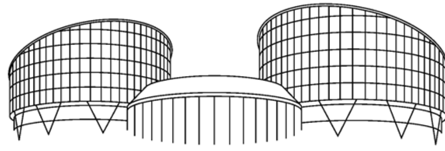

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

GRAND CHAMBER

CASE OF PINDO MULLA v. SPAIN

(Application no. 15541/20)

JUDGMENT

STRASBOURG

17 September 2024

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

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

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In the case of Pindo Mulla v. Spain,

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

Síofra O'Leary, *President*,
Marko Bošnjak,
Gabriele Kucsko-Stadlmayer,
Pere Pastor Vilanova,
Arnfinn Bårdsen,
Georges Ravarani,
Egidijus Kūris,
Branko Lubarda,
Mārtiņš Mits,
Stéphanie Mourou-Vikström,
Pauliine Koskelo,
María Elósegui,
Anja Seibert-Fohr,
Ioannis Ktistakis,
Frédéric Krenc,
Mykola Gnatovskyy,
Anne Louise Bormann, *judges*,
and Marialena Tsirli, *Registrar,*

Having deliberated in private on 10 January 2024 and on 19 June 2024,

Delivers the following judgment, which was adopted on the latter date:

INTRODUCTION

1. This case concerns the response of the authorities to the refusal of medical treatment in the form of blood transfusions by an adult patient under the public health system of a Contracting Party. The applicant is a Jehovah's Witness who complained that in the course of emergency surgery she was given transfusions despite having previously stated her rejection of this procedure, a stance inspired by her religious beliefs. Before the Court she raised complaints under Articles 8 and 9 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention").

PROCEDURE

2. The case originated in an application (no. 15541/20) against the Kingdom of Spain lodged with the Court under Article 34 of the Convention by an Ecuadorian national, Ms Rosa Edelmira Pindo Mulla ("the applicant"), on 13 March 2020.

3. The applicant was represented by Mr P. Muzny, a lawyer based in Switzerland. The Spanish Government ("the Government") were represented by their Agent, Mr A. Brezmes Martínez de Villarreal.

4. The application was allocated to the Fifth Section of the Court, pursuant to Rule 52 § 1 of the Rules of Court. On 16 April 2021, the Government were given notice of the applicant's complaints relating to her right to respect for private life and her right to freedom of religion, raised under Articles 8 and 9 of the Convention respectively. The remainder of the application was declared inadmissible pursuant to Rule 54 § 3.

5. On 4 July 2023, a Chamber of the Fifth Section decided to relinquish jurisdiction in favour of the Grand Chamber (Article 30 of the Convention and Rule 72).

6. The composition of the Grand Chamber was determined according to the provisions of Article 26 §§ 4 and 5 of the Convention and Rule 24 of the Rules of Court. During the second deliberations, Georges Ravarani and Egidijus Kūris, whose terms of office expired in the course of the proceedings, continued to deal with the case (Article 23 § 2 of the Convention and Rule 24 § 4).

7. The President of the Grand Chamber granted leave to intervene in the proceedings to the European Association of Jehovah's Witnesses, as well as to the French Government, both of whom submitted written comments (Article 36 § 2 of the Convention and Rule 44 § 3).

8. A hearing took place in public in the Human Rights Building, Strasbourg, on 10 January 2024.

There appeared before the Court:

(a) *for the Government*
Mr A. BREZMES MARTÍNEZ DE VILLARREAL, *Agent*,
Ms H. NICOLÁS MARTÍNEZ, *Co-Agent*,
Mr F. SANZ GANDASEGUI, *Counsel*,
Mr F. REINOSO BARBERO,
Ms F. MOLINA AGEA, and
Ms A. DOMÍNGUEZ BRAVO, *Advisers;*

(b) for the applicant
Mr P. MUZNY,
Mr S. BRADY, and
Mr D. GARCÍA MARTÍN, *Counsel*.

The applicant also attended the hearing.

The Court heard addresses by Ms Nicolás Martínez, Mr Brezmes Martínez de Villarreal, Mr Muzny and Mr Brady. It also heard their replies, and that of Mr Reinoso Barbero, to questions put by judges.

THE FACTS

THE CIRCUMSTANCES OF THE CASE

A. Treatment of the applicant at Soria hospital

9. The applicant was born in 1970 and lives in Soria, located in the Autonomous Community of Castile and Leon, Spain.

10. In May 2017 she was treated as an outpatient at the Santa Bárbara hospital at Soria (hereafter "the Soria hospital"), a public hospital run by the Autonomous Community of Castile and Leon, for a problem of urinary retention. Medical testing carried out over the following two months established that her complaint was due to the presence of a uterine fibroid (myoma). The applicant was advised to have surgery to remove it (hysterectomy and double salpingectomy). According to the applicant, she agreed with this advice while also informing the Soria hospital of her refusal of blood transfusion, based on the teachings of her religious community.

11. On 4 August 2017, and in view of the prospect of surgery, the applicant drew up two documents setting out her refusal of blood transfusion. In accordance with the relevant statutory provision – Article 11 of Act No. 41/2002 (see further under "Domestic law and practice" below) – she drew up an advance medical directive (*documento de instrucciones previas*), which provided as relevant (emphasis in the original):

> "Acting freely and with full capacity, having received sufficient information and after having carefully reflected, I have come to the decision to express through this document the following advance directive regarding care and treatment, that I desire to be taken into account for my medical care if I come to be in a situation in which I cannot express my will [...].
>
> **I DECLARE**
>
> That I formulate this advance medical directive with full moral conviction and under the protection of current legislation. I am one of Jehovah's Witnesses, and I obey the Biblical command to 'abstain from blood' (Acts 15:28,29). This is my firm religious conviction that I have freely adopted in agreement with my conscience.
>
> That this advance medical directive expresses my informed decision regarding the medical treatment that I want to be taken into account **in all healthcare situations**. Having been informed of the dangers and risks associated with blood and blood product transfusions, I have decided to avoid them and accept the risks that may derive from my choice of non-blood alternative treatments.
>
> **I DIRECT** that no transfusions of whole blood, red cells, white cells, platelets or plasma be given to me under any circumstances, even if health-care providers consider that such are necessary to preserve my life or my health. However, I accept non-blood expanders of plasma volume and all medical treatment that does not involve the use of blood."

12. The applicant appointed two trusted friends as her representative and substitute representative, Mr A.G.J and Mr R.A.L. respectively. Their

addresses and telephone numbers were included in the document. The role and remit of the representative were stated as follows (emphasis in the original):

> "In case of total or partial, temporal or permanent loss of my decision-making capacity, I **appoint the person** named herein as my representative. The person appointed as my representative shall make any interpretation that may be necessary on my behalf, as long as it does not contradict any of the instructions recorded in this document, and will ensure the application of its content. This person should be considered as a necessary and valid interlocutor with the health care team in charge of my care to make decisions in my name, to be responsible for my care and to ensure that my wishes are honoured."

13. The applicant's signature on the advance directive was witnessed by three witnesses, in keeping with the formalities provided for by law. On the same day, she deposited her advance directive with the Register of Advance Directives of Castile and Leon. Following this, the document was accessible to Soria hospital via the electronic system used by health professionals in Castile and Leon (known as "Jimena"). For reasons unknown to the Court, it was not physically added to her medical file at Soria hospital.

14. The second document was a continuing power of attorney (*declaración de voluntades anticipadas*), in which she expressed her refusal of blood transfusion in terms similar to those used in her advance medical directive and appointed the same persons as her healthcare representative and substitute. It was signed by the applicant and counter-signed by three witnesses. The applicant indicated that she carried this document with her.

15. In December 2017, the applicant attended a private clinic, where the presence of a uterine myoma was confirmed.

16. At the beginning of January 2018, the applicant returned to the emergency department of the Soria hospital complaining of vaginal bleeding and spells of dizziness. Following examination and tests, she was prescribed medication to stop the bleeding (tranexamic acid) and to reduce the size of the myoma (ulipristal acetate). As she was anaemic (haemoglobin of 7.7 g/dL), she was also prescribed iron. Her previous agreement to undergo surgery was noted in her medical file. According to the applicant, she followed this course of medication until the month of June.

17. On 5 June 2018, the applicant went to the emergency department of the Soria hospital complaining of bleeding and abdominal pain. A blood test done that day measured her haemoglobin at 12.2 g/dL. She was discharged the same day but returned the following day on account of further bleeding. This time she was admitted to the hospital's obstetrics and gynaecology service. Blood tests carried out that day measured her haemoglobin at 8.9 g/dL and later at 6.5 g/dL. It was established by ultrasound and CT scan that the myoma had become very large.

18. Late on 6 June, a gynaecologist, Dr B.L., spoke to the applicant about receiving a blood transfusion, which the applicant refused. She expressed her

refusal in writing on the hospital's informed consent document, which she signed as did Dr B.L. This document became part of the applicant's medical file at Soria hospital.

19. The following day, 7 June 2018, Dr A. F., a haematologist, noted in a medical report that the applicant was suffering from severe anaemia, referring to a decrease in her haemoglobin from 12.2g/dL the previous day to 5.7 g/dL around midnight and to 4.7 g/dL by that morning. He observed that the decrease seemed to have attenuated. He noted in the report:

> "The patient for religious reasons (Jehovah's Witness) does not wish to be transfused under any circumstances. I inform the patient of possible life-threatening seriousness in case in any circumstance the bleeding worsens again, and she consciously refuses any transfusion."

The report further noted that treatment with tranexamic acid appeared to have been effective. The doctor explained that he was modifying the treatment in order to stop the bleeding and recover haemoglobin levels.

20. By around 11.00 on the morning of 7 June 2018 the decision had been taken to transfer the applicant to La Paz hospital in Madrid, situated in a different Autonomous Community, an establishment that is known for its capacity to provide forms of treatment that do not involve blood transfusions. In a discharge report drawn up by Dr B. L, the following appears (capitalisation in the original):

> "We propose BLOOD TRANSFUSION BUT THE PATIENT REFUSES (SIGNS INFORMED CONSENT indicating that she does not accept blood transfusion, Jehovah's Witness patient). Given the clinical situation and the impossibility of performing blood transfusion, it was decided to transfer to the Referral Hospital with Interventional Radiology to assess uterine artery embolization treatment." [1]

The patient history report notes that there was little bleeding at 7.40 a.m., and no bleeding at 9.14 a.m. or at 12.12 p.m., when the applicant was prepared for transfer.

21. The applicant agreed to the transfer to La Paz, her understanding being that she could be treated there without resort to blood transfusion.

B. Transfer of the applicant to La Paz hospital

22. The applicant was transferred by mobile intensive care ambulance with a doctor on board to monitor her condition during the journey to Madrid, a distance of approximately 240 km. The applicant was on board the ambulance by 12.12 p.m. Her medical records were brought with her, but at no point in these proceedings was the Court informed of what those medical

[1] This is an alternative and minimally invasive procedure to hysterectomy or the removal of a myoma (myomectomy). The procedure involves blocking the arteries that feed the myoma, causing it to shrink.

records contained. She was not accompanied by any member of her family; her husband travelled separately to La Paz by car.

23. Shortly after the journey began, there was telephone contact between a doctor at La Paz and the doctor on board the ambulance, the latter warning of the gravity of the applicant's condition and referring to the probability that she would be in a state of circulatory collapse or even cardiac arrest by the time the ambulance arrived. The applicant informed the doctor at La Paz of her position regarding blood transfusion.

24. The applicant's condition was monitored throughout the journey. It was recorded that her bleeding at that stage was limited (less than menstrual bleeding). It was also recorded that she was conscious, orientated and cooperative.

C. Application by La Paz doctors to the duty judge

25. At 12.36 p.m., a fax was sent in the name of three La Paz doctors to the duty judge (*juez de guardia*) of Investigating Court (*Juzgado de Instrucción*) No. 9 of Madrid. The message read as follows:

> "Good morning, we are anaesthesiologists at the La Paz Hospital in Madrid, and today, 7 June 2018, we have just been informed that a Jehovah's Witness patient will be transferred from the hospital in Soria. The patient has active bleeding due to her myomatous uterus and she is being transferred with a 4 gr/dl. haemoglobin level. The patient in Soria has verbally expressed her rejection of all types of treatment.
>
> The patient is on her way, and we want to know how to proceed since the patient will be very unstable upon arrival.
>
> Please reply as soon as possible."

26. The duty judge requested an opinion on the doctors' request from the forensic doctor (*médico forense*) assigned to Investigating Court No. 9. The forensic doctor's opinion, which was based solely on the information provided in the fax, stated:

> "The medical report describes the situation of a patient (whose identity is unknown) who is being transferred from the hospital in Soria on account of active bleeding due to her myomatous uterus with a haemoglobin level of 4 g/dl. The patient in Soria has verbally expressed her refusal of all types of treatment, as stated in the report.
>
> Although for now it is unknown whether the patient is in a position to grant and/or refuse her consent, as well as the nature of the treatment that she will be submitted to, it can be said that if the patient's haemorrhage persists and in view of her haemoglobin levels, the situation poses a serious risk to the patient's life."

27. The duty judge also contacted the local prosecutor (*Ministerio Fiscal*). The reply received referred to the forensic doctor's warning that a failure to treat the applicant could lead to a fatal outcome and noted that there was an absence of "any reliable evidence" of a refusal on the applicant's part to receive medical treatment. It stated that, with the aim of safeguarding the supreme legal value of the right to life, the prosecutor was not opposed to the

necessary medical and surgical measures being taken to safeguard the life and physical integrity of the applicant.

28. The duty judge's decision (*auto*) on the matter was transmitted by fax to La Paz hospital at 1.36 pm. It stated, as relevant:

> "FIRST. According to the legal doctrine established by the judgment issued by the plenary formation of the Constitutional Court on 27 June 1990[2] [...], the fundamental right to life, as a subjective right, grants its holders the possibility to seek judicial protection against any action by the public authorities that may threaten their life or integrity. On the other hand, as one of the objective fundamentals of the legal order, it also imposes upon the public authorities the duty of taking the necessary measures to protect those legal values, [*namely*] life and physical integrity, against attacks by third parties, disregarding the will of the right holders ... The content of the right to life comprises positive protection that prevents its interpretation as a freedom including the right to one's own death. Article 16 of the Spanish Constitution does not grant the right to religious freedom without any type of limitation. Inherent in the right to religious freedom is the limitation of that right where it collides with other fundamental rights.
>
> SECOND. In this case, the information provided in the report issued by the forensic doctor reveals that, if the current haemorrhage rate suffered by the unidentified patient were to continue, and in view of the levels of haemoglobin that appear in the request, leaving the patient untreated would pose a serious threat to her life.
>
> Thus, and as stated by [*La Paz hospital*], since refraining from any medical treatment for the patient coming from Soria (whose identity is unknown) could lead to a fatal outcome, and there is no reliable evidence of any refusal by the patient to receive medical treatment, in order to safeguard the supreme legal value that is the right to life, authorisation must be given to treat this patient with the medical and surgical measures necessary to safeguard her life and physical integrity."

The operative provision granted authorisation "to treat the patient arriving from Soria, whose identity is unknown for the moment, with the medical or surgical measures necessary to safeguard her life and physical integrity". The decision indicated that it could be appealed against within five days of being notified.

