

ADVANCING HUMAN RIGHTS
IN PATIENT CARE:

The Law in Seven Transitional Countries



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Executive Summary:

Emerging from philosophical and legal canons where collective interests trumped individual rights, many countries in transition have yet to adequately define frameworks for protecting basic rights in the delivery of health care services. They face challenges in areas such as health care financing, transparency and corruption of governments, and updating regulatory structures, for example, all of which hamper quality and equity of health care services. Significant additional law reform is needed in some settings; in others, existing laws on informed consent, confidentiality, privacy, non-discrimination, and other issues are rarely implemented and enforced effectively.

As a companion to other efforts, legal approaches can motivate improved implementation of these laws and precipitate improvements in the protection of human rights of both patients and providers in health care settings. These include formal litigation as well as the use of alternative adjudicative mechanisms. In many transitional contexts, the capacity of legal professionals to develop and lead such litigation or the use of alternative mechanisms in the human rights and patient care arena is limited.

Through a collaborative networked process, the Open Society Foundations are creating practitioner guides to inform and facilitate the utilization of legal tools to advance human rights in patient care. Six of the countries emerged from the former Soviet Union and share a common ancestry of Soviet-era communism and the highly-centralized Soviet health care system. The former Yugoslav Republic of Macedonia,¹ now a candidate for accession to the European Union, emerged from the former Socialist Federal Republic of Yugoslavia and inherited the former Yugoslav highly-decentralized health care system.

Utilizing the European Charter of Patients' Rights as an overarching framework, groups of domestic experts have generated a set of "how-to" guides for lawyers taking cases in the realm of protecting human rights in the delivery of health care services. Each country guide systematically reviews the legal landscape

1 The former Yugoslav Republic of Macedonia, or fYR Macedonia, is the full name of the country as admitted to the United Nations, but hereafter the country will be referred to as "Macedonia."

applicable to patients and providers at the national, regional, and international levels, highlighting illustrative cases and providing an overview of the procedural mechanisms. These rights are then cross-referenced with established human rights norms in the international and European systems.

Within this analytical structure, this Compendium summarizes and synthesizes the outcomes of this innovative initiative in seven of the eight countries (Moldova is not included, as it is being drafted at the time of this writing). After defining and situating the concept of human rights in patient care, describing the general setting for health care in the region, and detailing the background and methodology of the project, we compare and contrast the legal mechanisms, cultural and professional contexts, and procedural particularities for vindicating patient and provider rights in these particular transitional settings. The findings suggest that significant formal legal reform over the last two decades has created significant gains in the legal frameworks and institutions designed to address human rights abuses in patient care.

The findings also suggest, however, that a number of challenges in six of the countries included here are intrinsic to a common heritage that includes vestiges of Soviet legal concepts, institutions, and attitudes that complicate the full implementation of human rights legislation. The actual expression of this legal, cultural, and institutional heritage varies significantly across the participating countries, providing an opportunity to build on successes in a horizontal exchange, through knowledge transfer and regional advocacy.

In all countries of the practitioner guide project, structural issues related to the turbulent transition of the health care and legal systems, such as degree and quality of oversight and financing, further complicate a human rights agenda in the health care sphere. In view of these structural limitations, utilizing administrative and alternative dispute resolution channels is often a strategy superior to Western-style legal advocacy. The human rights framework provides a critical lens for addressing a spectrum of problems in the health care sphere, including discrimination, breach of confidentiality, compulsory treatment, and labor rights.

Vulnerable groups stand to gain the most from efforts to bolster equity, quality, access, and other human rights in patient care. Within the context of a larger project, the information from this Compendium offers a number of promising directions for future programming and research efforts aimed at advancing human rights in patient care. A discussion of how these findings inform future research, programmatic, and funding activities conclude this Compendium.

List of Abbreviations

CAT	Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment
CAT-OP	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERD	Convention on the Elimination of All Forms of Racial Discrimination
CHRB	Convention on Human Rights and Biomedicine
CIOMS	Council for International Organizations of Medical Sciences
CMW	International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
ECPR	European Charter of Patients' Rights
ESC	European Social Charter
ICCPR	International Covenant on Civil and Political Rights
ICCPR-OP	Optional Protocol to the International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
MoLHSA	Ministry of Labor, Health and Social Affairs
NGO	Non governmental Organization
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization
WMA	World Medical Association

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2 Also known officially as the Kyrgyz Republic, all references hereinafter will be to "Kyrgyzstan."

Background

Legal, ethical, and human rights norms are an increasingly important but still-often-neglected component of the delivery of quality medical care. This is so even though respect for human rights in patient care is increasingly understood as an issue that has implications for public health, as well as for broader functional economic and societal development. Across the world, especially in totalitarian and post-totalitarian settings, health systems have too often served at times as venues of punishment, coercion, and violations of basic human rights. In countries transitioning from totalitarian regimes, for example, health care practitioners and institutions are often constrained in their ability to provide quality care, sometimes unaware of ethical and human rights abuse that may be occurring, and sometimes lacking in incentives to reform individual, organizational, or system-wide norms and practices.

In regard to patients, there is a growing, global body of empirical evidence documenting patterns of systemic maltreatment of members of marginalized communities, including migrants or other displaced people; ethnic minorities such as the Roma; sexual minorities; women; people living with HIV/AIDS, tuberculosis, viral hepatitis and other infectious diseases; people needing palliative care; people who use drugs; people with disabilities; and the poor. Many of these groups are especially vulnerable to abuse because they often lack access to both formal and informal resources and structures to vindicate their individual rights and to address violations on the systems level. Across the Eastern and Central European region and Central Asia, the geographic region of the Practitioner Guides, for example, a culture of disrespect, abuse, and/or poor oversight in many health care institutions over time created a fertile environment for endemic and severe human rights abuse of patients, particularly those in marginalized communities.³

Patients, however, are not the only group that suffers human rights abuses in health care settings globally: medical professionals may be persecuted for providing evidence-based health care to marginalized groups, ordered to destroy medical records or disclose confidential health information to the state, or coerced into participating in (or covering up) torture and crimes against humanity.⁴ Even in open societies, health providers may be denied safe working conditions, punished for alleged ethical breaches without proper due process, or forced to provide care that violates their professional or personal ethical principles.⁵ Recognizing that universal human rights norms have special relevance to health

3 See, e.g. International Dual Loyalty Working Group, *Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms*. 1993.

4 *Ibid.*

5 *Ibid.* at 12; see also F. Hashemian, et al. *Broken Laws, Broken Lives: Medical Evidence of Torture by US Personnel and Its Impact*. Boston, Physicians for Human Rights. 2008.

care providers as well as patients is essential to nurturing a culture of respect for these norms within the health care delivery context.

Beyond their impact on individuals, systemic violations of human rights in patient care also weaken societies. Left unchecked and uninvestigated, medical errors become significant sources of morbidity and mortality. Discrimination against and under-treatment of patients with stigmatized diseases push epidemics underground and fuel their spread. Fear of disclosure of confidential health information to employers, family members, and law enforcement authorities creates deadly barriers to health care institutions and emergency services. Corruption sentences the least resourced patients to receiving inadequate care, further marginalizing them. Lack of transparency hampers public health surveillance and response to emerging threats. Lack of access to quality preventative services increases susceptibility to population-level health problems and increases overall medical expenditures. These and other human rights abuses perpetuate cycles of ill-health, poverty, negligence, corruption, and dysfunctional governance.

There is an urgent need to support and strengthen legal, administrative, and other remedies for individual and systemic human rights abuses, and to do so in a way that promotes access to quality health care services. By helping identify and support effective mechanisms, advocates and funders can help ensure safe, effective, and respectful patient care.

About this Guide

Practitioner Guide Project

Driven by the need to strengthen legal remedies for abuses within health care settings, the Open Society Foundations are generating a series of practitioner guides to inform and facilitate the utilization of legal tools to advance human rights in patient care. The practitioner guides were developed through a collaboration of international experts with national working groups comprised of lawyers and legal educators, members of the judiciary, physicians and medical educators, public health and health management professionals, government regulators, patient representatives, ethicists and ombudspersons convened to research, review, and debate laws and regulations and to formulate these guides.

Designed as practical, “how-to” manuals for lawyers, these guides aim to facilitate the use of legal tools to protect basic rights in the delivery of health care. Each national working group conducted a comprehensive review of the laws and regulations as they relate to human rights in patient care in their country. Published judicial decisions and other key examples from legal practice gleaned from a variety of formal and informal sources were identified and summarized. International experts conducted a similar inquiry into applicable international and European law. The research also included the distillation and description of procedural mechanisms for enforcing human rights in patient care on the institutional, national, regional, and international levels. As enforcement can be accomplished through both formal and informal mechanisms, the guides cover litigation and alternative forums for dispute resolution, such as ombudspersons and ethics review committees.

In addition to their use in legal practice, the guides are intended to facilitate training, particularly in clinical legal education programs. Additionally, they were written to inform a firmer understanding of the legal basis for patient and provider rights and responsibilities and available mechanisms for enforcement among medical professionals, public health professionals and health managers, ministries of health and justice personnel, patient advocacy groups, and patients themselves.

Considering the rapid pace of change in this field, updatable web-based resources were developed to accompany the hard copies of the practitioner guides. Electronic versions of the guides are available on the Internet and are regularly updated.⁶ An international portal links to country websites, which,

6 Please see www.health-rights.org/ (follow “Community of Practice” and then “Practitioner Guides” hyperlinks). Accessed July 31, 2012.

along with the particular country guide, include additional resources gathered by the country working groups that prepared each guide. These include other related laws and regulations not included in the guides, case law, tools and sample forms, and practical tips for lawyers. The websites also provide innovative communication tools to connect lawyers, health providers, and patients concerned about human rights in patient care. Each of the websites provides a mechanism for feedback on the guides.

The second phase of this project has included trainings for lawyers, judges, and health care providers based on the guides; production of patient-friendly materials (written in everyday language rather than legal terminology) with a focus on marginalized populations; and gaps analyses comparing domestic legislation with international and regional human rights standards. A legal fellow in human rights in patient care in each country coordinates updates to the Guides, trainings, and development of patient-friendly versions in collaboration with their host NGOs, practitioner guide authors, and representatives of marginalized patient groups. Fellows are recent law graduates based at local nongovernmental organizations with expertise and interest in expanding work in law, human rights, and patient care.⁷ A parallel activity is the development and teaching of sixteen courses to date in law and health and human rights in the same eight countries in law, medical, and public health faculties, in which the practitioner guides are included as teaching materials.⁸

The Aims and Structure of this Compendium

This compendium synthesizes seven⁹ country-specific practitioner guides drafted as of July 2012 into a single, macro-level analysis. Aimed at policymakers, advocates, academics, and other observers, it is intended to provide a bird's-eye view of the overall legal, case law, and procedural state of human rights in patient care in these seven particular transitional settings. It is designed to facilitate cooperation and to provide a baseline for comparative analyses in the future by highlighting similarities, identifying common issues, and contrasting specific examples.

The structure of the compendium parallels that of the individual country-specific practitioner guides. Section 2 (P. 19) describes the international and regional law governing human rights in patient care, with examination of the relevant body of law and provision of illustrative examples of cases and interpretations of treaty provisions. This section is organized around established human rights ap-

7 As of June 18, 2010, fellows in Armenia, Georgia, Macedonia, and Ukraine initiated work on this project; fellows in Kazakhstan, Kyrgyzstan, and Russia began in 2011. For additional information on the Fellows, please see www.health-rights.org/fellowships.

8 For additional information on these courses, please see <http://cop.health-rights.org/teaching>.

9 Moldova is not included in this compendium.

plicable to both patients and providers. For patients, these are rights to liberty and security of the person; privacy; information; bodily integrity; life; the highest attainable standard of health; freedom from torture, cruel, inhuman, and degrading treatment; participation in public policy; and non-discrimination and equality. Provider topics include the right to work in decent conditions and freedom of association, as well as due process-related rights.

Sections 3, 4, 5, and 6 focus on the national legal frameworks and mechanisms of seven of the countries of the Practitioner Guide project.

- Section 3 (P. 34) clarifies the legal status of international and regional treaties ratified, signed or adopted across the seven countries; analyzes the governance, legal, and health care systems across the countries; and addresses the countries' use of legal precedent.
- Section 4 (P. 45) synthesizes patients' rights and responsibilities. The patients' rights section is organized according to the rights in the European Charter of Patients' Rights with the addition of any country-specific rights not specifically covered by the charter. The charter attempts to translate regional documents on health and human rights into 14 concrete provisions for patients: rights to preventive measures, access, information, consent, free choice, privacy and confidentiality, respect of patients' time, observance of quality standards, safety, innovation, avoidance of unnecessary suffering and pain, personalized treatment, the filing of complaints, and compensation. Each of these rights is then cross-referenced with established international and regional human rights norms listed above. The patients' responsibilities section contains those responsibilities identified in the national legislation by each country working group.
- Section 5 (P. 67) focuses on provider rights and responsibilities, using the same structure as Section 4, including specifically the rights to work in decent conditions, freedom of association, and due process, plus any other relevant national-level rights, as well as responsibilities of health providers that the working groups identified.
- Section 6 (P. 80) covers the national procedures and mechanisms for enforcement of both patient and provider rights and responsibilities. This encompasses administrative, civil, and criminal procedures and alternative mechanisms, including examples such as the office of the public prosecutor, ombudspersons, ministries of health and internal affairs, ethics review committees, and inspectorates of health facilities. It additionally describes what the participant countries chose to include in the annex of sample forms and documents of their country guides.

As this compendium illustrates, the field of human rights in patient care is still new and evolving in this region, as it is globally. Courts have not authoritatively interpreted many of the statutory provisions cited in the practitioner guides, and those that have been remain open to additional application and interpretation.

There remain huge gaps in understanding how human rights in patient care apply in practice. This compendium is thus a platform for academic and empirical inquiry, as well as a resource for legal and health care practitioners. The authors hope that this compendium will attract wider interest in the field of human rights in patient care, especially to efforts to compare and inform both policy and practice in this realm across the region.

Significance of the European Charter of Patients' Rights

Developed in 2002 by the Active Citizenship Network, the European Charter of Patients' Rights (ECPR)¹⁰ provides a clear, comprehensive statement of patients' rights. This formulation of rights is part of a grassroots movement across Europe, which calls for patients to play a more active role in shaping the delivery of health services and has attempted to translate regional documents on the right to health care into specific provisions.¹¹

As listed above, the charter systemizes patients' rights into fourteen concrete provisions. This charter presents a useful legal framework for the application of general human rights principles to the particular context of patient care (See Table 1).

Although the charter is not legally binding, a strong network of patients' rights groups across Europe has successfully lobbied their national governments for recognition and adoption of the rights it addresses.¹² Similar patients' rights charters have been developed in other regions and countries.¹³ The charter has also been used as a reference for monitoring and evaluating health care systems across Europe, and is one of the most comprehensive, recent and widely-endorsed expressions of patients' rights. For these reasons, the ECPR was chosen as the conceptual organizing framework for the practitioner guide projects in the participating countries. However, it is important to recall which human rights of general application lie behind the particular "patients' rights" that are articulated in the ECPR (See Table 1).

10 European Charter of Patients' Rights (ECPR). www.patienttalk.info/european_charter.pdf. Accessed July 31, 2012.

11 It is important to note that the pharmaceutical company Merck & Co., Inc, also provided funding for this movement.

12 One of the activities of new European Union (EU) member states during the process of preparation for accession in the EU is adjustment of health care legislation toward European legislation and standards. Many countries, such as Bulgaria, adopted new health laws, whose structure and contents are in line with the European Charter of Patients' Rights. Of the practitioner guide countries, Macedonia is an official candidate county for EU accession.

13 See, e.g., Uganda Ministry of Health. Patients' Charter. www.health.go.ug/Patient.pdf. Accessed July 31, 2012; see also Israeli Patient's Rights Act, 1996. <http://waml.haifa.ac.il/index/reference/legislation/israel/israel1.htm>. Accessed July 31, 2012; see also Argentina Ministry of Health. Legislation. <http://leg.msal.gov.ar/bioetica.htm>. Accessed July 31, 2012.

TABLE 1. CROSS-REFERENCING THE EUROPEAN CHARTER OF PATIENTS' RIGHTS WITH HUMAN RIGHTS OF GENERAL APPLICATION

European Charter of Patients' Rights	Human Rights of General Application
Right to Preventive Measures	Right to Health
Right of Access	Right to Non-discrimination & Equality
Right to Information	Right to Information
Right to Consent	Right to Bodily Integrity; Right to Liberty & Security of Person; Right to Freedom from Torture & Cruel, Inhuman, Degrading Treatment; Right to Privacy; Right to Health
Right to Free Choice	Right to Bodily Integrity; Right to Liberty & Security of Person; Right to Freedom from Torture & Cruel, Inhuman, Degrading Treatment; Right to Privacy; Right to Health
Right to Privacy & Confidentiality	Right to Privacy
Right to Respect for Patients' Time	Right to Health
Right to Observance of Quality Standards	Right to Health; Right to Life
Right to Safety	Right to Health; Right to Life
Right to Innovation	Right to Health; Right to the Benefits of Scientific Progress
Right to Avoid Unnecessary Pain & Suffering	Right to Health; Freedom from Torture & Cruel, Inhuman, Degrading Treatment
Right to Personalized Treatment	Right to Health; Right to Non-discrimination & Equality
Right to Complain, Right to Compensation	Right to a Remedy

Situating “Human Rights in Patient Care” in the Philosophical Landscape

Unlike the concept of “patients’ rights,” which articulates particular rights specific to patients, the concept of “human rights in patient care” refers to the application of general or universal human rights principles to all stakeholders in the delivery of health care services. In this latter paradigm, patient and provider rights are interdependent. Just as patients face risk of violations of rights to informed consent, confidentiality, privacy, non-discrimination, and even egregious abuses that rise to the level of torture and cruel, inhuman and degrading treatment, health care providers likewise may face abuses such as unsafe working conditions, sanctions for providing evidence-based health care, and denial of due process when patients make complaints against them. These abuses impede the delivery of quality health care services and contribute to a human rights environment that undermines the provider-patient relationship. Socially marginalized groups such as migrants or other displaced people; ethnic minorities such as the Roma; sexual minorities; people living with HIV/AIDS, tuberculosis, viral hepatitis and other infectious diseases; people needing palliative care; people who use drugs; and people with disabilities are especially vulnerable to this dynamic. Thus, the concept “human rights in patient care” acknowledges the rights of both patients and providers as important and interrelated, while still retaining a focus on patient care.

Discussions of human rights in medical and scientific settings conventionally rely on a number of well-established philosophical and legal frameworks. These include bioethics, patients’ rights, right to health, and patient safety, among others. Therefore, it is important to situate the novel term “human rights in patient care,” which serves as the main focus of the practitioner guides, among traditional key conceptual frameworks.

Bioethical pillars of beneficence, autonomy, and justice, with added consideration of non-maleficence and human dignity by some commentators, counter many of the types of patient abuses and human rights violations that may occur in health care settings.¹⁴ While the field of bioethics has traditionally been concerned exclusively with protecting patients and research participants, the international human rights framework takes a wider scope to encompass other key stakeholders, including health care providers.¹⁵ Further, this more expansive

14 International Dual Loyalty Working Group, *supra* note 1.

15 Cohen J, Kass N, and Beyrer C. “Human Rights and Public Health Ethics: Responding to the Global HIV/AIDS Pandemic.” In: Beyrer C and Pizer HF, eds. *Public Health and Human Rights: Evidence-based Approaches*. Baltimore, MD: Johns Hopkins University Press, 2007:362-390.

framework adds a concrete and operational set of concepts and mechanisms, including a system of norms and procedures that can be used to identify, classify, and address abuses in health care service delivery.¹⁶

An important distinction between human rights in patient care and another relevant key concept of the “right to health”¹⁷ is that the latter encompasses the vast range of human rights that fall outside the patient care delivery context but nevertheless plays an important role in determining health outcomes. These “underlying determinants of health” may include not only social and economic rights to adequate housing, potable water and food, but also civil and political rights to freedom from violence, censorship, discrimination, and torture—all of which can have serious health consequences.¹⁸ Human rights in patient care, by contrast, specifically address stakeholder rights inside health care settings—be they hospitals, clinics, outreach facilities, places of detention, or private homes—and in the particular context of patient care, which may be defined as actual services rendered by health providers for the benefit of patients.

The Committee on Economic, Social and Cultural Rights, the expert committee responsible for interpreting the International Covenant on Economic, Social and Cultural Rights (ICESCR), provides a seminal discussion of the related concept of the right to the highest attainable standard of health in its General Comment Number 14. This document distinguishes the spectrum of attendant rights into the categories of availability, accessibility, acceptability, and quality of care. Going beyond the traditional attributes defining medical care, these categories provide space for addressing human rights violations in the broader patient care context. Among the committee’s relevant observations are the following:

- The rights to human dignity, prohibition against torture, privacy, and access to information address integral components of the right to health. (para. 3)
- The right of **acceptability** of health care “includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.” (para. 12(b))
- The right of **acceptability** of health care provides that “all health facilities, goods and services must be respectful of medical ethics...as well as being designed to respect confidentiality.” (para. 12(c))
- The obligation to protect the right to health includes the duty of states “to ensure that medical practitioners and other health professionals meet appropriate...ethical codes of conduct.” (para. 35)

16 Ibid.; see also Marks SP. The new partnership of health and human rights. May 16, 2001. www.cceia.org/resources/publications/dialogue/2_06/articles/650.html. Accessed July 31, 2012.

17 See, e.g., World Health Organization (WHO). The determinants of health. www.who.int/hia/evidence/doh/en/. Accessed July 31, 2012.

18 Cohen, Kass, and Beyrer, *supra* note 15 at 366.

By recognizing that the health care environment is prone to foster relevant abuses and by providing specific case examples, Comment 14 highlights the troubled history and complex reality that surrounds patient care in many regions across the globe, including that of the practitioner guide participant countries. In the last fifty years, patients' rights have been codified in key regional instruments. In the European context, the *European Charter of Patients' Rights*¹⁹ and the World Health Organization's *Declaration on the Promotion of Patients' Rights in Europe*²⁰ provide additional obligations and guidance for participating states; these documents are discussed in the next section. Furthermore, the *European Convention on Human Rights and Biomedicine* establishes an additional regional mechanism to the patient rights framework.²¹

These instruments are representative of a patients' rights approach, which differs in at least two respects from the application of general human rights principles in the context of patient care. The first distinction is that the human rights framework applies not only to patients but to all stakeholders in health care delivery, including providers. A second difference is that some patients' rights charters advance rights that are relatively new in the cannon of international law.

Human rights in patient care also closely relate to issues arising from dual loyalty, or "simultaneous obligation to a patient and a third party,"²² including insurers and governments. This phenomenon includes such issues as resource rationing, mandatory reporting, and compulsory medical or mental health treatment. In cases where the interests of the patient and the third party are aligned, there is arguably much lower risk of human rights violations. Their misalignment, however, often facilitates abuses that can affect the provider as well as the patient.²³ Dual loyalty is an important concept not only because it sheds light on the causes and manifestations of human rights violations in patient care, but also because it provides a framework for spotting and resolving such conflicts in health care settings.

19 ECPR, see supra note 10.

20 World Health Organization Declaration on the Promotion of Patients' Rights in Europe. www.who.int/genomics/public/eu_declaration1994.pdf. Accessed July 31, 2012.

21 Council of Europe (COE). Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. April 4, 1997. <http://conventions.coe.int/Treaty/en/Treaties/Html/164.htm>. Accessed on July 31, 2012. (hereinafter European Convention on Human Rights and Biomedicine).

22 International Dual Loyalty Working Group, supra note 1 at 11.

23 Ibid. at 12.

International and European Legal Framework

The human rights architecture at the international, regional, and national levels provides an important formal and procedural framework for addressing abuses of human rights in patient care. This legal framework creates a number of specific mechanisms that can be utilized to hold abusive governments and state actors accountable.

This section provides an overview of the key instruments designed to safeguard patients' and providers' rights internationally, as well as specifically within the 'European Region' (defined here as the member states of the European Region of WHO). Within the United Nations regime, a number of the major binding treaties and covenants contain applicable provisions.²⁴ These include various EU instruments, such as the European Convention on Human Rights ("ECHR") and the European Social Charter ("ESC"). Below is a condensed overview of the relevant documents and their application to patient care, as well as illustrative examples of their application to the various issues of interest.²⁵ (A summary of participating countries' ratification of these instruments appears in [Table 2](#).)

The international and European human rights regime utilizes individual monitoring bodies, courts and other special procedures to enforce its provisions. These bodies include such treaty bodies as the United Nations Human Rights Committee, courts like the International Court of Justice and the European Court of Human Rights (ECtHR), and a number of special procedures, e.g. the Special Rapporteurs mandated by the Human Rights Council. Extending beyond treaties that fall within the scope of the UN regime, this section addresses several documents and frameworks developed by international and European organizations and civil society groups that aim to interpret international and European human rights law for the purposes of national legislation and enforcement.

24 See *Appendix: Thirteen Health and Human Rights Documents in Health and Human Rights: A Resource Guide*, published by Open Society Institute and Equitas and edited by J. Cohen, T. Ezer, P. McAdams, and M. Miloff. An HTML version of this resource guide is available at: <http://equal-partners.info/>.

25 See generally *Health Rights: Human Rights in Patient Care Home Page*, www.health-rights.org, for a more detailed discussion of international legal frameworks of human rights in patient care, including an exhaustive enumeration of the international treaty and other instruments.

**TABLE 2. RATIFICATION OF MAJOR HUMAN RIGHTS INSTRUMENTS
BY PARTICIPATING COUNTRIES**

	Armenia	Georgia	Kazakhstan
INTERNATIONAL			
ICCPR	09.23.1993	05.03.1994*	11.28.2005
Optional Protocol, ICCPR	09.23.1993	05.03.1994*	02.11.2009
ICESCR	12.13.1993	05.03.1994*	11.21.2005
CEDAW	10.13.1993	10.26.1994*	
CERD	07.23.1993	10.26.1994*	
CAT	10.13.1993	10.26.1994*	
CAT-OP	10.14.2006	10.26.1994*	06.26.2008
CRC	07.22.1993	06.02.1994*	06.08.1994
CMW		06.02.1994*	
DRC			
REGIONAL			
Convention on Human Rights and Biomedicine 1997		09.27.2000	
Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings		09.27.2000	
Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin		09.27.2000	
Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research		04.08.2010	
ECHR	04.26.2002*	05.20.1999	
European Social Charter 1996	03.01.2004	08.22.2005	
Framework Convention for the Protection of National Minorities 1995	11.01.1998	12.22.2005	

* date of accession for instruments not yet ratified ** date of signature for instruments not yet ratified

Kyrgyzstan	Macedonia	Russia	Ukraine
01.07.1995	01.18.1994	09.18.1973	
01.07.1995	12.12.1994		10.25.1991
10.07.1994	01.18.1994	09.18.1973	
03.12.1997	01.18.1994	12.19.1980	09.03.1981
10.05.1997	01.18.1994	01.22.1969	04.07.1969
10.05.1997	06.06.1997	01.21.1987	09.01.1997
01.29.2009	09.01.2006	-	
11.06.1994	12.02.1993	06.13.1990	09.27.1991
01.01.2004		09.24.2008*	
	09.03.2009	05.05.1998	
	09.03.2009		
	09.03.2009		
	04.10.1997		09.11.1997
	05.27.2009**	12.01.2009	
	04.10.1997	8.21.1998	

Patients' Rights

Within the many treaties and instruments that make up the international human rights system, there are a great number of provisions that can be and have been applied to the context of patient care. Primary among these is the right to the highest attainable standard of health, recognized in Article 12 of the ICESCR and other treaties.²⁶ Under the UN regime, this right obliges states with a number of affirmative duties, including the implementation of effective measures for prevention, treatment, and control of disease. These rights are enumerated in a variety of sources,²⁷ including Article 12 of the ICESCR.²⁹

The seminal General Comment 14 interprets this Article by including freedom from human rights abuses as inherent to the delivery of highest attainable quality of health care. Among the Committee's key points is the call for guarantees of the right to human dignity, privacy, and access to information.³⁰ General Comment 14 interpretations also include key protections against torture and non-consensual medical treatment, discussed above.³¹

Under European Union and Council of Europe law, the right to the highest attainable standard of health is defined broadly to include quality health services and public health prevention and promotion,³² epidemic control, and efforts to reduce accidents.³³ The European Committee on Social Rights has held that this right also implies the responsibility of health systems and institutions to track and prevent iatrogenic events in health care settings.³⁴

26 See also Article 24 of the Convention on the Rights of the Child and Articles 12 and 14 of the Convention on the Elimination of Discrimination Against Women.

27 Convention on the Rights of the Child (CRC). United Nations (UN) General Assembly Resolution 44/25. November 20, 1989. www2.ohchr.org/english/law/crc.htm. Accessed July 31, 2012. Article 24.

28 Convention on the Rights of Persons with Disabilities (CRPD). UN General Assembly Resolution. December 13, 2006. www2.ohchr.org/english/law/disabilities-convention.htm. Accessed July 31, 2012. Article 25.

29 International Covenant on Economic, Social and Cultural Rights (ICESCR). United Nations General Assembly Resolution 2200A[XXI]. December 16, 1966. www2.ohchr.org/english/law/cescr.htm. Accessed July 31, 2012. Article 12. ("(1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: . . . (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.")

30 ICESCR. Article 12, General Comment 14, Paragraph 12.

31 *Ibid.*, at Paragraph 3.

32 Charter of Fundamental Rights of the European Union. www.europarl.europa.eu/charter/default_en.htm. Accessed July 31, 2012. Article 35.

33 European Social Charter (ESC). Article 11 (3); see also COE. Conclusions of the European Committee of Social Rights. (XVII-2); Conclusions 2005. Statement of Interpretation of Article 11.

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

In addition to the right to the highest attainable standard of health, a number of internationally recognized civil, economic, and political rights, such as the right to liberty and security of the person and the right to privacy, have been applied to the context of patient care. The remainder of this section provides examples of such application.

