Republic of Macedonia* (dec.), no. 41107/07, 22 October 2013; and *Cavit Tınarlıoğlu v. Turkey*, no. 3648/04, §§ 104-06, 2 February 2016), of accidents on board boats (*Leray and Others v. France* (dec.), no. 44617/98, 16 January 2001) or trains (*Bone*, cited above), or of road-traffic accidents (*Zavoloka v. Latvia*, no. 58447/00, § 39, 7 July 2009).

141. *Kalender*, cited above, §§ 41 and 47.

142. *Erikson v. Italy* (dec.), no. 37900/97, 26 October 1999.

143. The *Erikson* case-law was first confirmed by *Powell v. the United Kingdom* (dec.), no. 45305/99, ECHR 2000-V, and later on by *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 48, ECHR 2002-I.

144. *Dodov v. Bulgaria*, no. 59548/00, §§ 70, 79-83 and 87, 17 January 2008.

Article 2 of the Convention¹⁴⁵. These principles are also valid for serious bodily injuries coming within the scope of application of Article 8¹⁴⁶.

50. Several applicants have suggested that under Article 2 or Article 8 of the Convention the State should pay for a particular form of treatment or type of drug because they are unable to meet the costs. Such claims have hitherto been met almost invariably with firm opposition from the Court. In *Nitecki*¹⁴⁷, the Court did not criticise the respondent State for not refunding the full price of a life-saving drug, but only 70% of its cost, in spite of the fact that the applicant could not afford the remaining 30% and consequently could not follow the prescribed pharmaceutical treatment; his medical condition (amyotrophic lateral sclerosis) deteriorated and his invalidity was assessed at the highest degree. In *Sentges*¹⁴⁸, a severely disabled person suffering from Duchenne Muscular Dystrophy, a disease that leads to progressive muscle degeneration, loss of ability to work and eventually to loss of lung and cardiac functions, was denied a robotic arm by a health insurance fund because it was not covered by any social-insurance scheme. Although it recognised the causal link, the Court rejected the Article 8 complaint on the basis of the margin of appreciation that should be accorded to States in the context of the allocation of limited State resources and the precedent that a decision in this case could have set for all Contracting Parties to the Convention. The Court emphasised that the applicant had access to basic health care and that every aspect above and beyond that basic standard fell within the State's margin of appreciation. In *Pentiacova and 48 Others*¹⁴⁹, the Court dismissed the case of several disabled applicants suffering from chronic renal failure who could not afford much-needed haemodialysis and were not provided with the necessary medication at public expense owing to budgetary constraints, because they had not adduced any evidence that their lives had been put at risk, regardless of the fact that one of the applicants had meanwhile died of this disease. In *Gheorghe*¹⁵⁰, the applicant suffered from haemophilia and could only be provided with a special coagulant, Factor VIII, free of charge in the event of a bleeding episode and in a hospital setting. Although the Court was aware of the applicant's grave and irreversible health situation and "deplored" the absence of ongoing medical treatment, it found in favour of the respondent State, since the applicant had had access to the same treatment that the Government provided to people in similar circumstances. Finally, in *Hristozov and Others*¹⁵¹, applicants suffering from different types of

145. See, in particular, *Calvelli and Ciglio*, cited above, § 49, and *Powell*, cited above.

146. *Spyra and Kranczkowski v. Poland*, no. 19764/07, § 82, 25 September 2012.

147. *Nitecki v. Poland* (dec.), no. 65653/01, 21 March 2002.

148. *Sentges v. the Netherlands* (dec.), no. 27677/02, 8 July 2003.

149. *Pentiacova and 48 Others v. Moldova* (dec.), no. 14462/03, 4 January 2005.

150. *Gheorghe v. Romania* (dec.), no. 19215/04, 22 September 2005.

151. *Hristozov and Others v. Bulgaria*, nos. 47039/11 and 358/12, ECHR 2012 (extracts).

terminal cancer claimed that, because conventional treatments did not work in their cases, domestic law should entitle them to have access to an experimental but untested product that would be provided free of charge by the company which was developing it. The Court granted a wide margin of appreciation to the Contracting States, arguing that each dealt differently with the conditions and manner in which access to unauthorised medicinal products was provided. The laudable exception to this trend is *Oyal v. Turkey*¹⁵², which acknowledged the right of access to vital, continued medication throughout his lifetime for a HIV-positive patient, as “the most appropriate remedy in the circumstances”.

51. Furthermore, in *Cyprus v. Turkey*¹⁵³, the Court considered that an issue under Article 2 may arise when the authorities of a Contracting State put an individual’s life at risk through the denial of health care which they have undertaken to make available to the population generally. The denial of urgent medical treatment was also the subject of *Mehmet Şentürk and Bekir Şentürk*¹⁵⁴, where the doctors caused their patient’s death by having her transferred without treatment and failed in their duties in that they had concerned themselves with payment of the fees for medical care. The Court considered that the patient’s decision to decline emergency medical treatment, which was subordinated to a prior financial obligation, could not in any way be considered as having been made in an informed manner or as being such as to exonerate the national bodies from their responsibility with regard to the treatment which ought to have been provided. The Court noted that the medical staff had been “perfectly aware” of the risk to the patient’s health were she to be transferred to another hospital¹⁵⁵. In addition, the domestic law did not have provisions capable of preventing the failure in this case to provide the medical treatment required by the deceased patient’s condition.

52. In *Asiye Genç v. Turkey*¹⁵⁶, the Court went so far as to assess the general health policy of the respondent State, by censuring the unsatisfactory quantity and condition of the neo-natal intensive care equipment, namely incubators, in the region’s hospitals, which showed that “the State had not taken sufficient care to ensure the smooth organisation and correct functioning of the public hospital service, and more generally of its system for health protection, and that the lack of places was not linked solely to an unforeseeable shortage of places arising from the rapid arrival of patients”. The Court thus found that, as a result of the lack of access to functioning incubators, a premature baby with a life-threatening condition had made several futile return trips in an ambulance pending any

152. *Oyal*, cited above.

153. *Cyprus v. Turkey* [GC], no. 25781/94, ECHR 2001-IV.

154. *Mehmet Şentürk and Bekir Şentürk v. Turkey*, no. 13423/09, ECHR 2013.

155. *Ibid.*, § 96.

156. *Asiye Genç v. Turkey*, no. 24109/07, 27 January 2015.

appropriate treatment or an examination and was ultimately deprived of any access to appropriate emergency care. In other words, the Court considered that such a situation was “analogous to a denial of medical care such as to put a person’s life in danger”¹⁵⁷, accepting that Article 2 gives rise to requirements as to the availability of a particular type of neo-natal intensive care equipment, namely incubators.

53. In *Aydoğdu*¹⁵⁸, the Court drew an analogy between the circumstances of the applicants’ baby’s stay in the Atatürk Hospital and circumstances in which an individual’s life is at risk from the criminal acts of another individual¹⁵⁹, by referring to the *Osman* test¹⁶⁰. Besides the negligence and lack of coordination of the doctors in charge, the Court established the existence of structural deficiencies, namely the chronic and known lack of appropriate neo-natal services and technical resources, and a causal link between these deficiencies and the death of the baby. Adapting the language of the *Osman* test to the case, the Court stated that it was required to determine whether the domestic authorities had done what could reasonably be expected of them to protect the baby’s life from a “real” risk (“*menacée de manière réelle*”) of which the Government could not have been unaware¹⁶¹, and not to show that the baby concerned would not have died if medical treatment had been provided¹⁶². On the basis of an argument drawn, *mutatis mutandis*, from *Nencheva and Others* (cited above, § 108), the Court further considered that the Government had not demonstrated that taking measures to avoid that risk would have represented an unbearable or excessive burden with regard to the operational choices to be made in terms of priorities and resources, thus assuming a power of review over economic and managerial measures. In a linguistically tortuous fashion, the Court concluded that the combined effect of the negligent conduct of the doctors in charge and the systemic shortcomings had led to the exclusion of the patient from access to “adequate” urgent treatment (“*soins urgents adéquats*”), a situation which was akin (“*ce qui s’apparente*”) to a denial of treatment capable of putting the life of the baby at risk¹⁶³. By so doing, the Court assimilated, as a matter of law, negligent malpractice (inadequate treatment) and denial of treatment.

157. *Ibid.*, § 82. Hence, paragraph 181 of the present judgment is not correct, because the Court never said that there “had been a refusal”.

158. *Aydoğdu v. Turkey*, no. 40448/06, 30 August 2016.

159. *Aydoğdu*, cited above, § 87.

160. *Osman v the United Kingdom*, 28 October 1998, § 115, *Reports* 1998-VIII.

161. *Mehmet Şentürk and Bekir Şentürk*, cited above, § 89; *Asiye Genç*, cited above, § 75; and *Aydoğdu*, cited above, § 77. Note that these cases extend the notion of risk to life to include risk to physical integrity.

162. *Mehmet Şentürk and Bekir Şentürk*, cited above, § 96, and *Aydoğdu*, cited above, § 83.