29. The steps described above were taken while the ambulance was on its way. The applicant was unaware of them.

D. Treatment of the applicant at La Paz hospital

30. The parties disagreed over the exact time of the applicant's arrival at La Paz. According to the applicant, it was at or shortly after 2.20 p.m., based on the time recorded on certain documents that were created by the hospital as part of the admission process. The Government put the time of arrival as around 2.50 p.m., based on the form recording her admission to the emergency department and a statement provided by the doctors who treated her there. The parties were also in disagreement over the seriousness of the applicant's condition at that point in time and, related to that, the therapeutic

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[2] See further under "Domestic law and practice" below.

alternatives. Their respective positions are included in the summary of their arguments below.

31. The applicant was conscious when she arrived. As noted in her medical file, she was assessed as being at the highest point of the Glasgow Coma Scale (a score of 15, indicating the patient is fully alert). The doctors there considered that there was an imminent risk to the applicant's life due to the amount of bleeding and that she required immediate surgical intervention. Treating the situation as a medical emergency, the hospital staff did not go through the usual procedure for seeking informed consent to surgical procedures. For her part, the applicant did not produce any document setting out her refusal of blood transfusion, nor did she refer to her advance medical directive which, in any event, was not part of the physical file sent with her from Soria. The National Register of Advance Medical Directives, where her directive was also held, was not consulted. It was still the applicant's understanding that she was to undergo uterine artery embolization, not having been informed of the nature of the intervention that was about to take place.

32. The applicant was taken into the operating theatre at 3 p.m. She was given a general anaesthetic and surgery commenced, consisting of a hysterectomy and double salpingectomy. There was major bleeding during the operation, necessitating three transfusions of red blood cells.

33. The applicant's husband arrived at La Paz about an hour after his wife and was informed that she was undergoing surgery.

34. The following day, 8 June 2018, the applicant was informed about the duty judge's decision, and about the surgery and transfusions that had been carried out. The medical file states:

> "The patient is informed of the events that occurred during the operation, and risk to life due to a massive haemorrhage, with extreme anaemia, that occurred when she was under the effects of general anaesthetic. ...
>
> She expresses her disagreement with the transfusions administered."

35. In a written statement made for the purposes of the proceedings before this Court, the applicant described the transfusions as "like a rape of my person, something disgusting, ... very, very bad".

E. The ensuing proceedings

36. The applicant sought a copy of the duty judge's decision, which she received on 12 July 2018. She then applied to have it set aside (*recurso de reforma*) and also brought a subsidiary appeal against it (*recurso de apelación*).

37. In her submissions, the applicant impugned the reasoning of the duty judge's decision, observing that it had been issued on the unilateral application of the hospital without consulting her, and that not even her identity had been communicated to the duty judge. She argued that there had been a distortion of the facts inasmuch as it had been taken that she was

refusing all forms of treatment for her condition. There was only one specific treatment that she refused – blood transfusion. She had been prepared to accept any other type of treatment that La Paz could provide to her, this being exactly why she had been transferred there. She further complained that the decision had not been notified to her, denying her the legal protection of her rights (referring to Article 24.1 of the Spanish Constitution). She appended to her submissions copies of her advance medical directive, her continuing power of attorney and the informed consent document from the Soria hospital. These established that the duty judge had erred in referring to the absence of evidence of her refusal of certain treatments, she maintained.

38. The applicant then invoked the rights set down in Articles 15 and 16 of the Constitution, as well as in Articles 8 and 9 of the Convention. She expressly cited the judgment of this Court in *Jehovah's Witnesses of Moscow and Others v. Russia*, no. 302/02, 10 June 2010, and argued that neither the State nor the courts were permitted to interfere with the freedom of the individual to make choices in relation to their health. The contested decision therefore represented a violation of her rights under the abovementioned provisions of the Convention.

39. In her conclusion, the applicant asked that the decision be annulled, and further that it be amended so as to comply with her rights and notified to La Paz hospital so that in future the rights of patients would be respected.

1. Initial examination of the applicant's appeal

40. Observations on the applicant's appeal were submitted by the local prosecutor (the same one who had been consulted by the duty judge before she ruled on the doctors' request). The local prosecutor stated the view that the decision had been fully justified in light of the particular factual and legal considerations. She noted that the specific details of the treatment given to the applicant were unknown, with no evidence whether a blood transfusion had actually been given or not. She further noted that the informed consent document submitted by the applicant lacked her signature (on this issue, see paragraph 54 below).

41. The application to set the decision aside was dismissed on 22 August 2018 by the same judge who had issued the contested decision. In the judge's reasoning, the circumstances giving rise to the decision were recalled, i.e., the gravity of the applicant's condition, as described by the doctors at La Paz and confirmed by the forensic doctor, her refusal of "any" medical treatment, and the danger this represented to her life. It was noted that the applicant had expressed her will orally but had not provided anything in writing. It further noted that it was not stated in the application what treatment the applicant had received. The judge referred to the applicant's advance medical directive, which the latter had appended to her submissions, observing that it had been drawn up almost a year before the operation and that it was not clear whose signature appeared on it. She concluded that it was not known in any event

whether the applicant had received any form of medical treatment that she expressed her refusal of.

42. In the same decision, the judge declared her subsidiary appeal admissible, thereby accepting it for examination by the *Audiencia Provincial*.

2. Proceedings before the Audiencia Provincial

43. The applicant's submissions before this court can be summarised as follows:

She argued that in rejecting her application to set aside the contested decision, the judge had avoided the substantive issue in the case (i.e., violations of the Constitution, the Convention and Spanish law) on the incorrect basis that her refusal of blood transfusions had not been expressed in writing, which it had. Moreover, as provided in the relevant domestic law, where the patient is conscious and capable and clearly expresses their will, this must be respected. She referred to the informed consent document, which could not be disregarded since it was part of the medical file and was the very reason for the transfer to La Paz. As for her advance medical directive, had there been any doubt about it on the part of the judge or the La Paz doctors, they should have consulted the relevant Register (it being held in the Castile and Leon Register and also in the National Register – see further under "Domestic law and practice" below). Taking account of these documents setting out her rejection of blood transfusion, and more particularly of her verbal statements to the doctors, there could not be any doubt about her clear, manifest and unequivocal will in this regard.

To the remark made by both the local prosecutor and the judge about it not being known whether the applicant had actually received a blood transfusion, she responded that this was irrelevant because her challenge was to the decision that had been issued beforehand granting authorisation to the La Paz doctors to take such action as they considered necessary; what had in fact happened subsequently was, from this perspective, of lesser importance. Even had there not been a blood transfusion, the legal harm had already been done by the decision permitting treatment that was contrary to her will, her conscience and her religious beliefs. In any event, the fact that transfusions had been given was recorded in her medical file.

She further contended that there were errors and contradictions in the reasoning dismissing her appeal, noted that she had not had access to the opinion of the forensic doctor, and that the latter had issued her opinion without examining the patient.

She asked the court to declare the contested decision to be contrary to the law and substitute it with one that was compatible with current legislation and case-law, and that this be notified to La Paz.

44. The local prosecutor submitted that the appeal should be dismissed, and the decision confirmed.

45. The *Audiencia Provincial* gave its ruling on 15 October 2018, dismissing the appeal. It stated at the outset that the issue before it was limited to the question of the lawfulness of the contested decision. It then set out the relevant provisions of Act No. 41/2002, namely Article 2.4, Article 8.1-3 and Article 11.1 (see under "Domestic law and practice" below for the text of these provisions). It acknowledged the relevance of the other constitutional and legislative provisions referred to in the applicant's appeal submissions. The court took it that the applicant had been able to freely express her will at the time of the surgery ("*la recurrente podía manifestar libremente su voluntad al tiempo de producirse la intervención*"), finding no indication to the contrary in the materials before it. It was therefore necessary to take account of what she had decided at that point in time. It referred to a clear tendency in case-law towards respecting the free, voluntary and conscious decision of a capable adult patient with respect to any form of medical intervention, such as a blood transfusion. This was exactly the stance taken in Act No. 41/2002.

46. The court observed that Act No. 41/2002 required that both the refusal of a specific treatment and consent to it must be stated in writing. The only document of relevance in the file was the informed consent document, which was key to the decision to be taken; oral refusal or consent in relation to blood transfusion was insufficient. As for the applicant's advance medical directive, the court considered that it was not applicable because, as appeared from the file, at the time of the intervention she had been capable of freely deciding whether or not to submit to blood transfusion.

47. The court noted that the informed consent document bore the signature of the doctor but not that of the patient. No explanation for this had been given. It considered that the lack of a signature prevented it from finding that the patient had either refused or accepted the treatment. In such circumstances, the duty judge's decision was to be considered lawful because, as the judge had stated, there was no reliable evidence of refusal on the part of the applicant of the medical treatment. The duty judge's actions had been justified, given the impasse in which the doctors had found themselves - unable to act or to refrain from acting due to the absence of the necessary document – and given the patient's condition, which, as stated in the forensic doctor's opinion, seriously endangered her life.

48. No ordinary appeal lay against that decision.

3. The applicant's appeal to the Constitutional Court

49. On 27 November 2018, the applicant lodged an *amparo* appeal with the Constitutional Court, arguing in particular that she had suffered a violation of her right to physical integrity (protected by Article 15 of the Constitution), her right to freedom of religion (Article 16.1) and the right to effective judicial protection of her rights (Article 24.1). In relation to the first two grounds, she claimed that authorising the La Paz doctors to decide by

themselves on the treatment to be given to her, with no regard to her express refusal of blood transfusions, violated her right to self-determination as a patient and her religious freedom. She considered that she had suffered an unjustified judicial interference as well as a coercive medical intervention, since a form of medical treatment had been imposed on her which both the doctors and the judge knew she rejected on religious grounds. The applicant argued that the case did not involve the right to life or the right to healthcare. Rather, what was at stake was her freedom to live according to her religious beliefs, and in particular the right to refuse an intervention on her person that was contrary to her values and her dignity.

50. The applicant submitted that the courts had erred in finding that there had been no reliable or valid refusal of treatment – her position had been conveyed very clearly to her caregivers verbally as well as in writing, including in her duly registered advance medical directive. Instead of authorising the doctors at La Paz to ignore her instructions, the duty judge should have ensured that they acted in accordance with their obligation to respect the patient's wishes. She should also have informed the applicant of the proceedings so as to permit her to defend her rights, since the patient must be able to participate in the process leading to a decision that affects their very person. The applicant, or her family members, should have been heard and the relevant facts and circumstances should have been duly established. There had in fact been no need for the involvement of the courts at all, it being clear from Article 8 of Act No. 41/2002 that medical interventions require the consent of the patient. While some exceptions were provided for in Article 9 of the Act, none of them applied to her case.

51. Along with her constitutional arguments, the applicant also relied on a series of provisions of the Convention (Articles 3, 8, 9 and 14).

52. She requested the following relief from the Constitutional Court:

(i) a declaration that her rights under the above-mentioned provisions of the Constitution had been violated by the actions of the judicial authorities in permitting medical treatment against her will;

(ii) the quashing of the impugned decisions, to be replaced by a decision in conformity with the rights in question.

53. A three-judge panel of the Constitutional Court adopted a decision on 9 October 2019 declaring the appeal inadmissible, without addressing the merits of the case, on the basis that there was a "clear absence of a violation of a fundamental right protected under the *amparo* appeal".

4. Provision to the applicant of the signed informed consent document

54. Both parties provided an explanation to the Court in relation to the informed consent document.

The applicant provided a sworn statement, dated 11 February 2020. In this she averred that in 2018 she had requested a copy of the informed consent document along with the other elements in her medical file at Soria hospital,

for use in the proceedings that she was about to bring. As the copy provided by the hospital only showed the doctor's signature, she returned there on 4 February 2020 to request a copy bearing both signatures, which the hospital provided to her. She then submitted this document to the Court when introducing her application.

The Government submitted a statement from the regional health authority, dated 6 April 2022, to the effect that there was no trace of any request in 2018 to Soria hospital for a copy of the document in question. The statement confirmed the applicant's request on 4 February 2020 and indicated that there was only one version of the document bearing the signatures of the doctor and the patient. It added that a copy of the entire medical file was provided to the applicant, at her request, on 28 December 2021.

RELEVANT LEGAL FRAMEWORK AND PRACTICE

I. DOMESTIC LAW AND PRACTICE

A. Spanish Constitution

55. In the domestic proceedings, the applicant invoked, *inter alia*, Articles 15 and 16 of the Constitution, which provide as relevant:

Article 15

"Everyone has the right to life and to physical and moral integrity ...."

Article 16

"1. Freedom of thought, religion and worship shall be guaranteed to individuals and communities, without any restrictions on its expression other than those necessary to maintain public order as protected by law.

..."

56. The Spanish Constitution provides that the Autonomous Communities may assume competence over health care (Article 148). All Autonomous Communities in Spain, including Castile and Leon and Madrid, have done so. However, the State retains exclusive competence for the general coordination of health care, that is to say setting minimum standards to be met by public health care services, establishing the means and systems to facilitate the exchange of information, and overseeing the coordination of the State and Autonomous health authorities in the exercise of their respective functions (see generally Article 149).

B. State legislation

57. The relevant provisions of Act No. 41/2002 of 14 November 2002 regulating patient autonomy and rights and obligations regarding clinical information and documentation read as follows:

Article 2. Basic principles

"...

2. Any act in the field of health requires, as a general rule, the prior consent of patients or users. Consent, which must be obtained after the patient receives adequate information, shall be given in writing in the cases provided for in the Act.

3. The patient or user has the right to freely decide, after receiving the appropriate information, among the available clinical options.

4. Every patient or user has the right to refuse treatment, except in the cases determined in the Act. Their refusal of treatment shall be recorded in writing.

...

6. Every professional involved in health care is required [...] to fulfil the duty of providing information and clinical documents, and to respect the decisions taken freely and voluntarily by the patient.

..."

Article 8. Informed consent

"1. Any act regarding the health of a patient requires the free and voluntary consent of the person concerned, once he or she has received the information provided for in Article 4 and has assessed the options specific to the case.

2. Consent shall as a general rule be given orally.

However, it shall be given in writing in the following cases: surgical intervention, invasive diagnostic and therapeutic procedures and, in general, the application of procedures that entail risks or inconveniences [that will have] notable and foreseeable negative repercussions on the patient's health.

3. Written consent from the patient shall be needed for each specific act mentioned in the previous subsection, without prejudice to the possibility of incorporating annexes and other general information, and shall contain enough information regarding the procedure and its risks.

...

5. The patient may freely revoke his or her consent in writing at any time".

Article 9. Limits to informed consent and consent by representation

"...

2. Doctors may carry out clinical interventions that are essential for the patient's health, without the patient's consent, in the following cases:

...

b) When there is an immediate serious risk to the physical or psychological integrity of the patient and it is not possible to obtain his or her authorisation, [but first]

consulting, when circumstances permit, his or her relatives or persons with *de facto* ties to him or her.

...”

Article 10. Conditions pertaining to informed written consent

“1. The doctor shall provide the patient with the following basic information before obtaining written consent [from him or her]:

(a) relevant or major consequences that the intervention is certain to give rise to;

(b) risks relating to the patient’s personal or professional circumstances;

(c) risks likely to occur under normal conditions, in line with experience and the current stage of scientific progress or directly related to the type of intervention [in question];

(d) contraindications.