Right to Liberty and Security of the Person

The International Covenant on Civil and Political Rights (ICCPR),³⁵ the Convention on the Rights of the Child (CRC),³⁶ and the Convention of the Rights of Persons with Disabilities (CRPD)³⁷ are among those treaties that have elaborated the right to liberty and security of the person and whose enforcement bodies have applied this right to the context of patients' rights. These instruments generally stipulate protections against unfounded detention, quarantine, or other restraint, requiring that procedural protections be created by the state legislatures to ensure due process review of any detention in the name of health or public health. In its application, this right has been held, for example, to prohibit institutionalization without due process of people with mental illness,³⁸ and to address hospital detention of patients for inability to pay bills.³⁹

In the European context, the right to liberty and security of the person is specifically constrained by the state's interests, including the mandate to protect public health, but only under strict limitations. The ECtHR has established a number of procedural guarantees in relation to the application of this limitation. Most notably, these protections stipulate that confinement must only occur according to a properly-prescribed legal procedure. In the mental health treatment setting, this means that the person must have a recognized mental illness and require confinement for the purposes of treatment.⁴⁰ For example, a medical facility was

35 International Covenant on Civil and Political Rights (ICCPR). UN General Assembly Resolution 2200A[XXI]. December 16, 1966. www2.ohchr.org/english/law/ccpr.htm. Accessed July 31, 2012. Article 9(1).

36 CRC. Article 25.

37 CRPD. Article 14 (The CRPD has yet to issue any opinions.)

38 UN Human Rights Committee (HRC). *A. v. New Zealand*, Communication No. 754/1997. (CCPR/C/66/D/754/1997). Views adopted July 15, 1999; see also UN Human Rights Committee (HRC). *Fijalkowska v. Poland*. Communication No. 1061/2002: Poland. (CCPR/C/84/1061/2002). Views adopted July 26, 2005.

39 Two provisions of the ICCPR are pertinent to this issue. Article 9(1) ("Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.") Article 11 ("No one shall be imprisoned merely on the ground of inability to fulfil a contractual obligation.").

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

found to be in violation of ECHR Article 5(1)(e)⁴¹ for detaining an individual who transmitted the HIV virus to another man as a result of sexual activity. The ECtHR concluded that the facility did not strike a proper balance between the need to contain the virus and the individual's right to liberty and security of the person.⁴²

Right to Bodily Integrity

Another important patient right is the right to bodily integrity, which is specifically guaranteed by the CRC,⁴³ CRPD,⁴⁴ and World Medical Association (WMA) Declaration on the Rights of the Patient.⁴⁵ This right is closely related to the bioethical principle of autonomy and focuses on self-determination, informed consent, and freedom from unwanted medical intervention. It has also been interpreted to be part of the right to security of the person,⁴⁶ the right to freedom from torture and cruel, inhuman, and degrading treatment,⁴⁷ the right to privacy,⁴⁸ and the right to the highest attainable standard of health.⁴⁹

Freedom from Torture and Cruel, Inhuman and Degrading Treatment

The related right to freedom from torture and cruel, inhuman, and degrading treatment⁵⁰ is covered under a number of international treaties, including the Convention against Torture (CAT),⁵¹ the ICCPR,⁵² the CRC,⁵³ and the CRPD.⁵⁴

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- 41 European Convention on Human Rights (ECHR). www.hri.org/docs/ECHR50.html. Accessed July 31, 2012. Article 5(1)(e). ("Everyone has the right to liberty and security of person. No one shall be deprived of his liberty...").
- 42 *Enhorn v. Sweden*. (56529/00).
- 43 Articles 12(1) and 39.
- 44 Article 17.
- 45 World Medical Association (WMA). Declaration on the Rights of the Patient. WMA Assembly September/October 1981. www.wma.net/en/30publications/10policies/14/index.html. Accessed July 31, 2012. Principle 3(a). ("Right to self-determination: The patient has the right to self-determination, to make free decisions regarding himself or herself. The physician will inform the patient of the consequences of his/her decisions.").
- 46 ICCPR. Article 9; see also *M.S. v. Sweden* (27/08/1997) and *Z v Finland* (1998) 25 EHRR 371, interpreting Article 8(1) of the ECHR.
- 47 *Ibid.* at Article 7.
- 48 *Ibid.* at Article 17.
- 49 ICESCR. Article 12.
- 50 ECHR. Article 3. ("No one shall be subjected to torture or to inhuman or degrading treatment or punishment.").
- 51 Convention against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT). UN General Assembly Resolution 39/46. December 10, 1984. www2.ohchr.org/english/law/cat.htm. Accessed July 31, 2012. ("(1) Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction. (2) No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political in stability or any other public emergency, may be invoked as a justification of torture.").
- 52 ICCPR. Article 7. ("No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.").

This right has received special attention within the European legal regime. Legal provisions related to this right include the right to adequate pain relief, which is not elaborated under binding international law but is specifically contained within the European Charter on Patients' Rights.⁵⁵ Historical and other factors prompted the creation of a unique surveillance mechanism, the European Committee for the Prevention of Torture ('the CPT'), which monitors compliance with Article 3 of the European Convention on Human Rights through regular visits to places of detention and similar institutions including prisons, juvenile detention centers, psychiatric hospitals, police holding centers, and immigration detention centers. The CPT has established detailed standards for implementing human rights-based policies, including those related to health care in prisons.⁵⁶ To address many of these issues, Open Society Foundations have also coordinated a Campaign to Stop Torture in Health Care.⁵⁷

In its rulings, the ECtHR has applied the right to freedom from torture and cruel, inhuman, and degrading treatment to the provision of adequate medical care for prisoners and detainees. This includes release from confinement, in limited circumstances, although there is no general right to release.⁵⁸ Examples of breaches of Article 3 include: the continued detention of a cancer sufferer where it caused "particularly acute hardship (France);"⁵⁹ significant defects in the medical care provided to a mentally ill prisoner known to be a suicide risk (UK)⁶⁰ and systematic failings in relation to the death of a heroin addict in prison (UK).⁶¹ In a 2006 case against Ukraine, the ECtHR found a breach of Article 3 both in terms of the conditions of detention in a pre-trial detention center – overcrowding, sleep deprivation and lack of natural light and air — and the failure to provide

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- 53 CRC. Article 37. ("States Parties shall ensure that: (a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.").
- 54 CRPD. Article 15. ("No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.").
- 55 ECPR. Article 11. ("Each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness. The health services must commit themselves to taking all measures useful to this end, like providing palliative care treatment and simplifying patients' access to them.").
- 56 See COE. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The CPT Standards. (CPT/Inf/E[2002, rev. 2006]). www.cpt.coe.int/en/documents/eng-standards.pdf. Accessed July 31, 2012. See also, generally, Adamowicz M, et al. Chapter 1: Human rights in patient care: Which are the most relevant international and regional human rights standards relevant to patient care? In *Health and Human Rights: A Resource Guide*, supra note 21.
- 57 Campaign to Stop Torture in Health Care. www.stoptortureinhealthcare.org/. Accessed July 31, 2012.
- 58 *Mouisel v. France*. (38 EHRR).
- 59 *Ibid.* Finding the detention amounted to inhuman and degrading treatment.
- 60 *Keenan v. UK*. (33 EHRR 48). Finding failure to refer to psychiatrist and lack of medical notes.
- 61 *McGlinchey and Ors v. UK*. (37 EHRR 821). Finding inadequate facilities to record weight loss, gaps in monitoring, failure to take further steps including admission to hospital.

timely and appropriate medical assistance to the applicant for HIV and tuberculosis infections.⁶² The court has also imposed robust requirements on detention settings to keep up-to-date and accurate records regarding the rationale, nature, and frequency of treatment (Romania).⁶³

The freedom from torture and cruel, inhuman, and degrading treatment has special relevance in post-totalitarian health care settings, for example, as medical and psychiatric institutions were often venues of physical and psychological torture during the Soviet era.⁶⁴ In addition to providing protection against torture, international human rights regimes also mandate humane treatment of prisoners and other institutionalized persons.⁶⁵

Right to Privacy and Confidentiality

Also in the realm of essential patient protections is the right to privacy and confidentiality as it applies to health information. This right is covered under a number of international treaties^{66, 67, 68} as well as by supplemental provisions of the ICESCR⁶⁹ and non-binding international instruments, such as the World Medical Association (WMA) Declaration on the Rights of the Patient.⁷⁰ These instruments address the related right to information, which emphasizes patient access to personal health records as well as broader health promotion content as a means to improve institutional transparency in the provision of health care.⁷¹ It is nonetheless important to recognize that the individual right to confidentiality is circumscribed by the individual's responsibility to contribute information to promote societal good, such as with disclosure of infectious disease status in some cases and inclusion of some limited health information in population-level public health research.⁷²

The right to participate in public policy⁷³ is closely related to such information access, but also engages the principle of meaningful participatory decision-making at both the individual and policy levels. These principles are enshrined in the

62 Yakovenko v. Ukraine. (15825/06). See also *Hurtado v. Switzerland* (A280-A). An X-ray, which revealed a fractured rib, was only ordered after a delay of six days.

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

64 Koryagin, A. "The Involvement of Soviet Psychiatry in the Prosecution of Dissenters." *British Journal of Psychiatry*. 1989; 154(1): 336-340.

65 ICCPR. Article 10(1). ("All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.")

66 ICCPR. Article 17(1). ("No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation.")

67 CRC. Article 16(1).

68 CRPD. Article 22.

69 ICESCR. Article 12, General Comment 14, Paragraph 12.

70 WMA. Declaration on the Rights of the Patient. Principle 7.

71 ICCPR. Article 19(2). See also CRC. Article 17.

72 Rahu M. and McKee M. "Epidemiological Research Labeled as a Violation of Privacy: the Case of Estonia." *International Journal of Epidemiology* (2008) 37: 678-682.

World Health Organization Alma-Ata Declaration, which serves as the seminal international proclamation for universal access and patient participation in health care and public health decision-making.⁷⁴ The international legal regime also includes special provisions designed to reduce barriers to the participation of traditionally excluded groups in civil governance and policy decision-making.⁷⁵ When reviewed by the UN Human Rights Committee in 1996, this right was upheld and interpreted to include unfettered patient access to health records.⁷⁶

Under the European regional regime,⁷⁷ these privacy and data-related rights are specifically focused on the protection of health information.⁷⁸ In response to the rapid development of information technology in the health care sector, applicable legal provisions in the European context have expanded to consider data security, data quality, and other issues related to electronic or other transmission of personal health information.⁷⁹ By the same token, the European framework focuses not only on protecting the patient's individual health records,⁸⁰ but also on the patient's right to know what information is being collected,⁸¹ as well as performance statistics and other information about the health care services and providers, and content-related medical and biomedical science.⁸² This last provision has special relevance in settings where access to information about evidence-based public health or medical care has been restricted in the name of morality, religion or other alleged state interest.⁸³

73 ICCPR. Article 25. See also Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). United Nations General Assembly. December 18, 1979. www2.ohchr.org/english/law/cedaw.htm. Accessed March 14, 2010. Article 7.

74 Declaration of Alma-Ata. September 6, 1978. www.who.int/hpr/NPH/docs/declaration_almaata.pdf. Accessed March 19, 2010. Article 4. ("The people have the right and the duty to participate individually and collectively in the planning and implementation of their health care.") This declaration has become one of the definitional formulations of the health and human rights framework.

75 See, e.g., CEDAW. Article 7(c).

76 HRC. *Zheludkov v. Ukraine*. Communication No. 726/1996. (CCPR/C/76/D/726/1996). Views adopted October 29, 2002.

77 ECHR. Article 8(1).

78 European Convention on Human Rights and Biomedicine. Article 10(1). ("Everyone has the right to respect for private life in relation to information about his or her health.")

79 Convention for the Protection of Individuals with Regard to Automatic Processing of Personal Data. January 28, 1981. <http://conventions.coe.int/treaty/EN/Treaties/Html/108.htm>. Accessed July 31, 2012. Articles 5-8.

80 European Charter of Patients' Rights (ECPR). http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf. Accessed July 31, 2012. Article 3. ("Every individual has the right to access to all kinds of information regarding their state of health, the health services and how to use them, and all that scientific research and technological innovation makes available.")

81 European Convention on Human Rights and Biomedicine. Article 10(2). ("Everyone has the right to know any information collected about his or her health.")

82 *Ibid.*

83 See, e.g., Radio Free Europe. "Anti-AIDS Campaigner Serving 7-year Sentence in Uzbekistan." February 24, 2010. www.rferl.org/content/Uzbeks_Give_AntiAIDS_Campaigner_SevenYear_Sentence/1967550.html. Accessed July 31, 2012.

Right to Life

The right to life has a specific meaning in the context of human rights in patient care related to the state responsibility to provide for and continuously improve health care services. This includes care for members of marginalized or criminalized groups or the disabled, whose lives may be seen as having less value in some settings, or are at risk as a result of arbitrary denial of health care services. Beyond merely imposing a government duty to respect life, this right is also understood to extend to the duty to provide citizens the conditions for a life with dignity. Among the treaties covering this right are the ICCPR,⁸⁴ CRC,⁸⁵ and CRPD.⁸⁶ Although abortion and euthanasia are not explicitly covered under the international human rights regime, some commentators have interpreted the right to abortion to be implied by the provisions guaranteeing access to adequate reproductive services,⁸⁷ while some assert the right to euthanasia flows from the right to be free from pain and the right to dignity of person.⁸⁸ The ECtHR has, however, declined to recognize the right to die as an extension of the right to life.⁸⁹

Right to Non-discrimination and Equality

In emphasizing universal and equal access for all people, the right to non-discrimination and equality represents a key component of human rights in patient care. Provisions that elaborate this right create special protection and enforcement mechanisms for marginalized groups, including racial, gender, and other minorities,⁹⁰ women,⁹¹ people living with HIV/AIDS,⁹² disabled persons,⁹³ children,⁹⁴ and migrants,⁹⁵ among others. The ECHR flatly prohibits discrimination on "any ground such as sex, race, color, language, religion, political or other opinion, national or social origin, association with a national minority, property,

84 ICCPR. Article 6(1).

85 CRC. Article 6.

86 CRPD. Article 10.

87 ECHR Article 2 and CRC Article 6; See, e.g., Zampas C. and Gher J.M.. "Abortion as a Human Right—International and Regional Standards." *Human Rights Law Review*. (2008) 8 (2): 249-294.

88 See, e.g., M. Otlowski. *Voluntary Euthanasia and the Common Law*. (Oxford: Oxford University Press, 2004), 195-200.

89 *Pretty v UK*. (35 EHRR 1).

90 ICESCR. Article 2(2).

91 CEDAW. Article 12. ("(1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. (2) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.")

92 Committee on Economic, Social, and Cultural Rights (CESCR). General Comment 14 of the Committee on Economic, Social and Cultural Rights: The right to the highest attainable standard of health. (E/C.12/2004/4).

93 CRPD. Article 12.

94 CRC. Article 23(1).

birth or other status.”⁹⁶ This provision of the ECHR is related to a wide array of more specific affirmative laws aimed at protecting and strengthening the rights and well-being of migrants and stateless persons,⁹⁷ persons with disabilities,⁹⁸ children,⁹⁹ and national minorities,¹⁰⁰ among others.

Provider Rights

Issues that are especially relevant to the discussion of human rights in patient care include providers’ rights to: (1) decent working conditions and fair pay; (2) freedom of association, including unionization; (3) due process and related rights such as fair hearing; protection of privacy and reputation; and freedom of expression and information. Relevant European regional standards appear in the European Convention on Human Rights (ECHR) and the European Social Charter (ESC), among other documents. Although health care workers’ rights may not be expressly mentioned in legal instruments, these employees enjoy the same kinds and levels of protection as workers of other sectors. Sources of international and European human rights law specifically related to the rights of health care providers generally consider the issue of occupational safety. Numerous international treaties and conventions include rights designed to protect workers and ensure safe and healthy work environments. The United Nations and its agencies, including the International Labor Organization (ILO), have developed some of these international standards and continually monitor their implementation.

Right to Work in Decent Conditions

International instruments widely recognize the right to work in decent conditions, which includes protection of occupational health and safety,¹⁰¹ fair pay,¹⁰²

95 International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families (CMW). UN General Assembly Resolution 45/158. December 18, 1990. www2.ohchr.org/english/law/cmw.htm. Accessed July 31, 2012. Article 28. (“Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.”)

96 ECHR. Article 14.

97 ESC. Article 13. See also Convention Relating to the Status of Stateless Persons. Article 23.

98 ESC. Article 15 (Rights of persons with disabilities to vocational training, rehabilitation and social resettlement.).

99 ESC. Article 17 (The right of children to protection).

100 Framework Convention for the Protection of National Minorities (FCNM).

101 Convention Concerning Occupational Safety and Health and the Working Environment. June 22, 1981. www.ilo.org/ilolex/cgi-lex/convde.pl?C155. Accessed July 31, 2012. Article 3.

102 ICESCR. Article 7. (“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favorable conditions of work which ensure, in particular: (a) Remuneration which provides all workers, as a minimum, with: (i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work. . .”).

provisions banning workplace discrimination against migrants,¹⁰³ women,¹⁰⁴ and specific racial and ethnic groups,¹⁰⁵ among others. At the international level, the ICESCR and numerous conventions promulgated by the ILO provide the widest coverage of workplace issues. This includes not just safety, but also basic working conditions, such as decent work hours and the equipment and supplies needed to fulfill duties.

Under European law, the right of every worker to a safe and healthy working environment has been held to constitute a “widely recognized principle, stemming directly from the right to personal integrity, one of the fundamental principles of human rights.”¹⁰⁶ The purpose of Article 3 of the ESC is thus linked to the right to life (Article 2, ECHR).¹⁰⁷ Under this Article, workers are also provided the right to participate in decision-making to determine policies and conditions pertaining to the overall occupational environment.¹⁰⁸

These international human rights regimes have been held to protect the rights of public sector employees from drastic downsizing;¹⁰⁹ to require better parity between public and private-sector employees in the same profession;¹¹⁰ and to address unsafe working conditions and lack of compensation for workplace injury.¹¹¹ International oversight bodies have called for effective implementation of legislative provisions concerning job security;¹¹² and excessive working hours in both the public and private sectors.¹¹³ However, the same bodies have upheld the right of states to screen and maintain quotas for foreign medical professionals.¹¹⁴

103 CMW. Article 25(1). (“ 1) Migrant workers shall enjoy treatment not less favorable than that which applies to nationals of the State of employment in respect of remuneration.”).

104 CEDAW. Article 11(1)(f).

105 CMW. Art. 25(1).

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

107 COE. Conclusions XIV-2. Statement of Interpretation on Article 3.

108 ESC. Article 22.

109 CESCR, U.N. Econ. & Soc. Council [ECOSOC], Geneva, Switz., April 26 to May 14, 1999, *Report on the Twentieth and Twenty-First Sessions*, Solomon Islands, 201, U.N. Doc. E/C.12/1999/11. ICESCR. *Concluding Observations: Solomon Islands*, 1999. (E/2000/22).

110 CESCR, ECOSOC, Geneva, Switz., Nov. 25 to Dec. 13, 1991, *Report on the Sixth Session*, Spain, 291, U.N. Doc. E/1992/23; *Ibid.* Colombia, at 320. ICESCR. *Concluding Observations: Spain*, 1991. (E/1992/23); *Concluding observations Colombia*, 1991 (E/1992/23).

111 CESCR, ECOSOC, Geneva, Switz., April 28 to May 6, 1997, *Report on the Sixteenth and Seventeenth Sessions, Conclusions 2006, Albania*, p. 30. Russian Federation, 104, U.N. Doc. E/1998/22 (ECOSOC condemned the large number of illegal dismissals and non payment of wages). ICESCR. *Concluding Observations: Russian Federation*, 1997. (E/1998/22). The committee later condemned the large number of illegal dismissals and nonpayment of wages.

112 CESCR, ECOSOC, Geneva, Switz., Nov. 13 to Dec. 1 2000, *Report on the Twenty-Second, Twenty-Third, and Twenty-Fourth Sessions, Finland*, 454, U.N. Doc. E/2001/22. ICESCR. *Concluding Observations: Finland*, 2000. (E/2001/22).

113 CESCR, ECOSOC, Geneva, Switz., Aug. 13 to 31, 2001, *Report on the Twenty-Fifth, Twenty-Sixth, and Twenty-Seventh Sessions, Japan*, 598, E/2002/22. ICESCR. *Concluding Observations: Japan*, 2001. (E/2002/22).

In the European context, the right to work in decent conditions under the ESC has been held to imply, for example, that the only jobs from which foreigners may be banned are those that are inherently connected with the protection of the public interest or national security and involve the exercise of public authority.¹¹⁵

Right to Freedom of Association

Another key provider right is the freedom of association, and the related right to organize. Given the complexities imposed by the dual loyalty framework, these rights have particular significance for the independence of the medical profession. This right is covered under a number of ICESCR,¹¹⁶ ICCPR,¹¹⁷ and ILO provisions,¹¹⁸ with specific provisions to eliminate various forms of discrimination,¹¹⁹ such as retaliatory discrimination against those participating in labor organizations.¹²⁰ Specifically outlined in ICESCR¹²¹ and ILO instruments is the right to participate in trade unions, the right to strike, and the right to engage in other collective bargaining activities.¹²² Even though the ICESCR's rights to assembly and work stoppages are broadly construed, the ILO provisions on this point include special exclusions for public sector employees engaged in "essential service," with implications for health care providers in many settings.¹²³

European law permits "lawful restrictions" to be placed on certain public officials

114 See, e.g., *B. M. S. v. Australia*, CERD, Comm. No. (8/1996), Available at www.bayefsky.com/pdf/102-Australiacerd08.pdf. Accessed July 31, 2012; see also CERD, *Report of the Committee on the Elimination of Racial Discrimination, Fifty-fourth Session, Fifty-fifth Session*, 80, U.N. Doc. A/54/18 (March 1-19, 1999).

115 COE. Conclusions 2006: Albania.

116 ICCPR. Article 22. ("(1) Everyone shall have the right to freedom of association with others, including the right to form and join trade unions for the protection of his interests. (2) No restrictions may be placed on the exercise of this right other than those which are prescribed by law and which are necessary in a democratic society in the interests of national security or public safety, public order (ordre public), the protection of public health or morals or the protection of the rights and freedoms of others.").

117 ICCPR. Article 22. ("(1) Everyone shall have the right to freedom of association with others, including the right to form and join trade unions for the protection of his interests. (2) No restrictions may be placed on the exercise of this right other than those which are prescribed by law and which are necessary in a democratic society in the interests of national security or public safety, public order (ordre public), the protection of public health or morals or the protection of the rights and freedoms of others.").

118 ILO. Convention No. 87 on the Freedom of Association and Protection of the Right to Organise. Table of ratifications. www.ilo.org/ilolex/cgi-lex/ratifce.pl?C087. Accessed July 31, 2012. Article 2.

119 See, e.g., ICERD. Article 5.

120 ILO Convention 98 on Right to Organize and Collective Bargaining. Article 1. Table of ratifications. www.ilo.org/ilolex/cgi-lex/ratifce.pl?C098.

121 ICESCR. Article 8(1).

122 ILO Convention 98. Article 2(1).

123 See, e.g., *Ibid.* at Article 6.

(e.g., the armed forces and the police) including members of the “administration of the state.”¹²⁴ However, the latter term should be narrowly interpreted, according to the ECtHR,¹²⁵ and it may or may not apply to medical professionals employed by the state.

The right to strike is similarly protected under European law. This right is implied in the right to conduct collective bargaining.¹²⁶ Any limitation to this right must serve a legitimate purpose and be necessary in a democratic society for the protection of the rights and freedoms of others or for the protection of public interest, national security, public health or morals.¹²⁷ However, outright bans on actions in essential sectors—particularly when they are expansively defined, e.g. “energy” or “health”—must be supported by specific determination weighing the proportionality of risk to the state from the work stoppage.¹²⁸

Due Process

Especially in view of the conflicts implied by the dual loyalty conundrum, protections for health care providers in the realm of human rights in patient care must include the right to due process and fair hearing. The right to a “competent, independent and impartial tribunal” before being administered any kind of penalty is broadly outlined in the ICCPR.¹²⁹ This expansive language covers administrative and disciplinary hearings typically employed by health care institutions to censure their employees. As with other rights, the international human rights regime includes special protections for traditionally marginalized groups, including racial minorities¹³⁰ and women.¹³¹ To vindicate these rights, victims have the related right to an effective remedy, as outlined in the ICCPR,¹³² including special provisions for administrative remedies. The right to

124 This approach has been endorsed by ESCR experts but not by the ILO Freedom of Association Committee, although Article 9(1) of ILO Convention No. 87 limiting public servants’ rights does not refer to “administration of the state.”

125 *Vogt v. Germany*. (21 EHRR 205).

126 ESC. Article 6. (The right to bargain collectively: “With a view to ensuring the effective exercise of the right to bargain collectively, the Parties undertake: (4) the right of workers and employers to collective action in cases of conflicts of interest, including the right to strike, subject to obligations that might arise out of collective agreements previously entered into.”).

127 COE. Conclusions: Norway. (X-1). Regarding Article 31 of the charter.

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

129 ICCPR. Article 14(1). (“All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.”).

130 CERD. Article 5(a).

131 CEDAW. Article 15(1) (“States Parties shall accord to women equality with men before the law.”).

132 ICCPR. Article 2(3). (“Each State Party to the present Covenant undertakes: (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity”).

due process is intrinsically linked to the patients' right to complain.

The European Court of Human Rights has provided extensive interpretation of the right to a fair hearing as guaranteed under Article 6 of the Convention. This includes rights to notice, representation, adjudication, and other aspects of conflict resolution deemed to be "fair" under European law. This procedural framework applies to the determination of civil rights abuses or criminal charges. It also covers all related proceedings between the state and the individual or between private parties. To attract protection, the proceedings must be "decisive" with respect to civil rights and other obligations. However, it includes disputes concerning licensing or other professional assets of health providers.¹³³

In the context of provider rights and responsibilities, health care settings create several complex legal and ethical issues involving information. Secure recording, handling, and communicating health-related information may be especially difficult in resource-constrained settings and/or cultural contexts where privacy concerns are not seen as a priority. Dual loyalty places competing demands on providers when they act as information gatekeepers, such as when advising patients about expensive or experimental treatment options under single-payer systems, or when the law requires mandatory reporting of confidential patient information to police or child protection services. A series of related rights are encompassed in the rights to free expression and information which are broadly outlined in the ICCPR,¹³⁴ while being subject to the legitimate power of governments to limit information dissemination to protect state interests, such as during public health emergencies. Providers' professional reputations also warrant special protection. Public criticism of their performance may have devastating consequences for their careers. In its provisions addressing damage to reputation, in the context of right to privacy, international law includes a number of safeguards from such attacks,¹³⁵ with close parallels to the right to due process outlined above.

The examples above demonstrate the applicability of the human rights regime in the patient care setting, with relevance to both patients and providers. There is ample room to expand this jurisprudence by bringing new cases of abuse and arguing for expansive interpretations of human rights treaties to apply to diverse health care delivery contexts.

133 Ringeisen v. Austria. (1 EHRR 466).

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

135 Ibid. at Article 17(2). ("Everyone has the right to the protection of the law against such interference or attacks.").

National Findings: Setting

Six of the countries included in this compendium (excluding Macedonia) share the experience of having emerged from Soviet rule sometime in the early 1990s, although they differ vastly in size, demographics, cultural and religious heritage, economic indicators, and many other ways. The Communist heritage, however, left an undeniable common legacy, and reforming governance and institutions has presented enormous challenges in those countries. This is especially discernible in the evolving legal and health care systems of these nations.

Sources external to the practitioner guides provide several background points about countries that emerged from the former Soviet Union. For example, the dismantling of the highly-centralized and regimented Communist-era health care provision networks gave rise to highly-disorganized, under-financed, and corrupt systems in most of these countries.¹³⁶ To varying degrees, this led to health care systems described as being characterized by drastic inequity and unreliable quality.¹³⁷ This has been concurrent with, and sometimes the cause for, precipitous population-level rise in infectious and chronic disease, substance abuse, and numerous other health problems. With the reduction in funding or de-funding of health care services and institutions, many of the countries in the region have seen their health and quality of life indicators dip during the transition period.¹³⁸ At the same time as effective government control of the health care systems and institutions eroded, the legal systems failed to fill the gap in oversight.¹³⁹ Although significant progress had been made by 2004, as noted in one article, many of these legal systems continued to face substantial challenges, including out-of-date and conflicting bodies of laws and regulations, lack of judicial independence, and under-funded legal education, as well as numerous structural issues, such as lack of proper compensation for judges and crumbling infrastructure.¹⁴⁰ A 2011 UNDP study,

136 WHO Regional Office for Europe. European Observatory on Health Systems and Policies Website Health systems in transition (HiT) list of summaries. www.euro.who.int/en/who-we-are/partners/observatory/health-systems-in-transition-hit-series/hit-summaries. Accessed July 31, 2012 (hereinafter WHO HiT); see also Thompson R, Witter S. Informal Payments in Transitional Economies: Implications for Health Sector Reform. *Int J Health Plann Manage*. 2000;15:169-187; see also Gaal P, et al. Informal Payments for health care: Definitions, Distinctions, and Dilemmas. *J Health Polit Policy Law*. 2006;31(2):251-253.

137 Balabanova D, et al. Health service utilization in the former Soviet Union: Evidence from eight countries. *Health Serv Res*. 2004;39(6):1927-1949.

138 WHO Regional Office for Europe, supra note 136.

139 Gerber T. When public institutions fail: Coping with dysfunctional government in post-Soviet Russia. *Contexts*. 2004;3(1):20-28. See, generally, American Bar Association, Europe and Eurasia Rule of Law Initiative. www.americanbar.org/advocacy/rule_of_law/where_we_work/europe_eur-asia.html (follow individual country hyperlinks for "regional publications" on continuing reform measures within each country). Accessed July 31, 2012.

140 Ibid.

in which three of the PG countries were included, reported that, in many transitional countries of Europe and Central Asia, there remains a deep-seated cultural distrust for the legal system, the courts, and for due process or the rule of law in general; informed by decades of abuse and neglect, this distrust is especially acute among members of economically, ethnically, and other marginalized groups.¹⁴¹ Reforms in both legal and health systems continue. For example, Kazakhstan, Kyrgyzstan and Russia are undergoing significant health reforms during the time of drafting of the practitioner guides.¹⁴²

Macedonia emerged from the Socialist Federal Republic of Yugoslavia in 1991 and in contrast to the centralized Soviet health system, inherited a highly-decentralized, highly-autonomous, socialist health system, with financing and control primarily at the local level.¹⁴³ Because of fragmentation of service delivery, oversupply and duplication of services and facilities, it moved to a more centrally-managed system of structures and compulsory health insurance after independence, with movement back towards decentralization beginning after August 2001.¹⁴⁴ The health care system of the new independent republic faced challenges that included the need to overcome legacies of the former health system: need to rationalize health care provider structures, reduce the oversupply of health care professionals and to secure stabilized financing.¹⁴⁵ After 2006, government policy included a focus on comprehensive health reform, with the aim of reduction of inequalities in health delivery at the point of service, according to the needs of patients.¹⁴⁶ Changes continue, some reflecting the same or similar continuing needs over time.¹⁴⁷ In 2012, the official website of the government of Macedonia, for example, states the main priorities in regard to the health system until 2015 to be the raising of health service quality, strengthening primary health care and prevention, and establishing a stable system for financing the health care of all citizens.¹⁴⁸ Due to major changes in health legislation in 2012, the Macedonia PG is undergoing a major comprehensive review and amendment process.