163. *Aydoğdu*, cited above, § 88.

Finally, in *Elena Cojocaru*¹⁶⁴, the Court concluded that the apparent lack of coordination of the medical services and the delay in administering the “appropriate” emergency treatment attested to a dysfunctionality of the public hospital services, although no real systemic or structural deficiencies were detected¹⁶⁵. The grave breach of *legis artis* by the practitioner, which had caused the death of the applicant’s pregnant daughter and her granddaughter, was the ground for the international-law responsibility of the respondent State.

C. Preliminary conclusion (§§ 54-59)

54. In its case-law, the Court sets very different health-care standards for different groups of the population. Detainees and servicemen hold a privileged status before the Court, often benefiting from a higher standard of protection than the general population. The justification given is that the members of these groups are in a “vulnerable position”¹⁶⁶. Since the required treatments and services for detained persons include the provision of essential drugs and primary health care¹⁶⁷, dentures¹⁶⁸, orthopaedic footwear¹⁶⁹, glasses¹⁷⁰, medication for chronic back pain¹⁷¹, care by qualified staff¹⁷², examination by specialists and follow-up care independent of the initiative being taken by the patient¹⁷³, it can be concluded that the minimum existential health care afforded to detainees is much higher than that afforded to the common man on the street¹⁷⁴. Furthermore, delays in diagnosis¹⁷⁵ or in necessary treatment¹⁷⁶, and the abrupt withdrawal of treatment¹⁷⁷, have been considered as Convention violations.

Outside of prisons and army barracks, only two groups benefit from the Court’s heightened protection: children and persons with disabilities. These

164. *Elena Cojocaru v. Romania*, no. 74114/12, 22 March 2016.

165. *Ibid.*, § 111.

166. *Salman v. Turkey* [GC], no. 21986/93, § 99, ECHR 2000-VII, and *Metin Gültekin and Others*, cited above, §§ 32 and 34.

167. *Tarariyeva v. Russia*, no. 4353/03, § 87, ECHR 2006-XV (extracts); *Dzieciak*, cited above, § 101; *Pitalev*, cited above, § 57; and *Mirilashvili v. Russia* (dec.), no. 6293/04, 10 July 2007.

168. *V.D. v. Romania*, no. 7078/02, §§ 97 and 98, 16 February 2010.

169. *Vladimir Vasilyev v. Russia*, no. 28370/05, §§ 68-70, 10 January 2012.

170. *Slyusarev v. Russia*, no. 60333/00, §§ 43 and 44, 20 April 2010.

171. *Kupczak v. Poland*, no. 2627/09, § 68, 25 January 2011.

172. *Farbtuhs*, cited above, § 60, and *Semikhvostov v. Russia*, no. 2689/12, 6 February 2014.

173. *Tarariyeva*, cited above, § 80.

174. But it does not include access to needle-exchange programmes, according to *Shelley v. the United Kingdom*, no. 23800/06, 4 January 2008.

175. *Vasyukov v. Russia*, no. 2974/05, §§ 75 and 76, 5 April 2011.

176. *Dzieciak*, cited above, §§ 94 and 101, and *Tarariyeva*, cited above, §§ 88 and 89.

177. *Paladi v. Moldova* [GC], no. 39806/05, § 68, 10 March 2009.

two groups, however, benefit from a lesser degree of protection than detainees and servicemen, since access to essential medicine and primary health care is not guaranteed to them. The health-care needs of migrants have been even more neglected by the Court, as is evident in the regrettable ruling in *N. v. the United Kingdom*, since this group has been accorded a worse, sub-standard level of protection.

55. The assessment of the evidence in cases involving health care also varies widely. Normally, in medical malpractice cases or cases concerning health-related incidents in hospitals and other health services, the Court does not dispute the findings of the national courts regarding the chain of events, the causal link between the conduct of the competent medical authority and the death or serious injury sustained by the victim, and the degree of knowledge of the competent medical authorities, and finds the national remedies sufficient¹⁷⁸. Only rarely has the Court departed from the findings of the domestic experts, as in *Elena Cojocaru*, or found that the national remedies were not sufficient, as in *Oyal*¹⁷⁹. Yet with other types of health-related incidents the Court does not refrain from challenging and re-establishing the facts laid out by the national courts. In some cases the Court has gone so far as to assess the available items of evidence, including scientific and medical evidence, and to replace the national courts' views with its own. Seemingly paradoxically, the scientific complexity of the evidence is sometimes an argument for restraint on the part of the Court, which on other occasions is swift to enter disputes on scientific facts and causation, as in *Makharadze and Sikharulidze*¹⁸⁰, *Tătar*¹⁸¹, and *Brincat and Others*¹⁸². Notably, the Court has even extended its competence in the field of causation by stating that the sphere of application of Article 2 cannot be interpreted as being limited to the time and direct cause of the individual's death, since the previous chain of events may also trigger international-law responsibility¹⁸³, and by determining what was or was not the "decisive factor" in the chain of events¹⁸⁴.

56. The scope of the Court's review in medical malpractice cases or cases concerning health-related incidents in hospitals and other health services is limited, since the Court confines its findings to the procedural

178. See, among many other authorities, *Eugenia Lazăr v. Romania*, no. 32146/05, 16 February 2010; *G.N. and Others v. Italy*, no. 43134/05, 1 December 2009; *De Santis and Olanda v. Italy* (dec.), no. 35887/11, 9 July 2013; *Balci v. Turkey* (dec.), no. 58194/10, 20 October 2015; and *Sayan v. Turkey*, no. 81277/12, § 112, 11 October 2016.

179. Both cited above.

180. *Makharadze and Sikharulidze*, cited above, §§ 78-81.

181. *Tătar*, cited above, §§ 104-107.

182. *Brincat and Others*, cited above, § 106. See, for other examples, *Metin Gültekin and Others*, cited above, §§ 43-45; *Cevrioğlu*, cited above, § 65; *Binişan*, cited above, §§ 80, 81, 88 and 89; and *İlbeyi Kemaloğlu and Meriye Kemaloğlu*, cited above, §§ 20, 21 and 41.

183. *Dodov*, cited above, § 70.

184. *Kalender*, cited above, §§ 43-47.

limb of Article 2 or 3 and seldom deals with the substantive limb. When it does so, the Court only assesses structural deficiencies in the medical system such as the lack of appropriate legislation or technical resources. Yet with other types of health-related incidents, the Court always assesses both limbs of the Article in question and only rarely considers the existence of structural deficiencies such as the lack of a proper legal framework¹⁸⁵. As a matter of principle, the Court has even stated, both in cases concerning health-related incidents in the free environment, as in *Öneryıldız*¹⁸⁶ and *Budayeva and Others*¹⁸⁷, and those concerning incidents in the workplace, as in *Brincat and Others*¹⁸⁸, that “the scope of the positive obligations under Article 2 of the Convention largely overlaps with that of those under Article 8”. This should also be valid for substantive positive obligations like the obligation to safeguard the health of patients in hospitals and other health services.

57. The prerequisites for State international-law responsibility in health-care cases could not be more uncertain. Situations that are not dissimilar are decided differently. Negligence, carelessness, wilful ignorance, an error of judgment on the part of a health professional, or deficient coordination among health professionals in the treatment of a detainee, as in *Tarariyeva*¹⁸⁹, or of a serviceman, as in *Metin Gültekin and Others*¹⁹⁰, 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 life¹⁹¹. This, however, is not the case with the treatment of any other citizen. Negligence, carelessness, wilful ignorance, an error of judgment on the part of a public employee, or deficient coordination among public employees in dealing with situations of risk for the general public or for a specific category of persons, are also sufficient to raise an issue under Article 2, as in *Budayeva and Others*¹⁹², but not in the case of health professionals or other medical staff.

58. Worse still, in medical malpractice cases or cases concerning health-related incidents in hospitals and other health services, the Court oscillates between the requirement for practitioners to have been “perfectly aware” of the negative consequences of their conduct, as in *Mehmet Şentürk and Bekir Şentürk*, and the classic *Osman* test, as in *Aydoğdu*, where the Court considers that it is sufficient to establish a causal link and knowledge

185. *Brincat and Others*, cited above, and *Lovyginy v. Ukraine*, no. 22323/08, 23 June 2016.

186. Cited above, §§ 90 and 160.

187. Cited above, § 133.

188. Cited above, § 85.

189. Cited above.

190. Cited above.

191. For other examples, see *Karsakova v. Russia*, no. 1157/10, 27 November 2014; *Mustafayev*, cited above; and *Kats and Others*, cited above.