2. The doctor in charge shall take into account in each case the fact that the more uncertain the outcome of an operation, the greater the need for the patient’s prior written consent”.

Article 11. Advance medical directives

“1. By means of an advance medical directive, a person of legal age, of full capacity and of his/her own free will, shall state his/her wishes in advance – with the aim of having them fulfilled when he/she reaches a situation in which the circumstances do not allow him or her to express them personally – regarding healthcare and treatment .... The issuer of the document may also appoint a representative to act as his/her interlocutor with the doctor or healthcare team in order to ensure that the advance medical directive is complied with.

2. Each health service shall regulate the appropriate procedure in order to guarantee compliance with each person’s advance medical directive, which shall always be given in writing.

3. Advance medical directives that are contrary to the legal system, to sound medical practice or do not correspond to the contingency foreseen by the person concerned at the time of expressing them, shall not be applied. A reasoned record shall be kept in the patient’s medical record of annotations related to these provisions.

4. Advance medical directives may be freely revoked at any time and [the revocation] shall be recorded in writing.

5. In order to ensure the effectiveness throughout the national territory of the advance medical directives issued by patients and formalised in accordance with the provisions of the legislation of the respective Autonomous Communities, a National Register of Advance Medical Directives shall be created within the Ministry of Health and Consumer Affairs...”.

58. The National Register of Advance Medical Directives envisaged in Article 11.5 of Act No. 41/2002 was established by Royal Decree 124/2007, of 2 February 2007. Its relevant provisions may be summarised as follows:

Once an advance medical directive is registered at the level of the relevant Autonomous Community, the National Register is notified within seven days and receives a copy of it, which it registers. Access to the National Register is granted to:

(a) persons whose directives have been registered,

(b) their legal representatives (or the persons they have designated for this purpose),

(c) accredited officials of the Autonomous Communities' Registers, and

(d) the persons designated by the health authority of the relevant Autonomous Community or the Ministry of Health.

The persons at (c) and (d) may access the Register electronically at the request of the doctor treating the person who made the directive, which is to be accessible on a twenty-four-hour basis.

C. Regional legislation

59. The applicant drew up her advance directive in the Autonomous Community of Castile and Leon. The relevant legislation there is Act No. 8/2003 on the rights and duties of persons in relation to health. It provides as relevant:

Article 30. Advance medical directives

> "1. Respect for decisions on one's own health shall also be enforceable in those cases in which such decisions have been previously adopted, by means of advance medical directives left in anticipation of a situation in which it is impossible to express such decisions personally.
>
> 2. Advance medical directives, which may only be made by persons of legal age who are capable and free, shall be formalised in the form of a document by means of one of the following procedures:
>
> a) before a notary, in which case the presence of witnesses shall not be necessary;
>
> b) before the personnel at the service of the Administration designated by the Regional Ministry as responsible for healthcare, under the conditions determined by [the relevant] regulation;
>
> c) before three witnesses of legal age and with full capacity to act, at least two of whom must not be related up to the second degree of kinship or linked by patrimonial or other ties of obligation with the issuer.
>
> The Government of Castile and Leon shall regulate the registration forms as well as the appropriate procedure so that, when necessary, there is a guarantee of compliance with the advance medical directives of each person, which must always be in writing and included in [that person's] clinical history – all without prejudice to the regulations applicable under the basic State legislation".

D. Relevant domestic case-law

1. Constitutional Court

60. The parties referred in their submissions to a number of judgments of the Constitutional Court, which has developed and consolidated its case-law in this area over the years.

(a) Judgment 120/1990 of 27 June 1990

61. The background to this judgment was a hunger strike by prisoners protesting over the fact that they had been placed in different prisons. The prison administration was granted judicial authorisation to provide necessary medical treatment to the prisoners if the hunger strike continued to a point where their lives were in danger, it being stipulated that there could be no force feeding by mouth and that treatment could not be given while the prisoners remained conscious. The prisoners brought a constitutional appeal against this decision. The Constitutional Court clarified that its ruling was specific to the prison context, in which there was a particular legal relationship between detainees and the prison administration. Limits could be applied to individual rights in that context that would not be permissible outside of it. Responding to the prisoners' argument that the impugned decision was incompatible with their right to life, the Constitutional Court stated that this right does not include the right to one's own death.

62. As for the right to physical and moral integrity (protected by Article 15 of the Spanish Constitution), the court observed that this protected the inviolability of the person not only against attack but also against any intervention affecting body or mind that was not consented to. Imposing medical assistance on a person against their will interfered with that right. A constitutional justification was therefore required, and the intervention had to satisfy the criteria of necessity and proportionality as well as respect the essence of the right. It concluded that, in the specific circumstances of the case, and given the terms in which it was expressed, the impugned decision fulfilled these requirements.

(b) Judgment 37/2011 of 28 March 2011

63. This judgment is considered to be a landmark ruling on the constitutional status of informed consent to medical treatment, linked to the right to physical and moral integrity. The background to the case is that the appellant, who was left partially paralysed following surgery, sought damages from the hospital, arguing that he had not been provided with the necessary information about the procedure, and its risks, beforehand. His claim was dismissed, the civil courts ruling that while he had not received this information, he still had knowledge of the surgical procedure since he had undergone similar treatment some years previously. They also considered that it had been an emergency situation, making it unnecessary to follow the usual consent protocol.

64. Examining the case under Article 15 of the Constitution, the Constitutional Court drew extensively on relevant international standards, notably the Convention and relevant case-law (especially *Pretty v. United Kingdom*, no. 2346/02, ECHR 2002-III) as well the provisions of the Oviedo Convention regarding consent to medical treatment (Articles 5 and 8 – see

under “Relevant international materials” below). The court reasoned that the patient’s consent to any form of medical intervention was integral to the fundamental right to physical integrity. He or she could refuse any unconsented medical treatment. The patient had a right of self-determination, using their autonomous will to decide freely on medical treatments and therapies that could affect their integrity, choosing among available options and consenting to them or not. In order to fully exercise this right, the patient needed to be adequately informed. Consent and information were so tightly intertwined that the proper exercise of the right to consent depended on being properly informed. An unjustified failure to provide information to the patient constituted a limitation or even a deprivation of their right to decide on, and consent to, medical treatment and thus their right to physical integrity. Prior information was therefore to be viewed as a means of guaranteeing the effectiveness of the principle of patient autonomy and thus of the constitutional precepts and fundamental rights that may be affected by medical procedures. It was an implied and obligatory consequence of the right to one’s integrity, thereby attaining constitutional relevance, such that the failure to provide adequate information was suggestive of a violation of that fundamental right. The court observed that Act No. 41/2002 took a strict approach to informing the patient, consistently with the relevant constitutional requirements.

65. In the case at hand, the Constitutional Court found that the appellant’s rights under Article 15 had not been respected. To hold that it was sufficient that he had been informed prior to surgery (and not an identical operation at that) carried out more than ten years before was not consistent with the content of the fundamental right affected. As to the existence of an emergency situation that might justify the doctors’ actions, the court observed that there was no indication that, as provided by law, the patient’s close family members could not have been approached to give informed consent on his behalf. Moreover, as the operation had taken place the following day, there had been time to go through the required process of obtaining informed consent. The existence of a risk to the patient was not sufficient to dispense with informed consent – it needed to be an immediate and serious risk, which had not been the case here.

(c) Judgment 19/2023 of 25 April 2023

66. This ruling, on a challenge brought by parliamentarians to Spain’s 2021 law on euthanasia, was referred to by the Government. They noted that in its extensive reasoning, the Constitutional Court reiterated the following principles:

– that the right to personal integrity protects those who in a free, informed and responsible manner refuse to undergo medical treatment, even when that decision could lead to a fatal outcome;

– that the patient’s right to consent to treatment can only be effectively exercised where the patient has received adequate information about such treatment;

– that prior information is a means to guarantee the effectiveness of patient autonomy, so that its omission or inadequacy may give rise to a violation of the relevant constitutional rights;

– that this guarantee has been given concrete form in the relevant provisions of Act No. 41/2002.

(d) Judgment 44/2023 of 9 May 2023

67. The applicant referred to this judgment, given on a challenge brought by parliamentarians to various provisions of Spain’s abortion law. Referring to the right to personal integrity, the Constitutional Court reiterated that this right protects the inviolability of the person not only against attacks intended to harm them, but also against any type of unconsented intervention, including those intended to be essentially positive, that affects the physical and moral aspects of their person. Along with this “negative” dimension, the jurisprudence had also underlined the “positive” dimension in relation with the free development of the personality. In this sense, the right to personal integrity was to be taken as also encompassing a right to individual self-determination that protected the essence of the person as a subject with the capacity for free and voluntary decision-making, which was violated when the individual was constrained or instrumentalised, forgetting that every person is an end in themselves.

2. From the ordinary courts

68. The parties’ submissions included references to the following decisions of different regional courts.

(a) *Audiencia Provincial* of Guipúzcoa (Section 2), appeal no. 2086/2004, Decision of 22 September 2004

69. The case was brought by a Jehovah’s Witness challenging the authorisation granted to doctors to give him a blood transfusion in the course of a medical intervention. The appellant had made an advance directive stating his refusal of transfusions, to be followed in the event of his being unconscious. The court stated that it was undisputed that the appellant was fully aware of the magnitude of the operation and of the possibility that during the course of the operation it could become necessary to give him blood. Even so, he had unequivocally expressed his refusal of transfusion, based on his religious beliefs. It considered that by means of the advance directive, the patient had already exonerated the doctors from taking any decision during the operation regarding the need for transfusion, because that decision had been taken by the patient himself. The court held that the fact that the doctors

had requested judicial authorisation to transfuse, based on their interest in exonerating themselves of any responsibility, did not comply with the provisions of Act No. 41/2002, contravened the Constitutional Court's case-law, and did not respect the appellant's right to physical integrity.

(b) *Audiencia Provincial* of Lleida (Section 1), appeal no. 440/2010, Decision no. 28/2011 of 25 January 2011

70. In this case, a Jehovah's Witness challenged the judicial order granted to his doctors authorising a blood transfusion. The appellant, having been duly informed before the operation, had freely and consciously expressed his opposition to being transfused. He had also registered an advance directive (in Castile and Leon), setting out his refusal of blood transfusions. The court found that the patient had been fully conscious and oriented at the time of refusing to consent to the transfusion. It referred to the framework established under Act No. 41/2002, providing for the patient's specific, free and informed consent to any medical intervention, and also for the refusal of treatment. It noted that there had been neither a risk to public health, nor a serious and immediate risk to the physical or psychological integrity of a patient from whom it had not been possible to obtain consent (or from the patient's relatives), so the appellant's decision not to consent to the blood transfusion should have been respected. All the more so in light of the advance directive that he had drawn up in accordance with the provisions of Article 11 of Act No. 41/2002. The appellant's refusal of transfusion had been an exercise in self-determination with respect to an intervention on his own body, protected by law. The imposition of the medical intervention against the clear and unequivocal will expressed by the patient was not justified.

II. RELEVANT INTERNATIONAL MATERIALS

A. Council of Europe

1. *The Convention on Human Rights and Biomedicine – the Oviedo Convention*

71. Opened for signature at Oviedo in October 1997, and in force since 1 December 1999, the Oviedo Convention has been ratified by thirty member States of the Council of Europe (including Spain)[3].

Article 1 of the Convention states its purpose and object in the following terms:

[3] Albania, Andorra, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Greece, Hungary, Iceland, Latvia, Lithuania, Montenegro, North Macedonia, Norway, Portugal, Republic of Moldova, Romania, San Marino, Serbia, Slovak Republic, Slovenia, Spain, Switzerland and Türkiye. Seven member States have signed, but not ratified, the Oviedo Convention: Armenia, Italy, Luxembourg, Netherlands, Poland, Sweden and Ukraine.

"Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine. Each Party shall take in its internal law the necessary measures to give effect to the provisions of this Convention."

72. Chapter II of the Convention concerns consent. It provides as relevant:

Article 5 - General rule

"An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time".

In relation to this provision the explanatory report states, as relevant:

"34. This article deals with consent and affirms at the international level an already well-established rule, that is that no one may in principle be forced to undergo an intervention without his or her consent. Human beings must therefore be able freely to give or refuse their consent to any intervention involving their person. This rule makes clear patients' autonomy in their relationship with health care professionals and restrains the paternalist approaches which might ignore the wish of the patient. The word "intervention" is understood in its widest sense, as in Article 4 – that is to say, it covers all medical acts, in particular interventions performed for the purpose of preventive care, diagnosis, treatment, rehabilitation or research.

35. The patient's consent is considered to be free and informed if it is given on the basis of objective information from the responsible health care professional as to the nature and the potential consequences of the planned intervention or of its alternatives, in the absence of any pressure from anyone. Article 5, paragraph 2, mentions the most important aspects of the information which should precede the intervention but it is not an exhaustive list: informed consent may imply, according to the circumstances, additional elements. In order for their consent to be valid the persons in question must have been informed about the relevant facts regarding the intervention being contemplated. This information must include the purpose, nature and consequences of the intervention and the risks involved. Information on the risks involved in the intervention or in alternative courses of action must cover not only the risks inherent in the type of intervention contemplated, but also any risks related to the individual characteristics of each patient, such as age or the existence of other pathologies. Requests for additional information made by patients must be adequately answered.

...

37. Consent may take various forms. It may be express or implied. Express consent may be either verbal or written. Article 5, which is general and covers very different situations, does not require any particular form. The latter will largely depend on the nature of the intervention. It is agreed that express consent would be inappropriate as regards many routine medical acts. The consent is therefore often implicit, as long as the person concerned is sufficiently informed. In some cases, however, for example invasive diagnostic acts or treatments, express consent may be required. ...

38. Freedom of consent implies that consent may be withdrawn at any time and that the decision of the person concerned shall be respected once he or she has been fully informed of the consequences. However, this principle does not mean, for example, that

the withdrawal of a patient's consent during an operation should always be followed. Professional standards and obligations as well as rules of conduct which apply in such cases under Article 4 may oblige the doctor to continue with the operation so as to avoid seriously endangering the health of the patient."

Article 6 - Protection of persons not able to consent

"...

3. Where, according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law.

The individual concerned shall, as far as possible, take part in the authorisation procedure.

...".

In relation to this provision the explanatory report states, as relevant:

"43. However, in order to protect the fundamental rights of the human being, and in particular to avoid the application of discriminatory criteria, paragraph 3 lists the reasons why an adult may be considered incapable of consenting under domestic law, namely a mental disability, a disease or similar reasons. The term "similar reasons" refers to such situations as accidents or states of coma, for example, where the patient is unable to formulate his or her wishes or to communicate them ..."

Article 8 – Emergency situation

"When because of an emergency situation the appropriate consent cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the health of the individual concerned".

In relation to this provision the explanatory report states:

"56. In emergencies, doctors may be faced with a conflict of duties between their obligations to provide care and seek the patient's consent. This article allows the practitioner to act immediately in such situations without waiting until the consent of the patient or the authorisation of the legal representative where appropriate can be given. As it departs from the general rule laid down in Articles 5 and 6, it is accompanied by conditions.