141 United Nations Development Programme (UNDP) Regional Bureau for Europe and CIS. *Regional Human Development Report: Beyond Transition, Towards Inclusive Societies*. 2011: 30-33, 49-51. Available at <http://europeandcis.undp.org/home/show/BCD10F8F-F203-1EE9-BB28DEE6D-70B52E1>. Accessed July 31, 2012.

142 See WHO Regional Office for Europe, *supra* note 136 (follow hyperlinks for these three countries for information on recent and ongoing reforms).

143 WHO HiT: Macedonia. www.euro.who.int/__data/assets/pdf_file/0005/96413/E89275.pdf. 2006: 27. Accessed July 31, 2012; see also Center for Research and Policy Making. *Rationalization of Health Care Services in Macedonia, Case Studies: Skopje, Tetovo, Sveti Nikolae, Negotino*. Available at www.crpm.org.mk. Accessed July 31, 2012.

144 *Ibid.*

145 WHO HiT: Macedonia at 17.

146 Lazarevik V. "Policy Interventions to Tackle Health Inequalities in Macedonia: Patient rights and reference pricing of pharmaceuticals." *Macedonian J of Med Sci*. 2010; 3(1):57-60.

147 Macedonia Government Website. Health Care. vlada.mk/?q=node/272&language=en-gb. Accessed July 31, 2012.

148 *Ibid.*

To introduce the legal and practical analysis in the practitioner guides, each of the participating countries' working groups was given the option to prepare a note describing the general structure and current state of its domestic legal and/or health care system. Some country groups provided descriptions of both; others provided a description of only one. The sections below provide a brief overview of these introductory notes.

Legal Systems

The countries included here have undergone a series of substantive—and at times drastic—reforms in recent years. These have included the adoption of new constitutions in the early 1990s in all countries, and several times since then in some cases.¹⁴⁹ To varying degrees, the laws in six of the states retain characteristics of Soviet-era law, and their judicial systems retain ties to the Soviet variation of the Romano-Germanic framework; Macedonia adopted the continental legal system as well instead of a common law model.¹⁵⁰

Notably, most of these states have made significant steps to harmonize their evolving legal regimes with international standards. Armenia, Georgia, Russia, and Ukraine, members of the Council of Europe, have done so in regard to European standards as well. (In 2009, Armenia, Georgia, and Ukraine joined the Eastern Partnership, a project initiated by the European Union.) Kazakhstan and Kyrgyzstan

149 Armenia (1995, 2005); Georgia (1995); Kazakhstan (1993, 1995); Kyrgyzstan (1993, 1996, 2003, 2007, 2010); Macedonia (1991); Moldova (1994); Russian Federation (1993); and Ukraine (1996).

150 See, generally, the following sections in each designated practitioner guide (PG): Chapter 5, Section 2, Status of precedent. In: Open Society Foundations. *Human Rights in Patient Care: A Practitioner Guide – Georgia*. 2011:125 (noting that “Unlike common law countries, power of precedent is not granted to the court.”) [hereinafter Georgia PG]; see also the following sections in each designated draft PG: Chapter 5, Section 2, Status of precedent. In: Open Society Foundations. *Human Rights in Patient Care: A Practitioner Guide – Kazakhstan*. 2012 (noting that “The legal system of the Republic of Kazakhstan belongs to the Roman-German (continental) legal system where sources of law are legislative acts.”) [hereinafter Kazakhstan PG]; see also Chapter 4, Section 2, Status of precedent. In: Open Society Foundations. *Human Rights in Patient Care: A Practitioner Guide – Kyrgyzstan*. 2012 (noting that “The Kyrgyz Republic is a country with the Roman-Germanic (continental) system of law. The main source of law in the Kyrgyz Republic is legislation.”) [hereinafter Kyrgyzstan PG]. See Chapter 5, Section 2, Specifics of the National Legal System. In: Open Society Foundations. *Human Rights in Patient Care: A Practitioner Guide – Macedonia*. 2010:135 (noting that “Characteristic of the judicial system in Macedonia is that it has accepted the continental model instead of the Common Law or Case Law model.”) [hereinafter Macedonia PG]; and Chapter 5, Section 2, The status of precedent. In: Open Society Foundations. *Human Rights in Patient Care: A Practitioner Guide – The Russian Federation*. 2012 (noting that “The legal system of the Russian Federation belongs to the Romano-Germanic legal family; this determines that the main source of law is a legal act....”) [hereinafter Russia PG]; see also Juviler P. *Freedom’s Ordeal: The Struggle for Human Rights and Democracy in Post-Soviet States*. Philadelphia, PA: University of Pennsylvania Press; 1998; and Chapter 5, Section 3, Legal and Health Systems: Legal system. In: Open Society Foundations. *Human Rights in Patient Care: A Practitioner Guide – Ukraine*. 2012:174 (noting that “Ukraine belongs to the continental legal system where the main source of law is a legal act.”) [hereinafter Ukraine PG].

are in the process of enacting and implementing major health reforms at the time of this writing. Macedonia, in addition to its Council of Europe membership, has further advanced harmonization of its laws, having become an official candidate country for EU accession in 2005; high-level accession dialogue (HLAD) with the European Union began in March 2012.¹⁵¹

Most have adopted international and regional treaties related to human rights in patient care, with the ECHR being one of the most widely-adopted (See Table 2). Once ratified and enacted, international laws become part of the domestic legal regime. Courts must consider binding and may consider non-binding international laws.¹⁵² Another regional treaty regime includes a set of regional mechanisms within the Commonwealth of Independent States (CIS),¹⁵³ in which the PG countries of Armenia, Kazakhstan, Kyrgyzstan, Moldova, and Russia are full members and Ukraine is a participatory country. However, as noted in the PGs, these regional and international instruments do not create effective oversight or monitoring mechanisms.¹⁵⁴

“Soft” legal instruments further play an important role in the field of human rights in patient care. The Georgia PG in particular reports the adoption of some of those instruments into national law (e.g., declarations and guidelines of the World Medical Association, Council of International Organization on Medical Sciences). The Georgia PG authors stated that, to a significant extent, reforms to patients’ rights laws have been informed and driven by these international instruments and concepts, noting that the documents that played a major role in the drafting of Georgia patients’ rights legislation are the Declaration on the Promotion of Patients’ Rights in Europe (WHO 1994) and the Convention on Human Rights and Biomedicine (Council of Europe; opened for signature, 1997).¹⁵⁵ The Armenia PG

151 European Commission. Start of the High Level Accession Dialogue with the government of the former Yugoslav Republic of Macedonia. MEMO/12/187. March 15, 2012. <http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/12/187&format=HTML&aged=0&language=EN&uiLanguage=en>. Accessed July 31, 2012. See also, generally, European Commission. Enlargement: Candidate countries. fYR Macedonia – Country profile. http://ec.europa.eu/enlargement/candidate-countries/the_former_yugoslav_republic_of_macedonia/index_en.htm. Updated April 19, 2012. Accessed July 31, 2012.

152 Hereinafter, “international” is used to refer to both UN or other international instruments as well as the European-level legislation.

153 See, e.g., Convention of the CIS on Human Rights and Fundamental Freedoms. Minsk, May 26, 1995.; see also Statute of the CIS Commission on Human Rights. Moscow, September 24, 1993.

154 See Kyrgyzstan PG, Chapter 4, Section 1 (“[T]he documents adopted within the Commonwealth of Independent States do not set forth the effective control mechanisms that could ensure execution of the agreements.”); Kazakhstan PG, Chapter 2, Section 3 (“lack of an individual complaint mechanism has hampered”); Armenia PG, Chapter 2, Section 3 at 23; Georgia PG, Chapter 2, Section 3 at 23; Macedonia PG, Chapter 2, Section 3 at 15; Ukraine PG, Chapter 2, Section 3 at 32. See also Russia PG, Chapter 2, Section 3; See, in general, Executive Committee of the CIS, CIS Human Rights Treaties 1991-2007. Available at www.geneva-academy.ch/RULAC/pdf_state/Human-Rights-1-.pdf. Accessed July 31, 2012.

155 Georgia PG, Chapter 5, Section 1 at 123.

highlights the fact that Armenia does not have an approved provider code of ethics at the time of writing of the PG, but that the Medical Association of Armenia is a member of the World Medical Association whose Medical Ethics Manual and other policies and declarations on ethical issues, though not necessarily legally binding, provide respected standards for medical professionals to follow.¹⁵⁶

At the present time, the legal environment in participating countries is still rapidly shifting. Traditionally, as noted above regarding the types of legal systems, precedent has not been a source of law and is not binding. However, the increasing penetration of international and European law has led to gradual “hybridization” of the existing and precedential frameworks in some instances, to the extent that international/European precedent may be cited to guide court decisions. In Armenia and Ukraine, the incorporation of binding precedent into legal decision-making has gone beyond consideration of international and European jurisprudence and has been legally sanctioned and codified.¹⁵⁷ The Armenia PG includes a detailed discussion of the potential of ECtHR decisions as sources for lawyers and judges at the domestic level but also notes that attorneys and judges are often uninformed or under-equipped to identify and consider this source of law in their work.¹⁵⁸ In other settings, such as Kazakhstan and Kyrgyzstan, the PGs note that precedent of any kind has no bearing on domestic jurisprudence.¹⁵⁹ The Russia PG notes that while there is no use of precedent in the Russian Federation, the jurisdiction of the European Court means that activities of state authorities, particularly their courts, decisions and procedures used, as well as legislative solutions “must not contravene the provisions of the Convention....”¹⁶⁰

Decades-long efforts to modernize the substantive body of law parallel functional reforms in the legal system, including professionalization of judges, systematization of court administration, governance, and anti-corruption mechanisms. In Georgia, for example, the system for investigating and adjudicating judicial misconduct is being completely revamped to include an entire system of new robust procedures and mechanisms to both ensure meaningful due process and minimize conflicts of interest.¹⁶¹ Armenia reformed its judiciary in 1999 from a two-level system into a three-level system, and is undergoing a second phase of judicial reforms aimed at improving impartiality, independence, and efficiency of judicial power.¹⁶² Macedonia is engaged in a continuing process of accession-related reforms, including reorganization to fill structural gaps and measures to

156 Armenia PG, Chapter 6, Section 1 at 145.

157 Article 15(3) of the Armenian Judicial Code; Ukraine PG, Chapter 5, Section 2 at 173.

158 Armenian PG, Chapter 5, Section 1 at 138.

159 Kazakhstan PG, Chapter 5, Section 2 (“recognition of legislation as a source of law”); Kyrgyzstan PG, Chapter 4, Section 2 (“Court decisions are not normative acts”).

160 Russia PG, Chapter 5, Section 2.

161 Georgia PG, Chapter 5, Section 2 at 125-129.

162 See the Judiciary of Armenia’s Official Website. www.court.am/?l=en. Accessed on July 31, 2012.

strengthen judiciary independence, although further steps are needed to improve both independence and professionalism, as well as to fight corruption.¹⁶³ Ukraine has undergone wide-ranging computerization of court administration and reform in its legal education system, including a single electronic register of published court decisions and large-scale implementation of clinical legal education.¹⁶⁴ In Kazakhstan and Kyrgyzstan, aid money from the European Commission has been explicitly earmarked for judicial reform and rule of law measures aiming at improving democratic development and good governance.¹⁶⁵ Legal education remains largely under the control and financing of the national governments, although numerous private law schools or law faculties within private universities have emerged in all seven countries included here.¹⁶⁶

The ongoing work to improve the rule of law and legal education, as well as the increasing influence of international legal instruments and procedures, offers an opportunity to integrate human rights in patient care into this broad agenda. Bundling programs addressing human rights in patient care with other human rights initiatives can help leverage international and domestic resources to alleviate this critical set of problems.

Health Care System and Its Regulation

As noted above, six countries included in this compendium have transitioned from the Soviet monolithic, centralized, low-cost, universal and population health-minded system of health care provision. They now have systems that include both private and public institutions, as well as hybrid institutions. Extensive decentralization changed the organization of health care as the role of the municipal and regional authorities and private entities in providing services expanded. While this

163 Conclusions on the former Yugoslav Republic of Macedonia. In *Communication from the Commission to the European Parliament and the Council "Enlargement Strategy and Main Challenges 2011-2012*. COM 2011:666 final.

164 Law Regarding Access to Judicial Decisions, 2005, Ukraine; Decision of Ministry of Education October 27, 1993 On Private Higher Educational Institutions in the National System of Education of Ukraine.

165 See European Commission. Development and Cooperation–Europeaid. Kazakhstan. http://ec.europa.eu/europeaid/where/asia/country-cooperation/kazakhstan/kazakhstan_en.htm. Updated February 17, 2012. Accessed on July 31, 2012; see also European Commission. Development and Cooperation–Europeaid. Kyrgyzstan. http://ec.europa.eu/europeaid/where/asia/country-cooperation/kyrgyzstan/kyrgyzstan_en.htm. Updated February 17, 2012. Accessed on July 31, 2012.

166 Ukraine has seen an especially vibrant expansion in the number of private law schools: see, e.g., Krok Economics and Law University. <http://int.krok.edu.ua/en/>. Accessed July 31, 2012; Other countries in the region also have frameworks for licensing private legal education, including Russia: see, e.g., Kazan Social-Law Institute (KSLI). www.aso-ksui.ru/eng Accessed July 31, 2012; Armenia, see, e.g., American University of Armenia, Law Department. <http://law.aua.am/home.html> Accessed on July 31, 2012; Kazakhstan, see, e.g., Adilet Law Academy, Turan University, and Kunaev University, all in Almaty; Macedonia, see, e.g., FON University in Skopje; Kyrgyzstan, see, e.g., American University of Central Asia in Bishkek; Georgia, see e.g. Caucasus University School of Law and Tbilisi Academy of Economy and Law, both in Tbilisi.

brought greater diversity, it also led to fragmentation of the system and complicated efforts to enforce standards and assure quality.¹⁶⁷

As also noted, the health care service delivery system in Macedonia at the time of independence was owned and managed by municipalities, with little central government influence at the local level. As was the case in the other six countries included here, decentralization led to fragmentation (oversupply and duplication of facilities and services as well). Another legacy of the local control combined with a concurrent lack of uniform performance standards was the resulting inequalities in health care delivery.¹⁶⁸ Legal responses collectively laid out the basis for changing the health care system and its organizational structure and created a now-independent Health Insurance Fund (HIF), providing the basis for compulsory health insurance.¹⁶⁹ A series of other reforms led to the creation of a network of health institutions that includes both public and private entities in three levels of care (primary, secondary and tertiary—with special focus on primary care).¹⁷⁰ HIF contracting with private entities began with primary care facilities at the outset; today most dental offices, general practitioners, gynecologists in primary care, and pediatricians are privatized, as are a growing number of pharmacies.¹⁷¹

The legislative framework for governing the health care sector varies among the participating countries. In several countries, including Ukraine, Georgia, Russia, and Kazakhstan, flowing from the constitutional provision of the right to health, a primary “Health Care Law” generally forms the overall contours of regulation, ownership, financing, and other issues.¹⁷² Many of these countries have also promulgated laws, legislative orders, and regulations governing certain facets of the health care sector. For instance, Kazakhstan, Georgia, Russia, Ukraine, Macedonia, Armenia, and Kyrgyzstan have laws governing health care and pharmaceutical

167 See, e.g., Armenia PG, Chapter 5, Section 3 at 141; Ukraine PG, Chapter 5, Section 3 at 176-177; Georgia PG, Chapter 5, Section 3 at 130; Kyrgyzstan PG, Chapter 4, Section 3 (“comprehensive integrated health care system”); Kazakhstan PG, Chapter 5, Section 3 (“management of medical care”); Russia PG, Chapter 5, Section 3 (“health systems in accordance with the fundamental principles of legislation of the Russian federation on public health care”).

168 Center for Research and Policy Making, *Rationalization of Health Care Services in Macedonia, Case Studies: Skopje, Tetevo, Sveti Nikole, Negotino*. Available at www.crpm.org.mk. Accessed July 31, 2012.

169 WHO HiT: Macedonia at 21.

170 Kameev N, Angelovska B, Kameeva G, Richter K. “Health Organization in Republic of Macedonia—the Place of Preventive Health Care in the Medical Health System: Advantages and Disadvantages.” *European Association for Predictive, Preventive, and Personalized Medicine (EPMA) Journal*. 2010; 1:595-599.

171 WHO HiT: Macedonia at 26.167

172 See, e.g., The Law of Ukraine, Principles of Ukrainian Health Care Legislation (1992); see also The Law on Health Care, Republic of Georgia (2007); Fundamental Principles of Legislation of the Russian Federation on Protection of the Health of Citizens (1993); The Code of the Republic of Kazakhstan On the Health of the People and the Healthcare System (2009).

professions.¹⁷³ In all of the PG countries, laws governing health care financing exist.¹⁷⁴ Additionally, laws governing the relationship between the state and other entities engaged in medical care activities exist in all seven countries.¹⁷⁵ In Georgia, for example, a pilot health care mediation project began in 2012 in which the government-ordered Health Mediation Service, under the umbrella of the Ministry of Labor, Health and Social Affairs, helps settle disputes among patients enrolled in the state-funded health benefits program, the insurance companies contracted with the state, and/or health care providers. In addition to mediation and dispute resolution, the service is also tasked with monitoring of health care facilities that participate in the state health insurance program.¹⁷⁶

Provisions in nearly all of the countries addressing high-priority topics, such as HIV/AIDS and other infectious diseases;¹⁷⁷ mental health and psychiatric services and treatment;¹⁷⁸ blood donation;¹⁷⁹ reproductive rights and technologies;¹⁸⁰ child and maternal health (specifically in Georgia and Ukraine);¹⁸¹ tobacco control;¹⁸² narcology and addiction;¹⁸³ as well as other high-visibility or controversial

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- 173 See, e.g., Decree No 1729 On Approving Rules of Organizing and Conducting Purchases of Medicines, Preventive Preparations, Products of Medical Purposes and Medical Equipment, Pharmaceutical Services for Rendering the Guaranteed Volume of Free Medical Services issued by the Government of the Republic of Kazakhstan (2009); The Law on Doctor's Professional Activity, Republic of Georgia (2001); Federal Act of the Russian Federation No. 86-FZ Concerning Medicines (1998); Ukraine Ministry of Health Order No. 427 On Approval of a Unitary Glossary on the Issues of Health Care Quality Management (2011); The Law on Drugs and Medical Devices, No. 106/07, Macedonia (2007); Article 19, Law on Medical Care and Services to the Population, Republic of Armenia (1996); Article 28, Law On Pharmaceuticals, of Kyrgyzstan (1997).
- 174 See, e.g., Resolution No. 2299 On Approving Rules and Conditions for Rendering Fee-paying Services in Medical Organizations issued by the Government of Kazakhstan on 30 December 2009; see also Government Decree N 318-N, Republic of Armenia (2004); Ukraine Ministry of Health Order No. 1071 On the Procedure for Purchasing of Medicines by Health Care Establishments and Institutions Financed from the Budget (1996); The Law on Health Insurance, Macedonia (2000); Article 11, The Law on the Rights of Patients, Republic of Georgia (2000); Law No. 112 On Health Insurance of the Citizens of Kyrgyzstan (1999); Federal Order No. 811 On the Program of State Guarantees for Citizens of the Russian Federation Providing Free Medical Care for 2010 (2009).
- 175 See, e.g., Federal Act No. 128-FZ of the Russian Federation Concerning the Licensing of Certain Types of Activities (2001); see also Article 29, The Basic Law of the Republic of Kazakhstan—The Constitution of the Republic of Kazakhstan (1995); Ukraine Cabinet of Ministers Resolution No. 14, Interdisciplinary Comprehensive Program for 2002-2011 "Health of the Nation" (2002); The Law on Safety and Health of Work, No. 92/07, Macedonia; The Law on Medical and Social Expertise, Republic of Georgia (2001); Article 2, Law on Medical Care and Services to the Population, Republic of Armenia (1996); Law No. 116 of Kyrgyzstan On Health Care Organizations (2004).
- 176 Georgia Government Decree No. 80, 29 February 2012, "Health Mediation Charter."
- 177 See, e.g., Law on Prevention of Disease Caused by HIV, Republic of Armenia; The law on HIV/AIDS Prevention Republic of Georgia (2000); Federal Act of the Russian Federation No. 38-FZ On Prevention of Communication of the Illness Caused by Human Immunodeficiency Virus (HIV) in the Russian Federation (1995); Law on HIV/AIDS in Kyrgyzstan (2005); Articles 112 and 114, Health Code, Republic of Kazakhstan (2009); Article 4, Law of Ukraine On Resistance to Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Protection of People Living With HIV (2010); Article 32, Law on Healthcare, Macedonia (1991).

areas, such as organ and tissue transplantation¹⁸⁴ and medical experimentation,¹⁸⁵ may function as stand-alone legislation, but are also commonly included in the framework of health care and public health regulation. Several countries, including Armenia, Georgia, Ukraine and Macedonia have passed laws specifically focused on patients' rights. (The following section will discuss this regime in

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- 178 See, e.g., Law of the Russian Federation No. 3185-1 Concerning Mental Health Care and Guarantees of the Rights of Citizens Under Such Care (1992); see also The Law of Ukraine On Psychiatric Care (2000); Law on Psychiatric Care, Republic of Armenia (2004); Law on Mental Health, Macedonia (1996); Law on Psychiatric Care, Republic of Georgia (1995); Article 116, Health Code, Republic of Kazakhstan (2009); Law of Kyrgyzstan On Psychiatric Care and Guaranteeing the Rights of Persons Receiving Such Care (1999).
- 179 See, e.g., Law on Blood Safety, Macedonia; Law of the Russian Federation No. 4180-1 Concerning the Donorship of Blood and Components Thereof (1992); Law on Prevention of Disease Caused by HIV, Republic of Armenia; The Law on Blood Donors and Blood Components, Republic of Georgia (1997); Law of Kyrgyzstan On Donorship of Blood and its Components (2007); Article 164, Health Code, Republic of Kazakhstan (2009); Law of Ukraine On Donation of Blood and Its Components (1995).
- 180 Law on Biomedically Assisted Reproduction, Macedonia (2008); Article 96, Health Code, Republic of Kazakhstan (2009); Law of Kyrgyzstan On Reproductive Rights of Citizens and Guarantees of Their Enforcement (2007); Ukraine Ministry of Health Order No. 372/34 On Approval of the Plan of Action to Carry Out Measures for Enforcing the Implementation of the State Program "Reproductive Health of the Nation for the Period Ending in 2015" (2007).
- 181 See, e.g., The Law on Protection and Promotion of Infant Natural Feeding, Republic of Georgia (1999); Law of Ukraine On Protection of Childhood (2001).
- 182 See, e.g., Anti-Smoking Law, Macedonia (1995); The Law on Tobacco Control in Georgia (2003); Law of Ukraine On Measures to Prevent and Reduce Tobacco Consumption and Harmful Impact on Public Health (2005); Law On Protection of Health of Citizens of Kyrgyzstan from Harmful Impact of Tobacco (2006); Law No. 193-III, Republic of Kazakhstan (2006).
- 183 See, e.g., The Law of the Republic of Kazakhstan On Forced Treatment of Alcohol and Drug Addicts (2004); Federal Act of the Russian Federation No. 3-FZ On Narcotic Drugs and Psychotropic Substances (1998); Law of Kyrgyzstan On Narcotic Drugs and Psychotropic Substances (2007); Law on Narcotic Drugs, Psychotropic Substances, Their Precursors and Narcologic Care, Republic of Georgia (2002); Law on Narcotic Drugs and Psychotropic Substances, Republic of Armenia (2002); Law of Ukraine On Measures Against Illicit Trafficking of Narcotic Drugs, Psychotropic Substances and Precursors as well as Their Abuse (1995). Law on Narcotic Drugs and Psychotropic Substances, Macedonia (1997); Federal Act of the Russian Federation No. 3-FZ On Narcotic Drugs and Psychotropic Substances (1998).
- 184 See, e.g., Order No. 415 On Approving Rules of Elimination, Preservation, Transplantation of Tissues and (or) Organs (Parts of Organs) from a Human to a Human, from a Corpse to a Human and from an Animal to a Human, issued by the minister of health, Republic of Kazakhstan (2006); Law of Kyrgyzstan On Transplantation of Organs and of Tissues (2000); Law on Conditions of Extracting, Exchange, Transportation and Transplantation of Human Body Parts for Medical Treatment Purposes, Macedonia (1995); Law on Transplanting Human Organs and/or Tissues, Republic of Armenia (2002); Law of Ukraine On Transplantation of Organs and Other Anatomical Materials to a Human Being (1999); Law on Human Organ Transplantation, Georgia (2000); Law of the Russian Federation No. 4180-1 On Transplantation of Organs and (or) Human Tissues (1992).
- 185 See, e.g., Law on Mental Health, Macedonia (2006) (prohibits the performance of clinical or experimental trials on a mentally ill person); Article 19, Constitution of the Republic of Armenia (1995); Article 28, Constitution of Ukraine (1996); Article 109, Law on Health Care, Georgia (1997); Article 22, Constitution of Kyrgyzstan (1996); Article 180, Health Code, Republic of Kazakhstan (2009).

more detail). Although participating countries generally have relatively well-developed bodies of law regulating health care services and public health issues, information compiled by the country working groups suggests wide implementation gaps and that the enforcement of these legal instruments is lacking in many settings.¹⁸⁶

Ministries of Health or subordinated agencies are generally responsible for monitoring and regulating the quality of care as well as basic standards for health care facilities and staff, but they do not necessarily have the tools or resources to regulate effectively.¹⁸⁷

As noted by several external sources, informal payments in the health system also serve to further undermine regulations as they can be so easily evaded.¹⁸⁸ National government committees, cross-sectoral coordinating councils, academies and other professional organizations hold additional responsibility for setting policies, generating standards, or coordinating planning around specific practice areas or public health issues.¹⁸⁹ Local governments retain ownership and functional control of many major health care institutions, including networks of clinics in some participant countries, as noted particularly in the Russia, Armenia, Kazakhstan, and Kyrgyzstan PGs.¹⁹⁰

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- 186 See, e.g., Ukraine PG, Chapter 5, Section 2 at 173; Macedonia PG, Chapter 5, Section 2 at 134; Georgia PG, Chapter 5, Section 2 at 125; Armenia PG, Chapter 5, Section 2 at 139; Kazakhstan PG, Chapter 5, Section 2 (“resolutions contain recommendations, instead of rules of law”); Kyrgyzstan PG, Chapter 4, Section 2 (“cannot legally be the sources of law”); Russia PG, Chapter 5, Section 2 (“not the ultimate authority in relation to the judicial system”).
- 187 See, e.g., Ukraine PG, Chapter 5, Section 3 at 176; Georgia PG, Chapter 5, Section 3 at 130; Armenia PG, Chapter 5, Section 3 at 141; Kazakhstan PG, Chapter 5, Section 3 (“management of medical care is carried out by an authorized body”); Kyrgyzstan PG, Chapter 4, Section 4 (“main task of the Ministry of Health is to create a unified state policy”); Russia PG, Chapter 5, Section 3 (“health systems in accordance with the fundamental principles of legislation of the Russian Federation on public health care”).
- 188 See, e.g., WHO HiT: Macedonia at 37; WHO HiT: Armenia. www.euro.who.int/__data/assets/pdf_file/0004/96430/E89732.pdf. 2006:41-47. Accessed July 31, 2012; Ensor, T, Savelyeva L. “Informal payments for health care in the former Soviet Union: Some evidence from Kazakhstan.” *Health Policy Plan*. 1998; 13:41-49; see also Baschieri A, Falkingham J. “Formalizing informal payments: The progress of reform in Kyrgyzstan.” *Central Asian Survey*. 2006; 25:441-460; Belli P, Gotsadze G, Shahriari H. Out-of-pocket and informal payments in health sector: Evidence from Georgia. *Health Policy* 2004, 70:109-123; Shishkin S, et al. *Informal Out-of-Pocket Payments for Healthcare in Russia*. Independent Institute for Social Policy. Moscow; 2003. Litvak A, et al. *Underground Economy in Health Care in Contemporary Ukraine*. Odesa: TEC; 2001.
- 189 See, e.g., Ukraine PG, Chapter 5, Section 3 at 176; Georgia PG, Chapter 5, Section 3 at 130; Armenia PG, Chapter 5, Section 3 at 141; Kazakhstan PG, Chapter 5, Section 3 (“management of medical care is carried out by an authorized body”); Kyrgyzstan PG, Chapter 4, Section 4 (“main task of the Ministry of Health is to create a unified state policy”); Russia PG, Chapter 5, Section 3 (“health systems in accordance with the fundamental principles of legislation of the Russian Federation on public health care”).

Working groups were not tasked with including sections in the guides on the financing of their health systems per se. To provide context, it is worth noting that health care financing remains a problem throughout the region, although the organization and funding of health services vary depending on the approaches to reform taken by different countries. In Kazakhstan, Armenia and Ukraine, public funding for health services still comes from general budgetary sources at the central or regional levels.¹⁹¹ In Kyrgyzstan and Macedonia, different forms of compulsory social health insurance (SHI) have been introduced to automatically collect payroll contributions from employers and employees to fund health services.¹⁹² In Russia there is a dual system of both budgetary funding and SHI.¹⁹³ Georgia is unique in embracing a voluntary health insurance model, wherein individuals are responsible for their own coverage. However, a 2012 state insurance program (covering approximately two million people) and a prior program (2007) provide coverage to the socially vulnerable, pension-age persons, children age five and under, students, disabled children, and severely-disabled adults; a new universal health care plan was added on February 28, 2013 to guarantee insurance for all non-insured individuals in the country, with emphasis on in-patient emergency care and outpatient services.¹⁹⁴ Both Georgia and Kazakhstan experimented with SHI systems in the 1990s before abandoning them as they were deemed inefficient. Even in these settings public sources of health funding are not necessarily the most significant.¹⁹⁵

However it is measured, health spending is still low in all the countries according to external sources. The main sources of health funding in Georgia, Armenia and Kyrgyzstan are direct out-of-pocket payments from patients,¹⁹⁶ and the proportion of out-of-pocket payments in total health spending in Ukraine, Kazakhstan, Russia and Macedonia is still very high.¹⁹⁷ This is a serious barrier to accessing care for

190 See, e.g., Russia PG, Chapter 5, Section 3 (“health systems in accordance with the fundamental principles of legislation of the Russian Federation on public health care”); Armenia PG, Chapter 5, Section 3 at 141; Kazakhstan PG, Chapter 6, Section 1 (“PHC organizations include health clinics [district and municipal] and their structural subdivisions”); Kyrgyzstan PG, Chapter 7, Section 3 (“concerted actions between practitioners of polyclinics, hospitals, and independent laboratories”).