192. Cited above.

or putative knowledge (“knew or ought to have known”) on the part of the competent medical authority¹⁹³. The Court’s hesitancy regarding the subjective link is compounded by an oversimplification of the various degrees of *mens rea*. Unconscious negligence, recklessness or wilful ignorance may be as grave as full awareness, depending on the circumstances. Yet with other types of health-related incidents, the Court is much less demanding. Often it explicitly disregards the causal link between the State agent’s conduct and the damage¹⁹⁴. Sometimes it pays no attention to the absence of an imminent risk, as in *Cevrioğlu* or *Georgel and Georgeta Stoicescu*¹⁹⁵. In many cases, it simply does not take into account the knowledge of the authorities in charge, omitting any explicit or implicit consideration of the *Osman* test. Despite the less demanding standard imposed by the Court with regard to these other types of health-related incidents, the Court has nevertheless been willing to find the State responsible under international law.

59. The easy argument could be made that this variety of methodological approaches is a result of the wide margin of appreciation in such a complex field of law, which is at the intersection of scientific knowledge and difficult negligence-law issues and may involve major budgetary consequences. The argument should be dismissed, because here again the case-law has proved very uneven. In assessing the margin of appreciation, State financial constraints and commitments and the possible budgetary consequences of the Convention obligations are prominent when it comes to deciding cases concerning migrants, but not in cases concerning detainees¹⁹⁶. In medical malpractice cases, like *Aydoğdu* and *Asiye Genç*, the Court accepts its jurisdiction to review the operational choices made in terms of priorities and resources, just as in cases concerning health-related incidents in the free environment, such as *Öneryıldız*, *Budayeva and Others* and *Kolyadenko and Others*¹⁹⁷. The Court also accepts its remit to review Government policy on safety conditions in the workplace, as in *Brincat and Others*¹⁹⁸. But when the issue is the provision of essential drugs to specific patients, as in *Sentges*¹⁹⁹, the Court is no longer ready to exercise the same competence, invoking a wide margin of appreciation. The principle of effectiveness (*effet utile*) of human rights protection, which in *Georgel and Georgeta Stoicescu*²⁰⁰, and so many other cases concerning health-related incidents in

193. All cited above.

194. For example, *Arskaya v. Ukraine*, no. 45076/05, § 90, 5 December 2013; *Metin Gültekin and Others*, cited above, § 36; *Mustafayev*, cited above, § 65; *Salakhov and Islyamova v. Ukraine*, no. 28005/08, §§ 167 and 181, 14 March 2013; *Tătar*, cited above, §§ 96 and 97, and *Brincat and Others*, cited above, §§ 109-117.

195. Both cited above.

196. *Poltoratskiy v. Ukraine*, no. 38812/97, § 148, 29 April 2003.

197. All cited above.

198. Cited above.

199. Cited above.

the free environment and in the workplace, limited the margin of appreciation, is suddenly forgotten. How can the Court criticise the national authorities for lacking costly functioning incubators, anti-pollution policy, land-planning policy, flood-protection policy, work safety policy or even a stray dog control policy, and at the same time tolerate the refusal of life-saving drugs? In order to avoid leaving the impression that it whimsically solves some problems while evading others, the Court should be prepared to consistently resolve legal dilemmas both at the macro level, with respect to the allocation of scarce resources between health and other legitimate sectors within the State, and at the micro level, with respect to the realisation of the competing health-care claims of individuals, on the basis of a *pro persona* approach to the right to health care. This calls for a principled, purposive (*effet utile*) interpretation of the Convention, to which the considerations set out below will be dedicated.

Second part – Taking the right to health care seriously (§§ 60-91)

IV. Conceptualising a *pro persona* approach to the right to health care under the Convention (§§ 60-72)

A. The substantive obligations (§§ 60-66)

1. The obligation to respect (§§ 60-61)

60. Health care is, first and foremost, an issue of personal autonomy²⁰¹. In principle, each individual should be free from any sort of imposed health care. The State therefore has an obligation to respect and not to interfere with the health-care choices of individuals. Consequently, the State must look for free and informed consent whenever an interference with a patient's physical integrity is needed, and require and guarantee such consent when the interference occurs in the private sector²⁰². Thus, the lack of appropriate rules for establishing patients' decision-making capacity, including their informed consent to treatment, constitutes a violation of Article 2 of the Convention²⁰³.

200. Cited above.

201. *Jehovah's Witnesses of Moscow and Others v. Russia*, no. 302/02, § 136, 10 June 2010, and the cases cited in paragraph 48 of this opinion.

202. See Article 5 of the Oviedo Convention and its explanatory report, and the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/64/272, 10 August 2009, on guaranteeing informed consent as fundamental to achieving the enjoyment of the right to health.

203. *Arskaya*, cited above, § 90.

61. Hence, informed consent and, in its absence, medical necessity are the cornerstones of any interference with the health of a patient²⁰⁴. This in principle proscribes the forced administration of medicine²⁰⁵, force-feeding²⁰⁶, forced administration of emetics²⁰⁷, forced surgery²⁰⁸, forced blood tests and photographs²⁰⁹, forced sterilisation²¹⁰, forced presence of medical students during medical acts²¹¹ and continued storage or implantation of embryos against the will of one of the donors²¹². In this context, it is worth mentioning the tension between the Court's acknowledgment of the "principle of sanctity of life" on the one hand and its growing openness to "quality of life" demands on the other²¹³. This tension has led the Court to state that an "undignified and distressing end to life" constitutes an interference with the right to respect for private life as guaranteed under Article 8 § 1 of the Convention²¹⁴, and to enshrine in the latter a so-called "right to decide in which way and at which time his or her life should end, provided that he or she was in a position freely to form her own will and to act accordingly"²¹⁵. In *Lambert and Others*, the Court revised the formulation, finding that this was true "even where the patient is unable to express his or her wishes"²¹⁶. In spite of the lack of consensus among the Council of Europe member States in favour of permitting the withdrawal of artificial life-sustaining treatment, the Court nevertheless considered, on the basis of unpublished comparative-law materials, that there was consensus as to the paramount importance of the patient's wishes in the decision-making process, however those wishes were expressed. Hence, the Court accepted that, in the absence of advance directives or of a

204. *Trocellier v. France* (dec.), no. 75725/01, 5 October 2006; *Codarcea v. Romania*, no. 31675/04, 2 June 2009; and *Csoma v. Romania*, no. 8759/05, 15 January 2013.

205. *Glass v. the United Kingdom*, no. 61827/00, ECHR 2004-II.

206. *Nevmerzhitsky v. Ukraine*, no. 54825/00, ECHR 2005-II (extracts); *Ciorap v. Moldova*, no. 12066/02, 19 June 2007; and *Rappaz v. Switzerland* (dec.), no. 73175/10, 26 March 2013.

207. *Jalloh v. Germany* [GC], no. 54810/00, ECHR 2006-IX.

208. *Bugomil v. Portugal*, no. 35228/03, 7 October 2008.

209. *M.A.K. and R.K. v. the United Kingdom*, nos. 45901/05 and 40146/06, 23 March 2010.

210. *V.C. v. Slovakia*, no. 18968/07, ECHR 2011 (extracts).

211. *Konovalova v. Russia*, no. 37873/04, 9 October 2014.

212. *Evans v. the United Kingdom* [GC], no. 6339/05, ECHR 2007-I.

213. *Pretty v. the United Kingdom*, no. 2346/02, § 65, ECHR 2002-III; *Koch v. Germany*, no. 497/09, § 51, 19 July 2012; *Arskaya*, cited above, § 69; and *Lambert and Others v. France* [GC], no. 46043/14, § 142, ECHR 2015 (extracts).

214. *Pretty*, cited above, § 67; *Haas v. Switzerland*, no. 31322/07, § 50, ECHR 2011; and *Lambert and Others*, cited above, § 180. Note the evolution of the language: in *Pretty*, the Court was "not prepared to exclude", but in *Haas* it was ready to include such a right under the aegis of Article 8.

215. *Haas*, cited above, § 51, and *Koch*, cited above, § 52.

216. *Lambert and Others*, cited above, § 178.

“living will”, the patient’s presumed wishes could be ascertained by a variety of means, including one or more testimonies²¹⁷.

2. The obligation to safeguard (§§ 62-66)

62. The State duty to take appropriate steps to safeguard the lives of those within its jurisdiction also extends in appropriate circumstances to a positive obligation to take preventive operational measures to protect an individual whose life or health is at risk from the criminal acts of another individual, or from self-harm²¹⁸. In such cases, the Court’s task is to determine whether the authorities knew or ought to have known of the existence of a real and immediate risk and, if so, whether they did all they could to prevent the life of the individual concerned from being, avoidably, put at risk²¹⁹. The same applies *a fortiori* to the obligation to take particular measures to protect vulnerable persons from ill-treatment of which the authorities had or ought to have had knowledge²²⁰. It is self-evident that people in need of urgent and primary medical treatment and essential drugs are in a vulnerable condition. More broadly, people in hospital or other health services are in a situation of vulnerability akin to that of people in other “total institutions”²²¹.