57. First, this possibility is restricted to emergencies which prevent the practitioner from obtaining the appropriate consent. The article applies both to persons who are capable and to persons who are unable either *de jure* or *de facto* to give consent. An example that might be put forward is that of a patient in a coma who is thus unable to give his consent (see also paragraph 43 above), or that of a doctor who is unable to contact an incapacitated person's legal representative who would normally have to authorise an urgent intervention. Even in emergency situations, however, health care professionals must make every reasonable effort to determine what the patient would want.

58. Next, the possibility is limited solely to medically necessary interventions which cannot be delayed. Interventions for which a delay is acceptable are excluded. However, this possibility is not reserved for life-saving interventions.

59. Lastly, the article specifies that the intervention must be carried out for the immediate benefit of the individual concerned."

Article 9 – Previously expressed wishes

“The previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account”.

In relation to this provision the explanatory report states:

“60. Whereas Article 8 obviates the need for consent in emergencies, this article is designed to cover cases where persons capable of understanding have previously expressed their consent (that is either assent or refusal) with regard to foreseeable situations where they would not be in a position to express an opinion about the intervention.

61. The article therefore covers not only the emergencies referred to in Article 8 but also situations where individuals have foreseen that they might be unable to give their valid consent, for example in the event of a progressive disease such as senile dementia.

62. The article lays down that when persons have previously expressed their wishes, these shall be taken into account. Nevertheless, taking previously expressed wishes into account does not mean that they should necessarily be followed. For example, when the wishes were expressed a long time before the intervention and science has since progressed, there may be grounds for not heeding the patient’s opinion. The practitioner should thus, as far as possible, be satisfied that the wishes of the patient apply to the present situation and are still valid, taking account in particular of technical progress in medicine.”

2. Text adopted by the Committee of Ministers

73. On 9 December 2009 the Committee of Ministers adopted Recommendation CM/Rec(2009)11 to member states on principles concerning continuing powers of attorney and advance directives for incapacity. It was noted in the preambular provisions that legislation in this area had been adopted or proposed in some member States, and that there were considerable disparities between the legislation in force in the States concerned. The text recommended that States take account of a set of principles, which provide as relevant:

Principle 1 − Promotion of self-determination

“1. States should promote self-determination for capable adults in the event of their future incapacity, by means of continuing powers of attorney and advance directives.

2. In accordance with the principles of self-determination and subsidiarity, states should consider giving those methods priority over other measures of protection.

...

Part III – Advance directives

Principle 14 – Content

Advance directives may apply to health, welfare and other personal matters, to economic and financial matters, and to the choice of a guardian, should one be appointed.

Principle 15 – Effect

1. States should decide to what extent advance directives should have binding effect. Advance directives which do not have binding effect should be treated as statements of wishes to be given due respect.

2. States should address the issue of situations that arise in the event of a substantial change in circumstances.

Principle 16 – Form

1. States should consider whether advance directives or certain types of advance directives should be made or recorded in writing if intended to have binding effect.

2. States should consider what other provisions and mechanisms may be required to ensure the validity and effectiveness of those advance directives.

Principle 17 – Revocation

An advance directive shall be revocable at any time and without any formalities."

3. Text adopted by the Parliamentary Assembly

74. On 25 January 2012, the Parliamentary Assembly adopted Resolution 1859 (2012) on protecting human rights and dignity by taking into account previously expressed wishes of patients. It states at paragraph 1:

> "There is a general consensus based on Article 8 of the European Convention on Human Rights (ETS No. 5) on the right to privacy, that there can be no intervention affecting a person without his or her consent. From this human right flow the principles of personal autonomy and the principle of consent. These principles hold that a capable adult patient must not be manipulated and that his or her will, when clearly expressed, must prevail even if it signifies refusal of treatment: no one can be compelled to undergo a medical treatment against his or her will."

Paragraph 6 of the text, addressed to the member States of the Council of Europe, makes the following recommendation:

> "6.3 [to] review, if need be, their relevant legislation with a view to possibly improving it:
>
> 6.3.1 for countries with no specific legislation on the matter – by putting into place a "road map" towards such legislation promoting advance directives, living wills and/or continuing powers of attorney, on the basis of the Oviedo Convention and Recommendation CM/Rec(2009)11, involving consultation of all stakeholders before the adoption of legislation in parliament, and foreseeing an information and awareness-raising campaign for the general public, as well as for the medical and legal professions after its adoption;
>
> 6.3.2 for countries with specific legislation on the matter – by ensuring that the relevant Council of Europe standards are met by this legislation, and that the general public, as well as the medical and legal professions, are sufficiently aware of it and implement it in practice."

Paragraph 7, addressed to national parliaments, recommends that they respect a series of principles when legislating in this field. These include:

> "7.1 self-determination for capable adults in the event of their future incapacity, by means of advance directives, living wills and/or continuing powers of attorney, should be promoted and given priority over other measures of protection;
>
> 7.2 advance directives, living wills and/or continuing powers of attorney should, in principle, be made in writing and be fully taken into account when properly validated and registered (ideally in state registries);
>
> ...
>
> 7.4 prior instructions contained in advance directives and/or living wills which are against the law, or good practice, or those which do not correspond to the actual situation that the interested party anticipated at the time of signing the document, should not be applied;
>
> ...
>
> 7.8 surrogate decisions that rely on general value judgments present in society should not be admissible and, in case of doubt, the decision must always be for life and the prolongation of life."

4. *Guide on the decision-making process regarding medical treatment in end-of-life situations*

75. This publication was drawn up by the Committee on Bioethics of the Council of Europe in the course of its work on patients' rights, with the intention of facilitating the implementation of the principles enshrined in the Oviedo Convention. In so far as relevant it states:

> "In view of their importance in the decision-making process as a means of ensuring the protection of the patient's wishes, special attention should be paid, in the organisation of the health system, to the arrangements for previously expressed wishes regardless of their legal force. This is a means of exercising patients' rights. All health system users and health professionals should be informed of the existence of such possibilities, how they are arranged and what their legal scope is.
>
> A formal, written document appears to be the safest and most reliable way of making known one's wishes expressed in advance. Accordingly, written advance directives are the means that most directly reflect patients' wishes. When they exist, they should take precedence over any other non-medical opinion expressed during the decision-making process (by a person of trust, a family member or a close friend, etc.), subject, of course, to the fulfilment of a certain number of requirements to ensure their validity (authentication of the author, legal capacity of the author, appropriate content, length of validity, arrangements for them to be redrafted so that they can be kept as closely in line as possible with current developments, possibility for them to be revoked, etc.), and their accessibility (arrangements for them to be kept in such a way that the doctor can access them in good time)."

B. European Union

76. The Charter of Fundamental Rights of the European Union provides as relevant:

Article 3
Right to the integrity of the person

"1. Everyone has the right to respect for his or her physical and mental integrity.

2. In the fields of medicine and biology, the following must be respected in particular:

(a) the free and informed consent of the person concerned, according to the procedures laid down by law;

..."

C. United Nations

77. The Universal Declaration on Bioethics and Human Rights was adopted by UNESCO's General Conference on 19 October 2005. Its relevant provisions read as follows:

Article 5
Autonomy and individual responsibility

"The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.

Article 6
Consent

1. Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice. ..."

78. In 2009 the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health was submitted to the United Nations General Assembly (A/64/272). It includes the following passage:

"9. Informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health-care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being."

79. In its General Comment No. 14 on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights set out its interpretation of Article 12 of the International Covenant on Economic, Social and Cultural Rights, stating as relevant:

"8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right

to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. ...”

The Committee identified a series of specific legal obligations of States including that of “supporting people in making informed choices about their health” (General Comment, paragraph 37(iv)).

D. Other relevant materials

80. Two texts of the World Medical Association can be referred to. Its Statement on Advance Directives (Living Wills)[4] includes the following passage:

> “A patient’s duly executed advance directive should be honoured unless there are reasonable grounds to suppose that it is not valid because it no longer represents the wishes of the patient or that the patient’s understanding was incomplete at the time the directive was prepared.”

Its Declaration of Lisbon on the Rights of the Patient[5] includes the following passage:

> “The unconscious patient
>
> If the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained whenever possible, from a legally entitled representative.
>
> If a legally entitled representative is not available, but a medical intervention is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient’s previous firm expression or conviction that he/she would refuse consent to the intervention in that situation.”

III. COMPARATIVE LAW

81. For the purposes of the present case a comparative survey covering 39 of the other Contracting States was prepared by the Court’s Research Division. The survey looked at the manner in which the previously expressed wishes of the patient are respected or taken into account in the context of a life-threatening emergency, specifically the refusal of blood transfusions by Jehovah’s Witnesses. The survey identified three groups of States in this respect. It found that in 17 States there is formal recognition of advance directives setting out the patient’s wishes in relation to medical treatment (Austria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Hungary, Ireland, Italy, Liechtenstein, Portugal,

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[4] Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003, and reaffirmed by the 194th WMA Council Session, Bali, Indonesia, April 2013 and reaffirmed with minor revisions by the 224th WMA Council, Kigali, Rwanda, October 2023.

[5] Adopted by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981 and amended by the 47th WMA General Assembly, Bali, Indonesia, September 1995 and editorially revised by the 171st WMA Council Session, Santiago, Chile, October 2005 and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015.

Slovenia, Switzerland and the United Kingdom). It is possible in these States for the patient to state in a directive their refusal of blood transfusions, although in Hungary the prior refusal of life-saving treatment is limited to cases of terminal illness. These States have made specific arrangements determining the form, accessibility and effects of advance directives. While it can be generally said that the purpose of these arrangements is to ensure that the patient's instructions in relation to medical treatment are respected, this presumes that in a particular case there are no grounds to doubt the authenticity, current validity, meaning and applicability of an advance directive drawn up in compliance with the relevant formal and substantive requirements. For example, it is a statutory requirement in Denmark that the patient have received information from a doctor about the consequences, in the current medical situation, of refusing a blood transfusion. Only then will the refusal be operative; otherwise, the patient's opposition to blood transfusion will be treated as a relevant factor rather than a binding instruction; it will not prevent the administration of urgent life-saving treatment.

82. The existence of an advance directive must also be known to the clinician. In this regard certain States have set up official registries for this purpose (e.g., Estonia, Finland, Italy, Portugal, Slovenia), whereas in other States the directive is accessible via the patient's electronic health records (e.g., Austria, Switzerland). In certain States, the patient's previously expressed refusal can be over-ridden in order to save their life (e.g., Cyprus), or essential treatment may be given to the patient pending a ruling by the courts on the validity or meaning of an advance directive (Ireland, United Kingdom). In France, the doctor may provide essential treatment during the time required to fully assess the patient's state of health, and is not required to respect an instruction that is manifestly inappropriate or not consistent with the patient's medical situation. In Portugal, doctors are not required to follow advance directives if accessing them would cause a delay in providing urgent treatment to protect the patient's life or health.

83. Where doubt arises as to the validity, meaning or applicability of an advance directive, the rule or practice in several States is that it should be attempted to establish the presumed or putative will of the patient through consulting any appointed representative (or similar), or members of the family, or others closely associated with the patient (e.g., Germany, Ireland, Italy, Switzerland, United Kingdom).

84. The role of the courts in resolving disputes between the patient's family or representatives and the medical team in relation to an advance medical directive, or other difficulties, is expressly provided for in a number of States. In Austria, Germany and Italy, this function is entrusted to the guardianship/custodianship courts, and in the United Kingdom to the Court of Protection. In Ireland and Cyprus, the relevant court is the High Court.

85. The second group of States comprises those that, whether in law or in practice, require that the previously expressed wishes of the patient be respected, but without laying down a specific regulatory framework for this (Belgium, Iceland, Latvia, Luxembourg, the Netherlands, Poland and Romania). In these States, a clear instruction given by the patient beforehand refusing medical treatment is to be respected. This would include the rejection by a Jehovah's Witness of blood transfusion (e.g., the 2005 decision in this sense by the Supreme Court of Poland[6]). However, it was emphasised that such a rejection must be stated in sufficiently specific terms in order for it to be treated as binding on medical staff. Where it is considered that the patient's statement lacks the requisite clarity, essential treatment will be given in emergency situations.

86. The States in the third group have not adopted any specific provisions dealing with previously expressed wishes of patients (Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Croatia, Lithuania, Malta, Moldova, Montenegro, North Macedonia, San Marino, Serbia, the Slovak Republic and Sweden). Rather, their laws and regulations in this area are framed in terms of the giving of consent to impending medical treatment. In many of these States, it is provided that if the patient is unable to give consent to vital treatment in an emergency situation, it should if possible be sought from their representative or relatives. Where the circumstances do not permit this, the necessary medical treatment is to be given to the patient.

THE LAW

I. ALLEGED VIOLATIONS OF ARTICLES 8 AND 9 OF THE CONVENTION

87. The applicant complained under Article 8 of the Convention that in the course of surgery performed pursuant to judicial authorisation she had been given blood transfusions despite her previously expressed refusal of this form of treatment. She considered that there had been a profound interference with her right to respect for her private life, and criticised both the medical and judicial decisions that were taken in her regard as being contrary to her right to self-determination.

Article 8 provides as relevant:

> "1. Everyone has the right to respect for his private and family life...
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

[6] Decision of 27 October 2005, no. CK 155/05.

The applicant also complained, on the basis of the same facts, of a violation of her right under Article 9 of the Convention to freedom of conscience and religion. The rejection of blood transfusions formed part of her core religious beliefs and was of paramount importance for her, making up her personal identity and shaping her personal conscience.

Article 9 provides:

> "1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
>
> 2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others."

A. Admissibility

1. The parties' submissions

(a) The Government

88. The Government disputed the admissibility of the application. They referred to the fact that the applicant had failed to provide the *Audiencia Provincial* with a copy of the informed consent document from Soria hospital showing her signature, an omission that had been pointed out to her at the time. The potential importance of this document had been acknowledged by the *Audiencia Provincial*. The Government argued that if that court had received a signed version of the document, it would have been able to examine the relevance of this previous written refusal of treatment for the actions undertaken the following day. Due to this omission, that question could not be properly examined in the domestic proceedings. The Government underlined that there had only ever been one version of the informed consent document in the applicant's medical file, bearing both signatures, which had been available to her all along (see paragraph 54 above). The applicant had therefore not shown the requisite diligence in the domestic proceedings and so could not complain about their final outcome. She could not be considered to be a "victim" of the alleged violations of the Convention.

89. The Government further observed that the focus of the domestic proceedings brought by the applicant had been on the decision of the duty judge, which she had sought to overturn. She had not, in those proceedings, challenged the medical decision-making that had taken place, i.e., the doctors' assessment regarding the state of her health on 7 June 2018 and the clinical intervention that this required. There had been remedies available to her – civil, administrative and criminal – in which she could have raised such arguments and given the domestic courts the opportunity to examine them.

Having failed to make use of such remedies, she could not now seek to impugn in the present proceedings the doctors' professional judgment. It would be contrary to the Court's subsidiary role to entertain arguments of this nature that had not been raised before the domestic courts.

(b) The applicant

90. The applicant denied any responsibility for the missing signature. The original document, bearing both signatures, had been in the possession of Soria hospital, and she had requested a copy of it for the purpose of the domestic proceedings (see paragraph 54 above). In good faith, she had submitted the copy received to the domestic courts. In any event, there had been ample written evidence in her medical file of her refusal of blood transfusions, which had been recorded by the doctors at Soria hospital. This should have been accepted as sufficient to satisfy the stipulation in Article 2.4 of Act No. 41/2002 that refusal of treatment be in writing. She therefore maintained that nothing had prevented the domestic courts from taking into account her written refusal of blood transfusions.