191 See, e.g., WHO HiT summaries, supra note 136, for Kazakhstan (2012) at 41; Armenia (2006) at 41; Ukraine (2010) at 27-28.

192 Ibid., Kyrgyzstan (2011) at 37-39; Macedonia (2006) at 29-31.

193 Ibid., Russia (2011) at 72.

194 “State-sponsored Universal Healthcare Program: Problems and Recommendations,” *Transparency International Georgia*, March 11, 2013, www.transparency.ge/en/blog/state-sponsored-universal-healthcare

195 See, generally, Chapter 3 on Financing in the WHO HiT summaries, supra note 137, for the following countries: Kazakhstan (2012) at 41-66; Georgia (2009) at 27-48; Armenia (2006) at 41-82; Kyrgyzstan (2011) at 37-60; Macedonia (2006) at 29-44; Russia (2011) at 67-93; Ukraine (2010) at 27-69.

196 See, e.g., WHO HiT summaries, supra note 136, for Georgia (2009) at 39; Armenia (2006) at 44; Kyrgyzstan (2011) at 49.

197 Ibid., Ukraine (2010) at 42; Kazakhstan (2012) at 55-56; Russia (2011) at 85; Macedonia (2006) at 37.

poorer households and marginalized communities.¹⁹⁸ Out-of-pocket payments include direct payments for services not covered under state guaranteed benefits or insurance packages (e.g., dental care in some countries¹⁹⁹ or cosmetic surgery);²⁰⁰ official co-payments for services (e.g., a fixed fee per visit to a doctor or per night in hospital);²⁰¹ and informal payments and gratuities (over and above any official payments) paid to doctors or facilities for services which are nominally covered by insurance or state guarantees.²⁰²

External sources also have noted that informal payments have proven very difficult to control in the former Soviet countries and are usually understood as a function of the underfunding of the health system relative to insurance benefits or state guarantees; the extremely low official wages for health sector workers; and cultural-historical explanations which underline how such 'gratuities' were a major feature of the health system in the Communist era.²⁰³

National Frameworks for Patient Rights and Responsibilities

This section synthesizes the findings made by the participating countries' working groups on the formal protections and practical implementation of human rights in patient care.²⁰⁴ As discussed in the previous section, the body of law in participant countries has undergone significant changes in the last two decades. Through international and domestic advocacy as well as multilateral mechanisms, the protection of patient rights, bioethics, and other related topics have become well-covered by legislation in the participating PG countries. Understanding and disseminating this legislation is critical to its enforcement. Using the ECPR as a guiding analytical framework, this section discusses patient rights and responsibilities.

198 Ibid., Kazakhstan (2012) at 56 ("Informal payments generally have a greater impact on poorer groups of the population, who might defer treatment or self-medicate.")

199 However, in Macedonia, basic dental care is covered under the country's compulsory insurance plan; the patient must pay for anything that goes beyond basic care.

200 Gaal P et al., *supra* note 132. See also, e.g., WHO HiT summaries, *supra* note 136, for Armenia (2006) at 47; Kazakhstan (2012) at 55; Georgia (2009) at 40-41.

201 Ibid. See also, e.g., WHO HiT summaries, *supra* note 137, for Macedonia (2006) at 34-36; Kyrgyzstan (2011) at 57, Georgia (2009) at 40-41.

202 Ibid. See also, e.g., WHO HiT summaries, *supra* note 137, for Ukraine (2010) at 43; Russia (2011) at 86-87; Georgia (2009) at 40-41.

203 Ibid.

204 Consult the individual guides for more detailed information.

Patient Rights

Right to Preventative Measures

The countries included in the PG project legislate strong protections for the right to preventative measures. Although not an explicit right at the constitutional level, preventative care is implied by a number of constitutional provisions among participating countries and is specifically enumerated in the general framework of health care laws of all participating countries.²⁰⁵ Legislation provides for free availability of such services in most settings,²⁰⁶ including specific examples of screening in Kazakhstan,²⁰⁷ vaccinations in Georgia,²⁰⁸ and other specific operational aspects of preventative medicine included in the Armenia PG.²⁰⁹ In some instances, countries have legislation focused on prevention of specific, high-priority diseases, including HIV (e.g. through provisions for testing, counseling, information and harm-reduction supplies in Kyrgyzstan),²¹⁰ and TB in Russia,²¹¹ and of addictive behavior such as smoking in Macedonia.²¹² Provisions also address special populations, including people working in hazardous conditions in Kyrgyzstan,²¹³ detainees in Armenia,²¹⁴ children in Kazakhstan,²¹⁵ those residing in remote regions of Georgia,²¹⁶ and women in Kazakhstan and Kyrgyzstan.²¹⁷ Regulation and testing for medical devices, cosmetic products, and drugs to prevent injury or death is also included under this family of legislation, as in the law on drugs and medical devices in Macedonia.²¹⁸

205 E.g., the right to preventative care is linked to the right to health protection (Article 47, Constitution of Kyrgyzstan) and the right to a natural environment favorable for life and health (Article 35 of the Constitution of Kyrgyzstan, Article 37 of the Constitution of the Republic of Georgia, Article 32 of the Constitution of the Republic of Armenia, Article 43 of the Constitution of Macedonia, Article 31 of the Constitution of the Republic of Kazakhstan, Article 41 of the Constitution of the Russian Federation, Article 50 of the Constitution of Ukraine); see also, Article 49(2) of the Constitution of Ukraine, providing for financing of public health promotion initiatives.

206 Ibid.; see also, e.g., Article 49(3), Ukrainian Constitution; Article 37(1), Georgian Constitution; Article 47(3), Kyrgyz Constitution; Article 41, Russian Constitution; Law on Public Health, 2009 amendments, Macedonia; Article 87, Health Code, Republic of Kazakhstan; Article 2, Medical Care Law, Republic of Armenia.

207 See, e.g., Articles 155-161, Health Code, Republic of Kazakhstan.

208 See, e.g., Article 78, Law on Health Care, Republic of Georgia.

209 See, e.g., Article 20, Medical Care Law, Republic of Armenia.

210 See, e.g., Article 5, Law on HIV/AIDS, Kyrgyzstan.

211 See, e.g., Federal Act of the Russian Federation, June 18, 2001, No. 77-FZ, On prevention of tuberculosis in the Russian Federation.

212 See, e.g., Anti-Smoking Law, Macedonia.

213 See, e.g., Article 215, Labor Code, Kyrgyzstan.

214 See, e.g., Article 21, Law on Keeping Arrested and Detained Persons, Republic of Armenia.

215 See, e.g., Articles 37 and 38, Law on the Rights of the Child, Republic of Kazakhstan.

216 See, e.g., Article 64, Law on Health Care, Republic of Georgia ("In high mountainous regions the State is directly funding programmes for prevention and treatment of goiter and other endocrinal diseases").

217 See, e.g., Article 67, Law On Citizens' Health Protection, Kyrgyzstan; Sub-item 5 of Article 113, Health Code, Republic of Kazakhstan.

218 See, e.g., Law on Drugs and Medical Devices, Macedonia.

The practitioner guides review not only existing legislation on human rights in patient care, but also illustrative violations, judicial decisions and experience and advice from lawyering practice. In the area of the right to preventative care, working groups cited violations such as patients being asked to pay for theoretically free preventative services in Georgia²¹⁹ or interference with health prevention in the form of overcrowded conditions in institutional settings in Kyrgyzstan.²²⁰ Working groups noted only one actual example of jurisprudence vindicating this right, a Russian case in which a health care facility was found in violation of various public health prevention regulations.²²¹ Practice notes on this point relate to specifics of regulations on high-visibility, but technical, topics like vaccination safety in Russia and Ukraine.²²² They also addressed procedural questions such as the need to identify and employ competent experts in those two countries,²²³ methods of calculating pecuniary and physical damages, as well as barriers to pursuing claims in this realm, as described in the Georgia PG.²²⁴

Right to Access

Right of access to free health care services is universally guaranteed in all participating countries.²²⁵ This right is closely linked to equal protection provisions, as noted in the Armenia PG,²²⁶ in one case specifically prohibiting various forms of discrimination in access to health care in the law on patient rights in Macedonia,²²⁷ and affirmatively extended to special populations, including prisoners, as included in the Russia PG.²²⁸ The right of free and universal access may be qualified with the enumeration of the kinds of services that may be

219 Case reported by the “Health care Ombudsman” office in the Republic of Georgia which operated from 2001-2007 at Georgian Health Law and Bioethics Society.

220 See, e.g., Kyrgyzstan PG, Chapter 5, Section 1 (“during naptime two children are put into one bed”) (The right to disease prevention is violated in some pre-school institutions, where during the quiet hours of sleep children are placed in pairs in a single bed).

221 Resolution of The Seventeenth Arbitration Court Of Appeal (as of August 29, 2008). No. 17-4673/08. The City Of Perm. Case No. 60-8573/2008.

222 Ukraine PG, Chapter 6, Section 1 at 187; Russia PG, Chapter 6, Section 1 (“poor organization of vaccinal prevention of infectious diseases among employees of the Center”)

223 Ibid.

224 Georgia PG, Chapter 6, Section 1 at 140-141.

225 See, e.g., Article 38, Armenian Constitution (“Everyone shall have the right to benefit from medical aid and service under the conditions prescribed by law.”); Part 1 of Article 41, Russian Constitution (“Everyone has the right to health protection and medical care. Medical care in the state and municipal health care institutions is free of charge for citizens because it is provided by means of respective budget, insurance premium payments and other takings.”); Article 37, Georgian Constitution; Article 49, Ukrainian Constitution; Part 3 of Article 47, Kyrgyz Constitution; Article 5, Law on Healthcare, Macedonia; Article 87, Health Code, Republic of Kazakhstan.

226 See, e.g., Article 4, Medical Care Law, Republic of Armenia.

227 See, e.g., Article 5 (2), Law on Patients’ Rights Protection, Macedonia.

228 See, e.g., Part 1 of Article 26, Federal Law of November 21, 2011, No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

covered, including the delegation of authority to agencies making such coverage determinations.²²⁹

Another qualification to this right in some countries is that the constitutional right to free health care, prevention, and pharmaceutical services is guaranteed only in public or “communal institutions.”²³⁰ Certain controversial treatments, such as assisted reproduction and high-priority diseases, such as HIV/AIDS, receive special attention in the legislative sphere, expressly providing for access to adequate care and treatment.²³¹ What constitutes “controversial” treatment varies by country. Conversely, Georgia devotes attention to treatment of rare diseases.²³² In addition to these legal instruments, professional codes of ethics for medical professionals may be cited as sources of relevant provisions covering this right.²³³

Working groups cited numerous and detailed examples of violations of the right to access. These violations related to unauthorized charges as noted in the Ukraine and Armenia PGs;²³⁴ poor medical emergency response as discussed in the Macedonia, Georgia, and Russia PGs;²³⁵ lack of availability of free and low-cost medications as discussed in the Kazakhstan PG,²³⁶ as well as lack of physical access for the handicapped at health care institutions as discussed in the Georgia

229 See, e.g., Article 2, Medical Care Law, Republic of Armenia; Order by the MOH of Ukraine, as of August 17, 1998, No. 1303; Part 1 of Article 26, Federal Law of November 21, 2011, No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Articles 5 & 9, Law on Health Insurance, Macedonia; Article 5, Law on Health Care, Republic of Georgia; Law on State Budget, Republic of Georgia; Article 72, Law on Health Protection of Citizens in Kyrgyzstan; Article 87, Health Code, Republic of Kazakhstan.

230 See, e.g., Article 49(3), Ukrainian Constitution; Article 41, Russian Constitution; Article 72, Law on Health Protection of Citizens in Kyrgyzstan; Article 5, Law on Health Care, Republic of Georgia; Articles 5 & 9, Law on Health Insurance; Articles 1 & 2, Medical Care Law, Republic of Armenia.

231 See, e.g., Law on Biomedically Assisted Reproduction (BAR), Macedonia; Law on Reproductive Health and Rights, Republic of Armenia; Articles 4, 5 and 14, Federal Act of the Russian Federation dated March 30, 1995, No. 38-FZ, On Prevention of Communication of the Illness Caused by Human Immunodeficiency Virus (HIV); Federal Act of the Russian Federation dated September 17, 1998, Concerning the Immunoprophylaxis of Infectious Diseases; Article 5, Law On HIV / AIDS, Kyrgyzstan; The Law of Ukraine for the Provision of Prevention, Care, and Treatment HIV-Infected Persons (2009).

232 See, e.g., Article 13, Law on Patients' Rights, Republic of Georgia (“Government shall ensure that patients with rare, uncommon diseases are able to receive appropriate medical services in accordance with the professional and service standards, acknowledged and established in Georgia.”).

233 See, e.g., Item 3 of Article 184 of the Health Code, Republic of Kazakhstan. See also, generally, Code of Ethics of the Macedonian Chamber of Medicine; Code of Professional Ethics of Macedonian Pharmacists' Obligations and Rights; Code of Ethics of Physicians of Georgia; Code of Ethics of Physicians of Ukraine; Code of Professional Ethics of a Healthcare Worker of Kyrgyzstan; Code of Medical Ethics in the Russian Federation; Code of Ethics for Physicians in the Russian Federation.

234 Ukraine PG, Chapter 6, Section 1 at 195-196; Armenia PG, Chapter 6, Section 1 at 151.

235 Macedonia PG, Chapter 6, Section 1 at 161; Georgia PG, Chapter 6, Section 1 at 147.; Russia PG, Chapter 6, Section 1 (“District court of Tver”).

236 Kazakhstan PG, Chapter 6, Section 1 (“children's right to free and low-cost medications was violated”); Russia PG, Chapter 6, Section 1 (“case no. 2-88/09).

PG.²³⁷ Similarly, there were cases involving litigation to reimburse for what should have been free services in the Macedonia and Ukraine PGs,²³⁸ and lack of access to adequate care in prisons, noted in the Georgia PG.²³⁹ Claims on these issues appeared to be seldom pursued, or when pursued, seldom successful in awarding the scope of damages sought; the Armenia and Ukraine PGs, however, provide two examples of success.²⁴⁰ Only Kyrgyzstan reported no such litigation on the right to access. The guides provide practice notes focused in particular on procedural and evidentiary issues, including, for example, using various administrative as well as civil litigation channels to vindicate patients' rights to access.²⁴¹

Right to Information

The right to Information is stipulated under the constitutions of all participating countries, although this right is construed broadly, typically referring to protection of citizens from having personal health information collected and stored without consent, as in Russia, for example,²⁴² or to be informed about what information is being collected about them by the government, as stated in the Constitution of Kyrgyzstan.²⁴³ Provisions relating specifically to protection of health information are also universal in the legislative frameworks of the participating countries. These rights relate to access to personal health records in Armenia and Georgia (and the related right to have that information be accurate and current in Macedonia),²⁴⁴ right to a second opinion in Georgia and Kazakhstan,²⁴⁵ accurate information about available treatment and preventive services in all of the participating countries,²⁴⁶ and the right to receive information about the

237 Georgia PG, Chapter 6, Section 1 at 147.

238 Macedonia PG, Chapter 6, Section 1 at 151-154; Ukraine PG, Chapter 6, Section 1 at 195-196.

239 Georgia PG, Chapter 6, Section 1 at 147.

240 See, e.g., Armenia PG, Chapter 6, Section 1 at 151 (citing a case where a claim against a health care provider who charged illegal fees was never pursued); Ukraine PG, Chapter 6, Section 1 at 195-196 (describing a case where a mother forced to pay for years for medication that should have been provided for free for her disabled son sought \$1,500 in damages won her suit but was awarded only about \$300 in damages).

241 Kazakhstan PG, Chapter 6, Section 1 ("appealing for the protection of a violated right to a government body or department does not exclude filing a suit in court"); Kyrgyzstan PG, Chapter 5, Section 1 ("protection of the protected right to accessibility may be provided in the judicial [i.e. with the help of state bodies] and non judicial [without such recourse] form"); Macedonia PG, Chapter 6, Section 1 at 157 (referring to p. 143).

242 See, e.g., Article 24, Russian Constitution.

243 See, e.g., Article 14, Kyrgyz Constitution.

244 See, e.g., Article 7, Medical Care Law, Republic of Armenia; Article 17, Law on the Rights of Patients, Republic of Georgia; Article 22, Law on the Protection of Patients' Rights, Macedonia.

245 See, e.g., Article 3, Law on Health Care, Georgia; Article 91, Health Code, Republic of Kazakhstan.

246 See, e.g., Article 6, Law On Citizens' Health Protection, Kyrgyzstan; Article 91, Health Code, Republic of Kazakhstan; Article 22, Federal Law, No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Articles 17 & 19, Law of Ukraine On Protection of the Population from Infectious Diseases; Article 7, Medical Care Law, Republic of Armenia; Article 18, Law on the Rights of Patients, Republic of Georgia; Article 7, Law on the Protection of Patients' Rights, Macedonia.

quality of medicines and other products as stated in consumer protection law in Russia and Ukraine, and the health laws of Kyrgyzstan and Kazakhstan.²⁴⁷ This body of legislation also includes specific considerations for information regarding reproductive technologies such as biomedically-assisted ones in Macedonia and Kyrgyzstan,²⁴⁸ and public health prevention and health promotion information regarding TB in Russia and Kyrgyzstan.²⁴⁹

Special populations, including prisoners, are covered by this right in Armenia, Georgia, and Kyrgyzstan,²⁵⁰ with the imposition of particular duties on Armenian correctional institutions to keep accurate medical records²⁵¹ and to provide post-test counseling for those undergoing HIV tests.²⁵² Access to information in mental health and psychiatric services also received universal legislative recognition, with robust affirmative legal rights of patients to obtain information about their diagnosis and treatment in all the participating countries,²⁵³ as well as the related obligation to submit to detention in applicable cases as noted in the Russia PG.²⁵⁴

One set of examples of the application of this right concerns the duty of a doctor to inform a patient (or next of kin) of the course of treatment as in cases from Russia and Macedonia,²⁵⁵ and the right to be informed of possible complications to vaccinations in Armenia.²⁵⁶ Another practical set of examples of the application of this right in the participating countries are also related to when and how the current health care institutions are to keep records, and who should have access to

247 See, e.g., Article 8, Law of the Russian Federation dated February 07, 1992, No. 2300-1, Concerning the Protection of Consumer Rights; Articles 4 & 21, Law of Ukraine On Protection of Consumer Rights; Article 15, Law On Pharmaceuticals, Kyrgyzstan; Article 88, Health Code, Republic of Kazakhstan.

248 See, e.g., Article 7, Law on Biomedically Assisted Reproduction, Macedonia; Article 16, Law on Reproductive Rights of Citizens and Guarantees of their Enforcement, Kyrgyzstan.

249 See, e.g., Article 12, Federal Act of the Russian Federation dated June 18, 2001, No. 77-FZ, On Prevention of Tuberculosis in the Russian Federation; Article 15, Law On Protection of the Population from TB, Kyrgyzstan.

250 See, e.g., Article 21 of the Law on Keeping Arrested and Detained Persons, Republic of Armenia; Article 53, Law on Doctor Professional Activity, Republic of Georgia; Article 23, Law On the Procedure and Conditions of Detention in Custody of Persons Apprehended on Suspicion and Accused of Committing Crimes, Kyrgyzstan.

251 See, e.g., Article 21, Law on Keeping Arrested and Detained Persons, Republic of Armenia.

252 See, e.g., Article 10, Law on Prevention of Disease Caused by HIV, Republic of Armenia.

253 See, e.g., Article 5 of the Law of the Russian Federation, No. 3185-1, Concerning Mental Health Care and Guarantees of the Rights of Citizens Under Such Care; Article 119, Health Code, Republic of Kazakhstan; Article 5, Law On Psychiatric Care and Guarantees of Rights of Citizens in its Provision, Kyrgyzstan; Article 119, Health Code, Republic of Kazakhstan; Article 13, Psychiatric Care Law, Republic of Armenia; Article 5, Law on Psychiatric Care, Republic of Georgia; Article 21, Law on Mental Health, Macedonia; Article 6, Law of Ukraine On Psychiatric Care.

254 See, e.g., Article 5, Law of the Russian Federation dated July 02, 1992, No. 3185-1, Concerning Mental Health Care and Guarantees of the Rights of Citizens Under Such Care.

255 Russia PG, Chapter 6, Section 1 ("Mirny City Court"); Macedonia PG, Chapter 6, Section 1 at 163.

256 Armenia PG, Chapter 6, Section 1 at 154.

those health records, especially in contexts where services may be rendered outside of the official channels. This included instances of denial of access to medical records on the grounds that they constituted hospital property in Georgia,²⁵⁷ and failure to provide access to information about a hospital's medical expert review of a malpractice case in Ukraine.²⁵⁸

Right to Consent

Within the scope of the closely-linked rights to human dignity, sovereignty of person, and self-determination, the right to informed consent is protected by all constitutions among the participating countries.²⁵⁹ In several cases, the right to be free from forced experimentation is specifically protected in the constitution, as in Ukraine, Armenia, Kyrgyzstan, and Russia.²⁶⁰ Patient rights legislation in these countries also uniformly covers this right, requiring voluntary informed consent to any medical procedures or research experimentation, as also included in the public health law of Ukraine, Macedonia, Georgia, and Kazakhstan,²⁶¹ but in some cases, also requiring the assent of third parties, including parents for minors regarding general medical treatment in Russia, Macedonia, Ukraine, Armenia, and Georgia,²⁶² and abortion procedures as in Kazakhstan,²⁶³ and additionally husbands for interventions involving abortion procedures as in Kyrgyzstan.²⁶⁴

These laws also cover a number of exceptions, varying by country, to the rule of informed consent, including urgent care,²⁶⁵ physical²⁶⁶ and mental incapacity,²⁶⁷ and

257 Georgia PG, Chapter 6, Section 1 at 156.

258 Ukraine PG, Chapter 6, Section 1 at 201.

259 See, e.g., Article 13-14, Kyrgyz Constitution.

260 See, e.g., Article 28, Constitution of Ukraine; Article 19, Constitution of the Republic of Armenia; Article 22, Constitution of Kyrgyzstan (revised in 2010); Article 21, Constitution of the Russian Federation.

261 See, e.g., Article 43, Public Health Law, Ukraine; Article 18, Law on the Protection of Patients' Rights, Macedonia; Article 109, Law on Health Care, Republic of Georgia; Article 180, Health Code, Republic of Kazakhstan.

262 See, e.g., Part 1 of Article 20, Federal Law, No. 323-FZ, On the basis of Health Protection in the Russian Federation; Article 15, Law on the Protection of Patients' Rights, Macedonia; Article 284, Civil Code of Ukraine, Article 8, Medical Care Law, Republic of Armenia; Article 41, Law on the Rights of Patients, Republic of Georgia.

263 See, e.g., Article 104, Health Code, Republic of Kazakhstan.

264 See, e.g., Article 14, Law On Reproductive Rights, Kyrgyzstan.

265 See, e.g., Article 15, Medical Care Law, Republic of Armenia; Article 12, Law on Health Care, Republic of Georgia; Article 16, Law on the Protection of Patients' Rights, Macedonia; Article 284, Civil code of Ukraine; Article 74, Law on Health Protection of Citizens in Kyrgyzstan; Article 97, Health Code, Republic of Kazakhstan; Part 9 of Article 20, Federal Law, No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

266 See, e.g., Article 14, Law on the Protection of Patients' Rights, Macedonia; Article 8, Medical Care Law, Republic of Armenia.

267 See, e.g., Article 74, Law On Citizens' Health Protection, Kyrgyzstan; Article 8, Medical Care Law, Republic of Armenia; Article 22, Law on the Rights of Patients, Republic of Georgia.

dangerous, contagious disease such as TB.²⁶⁸ Notably, the participating countries of Armenia, Kazakhstan, Russia, and Kyrgyzstan provide for compulsory treatment of drug addiction in some settings.²⁶⁹ As in other rights, and especially in view of the past abuses of institutionalized populations, these laws also afford robust legal protections to prisoners and psychiatric patients, in some cases making medical or scientific interventions with vulnerable populations a criminal offence, as in Armenia.²⁷⁰ In the same vein, some procedures are seen as warranting a bolstered level of consent, including tissue donation, where a notarized consent letter is required and criminal penalties imposed for violations, as in Kazakhstan.²⁷¹ Professional ethical standards are also often cited in regard to the patients' right to consent,²⁷² particularly where provider ethics standards are incorporated into the health code as in Kazakhstan.²⁷³

Practical examples emerging from sections on this right involve numerous cases of inadequate consent or failure to obtain consent.²⁷⁴ Out of the cases listed by Armenia, Kazakhstan, Russia and Ukraine, plaintiffs were only successful in Ukraine.²⁷⁵ Georgia, Macedonia, and Kyrgyzstan did not list any illustrative litigation on this issue. Practical advice in this realm includes discussions of when consent is or is not required, when oral consent may be adequate under the law, or when written consent—and its formal nature—may be required.²⁷⁶ Decisions about

268 See, e.g., Article 94, Code of the Republic of Kazakhstan on the Health of the People and the Health Care System; Article 30, Law On Sanitary-Epidemiological Welfare of the Population, Kyrgyzstan; Federal Act No. 52-FZ of the Russian Federation On Sanitary and Epidemiological Welfare of the Population.

269 See, e.g., Article 49(4), Law on Narcotic Drugs and Psychotropic (Psychoactive) Substances, Republic of Armenia; Law of the Republic of Kazakhstan On Forced Treatment of Alcohol and Drug Addicts (2004); Part 3 Article 54, Federal Act of the Russian Federation, No. 3-FZ, On Narcotic Drugs and Psychotropic Substances (providing for compulsory drug treatment in some settings); Part 5, Article 28, Law on Psychiatric Care and Guarantees of Rights of Citizens in Its Provision, Kyrgyzstan (providing that compulsory medical measures may be appointed by the court for prisoners who suffer from alcoholism and drug addition, among other things).

270 See, e.g., Article 127 (3), Criminal Code, Republic of Armenia.

271 See, e.g., Article 169 (8), Health Code, Republic of Kazakhstan.

272 Macedonia PG, Chapter 6, Section 1 at 168; Armenia PG, Chapter 6, Section 1 at 158-159; Georgia PG, Chapter 6, Section 1 at 162; Russia PG, Chapter 6, Section 1 ("right to consent in code of ethics"); Kyrgyzstan PG, Chapter 5, Section 1 ("health care worker has no right to apply medical measures"). (Ukrainian Code of Ethics of Physicians has only advisory, and not legal, force; See Ukraine PG, Chapter 6, Section 1 at 209.)

273 Kazakhstan PG, Chapter 6, Section 1 (citing to Article 184, Health Code, Republic of Kazakhstan).

274 See, e.g., Armenia PG, Chapter 6, Section 1 at 159; Kazakhstan PG, Chapter 6, Section 1 ("puncture was performed without notifying the parents and obtaining their written consent"); Russia PG, Chapter 6, Section 1 ("State of Health of the Kemerovo region"); Ukraine PG, Chapter 6, Section 1 at 210-211.

275 After several false starts, the civil suit ended with an award of about \$1,300 in pecuniary and moral damages for a breach of informed consent. See Ukraine PG, Chapter 6, Section 1 at 210-211.

276 See, e.g., Kazakhstan PG, Chapter 6, Section 1 ("absence of a written consent gives the opportunity to say that doctors performed their actions with violations"); Kyrgyzstan PG, Chapter 5, Section 1 ("necessary to consider that the law allows the opportunity of providing medical care without his/her consent"); Ukraine PG, Chapter 6, Section 1 at 211-214.

when to use criminal law to address cases of unconsented treatment as instances of battery are also discussed in the Armenia and Macedonia PGs.²⁷⁷

Right to Free Choice

Constitutional protections for the right to free choice and other linked rights appear to be limited across the participating countries, with the exception of Kazakhstan.²⁷⁸ National legislative frameworks dealing with patient rights, consumer choice, and health care administration generally support patients' rights to choose their services and doctors, but often with stipulation that such choice may be limited, for example by the patient's place of residence²⁷⁹ or by the terms of the insurance.²⁸⁰ In Armenia, laws also address the right of detained persons to medical services of their choosing, but stipulate that government funding may not cover these services.²⁸¹ In the realm of choice to accept or reject treatment, patients' rights were voiced in legislation across the countries, but with two major caveats: for infectious disease quarantine, and in case of mental incapacity.²⁸² In some cases, legislation opened doors for potential contradiction: in Kazakhstan, for example, compulsory drug treatment was covered under the law allowing patients to choose their treatment.²⁸³ The right to choose contraceptive and reproductive services and technologies appears to receive special legislative attention and support in countries such as Kazakhstan and Kyrgyzstan.²⁸⁴

Case discussion on this topic in the Armenia PG focuses on the issues involving conflicts of interest, where doctors working in the governmental sector made exclusive referrals to private services or providers with whom they had a financial or other relationship.²⁸⁵ There were also several cases arising from residence-

277 See, e.g., Armenia PG, Chapter 6, Section 1 at 160; Macedonia PG, Chapter 6, Section 1 at 170. 278 See, e.g., Article 29, Constitution, Republic of Kazakhstan.

279 Government Decree on Approving Procedure of Selection of a Physician Providing Primary Health Care Services and Registration of Population with Him/Her dated March 30, 2006, Republic of Armenia; Article 66, Law On Health Protection of Citizens in Kyrgyzstan; Article 21, Federal Law, No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

280 See, e.g. Article 16, Federal Law, No. 326-FZ, On Compulsory Health Insurance in the Russian Federation; Article 14, Law on Health Care, Republic of Georgia.

281 See, e.g., Article 13, Law on Keeping Arrested and Detained Persons, Republic of Armenia ("an arrested and detained person has the right to be examined by the doctor selected by him/her ... [payment of] which is to be covered on his/her own.").

282 See, e.g., Article 4, Law on the Rights of Patients, Republic of Georgia; Article 7, Medical Care Law, Republic of Armenia; Article 28, Law of Ukraine On Ensuring Sanitary and Epidemiological Welfare of the Population; Articles 6 & 14, Law on the Protection of Patients' Rights, Macedonia.

283 See, e.g., Article 133, Health Code, Republic of Kazakhstan (stating that, although treatment is compulsory, "individuals suffering from alcoholism, drug addiction and toxicomania have the right to choose a narcological organization" to administer this treatment).