Hence, under the Convention, State international-law responsibility for failure to protect in the context of health-related incidents depends on three cumulative conditions, two of which are objective and one subjective. These are (1) the existence of a situation of real and immediate risk, (2) a causal link between the authorities’ conduct and the harm caused and (3) the

217. It is also highly debatable whether there is a Convention right of access to pre-natal screening (see *Costa and Pavan v. Italy*, no. 54270/10, 28 August 2012, and *R.R. v. Poland*, no. 27617/04, ECHR 2011 (extracts); see also my opinion joined to the *Parrillo v. Italy* judgment ([GC], no. 46470/11, ECHR 2015)). However, it seems clear that there is no Convention right of access to artificial insemination (*Dickson v. the United Kingdom* [GC], no. 44362/04, ECHR 2007-V), abortion (*Tysiąc v. Poland*, no. 5410/03, ECHR 2007-I; *A, B and C v. Ireland* [GC], no. 25579/05, ECHR 2010; and *P. and S. v. Poland*, no. 57375/08, 30 October 2012), in vitro fertilisation using donated gametes (*S.H. v. Austria* [GC], no. 57813/00, ECHR 2011), assisted suicide (*Pretty*, cited above) or medication necessary to suicide (*Haas*, cited above), and surrogacy arrangements (*Mennesson v. France*, no. 65192/11, ECHR 2014 (extracts)). The Court is even ready to accept blanket prohibitions in some of these cases.

218. *Osman*, cited above, § 115, and *Keenan*, cited above, §§ 89 and 90.

219. *Uçar v. Turkey*, no. 52392/99, §§ 85 and 86, 11 April 2006, and *Renolde v. France*, no. 5608/05, §§ 80 and 81, ECHR 2008 (extracts).

220. *Z and Others v. the United Kingdom* [GC], no. 29392/95, § 73, ECHR 2001-V.

221. Although I cannot expand on the concept of “total institution” in the limited space of this opinion, it is important to note that the vulnerability of people in hospital or other health services, such as nursing homes, leprosariums and sanitariums, has been well known to sociologists, from Erving Goffman’s *On the Characteristics of Total Institutions* to Michel Foucault’s *Discipline and Punish*, since at least the early fifties of the last century. Their situation has been equated to that of people in other “total institutions” like jails, army barracks, orphanages and schools.

authorities’ knowledge or putative knowledge (“knew or ought to have known”) of the possible harmful consequences of their actions and omissions. In any event, such responsibility can be discounted when no other conduct could be reasonably expected from the authorities.

63. The first condition for State international-law responsibility must be qualified when the health-care needs of a specific group of the population encounter structural or systemic deficiencies. If the authorities know or ought to know that a segment of the population, such as a particular category of patients (for example, the citizens of a town or the patients of a certain hospital), receives health care with structural or systemic deficiencies, and they fail to prevent harm from befalling the members of that group, the State can be found responsible by omission for the resulting human rights violations, even when the persons concerned do not yet face an imminent risk²²². The structural or systemic nature of the deficiencies creates *per se* a present risk of harm which can materialise at any moment²²³.

64. For a State to avoid international-law responsibility under the Convention, it is not sufficient for health-care activities to be circumscribed by a proper legislative, administrative and regulatory framework and for a supervisory mechanism to oversee the implementation of this framework, as the Court held in *Powell*²²⁴. The obligation to undertake appropriate legislative or other general measures is by no means exhaustive of the obligations of States Parties²²⁵. Concrete due diligence obligations also emanate from the Convention right to health care. By evading the question of the specific protection of the individual right of each patient and instead protecting health professionals in an untouchable legal bubble, *Powell* renders the Convention protection illusory for patients²²⁶. *Powell* seeks a Convention that is for the few, the health professionals and their insurance companies, not for the many, the patients. This must be rejected outright. After all, the Court itself accepts that “knowledge of the facts and of possible errors committed in the course of medical care is essential to enable the institutions and medical staff concerned to remedy the potential deficiencies and prevent similar errors”²²⁷.

222. In my opinion joined to *Valiulienė v. Lithuania*, no. 33234/07, 26 March 2013, I already pleaded for a review of the *Osman* test in domestic violence cases when the generalised nature of this problem is known to the authorities, as in Lithuania.

223. For examples of this present danger, see *Cevrioğlu*, cited above, or *Georgel and Georgeta Stoicescu*, cited above.

224. *Powell*, cited above.

225. For a similar line of reasoning, see CESCR, General Comment No. 3, cited above, paragraph 4.

226. As referred to in paragraph 69 of the *Arskaya* judgment, cited above. To date, this is the sole medical negligence case where the Court has found deficiencies in the regulatory framework of a member State.

227. *Oyal*, cited above, § 76, and again in *Genç*, cited above, § 85.

65. The State’s duty to safeguard the rights to life and physical integrity must be considered to involve the taking of reasonable measures to ensure the health of individuals²²⁸. Interferences with the right to life are submitted to a stringent proportionality test (“absolutely necessary”, Article 2 § 2 of the Convention) and furthermore to an absolute, non-derogable norm (Article 15 § 2 of the Convention), which presupposes respect for an inviolable core that transcends the circumstances of each specific case. The same non-derogable norm applies to interferences with the prohibition of torture and ill-treatment (Articles 3 and 15 § 2 of the Convention). Neither war nor any other situation of public danger, neither cultural tradition nor religious diversity, limits the enforceability of the right’s core, since it gives rise to an irreducible, fundamental entitlement in the absence of which the right loses its value²²⁹. A case-specific core would not be conducive to implementation by the courts, in view of its indeterminacy. But this does not mean that the right’s core is an unduly rigid, context-independent, immutable value-based entity. The definition of the right’s core may evolve in the light of better information and scientific developments.

66. The rights to life and physical integrity impose core obligations to safeguard the life and health of any person under the jurisdiction of States Parties to the Convention. Reading the Convention in the light of the above-mentioned customary international norm, these core obligations include access to emergency services and primary medical treatment²³⁰, as well as access to essential drugs²³¹. This result-oriented core is a “floor”, the foundational level of Convention health protection, but not a “ceiling”. Beyond the protection of its core, the right to health care is subjected, at its “outer edge”, to a proportionality test in so far as there may be cases where the obligation to protect the core is met, but States are still failing to provide “reasonable” (proportionate) health-care measures²³². Such a proportionality test avoids, on the one hand, the danger of under-protection of the “outer

228. *Centre for Legal Resources on behalf of Valentin Câmpeanu*, cited above, § 132.

229. See my opinion joined to the *Konstantin Markin v. Russia* judgment ([GC], no. 30078/06, ECHR 2012 (extracts)) and its discussion of the German and Swiss constitutional case-law on the *menschenwürdiges Existenzminimum*.

230. See, to the same effect, *Mehmet Şentürk and Bekir Şentürk*, cited above, and *Furdik*, cited above.

231. See, to the same effect, the most remarkable *Oyal*, cited above.

232. See the South Africa constitutional-law case of *Minister of Health and Others v. Treatment Action Campaign and Others*, Case CCT 8/02, 5 July 2002, which rejected the direct enforceability of a minimum core, but in any event found that the restrictions on nevirapine excluded those who could reasonably be included in the programme, and ordered the Government to extend availability of the medicine. As Justice Goldstone argued *extra curia*, this case-law should be considered as a challenge to provide more information on the concept of the minimum core and not as a definitive decision to abandon it (Foreword to *Courting Social justice, Judicial Enforcement of Social and Economic Rights in Developing World*, ed. Gauri and Brinks, Cambridge: CUP, 2008, p. xii).

edge” of the right and, on the other hand, the opposite risk of an overly expansive, colonising effect of the “outer edge” of the right to health care, whereby it would subsume the content of other independent rights related to the underlying determinants of health, such as basic shelter, sanitation and water. More importantly, even if judicial enforcement of the right to health care may impact on budgets and social policy, this certainly does not breach the principle of the democratic separation of powers, since judicial scrutiny of health-care measures is limited by the available scientific information and the proportionality (or reasonableness) test²³³.

B. The procedural obligations (§§ 67-70)

1. The obligations to account for and explain (§§ 67-68)

67. A State has special obligations to care for the life of individuals under its control. As a general rule, an individual’s death or ill-treatment while in custody raises an issue as to whether the State has complied with its obligation to protect that person’s right to life²³⁴. This subsequently makes it incumbent on the State to account for any injuries suffered in custody, an obligation which is particularly stringent when an individual dies²³⁵. This obligation has been further extended to other instances where individuals are under the control of the State, such as servicemen during their military service²³⁶, as well as incidents involving the general population²³⁷. The same State obligation should apply to those individuals who find themselves in public hospitals or in the hands of medical doctors and other health practitioners and staff who are public employees, all the more so where the patients’ capacity to look after themselves is limited²³⁸.

68. Where no convincing explanation is provided for death or injuries occurring in the above-mentioned circumstances, a substantive violation of the right to health care must be established. In fact, the Court has already accepted such an obligation in a recent Turkish medical malpractice case. In

233. This also replies to the argument that judges are not competent in the sphere of medical care micro-management. This critique simply ignores the fact that civil, administrative and criminal judges are often confronted with concrete dilemmas involving the competing health-care claims of different patients, in situations where insufficient resources are available. They determine them precisely on the basis of the proportionality test.