91. Responding to the Government's submission about available remedies, the applicant stated that, in theory, she might have attempted to bring civil or administrative proceedings against the doctors or the hospital, in which context the issue of possible medical error or negligence might have been raised. She might also have filed a criminal complaint. However, she had been advised that there would have been no prospect of success with these remedies, given that the doctors' actions had been authorised beforehand by the duty judge. Therefore, it had been appropriate for her to appeal that decision, and then to make it, and the two subsequent appellate decisions, the focus of her application to the Constitutional Court. The issue at stake was essentially one of principle – whether a competent patient can be treated against their will – not one of possible medical negligence. As she had brought this issue of principle before the domestic courts, relying on the relevant provisions of the Constitution and the Convention, she had complied with her duty to exhaust domestic remedies with respect to her complaint.

2. *The Court's assessment*

92. The Court's case-law on the meaning of the term "victim" in Article 34 of the Convention is well established. The individual concerned must be able to show that he or she was "directly affected" by the measure complained of (see *Communauté genevoise d'action syndicale (CGAS) v. Switzerland* [GC], no. 21881/20, § 105, 27 November 2023). In the present case, the measure complained of is the decision of the duty judge of 7 June 2018 that authorised the doctors at La Paz to provide the applicant with the treatment necessary to safeguard her life and physical integrity (see paragraph 28 above). On foot of that decision, the applicant was operated on,

and in that context received transfusions, contrary to the wishes which she had previously expressed by various means and which were based on her religious beliefs. In the Court's view, the direct effect on the applicant of the measure complained of is clear and it therefore rejects this preliminary objection. That the applicant did not submit a valid copy of the informed consent document in the subsequent legal proceedings – it being accepted that she did indeed express her refusal in the required form at Soria hospital – has no bearing on her victim status with respect to the complaints examined in these proceedings. The implications of this fact for the merits of the case will be considered below.

93. The Court recalls that the rationale of the exhaustion rule is to afford the Contracting States the opportunity of preventing or putting right the violations alleged against them before those allegations are submitted to the Court. This reflects the subsidiary character of the machinery of protection established by the Convention in relation to the national systems safeguarding human rights (see, among many others, *Communauté genevoise d'action syndicale (CGAS)*, cited above, § 138). It is well established in case-law that the obligation to exhaust domestic remedies requires an applicant to make normal use of remedies which are available and sufficient in respect of his or her Convention grievances (ibid., § 139).

94. As noted above, the applicant's position is that her case essentially involves a question of principle and the form of remedy she sought before the domestic courts reflected this. Having already identified above the decision of the duty judge as being the measure that directly affected the applicant, the Court considers that in seeking to overturn that decision she made use of an appropriate remedy. At each stage of the domestic proceedings, the applicant challenged the validity of the decision, relying on the relevant constitutional provisions and jurisprudence, as well as on corresponding provisions of the Convention and relevant case-law. By so doing, she satisfied the obligation to afford the domestic judicial authorities the opportunity to deal with the alleged violations of her rights that she has now brought before the Court.

95. As for the other types of remedy referred to by the Government, the purpose of these would have been to seek to establish the liability of the doctors or the hospital under civil, criminal or administrative law for the manner in which the applicant was treated. Yet that does not correspond to the essential grievance that she has raised before the Court, which, as the applicant has put it, relates to a matter of principle rather than any alleged error or negligence in her medical care. The scope of the Court's examination of the case is, however, necessarily affected by the applicant's decision not to bring before the domestic courts any complaint related to the soundness of the medical assessments made in her case. The Court will revert to this matter below (see paragraph 130).

96. To conclude on the admissibility of the application, the Court considers that it is not manifestly ill-founded within the meaning of Article 35

§ 3 (a) of the Convention. It further notes that it is not inadmissible on any other grounds. It must therefore be declared admissible.

B. Merits

1. Legal characterisation of the case

97. The Court observes that the two distinct rights relied on by the applicant, the right to respect for private life and the right to freedom of conscience and religion, are here very closely intertwined; her wishes with respect to the treatment of her illness were rooted in her fidelity to the relevant teaching of her religious community. It further observes that in her submissions on the case, summarised above, the applicant concentrated to a far greater degree on Article 8. With respect to Article 9, she mostly reiterated the same arguments. The position of the Government was that the key issue in the case was broader than freedom of religion, and their arguments were entirely directed to Article 8.

98. For its part, the Court considers that the issue in this case, which principally pertains to the autonomy and self-determination of the patient in relation to medical treatment, may be appropriately examined under Article 8, it being clear that this comes within the scope of "respect for private life" (see below for the relevant principles and case-law authorities). The religious aspect of the applicant's complaint can be adequately accommodated by interpreting and applying Article 8 in the light of Article 9 (see for a similar approach *Abdi Ibrahim v. Norway* [GC], no. 15379/16, 10 December 2021, in which the applicant complained that the withdrawal of her parental rights in relation to her son and his placement for adoption with a family of a different religion to hers was in violation of her right to respect for family life and her freedom of religion and which the Court examined under Article 8 read in the light of Article 9; see also § 142 of the judgment providing several further examples).

2. The parties' submissions

(a) The applicant

99. In her submissions, the applicant sought to show that the state of her health on the day in question had not been so serious as to put her life in immediate danger. To this end she submitted two expert reports that she had commissioned for the purposes of the present proceedings. Both experts considered that, based on the information in her medical file, the applicant's life had not in fact been in imminent danger. Rather, they considered that her situation had been stable at the time of her arrival at La Paz and saw no basis in the medical file to consider that her lucidity at that moment had been impaired. They stated that it would have been possible to treat her effectively without recourse to blood transfusion, in keeping with her wishes. The

applicant also submitted, however, that even assuming there had been an imminent threat to her life, the central issue in the case was one of legal principle rather than of medical fact, i.e., the principle of respect for the will of a competent adult patient.

100. The applicant maintained that there had been ample time for the doctors at La Paz to apprise themselves of her wishes, given that the arrangements to transfer her there had been made by approximately 11 o'clock on the morning in question. With some four hours available to them between then and the commencement of surgery, it would have been perfectly possible for them to consult her directly. This could have been done before she left Soria, or during the transfer, or at La Paz itself, given that she had been fully lucid throughout this time, as noted in her medical file and accepted by the *Audiencia Provincial*. Had there been any real need to further clarify or confirm her wishes, there had been several ways of doing so. Contact could have been made again with Soria hospital. In this regard, the applicant argued that there was a positive duty on States to organise their health systems to ensure medical staff were promptly informed of a patient's relevant treatment instructions, through the sharing of information between hospitals where a patient is transferred, so as to avoid needless delay in implementing the patient's instructions. The other steps that could well have been taken were to access her advance medical directive held by the National Register, or to contact her health care representatives. However, none of these steps had been taken. She considered that a paternalistic attitude had instead been taken towards her.

101. Coming to the decision-making process, which was the focus of the domestic proceedings brought by her, the applicant advanced a series of criticisms of it. The duty judge had decided solely on the basis of a few sentences in a fax. Yet the message sent was incomplete, providing virtually no information about the patient, not even her name. It was also incorrect in the way it presented the applicant's health situation and her decision regarding treatment. The judge had not made any attempt to verify the information or to obtain further details, although this could have been done by contacting the applicant directly, or Soria hospital, or the applicant's health care representative. The judge's reasoning drew on outdated constitutional case-law that omitted the importance of respecting the autonomy and beliefs of the patient. The decision effectively gave the doctors *carte blanche* to decide on the treatment to be given to the applicant. Moreover, the applicant had had no knowledge of, let alone involvement in, the decision-making process.

102. The applicant further criticised the reasoning of the duty judge in rejecting her application to set the decision aside. It had been wrong to cast doubt on the validity of the applicant's advance medical directive, which, as a duly registered document, should have been treated as authentic. Regarding the decision of the *Audiencia Provincial*, the applicant argued that it had made

an error of law by insisting that a refusal of medical treatment must be given in written form. This interpretation of Act No. 41/2002 had been arbitrary and unforeseeable. She submitted that what the law required was a written record of such refusal in the patient's medical file; this had been done at Soria hospital. Had the doctors at La Paz sought her consent to the intended surgical intervention, as they should have, she would have reiterated her refusal of blood transfusion and that would have been noted in her medical file, satisfying the statutory requirement. Moreover, she considered that there had been ample written evidence of her refusal, which was set out in her advance medical directive, her continuing power of attorney and the informed consent document signed by her at Soria hospital on 6 June 2018. Accordingly, she considered that the interference with her rights had not been lawful.

103. Nor did the interference pursue any of the aims recognised in Article 8 § 2. In particular, her refusal of blood transfusion did not in any way endanger the rights or freedoms of others. Since the refusal represented her clear and conscious position, it could not properly be said that the duty judge's decision was aimed at protecting her health, since that would be in contradiction with her autonomy. With no countervailing rights or interests at stake, the applicant submitted that her right to refuse blood transfusion enjoyed absolute protection under the Convention.

104. Given the fundamental importance of respecting patient autonomy and self-determination, any margin of appreciation for the domestic authorities in this respect would have to be very narrow. This was borne out by the fact that in the great majority of European States, a valid refusal of treatment on the part of a competent patient could not be overridden in any circumstances. This represented a broad consensus over the paramount importance of respecting the patient's wishes. It would require convincing and compelling reasons to justify overriding the patient's wishes, such as actual evidence that the patient's decision was not a voluntary one. It was not sufficient to generally invoke doubts, since this could see the ultimate decision regarding treatment placed in the hands of the doctor rather than the patient. There was a risk that such a power would effectively be unfettered and could be misused in relation to Jehovah's Witnesses, an unpopular religious minority who were prone to stereotyping, discrimination and victimisation. As long as the patient's wishes were clear and precise, were applicable to the situation at hand, and there was no reason to doubt their authenticity, they must be given full effect. This applied equally to previously expressed wishes where, in the States that make provision for such instruments, these have been set out in an advance medical directive drawn up in accordance with the relevant provisions of domestic law. It was clear on the facts of the case that there had been no reason whatsoever to doubt the validity of her refusal of blood transfusions. There was therefore nothing in the facts of the case that could be taken as revealing a pressing social need,

or as constituting a relevant and sufficient reason for interfering with her right to respect for private life.

105. In reply to a question put at the hearing about whether the applicant had been ready to accept the risk of dying on 7 June 2018, her counsel replied that she had set out a very clear choice in her advance medical directive about refusing blood transfusion. While she wanted to recover, she appreciated that a personal choice may turn out to have fatal consequences. Nevertheless, she had been ready to accept the consequences of her choice.

(b) The Government

106. The Government emphasised how gravely ill the applicant had been on the day in question. In view of her refusal of blood transfusion, Soria hospital had had no option but to arrange her transfer to La Paz, situated in a different Autonomous Community, to see whether she could be treated there without the use of transfusion. It had been an emergency situation posing an imminent threat to the applicant's life. The Government rejected her claim that her condition had not been that serious. Speaking at the hearing, a senior doctor from La Paz hospital stated that the applicant's case had been clinically complicated and the risk for her life had been extreme. He further explained the effects of severe anaemia on the body and the mind. While individual patients responded differently, due to factors such as age, health condition and the speed and magnitude of bleeding, decreasing haemoglobin levels denoted a growing risk for the patient. A haemoglobin level of less than 7g/dL required immediate transfusion. Where, as recorded here, the level went below 5 g/dL, this placed the patient's life in imminent danger. The condition also affected the patient's upper cognitive functions, impairing the capacity to take fully autonomous decisions. This effect was not necessarily visible. It would be very difficult to accurately evaluate the lucidity of a patient in such a condition within the space of a few minutes, which was the time available to the doctors when the applicant arrived at La Paz. The Government underlined that the remark made by the *Audiencia Provincial* about the applicant being in a position to express her will at La Paz hospital should not be treated as a finding of fact, since the purpose of its ruling had been to review the circumstances in which the duty judge had taken the decision to authorise treatment.

107. Following telephone contact from Soria hospital on the morning of 7 June 2018, the doctors at La Paz knew about the seriousness of the applicant's condition, and also her refusal of blood transfusion on religious grounds. They were then warned by the doctor in the ambulance about the risk of a serious deterioration in the applicant's health by the time of arrival. It was in these circumstances that an application was made to the duty judge. At the hearing it was explained that it was the standard practice of La Paz hospital to seek judicial guidance when a patient ruled out blood transfusion. Such applications always included the relevant and available information

regarding the patient. Concerning the applicant, who was then on her way from another hospital in a different Autonomous Community, the doctors had submitted the elements of information that were in their possession at that point in time, which were very limited. Moreover, the transfer was being carried out at a time when the staff of the emergency department had also been attending to many other urgent cases. The Government acknowledged that the fax had not been entirely accurate, notably in stating that the applicant was refusing all types of treatment. Yet the only form of treatment that she actually rejected was the one deemed necessary to save her life.

108. In the Government's view, it had been prudent for the doctors to apply to the duty judge at the time that they did. Given the circumstances, the application was an urgent one that required an extremely rapid response from the judge based on the factual elements communicated to her. She had nonetheless been able to obtain two opinions before issuing her decision, one confirming the gravity of the situation (from the forensic doctor) and one addressing the legal aspects of the situation (from the local prosecutor). Further steps were not feasible in the circumstances. In particular, there were no means by which the judge could have ascertained in the course of examining the application whether the applicant had the cognitive capacity to confirm her rejection of blood transfusion – this could not have been done over the telephone and it would have been inappropriate to attempt to do so. As for the applicant's advance medical directive, while the judge could, in theory, have ordered the Register to provide a copy, in reality this could not have been done, given the urgency of the situation. Therefore, the judge had been faced with a lack of certainty regarding the applicant's wishes. She had not ordered any particular form of treatment but had left it to the doctors to exercise their medical judgment once the applicant had arrived. That the applicant's identity had not been communicated to the duty judge could not be seen, given the purpose and the context of the application, as the omission of an essential detail.

109. With the arrival of the ambulance, the doctors at La Paz judged that they indeed had a serious clinical emergency to deal with that left them with no alternative to surgery. This had to commence without delay. The applicant did not inform them verbally of her position, produce any document stating her refusal of blood transfusion, or inform the doctors of the existence of any such document.

110. The Government rejected the applicant's criticism about paternalism. They submitted that in the Spanish system, and in ordinary conditions, the free and conscious decision of a competent patient to refuse treatment was always respected, even where there was a threat to life. In Spanish constitutional case-law, the right of the patient to refuse any non-consensual medical intervention was clearly established. Yet the present case involved a situation of extraordinary urgency in which the usual

procedure for ascertaining the patient's wishes with sufficient certainty simply could not be followed.

111. The principle of free and informed consent, as provided for in Article 5 of the Oviedo Convention, was fully respected in the domestic framework, which required that the patient receive the necessary information about medical treatment and, as an additional safeguard, required that patients express their wishes in writing. Respect for the patient's previously expressed wishes was also ensured through the system of advance medical directives, corresponding to Article 9 of the Oviedo Convention. However, it needed to be borne in mind that the patient might, when facing the prospect of death, override a previously expressed refusal of vital treatment, this having been observed in medical practice. Therefore, where the patient's life was at stake, it was necessary to verify the authenticity and applicability of a previously expressed refusal of treatment. Where, as here, the urgency of the situation rendered that impossible, then it was right for the medical authorities to proceed with the necessary treatment.