284 See, e.g., Article 102, Health Code, Republic of Kazakhstan (ensuring the right to choose methods and means of contraception, including medical contraception); Article 17, Law On Reproductive Rights of Citizens and Guarantees of Their Enforcement, Kyrgyzstan.

285 Armenia PG, Chapter 6, Section 1 at 162.

based limitations to the choice of medical services in the Ukraine and Kazakhstan guides.²⁸⁶ In Russia, Kazakhstan, Georgia, Ukraine, and Macedonia, formal and informal remnants of this system continue to pose problems for patients attempting to change service providers.²⁸⁷

Right to Privacy and Confidentiality

The right to privacy and confidentiality is universally present in the constitutional protections of the participating countries. In the legislative sphere, this right is well-developed, especially in the protection of medical information, or “medical secrets,”²⁸⁸ including the fact of diagnosis, medical treatment and its content.²⁸⁹ Intentional violations of this right may lead to criminal penalties in nearly all of the participating countries, although not noted in the Georgia and Macedonia PGs.²⁹⁰

This right is universally curtailed by other legal provisions, including a number of exceptions identifying state interests, particularly limitations to patient privacy to prevent deleterious impact on public health such as during epidemics or to prevent an environmental disaster.²⁹¹ Additionally, certain conditions regarding potential harm to public safety require medical professionals to report patient injuries or other circumstances to persons who may be harmed or to law enforcement or other authorities.²⁹² As a

286 See, e.g., Ukraine PG, Chapter 6, Section 1 at 218; Kazakhstan PG, Chapter 6, Section 1 (“Assignments of citizens to primary medical aid”)

287 Kazakhstan PG, Chapter 6, Section 1 (“Citizen A complained to the ombudsman about the violation of her right to freely choose a medical establishment”); Russia PG, Chapter 6, Section 1 (“Citizen AP denied it; Georgia PG, Chapter 6, Section 1 at 170; Ukraine PG, Chapter 6, Section 1 at 218; Macedonia PG, Chapter 6, Section 1 at 173.

288 See, e.g., Article 95, Health Code, Republic of Kazakhstan; Article 25, Law on the Protection of Patients’ Rights, Macedonia; Article 4, Law on Health Care, Republic of Georgia; Article 19, Medical Care Law, Republic of Armenia; Article 286, Civil Code of Ukraine; Article 73, Law on Health Protection of Citizens in Kyrgyzstan.

289 See, e.g., Article 19(e), Medical Care Law, Republic of Armenia; Article 91, Law on Health Protection of Citizens in Kyrgyzstan; Article 13, Federal Law, No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Articles 285 & 286, Civil Code of Ukraine; Article 25, Law on the Protection of Patients’ Rights, Macedonia; Article 4, Law on Health Care, Republic of Georgia; Article 87, Health Code, Republic of Kazakhstan.

290 See, e.g., Article 145, Criminal Code, Republic of Armenia; Article 145, Criminal Code of Kyrgyzstan; Article 144, Criminal Code, Republic of Kazakhstan; Article 137, Criminal Code, Russian Federation, No. 63-FZ; Article 132, Criminal Code of Ukraine.

291 See, e.g., Part 4 of Article 13, Federal Law, No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 95(4), Health Code, Republic of Kazakhstan; Article 91, Law on Health Protection of Citizens in Kyrgyzstan; Article 42, Law on Health Care, Republic of Georgia; Article 19, Medical Care Law, Republic of Armenia; Article 32, Constitution of Ukraine; Article 25, Law on the Protection of Patients’ Rights, Macedonia.

292 See, e.g., Article 19(e), Medical Care Law, Republic of Armenia; Article 95, Health Code, Republic of Kazakhstan; Article 91, Law on Health Protection of Citizens in Kyrgyzstan; Part 4 of Article 13, Federal Law, No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 42, Law on Health Care, Republic of Georgia; Article 19, Medical Care Law, Republic of Armenia; Article 32, Constitution of Ukraine; Article 25, Law on the Protection of Patients’ Rights, Macedonia.

reflection of the stigmatization and high sensitivity of these conditions in the region (as well as elsewhere), special protection is given to information pertaining to particular areas, such as mental health status,²⁹³ HIV/AIDS testing and diagnosis,²⁹⁴ and for genetic data in the context of procedures involving donated blood and/or organs.²⁹⁵

Among the numerous cases quoted by the working groups addressing the right to privacy, there were many examples of blatant and negligent disclosure of patient data in a variety of settings. This includes prison settings in Georgia,²⁹⁶ disclosure in the media of confidential medical information in Macedonia, Georgia and Kyrgyzstan,²⁹⁷ the demand for information not essential for the provision of the given medical service in Macedonia,²⁹⁸ as well as the unwarranted disclosure of such information to family members in Ukraine and Armenia²⁹⁹ and donors in Russia.³⁰⁰ Additionally, in contrast to European law³⁰¹ and legislation such as The Health Insurance Portability and Accountability Act (HIPAA)³⁰² in the United States, the PGs did not note that legislatures among the participant countries have focused their attention on health data security issues in the digital realm.

Also, an external study in 2009 showed that regulations in Russia, Georgia, and Ukraine require special registration of known and suspected drug users when they

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- 293 See, e.g., Article 9, Federal Act of the Russian Federation, No. 3185-1, On Psychiatric Health Care and Guarantees of the Rights of Citizens in such Health Care; Article 9, Law on Psychiatric Care and Guarantees of Rights of Citizens in its Provision; Article 13, Psychiatric Care Law, Republic of Armenia; Article 6, Law of Ukraine On Psychiatric Care; Article 7, Law on Mental Health, Macedonia; Article 26, Law on Psychiatric Care, Republic of Georgia.
- 294 See, e.g., Article 112, Health Code, Republic of Kazakhstan (regarding anonymity or [and] confidentiality of medical examination of HIV positive and AIDS patients); Article 9, Law on HIV/AIDS in Kyrgyzstan; Article 8, Federal Act of the Russian Federation, No. 38-FZ, On Prevention of Communication of the Illness Caused by Human Immunodeficiency Virus (HIV) in the Russian Federation; Article 13, Law of Ukraine On Resistance to Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Protection of People Living with HIV; Article 9, Law on HIV/AIDS, Republic of Georgia; Article 10, Law on Prevention of Disease Caused by HIV, Republic of Armenia.
- 295 See, e.g., Article 17, Law on Blood Safety, Macedonia; Article 171, Health Code, Republic of Kazakhstan; Article 12, Law on Transplantation of Human Organs and/or Tissues, Kyrgyzstan.
- 296 Georgia PG, Chapter 6, Section 1 at 175.
- 297 Macedonia PG, Chapter 6, Section 1 at 179; Georgia PG, Chapter 6, Section 1 at 175; Kyrgyzstan PG, Chapter 5, Section 1 ("disclosure of the HIV-positive status of a patient through mass media").
- 298 Macedonia PG, Chapter 6, Section 1 at 179.
- 299 Ukraine PG, Chapter 6, Section 1 at 225; Armenia PG, Chapter 6, Section 1 at 166.
- 300 Russia PG, Chapter 6, Section 1 ("Citizen H. appealed to the Supreme Court of the Russian Federation").
- 301 Convention for the Protection of Individuals with Regard to Automatic Processing of Personal Data. January 28, 1981. <http://conventions.coe.int/treaty/EN/Treaties/Html/108.htm>. Articles 5-8. Accessed July 31, 2012.
- 302 The Health Insurance Portability and Accountability Act of 1996. Summary of the HIPAA Security Rule. Technical Safeguards. www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html. Accessed on July 31, 2012.

seek treatment.³⁰³ It also showed that registration itself leads to serious consequences in terms of the ability of a patient to obtain employment, residence permits, or other social entitlements; it can also lead to criminal justice involvement.³⁰⁴ There is some evidence that constitutional litigation challenging the registration system can vindicate patients' rights, at least on appeal, as noted in the Russia PG.³⁰⁵

Right to Respect for Patient's Time

This right, which does not have an obvious source in international or European law, is not directly recognized by constitutional provisions in the participating countries and scarcely is covered under national legislative regimes.³⁰⁶ The related rights to quality care, access, and to be informed about all aspects of health care (including time) are discussed under other sections herewith.

Areas especially relevant to this right are in provision of emergency care noted in a majority of the PGs³⁰⁷ and in regulations that apply to the arrangement of waiting lists for high-demand health care procedures in Armenia.³⁰⁸ These areas of law are apparently underutilized. Working groups offered illustrative cases related to undue delay in health care provision leading to detrimental health consequences, using administrative channels, both successfully and unsuccessfully, in Kazakhstan and successfully using criminal negligence charges in Georgia for failure to provide timely care,³⁰⁹ and a couple of cases related to delay in ambulance response in Ukraine and Russia.³¹⁰

Rights to Observance of Quality Standards

Implicitly tied to the right to access, this right is widely recognized in the con-

303 See International Harm Reduction Development Program (IHRD). *The Effects of Drug User Registration Laws on People's Rights and Health: Key Findings from Russia, Georgia, and Ukraine*. Open Society Institute. 2009.

304 *Ibid.* at 13-15.

305 See Russia PG, Chapter 6, Section 1 ("Certificate of the Kemerovo Regional Court") for discussion of the Certificate of the Kemerovo Regional Court (August 8, 2006), No. 01-11/19-429, regarding the quality of civil investigations by the courts of the Kemerovo Region.

306 See, e.g., Article 6, Federal Law, No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

307 See, e.g., Article 12, Law on Health Care, Republic of Georgia ("Clinical emergency medical care shall be initiated without delay in accordance with the health interests of the patient"); Article 23, Law on Health Protection of Citizens in Kyrgyzstan; Article 88, Health Code, Republic of Kazakhstan; Article 78, Law of Ukraine, Principles of Ukrainian Health Care Legislation.

308 See, e.g., Government Decree, March 04, 2004, N 318-N, on Waiting List Procedures, Republic of Armenia.

309 Kazakhstan PG, Chapter 6, Section 1 ("50-year-old woman came from Kyzylorda to Almaty") (listing two cases, both of which proceeded through administrative channels, one of which was successful and on the other unsuccessful); Georgia PG, Chapter 6, Section 1 at 178 (discussing a case where criminal charges were successfully imposed on a doctor for criminal negligence to provide timely care).

310 Ukraine PG, Chapter 6, Section 1 at 229; Russia PG, Chapter 6, Section 1 ("Iglinskiy central regional hospital").

stitutions and legal frameworks of the participating countries, which generally outline the right to health,³¹¹ or more specifically to health care services according to the individual needs in order to attain the highest levels of health, as noted in the Kazakhstan and Macedonia PGs.³¹² As with other rights, special provisions cover quality standards in both HIV care³¹³ and diabetes care³¹⁴ in Kyrgyzstan, and organ transplantation in Georgia and Macedonia,³¹⁵ for example. Thematically, this right is closely linked with the right to information and the right to patient safety. Failure to provide quality health care services, with deleterious consequences, is specifically addressed in some countries' criminal codes, including Ukraine, Kazakhstan and Russia.³¹⁶

Throughout the domestic legal regimes, the word "standards" appeared to receive substantial attention, but the way in which the law operationalized the right to quality standards was not readily apparent from the formal provisions. Working groups in four countries understood licensing and similar accreditation mechanisms as the mechanism that makes this right operational.³¹⁷ This focus on the state as the arbiter of quality in health care provision, as opposed to self-regulation by the medical profession³¹⁸ is notable in view of the apparent failures in regulation and oversight exemplified by the practical examples and cases on failure to meet licensing and quality standards included by various working groups.³¹⁹ Numerous instances of the fruitful use of litigation to vindicate patients' right to quality standards in these cases gives rise to hope that such channels may be used to create enough financial and regulatory pressure to help facilitate positive reform.³²⁰ The creation of special adjudicative bodies in Kazakh-

311 See, e.g., Article 47, Kyrgyz Constitution; Article 87, Health Code, Republic of Kazakhstan; Article 37, Federal Law, No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 49, Ukrainian Constitution; Article 5, Law on the Rights of Patients, Republic of Georgia; Article 38, Armenian Constitution.

312 See, e.g., Article 5, Law on Patients' Rights Protection, Macedonia; Item 1.3 of Article 88, Health Code, Republic of Kazakhstan.

313 See, e.g., Article 6, Law On HIV/AIDS, Kyrgyzstan.

314 See, e.g., Articles 4 & 7, Law On Diabetes, Kyrgyzstan.

315 See, e.g., Article 27, Law on Human Organ Transplantation, Republic of Georgia; Article 1, Law on Conditions of Extracting, Exchange, Transportation and Transplantation of Human Body Parts for Medical Treatment Purposes, Macedonia.

316 See, e.g., Articles 139-140, Criminal Code of Ukraine; Article 114, Criminal Code, Republic of Kazakhstan; Articles 109 & 118, Criminal Code, Russian Federation, No. 63-FZ.

317 See, e.g., Article 18, Medical Care Law, Republic of Armenia; Article 33, Health Code, Republic of Kazakhstan; Article 5, Law on Health Protection of Citizens in Kyrgyzstan; Articles 16, 23-33, 53-64, Law on Health Care, Republic of Georgia.

318 See, e.g., Articles 4 & 16, Law on Health Care, Republic of Georgia (regarding control over the quality of medical activity); Article 5, Law on Health Protection of Citizens in Kyrgyzstan; Part 1, Code of Medical Ethics in the Russian Federation; Article 18, Medical Care Law, Republic of Armenia.

319 See, e.g., Georgia PG, Chapter 6, Section 1 at 182-183; Macedonia PG, Chapter 6, Section 1 at 186; Ukraine PG, Chapter 6, Section 1 at 234-235; Kazakhstan PG, Chapter 6, Section 1 ("using medications unsuitable for the diagnosis"); Kyrgyzstan PG, Chapter 5, Section 1 ("physician of the nursery was found guilty"); Russia PG, Chapter 6, Section 1 ("dental clinic number 16 Admiralty district").

320 Ibid.

stan and Kyrgyzstan to consider cases of malpractice and other complaints against quality violations in the health care sector is also a promising development.³²¹

Right to Safety

Closely linked to quality health care standards, this right is widely stipulated in the legislative regimes of the participating countries.³²² Generally, safety provisions are interpreted to protect patients from illnesses caused in the course of medical treatment as well as to provide hygienic and injury-free experience in the health care setting.³²³ Special provisions exist for safety in pharmaceuticals,³²⁴ blood supply,³²⁵ infectious disease treatment and diagnostics,³²⁶ and mental health services,³²⁷ among others. Ethical codes for doctors, nurses, and other health care workers contain provisions applicable to the patients' right to safety.³²⁸ Medical errors and other actions that fail to meet safety standards can carry civil, criminal and administrative penalties, including the suspension or revocation of provider or

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- 321 See, e.g., Certain Issues Relating to the Ministry of Health, Republic of Kazakhstan (as of October 7, 2009), Order No. 1541, creating the Committee for Control over Medical and Pharmaceutical Activities, responsible for considering complaints filed by citizens on issues relating to the quality of medical services; Chapter 51, Obligations as a Consequence of Injury, Kyrgyzstan.
- 322 See, e.g., Article 5, Medical Care Law, Republic of Armenia; Articles 22 & 24, Law of Ukraine, Principles of Ukrainian Health Care Legislation; Article 5, Law on the Protection of Patients' Rights, Macedonia; Articles 70-79, Law on Health Care, Republic of Georgia; Article 87, Health Code, Republic of Kazakhstan; Article 4, Law on Health Protection of Citizens in Kyrgyzstan; Article 18, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.
- 323 See, e.g., Article 5, Medical Care Law, Republic of Armenia; Articles 70-79, Law on Health Care, Republic of Georgia; Article 10, Law on Health Protection of Citizens in Kyrgyzstan; Article 19, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.
- 324 See, e.g., Law on Drug and Pharmaceutical Activity, Republic of Georgia; Article 84, Health Code, Republic of Kazakhstan; Articles 5 & 15, Law on Pharmaceuticals, Kyrgyzstan; Federal Act of the Russian Federation On Drugs.
- 325 See, e.g., Law on Blood and Blood Products Donorship, Republic of Georgia; Law on Blood Safety, Macedonia; Article 164, Health Code, Republic of Kazakhstan; Article 3, Law on Donorship of Blood and its Components, Kyrgyzstan; Articles 8 & 15, Law of the Russian Federation, No. 142-1, Concerning the Donorship of Blood and Components Thereof.
- 326 See, e.g., Article 4, Federal Act of the Russian Federation dated March 30, 1995, No. 38-FZ, On prevention of Communication of the Illness Caused by Human Immunodeficiency Virus (HIV) in the Russian Federation; Article 13, Law of Ukraine On Protection of the Population from Infectious Diseases; Article 13, Law on the Protection of the Population against Communicable Diseases, Macedonia; Articles 5 & 8, Law on Public Health, Republic of Georgia.
- 327 See, e.g., Article 5, Law of the Russian Federation dated July 02, 1992, No. 3185-1, Concerning Mental Health Care and Guarantees of the Rights of Citizens Under Such Care; Article 127, Health Code, Republic of Kazakhstan; Article 7, Law of Ukraine On Psychiatric Care; Article 14, Law on Mental Health, Macedonia; Article 13, Law on Psychiatric Care, Republic of Georgia;
- 328 See, e.g., Article 5, Code of Ethics for Nurses in the Russian Federation; Article 2, Code of Medical Ethics in the Russian Federation; Article 3, Code of Ethics for Physicians in the Russian Federation; Article 36, Code of Ethics of the Macedonian Chamber of Medicine; Article 38, Code of Professional Ethics of Macedonian Pharmacists' Obligations and Rights; Chapter 8, Code of Ethics of Georgian Physicians; Paragraphs 3.8, 3.12 & 3.14, Code of Ethics of Physicians of Ukraine; Article 3, Code of Professional Ethics of a Health Care Worker of Kyrgyzstan; Article 184, Health Code, Republic of Kazakhstan.

provider institution's license, as noted in the Ukraine and Kazakhstan PGs.³²⁹

Just as with the right to observance of quality standards discussed above, the issue of safety in health care proved a fertile ground for identification and discussion of actual instances of gross violations in the participating countries. Some specific examples from the PGs included poor facility conditions in Armenia,³³⁰ production of medications not safe for use in Kazakhstan,³³¹ misdiagnosis in Kazakhstan,³³² and practices rife with medical error in Georgia, Ukraine, Kyrgyzstan, and Russia.³³³

Right to Innovation

This right, which may derive from the right to the benefits of scientific progress under international law, is generally not directly recognized in constitutional or legislative provisions of the participating countries. The right can be extrapolated from provisions related to health care standards and access described above, especially in the context of provisions guaranteeing "modernization" or access to "modern" medical care, as seen in Macedonia, Kazakhstan, Kyrgyzstan, and Russia, for example.³³⁴ In the context of reproductive technology, the right to innovation is operationalized in the legislative framework of four participating states.³³⁵ It is similarly implied in the access to transplantation services in Ukraine,³³⁶ and the right to access services abroad in Kazakhstan.³³⁷ Especially in resource-constrained settings, the right to innovation may be controversial because medical providers and payers may see it as opening the door to patient

329 See, e.g., Articles 139 & 140, Criminal Code of Ukraine; Article 324, Code of Administrative Offences, Republic of Kazakhstan.

330 Armenia PG, Chapter 6, Section 1 at 175.

331 Kazakhstan PG, Chapter 6, Section 1 ("sale of 205 packs of expired Sandoglobulin").

332 Kazakhstan PG, Chapter 6, Section 1 ("hospital in the town of Tekeli").

333 Georgia PG, Chapter 6, Section 1 at 187; Ukraine PG, Chapter 6, Section 1 at 241; Kyrgyzstan PG, Chapter 5, Section 1 ("infection with HIV due to improper implementation of a health worker's professional duties"); Russia PG, Chapter 6, Section 1 ("cost of operations for excision of keloids")

334 See, e.g., Article 30, Law on Health Insurance, Macedonia (providing for funding of patient care abroad, when necessitated by availability of innovative treatment); Article 29, Health Code, Republic of Kazakhstan (adoption of global innovative technologies and the modernization of the healthcare system) and Article 89, Health Code, Republic of Kazakhstan (regarding a child's right to use modern and efficient services of the health care system of means of treating diseases and recovering health); Government Regulation N-350, On the Program of State Guarantees of Provision of Citizens of Kyrgyzstan with Health Care in 2011, dated July 1, 2011 (providing that citizens who need high-tech and expensive treatments can receive such treatments partly or fully paid by the Fund of High Technologies); Article 14, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 8, Federal Law of September 8, 2010, No. 44-FZ, On the Innovation Center-Skolovo.

335 See, e.g., Articles 4 & 11, Law on Reproductive Health and Rights, Republic of Armenia; Articles 98 & 99, Health Code, Republic of Kazakhstan; Article 5, Law on Reproductive Rights of Citizens and Guarantees of Their Enforcement, Kyrgyzstan; Ukrainian MOH Order on the Implementation of Assistive Reproductive Technologies, dated December 23, 2008, No. 771.

336 See, e.g., Article 6 of the Law on Organ Transplantation and other Anatomical Materials, Ukraine. July 16, 1999.

337 See, e.g., Article 88, Article 1 of the Health Code, Republic of Kazakhstan.

demands for unrealistically expensive technology and medications, as described in the Macedonia and Armenia PGs.³³⁸

Right to Avoid Unnecessary Suffering and Pain

A previously neglected area of the law, the right to avoid unnecessary suffering, has found its way, in one form or another, into the legislative frameworks on medical care of the countries included here.³³⁹ Access to pain management and palliative care is addressed in the legislation in most participating countries.³⁴⁰ Clinical protocols on palliative and other kinds of key pain management issues have emerged in some settings.³⁴¹ However, in some countries, laws stipulate that availability of and access to pain management and palliative care remain substantially curtailed, including requirements that powerful narcotic medications be available only to terminally-ill patients or that state funding for such medication is guaranteed only at government-run medical facilities.³⁴² In Georgia, for example, even for cancer patients there are very strict limitations in medication courses that can be prescribed.³⁴³ Similar limitations apply to AIDS

338 See, e.g., Practical Notes in Macedonia PG, Chapter 6, Section 1 at 194, and Armenia PG, Chapter 6, Section 1 at 178.

339 See, e.g., Article 91(1), Health Code, Republic of Kazakhstan (regarding easing sufferings to the extent allowed by existing medical technologies); Government of Armenia Decree, N 1771-N (2003) (providing for cancer patients to be supplied with pain medications, and narcotics by ambulatory, dispensary and inpatient facilities covered from the state funds); Article 24.1, Law on the Rights of Patients, Republic of Georgia; Order of the Minister of Labor, Health and Social Affairs, Republic of Georgia, (dated July 10, 2008), No. 157/n; Order of the Ministry of Health, Ukraine, (dated December 27, 2007), No. 866; Decree of the Government of Kyrgyzstan dated July 2, 2011, N-350, Government Regulation On the Program of State Guarantees of Provision of Citizens of Kyrgyzstan with Health Care in 2011; Article 19, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 3, Law on the Protection of Patients' Rights, Macedonia.

340 *Ibid.*; see also Article 36, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 3, Law on the Protection of Patients' Rights, Macedonia.

341 See, e.g., Appendix No. 6, Order of the Health Ministry, Kyrgyzstan (regarding Approval of New Clinical Protocols); Guidelines on the Organization of Palliative Care, approved by the Health Ministry of Russian Federation, September 22, 2008, No. 7180-RC; Principles of the clinical use of Narcotic and Non-Narcotic Analgesics in Pain Treatment, Practical Policy No. 819 Health and Human Services Agency of the Russian Federation (2004); Government Decree No. 1343 On Approval of the Rules of Executing Palliative and Nursing Care, dated November 15, 2011, Republic of Kazakhstan; Ukrainian Ministry of Health Order No. 368 On Approval of the Clinical Protocol for Providing Palliative Care, Symptomatic and Immunosuppressive Therapy to HIV and AIDS Patients, dated July 3, 2007; Government of Armenia Decree No. 1771-N, dated November 13, 2003 (providing that persons who have malignant tumors are to be provided with anti-tumor drugs, pain medications, and other narcotics covered by state funds); see generally, Article 16, Law on Health Care, Republic of Georgia.

342 See, e.g., Government of Armenia Decree, N 1771-N (2003); Article 24.1, Law on the Rights of Patients, Republic of Georgia.

343 See, e.g., Order of the Minister of Labor, Health and Social Affairs, Republic of Georgia, (dated July 10, 2008), No. 157/n, (concerning approval of "Instruction for palliative care of patients with chronic incurable diseases").

patients in hospice care in some settings, as in Ukraine.³⁴⁴

An overview of the practical examples of violations provided by working groups suggests that many problems of access to effective pain management exist in the participating countries,³⁴⁵ including a case where a former drug user, now a cancer patient, was denied anesthesia during an operation out of fear that he may resume drug dependence in Georgia.³⁴⁶ Indeed, jurisprudence specifically addressing the right to effective pain management apparently remains very sparse in the participating countries—out of the cases listed, only the Georgian case law dealt with a customary health care setting; Russia and Ukraine provided adjudicative examples from the prison setting. The majority of the working groups did not find examples of litigation on this point, suggesting this as an area of potential development, given pervasive pain management problems in the region noted by observers external to the PG project.³⁴⁷

Right to Personalized Treatment

This right is closely linked to the right to quality treatment discussed above. In the legal frameworks of the participating countries, this right does not appear explicitly. However, this right can be inferred from provisions that give patients the right to care that meet their needs and the medical necessity implied by their conditions.³⁴⁸ There are specific provisions, such as the Macedonia mental health law, stipulating a personalized approach to care in limited settings, including mental health treatment,³⁴⁹ reproductive health services in Russia,³⁵⁰ patients with disabilities in Kazakhstan,³⁵¹ and patients with diabetes in Kyrgyzstan.³⁵² Georgia, which has a more patient-oriented approach to health care provision, also stipulates culturally and religiously-appropriate care.³⁵³ Beyond examples

344 See, e.g., Order of the Ministry of Health, Ukraine, (dated December 27, 2007), No. 866, (Regarding Hospice Care for People Living with HIV/AIDS).

345 See, e.g., Ukraine PG, Chapter 6, Section 1 at 251-252; Russia PG, Chapter 6, Section 1 (“Moscow City Polyclinic No. 194”); Kazakhstan PG, Chapter 6, Section 1 (“did not receive medical aid after his legs were frostbitten”).

346 Georgia PG, Chapter 6, Section 1 at 194.

347 Human Rights Watch. *Please Do Not Make Us Suffer Anymore: Access to Pain Treatment as a Human Right*. 2009. Available at www.hrw.org/en/node/81080/. Accessed July 31, 2012.

348 See, e.g., Article 5, Law on Patients’ Rights Protection, Macedonia; Article 102, Health Code, Republic of Kazakhstan; Article 30, Law on Health Care, Republic of Georgia.

349 See, e.g., Article 23, Law on Mental Health, Macedonia.

350 See, e.g., Order by Health and Human Services Agency of the Russian Federation as of September 24, 2007, No. 623, On Measures to Improve Obstetric-and-Gynecologic Care for Population of the Russian Federation.

351 See, e.g., Government Decree No. 754 On Approval of Rules of Providing the Disabled Patients with Special Means of Transportation, Republic of Kazakhstan.

352 See, e.g., Article 7, Law On Diabetes, Kyrgyzstan.

353 See, e.g., Article 15, Law on the Rights of Patients, Republic of Georgia (specifically entitling patients the right “to request from the health care provider to be treated with dignity and to respect his/her culture, religious convictions and personal values”).

that fit under the rubric of negligent, ineffective, or inappropriate care, working groups did not provide illustrative examples of violations, jurisprudence, or practical advice on this point.³⁵⁴

Right to Complain

In addition to constitutional protections of due process and access to adjudication in all seven countries, the right to appeal to authorities in cases involving patients' complaints is well-established in the countries' legislative regimes. Bolstered by the increasing influence of the principle of transparency and open government, countries have created a number of specific grievance mechanisms, including those involving administrative, arbitral, and adjudicative mechanisms.³⁵⁵ In addition, the right to appeal the decisions of administrative committees and government experts may also be expressly provided.³⁵⁶ Public defender laws creating an ombudsman's office are designed to facilitate grievance-seeking and are constitutionally-guaranteed in some settings, such as Armenia.³⁵⁷

Practical cases offered by the working groups suggest that these theoretical protections remain poorly implemented in many settings. Misinformation about complaint mechanisms exists both on the provider side (Georgia PG)³⁵⁸ and the patient side (Russia PG),³⁵⁹ while oversight and enforcement are lacking, as noted in the Armenia, Kazakhstan and Kyrgyzstan PGs.³⁶⁰ However, it is clear from the cases cited in the Armenia and Russia guides that some public defenders have been more active than others on issues of human rights in patient care.³⁶¹

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- 354 Armenia PG, Chapter 6, Section 1 at 182; Georgia PG, Chapter 6, Section 1 at 198; Macedonia PG, Chapter 6, Section 1 at 196; Ukraine PG, Chapter 6, Section 1 at 255; Kazakhstan PG, Chapter 6, Section 1 ("services of mass healing over TV"); Kyrgyzstan PG, Chapter 5, Section 1 ("anesthesiologist did not take into account the physiological characteristics and condition of the patient"); Russia PG, Chapter 6, Section 1 ("Regional Office of the Social Insurance Fund of the Russian Republic of Sakha").
- 355 See, e.g., Article 72, Law On Citizens' Health Protection, Kyrgyzstan; Article 88, Health Code, Republic of Kazakhstan; Article 98, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 6, Law of Ukraine, Principles of Ukrainian Health Care Legislation; Article 47, Law on the Protection of Patients' Rights, Macedonia; Article 104, Law on Health Care, Republic of Georgia.
- 356 See, e.g., Articles 46-50, Law On Citizens' Health Protection, Kyrgyzstan, Article 88, Health Code, Republic of Kazakhstan; Law on the Procedure of Discussing Citizens' Proposals, Applications and Complaints, dated November 24, 1999, Republic of Armenia.
- 357 See, e.g., Article 18, Armenian Constitution.
- 358 See, e.g., Georgia PG, Chapter 6, Section 1 at 202.
- 359 See, e.g., Russia PG, Chapter 6, Section 1 ("she failed to provide medical records of her deceased father").
- 360 Kazakhstan PG, Chapter 6, Section 1 ("complained to the ombudsman about the violation of her right to complain"); Kyrgyzstan PG, Chapter 5, Section 1 ("did not receive a response within the statutory period").
- 361 See, e.g., Armenia PG, Chapter 6, Section 1 at 185; Russia PG, Chapter 6, Section 1 ("Gagarin District Court of Moscow").