234. *Slimani v. France*, no. 57671/00, § 27, ECHR 2004-IX (extracts).

235. *Salman*, cited above, § 99, and *Makharadze and Sikharulidze*, cited above, §§ 71-72, and the cases cited therein.

236. *Metin Gültekin and Others*, cited above, §§ 32 and 33; *Beker*, cited above, §§ 41-43; and *Muradyan v. Armenia*, no. 11275/07, § 133, 24 November 2016.

237. *Oruk*, cited above, § 67.

238. *Dodov*, cited above, § 81; *Câmpeanu*, cited above, § 130; *Kats and Others*, cited above, § 104; *Aleksanyan*, cited above, § 147; *Khudobin*, cited above, § 84; and *Z.H. v. Hungary*, no. 28973/11, §§ 31-32, 8 November 2012.

Aydoğdu, the Court grounded the finding of a substantive violation on, among other arguments, the lack of sufficient explanation for the events and the fatal outcome²³⁹.

2. The obligations to investigate and prosecute (§§ 69-70)

69. As demonstrated above, accountability is a crucial dimension of the guarantee of the right to life and the right to physical integrity under international and European law. This evidently includes the obligation to investigate, prosecute and eventually punish breaches of these rights, which in practical terms means that the State authorities have an *ex officio* duty to identify the causes of death or serious injury and the persons responsible²⁴⁰. This is even more the case in the context of medical malpractice, in view of the complexity of the factual and technical issues normally involved in these cases and the fact that the true circumstances of the death or serious injury are, or may be, largely confined within the knowledge of State officials or authorities²⁴¹.

70. Hence, it is not sufficient, in the specific sphere of medical negligence, for victims to have a remedy in the civil courts, either alone or in conjunction with a remedy in the criminal courts, enabling the liability of the doctors concerned to be established and appropriate civil redress to be obtained. Even less sufficient are disciplinary measures alone. In fact, the Court has acknowledged that criminal-law remedies must be available where it is established that the negligence attributable to State officials or bodies goes beyond an error of judgment or carelessness, in that the authorities in question, fully realising the likely consequences and disregarding the powers vested in them, failed to take measures that were necessary and sufficient to avert the risks inherent in a dangerous activity²⁴². As mentioned above, this view oversimplifies the issue of *mens rea* and sets double standards for similarly dangerous situations. For example, in *Sinin v. Turkey*²⁴³, the Court criticised the “reckless disregard” of the relevant rules on the transportation of dangerous goods, namely the fact that no licence had been obtained for the transportation of such goods and the shipment was incorrectly described. For the Court, such disregard required a criminal investigation²⁴⁴. It is hard to understand why the reckless disregard

239. *Aydoğdu*, cited above, § 77.

240. *Öneryıldız*, cited above, § 93, as well as *Al Fayed v. France* (dec.), no. 38501/02, §§ 73-78, 27 September 2007, and *Railean v. Moldova*, no. 23401/04, § 28, 5 January 2010.

241. This argument is frequently put forward in relation to other similarly dangerous activities, such as in *Oruk*, cited above, § 49; *Öneryıldız*, cited above, § 93; *Stoyanovi v. Bulgaria*, no. 42980/04, §§ 61 and 63, 9 November 2010; and already in *McCann and Others v. the United Kingdom*, 27 September 1995, §§ 157-64, Series A no. 324.

242. *Öneryıldız*, cited above, § 93; *Oruk*, cited above, §§ 50 and 65; and *Mehmet Şentürk and Bekir Şentürk*, cited above, § 104.

243. *Sinin v. Turkey*, no. 9441/10, § 63, 6 June 2017.

of safety rules in the transportation business should require a criminal investigation, but the careless disregard of medical rules with fatal or other serious consequences should not. Furthermore, the obligation for the authorities to open a criminal investigation of their own motion also applies in case of potentially fatal injuries caused by negligence and sustained by the victim in suspicious circumstances, even when the State has no direct responsibility for the death²⁴⁵. However, it should in no way be inferred from the foregoing that Article 2 may entail an absolute obligation for all prosecutions to result in conviction, or indeed in a particular sentence²⁴⁶.

C. Preliminary conclusion (§§ 71-72)

71. The right to health care is enshrined in the Convention. Like any other right, it imposes negative and positive obligations on the State. The core content of the right includes the provision of urgent and primary health care and essential drugs to people in need. Regarding this core, both an imperative of human dignity²⁴⁷ and a customary international law-friendly interpretation of the Convention impose a standardised approach. The core of the right comes neither under the derogation clause of Article 15 of the Convention, nor under the limitation clause of Article 8²⁴⁸. Retrogressive measures must not call this core into question. There should be no double, triple or multi-standard approach to a basic human need such as fundamental health care, since this would equate to valuing life differently in different parts of Europe. Such an approach would certainly fail to comply with the “principle of sanctity of life”, which, in the Court’s own words, “is especially evident in the case of a doctor, who exercises his or her skills to save lives and should act in the best interests of his or her patients²⁴⁹”.

72. Beyond the limits of the core of the right to health care, a progressive realisation obligation applies and resources constraints must be

244. This case is remarkable because the Court acted as a court of first instance, establishing causality and *mens rea* on the part of the persons responsible (“the death in the instant case resulted from the responsible parties’ voluntary and reckless disregard of their legal duties under the relevant legislation, as opposed to a simple omission or human error”) in spite of the dismissal of the criminal case and the pending civil case.

245. *Pereira Henriques v. Luxembourg*, no. 60255/00, § 56, 9 May 2006.

246. See, *mutatis mutandis*, *Tanlı v. Turkey*, no. 26129/95, § 111, ECHR 2001-III.

247. I use these words in the same sense as the ECSR (see its Digest, cited above). Clothing an assertion as to the content of a concrete human right with the apparel of human dignity not only satisfies an ethical urge, but also accords with the nature of the core obligation actually assumed by States under the Convention, which consists in protecting that same dignity.

248. See Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, cited above, paragraphs 6 and 8.

249. *Arskaya*, cited above, § 69.

considered. The assessment of resources warrants a proportionality test. The denial or inadequate provision of health care in public hospitals or at the hands of medical doctors and other health practitioners who are public employees calls for reasonable explanation by the State and, when no such explanation is put forward, the State's international-law responsibility is engaged. The lack of a criminal-law avenue for alleged victims or their relatives in the event of fatal or other serious consequences arising out of the breach of the Convention right to health care also triggers State international-law responsibility.

V. The application of a *pro persona* approach to the present case (§§ 73-91)

A. Critique of the majority's ideological approach (§§ 73-81)

1. Narrowing the Court's case-law (§§ 73-78)

73. If *Powell* is the king of a line of cases, *Lopes de Sousa Fernandes* is more royal than the king. From the outset, the ideological tenor of the present judgment is evident in the majority's straightforward statement that in the present case the appropriate legal avenue was the civil one²⁵⁰. No justification is given, either from the perspective of national law or from the perspective of the Convention. According to Portuguese law, such a statement is simply wrong. In Portuguese law, no preference is accorded to the civil-law avenue over the penal-law or other legal avenues available to fight a medical malpractice case. In Convention law the issue was hitherto not clear²⁵¹, but the Court normally considered criminal, administrative and civil avenues as alternatives.

What the above-mentioned statement by the majority shows is an ideological choice in favour of the privatisation of remedies against medical malpractice²⁵², which leaves ordinary patients and their relatives, and especially middle-class and poor families, on their own when they have to fight their medical malpractice cases against health professionals and their insurance companies. Ordinary patients and their relatives and their (often legal-aid) lawyers can do little against these powerful tycoons. Releasing the State from the obligation to investigate and prosecute violations of the right to life and serious violations of the right to physical integrity

250. See paragraph 138 of the judgment.

251. In *Vo*, cited above, § 93, the Court favoured the administrative-law avenue in general, but in *Calvelli and Ciglio*, cited above, § 55, it considered that the "best means" of elucidating the doctor's responsibility for the death of the applicants' child was the civil remedy.

252. See the critique by the applicant in *Dodov*, cited above, § 76.

downgrades these rights to such an extent that they vanish. Since in the vast majority of cases ordinary patients and their relatives do not have the means (including the financial, logistical, scientific and other means) to investigate and prosecute death or serious injury caused by medical malpractice, it is simply not possible to establish the causal link between the practitioners' conduct and the harm caused or to determine the degree of the practitioner's knowledge of the patient's medical situation. Ultimately, no explanation is provided for the death or serious injury, sometimes with life-changing consequences. Like the ostrich, the State buries its head in the sand.