112. Domestic law allowed an exception to the consent rule in emergency situations where the patient faced an immediate serious risk to their health and was unable to give consent to – or to refuse – essential treatment (Article 9.2b) of Act No. 41/2002). As with Article 8 of the Oviedo Convention, priority was given to the patient's right to life in such circumstances. The applicant had been in precisely that situation. Therefore, her right to life, and the State's duty to protect it, had been engaged. That placed on the authorities an obligation to establish, to a very high standard of proof, that her wish to refuse life-saving treatment represented a genuinely free and conscious decision, made in full awareness of the consequences it would bring. It could not have been simply presumed that the applicant would have maintained her refusal of blood transfusion notwithstanding the imminent threat to her life that emerged between 6 and 7 June 2018. As it had not been possible in the circumstances to establish with the utmost rigour the authenticity of her previously expressed refusal, it had been the legal duty of the doctors to proceed with the necessary treatment, having been authorised to do so by the duty judge. Indeed, to have let the applicant die without knowing for certain her wishes regarding treatment would have been so serious as to engage not only the professional responsibility but also the criminal liability of the duty judge and the clinicians concerned.

113. That could not be regarded as an infringement of the applicant's personal autonomy contrary to Article 8 of the Convention. The duty judge and the doctors had acted in keeping with domestic law, and the aim of the intervention, as explained above, had been to protect the applicant's life in circumstances in which her wishes could not be verified to the necessary degree. In the circumstances, saving the applicant's life could not be deemed an unjustified or disproportionate interference with her right to respect for private life. Owing to the uncertainty over the applicant's wishes at the critical

moment, there had been a conflict between the need to respect her autonomy and the duty to protect her life. It had clearly been within the margin of appreciation of the medical authorities to resolve that conflict by giving priority to the latter. Their decision to proceed in this way could not be faulted from a Convention perspective.

114. Finally, in reply to a question posed at the hearing, the Government clarified that there was, as such, no legal duty in Spain of coordination among hospitals, including those based in different Autonomous Communities. However, in practice they worked together for the benefit of patients' well-being, illustrated in this case by the willingness of La Paz hospital to take charge of the applicant's care when this was requested by Soria hospital.

(c) The third parties

(i) The European Association of Jehovah's Witnesses

115. The principal submission by this intervenor (hereafter "the EAJW") was that the Grand Chamber should endorse the statements made in previous cases concerning the religious rights of Jehovah's Witnesses affirming the right of competent adult patients to freely decide on what medical treatment they will or will not accept, and the duty of the State to respect such decisions.

116. The EAJW provided an explanation of the scriptural basis for the rejection of blood. It further explained how Jehovah's Witnesses decided to organise themselves with a view to ensuring that medical treatment given to the members of this faith was in conformity with their beliefs, leading to the establishment across the world of hospital liaison committees to assist patients and ensure the awareness of clinicians in this respect. It noted that developments in medicine making it possible to perform complex surgery without blood transfusions, and also some highly publicised contaminated blood scandals, had brought about wider use of such techniques, leading to what is now known as Patient Blood Management, which had the endorsement of the World Health Organisation.

117. The intervenor then addressed the issues of advance medical directives and powers of attorney. It referred to the emergence of cases in Europe and North America in the 1970s and 80s that challenged medical paternalism (i.e., patients given little or no information about the treatment given; treatment imposed against patients' wishes). These decisions had affirmed the patient's right to self-determination as regards health care, a tendency mirrored in a series of international human rights instruments at regional and world level and also in texts adopted by the World Medical Association. The submission stated that individual Jehovah's Witnesses had experienced profound violations of their bodily autonomy and religious conscience in the 1970s and 80s, when blood transfusions were given when the person was under anaesthetic or brought to hospital unconscious. To avoid this, Jehovah's Witnesses began to carry advance medical directives on their

persons, clearly stating their refusal of blood transfusions in all circumstances. Many superior courts in various jurisdictions around the world had affirmed the binding nature of such directives, a trend that been noted and followed by the Court in its *Jehovah's Witnesses of Moscow and Others* judgment.

118. The EAJW submitted that the following issues had been clarified by the relevant decisions of this Court, domestic courts in Europe and domestic courts elsewhere:

– refusal of vital medical treatment is not tantamount to suicide, but a freedom of choice that is protected by self-determination, autonomy, human dignity and religious conscience.

– doctors are not exposed to civil or criminal liability when they refrain from treating a patient in accordance with the latter's wish, however expressed.

– the patient's refusal of blood transfusions does not mean refusal of all treatment; conversely, their acceptance of a particular course of treatment does not mean consent to a blood transfusion that may become necessary during the course of the treatment.

119. The EAJW concluded with an invitation to the Court to hold that the clear and precise decision of a capable patient regarding treatment, whether expressed orally or in an advance directive, cannot be overridden by doctors and courts.

(ii) The French Government

120. The intervening Government submitted that while both the Convention and the Oviedo Convention protected the personal autonomy of patients, the two treaties allowed the Contracting States a wide margin of appreciation in their legal provisions on consent to medical treatment designed to ensure a fair balance between protecting the patient's right to life, right to respect for private life and personal autonomy and, where applicable, religious freedom. The patient's right to consent was the means by which personal autonomy was protected in the sphere of health. National laws providing for the patient's prior and express consent to treatment, and allowing the patient to specify in advance their choices with respect to medical treatment in case they no longer have the requisite capacity when the moment comes, made the notion of personal autonomy effective. As recognised in the Court's case-law, imposing medical treatment on a capable adult patient represented an interference with their physical integrity. Yet such an interference could be acceptable if it complied with the conditions set down in the second paragraph of Article 8, as shown in various cases decided by the Convention organs, most recently the case of *Vavřička and Others v. the Czech Republic* [GC], nos. 47621/13 and 5 others, 8 April 2021.

121. The French Government referred to the interlinkages between Articles 2, 8 and 9 of the Convention, as acknowledged in the Court's

case-law. Article 2 placed States under a positive obligation to take measures to protect patients' lives. In the context of access to assisted suicide, the Court had ruled that States must ensure that a person's decision to put an end to their life is a free and informed one. In other words, the right to life implies providing safeguards ensuring that a person seeking to end their life has properly reflected on this decision, has taken it free of any pressure, and with knowledge of its implications and consequences. The same essential points – a free and informed decision – appeared in Article 5 of the Oviedo Convention governing consent. Thus, a statutory duty to provide comprehensive information to a person regarding their health and the available treatments, and also the consequences of refusing them, ensured that the person would be in a position to make a free and informed decision, as required by Article 2 of the Convention.

122. The same reasoning could be transposed to situations involving religious freedom. While the Court had already held that a Jehovah's Witness' decision to refuse blood was protected by Articles 8 and 9 of the Convention, this had been stated in cases that concerned the dissolution of religious communities. The context of the present case was very different. On the issue of advance directives affecting the individual's right to life, the Court had acknowledged that Member States were entitled to a margin of appreciation; this margin should be wider where there was no consensus among European States and where it concerned delicate moral issues. Furthermore, where the authorities had to strike a balance between competing private and public interests, or among conflicting Convention rights, this too indicated a wide margin of appreciation for the State. Accordingly, the Court had recognised a measure of discretion for States over whether to adopt legislation on assisted suicide, or on the withdrawal of treatment keeping a person alive artificially, or on euthanasia. In cases that involved scientific, legal and ethical questions, and particularly where there was no consensus, it was important that the Court allow the necessary latitude to States to define the desired societal balance between respecting the will and freedom of individuals and protecting life.

123. It followed from this that States should have the power to determine the conditions in which a doctor could dispense with the patient's consent. Where an emergency situation was concerned, this was already addressed by Article 8 of the Oviedo Convention. Outside of such situations, States should also have the power to determine the conditions in which a patient's advance instructions could be disregarded. This was reflected in the wording of Article 9 of the Oviedo Convention. In other words, just as it was for States to provide in their laws for the recognition of advance directives in relation to the end of a person's life, so they should be free to determine the form and status to be given to these. The organisation of the decision-making process, including the issue of who should take the final decision and the modalities for this, should also fall within the State's margin of appreciation, as

illustrated by the judgment in *Lambert and Others v. France* ([GC], no. 46043/14, ECHR 2015 (extracts)).

124. A further reason for allowing a wide margin of appreciation was the lack of common ground among European States in relation to the civil and/or criminal liability of doctors who treated a patient without having been able to obtain their consent. In a significant number of those States, the decision not to treat a patient – especially where this can lead to the patient's death – may result in criminal proceedings against the doctor. Hence the importance for doctors of making every effort to discover the patient's will and of verifying that a decision to refuse treatment was a free and informed one. In view of their potential liability, the clinician must take all necessary precautions to ensure that the patient's refusal of treatment was sufficiently clear and devoid of all ambiguity, in compliance with the applicable domestic law, complemented by the safeguards derived from the Convention.

3. *The Court's assessment*

(a) Preliminary observations

125. The Court notes at the outset that the case before it differs from certain previous cases that also involved the issues of respect for personal autonomy and the refusal of medical treatment. As she stressed in her submissions, the applicant wished to be cured of her ailment, and she was ready to accept all appropriate treatment, subject to her refusal of blood transfusion. This case is therefore to be distinguished from those that involved the wish of an individual to put an end to their life, whether by the withdrawal of life-sustaining treatment (*Lambert and Others*, cited above), euthanasia (*Mortier v. Belgium*, no. 78017/17, 4 October 2022) or assisted suicide (*Pretty v. the United Kingdom*, no. 2346/02, ECHR 2002-III, *Haas v. Switzerland*, no. 31322/07, ECHR 2011, and *Koch v. Germany*, no. 497/09, 19 July 2012). That is not to say that none of the general principles set out in those judgments are of relevance in the present context. The Court will return to this matter below.

126. The present case is also to be distinguished from those featuring disputes over the treatment of a child (see for example, *Glass v. the United Kingdom*, no. 61827/00, ECHR 2004-II) or the withdrawal of life-sustaining treatment from a child (see for example, *Parfitt v. United Kingdom* (dec.), no. 18533/21, 20 April 2021), in which the issue of safeguarding the child patient's best interests was the primary consideration. Nor does the applicant's refusal of blood transfusion involve any direct risk to the health of third parties.

127. Furthermore, given its setting in the general public health care system, the case is to be distinguished from those that involved the treatment of persons deprived of their liberty and who were thus under the control and responsibility of the State, be it in the criminal law context (as in *Bogumil*

v. Portugal, no. 35228/03, 7 October 2008) or the mental health context (as in *Aggerholm v. Denmark*, no. 45439/18, § 83, 15 September 2020).

128. Finally, the Court refers to its long-standing practice, which reflects the rule laid down in Article 31 § 3 (c) of the Vienna Convention, of interpreting the Convention taking into account any relevant rules of international law applicable in relations between the parties (see the *Decision on the competence of the Court to give an advisory opinion under Article 29 of the Oviedo Convention*, [GC], § 42, 15 September 2021). In the present context, it will take account of the relevant provisions of the Oviedo Convention, as ratified by the respondent State.

(b) The interference with the applicant's right to respect for private life

129. As already noted above, the applicant's choice of remedy was to seek to overturn the decision of the duty judge. She challenged it on the grounds of factual and legal error, and infringement of her rights under the Constitution and the Convention. She further submitted that the procedure followed had been flawed, notably in that she had been denied the opportunity to protect her rights and interests. The duty judge's decision was, she argued, the legal harm that had been done to her. The case having been argued on this basis domestically, it follows that what was there identified as the "legal harm" should now be considered to be the interference about which the applicant complains. The Court will therefore examine whether or not this interference can be accepted as justified in the light of the conditions set out in the second paragraph of Article 8. In so doing, it will situate the duty judge's decision in its relevant legal and factual context. Given the importance of procedural safeguards under Article 8 (see further below), the Court will also examine the decision-making process as a whole, that is to say the manner in which it was set in motion, was conducted and was subsequently reviewed.

130. Before proceeding, though, the Court finds it appropriate to clarify the following matter. In her submissions, the applicant sought to cast doubt on the clinical judgments made in her case, that is to say the assessments by the doctors at La Paz regarding the threat posed to her life on the day in question, the imperative of immediate surgical intervention following her arrival, and the absence of any alternative treatment that could save her. The Government went to some length to counter those submissions. The Court would recall here the position taken in its case-law regarding the responsibility of Contracting States under the Convention in the public health sphere, in particular where it is alleged that doctors have made an error of judgment in the treatment of a patient. In *Lopes de Sousa Fernandes v. Portugal* [GC], no. 56080/13, 19 December 2017, the Court clarified the scope of the State's responsibility under Article 2, affirming that only in very exceptional circumstances could the responsibility of the State be engaged in respect of the acts and omissions of health-care providers (see § 190). As long

as the necessary measures for securing high professional standards among health professionals and protecting lives of patients have been taken, errors of judgment with respect to clinical assessments and decisions could not be considered sufficient of themselves to hold a State accountable from the standpoint of its positive obligations under that provision (see §§ 186-187). The same position has been taken in cases pertaining to acts by health care providers brought under Article 8 (*Reyes Jimenez v. Spain*, no. 57020/18, § 28, 8 March 2022, *Mayboroda v. Ukraine*, no. 14709/07, §§ 51-54, 13 April 2023, and *Y.P. v. Russia*, no. 43399/13, § 49, 20 September 2022 from the standpoint of the State's positive obligations). The doctors at La Paz assessed that the applicant would be in an urgent, life-threatening situation upon arrival there and that, in order to survive, she would need surgery that was likely to require blood transfusions. The Court would reiterate that it is not its function to call into question the assessment of a person's health by medical professionals or their decisions on the treatment to be given (see in particular *Lopes de Sousa Fernandes*, cited above, § 198). This is especially so when such clinical assessments and decisions have not been directly challenged via appropriate means at the domestic level. As submitted by the Government, it would be inappropriate for the Court to entertain arguments of this nature and it will not do so in the present case. Therefore, and as follows from paragraph 95 above, the Court's focus is on whether the decision-making process as it operated in this case showed sufficient respect for the applicant's autonomy.

(c) Justification for the interference

(i) Lawfulness of the interference

131. The applicant maintained that the interference was the consequence of a failure to comply with the relevant provisions and principles of domestic law, and that the decision-making process in her case had been marred by legal errors that had ultimately gone uncorrected. The Government rejected this, asserting that domestic law had been duly followed in all relevant respects.

132. The Court recalls that its power to review compliance with domestic law is limited, it being primarily for the domestic courts to interpret and apply domestic law. Except where this has been done in an arbitrary or manifestly unreasonable way, the Court's role is confined to ascertaining whether the effects of that interpretation are compatible with the Convention (see, among others, *Sanchez v. France* [GC], no. 45581/15, § 128, 15 May 2023, with further references). As regards the applicant's argument that it is not a requirement of domestic law that a decision to refuse treatment be expressed in written form, the Court notes that at every stage of the decision-making process the position was consistently taken that verbal refusal of treatment was not sufficient. It also notes that the applicant did not support her

interpretation of domestic law with any examples drawn from domestic judicial practice. For the Court, it cannot be said that the stance taken by the duty judge and by the *Audiencia Provincial* in this regard was arbitrary or manifestly unreasonable. As the Constitutional Court dismissed the applicant's appeal as inadmissible on the basis of a summary procedure, it did not address this issue (see paragraph 53 above).