Right to Compensation

Closely related to the right to complain, the right to compensation is a procedural right that is uniformly recognized by the constitutional and legislative regimes across participating countries. Patients' rights to be compensated are also specifically covered by legislation in all of the countries.³⁶² Domestic civil codes outline the amounts, kinds, and other provisions governing the calculation of damage awards in malpractice cases, including pecuniary and physical damages as noted in the Armenia and Kyrgyzstan PGs.³⁶³ At least in Russia, legislation also stipulates the impact of damage awards on other kinds of administrative or criminal liability for the same incident.³⁶⁴ To facilitate patient compensation in malpractice cases in Georgia, legislation provides for the creation of special malpractice award funds.³⁶⁵ Overall, these regulatory regimes might be considered as creating a codified framework for the common law system of tort damages.

The examples provided generally deal with the complexities of civil procedure in the various settings, providing several cases indicating that the system is capable of effectively adjudicating medical malpractice cases, with the courts awarding sizable damages to patients even in cases against the government.³⁶⁶ Criminal law mechanisms are also available—and utilized, in egregious cases—to prosecute cases of malpractice, as in Ukraine, for example.³⁶⁷

Additional Rights

The working groups were asked to identify and discuss additional patient rights that exist in their national legislation. Topics that were listed included the right to have an advanced will in Georgia,³⁶⁸ the right to life in Ukraine,³⁶⁹ the right not to be unlawfully discriminated against for health reasons in Ukraine,³⁷⁰ the right to respect

362 See, e.g., Article 6, Medical Care Law, Republic of Armenia (“Everyone shall have the right to receive compensation for the harm caused to his/her health during the organization and realization of medical care and services.”); Article 10, Law on the Rights of Patients, Republic of Georgia; Article 55, Law on Health Care, Macedonia; Paragraphs k & l, Law of Ukraine, Principles of Ukrainian Health Care Legislation; Articles 917 & 921, Civil Code, Republic of Kazakhstan; Articles 1012-1022, Civil Code, Kyrgyzstan; Article 9, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

363 See, e.g., Articles 1077-1087, Civil Code, Republic of Armenia; Articles 1012-1022, Civil Code, Kyrgyzstan.

364 See, e.g., Russia PG, Chapter 6, Section 1 (“copy of the decision to discontinue criminal proceeding”).

365 See, e.g., Article 58, Law on Health Care, Republic of Georgia.

366 See, e.g., Armenia PG, Chapter 6, Section 1 at 189-190; Georgia PG, Chapter 6, Section 1 at 205-206; Ukraine PG, Chapter 6, Section 1 at 266-267; Kyrgyzstan PG, Chapter 5, Section 1 (“imprisonment for a term of 2 years with compensation of 200,000 soms”); Russia PG, Chapter 6, Section 1 (“from the decision of the district division of the Federal Court of Saint Petersburg”); Kazakhstan PG, Chapter 6, Section 1 (“City Court of Krasnoyarsk”).

367 See, e.g., Article 139-140, Criminal Code, Ukraine.

368 Georgia PG, Chapter 6, Section 1 at 206-208.

369 Ukraine PG, Chapter 6, Section 1 at 270-276.

370 *Ibid.* at 276-280.

for human dignity in the course of receiving medical care in Ukraine,³⁷¹ the right to admission of one's attorney or priest in Russia,³⁷² various rights related to genetic and reproductive treatments, as in Georgia,³⁷³ the right to a second medical opinion in Macedonia,³⁷⁴ the right to maintain contact with the outside world when institutionalized in Macedonia,³⁷⁵ and other specific provisions covering health rights of people in detention in Georgia, such as the right to consent.³⁷⁶ Though not mentioned in the country PG, the right to a sex change also exists in Kazakhstan.³⁷⁷

Patient Responsibilities

In addition to the rights of patients, working groups from the participating countries reviewed the legislative framework for patient responsibilities. The following section is a summary of the working groups' formulations of their countries' theoretical and practical approaches in this realm. Since the human rights framework used to structure the rights analysis does not cover patient responsibilities, working groups used their own taxonomy of patient responsibilities, using the same structure as that of the patient rights, to guide their discussion. Overall, these obligations can be divided into the categories of patients' healthy lifestyles, and consumer and public health responsibilities. Four participating countries impose the vague duty on citizens to conduct healthy lifestyles and take measures to preserve their health.³⁷⁸ Duties to maintain health and seek timely medical treatment also apply to the citizens' children and others under their care in the Kyrgyzstan and Ukraine,³⁷⁹ and, in some instances, as in Ukraine, under the threat of criminal penalties.³⁸⁰

Patients' consumer obligations highlighted by four working groups included broad responsibilities to abide by the rules and regulations of the system.³⁸¹ More substantively, laws in four participating countries imposed a duty on patients to comply with prescribed and recommended treatment³⁸² and to conduct the necessary activities

371 Ibid. at 280-283.

372 Russia PG, Chapter 6, Section 1 ("Right to legal assistance, access to counsel, legal representative, and the priest").

373 Georgia PG, Chapter 6, Section 1 at 214-217.

374 Macedonia PG, Chapter 6, Section 1 at 206-207.

375 Macedonia PG, Chapter 6, Section 1 at 207-210.

376 Georgia PG, Chapter 6, Section 1 at 208-213.

377 Article 88, Health Code, Republic of Kazakhstan.

378 See, e.g., Articles 93-94, Law On Citizens' Health Protection, Kyrgyzstan; Article 92, Health Code, Republic of Kazakhstan; Article 29, Law on the Protection of Patients' Rights, Macedonia; Articles 10 & 32, Law of Ukraine, Principles of Ukrainian Health Care Legislation.

379 See, e.g., Articles 93, Law On Citizens' Health Protection, Kyrgyzstan; Article 5, Law of Ukraine On Ensuring Sanitary and Epidemiological Welfare of the Population.

380 See, e.g., Article 166, Criminal Code, Ukraine.

381 See, e.g., Items 1 & 2 of Article 91, Health Code, Republic of Kazakhstan; Article 94, Law On Citizens' Health Protection, Kyrgyzstan; Article 29.5, Law on the Protection of Patients' Rights, Macedonia; Article 34, Law of Ukraine, Principles of Ukrainian Health Care Legislation.

382 See, e.g., Article 92, Health Code, Republic of Kazakhstan; Article 34, Law of Ukraine, Principles of Ukrainian Health Care Legislation; Article 94, Law on Protection of Health of Citizens in Kyrgyzstan; Article 27, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

to facilitate their treatment in Macedonia.³⁸³ This also includes the duty to prevent the use of their insurance documents by others to obtain care, as in Kyrgyzstan,³⁸⁴ and to pay the requisite fees or co-payments for services rendered in Russia.³⁸⁵

In the realm of patient obligations relevant to public health, some countries list specific legislative mandates related to the obligations of patients to contain infectious disease. In relation to contagious disease, patients in Kazakhstan and Macedonia, for example, may be obliged to disclose their health status and inform medical professionals of significant changes in this status when receiving medical care.³⁸⁶ This includes responsibilities for treatment compliance/adherence and behavior change in view of HIV in Georgia, Kyrgyzstan, and Russia, for example,³⁸⁷ and other sexually-transmitted diseases, as well as TB, in Russia, Kyrgyzstan, and Kazakhstan.³⁸⁸ Although they are less directly relevant to public health, stringent laws in some countries also apply to drug users, who are required to undergo medical testing and treatment in the majority of the participating countries (Armenia, Kazakhstan, Russia, and Ukraine).³⁸⁹

In addition, those infected with highly-contagious diseases or suspected of infection are obliged to comply with medical screening, vaccination, and/or quarantine rules, as in Ukraine, Kyrgyzstan, Georgia, and Macedonia.³⁹⁰ Working groups in

383 See, e.g., Article 29, Law on Patients' Rights Protection, Macedonia (declaring that "while admitted in a health care institution, the patient is obliged, in line with his/her health status, to care about his/her health").

384 See, e.g., Article 13, Law On Medical Insurance for Citizens, Kyrgyzstan.

385 See, e.g., Part 1 of Article 779, Civil Code of the Russian Federation (as of November 30, 1994), No. 51-FZ.

386 See, e.g., Article 92, Health Code, Republic of Kazakhstan (regarding the timely informing of medical personnel about changes in the state of health in the process of diagnostics and treatment and cases of diseases which pose a threat to surrounding people or suspicions about these diseases); Article 29, Law on the Protection of Patients' Rights, Macedonia.

387 See, e.g., Article 5, Federal Act of the Russian Federation (dated March 30, 1995), No. 38-FZ, On Prevention of Communication of the Illness Caused by Human Immunodeficiency Virus (HIV) in the Russian Federation; Article 7, Law On Sanitary-Epidemiological Welfare of the Population, Kyrgyzstan; Article 11.2, Law on HIV/AIDS, Republic of Georgia.

388 See, e.g., Article 13, Federal Act of the Russian Federation (dated June 18, 2001), No. 77-FZ, On Prevention of Tuberculosis in the Russian Federation; Article 16, Law on Protection of Population from Tuberculosis, Kyrgyzstan; Article 105, Health Code, Republic of Kazakhstan.

389 See, e.g., Article 44(1), Code of Ukraine on Administrative Offences (as of December 7, 1984); Article 49(4), Law on Narcotic Drugs and Psychotropic (Psychoactive) Substances, Republic of Armenia; Part 3 of Article 54, Federal Act of the Russian Federation, No. 3-FZ, On Narcotic Drugs and Psychotropic Substances (dated 1998); The Law of the Republic of Kazakhstan On Forced Treatment of Alcohol and Drug Addicts (2004); however, Macedonia, Georgia, and Kyrgyzstan do not report laws on compulsory drug treatment.

390 See, e.g., Articles 5 & 7, Law of Ukraine On Ensuring Sanitary and Epidemiological Welfare of the Population (providing that medical screening and vaccinations may be required for certain activities and occupations); Article 5, Law of Kyrgyzstan on Immunoprophylaxis of Infectious Diseases (providing that mandatory vaccinations may be required for certain activities and occupations); Article 11, Law on Public Health, Republic of Georgia; Article 29, Law on Population Protection against Communicable Diseases, Macedonia.

Russia, Georgia, and Macedonia, for example, list special laws requiring mandatory reporting of sexual partners and others potentially exposed to the disease.³⁹¹ Being infected with a communicable disease implied duties to report their status when participating in certain health care activities, like blood or tissue donation in Russia and Kyrgyzstan.³⁹² Laws specifically criminalizing non-disclosure and transmission of HIV were prevalent among participating countries, but states with recent law reforms addressing HIV, such as Armenia, Georgia, and Macedonia, did not report such criminal provisions.³⁹³ Laws requiring patient compliance with epidemic control also provide for forcible hospital detention of patients who evade inspection and treatment for communicable disease, including TB, as in Russia and Kyrgyzstan.³⁹⁴ Patient obligations in this realm, such as those found in Kazakhstan, Kyrgyzstan, and Ukraine, also include complying with laws requiring compulsory vaccinations for adult patients and their children.³⁹⁵

Practical examples identified by the participating working groups focus on patients' duty to provide information when seeking treatment, specifically in cases when failure to disclose or failure to comply with a doctor's prescription causes harm to themselves or to others and can be used as a mitigating factor in defending medical providers in malpractice suits, as noted in the Macedonia, Ukraine, Kazakhstan, Kyrgyzstan, and Russia PGs.³⁹⁶

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- 391 See, e.g., Article 5, Federal Act of the Russian Federation (dated March 30, 1995), No. 38-FZ, On Prevention of Communication of the Illness Caused by Human Immunodeficiency Virus (HIV) in the Russian Federation; Articles 8.7 & 11.2, Law on HIV Infection/AIDS, Republic of Georgia; see also, generally, Law on Population Protection against Communicable Diseases, Macedonia.
- 392 See, e.g., Article 12, Law of the Russian Federation (dated June 9, 1993), No. 5142-1, Concerning the Donorship of Blood and Components Thereof; Article 10, Law of Kyrgyzstan on the Donation of Blood and Its Components.
- 393 See, e.g., Article 122, Criminal Code of the Russian Federation (stating that "Introduction of HIV infection by a person who was aware of his disease to another person shall be punished by imprisonment for a period not exceeding five years."); Articles 130 & 133, Criminal Code, Ukraine; Article 7, Law On Sanitary-Epidemiological Welfare of the Population, Kyrgyzstan; Part 4 of Article 116, Criminal Code, Republic of Kazakhstan. However, Armenia, Georgia, and Macedonia did not appear to specifically criminalize HIV non-disclosure or transmission.
- 394 See, e.g., Article 10, Federal Act of the Russian Federation (dated June 18, 2001), No. 77-FZ, On Prevention of Tuberculosis in the Russian Federation; Article 17, Law of Kyrgyzstan on Protection of the Population from Tuberculosis.
- 395 See, e.g., Resolution No 2295 On Approving a List of Diseases that Should Be Vaccinated against, Rules for Carrying Out Them, and Population Groups that Are Subject to Scheduled Vaccinations, issued by the Government of the Republic of Kazakhstan on December 30, 2009; Article 5, Law of Kyrgyzstan on Immunoprophylaxis of Infectious Diseases; Articles 5 & 7, Law of Ukraine On Ensuring Sanitary and Epidemiological Welfare of the Population (providing that medical screening and vaccinations may be required for certain activities and occupations).
- 396 Macedonia PG, Chapter 6, Section 2 at 216; Ukraine PG, Chapter 6, Section 2 at 287; Kazakhstan PG, Chapter 6, Section 2 ("mother had broken the rules of feeding"); Kyrgyzstan PG, Chapter 5, Section 2 ("M. failed to follow the doctor's instructions"); Russia PG, Chapter 6, Section 2 ("second district court of Krasnoyarsk").

National Frameworks for Provider Rights and Responsibilities

The interdependent relationship between the rights and obligations of patients and providers is at the heart of the framework for human rights in patient care. This section synthesizes the findings made by the seven countries' working groups on the formal protections and practical implementation of human rights in patient care as they apply to health care providers. Since the provider rights discussed in this section are not covered by a construct such as the ECPR, the Open Society Foundations' Law and Health Initiative identified three specific provider rights to be included in the national sections of all the practitioner guides (right to work in decent conditions, right to freedom of association, and right to due process), with the individual country working groups adding other provider rights that are included in their national legislation. As in the case of patient responsibilities, the individual country working groups identified the provider responsibilities included in their national legislation. The structure for each right and responsibility is basically the same as the structure used in both rights and responsibilities of patients.

Provider Rights

Since provider rights concern the rights of individuals or institutions in the setting of health care provision, this discussion centers primarily on labor law constructs and legal frameworks. The rights of providers in this realm derive from both general labor law as well as relevant provisions in health care law concerned with the human-resource management and administration of medical services.

Right to Work in Decent Conditions

The participating countries have relatively well-developed and detailed legal frameworks for labor protections. These include general protection of workers' rights to enjoy safe and healthy work environments, present in some form in all of the countries.³⁹⁷ The body of labor law directed at providing safe working conditions and addressing occupational health issues is well-developed in the general sphere,³⁹⁸ and includes

397 See, e.g., Article 43 (4), Ukrainian Constitution; Article 32, Armenian Constitution; Article 30, Georgian Constitution; Article 24, Kazakh Constitution; Article 41, Kyrgyz Constitution; Article 37, Russian Constitution; Article 42, Labor Relations Act, Macedonia.

398 See, e.g., Articles 311 & 314, Labor Code, Republic of Kazakhstan (stipulating the guarantees of the rights to labor safety and protection during labor activities); Article 2(2), Labor Code, Ukraine (December 10, 1971); Article 42, Labor Relations Act, Macedonia; Chapter 23, Labor Code, Republic of Armenia; Article 35, Labor Code, Republic of Georgia; Article 2, Labor Code, Kyrgyzstan; Article 21, Labor Code of the Russian Federation as of December 30, 2001, No. 197-FZ (as amended November 25, 2009).

the right of employees to physical space, training, protective equipment and other relevant entitlements.³⁹⁹ Health care regulations specifically address occupational safety in health care institutions.⁴⁰⁰ Generally, these laws are enforced through regulations that make continued licensing and certification contingent on compliance with occupational safety rules, as shown in the Armenia and Georgia PGs.⁴⁰¹

Linked to obligations of health care providers to undergo screening and other measures to protect public health in four of the countries are entitlements to be reimbursed for these diagnostic activities by the employer.⁴⁰² These rights are also subject to human rights protections, including those against workplace discrimination on various bases, including disability or health status, as stipulated in the constitutions of Kazakhstan and Russia, for example.⁴⁰³

Illustrative examples in this realm focus on systematic failures of health care institutions to provide a safe and hygienic workplace environment, including the absence of such basics as heat, hot water, and ventilation, as demonstrated in the Armenia PG,⁴⁰⁴ and the absence of basic equipment to enable the fulfillment of clinical duties as shown in the Kyrgyzstan PG.⁴⁰⁵ Examples from the Macedonia, Kazakhstan, Kyrgyzstan, and Russia PGs illustrate the difficult working conditions of some medical professionals with regard to long hours and not being compensated for hours worked,⁴⁰⁶ while difficult working conditions for healthcare workers providing care in prisons and other detention centers also exist in Georgia.⁴⁰⁷

399 See, e.g., Article 43, Law on Licensing, Republic of Armenia; Article 35, Labor Code, Republic of Georgia; Article 211, Labor Code, Kyrgyzstan; Article 22, Labor Code of the Russian Federation, No. 197-FZ; see generally, The Law on Health and Safety at Work, Macedonia.

400 See, e.g., Article 96, Law on Health Care, Republic of Georgia (mandating that employers provide employees with comprehensive information on the existence of harmful factors, and the measures to be taken against their influence) Article 72, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Sanitary-Epidemiological Requirements to Health Care Facilities, approved by Regulation No. 87, dated January 17, 2012, Republic of Kazakhstan; Article 84, Law on Protection of Health of Citizens in Kyrgyzstan; Article 77, Law of Ukraine, Principles of Ukrainian Health Care Legislation.

401 See, e.g., Article 11(1), Law on Licensing, Republic of Armenia (stipulating that licensees comply with requirements relating to decent working conditions, access to/use of necessary equipment and observance of hygiene and sanitary rules); Article 6, Law on Licenses and Permissions, Republic of Georgia.

402 See, e.g., Appendix 1, Order of the Minister of Labor Health and Social Affairs, Republic of Georgia, (dated July 11, 2007), No. 215/n; Government of Armenia Decree No. 347, dated March 27, 2003; Article 44, The Collective Agreement of Healthcare Profession in the Macedonia; Article 87, Law on Protection of the Health of Citizens in Kyrgyzstan.

403 See, e.g., Article 24, Kazakh Constitution; Article 37, Russian Constitution.

404 Armenia PG, Chapter 7, Section 1 at 196.

405 Kyrgyzstan PG, Chapter 6, Section 1 (“lack or absence of personal protective equipment”).

406 Macedonia PG, Chapter 7, Section 1 at 229; Kazakhstan PG, Chapter 7, Section 1 (“hospital staff complained that they were not paid for overtime at the hospital”); Kyrgyzstan PG, Chapter 6, Section 1 (“heavy workload of the medical staff”); Russia PG, Chapter 7, Section 1 (“Moscow PB No. 14”).

407 Georgia PG, Chapter 7, Section 1 at 228.

A case from Ukraine highlights the difficulties some health care workers face in seeking compensation from employers for necessary medical examinations and treatments.⁴⁰⁸ These examples vividly illustrate the interconnectedness between the right of providers to safe and decent working conditions and the right of patients to quality health care.

Right to Freedom of Association

A fundamental right, the right to freedom of association is well-covered under constitutional and legislative frameworks of the participating countries.⁴⁰⁹ Uniformly, this right is tied to the right to organize, to join trade unions, and to strike; these rights are often addressed together under constitutional and general labor laws.⁴¹⁰ Health care legislation also addresses the right to association.⁴¹¹ In turn, legislative provisions guarantee the right of these organizations to participate in policy decision-making activities.⁴¹² The right to strike is customarily curtailed for health care workers, usually imposing work stoppage prohibitions on essential or emergency personnel as in Armenia and Georgia.⁴¹³ Based on the lack of reported violations and case law provided in the PGs, it appears that this area of practice and jurisprudence remains underdeveloped in the region.

Right to Due Process

Like others in this section, this right generally figures into the overall civil rights framework in the participant countries. As such, it is protected both on the con-

408 Ukraine PG, Chapter 7, Section 1 at 305-306.

409 See, e.g., Article 35, Kyrgyz Constitution; Article 23, Kazakh Constitution; Article 30, Russian Constitution; Article 28, Armenian Constitution; Article 26, Georgian Constitution; Article 20, Macedonian Constitution; Article 35, Ukrainian Constitution.

410 See, e.g., Article 26, Georgian Constitution (“Everyone shall have the right to form and to join public associations, including trade unions”); Article 32, Armenian Constitution (guaranteeing employees’ right to strike); Article 20, Macedonian Constitution; Part 1 of Article 30, Russian Constitution; Part 3 of Article 35, Ukrainian Constitution; Article 22, Labor Code, Republic of Kazakhstan; Article 2, Labor Code, Kyrgyzstan.

411 See, e.g., Article 16, Law on Protection of Citizens’ Health, Kyrgyzstan; Articles 72 & 76, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 18, Law on Medical Care and Services to the Population, Republic of Armenia; Article 18, Law on Health Care, Republic of Georgia; Article 155, Law on Healthcare, Macedonia; Article 77, Law of Ukraine, Principles of Ukrainian Health Care Legislation; see also Law On Public Associations, Republic of Kazakhstan.

412 See, e.g., Article 18, Law on Health Care, Republic of Georgia (“Professional associations, as other organizations (e.g. academies, private or state organizations) are entitled to participate in the process of management of health care system of the country.”); Article 18, Law on Medical Care and Services to the Population, Republic of Armenia; Article 155, Law on Healthcare, Macedonia; Article 17, Law on Protection of Citizens’ Health, Kyrgyzstan; Articles 76, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

413 See, e.g., Article 75, Labor Code, Republic of Armenia; Article 51, Labor Code, Republic of Georgia.

stitutional level,⁴¹⁴ as well as on the level of national legislation. The right to due process is specifically addressed in the health care legislation sphere, including its application to reputation,⁴¹⁵ as well as licensing, certification, and other administrative privileges.⁴¹⁶ Principles of procedure are addressed, including burden of proof and the protections against double jeopardy.⁴¹⁷

These rights are operationalized through a number of mechanisms. Medical professionals in Georgia are specifically entitled to review complaints lodged against them⁴¹⁸ and to be present at adjudicative hearings,⁴¹⁹ including those addressing licensing, as in Macedonia.⁴²⁰ Access to public defense is stipulated by legislation for criminal cases and cases when a provider's professional reputation is at stake in Ukraine and Armenia, for example, although it is not clear if these laws would cover administrative cases.⁴²¹

Based on the listed examples, this area of jurisprudence is contentious and, at

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- 414 See, e.g., Articles 19 & 46-50, Russian Constitution; Articles 14 & 19, Armenian Constitution (guaranteeing everyone's right to restore his/her revealed rights, and to have the grounds of the charge against him/her heard in a fair public hearing under the equal protection of the law and fulfilling all the demands of justice by an independent and impartial court within a reasonable time); Articles 18, 40, 42 and 84, Georgian Constitution; Articles 12-18, 24, and 50, Macedonian Constitution; Part 1 of Article 59, Ukrainian Constitution; Articles 13 & 14, Kazakh Constitution; Article 40, Kyrgyz Constitution.
- 415 See, e.g., Article 18, Law on Medical Care and Services to the Population, Republic of Armenia (stating that health care service providers have the right to uphold their professional honor and dignity); Article 77, Law of Ukraine, Principles of Ukrainian Health Care Legislation; Article 182, Health Code, Republic of Kazakhstan; Article 90, Law on Protection of the Health of Citizens of Kyrgyzstan; Article 75, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.
- 416 See, e.g., Article 6, Ukrainian Administrative Code of July 7, 2005, and Article 3, Civil Procedure Code, Ukraine; see also, generally, Law on Fundamentals of Administrative Action and Administrative Proceedings, Republic of Armenia (outlining procedures and access to defense in administrative matters); Article 84, Civil Code, Kyrgyzstan; Order of the Minister of Labor, Health and Social Affairs, No. 122/n of May 16, 2008 On Establishment of the Professional Development Council at the Minister of Labor, Health and Social Affairs and Approval of its Bylaw, Republic of Georgia; Article 153, Law on Health Care, Macedonia.
- 417 See, e.g., Articles 12-18, 24, and 50, Macedonian Constitution; see also, generally, Civil Procedure Code, Criminal Procedure Code, and Administrative Procedure Code, Republic of Armenia; Code of Civil Procedure and Code of Criminal Procedure, Republic of Kazakhstan; Criminal Code, Code of Civil Procedure, and Code of Administrative Liability, Kyrgyzstan.
- 418 See, e.g., Article 84, Law on Doctors' Professional Activity, Republic of Georgia (stating that a "doctor can give oral or written comments on the document containing complaint or note about doctor's professional misconduct").
- 419 Ibid. at Article 87 (stating that a "doctor is entitled to attend the decision making process about his/her professional misconduct").
- 420 See, e.g., Article 153 of the Law on Health Care, Macedonia, defining the conditions under which the license can be revoked and the procedure for revocation of the license.
- 421 See, e.g., Article 77, Principles of Ukrainian Health Care Legislation of November 19, 1992; See also, generally, Law on the Human Rights Defender, Republic of Armenia.

times, confusing. For example, the Kyrgyzstan PG describes the interface of civil, administrative, and internal institutional laws and regulations that may be difficult to navigate for health care workers who seek redress for their violated rights, and examples of such difficulties may be found in the Armenia, Macedonia, and Ukraine PGs.⁴²² Individuals or institutions engaged in conflicts with governmental licensing or certification entities face many barriers, and the courts sometimes have trouble interpreting administrative privileges as rights deserving of due process.⁴²³ Practical notes in the Macedonia, Ukraine, Kazakhstan, and Kyrgyzstan PGs remind that health care providers must be conscious of the differing provisions within the civil, criminal, and administrative contexts.⁴²⁴

Additional Rights

Working groups were also asked to identify and discuss additional provider rights contained in their national legislation. Topics listed included the right to compensation for services provided, an issue of key importance to health care workers in the region. The right to fair remuneration is protected by constitutional and legal frameworks of several participating countries, particularly Georgia, Macedonia, Russia, and Kazakhstan.⁴²⁵ However, as the paucity of case law and practice notes in the PGs suggest, medical professionals' ability to use or to access the legal tools to secure or increase remuneration to vindicate their rights remains limited and largely untested, as noted in the Georgia and Kazakhstan PGs.⁴²⁶

Another linked right noted by the Kazakhstan and Ukraine working groups is the right of providers to be compensated for harms occurring to them in the scope of their employment, or in other words, a right to employer-covered health insurance.⁴²⁷ Relatedly, an issue of great importance and controversy in the United States, for example, the protection of providers from malpractice claims, is not nearly as

422 Kyrgyzstan PG, Chapter 6, Section 1 (“health care worker can choose the pre-trial or judicial forms of protection”). See also, e.g., Armenia PG, Chapter 7, Section 1 at 201; Macedonia PG, Chapter 7, Section 1 at 226; Ukraine PG, Chapter 7, Section 1 at 317-318.

423 Kazakhstan PG, Chapter 7, Section 1 (“non-state clinic was reorganized as a private clinic in 2003”). See also Russia PG, Chapter 6, Section 1 (“appealed to the city hospital to a VA doctor with complaints of epigastric pain”).

424 Macedonia PG, Chapter 7, Section 1 at 226; Ukraine PG, Chapter 7, Section 1 at 318-319; Kazakhstan PG, Chapter 7, Section 1 (“when one defends one’s rights judicially, one should remember that the civil law applies presumption of guilt”); Kyrgyzstan PG, Chapter 6, Section 1 (“health care worker can choose the pre-trial or judicial forms of protection”).

425 See, e.g., Article 30, Georgian Constitution (providing for “fair remuneration of labor”) and Article 93.2, Law on Doctor’s Professional Activity, Republic of Georgia; Article 105, Labor Relations Act, Macedonia; Articles 21 & 22, Labour Code of the Russian Federation, No. 197-FZ; Article 24, Kazakh Constitution.

426 Georgia PG, Chapter 7, Section 1 at 237. See also Kazakhstan PG, Chapter 7, Section 1 (“hospital staff complained that they were not paid for overtime at the hospital”).

427 Sub-item 5 of Item 1 of Article 182 of the Health Code, Republic of Kazakhstan; Article 77, Law of Ukraine, Principles of Ukrainian Health Care Legislation.

prominent a topic in the Eastern European and Central Asian countries, nor is malpractice insurance widespread, though the right to insurance for professional errors is explicitly provided for in Armenia, Georgia, Kyrgyzstan, and Russia.⁴²⁸

Additional rights had to do with professional activities, including participation in education (Russia, Macedonia, and Ukraine),⁴²⁹ and the right to work according to one's specialization (Russia, Armenia, Macedonia, and Ukraine).⁴³⁰ The right to refuse to provide care exists in Georgia and Ukraine, though the right appears limited by such requirements as non-emergency circumstances, safe alternatives, and for non-discriminatory, valid cause (such as prior non-compliance with the rules or treatment regimen).⁴³¹

Provider Responsibilities

In addition to the rights of providers, working groups were tasked with reviewing the legislative framework for provider duties and responsibilities. This section summarizes the working groups' findings in this realm. Although similar, the responsibilities included vary across the country guides, as there was no list of specific provider responsibilities provided as a construct in the template for the guides. The participant groups developed their own conceptions of these responsibilities, which are closely linked to patient rights. Structure for the discussion of provider responsibilities is the same as for patient and provider rights and patient responsibilities.

Responsibility to Provide Care

Providers' duty to provide medical care is closely linked to patients' right to access, patients' right to safety, and other patient rights discussed in the previous chapter, such as the right to informed consent and the right to privacy and confidentiality. The additional interpretations of this duty to provide medical care

428 Article 18, Medical Care and Services to the Population, Republic of Armenia; Article 50 & 58, Law on Health Care, Republic of Georgia; Article 84, Law on Protection of the Health of Citizens in Kyrgyzstan; Article 72, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

429 See, e.g., Article 43, Russian Constitution; Articles 21, 197, and 225, Labor Code of the Russian Federation, No. 197-FZ; Article 72, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Articles 154 & 155, Labor Relations Act, Macedonia; Article 53, Ukrainian Constitution; Law of Ukraine On Education, dated May 1991; Article 77, Law of Ukraine, Principles of Ukrainian Health Care Legislation.