74. Although grave, the major fault of *Lopes de Sousa Fernandes* is not this push for the privatisation of medical malpractice cases. Rather, it is the majority's herculean effort to narrow the previous case-law as much as possible with a view to limiting the Court's jurisdiction. The direct consequences of this ideological choice are not victim-neutral, since they allow the State to shirk responsibility for negligent death or serious injury under the Convention and, by so doing, to shunt off victims and their relatives into a corner of neglect and secondary victimisation, also known as post-crime victimisation. Moreover, excessive deference to some governmental interests in privatising and narrowing human rights traps the Court in a prison house of irrelevance²⁵³. When political and economic considerations commodify health services and render health care defunct, the right to life of the many is forgotten. When the margin of appreciation reduces the Convention to an ignoble charter of privileges of the few, ignoring the disgraceful fate of the many, even at the cost of life, the ideals of the founding fathers have been abandoned. An excessively restrictive approach to subsidiarity, focused on the appeasement of certain Governments with a minimal, night-watchman State social-welfare disengagement policy, jeopardises the effective implementation of the right to health care in all member States. To substantiate my view, I will address first the language used by the majority and then the content of their argumentation.

The basis of the majority's effort is an artificial linguistic distinction between the "denial of access to life-saving emergency treatment" and "mere medical negligence", whose artificiality is recognised by the majority themselves in paragraph 193 of the judgment. Furthermore, in paragraphs 183 and 184, the majority equate cases of denial of emergency treatment in full awareness ("fully aware") of the risk of fatal consequences, and cases of dysfunction of which the medical authorities "were or ought to have been aware" (the *Osman* test). By so doing, the majority treat similarly situations in which the *mens rea* is totally different. This conflates very distinct modes of criminality. To complicate things further, in paragraph 191 the first group

253. A similar critique has been made by both the CESCR and the CRC, which have pointed out that the respective Contracting Parties retain their international obligations in spite of privatisation of the health sector (Tobin, cited above, 222-223).

of cases (denial of access to life-saving emergency treatment) is linked to a different, lesser degree of awareness (“knowingly”). The lack of rigour in the language of the majority is incomprehensible. The majority admit that the obligation to regulate includes “in a broader sense” the duty to ensure the “effective functioning” of the regulatory framework, and even a duty to implement it. Astonishingly, this amounts to equating the issues of concrete provision of medical treatment and its overall regulation, deleting any diving line between the two. But the broadness of this reasoning in paragraph 189 is then immediately restricted to the “exceptional circumstances” mentioned in paragraph 190. The language used not only lacks rigour, it lacks consistency too.

75. The core of the judgment is paragraphs 194 to 196. Here the majority refer to the “latter category [of cases]”, meaning the cases of systemic structural dysfunction of which the authorities knew or ought to have known (the second group of cases). The majority set out four cumulative conditions for State international-law responsibility²⁵⁴.

The first condition is the highest degree of awareness (“fully aware”). This means that the main subjective characteristic of the second group of cases (the *Osman* test) is abandoned. From now on, the *Mehmet Şentürk and Bekir Şentürk* condition of “full awareness” is also required for cases where previously the Court had accepted a form of putative knowledge (“ought to have known”). In other words, since the most demanding subjective requirement of the first group of cases is also to be applied to the second group of cases, the majority eliminate the reason for the distinction between them and *de iure* merge the two groups of cases.

76. The second condition is the requirement that the systemic or structural problem should not merely comprise individual instances. The majority clarify what they mean by this condition by citing paragraph 87 of *Aydoğdu*, which refers to statistical evidence. Implicitly, the majority aim to set the evidentiary bar at a very high level for finding a “systemic or structural” failure.

77. The third and fourth conditions refer to the requirement of causality as a condition for State international-law responsibility in medical malpractice cases. In paragraph 187 of the judgment the majority refer to the causal link, requiring the establishment *in concreto* of a link between the regulatory framework and the harm sustained by the patient, since the former “must be shown to have operated to the patient’s detriment”. Neither of the authorities cited by the majority, namely *Z v. Poland* and *Arskaya*, supports this reasoning. But in paragraph 196 the majority are even more demanding, in so far as they mention a “link” between the dysfunction and the harm and, in addition to this, a link (“must have resulted”) between the

254. The language used in paragraphs 194 to 196 of the judgment (“firstly”, “secondly”, “thirdly”) is intended to refer to cumulative conditions.

dysfunction and the regulatory framework. This means that a double causal link is required. The authorities cited by the majority do not support this reasoning. Paragraph 96 of *Mehmet Şentürk and Bekir Şentürk* does not refer to any causal link and paragraphs 87 and 88 of *Aydoğdu* refer only to causality between the dysfunction and the harm.

78. Finally, the majority do not make any effort to put this case into perspective, seeking a coherent approach that is consistent with the Court's previous case-law on the right to health care, at least that related to health-care incidents affecting specific groups of the population. In view of this omission, it comes as no surprise that crucial United Nations, Inter-American, African and European health-care access standards, as well as the advancement of the justiciability of the right to health care worldwide and especially within the Council of Europe, were ignored.

2. Rewriting history (§§ 79-81)

79. Two years after the death of Mr Fernandes, the infectious-diseases panel of experts of the Portuguese Medical Association issued a report according to which the applicant's husband's case reflected "the appalling structural and operational" working conditions in public hospitals of the same type as the CHVNG at the relevant time. Yet the majority dispute the finding of the most important medical experts on infectious diseases in Portugal seventeen years after it was issued. The majority's argumentation lacks credibility.

80. Firstly, the majority claim entitlement to rule on a matter that is not within their remit. In spite of the pious repetition of the case-law in paragraph 199 of the judgment, the fact is that paragraph 201 rewrites history, by attacking the credibility of the infectious-diseases panel's finding²⁵⁵. Secondly, the majority argue that this finding was not confirmed by additional evidence presented by the panel or by subsequent reports, but they forget that no one, not even the Government, disputed the finding as to "the appalling structural and operational" working conditions in the CHVNG at the time of the events or the need for "urgent analysis and change". Thirdly, the majority ignore the additional evidence in the file which further reinforced the case for the existence of a structural dysfunction.

81. According to additional evidence contained in the file, since its inception in 1979, the Portuguese National Health System (NHS) has seen major developments in terms of both its efficiency and its quality²⁵⁶.

255. It is not the Court's task to rule on matters lying exclusively within medical specialists' field of expertise (see *Metin Gültekin and Others*, cited above, § 36, and *Kozhokar*, cited above, § 108).

256. For my subsequent remarks, see among others, the working paper of the European Parliament Directorate-General for Research, *Health care systems in the EU, a comparative study*, Public Health and Consumer Protection Series, SACO 101 EN, 1998,

However, the NHS has also faced recurring problems such as the overuse of emergency departments; very long waiting lists; inequitable distribution of health-care resources; difficult access to primary health care; lack of coordination among primary care centres, hospital doctors, hospitals and private doctors; limited access to health-care services for poorer and geographically isolated people; and a lack of motivation on the part of general practitioners working in isolation and for fixed salaries. A series of health-care reforms was adopted in 1995/96 to tackle these problems by increasing accessibility, improving quality, increasing general practitioners' motivation with a new payment system, and improving continuity of care. A 1996 governmental report entitled "Recommendations for the prevention and control of nosocomial infections acquired in health-care establishments", attached by the Government themselves to the Grand Chamber file, referred to two studies on the situation in Portuguese hospitals which "show[ed] that, at any given time, approximately 30 % of hospital inpatients [had] an infection and one-third of them acquired the infection while in hospital"²⁵⁷. In 1998, a national health strategy and health-care policy with quantified objectives and targets was developed for the first time. Most importantly, in December 1998, a few months after the death of Mr Fernandes, Resolution no. 140/98 of the Council of Ministers²⁵⁸ was adopted in order to address the "need for a qualitative leap forward in the development of human resources in the medical field" (*necessidade de um salto qualitativo no desenvolvimento dos recursos humanos no domínio da saúde*), with the aim of solving the problem of a lack of specialised medical doctors and nurses and the excessively long waiting lists for surgery, particularly in some parts of the country, by providing for a new public university structure in the domain of health sciences and creating a new university in the countryside. This is a crystal-clear acknowledgment by the Government of how serious the systemic problem of lack of specialised doctors was at that time.

B. A human rights-based approach to the present case (§§ 82-89)

1. The "appalling structural and operational conditions" of treatment (§§ 82-85)

82. The applicant in this case complained about the delay in diagnosis and surgery and the defective treatment to which her husband had been subjected, relating these shortcomings to the lack of medical staff²⁵⁹.

pp. 105-110; and Pereira et al., "Health Care Reform and Cost Containment in Portugal", in Mossailos and Le Grand, *Health Care and Cost Containment in the European Union*, Aldershot: Ashgate, 1999, pp. 635-660.

257. See paragraph 104 of the judgment.

258. Resolution no. 140/98 of the Council of Ministers of 4 December 1998.

259. See point 14.40 of the initial application, pages 12 and 48 of the observations of 8 June 2015 and paragraph 99 of the Chamber judgment.