133. As for the applicant's argument that she had in any event expressed her refusal of blood transfusion in writing (referring to her advance medical directive, her continuing power of attorney and to the informed consent document signed at Soria hospital), the Court considers that the manner in which these documents were – or were not – taken into account in the decision-making process goes to the broader question of how the domestic framework actually operated in relation to the applicant, examined below. At this stage of its analysis, the Court is prepared to accept that the interference in this case was in accordance with domestic law.

(ii) Aim of the interference

134. The applicant submitted that the interference with her rights had not pursued any of the aims set out in the second paragraph of Article 8. Her rejection of blood transfusion was a strictly personal matter intimately connected with her religious beliefs with no repercussions for the rights or freedoms of anyone else, or for the general public interest in protecting health. The thrust of the Government's argument was that given the clinical emergency here, the aim expressly pursued by the duty judge in granting authorisation to treat the applicant was to safeguard her life and physical integrity. The case came within the exception to informed consent provided for in domestic law (Article 9.2.b) of Act No. 41/2002), the purpose of this provision being to ensure the protection of the life and health of patients.

135. The Court accepts the Government's position on this point. It observes that the emergency exception that is provided for in domestic law corresponds very closely in substance to the Oviedo Convention, read in light of the explanatory report (see also to similar effect paragraph 7.4 of Resolution 1859(2012) of the Parliamentary Assembly, and the World Medical Association's Declaration of Lisbon, both quoted above). All of these texts share the concern of permitting vital medical treatment to be given in emergency situations, in order to save the lives of patients when their will cannot be sufficiently established.

136. Furthermore, the State's duty under Articles 2 and 8 to ensure the protection of hospital patients – discussed further below – must also be borne in mind in this connection. It can therefore be said that the interference had as its aim "the protection of health".

(iii) Necessity of the interference

(α) Relevant case-law principles

– *On personal autonomy in the sphere of health care*

137. It has long been recognised by the Court that the right to respect for private life encompasses personal autonomy. As stated in the *Pretty* case, cited above, this is an important principle underlying the interpretation of the guarantees of Article 8 (at § 61; see also *Lambert and Others*, cited above, § 142). That judgment refers to personal autonomy as the right to make choices about one's body (at § 66; see also *Nicolae Virgiliu Tănase v. Romania* [GC], no. 41720/13, § 126, 25 June 2019).

138. In the sphere of health care, respect for personal autonomy is a general and fundamental principle. It is safeguarded notably by the universally recognised rule of free and informed consent. The legally competent patient who has been duly informed about his or her health condition and the available treatments, as well as the implications if no treatment is accepted, has the right to freely decide whether to give consent to treatment or to withhold it (see Article 5 of the Oviedo Convention and paragraphs 34-35 of its explanatory report, Article 3 of the Charter of Fundamental Rights of the European Union, and Article 6 of the Universal Declaration on Bioethics and Human rights, all quoted above). The Court has decided a number of cases involving the issue of consent to medical treatment, which mostly focussed on the need to ensure that the patient is placed in a position to take an informed decision about his or her health care (see as an early authority *Trocellier v. France* (dec.), no. 75725/01, ECHR 2006-XIV, and more recently *Mayboroda*, cited above, § 52, with further references). Another aspect that the Court has examined is whether the consent procedure laid down in the law of the respondent State was correctly followed. In this respect, the Court has stated that even if the Convention does not lay down any particular form of consent, where certain requirements are imposed by domestic law, these must be fulfilled; if they are not, an adequate and effective response to the patient's complaint is required from the domestic system (see *Reyes Jimenez*, cited above, §§ 36-38).

139. As for the refusal of treatment, in *Pretty* the Court stated that while this might lead to a fatal outcome, the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention (at § 63; see also *Lambert and Others*, cited above, § 180).

140. The right to refuse medical treatment, specifically the religious objection to blood transfusion, featured in the cases *Jehovah's Witnesses of Moscow and Others v. Russia* (cited above) and *Taganrog LRO and Others v. Russia* (nos. 32401/10 and 19 others, 7 June 2022). As the respondent Government and the intervening Government have pointed out, the context

of those cases was very different to that of the present one. They involved the dissolution and banning of Jehovah's Witness organisations in Russia. Consequently, the Convention rights at issue were different, notably those of freedom of association and freedom of religion. The right of the patient to refuse medical treatment was not directly addressed as such. Even so, these judgments may be recalled here inasmuch as they affirm, in relation to Jehovah's Witness beliefs, the principles set out in *Pretty*. In *Jehovah's Witnesses of Moscow and Others*, the Court stated that the freedom to accept or refuse specific medical treatment was vital to self-determination and personal autonomy. A competent adult patient was free to decide on surgery or medical treatment, including blood transfusion. It referred to cases decided in various jurisdictions concerning the refusal of blood by Jehovah's Witnesses in which the position taken was that although the public interest in protecting the life and health of patients was legitimate and very strong, the interest of patient autonomy was stronger still, and that free choice and self-determination were themselves fundamental constituents of life. The Court also observed that in the absence of any need to protect third parties, the State had to abstain from interfering with the individual's freedom of choice regarding health care (see § 136; see also *Taganrog LRO and Others*, cited above, § 162).

– *On the duty of the State to protect the life and health of patients*

141. As the Court has often affirmed, the Convention must be read as a whole (see, among many authorities, *Haas*, cited above, § 54, and *Lambert and Others*, cited above, § 142). Given that in the present case the applicant was assessed as facing an imminent danger to her life, it is necessary to have regard to the principles that the Court has derived regarding the Contracting Parties' duty to safeguard patients. Thus, in *Lopes de Sousa Fernandes*, cited above, it was stated that the Contracting States' substantive positive obligation under Article 2 requires that they enact regulations compelling public and private hospitals to adopt appropriate measures for the protection of patients' lives (at §§ 166 and 186). A parallel duty has been derived from Article 8 with respect to patients' physical integrity (see *Mayboroda*, cited above, § 51).

142. In addition, as already noted (see paragraph 125 above), the principles set out in certain cases that concerned end-of-life situations are not, despite the very different subject-matter, devoid of relevance for the present case. The Court emphasised there the necessity of robust legal and institutional safeguards in the relevant decision-making process so as to ensure that a decision of such consequence is explicit, unambiguous, free and informed. The person has to be truly conscious of the implications of what they are asking for and must be protected against pressure and abuse (see in particular *Mortier*, cited above, at §§ 139 and 146).

143. The Court has also adverted to the importance of establishing that the patient still has the capacity to take such a decision, if there are circumstances that may give rise to doubt in this regard. The case of *Arskaya v. Ukraine* (no. 45076/05, 5 December 2013) involved a complaint under Article 2 about the failure to protect the life of the applicant's adult son, who died following his persistent refusal of the necessary treatment for a serious respiratory illness. At the time, the deceased had shown signs of mental disorder, but his refusals had nevertheless been taken at face value by the doctors treating him. The Court considered that, from the standpoint of Article 2, a clear stance should have been taken by the medical staff regarding the validity of the deceased's refusal of life-saving treatment so as to remove the risk that that decision was made without a full understanding of its implications. It pointed to the need for sufficient guarantees in this respect, and for a regulatory framework which adequately ensures that, where necessary, a patient's decision-making capacity can be promptly and objectively established via a fair and proper procedure (see *Arskaya*, cited above, § 88).

– *On procedural safeguards*

144. Finally, while Article 8 does not contain any explicit procedural requirements, it is important for the effective enjoyment of the rights guaranteed by this provision that, where decisions are taken that impinge upon a person's private life, the decision-making process is fair and such as to afford due respect for the interests safeguarded by it. In this regard the Court examines whether, in light of the particular circumstances of the case and notably the nature of the decision to be taken, the person affected has been sufficiently involved in the decision-making process, seen as a whole, to afford them the requisite protection of their interests (see *R.R. v. Poland*, no. 27617/04, § 191, ECHR 2011 (extracts)). Such an examination allows the Court to satisfactorily assess whether the reasons adduced by national authorities to justify their decisions were "sufficient" for the purposes of Article 8 § 2 (see *Fernández Martínez v. Spain* [GC], no. 56030/07, § 147, ECHR 2014 (extracts)).

145. Furthermore, in the authorities referred to above, *Lopes de Sousa Fernandes* and *Mayboroda,* the Court stated that the obligation to put in place a regulatory framework protecting patients must be understood in a broader sense which includes the duty to ensure the effective functioning of that framework. The regulatory duties thus encompass necessary measures to ensure implementation, including supervision and enforcement (*Lopes de Sousa Fernandes*, cited above, § 189, *Mayboroda*, cited above, § 53).

(β) Reconciling the Convention rights and duties at stake

146. The Court has not yet had the opportunity in its practice to consider how the Convention rights and duties referred to above are to be reconciled in an emergency situation. It would commence by affirming the position that comes through clearly in its existing case-law in relation to patient autonomy, namely that in the ordinary health care context it follows from Article 8 of the Convention that the competent, adult patient has the right to refuse, freely and consciously, medical treatment notwithstanding the very serious, even fatal, consequences that such a decision might have. It is a cardinal principle in the sphere of health care that the right of the patient to give or withhold consent to treatment has to be respected. As important as that right is, however, its location within the scope of Article 8 means that it is not to be construed in absolute terms. The right to respect for private life, being the broader right that encompasses patient autonomy, is a qualified right. The exercise of any facet of that right may therefore be limited in accordance with the second paragraph of Article 8 (see for example *Pretty*, cited above, § 70).

147. In a situation involving real and imminent danger for an individual's existence, the right to life will also be in play, in tandem with the individual's right to decide autonomously on medical treatment. From the perspective of the State, its duties to ensure respect for both of these rights will likewise be engaged, that is to say its duties deriving from Article 8 and Article 2 of the Convention. Concerning the latter provision, the Court reiterates that the right to life ranks as one of the most fundamental provisions in the Convention and also enshrines one of the basic values of the democratic societies making up the Council of Europe. It requires the State not only to refrain from the "intentional" taking of life, but also take appropriate steps to safeguard the lives of those within its jurisdiction (see *Lopes de Sousa Fernandes*, cited above, § 164, and also *Lambert and Others*, cited above, § 117).

148. While it was stated in *Jehovah's Witness of Moscow and Others* that the public interest in preserving the life or health of a patient must yield to the patient's interest in directing the course of his or her own life, the Court also acknowledged that the authenticity of refusal of medical treatment is a legitimate concern, given that the patient's health and possibly life itself are at stake (see § 138 of that judgment). This is consistent with the requirement that the Court has derived from Article 2 for robust legal safeguards and sufficient guarantees where the patient's very life is at stake, referred to at paragraphs 142-143 above. What must be ensured is that, in an emergency situation, a decision to refuse life-saving treatment has been made freely and autonomously by a person with the requisite legal capacity who is conscious of the implications of their decision (see Article 5 of the Oviedo Convention and paragraph 34 of the explanatory report in relation to this provision, set out at paragraph 72 above). It must also be ensured that the decision – the existence of which must be known to the medical personnel – is applicable in the circumstances, in the sense that it is clear, specific and unambiguous in

refusing treatment, and represents the current position of the patient on the matter (see Article 9 of the Oviedo Convention and paragraph 62 of the explanatory report in relation to this provision, set out at paragraph 72 above; see also the *Arskaya* case, cited above, at § 88).

149. It follows that where in an emergency there are reasonable grounds to doubt the individual's decision in any of these essential respects, it cannot be considered a failure to respect his or her personal autonomy to proceed with urgent, life-saving treatment. The Court observes that this position is fully in harmony with Article 8 of the Oviedo Convention, which permits in an emergency situation an exception, that must be narrowly construed, to the general rule of consent. It also follows from the weight to be accorded to respecting the patient's autonomy that reasonable efforts should be made to dispel the doubt or uncertainty surrounding the refusal of treatment. As the Court has previously observed, albeit not in the same context, the wishes of the patient must be treated as being of paramount importance (see *Lambert and Others*, cited above, § 147). The text of Article 8 of the Oviedo Convention does not further elaborate on what is required in such circumstances. In relation to this provision the explanatory report underlines the need for health care professionals "to make every reasonable effort to determine what the patient would want". What constitutes a "reasonable effort" will necessarily depend on the circumstances of the case and may also be influenced by the content of the domestic legal framework.

150. Where, despite reasonable efforts, the physician – or the court, as the case may be – is unable to establish to the extent necessary that the patient's will is indeed to refuse life-saving medical treatment, it is the duty to protect the patient's life by providing essential care that should then prevail.

– *Previously expressed wishes of the patient*

151. The Court refers to Article 9 of the Oviedo Convention, according to which the previously expressed wishes of a patient who is not, at the time of the intervention, in a position to express his or her wishes "shall be taken into account". As stated in the corresponding passage of the explanatory report to this treaty, it was not intended that such wishes must be automatically followed in all circumstances. It is acknowledged that there may be a need to verify that wishes previously expressed remain applicable and valid in a given situation (see paragraph 62 of the explanatory report, set out above; see also the World Medical Association's Statement on Advance Directives, quoted at paragraph 80 above).

152. The Oviedo Convention does not enter any further into the arrangements that States must or may make with respect to previously expressed wishes. Nor does Article 8 of the Convention. While the principal institutions of the Council of Europe have taken positions in favour of advance directives and continuing powers of attorney in the medical sphere, the Court notes that, in keeping with their non-binding nature, these positions

contemplate considerable discretion for States regarding the status of and the modalities in relation to such instruments.

153. In the Court's view, the aforementioned texts reflect both the complexity and the sensitivity that attach to the introduction and operation of a system of advance medical directives (and similar instruments). As found by the comparative survey that was completed for the purposes of the present case, while a considerable number of Council of Europe member States have specific provisions and arrangements in place for advance medical directives, or for taking into account previously expressed wishes, they have not done so in a uniform manner. In the other States surveyed, domestic law does not include provisions dealing specifically with the previously expressed wishes of patients regarding medical treatment. Therefore, it appears that there is a diversity of practice in Europe when it comes to the modalities for reconciling as far as possible the right to life and the right to respect for the autonomy of the patient by taking account of previously expressed wishes. In light of the above considerations, the Court takes the view that both the principle of giving binding legal effect to advance directives, as well as the related formal and practical modalities, come within the margin of appreciation of the Contracting States.

(γ) Application of the above principles and considerations to the present case

– *Safeguards under the domestic legal framework*

154. As stated above (see paragraph 129), the Court's examination of the interference with the applicant's right to respect for her private life, which took the form of the decision of the duty judge, will take account of the legal and factual context in which that decision was given. That context is formed principally by Act No. 41/2002, legislation that is primarily concerned, as its title indicates, with respect for patient autonomy. The rules and modalities for the exercise by the patient, in a free and informed manner, of the right to give, withhold or revoke consent to medical treatment are detailed in the Act. The Court has already had the occasion to consider the provisions of the Act that govern the giving of consent and observed that they were fully in conformity with the corresponding provisions of the Oviedo Convention (see *Reyes Jimenez*, cited above, § 32).