430 Article 8, Russian Constitution; Article 69, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 32, Armenian Constitution; Article 18, Law on Medical Care and Services to the Population, Republic of Armenia; Articles 138-140 and 146, Law on Health-care, Macedonia; Article 43, Ukrainian Constitution; Articles 74 & 77, Law of Ukraine, Principles of Ukrainian Health Care Legislation.

431 Article 37, Law on Health Care, Republic of Georgia; Article 34, Law of Ukraine, Principles of Ukrainian Health Care Legislation.

by the participating working groups focus on the duty to provide timely care, including in cases of emergency.

As discussed above, the right to access medical care is well covered in the domestic legislative frameworks of the participating countries. Generally, health care institutions are obliged to provide care whenever requested.⁴³² Free care, including emergency care, is a constitutional right in some settings (Kazakhstan, Ukraine, Georgia, Kyrgyzstan, Russia, Armenia),⁴³³ but in all seven countries, laws provide for timely and free emergency medical assistance.⁴³⁴

This duty to provide medical assistance is imposed on doctors regardless of their specialty, expectation for reimbursement, or the setting in which the emergency occurs.⁴³⁵ Failure to provide such assistance carries both criminal and administrative penalties and may result in the suspension or revocation of one's license or credential to practice.⁴³⁶ Specific laws outline the organization of emergency health services, stipulating specific geographic coverage and response times in Kyrgyzstan and Russia, for example.⁴³⁷

Across the participating countries are numerous examples of violations of these institutional and individual duties to provide timely emergency aid. The working groups cite cases of non-responsive or unacceptably long response times

432 See, e.g., Article 46 of the Law on Health Care, Macedonia (regulating the responsibility of the health care setting to provide health care services for every person who requests them); see also *supra* note 216.

433 See, e.g., Article 29, Kazakh Constitution (guaranteeing "Citizens of the Republic of Kazakhstan shall be entitled to free, guaranteed, extensive medical assistance established by law."); Article 49(3), Ukrainian Constitution; Article 37(1), Georgian Constitution; Article 47(3), Kyrgyz Constitution; Article 41(1), Russian Constitution; Article 38, Armenian Constitution ("Everyone shall have the right to benefit from medical aid and service under the conditions prescribed by law.").

434 See, e.g., Article 19, Law on Medical Care and Services to the Population, Republic of Armenia; Article 46, Law on Health Care, Macedonia; Articles 34 & 182 of the Health Code, Republic of Kazakhstan; Article 12, Law on the Rights of Patients, Republic of Georgia; Article 38, Law on Health Care, Republic of Georgia; Article 78, Law of Ukraine, Principles of Ukrainian Health Care Legislation; Article 22, Law on Health Protection of Citizens in Kyrgyzstan; Articles 11 & 73, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

435 *Ibid.*

436 See, e.g., Article 129, Criminal Code, Republic of Armenia; Article 129, Criminal Code, Republic of Georgia; Article 139, Criminal Code, Ukraine; Articles 85 & 96, Code of Administrative Liability, Kyrgyzstan; Articles 119-121, Criminal Code, Kyrgyzstan; Article 124, Criminal Code of the Russian Federation, dated June 13, 1996, No. 63-FZ; Article 6, Code of the Russian Federation on Administrative Violations, dated December 30, 2001, No. 195-FZ.

437 See, e.g., Order by Ministry of Public Health and Social Development of the Russian Federation, dated November 1, 2004, No. 179, On Approval of the Ambulance Medical Care Procedure; see also Annex 2, Regulation On Organizing the Activity of the Medical Emergency and First Aid Department (Substation) / Emergency Outpatient Medical Aid Center, approved by the Order of the Health Ministry of Kyrgyzstan, dated January 30, 2004, No. 32.

in Kazakhstan, Kyrgyzstan, Russia, Georgia, and Ukraine.⁴³⁸ Cases from Armenia included instances of refusal of emergency aid for persons infected with HIV.⁴³⁹

This rich body of examples helps explain the interest of the working groups in the topic of emergency care. Based on the examples provided above, this interest is rooted in the everyday difficulties of attaining basic, life-saving care, where emergency response is not available when and where it is mostly needed. Case examples provided by working groups present a mixed picture of successful outcomes favoring the patient when the law is used to enforce state and provider obligations for emergency services; successes include cases in Kazakhstan and Ukraine where some civil and administrative remedies may feasibly improve the situation.⁴⁴⁰

Responsibility Not to Engage in Discrimination

Related to the above discussion of discrimination in the context of the duty to provide emergency care, nondiscrimination in patient care is also a provider responsibility identified by some of the working groups. As discussed in the international and regional chapters, access to care without discrimination is a well-accepted norm both internationally and regionally. Provisions imposing prohibitions against patient discrimination on the basis of traditionally-protected categories, including sex, race, disability, or HIV status appear in the national legislation instruments on health care access.⁴⁴¹ However, special anti discrimination provisions based on migration status and sexual orientation were apparently absent from health care legislation.

In regard to actual examples, the Armenia and Macedonia PGs present salient cases illustrating egregious discrimination in the health care sector.⁴⁴² Given the attention that migrants receive under international law, it is notable that national

438 Kazakhstan PG, Chapter 7, Section 2 (“ambulance doctor stated to the woman and her husband that their child had died”); Kyrgyzstan PG, Chapter 6, Section 2 (“critical condition of the child was not taken into account”); Russia PG, Chapter 7, Section 2 (“decision of the district court Krasnoselskii St. Petersburg”); Georgia PG, Chapter 7, Section 2 at 245; Ukraine PG, Chapter 7, Section 2 at 361.

439 Armenia PG, Chapter 7, Section 2 at 209.

440 See, e.g., Ukraine PG, Chapter 7, Section 2 at 361; Kazakh PG, Chapter 7, Section 2 (“only one car for the emergency room in Alamedin”) (resulting in the reprimand of thirteen doctors and the dismissal of four).

441 See, e.g., Article 4, Medical Care Law, Republic of Armenia; Article 6, Law on Health Care, Republic of Georgia; Article 32, Law on the Protection of Patients’ Rights, Macedonia; Article 6, Law of Ukraine, Principles of Ukrainian Health Care Legislation; Article 26, Federal Law of November 21, 2011, No. 323-FZ, On the Basis of Health Protection in the Russian Federation; Article 5, Law On HIV/AIDS, Kyrgyzstan; Articles 91 & 112, Health Code, Republic of Kazakhstan.

442 See, e.g., Armenia PG, Chapter 7, Section 2 at 209 (refusal to treat persons/patients who were HIV-infected); Macedonia PG, Chapter 6, Section 1 at 154 (Case Study 2.13: stigma and discrimination against sex workers).

legislatures in most of the participating countries apparently have not moved to impose specific prohibitions to discrimination against this group.⁴⁴³

Responsibility to Obtain Informed Consent

The working groups also re-visit the issue of informed consent in the section on Provider Responsibilities. While reiterating the duty to obtain consent from patients as a general rule, these discussions also focused on clarifying the circumstances under which the obligation was lifted. These cases include provision of emergency care, and care in the interest of the patient in cases of incapacity, as in Georgia, Kyrgyzstan, and Macedonia,⁴⁴⁴ and even in cases of detention as in Georgia.⁴⁴⁵ Additionally, where treatment is compulsory—as in cases of infectious disease, psychiatric treatment, or certain kinds of drug treatment—health care providers in Armenia and Russia, for example, are relieved of the duty to obtain informed consent.⁴⁴⁶

Special attention in this legislation and in the guides is given to mental health settings. In Armenia, Macedonia and Kyrgyzstan, providers are legally obligated to not only inform the patient about the risks or consequences of treatment, but upon release or changes in treatment, their partners and others who may be affected by the course of treatment.⁴⁴⁷ This duty is closely tied to legal protections, including court oversight for patients who are deemed incapacitated, as also found in Armenian, Macedonia, and Kyrgyz law.⁴⁴⁸ Based on the cases provided by the working groups, it appears that jurisprudence on issues related to informed consent in general is already occurring in the majority of participating countries (Kyrgyzstan, Ukraine, Macedonia, Kazakhstan, and Russia), but in the specific area of violations in informed consent for psychiatric treatment, it is not yet well-developed.⁴⁴⁹

443 CMW. Articles 28, 43, and 45.

444 See, e.g., Article 45, Law on Doctor's Professional Activity, Republic of Georgia; Article 73, Law on Protection of the Health of Citizens in Kyrgyzstan; Article 24, Law on Mental Health, Macedonia.

445 Article 44, Law on Health Care, Republic of Georgia.

446 See, e.g., Article 49(4), Law on Narcotic Drugs and Psychotropic (Psychoactive) Substances, Republic of Armenia; Article 174-177, Civil Procedures Code, Republic of Armenia; Part 3 of Article 54, Federal Act of the Russian Federation, No. 3-FZ, On Narcotic Drugs and Psychotropic Substances, (dated 1998) (providing for compulsory drug treatment in some settings).

447 See, e.g., Article 21, Law on Mental Health, Macedonia; Article 15, Law on Psychiatric Care, Republic of Armenia; Article 11, Law on Psychiatric Care and Guarantees of Citizens' Rights in its Provision, Kyrgyzstan.

448 Ibid.

449 See, e.g., Kyrgyzstan PG, Chapter 6, Section 2 ("due to the fact that it was not possible to obtain the consent of his parents to intervene"); Ukraine PG, Chapter 6, Section 1 at 210-211; Macedonia PG, Chapter 6, Section 1 at 169-170; Kazakhstan PG, Chapter 6, Section 1 ("puncture was performed without notifying the parents and obtaining their written consent"); Russia PG, Chapter 6, Section 1 ("State of Health of the Kemerovo region").

Responsibility to Maintain Confidentiality

The responsibility to maintain confidentiality, though closely related to the patient's right to privacy and confidentiality, was included again in nearly all of the participating country PGs, save for the Russia PG. As previously noted, participating countries impose a general requirement on medical providers to maintain confidential any health care information, including the fact that a person has chosen to seek treatment, as in Kyrgyzstan and Ukraine.⁴⁵⁰ These rules apply even after the patient's death in Macedonia, Georgia, and Ukraine, for example.⁴⁵¹

In discussing this right within the context of the provider responsibility section, however, the Georgia, Kazakhstan, and Kyrgyzstan PGs focused on specific circumstances when medical providers may be relieved. This includes cases when such information is shared within the context of the medical institution to facilitate the person's care, can prevent the spread of infectious disease, prevent a disaster, doing so can prevent harm to a third person, when required to do so by the courts, and if the information is used in educational or research settings, after being de-identified.⁴⁵² There is also a class of allowed disclosures in the context of occupational health, when medical examinations are conducted to determine qualification of a new employee or to screen existing employees for specific diseases, including communicable disease that can spread easily in such settings as the food industry and pharmaceutical manufacturing, as in Macedonia's law to protect the population against communicable diseases.⁴⁵³

There were also potentially controversial provisions, such as the Georgia law on doctors' professional activities, allowing the disclosure of patient information when "there is a reasonable ground to suspect existence of the disease subject to mandatory registration,"⁴⁵⁴ referring to the registration for drug or other kinds of addictive disorders. The wording of this provision and the ones like it, such as Georgian, Kyrgyz, Kazakh, Ukrainian and Armenian laws that allow disclosure of patient information without patient consent via court orders, subpoenas, etc. to

450 See, e.g., Article 91, Law on Protection of the Health of Citizens in Kyrgyzstan; Article 286, Civil Code, Ukraine.

451 See, e.g., Article 25, Law on the Protection of Patients' Rights, Macedonia; Article 48, Law on Doctor's Professional Activity, Republic of Georgia; Paragraphs 2.1, 2.2, and 3.6, Code of Ethics of Physicians of Ukraine, adopted and signed at the National Congress of Health Care Organizations and at the X Congress of the Ukrainian Medical Association, September 27, 2009.

452 See, e.g., Article 95, Health Code, Kazakhstan; Article 48, Law on Doctor's Professional Activity, Georgia; Article 91, Law on Protection of the Health of Citizens in Kyrgyzstan.

453 See, e.g., Article 44, Law on Population Protection against Communicable Diseases, Macedonia.

454 See, e.g., Article 48, Law on Doctor's Professional Activity, Republic of Georgia.

455 See, e.g., Article 48.2, Law on Doctor's Professional Activity, Republic of Georgia; Article 91, Law on Protection of Health of Citizens in Kyrgyzstan; Item 4 of Article 95, Health Code, Republic of Kazakhstan; Article 14, Law on Measures to Prevent the Illegal Circulation of Narcotics, Psychotropics, and other substances, Ukraine (dated February 15, 1995); Article 13, Law on Transplanting Human Organs and/or Tissues, Republic of Armenia.

law enforcement personnel in a criminal or administrative investigation,⁴⁵⁵ can open the door to loose interpretation and abuse, as noted by external sources.⁴⁵⁶

Depending on the particular national framework, medical providers are required to make disclosures of patient information to the authorities. In addition to the instances enumerated above, scenarios allowing for the disclosure of confidential information include reporting of cases that signal an emerging epidemic in Kazakhstan and Kyrgyzstan,⁴⁵⁷ placement of patients under quarantine in Macedonia,⁴⁵⁸ or to prevent the imminent commission of a violent crime or other harm to a third party in Georgia.⁴⁵⁹ The working groups do not provide specific examples or other practical information on the application or invocation of these provisions in litigation.

Duty to Keep Records

Closely related to the patient's right to information is the provider's duty to keep records. Recordkeeping is identified in the national health care regulation cannon as a key aspect of the provider's obligation. The manner in which the records have to be kept, what information must be included, and the fact that they should be signed are stipulated by laws in Georgia, Armenia, Macedonia, and Kyrgyzstan.⁴⁶⁰ In Kyrgyzstan, this duty also entails the requirement to specifically document any refusal of treatment and the information provided to a patient to form the basis of such a decision.⁴⁶¹

In other settings, medical providers are obligated to keep specific records of interest to public health authorities for surveillance purposes. For example, in one country, Armenia, a uniform patient registration and documentation system is in place to facilitate disease prevention efforts.⁴⁶² In this setting, providers are required to periodically submit aggregate information to the centralized authorities.

Practical illustrations in the PGs of jurisprudence arising from these obligations highlight the low level of systematization and automation of the record-keeping processes in the participating countries. This introduces the opportunity for mis-

456 IHRD, *supra* note 303.

457 See, e.g., Article 91, Law on Protection of Health of Citizens in Kyrgyzstan; Item 4 of Article 95, Health Code, Republic of Kazakhstan.

458 See, e.g., Articles 20-21, Law on Population Protection against Communicable Diseases, Macedonia.

459 See, e.g., Article 48.2, Law on Doctor's Professional Activity, Republic of Georgia.

460 See, e.g., Articles 41 & 56, Law on Doctor's Professional Activity, Georgia; Article 20, Law on State Statistics, Republic of Armenia; Article 3, Law on the Protection of the Population against Communicable Diseases, Macedonia; Article 96, Law of Kyrgyzstan On Protection of the Health of Citizens in the Republic.

461 See, e.g., Article 5, Law On Immune-Prophylactic of Infectious Diseases, Kyrgyzstan.

462 See, e.g., Article 20 Law on State Statistics, Republic of Armenia.

463 Macedonia PG, Chapter 7, Section 2 at 254.

takes and otherwise complicates quality care, as noted in the Macedonia PG.⁴⁶³ In another case, the disappearance of a paper medical chart in Armenia barred a malpractice case from proceeding, as it served as the single source of documentation about a doctor-patient encounter in question.⁴⁶⁴ The Georgia PG also highlights how prison medical records are often incomplete or nonexistent.⁴⁶⁵ As the Kyrgyzstan PG points out, the lack or nonexistence of medical records can be harmful to a patient's malpractice claim against a medical provider.⁴⁶⁶

Other Duties and Responsibilities

There are a number of other areas of provider responsibility discussed in various PGs. The obligation to undergo periodic licensing and accreditation is prevalent among all of the participating countries.⁴⁶⁷ This responsibility is closely linked to the patient right to quality care and the provider right to a safe working environment described above. In the PG countries facing consistent problems transitioning from a centralized, state-owned, state-run system to hybrid schemes, health-related organizations have encountered implementation barriers to licensing, as demonstrated in the numerous health care and pharmaceutical organizations operating in Kazakhstan and Kyrgyzstan, for example, without licenses and without complying with any standards whatsoever.⁴⁶⁸ In Georgia and Kazakhstan, the system is being re-structured, including efforts to set up a single set of standards and one licensing authority.⁴⁶⁹ In such a context, as listed examples and cases in the PGs illustrate, there are issues about the ownership, due process, and other legal privileges related to licensing, its revocation, and other critical questions that are not clear, as exhibited in a case from Russia.⁴⁷⁰

Similar issues exist in education and certification of individual providers. Although details vary, each system includes a basic set of educational, training, examination, and licensing (or certification) requirements for medical providers.⁴⁷¹ These professionals are obligated to maintain their licensing (or re-accreditation) in order to practice general medicine or a specialization, as noted in the Macedonia PG.⁴⁷²

464 Armenia PG, Chapter 7, Section 2 at 220-221.

465 Georgia PG, Chapter 7, Section 2 at 258.

466 Kyrgyzstan PG, Chapter 6, Section 2 ("Ministry of Health of the KR investigated the case and found no evidence").

467 See, e.g., Article 6.2, Code of the Russian Federation on Administrative Violations dated December 30, 2001, No. 195-FZ; Article 43, Law on Licensing, Republic of Armenia; Article 115(b), Law on Health Care, Macedonia; Article 33, Health Code, Republic of Kazakhstan; Article 16, Law on Health Care, Republic of Georgia; Article 5, Law on Protection of the Health of Citizens in Kyrgyzstan; Article 56, Law on Licenses and Permissions, Ukraine.

468 Kazakhstan PG, Chapter 7, Section 2 ("closed down the Senim private clinic"); Kyrgyzstan PG, Chapter 6, Section 2 ("Issyk-Ata district court of Chui region").

469 Kazakhstan PG, Chapter 7, Section 2 ("In line with Sub-item 15 of Article 11 of this law, health care activities are subject to licensing"); Georgia PG, Chapter 6, Section 1 at 228.

470 See Russia PG, Chapter 6, Section 1 ("dental clinic number 16 Admiralty district").

In some countries, as noted by the Armenia, Macedonia and Ukraine working groups, providers are also under a legal and ethical duty to undertake continuing education,⁴⁷³ and remain up-to-date on the new developments in the field, so as to maintain a high standard of care and maximize benefit to the patient and to the society in Kyrgyzstan and Macedonia, for example.⁴⁷⁴ According to Georgian law and the Macedonian pharmaceutical code of ethics on the topic, professionals also have a duty to share this information with colleagues, especially with younger colleagues.⁴⁷⁵

Another related area of discussion is the broader topic of the practitioner duty to maintain ethical conduct. Like other professionals, doctors are bound by codes of ethics. Such codes can exist on the international level (as with the World Medical Association code); in some settings, the ethics code has been enacted into law and integrated into the overall framework of health care regulation.⁴⁷⁶ In others, as in Armenia, it is seen as providing strong guidance to national standards of practice.⁴⁷⁷

Such codes of ethics apply to many of the rights and obligations discussed in this chapter, and some can serve as additional sources for vindicating these rights and obligations through various adjudicative channels. However, based on the number and nature of the cases provided in the PGs, there is little adjudicative experience with these sources of law—a paradigm that is unlikely to shift, since most countries in our sample have not adopted a code of medical ethics into law.⁴⁷⁸

471 See, e.g., Article 138, Law on Medical Care, Macedonia; Articles 7-37.5, Law on Doctor's Professional Activity, Republic of Georgia; Article 43, Law on Licensing, Republic of Armenia; Articles 5 & 25, Law of Kyrgyzstan on Education; Articles 5, 14, and 15, Law on Protection of the Health of Citizens in Kyrgyzstan; Government Resolution No. 2301, Qualification Requirements and Rules for Licensing Medical and Pharmaceutical Activities, Republic of Kazakhstan, December 30, 2009; Articles 138-145, Law on Health Care, Macedonia; Order of the Ministry of Health of Ukraine, No. 359, On Further Improvement of Certification of Physicians, December 19, 1997; Article 72, Federal Law No. 323-FZ, On the Basis of Health Protection in the Russian Federation.

472 See, e.g., Article 153, Law on Medical Care, Macedonia.

473 See, e.g., Article 78, Law of Ukraine, Principles of Ukrainian Health Care Legislation; Government Decree No. 1936-N, dated December 5, 2002 Republic of Armenia; Government Decree No. 1662-N, dated October 17, 2002, Republic of Armenia; Article 4, Macedonian Chamber of Medicine's Code of Ethics and Deontology.

474 See, e.g., Article 153, Law on Medical Care, Macedonia; Article 5, Law of Kyrgyzstan on Education.

475 See, e.g., Article 64, Law on Doctor's Professional Activity; Article 42, Code of Professional Ethics of Macedonian Pharmacists' Obligations and Rights.

476 See, e.g., Article 184, Health Code, Republic of Kazakhstan; Macedonian Chamber of Medicine's Code of Ethics and Deontology; see also generally, Law on Doctor's Professional Activity, Republic of Georgia; Code of Professional Ethics of a Health Care Worker of Kyrgyzstan.

477 Armenia PG, Chapter 7, Section 2 at 208.

478 Armenia, for instance, does not have an approved code of ethics.

Procedure Overview

General Governance in Participating Countries

In addition to providing a comprehensive analysis of the domestic legislative framework for human rights in patient care, the PGs are designed to help lawyers, advocates, patients, providers, and others understand and navigate the various adjudicative channels available to vindicate human rights. To this end, the guides provide a detailed description and practical advice on relevant remedial procedures and institutions. This includes legal, administrative, and other systems relevant to patient care and consumer rights. This description is supplemented in the practitioners' guides by diagrams and other visual aids to help readers understand the sometimes complex systems of procedure and governance that exist in many of the settings. The following section provides a brief overview and synthesis of these procedural sections across the participating countries.

In all of the countries included here, the government is divided into branches, with an elected legislature, an executive branch, and a judicial branch. As constitutional or parliamentary democracies, all of the participating countries are governed by a hierarchical system of legal instruments.

In this framework, constitutional law is always supreme. The constitutions also act as legal conduits for international treaties and charters, if these are ratified by the legislature. The constitutional framework is followed in the hierarchy by laws passed by the legislature (e.g., the parliament), acts of the president, and administrative regulations of the national government. In Kazakhstan, there are two levels of presidential decrees, one of which has the power of constitutional law, with the other having power of ordinary legislation.⁴⁷⁹ Regional and local laws follow as subordinate to the national level instruments.

Although the power of provincial, state, and municipal government entities is stronger in some countries with a federal model (e.g., Russia) as compared to others that run on a centralized republic model (e.g., Kazakhstan), laws and regulations relevant to the management of health care services, administrative and civil procedures are relatively uniform throughout six of the states. Functionally, the power of those national governments remains extremely centralized and influential. Aside from legislative legal mechanisms, the power of the government on the national, as well as provincial and local levels is operationalized through orders and decrees.

479 See, e.g., Law on Legislative Acts, Kyrgyzstan, March 24, 1998; Kazakhstan PG, Chapter 5, Section 3 ("Regulatory Legal Act").

In regard to laws applicable to and the management of health care services and institutions in Macedonia, the central government had little influence on decision-making or management of local health care services at the time of independence. In 1991, the Law on Health Care defined the rights and responsibilities of the state, employers, and citizens. The Health Insurance Fund (HIF), established in 1991, became an independent entity in 2000 (Law on Health Insurance), with decision-making authority to the HIF Management Board. Lower level acts specify the individual provisions and set out the methods of enforcement of the law. The professional chambers (doctors, dentists, and pharmacists) were to monitor professional standards, set up a professional licensing system, and develop clinical guidelines.⁴⁸⁰ The new Law on Health Protection, enacted in 2012, contains new regulations for health care institutions, health services, health professionals, and monitoring of quality by a to-be-established accrediting agency.⁴⁸¹

As discussed briefly above, the structure, function, and power of the judicial system in some of these settings remain in flux.⁴⁸² Uniformly, the system consists of the central supreme court, a regional appellate system, and a network of district or local courts. In addition to these courts, Georgia, Macedonia, Kyrgyzstan, Russia, Ukraine, and Armenia also have a constitutional court, a specialized body that adjudicates upon conformity with each country's respective constitution.⁴⁸³ Aside from being the court of last instance, the supreme court structures have rule-making and administrative authority over the entire judicial system. Depending on government design, this structure may or may not be fully independent from the executive branch (specifically, the Ministry of Justice), as noted in the Ukraine PG.⁴⁸⁴ The Macedonia PG, for example, discusses the issue of independence of the judiciary and courts and notes the important role of the constitutional court in the protection of human rights.⁴⁸⁵ Additionally, the Kazakhstan PG gives an overview of the assignment of judicial authority in that

480 WHO HiT: Macedonia at 25.

481 Law on Health Protection adopted by Parliament on March 28, 2012. It was published in the Official Gazette on March 29, 2012 (nb.43/2011) and entered into force after the "vacatio legis" period of eight days. The text of the Law on Health Protection was prepared and became available as part of the legal database available at <http://akademika.com.mk> on April 10, 2012. Accessed July 31, 2012.

482 See, e.g., Georgia PG, Chapter 5, Section 3 at 127-128 (describing the wholesale reform of the national judicial system since 2005).

483 See Articles 83 & 88, Georgian Constitution; Articles 108-113, Macedonian Constitution; Articles 79 & 82, Kyrgyz Constitution; Article 125, Russian Constitution; Articles 124-128, Ukrainian Constitution; Articles 92 & 93, Armenian Constitution (noting that the Constitutional Court of Armenia administers constitutional justice while the court of cassation acts as the country's highest court of instance for all other matters). In Kazakhstan, instead of a constitutional court, there exists the constitutional council whose members are comprised of the President of the Republic and members of the Parliament.

484 See, e.g., Ukraine PG, Chapter 5, Section 3 at 174-175.

485 Macedonia PG, Chapter 5, Section 2 at 134-135.

country as a means of ensuring implementation of the constitution, laws, legislative acts, and international agreements.⁴⁸⁶

International and European Procedure Relevant to Human Rights in Patient Care

Depending on national ratification and enactment of international human rights instruments (see Table 2), domestic laws and judicial decisions may be subject to review by international bodies. In addition, since Macedonia has been an official candidate country for accession to the EU since 2005, it has been in the process of harmonizing its laws with the EU for several years.

Detailed analysis of international litigation and administrative procedure is covered in earlier chapters of the participating country PGs.⁴⁸⁷ In short, there are two main types of enforcement mechanisms for international human rights regimes: courts, which act in a judicial capacity and issue binding rulings, and committees, which examine reports submitted by governments on their compliance with human rights treaties and, in some cases, consider individual complaints of human rights violations.

Under the UN regime, a number of bodies are responsible for monitoring the implementation of international treaties and conventions on human rights. States and NGOs have general standing to submit complaints or “shadow reports” to these bodies to call attention to human rights violations. Some of these bodies, including the Committee on Economic, Social, and Cultural Rights (CESCR) and the Committee on the Rights of the Child (CRC) oversee government compliance with international treaties and can comment on their progress. Other bodies, including The Human Rights Committee (HRC) and The Committee on the Elimination of Racial Discrimination (CERD) can examine individual complaints, in addition to their general monitoring and reporting role.

In addition to the treaty bodies listed above, there are a number of institutions created under the Charter of the United Nations for the protection and promotion of human rights. The principal among them is the Human Rights Council (HRC), a subsidiary of the UN General Assembly with a mandate “to address situations of violations of human rights, including gross and systematic violations.”⁴⁸⁸ Among its

486 Kazakhstan PG, Chapter 8, Section 1 (“Mechanisms to Protect/Enforce Rights and Responsibilities in Court”).

487 See, e.g., Armenia PG, Chapter 4; Georgia PG, Chapter 4; Macedonia PG, Chapter 4; Ukraine PG, Chapter 4; Kazakhstan PG, Chapter 4; Kyrgyzstan PG, Chapter 3; Russia PG, Chapter 4; see also, generally, The United Nations Human Rights Treaty System: Core Human Rights Treaties and Treaty Bodies, available at www.ohchr.org/Documents/Publications/FactSheet30en.pdf. Accessed July 31, 2012.

488 See the OHCHR Website at www.ohchr.org/EN/PublicationsResources/Pages/FactSheets.aspx for a list of resources on the HRC and other charter and treaty bodies. Accessed July 31, 2012.

other aspects, charter structure includes “special procedures” that call for a set of individual experts such as special rapporteurs and working groups responsible for addressing specific topics on human rights throughout the world. With its diverse set of mechanisms, the HRC receives and investigates individual or organizational human rights complaints against member states.

On the regional level, a number of institutions provide a monitoring and adjudicative framework relevant to human rights in patient care. Chief among these is the European Court of Human Rights (ECtHR), an institution that enforces the provisions of the European Charter of Human Rights. The ECtHR adjudicates both disputes between states and complaints of individual human rights violations. Provided they have exercised all other options available to them domestically, any individuals can lodge a complaint directly with the ECtHR alleging a violation of one of the rights guaranteed under the Convention by simply filling out and mailing an application form.⁴⁸⁹

A legal aid scheme is available to complainants who cannot afford legal representation. NGOs can file amici briefs if they can show that they have an interest in the case or special knowledge of the subject matter, and that their intervention would serve the administration of justice. In addition to the ECtHR, the European human rights enforcement regime includes the European Committee of Social Rights (ECSR), the Committee of Ministers of the Council of Europe, and other monitoring organizations such as the Advisory Committee and NGOs throughout the region. The Committee of Ministers is responsible for monitoring the implementation of judgments made by the ECtHR.

Domestic Administrative Procedure

Administrative complaints in the health care realm can be made in several ways in the participating countries. In the case of complaints against state-run health care institutions, a complainant can direct an application directly to the agency managing the facility, such as the mayors’ office, regional health committee, Ministry of Health, or Ministry of Justice (in case of correctional institutions).⁴⁹⁰ In some countries, specific administrative courts are charged with hearing cases, sometimes by sector of activity, as in Armenia, Kazakhstan, and Macedonia.⁴⁹¹ When an issue

489 An application form may be obtained from the ECtHR website at www.echr.coe.int/ECHR/EN/Header/Applicants/Apply+to+the+Court/Application+pack/. Accessed July 31, 2012.

490 See, e.g., Article 28, Code of the Russian Federation on Administrative Violations (dated December 30, 2001), No. 195-FZ; Articles 1 and 5, Law of Ukraine on Public Appeals; Article 28, Code of Administrative Offences, Republic of Kazakhstan; Law No. 67 On the Order of Considering Citizens’ Appeals of May 4, 2007, Kyrgyzstan; Article 31, Law on the Fundamentals of Administrative Action and Administrative Procedure, Republic of Armenia; Article 104, Law on Health Care, Republic of Georgia; Law on General Administrative Procedure, Macedonia.