83. Although the first²⁶⁰ and second medical reports²⁶¹ pointed to possible shortcomings in the medical procedure, they were not entirely confirmed by the subsequent report of the regional disciplinary council of 28 December 2001, which left open the question whether an earlier diagnosis would have been possible had a specialist in infectious diseases been available (“might have enabled a diagnosis to be made sooner”) and considered “justified” the lapse of time between the diagnosis of the perforated duodenal ulcer and the surgery²⁶². Yet the subsequent report of the Inspectorate General for Health (IGH) of 25 July 2006 clearly concluded that there had been “negligent conduct in the medical assistance provided” by Dr J.V., but stayed the disciplinary proceedings pending the outcome of the criminal proceedings²⁶³. While these latter proceedings did not establish the assistant doctor J.V.’s liability, this was because there was no autopsy, which was mandatory in this case, as admitted by the infectious-diseases panel itself. The lack of an autopsy “undermined to an incalculable extent” the clarification of the facts, a situation which the panel denounced²⁶⁴. This omission is the best evidence that there was, from the outset, no willingness to clarify the facts, investigate thoroughly those involved and eventually bring them to justice²⁶⁵. The fact that it took two years for the IGH to open an investigation and a further year to appoint an inspector as head of the investigation is also eloquent.

84. The facts of this case were not an unfortunate episodic incident, but the consequence of a structural dysfunction depriving a patient of access to health care while putting other lives in danger as well. There was a systemic problem with the lack of specialised medical staff, such as specialists in infections, in hospitals like the CHVNG. The evidence in the file speaks for itself. The words of the report of panel on infectious diseases could not be clearer:

“The inhuman conditions described in this process, as regards how the patient was treated, are another example of the situation encountered on a daily basis in our hospitals; a reflection of the appalling structural and operational conditions which require urgent analysis and change.

260. Paragraph 52 of the judgment.

261. Paragraph 53 of the judgment.

262. Paragraph 57 of the judgment.

263. Paragraph 49 of the judgment. The IGH report was final and therefore it is simply not true that “none of the judicial and disciplinary bodies” which examined the case found any fault with the medical treatment (paragraph 198 of the judgment).

264. See paragraph 53 of the judgment. Nonetheless, the majority wrongly argue, in paragraph 227, that there was no need for an autopsy.

265. See *Pereira Henriques*, cited above, § 57 (arguing that an autopsy can help to provide a complete and accurate record of injuries and an objective analysis of the clinical findings).

This board of the Infectious-Diseases Panel of the Medical Association must have a fundamental role in advocating the rights of patients and doctors in order to create better conditions of care for the former and better working conditions for the latter.

We reiterate, once more, the need to consider the creation of infectious-diseases departments/units in hospitals of the same type as Vila Nova de Gaia Hospital, in order to improve the quality of care in this regard”²⁶⁶.

85. This piece of evidence alone provided by the Portuguese Medical Association shows two things. First, that the inadequacy of the local regulation and provision of health care in 1998 reflected a structural problem which concerned not only the CHVNG but all similar hospitals. Second, that the inadequacy of the local regulation and provision of health care was known to the health authorities, since the panel took care to “reiterate” the criticism made previously. The domestic authorities knew of the risks in question and therefore failed in their duty to protect the lives of the patients concerned.

2. Drawing consequences from history (§§ 86-89)

86. Like the majority, I too find that there has been a procedural violation of Article 2 of the Convention, because the national authorities failed to clarify the different stages of Mr Fernandes’s hospital treatment and the human causes of his tragic death. In the present case the Government did not provide a sufficient explanation for what happened, and that alone should suffice to find a substantive violation, as explained above. Furthermore, in *Aydoğdu*²⁶⁷, the Court used official data to establish the situation in the two hospitals involved. In the present case, since the Government did not provide a sufficient explanation for what happened, the Court should have taken note of the official data available in the file, which reveal a structural problem in the public-health system at the time of the facts, as described above.

87. The Grand Chamber has not yet ruled on the question whether it is possible to apply the *Osman* case-law to a failure to provide adequate medical treatment to a person known to be at risk. The present case involves just such a situation. In my view, the *Osman* case-law must be extended not only to cases involving denial of medical treatment to a person whose life is known to be at immediate risk, but also to cases where medical treatment has been provided deficiently to that person. This also includes situations of structural or systemic health-care deficiencies, such as a lack of specialised medical staff, which create a present risk for patients²⁶⁸.

266. Paragraph 53 of the judgment.

267. *Aydoğdu*, cited above, § 85.

268. Compare the crucial § 81 of the *Aydoğdu* judgment and the report of April 2000 by the infectious-diseases panel of the Medical Association, cited in paragraph 53 of the judgment.

88. In the light of the evidence in the file, one cannot but conclude that when Mr Fernandes was admitted to the Oporto hospital, the medical doctor revoked entirely the treatment followed by the CHVNG²⁶⁹. On 6 March 1998 Mr Fernandes faced an immediate risk of death, which materialised after an agonising period of two days. A duodenal perforation had occurred²⁷⁰. Urgent surgery was delayed until 7 March at 8 p.m.²⁷¹. He died on 8 March at 2.55 a.m.

89. Furthermore, since the sphere of application of Article 2 cannot be interpreted as being limited to the time and direct cause of the individual's death, the previous chain of events may also trigger international-law responsibility²⁷². In the “appalling structural and operational” working conditions of the CHVNG, especially in the field of infectious-disease prevention, Mr Fernandes faced a present risk when he was finally discharged from the CHVNG on 3 February 1998. The fact that the discharge was voluntary clearly does not exonerate the discharging medical doctor, Dr J.V., from professional responsibility, as the IGH also concluded. Since the aforementioned working conditions were known to the medical authorities, the international responsibility of the State is engaged. These circumstances were ignored by the majority. Ultimately, the majority's criticism that the domestic courts “approached the chain of events as a succession of medical incidents, without paying particular attention to how they may have related to each other”²⁷³ fits like a glove to the majority themselves.

C. Preliminary conclusion (§§ 90-91)

90. The horrendous suffering that the applicant's husband, a young, healthy man, went through from November 1997 to March 1998 is indescribable. The obnoxious way he was treated was matched by the contempt with which the applicant, in her painful and persistent search for the truth, was herself treated. A culture of silence surrounded this tragedy. No explanation for the tragedy was ever forthcoming from the multitude of authorities dealing with the case. No accountability was afforded for the

269. See fact NN of the Facts part of the Supreme Administrative Court judgment of 26 February 2013. Paragraph 79 of the present judgment cites the Supreme Administrative Court's judgment but omits this fact.

270. See the Facts part of the Oporto Administrative and Fiscal Court judgment of 23 January 2012 (“The perforation had occurred 24 hours before surgery”), which was upheld by the Supreme Administrative Court. The fact was cited in paragraph 76 of the present judgment, but disregarded in its Law part.

271. Paragraph 24 of the Chamber judgment established that the first decision to operate was taken already on 6 March 1998. Without any explanation, paragraph 25 of the present judgment omitted this fact.

272. See the principled formulation in *Dodov*, cited above, § 70.

273. Paragraph 237 of the judgment.

conduct of medical doctors who were public officials working in public hospitals.

91. The majority are right in stating that systemic or structural dysfunctions depriving the patient of access to adequate health care while also putting other lives in danger trigger State responsibility for a substantive violation of Article 2. In situations of systemic or structural dysfunction which are known or ought to be known to the authorities, the *Osman* test must be qualified, in so far as the requirement of “immediate risk” must be scaled down to one of “present risk”. This should have happened in the present case. The facts of the present case show a systemic or structural dysfunction on the part of the CHVNG which represented a present risk for Mr Fernandes on 3 February 1998, the day he was finally discharged from the CHVNG. That risk was known to the health authorities, which had been warned repeatedly by the Medical Association and particularly by the board of the infectious-diseases panel, and could have been avoided by the timely creation of an infectious-diseases department in the CHVNG, as proposed by the same experts. Given that this avoidable, known and present risk materialised, first into an immediate risk of death on 6 March 1998 and finally into Mr Fernandes’s death two days later, the Grand Chamber should have found a violation of the substantive limb of Article 2.

VI. Conclusion (§§ 92-94)

92. In many respects the Convention remains an unfulfilled promise. The Court has still to take practical steps to move issues of health care from useless rhetoric to human rights implementation. Simply lamenting avoidable death or serious injury caused by the State’s retreat from public health-care responsibilities and by negligent conduct on the part of State agents, including medical practitioners, is not enough. Looking the other way is even worse and tarnishes the Court’s reputation as a staunch defender of human dignity. Progress has been slow and remains below expectations, in view of the customary nature of the right to health care in international law and the long-established *Airey* principle that all human rights are interdependent and interrelated, which means that the civil right to life means nothing if the State does not guarantee the effective conditions for its realisation for those patients in absolute need of health care.

93. In Europe, there was a time when the law did not enter prisons or army barracks, when wardens and officers were untouchable gods while prisoners and soldiers were insignificant subjects. That time is long over for prisons and army barracks. Regrettably, it is not yet over for hospitals. As the majority see it, the Convention should stay at the hospital door.

94. This case could have been a tipping point. The Grand Chamber did not want it to be that way. I regret that, by rejecting a purposive and principled reading of the Convention, the Court did not deliver full justice.