491 See, e.g., Article 84, Code of Administrative Offences, Republic of Kazakhstan; see also, generally, Administrative Procedure Code, Republic of Armenia; Law on General Administrative Procedure, Macedonia.

arises from services rendered by a private service provider, as in Kazakhstan for example, the agency responsible for licensing this provider acts as the oversight body and will consider administrative complaints against the organization.⁴⁹²

In the participating countries, the ministry of health also acts as a global oversight body. Any human-rights or other complaint related to the health care system can be directed there as noted in the PGs, particularly to the ombudsman's office or the human rights defender's office, where such structures are available.⁴⁹³ For example, by law in Russia, complaints submitted to the incorrect review body will be forwarded to the appropriate institution, with notice to the complainant.⁴⁹⁴

As set out by law, applications of administrative complaints must adhere to a certain format. Some countries require that these complaints are made on set forms to be filled out by the complainant. If a representative is submitting an application, various formalities may be needed to supply proof of authorization, including notarization or power of attorney, as stated in the Armenia, Kazakhstan, and Ukraine PGs.⁴⁹⁵ Notably, in Armenia and Kazakhstan, for example, the administrative body may be barred from unilaterally creating requirements for documents to be notarized, without having this requirement specifically enumerated in the law.⁴⁹⁶

At least in Armenia, complaints can also be made orally, directly at the "reception" of the oversight body, which amounts to open office hours for oversight officials to hear grievances directly from affected individuals;⁴⁹⁷ and complaints thus made are considered equivalent to a written application for the purposes of administrative procedure.⁴⁹⁸ Depending upon the country, complaints may be in the national language or in a different language more familiar to the complainant, as noted in the Kazakhstan PG.⁴⁹⁹

Legislation limits the maximum time for administrative bodies to consider the

492 See, generally, Code of Administrative Offences, Republic of Kazakhstan.

493 See, e.g., Armenia PG, Chapter 8, Section 5 at 260-262; Georgia PG, Chapter 8, Section 3 at 282; Macedonia PG, Chapter 8, Section 2 at 296.; Ukraine, PG, Chapter 8, Section 2 at 420; Kazakhstan PG, Chapter 8, Section 5 ("Appeal to the Ombudsman"); Kyrgyzstan PG, Chapter 7, Section 3 ("Institute of Akyikatchy"); Russia PG, Chapter 8, Section 4 ("Appeal to the Commissioner for Human Rights").

494 See, e.g., Chapter 29, Code of the Russian Federation On Administrative Violations, No. 195-FZ.

495 See, e.g., Article 28, Code of Administrative Offences, Kazakhstan; Article 31, Law on Fundamentals of Administrative Action and Administrative Procedure, Republic of Armenia; Ukraine PG, Chapter 8, Section 2 at 404.

496 See, e.g., Code of Administrative Offences, Republic of Kazakhstan; Article 42, Law on Fundamentals of Administrative Action and Administrative Procedure, Republic of Armenia.

497 See, e.g., Article 31, Law on Fundamentals of Administrative Action and Administrative Procedure, Republic of Armenia.

498 Ibid.

499 Kazakhstan PG, Chapter 8, Section 5 ("forms of complaints").

application before issuing a decision; in Ukraine, however, exceptions may limit these provisions.⁵⁰⁰ The parties shall be notified of the extension. If the parties so demand, the administrative body in Armenia, for example, must provide an opportunity for a hearing.⁵⁰¹ In Kazakhstan, for example, the administrative body to which the complaint is being addressed is also tasked with helping complainants become familiar with the laws and regulations applicable to their grievance.⁵⁰²

If the participation of a medical expert is required, the administrative body appoints and pays such an expert to make a determination. The parties can challenge the expert's findings. Within a set, limited time period in Armenia, for example, an administrative decision can be appealed using two channels: to the administrative body that issued the decision or one superior to it, or through the judicial system.⁵⁰³ In some cases, as noted in the Kyrgyzstan PG, a special Constitutional court will handle cases where the constitutionality of a law, regulation, or policy is at issue.⁵⁰⁴

Domestic Civil Procedure

The procedure for filing civil suits is generally uniform across the participating countries. Civil complaints have to be filed with the courts of first instance with jurisdiction over the geographical location of the incident at issue or the official residence (or registration) of the defendant.⁵⁰⁵ As elsewhere in continental law systems, anyone with standing to do so can bring a claim.⁵⁰⁶

To be accepted, the claim must be written; its formulation has to meet minimum standards of formality and content.⁵⁰⁷ In Armenia, defective claims are returned, and can be refiled within a short period without prejudice.⁵⁰⁸ Parties can appear *pro se* in cases involving small claims; in matters involving significant sums or other material damages, as in Kazakhstan, for example, they must be represented by counsel.⁵⁰⁹

500 See, e.g., Article 20, Law of Ukraine on Public Appeals.

501 See, e.g., Armenia PG, Chapter 8, Section 2 at 232-233.

502 See, e.g., Article 5, Code of Administrative Offences, Republic of Kazakhstan.

503 See, e.g., Article 70, Law on Fundamentals of Administrative Action and Administrative Procedure, Republic of Armenia.

504 See generally, Rules of the Constitutional Court, Kyrgyzstan.

505 See, e.g., Article 83, Civil Procedure Code, Republic of Armenia.

506 See, e.g., Article 4, Civil Code of the Russian Federation, No. 51-FZ.

507 See, e.g., Article 22, Civil Code of the Russian Federation, No. 51-FZ; Article 87, Civil Procedure Code, Republic of Armenia (outlining the information that must be included in the official complaint: including names and designations of the parties, causes of action, evidence, and damages claimed).

508 Article 92, Civil Procedure Code, Republic of Armenia (stipulating that defective claims must be re-filed within a three-day period).

509 See, e.g., the Supreme Court of the Republic of Kazakhstan's legislative resolution of December 25, 2006, On Court Practice in Cases of Private Prosecution.

Access to legal counsel is a major issue across the participating sample. Although the right to free legal defense for criminal defendants through legal aid is available in some settings, such as Russia,⁵¹⁰ in at least two participating countries, Armenia and Georgia, an office of “public defender” exists to handle human rights complaints, while in the other participating countries the office of the ombudsman functions in a similar capacity.⁵¹¹ Based on the information provided by the working groups, these offices have a function that is more akin to an ombudsman (see above), so it is not clear, nor is it possible to ascertain to what extent these offices play a legal aid role, including providing individual-level legal counsel or to link victims to legal aid services.

After the proceedings are initiated, parties are notified and granted access to all complaints and other documents submitted by the opposing side; parties have the right to invite their experts to supplement testimony by the court appointees. The case can be settled before proceeding to trial or during its course, provided that the settlement agreement does not contravene the law or the rights of the parties, as determined by the judge.⁵¹² Judgments can be appealed to the court of next instance, provided that an appeal is made within the specified time limit, including appeals to the Constitutional Court as a court of last instance.⁵¹³ The PGs do not discuss the system for enforcing judgments.

Domestic Criminal Procedure

Patient victims (or their successors) can turn to police or a prosecutor’s office in cases that involve violations of rights that may rise to the level of criminality. Complaints to law enforcement authorities can be made orally or in writing, including a set of specific information and identification documents in some settings such as Armenia and Kazakhstan.⁵¹⁴ Oral statements will generally be transcribed into a “protocol” and the complainant’s signature, countersigned by the accepting of-

510 See, e.g., Article 5, Law of the Russian Federation, No. 3185-1, On Mental Health Care and Guarantees of the Rights of Citizens Under Such Care.

511 See, e.g., Law on Human Rights Defender, Armenia; Georgia PG, Chapter 8, Section 3 at 283. The office of public defender was established in 1997 in Georgia. For information on the ombudsman offices in the other participating countries, see Macedonia PG, Chapter 8, Section 2 at 296; Kyrgyzstan PG, Chapter 7, Section 3 (“Institution of Ombudsman”); Kazakhstan PG, Chapter 8, Section 5 (“Appeal to the Ombudsman”); Russia PG, Chapter 8, Section 4 (“Appeal to the Commissioner for Human Rights”). Ukraine’s ombudsman office has been in existence since 1997. See also Ukraine PG, Chapter 8, Section 2 at 420-422 for information on the Commissioner of Verkhovna Rada of Ukraine on Human Rights.

512 See, generally, Civil Procedure Code, Republic of Armenia.

513 See generally, Rules of the Constitutional Court, Kyrgyzstan.

514 See, e.g., Article 177, Code of Criminal Procedure, Republic of Kazakhstan; Article 175, Criminal Procedure Code, Republic of Armenia (stipulating that the complaint “must indicate the surname and the first name of the applicant, his/her date of birth, home and work address, the relation to the crime and the source of information, as well as data about identification documents submitted by him/her”).

ficial, will be required to formalize the claim, as in Russia, for example.⁵¹⁵ Statutes of limitations were not discussed for criminal complaints across the PGs.

Once the complaint is filed, it must be transferred to the prosecutor within a short timeframe determined by the national legislation. The authorities must respond to criminal claims within a specified period and inform the reporting party of the decision to open, or not open, an investigation; the patient/victim or successor(s) can appeal the decision not to initiate an investigation by filing an official appeal in the court of first instance. Once the process of investigation is initiated, the victim (or successor) may have the right to review and comment on official descriptions and other evidence related to events in which the victim was involved, to give evidence, and to appear in court, as explained in the Armenia PG.⁵¹⁶ In turn, the victim undertakes a number of obligations, including giving testimony and, in cases where an injury or other physical or psychological damage is at issue, such as undergoing medical examination by a professional chosen by the law enforcement agencies, as noted in Armenia, Russia and Ukraine PGs.⁵¹⁷

While the investigation and trial proceed, the accused may be detained. Criminal judgments are subject to appeal, if mounted within a reasonable time. Missing the deadline for appeal with good cause may be grounds for a court's waiving the disqualification of the appellate claim, at least in Armenia.⁵¹⁸

Alternative Channels and Dispute Resolution Mechanisms

The working groups were tasked with describing available alternative complaint channels or dispute resolution mechanisms they identified as relevant to the protection and vindication of human rights in patient care.

Russia and Kazakhstan, for example, have broadly-defined systems for citizen appeals, akin to the administrative system described above, but with less formality.⁵¹⁹ All of the working groups identified ombudsman-based systems in their domestic settings.⁵²⁰ As an office established within the legislature or the executive, ombudsman officials receive sweeping human rights mandates.⁵²¹ In some

515 See, e.g., Article 140, Criminal Procedure Code of the Russian Federation (dated December 18, 2001), No. 174-FZ; Article 75, Code of Criminal Procedure, Republic of Kazakhstan.

516 See, e.g., Article 58, Criminal Procedure Code, Republic of Armenia.

517 See, e.g., Article 433, Criminal Procedure Code, Russian Federation; Article 76, Criminal Procedure Code, Ukraine; Armenia PG, Chapter 8, Section 4 at 253.

518 Armenia PG, Chapter 8, Section 4 at 255.

519 See, e.g., Article 8, Order No. 59-FZ, Concerning the Procedure for Consideration of Appeals of Citizens of the Russian Federation (2006).

520 See Law on Procedures for Considering Appeals from Individuals and Legal Entities, Republic of Kazakhstan, January 12, 2007.

521 See, e.g., Armenia PG, Chapter 8, Section 5 at 260-262; Georgia PG, Chapter 8, Section 3 at 282; Macedonia PG, Chapter 8, Section 2 at 296; Kazakhstan PG, Chapter 8, Section 5 ("Appeal to the Ombudsman"); Kyrgyzstan PG, Chapter 7, Section 3 ("Institute of Akykatchy").

settings, such as Kazakhstan, Armenia, Georgia, Macedonia, and Kyrgyzstan, as long as one conforms to formal filing requirements, which include name and place of residency, anyone can apply to this office for protection.⁵²² The office has a duty to respond within a short period. In Russia, specific last resort ombudsman bodies exist to handle only the cases that have exhausted review options through other mechanisms.⁵²³

These last resort options include an office of Human Rights Defender, established in three countries: Armenia, Georgia and Ukraine.⁵²⁴ In Georgia, for instance, the defender's office is a specific position for an official elected by the Parliament; in Ukraine, the commissioner of the Verkhovna Rada of Ukraine on Human Rights operates under parliamentary oversight, while a separate ombudsman office operates under the control of the president and specializes in the protection of the rights of children. These officials are charged with overseeing the protection of international and domestic human rights norms.⁵²⁵ The Georgia guide listed a number of examples of the human rights defender's successful intervention to vindicate patients' rights violations in health care and correctional institutions.⁵²⁶

In Armenia, the office is designed specifically to prioritize cases that exemplify systemic or mass abuse and to focus on vulnerable populations, including prisoners.⁵²⁷ Set up to pursue any human rights violations alleged of any state actor, be they individual state employees or entire institutions,⁵²⁸ this office is nonetheless barred from initiating complaints against health care institutions. For the complaint to come under the jurisdiction of the Human Rights Defender, the victim must first file a complaint with the state supervising agency, specifically the local governing authority or the minister of health. If and when that governmental body fails to respond or to respond adequately, the human rights and/or administrative violation then enters the purview of the defender's office, which is also tasked with a mandate to inform victims about their rights and responsibilities.⁵²⁹

If the case is accepted, the Defender undertakes an administrative-style procedure whereby the alleged violator is informed of the complaint against him/her and has to respond within a short period outlining a plan to eliminate and/or prevent

522 Ibid.

523 See, e.g., Federal Constitutional Law (dated February 26, 1997), No. 1-FKZ, Concerning the Plenipotentiary on Human Rights in the Russian Federation.

524 See, e.g., Law on Human Rights Defender, Armenia; Georgia PG, Chapter 8, Section 3 at 283; Ukraine PG, Chapter 8, Section 2 at 420-422.

525 Georgia PG, Chapter 8, Section 3 at 282; Ukraine PG, Chapter 8, Section 2 at 420; Armenia PG, Chapter 8, Section 3 at 260-262.

526 Georgia PG, Chapter 8, Section 3 at 282.

527 Armenia PG, Chapter 8, Section 3 at 260-262.

528 See, e.g., Article 11, Law on Human Rights Defender, Republic of Armenia.

529 Ibid.

future violations. The defender can file a lawsuit in court addressing the constitutionality or legality of laws, regulations, or procedures if these are deemed by the defender to contradict domestic or international human rights norms.⁵³⁰

In practice, the Armenia guide suggests that the involvement of the human rights defender is most useful in helping to direct much-needed attention to pervasive abuse, which usually leads to corrective action on the part of the government without resorting to formal litigation.⁵³¹

Another mechanism the Georgia working group identifies for vindicating human rights outside of the traditional channels are ethics bodies. Research ethics committees and medical ethics committees both exist across the participating countries, although the former appears more widespread.⁵³² In the context of complaint procedures for both kinds of bodies, claims may be submitted in written form, but the claimant may be asked to testify at a board or committee meeting.⁵³³ However, the Georgia PG notes that it is not clear how functional the hospital or medical care committees are at this time.⁵³⁴ Based on the information provided by the participating working groups, it is not possible to evaluate the overall impact of these alternative structures on improving the situation with human rights in patient care.

Additional Materials

The working groups were asked to provide additional materials such as diagrams, forms, and decision algorithms at their discretion. Materials the working groups chose to provide in the PGs were generally related to official forms for submitting claims to various adjudicative and law enforcement bodies,⁵³⁵ flowcharts outlining various steps of administrative, civil, and criminal procedure,⁵³⁶ and lists of specialties and patient groups warranting special treatment under the law.⁵³⁷

530 Armenia PG, Chapter 8, Section 3 at 262.

531 Ibid. at 260-262.

532 See, e.g., Order of Federal Service for the Supervision of Public Health and Social Development (dated August 17, 2007), No. 2314-Pr/07, "Provision on the Ethics Committee attached to the Federal Service for the Supervision of Public Health and Social Development," Article 107 of the Law on Health Care, Republic of Georgia. As a result of this law, passed in 1997, there are now about ten research ethics boards functioning in Georgia. See Georgia PG, Chapter 8, Section 3 at 283-286.

533 Ibid.

534 Georgia PG, Chapter 8, Section 3 at 283-286.

535 Kyrgyzstan PG, Chapter 7, Section 5 ("Examples of documents and forms"); Russia PG, Chapter 8, Section 6; Georgia PG, Chapter 8, Section 4 at 287-291; Kazakhstan PG, Chapter 8, Section 6 ("Appendixes"); Ukraine PG, Chapter 8, Section 5 at 432-433.

536 Macedonia PG, Annex 1 at 309-315.

537 Armenia PG, Chapter 8, Sections 7 & 8 at 264-265.

Discussion and Conclusions

Using the lens of human rights in patient care, this compendium provides an overview of the legal norms, practice cannons, and procedural frameworks addressing health care and public health regulation, patients' and consumer rights, and labor law in seven transitional countries. This analysis highlights a number of notable patterns, discrepancies and similarities, as well as points for further inquiry and priorities for advocacy.

There is similarity of content, structure, and mechanisms of legislation across six of the countries included here.⁵³⁸ In some cases, the similarities go beyond statutory language—the laws and legal systems also have similar internal architecture and many of the same procedural details.⁵³⁹ More than likely, much of this uniformity reflects their common ancestry in former Soviet law.⁵⁴⁰

Another likely explanation for other cross-country similarities is linked to the timing of and the influences on the legal reforms that produced the contemporary legal cannons analyzed. With the fall of the Soviet Union, the six newly-independent states included here, along with the other former Soviet republics, found themselves in need of new legal instruments and institutions. This was true also of Macedonia (and the other former Yugoslav republics). In a few short years, new constitutions and entire bodies of law emerged, often with the help of international experts and informed by international human rights documents.⁵⁴¹ It should not come as a surprise, therefore, that the resulting instruments carry the stamp of “best practices” in constitutional and human rights law of the early 1990s (as well as the decades following, which brought continuous legal reforms to many of these countries).

By comparing and contrasting the outcomes from the PG project, it is possible to identify strengths and weaknesses across the participating sample and to use this information to tailor specific programming or other assistance to national partners to build their capacity to build human rights in patient care.

538 Consider, e.g., the “model law” system in the United States or the dissemination of common legal norms across the European Union member states.

539 See, e.g. 30-day response times for administrative complaints under Armenian and Ukrainian Administrative Codes.

540 See, e.g., Code of Ukraine on Administrative Offences, dated December 7, 1984.

541 For a discussion of the effects of international intervention on healthcare and human rights reform, particularly as these interventions tended to elide the cultural and historical determinants of health in post-Soviet nations, see Rivkin-Fish, M. *Women's Health in Post-Soviet Russia*. Bloomington, Indiana: Indiana University Press; 2005.

It is notable, for instance, that there are laws in some of the sample countries that can continue to hamper the human rights agenda. For example, vestiges of the Soviet narcology registration and compulsory treatment systems remain in place across the region, as shown in four of the PGs,⁵⁴² with documented implications for patients' rights by external bodies.⁵⁴³ Although there are efforts to reform this structure by allowing for anonymous treatment, as discussed in the Russia PG,⁵⁴⁴ enormous gaps exist between the reformed regulations and their implementation.⁵⁴⁵ Other examples include: the apparent lack of special protections for migrants since this group was not discussed in any of the PGs, the existence of laws requiring the consent of husbands for family planning services, as in the Kyrgyz Republic,⁵⁴⁶ and the system of residential registration still in place in several PG countries, including Russia, Kazakhstan and Kyrgyzstan,⁵⁴⁷ all of which continue to pose problems for patient access.

Some of the laws purportedly designed to safeguard human rights appear largely aspirational, such as legislation that imposes duties on administrative bodies to systematically review and quickly respond to citizen complaints, when numerous and expansive exceptions like those found in Ukraine make these stipulations difficult to enforce,⁵⁴⁸ and suggestions, as in Kazakhstan, that the administrative body to which the complaints are addressed work to educate the claimants about laws and regulations applicable to their grievance.⁵⁴⁹

Structural issues complicate the environment for vindicating human rights in the health care setting. The lack of a tradition and incentive for effective self-governance has limited the ability to implement new systems of ethics or professional conduct to improve professionalism and quality of services, as discussed in the Georgia PG.⁵⁵⁰ Quality remains an issue; as noted in the Kazakhstan PG, the system there is now being re-structured to mandate uniform standards under a single licensing system.⁵⁵¹ In such a context, there is often substantial confusion about

542 See, e.g., Article 49(4), Law on Narcotic Drugs and Psychotropic (Psychoactive) Substances, Republic of Armenia; Law on Forced Treatment of Alcohol and Drug Addicts, Republic of Kazakhstan (dated January 25, 2004); Article 44(1), Code of Ukraine on Administrative Offences, December 7, 1984; Part 3 of Article 54, Federal Act of the Russian Federation, No. 3-FZ, On Narcotic Drugs and Psychotropic Substances, (dated 1998).

543 See, generally, IHRD, *supra* note 303.

544 See, e.g., Part 2 of the Order by Health Ministry of the Russian Federation No. 327, Concerning Anonymous Narcology Treatment in Medical Institutions (1999).

545 IHRD, *supra* note 303.

546 See, e.g., Article 14, Law On Reproductive Rights, Kyrgyzstan.

547 Human Rights Watch. World Report 2003: *Europe & Central Asia: Russian Federation*. Available at www.hrw.org/wr2k3/europe11.html. Accessed July 31, 2012.

548 See, e.g., Articles 16 & 20, Law of Ukraine on Public Appeals.

549 See, e.g. Article 5, Code of Administrative Offences, Republic of Kazakhstan.

550 Georgia PG, Chapter 8, Section 3 at 283-286.

551 Kazakhstan PG, Chapter 7, Section 2 ("In line with sub-item 15 of Article 11 of this law, health care activities are subject to licensing").

the oversight, due process, and other legal privileges related to licensing, as noted in the Right to Quality section of the Russia PG.⁵⁵² Licensing agencies must become more transparent and accountable.

As various legal systems discussed have been slow to reform, the Georgia and Armenia PGs, for example, stress the benefit of non-litigation approaches, including administrative and ombudsman channels in their discussions of remedies and procedural options for plaintiffs.⁵⁵³ From the discussions in the PGs, it appears that the utilization of international instruments and mechanisms, including the ECtHR and its decisions as a source of law in domestic courts, remain relatively rare and inconsequential, although ECtHR litigation and the use of the Court's decisions appear to be on the rise as noted in the Armenia, Russian and Ukraine PGs.⁵⁵⁴

Even with the working groups' scrupulous efforts to systematically review formal and informal sources to collate judicial and administrative decisions, the paucity of case law and practice notes in many sections of the PGs suggest that the ability of both patients and providers to utilize legal tools to vindicate their rights is weak. This is especially true, for example, in the case of providers' right to fair remuneration, where no truly applicable successful case is presented across the seven sites.⁵⁵⁵

The practical and adjudicative examples presented by the working groups show numerous violations to confidentiality, informed consent, and other human rights. The real-life illustrations shed light onto difficulty to attain basic, life-saving care in some countries when emergency response is not available when and where it is most needed; this can impact marginalized groups like people living with HIV/AIDS or drug users who are more likely to face barriers to mainstream health services and are more likely to require emergency assistance.⁵⁵⁶

At the same time, however, much is positive. The extensive body of new, progressive legislation that exists across the participating countries focuses on high-priority diseases, access to HIV testing, counseling, information and harm-reduction

552 See Russia PG, Chapter 6, Section 1 under Right to Quality Standards subsection ("Availability and quality of care provided").

553 See, e.g., Armenia PG, Chapter 8, Section 5 at 260-262; Georgia PG, Chapter 8, Section 3 at 282-286.

554 See Armenia PG, Chapter 5, Section 2 at 138-139; Russia PG, Chapter 5, Section 2; Ukraine PG, Chapter 5, Section 2 at 172-173.

555 See, e.g., Georgia PG, Chapter 7, Section 1 at 237.

556 See, e.g., Article 5, Law on HIV/AIDS, Kyrgyzstan; Law on Prevention of Disease Caused by HIV, Republic of Armenia; The Law on HIV/AIDS Prevention Republic of Georgia (2000); Federal Act of the Russian Federation No. 38-FZ On Prevention of Communication of the Illness Caused by Human Immunodeficiency Virus (HIV) in the Russian Federation (1995); Articles 112 and 114, Health Code, Republic of Kazakhstan (2009); Article 4, Law of Ukraine On Resistance to Diseases Caused by Human Immunodeficiency Virus (HIV), and Legal and Social Protection of People Living With HIV (2010); Article 32, Law on Healthcare, Macedonia (1991).

supplies,⁵⁵⁷ TB (particularly in Russia and Kyrgyzstan),⁵⁵⁸ and addictive behavior such as smoking (Macedonia).⁵⁵⁹ Provisions also address protections for special populations, including people working in hazardous conditions in Kyrgyzstan,⁵⁶⁰ detainees in Armenia and Georgia,⁵⁶¹ and children in Kazakhstan.⁵⁶² New, revised laws on patients' rights are appearing in the region.⁵⁶³ These laws are impressive in their scope and level of detail. Even if enforcement remains problematic, these legal provisions create an important and extensive foundation on which advocacy, training, and other interventions can be built. And there is evidence, from Armenia, for example, that lawmakers in the region are becoming more attuned to legislating for better implementation.⁵⁶⁴

Perhaps most importantly, information from the guides gives grounds to be optimistic for the future of legal and administrative advocacy tools as part of the package of interventions to improve and vindicate human rights in patient care. The examples and cases in the PGs show the legal systems' capacities to effectively adjudicate medical malpractice cases, with the courts awarding substantial (by local standards) damages to patients even in cases against the government Armenia and Ukraine, for example.⁵⁶⁵ This was unthinkable two decades ago. The increasing prominence and popularity of human rights in patient care as a field of legal practice and activism is an ongoing positive development in a region rife with public health challenges. By comparing and contrasting the outcomes from the PG project, it is possible to identify strengths and weaknesses across the participating countries. This information can be used to tailor specific programming or other assistance to national partners in order to increase their capacity to build human rights in patient care.

The information discussed here emerged from coordinated research efforts by expert working groups. Comprised of academics, practitioners, advocates, and gov-

557 Ibid.

558 See, e.g., Federal Act of the Russian Federation, No. 77-FZ, On prevention of tuberculosis in the Russian Federation; Article 15, Law On Protection of the Population from TB, Kyrgyzstan.

559 See, e.g., Anti-Smoking Law, Macedonia.

560 See, e.g., Article 215, Labor Code, Kyrgyzstan.

561 See, e.g., Article 21, Law on Keeping Arrested and Detained Persons, Republic of Armenia; Article 53, Law on Doctor's Professional Activity, Republic of Georgia.

562 See, e.g., Articles 37 & 38, Law On the Rights of the Child, Republic of Kazakhstan.

563 See, generally, Law on the Rights of Patients, Republic of Georgia; Law on Protection of Patients' Rights, Macedonia PG.

564 See, e.g., Article 42, Law on Fundamentals of Administrative Action and Administrative Procedure, Republic of Armenia (specifically barring administrative agencies from creating extra requirements to deter applicants).

565 See, e.g., Ukraine PG, Chapter 6, Section 1 at 266-267 (noting an award of over \$5,000 in pecuniary and moral damages); Armenia PG, Chapter 6, Section 1 at 189-190 (listing a case where \$15,900 was awarded in a wrongful death suit); Armenia PG, Chapter 6, Section 1 at 185 (listing a lawsuit where \$5,100 was awarded for surgical malpractice). However, in many of the illustrative plaintiff victories listed by PG working groups, the damages are limited to several hundred dollars.

ernment regulators, among others, these teams were optimally positioned to compile the latest, most complete, and well-triangulated set of legislative, practice, and procedural data in the realm of human rights in patient care. In the course of their work, these groups received extensive technical assistance and guidance to help assure the highest quality and exhaustive completeness of research. Similar technical assistance efforts supported the writing of the individual country guides. Despite these concerted efforts by dedicated colleagues, it remains possible that some information in the country guides may be incomplete, outdated, or otherwise inaccurate. Because our analysis rests almost exclusively on the information derived from the practitioner guides, any omissions or other inaccuracies in the source document may inform unwarranted hypothesis or conclusions. Conversely, we take responsibility for any errors or omissions in this compendium that misrepresent the content of the country Guides. By providing a structure for continuous review, revision, feedback, and dissemination of the guides, however, the larger project minimizes the perpetuation of errors such derived.

Recommendations

Within the context of a larger project, the information from this compendium suggests a number of promising directions for future programming and research efforts aimed at advancing human rights in patient care. As outlined in the description of the PG project, several of the activities listed below already have begun. These (1-5) and other potential activities include:

1. **Continue to monitor legislative and jurisprudential developments** in the field of human rights in patient care, as well as the experiences of legal professionals working in this field;
2. **Continue to analyze and address any gaps** in the legislative framework protecting human rights in patient care in the participating countries;
3. **Continue to develop user-friendly materials** on human rights in patient care for patients and providers themselves, and disseminate these materials through organizations working with patients;
4. **Continue to develop and integrate curricular materials** on human rights in patient care for use in higher education, including medical, nursing, public health, legal, and public policy education;
5. **Continue to embed human rights in patient care** in larger advocacy, reform, and training agendas by governmental and civil society organizations working to improve human rights through adjudicative reform, including court-based, ombudsman, and other mechanisms;
6. **Improve monitoring and documentation of complaints** in the realm of human rights in patient care, including duration, cost, and legal channels and rationale used;
7. **Explore the contribution of providers as an organized advocacy group** to defend both provider and patient rights in the health care setting;
8. **Equip public interest attorneys to pursue human rights in patient care** complaints through a variety of adjudicative mechanisms, including administrative, mass media, and other channels;
9. **Maintain and expand support for programs** that bundle social and health services for vulnerable populations with legal assistance;
10. **Expand this work to additional countries**, and provide networking opportunities for legal and other practitioners working in the emerging field of human rights in patient care.

Across the world—especially in totalitarian and post-totalitarian settings—health systems have too often served as venues of punishment, coercion, and violations of basic human rights. In Eastern Europe and Central Asia, the geographic region of the practitioner guide, a culture of disrespect, abuse, and poor oversight in health care institutions over time created a fertile environment for endemic and severe human rights abuse of patients and unsafe working conditions for health workers. The application of general human rights principles to all stakeholders in the delivery of health care services is increasingly understood as an issue that has implications for public health, as well as for broader economic and social development. There is an urgent need to support and strengthen legal, administrative, and other remedies for individual and systemic human rights abuses in these settings, and to do so in a way that promotes access to quality health care. By helping identify and support effective mechanisms, advocates and funders can help ensure safe, effective, and respectful patient care.