PARTLY DISSENTING OPINION OF JUDGE SERGHIDES

1. My only disagreement with the majority is that I respectfully find, as the Chamber did at paragraph 114 of its judgment, that there has been a violation of the substantive limb of Article 2 of the Convention.

2. As I subscribe to the facts outlined in the judgment, I need not delve into them.

3. In my humble opinion, the respondent State failed to fulfil its substantive positive obligation under Article 2 of the Convention taken in conjunction with Article 1 of the Convention to secure and protect the life of the applicant's husband. In particular, I believe that the respondent State placed the life of the applicant's husband at serious risk by depriving him of the possibility of access to immediate and appropriate emergency care. That was so because of the lack of coordination between the hospital in which he had undergone surgery for the removal of nasal polyps and the hospital's emergency department, from which he requested immediate assistance after the surgery owing to complications and to the appearance of meningitis. Although the procedural positive obligation is independent of the substantive positive obligation, the unanimous finding of the Court at paragraph 238 of the judgment, that the case at hand was an arguable case of medical negligence, cannot be ignored when dealing with the substantive positive obligation.

4. This substantive positive obligation of the State is based on the principle of effectiveness, which requires that the provisions of Article 2 of the Convention should be interpreted and applied in a practical and effective manner so as to fulfil the purpose of the guarantee of the right and secure for the applicant the full benefit of the Convention's protection.

5. Although the above principle is correctly enunciated in the judgment, when it eventually comes to be applied its more important role is overlooked.

6. To be more precise, in paragraph 186 of the judgment, under the sub-section headed: "The Court's approach", it is correctly stated as follows:

"In this regard the Court reaffirms that in the context of alleged medical negligence, the States' substantive positive obligation relating to medical treatment are limited to a duty to regulate, that is to say, a duty to put in place *an effective* regulative framework compelling hospitals whether private or public, to adopt appropriate measures for the protection of patients' lives" (emphasis added).

In paragraph 189 of the judgment, under the same heading as the previous paragraph, the principle of the effective protection of the right to life at all stages of protection, including implementation, is even more clearly emphasised:

"It must, moreover, be emphasised that the States' obligation to regulate must be understood in a broader sense which includes the duty to ensure the effective

functioning of that regulatory framework. The regulatory duties thus encompass necessary measures to ensure implementation, including supervision and enforcement.”

7. However, in paragraph 203 of the judgment, which comes under the sub-section headed: “Application of those criteria to the present case”, although a reference is made in brackets to the above-mentioned two paragraphs, it is stated as follows:

“In these circumstances Portugal’s substantive positive obligations *are limited* to the setting-up of an adequate regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients’ lives (see paragraphs 186 and 189 above)” (emphasis added).

8. Indeed, judging not only from what is stated in paragraph 203, cited above, but also from the conclusion of the judgment, it is clear that the principle of effectiveness is applied by the majority, if at all, only partially. Ultimately, the majority limit this principle to the setting-up of an adequate regulatory framework – which eventually turned out not to be adequate – while overlooking and not applying what they have accepted in principle, namely that there must also be effective implementation of this framework.

9. As is clear from the case-law of the Court, a State is required to take appropriate steps to protect life (see, *inter alia*, *L.C.B. v. the United Kingdom*, 9 June 1998, § 36, *Reports of Judgments and Decisions* 1998-III). As pertinently held in the case of *Calvelli and Ciglio v. Italy* ([GC], no. 32967/96, § 48, ECHR 2002-I), a State “... must take appropriate steps to safeguard the lives of those within its jurisdiction ...” A State will not only be held to account for the intentional and unlawful taking of life, protected under Article 2 § 1 of the Convention, but will also be held to account for its omissions that result in putting the patient at risk. In *Karpylenko v. Ukraine* (no. 15509/12, § 81, 11 February 2016), the Court held as follows with regard to how it is established whether or not the respondent State has complied with its obligation to protect life under Article 2 of the Convention:

“Turning to the present case, the Court notes that the applicant’s son died on 7 November 2011 of a number of HIV-related illnesses, while in custody and having been under the authorities’ control since 26 December 2009. In order to establish whether or not the respondent State complied with its obligation to protect life under Article 2 of the Convention, the Court must examine whether the relevant domestic authorities did everything reasonably possible, in good faith and in a timely manner, to try to avert the fatal outcome. Whether or not the authorities’ efforts could in principle have averted it is not decisive when examining the discharge by the State of its positive obligation to protect the applicant’s son’s health and life ...”

10. In *Powell v. the United Kingdom* ((dec.), no. 45305/99, § 1, ECHR 2000-V), the Court held that although a State must make “adequate provision for securing high professional standards among health professionals ... [the Court] cannot accept that matters such as error of judgment on the part of 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 ...” Nevertheless, in a very recent case, namely *Elena Cojocaru v. Romania* (no. 74114/12, §§ 108, 111 and 125, 22 March 2016), the Court took a different stance. In that case, the Court found the respondent State liable under Article 2 when the applicant’s daughter, who was suffering from a serious pre-natal condition, died after a doctor at the public hospital refused to perform an emergency C-section and she was transferred to another hospital, 159 km away, without medical supervision. It should be noted that the newborn baby died two days later. The Court held that the circumstances of the case, and in particular the apparent lack of coordination of the medical services and the delay in administering the appropriate emergency treatment, constituted a failure to provide adequate emergency treatment because, irrespective of the reason, the patient’s transfer had delayed the emergency treatment she needed. Also, in *Mehmet Şentürk and Bekir Şentürk v. Turkey* (no. 13423/09, § 97, ECHR 2013), the Court found the respondent State liable under Article 2 of the Convention when a woman died after medical staff in a State hospital refused her treatment in an emergency, life-threatening situation because she could not pay a deposit in advance for the operation.

11. Although not related to a health-care situation, in another case, namely *Öneryıldız v. Turkey* ([GC], no. 48939/99, ECHR 2004-XII), as well as in many further cases, the Court held that “this obligation [to take appropriate steps to safeguard the lives of those within the State’s jurisdiction] must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake” (§ 71). Similarly, in cases that involve the actions of third parties, the test that ought to be applied is that it must be established that the “authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk” (see *Osman v the United Kingdom*, 28 October 1998, § 116, Reports 1998-VIII).

12. The majority argue that for a denial of access to life-saving emergency treatment to be established “the dysfunction at issue must be ... genuinely identifiable as systemic or structural in order to be attributable to the State authorities” (see paragraph 195 of the judgment). I do not support this view, because in no situation, other than health-care situations, in which there is a serious risk threatening life and which triggers a substantive positive obligation on the part of the State to protect life, does the Court’s case-law require a systemic problem as a precondition for a possible violation of Article 2 of the Convention. Besides, with due respect, what is said in the above-mentioned paragraph 195 of the judgment does not seem

to be quite in line with what is said in paragraphs 191-192, where a systemic or structural dysfunction in hospital services is considered to be one of the two exceptional circumstances in the field of health care which may engage the responsibility of the State and which do not have to apply cumulatively.

13. One should not distinguish health-care situations from other situations which trigger the substantive positive obligation of a State to protect the lives of individuals, since the crux of the matter should be the protection of life and not the situation from which the risk to life arises. In any event, if one were to make some distinction between different risks one could say that people whose life is threatened by health problems are in a more vulnerable situation than people whose life is threatened by risks whose existence is unknown to them. This is an additional argument as to why the positive obligation of the State to protect life should not depend on whether there is a systemic dysfunction in hospital services.

14. The principle enunciated in the *Powell* decision, cited above, according to which negligent coordination among health-care professionals in the treatment of a particular patient cannot be considered sufficient of itself to call a Contracting State to account, seems no longer to be followed by the recent case-law of the Court. In any event, one should make the following observations regarding *Powell*. Firstly, it was a decision on admissibility and not a judgment, unlike the other cases cited above. Secondly, it did not concern a lack of cooperation between a medical department and the emergency department, unlike in the present case. Thirdly, it would go against the essence of the right of life, the principle of effectiveness and the scope of the Convention, to exclude from any risk threatening life those risks arising from negligent coordination among health-care professionals. When health is in the hands of doctors, human life and human integrity must be secured without any excuse based on a lack of cooperation between medical departments. Fourthly, it should not be an onerous and excessive duty for the different medical departments to cooperate, especially when one of them is the emergency department. On the contrary, it should be the duty of all doctors to exercise their profession according to the Hippocratic oath and of all medical departments to cooperate to protect life.

15. Unfortunately, the Grand Chamber has missed a good opportunity to follow *Elena Cojocaru* and to abandon the *Powell* principle for good or distinguish the present case from that old decision.

16. In view of the above, I conclude that in the present case there has been a violation of the substantive limb of Article 2 of the Convention.

17. My conclusion set out above would have led me to award the applicant an amount in respect of non-pecuniary damage for the violation of the substantive limb of Article 2 of the Convention. However, as I was in the minority the estimation of that amount would be purely theoretical.