155. As for the applicant's disagreement with the position of the *Audiencia Provincial* that the patient's refusal of treatment must be given in writing in order to be valid – a position shared by the Government –, the Court observes that to require that refusal of medical treatment be given in written form is not *per se* at variance with Article 8 of the Convention, which does not contemplate any particular form in relation to consent (see *Reyes Jimenez*, cited above, § 36). The same is true of the Oviedo Convention (see Article 5 of that treaty and paragraph 37 of its explanatory report, set out above).

156. In arguing that she had in any event expressed her refusal of blood transfusion in writing, the applicant referred, *inter alia*, to the advance medical directive that she drew up and filed with the Register of Castile and Leon in August 2017. While the significance of her directive, in the context of the interference complained of, will be considered below, the Court observes that, exercising its power of appreciation in this respect (see paragraph 153 above), the respondent State has chosen to confer binding effect on advance medical directives, and has made specific practical arrangements in order to ensure that the instructions given by patients are known and followed in the health care system throughout the national territory. The Court would underline that where such a system has been put in place, which is a choice falling within the State's margin of appreciation, and is relied on by patients who have made use of it correctly, it is important that it functions effectively to achieve its purpose.

157. Another feature of Act No. 41/2002, which the Government regarded as being of central relevance to the case, is the limitation on consent that is provided for in Article 9.2b). The Court notes the correspondence between this provision and Article 8 of the Oviedo Convention, the purpose of both provisions being to directly authorise essential interventions in emergency situations in which there is a serious and immediate threat to the patient's health, and where the patient's consent cannot be obtained. Article 9.2b) adds the condition of consulting, when circumstances permit, with members of the patient's family or persons with *de facto* ties to him or her.

158. The applicant has not sought to argue that the facts of the case disclose any deficiency in the framework formed by Act No. 41/2002 and the related legal texts. Indeed, having opted for a system of advance medical directives, Spain's regulatory framework in that regard appears well-developed, and is guided by the relevant provisions and principles of the Oviedo Convention concerning patient autonomy. The legal context of this case should also be taken as including the relevant constitutional jurisprudence, this having been pleaded by the applicant in the domestic proceedings and brought to the attention of this Court by both parties. The Court notes significant similarities between its own case-law and that of the Constitutional Court, notably in recognising the right of a legally competent patient to reject a form of medical treatment, including where this is likely to produce a fatal outcome. Furthermore, constitutional case-law affirms the need to justify the administering of medical treatment against the patient's will, with reference to the principles of necessity, proportionality and respect for the essence of the patient's autonomy (see paragraph 62 above).

– *The application to the duty judge*

159. The doctors' application was made by fax shortly after the ambulance left Soria hospital and following telephone contact with it. The Court has been informed that it was the standard practice of La Paz hospital

to apply to the courts when a patient put their life at risk by refusing blood transfusions, and to provide the duty judge with all relevant information about the patient. Regarding the applicant, the information provided was very limited, omitting elementary matters such as her name and her age. The Government conceded at the hearing that the fax was inaccurate inasmuch as it informed the duty judge that the applicant was rejecting "all types of treatment". The Court points out that the fax also specified that the applicant's refusal was verbal. This gave to understand – and was so understood by the duty judge – that the applicant's refusal had only been verbal. What was not communicated to the duty judge was the information that the previous night at Soria hospital a clinician (Dr B.L.) had gone through the relevant consent procedure with the applicant, who had expressed her refusal of blood transfusion in writing on the informed consent document. In spite of the controversy that later arose regarding the signatures on this document, the fact that it was signed by the applicant on 6 June 2018 is attested in the applicant's medical records and was later confirmed by the regional health authority (see paragraph 54 above).

160. The Government have not clearly explained why this information was not included or referred to in the application to the duty judge. They stated that in applying to the courts the La Paz doctors passed on the information that they had regarding the applicant at that particular point in time (see paragraph 107 above), implying that they had not yet specifically been made aware that the applicant had in fact expressed her firm refusal of blood transfusion in writing while under the care of Soria hospital. The Court observes that while it is understandable that the application to the duty judge was made in anticipation of the applicant's arrival at La Paz, the lack of this information in the fax had a determinative effect on the decision making in relation to the applicant's care. In a system in which, as later confirmed by the *Audiencia Provincial*, the refusal of medical treatment needs to be expressed in writing, that lacuna can only be regarded as a significant one, and it was not made good later on.

– *The consideration of the application by the duty judge*

161. The information before the judge, which was both very limited and incomplete, related to the applicant's faith, the very worrying clinical signs, the doctors' fears regarding her state on arrival, and her having verbally rejected all types of treatment. With only these elements of information in her possession, and very limited time, the duty judge contacted two officials, the forensic doctor and the local prosecutor. From the forensic doctor the judge obtained a short report assessing the information contained in the fax from La Paz. The forensic doctor confirmed the life-threatening nature of the applicant's condition. Aside from that, the forensic doctor noted that the patient's capacity at that time to grant or refuse consent was unknown, as was the nature of the treatment that she would receive at La Paz. For her part, the

local prosecutor took it that, based on the information provided, there was no reliable evidence of refusal of medical treatment by the applicant. She concluded in favour of authorising the necessary treatment.

162. The Court observes that in their assessment of the situation, the abovementioned officials started from the assumption that the applicant's refusal was only verbal. As for the issue of the applicant's decision-making capacity at the time, it was acknowledged that this was unknown. As stated above, the existence of doubt in relation to the patient's wishes calls for a reasonable effort from the competent decision maker to dispel it (see paragraph 149 above). The Court would underline that it is sensitive to the very pressing circumstances that confronted the duty judge. The doctors had stressed the gravity of the situation and requested a reply as soon as possible, which the duty judge gave within one hour and after having consulted the forensic doctor and the prosecutor. It notes, however, that no step was taken in relation to the doubt raised by the forensic doctor, nor was it alluded to in the formulation of the impugned decision (see under the following sub-heading).

– *The terms of the decision*

163. The duty judge's decision referred in the first place to constitutional principles. Referring specifically to the judgment of the Constitutional Court of 27 June 1990, it emphasised the individual's right to life and the duty of the public authorities to uphold it. It considered that this fundamental right set limits to the right to freedom of religion. In the second part of the reasoning, the decision invoked the right to life as the supreme legal value. The applicant criticised this reasoning as relying on an outdated precedent.

164. The Court would note first of all that any assessment of the decision must bear in mind the limits inherent in the form of the proceedings and the urgency with which they had to be conducted. In such circumstances, extensive legal reasoning was not feasible. With respect to the applicant's criticism above, the Court reiterates that its power to review compliance with domestic law is limited (see paragraph 132 above). That said, it observes that the duty judge's reference to the 1990 case-law of the Constitutional Court appears incomplete inasmuch as it drew on what that judgment stated with respect to the right to life, but not on what it said regarding the right to physical and moral integrity and, linked to that, the importance of consent to medical interventions as well as the manner in which the two rights should be reconciled (see paragraphs 61-62 above).

165. Viewed from the perspective of the Convention and the applicable principles that have been laid out above, the Court observes that the reasoning of the decision clearly addressed the importance of protecting the right to life. As for the importance of respecting the right of the patient to decide autonomously on medical treatment, it appears that this was considered to a lesser extent. The issue of consent featured in the decision, insofar as the

judge adopted the position that there was no reliable evidence before her that the applicant was refusing treatment. But it did not advert at all to the issue whether the applicant retained sufficient capacity to be still able to take, in the required form and in the time that was still available, a decision about the treatment that she would accept or not. Referring to the fatal consequences that would ensue if treatment were withheld, authorisation was granted in unqualified terms to give the applicant whatever treatment was necessary to save her. In effect, the decision transferred the power to decide, as from the moment it was given, from the applicant to the doctors.

166. The Government emphasised that the judge had acted consistently with the provision governing emergency situations in which the patient's consent simply could not be obtained (Article 9.2b) of Act No. 41/2002). The Court notes, however, that the decision made no reference to this provision, or to any other part of the Act in question, or to whether it was possible to consult with the applicant's relatives or persons with *de facto* ties to her.

– *The implementation of the decision*

167. The duty judge's decision was transmitted to La Paz at 1.36 p.m., approximately one hour before the arrival of the ambulance (it not being possible to establish the exact time that the applicant reached La Paz). The applicant was taken into the operating theatre at 3 p.m. and prepared for surgery. The information available to the Court suggests that there was no real communication between the medical staff and the applicant about the impending intervention. The usual consent procedure was not followed, and no mention at all was made of the decision issued by the duty judge. In return, the applicant did not reiterate her refusal or refer to any written document stating that refusal. The applicant was recorded in La Paz as being conscious at that time, and indeed fully alert according to the Glasgow Coma Scale (see paragraph 31 above). During the oral hearing on 10 January 2024, a senior doctor from La Paz, who had not treated the applicant, explained that in view of her gravely weakened state it could not be assumed that she was sufficiently lucid to refuse blood transfusion, and that the necessary testing could not be done at that stage. For its part, the *Audiencia Provincial* took it that the applicant had been able to freely express her will at the time of the surgery (see paragraph 45 above). According to the Government, it was not feasible for the doctors to then inquire into the existence of an advance medical directive and verify its content.

168. The Court is evidently not in a position to make its own assessment about the applicant's capacity to give or refuse consent to medical treatment when she reached La Paz hospital. Its focus in these proceedings is on the decision-making process that was followed in relation to the applicant's medical care, in which it has noted with concern that the applicant's capacity was not a factor taken into consideration. In addition, the Court cannot but

observe that the authorisation to proceed with treatment was acted on without further ado.

– *The review of the decision*

169. The applicant sought to have the decision set aside and also brought a subsidiary appeal against it. She subsequently lodged an *amparo* appeal with the Constitutional Court, which summarily dismissed it for a clear absence of any violation of a fundamental right.

170. The Court will focus on the subsidiary appeal, as it was the subject of the more significant of the two appellate rulings. The *Audiencia Provincial* examined the lawfulness of the decision of 7 June 2018 principally in the light of Act No. 41/2002. It took the position that the applicant had retained the capacity to express her will. The Government submitted that this position was not to be taken as a finding of fact regarding the applicant's degree of lucidity at the relevant time. The Court notes that the position of the *Audiencia Provincial* did not result from any assessment of evidence regarding the applicant's condition; whether or not her cognitive capacity had been impaired was thus not examined at any point in the judicial proceedings. It would further observe that by adopting this position, the appellate court took the case outside of the scope of Article 9.2b) of Act No. 41/2002, which is premised on the impossibility of obtaining the person's consent to treatment. It also took the case outside of the scope of Article 11 on advance medical directives, which is premised on the person not being able to express his or her wishes personally. The *Audiencia Provincial* treated the applicant's advance medical directive as inapplicable in the circumstances (see paragraph 46 above).

171. Holding that consent had to be given in written form, the *Audiencia Provincial* limited itself to noting that the absence of the applicant's signature on the copy of the informed consent document provided to it prevented it from finding that the applicant had either refused or accepted the treatment. On this basis, it affirmed the lawfulness of the decision and dismissed the appeal.

– *Overall assessment of the decision-making process*

172. In the light of the foregoing, the Court will now make an overall assessment of the decision-making process as a whole, taking account of the domestic legal context (see paragraph 129 above). As already observed, the domestic framework for ensuring that patient autonomy is respected within the Spanish health system appears to be a well-developed one, and its features as such have not been criticised by the applicant. Indeed, it can be said to represent a judicious balancing by the legislature between the fundamental rights of patients, the corresponding duties of the State and weighty public interests. The applicant relied on that framework and took the relevant steps

to make clear her refusal of blood transfusions, this being for her a matter of profound religious importance. Following the diagnosis of her condition in 2017, she took the precaution of registering an advance medical directive so that her instruction regarding transfusion would be known and respected by her caregivers if the situation were to come about in which she was not in a position to express her will. Her directive was accessible through the electronic system used in the health service of Castile and Leon and through the National Register. Following her hospitalisation in Soria, and before her transfer to La Paz, her refusal of consent to transfusion was given in the required written form, and the fact of this was noted in her medical records. As the Government observed in their pleadings, her wishes were clearly known and fully respected while she was under the care of Soria hospital. It was further affirmed that in ordinary circumstances, a refusal of treatment validly given by a competent patient will always be respected in the Spanish system.

173. The Government also made reference to the fact that La Paz hospital is situated in a different Autonomous Community, that of Madrid. The Court has no doubt that the two hospitals sought to cooperate in caring for the applicant. It has not been informed of the exact content of the applicant's medical records which were transmitted from Soria to La Paz (see paragraph 22 above). Nor have the Government explained why the doctors at the receiving hospital seem not to have been fully informed about the applicant's written refusal of blood transfusion. By the time the ambulance arrived bearing the applicant's medical records, authorisation had already been given in unqualified terms by the duty judge to proceed with the treatment considered by the doctors to be necessary to safeguard the applicant's life and physical integrity (see paragraphs 28 and 165 above).

174. The applicant's advance medical directive, which was accessible through both the Castile and Leon and the National Registers, appears not to have been mentioned at all in the contacts between the two hospitals. Yet given what has been explained in the present proceedings about the effects that the applicant's condition – severe anaemia – can have on a person's lucidity, and given the binding status of advance directives in the domestic system, it appears to the Court that this would have been a highly relevant piece of information to bring to the attention of the La Paz medical team when the applicant's transfer was being arranged.

175. The key feature of this case is the decisive involvement of the duty judge, said to be a standard practice for La Paz hospital when caring for a patient who refuses blood transfusion (see paragraph 107 above). The Court has recognised the important role that courts can play in resolving disputes or giving legal guidance in relation to medical treatment. This is to be seen, for example, in the *Glass* case, cited above, in which it was precisely the non-involvement of the courts in resolving the dispute between the doctors and the patient's family that was the reason for finding a violation of Article 8

(see also, in a different context, the significance attached to judicial remedies in *Lambert and Others*, cited above). However, the benefits of judicial decision-making on delicate issues arising in difficult circumstances will necessarily depend on the information that is provided to, or can be obtained by, the decision maker. It was explained at the hearing of 10 January 2024 that in practice applications from La Paz hospital to the duty judge include all relevant information about the patient to allow for a sufficient examination of the request, and that in certain cases the decision was that the patient's refusal of treatment was to be respected. It was further explained that the present case had been unusual, precisely because of the very limited information in the possession of the La Paz doctors when they made their application. However, irrespective of the scope of the information available to those doctors, the fact remains that the duty judge was left with an incomplete factual basis on which to take a decision.

176. As recalled above, procedural safeguards need to be available in the process that leads to a decision which impinges on a person's right to respect for private life. The case-law refers *inter alia* to the importance of affording due respect to the relevant interests at stake, and of a degree of involvement in the relevant process for the person affected so as to afford the requisite protection of his or her interests. These criteria are assessed in light of the circumstances of the case and the nature of the decision taken. The particular feature of this case is that the right now relied on by the applicant arose in tandem with her right to life, requiring the consideration of both. The Court can accept that in view of the circumstances and the degree of urgency, the practical possibility to involve the applicant at what was the critical stage of the process – the proceedings before the duty judge – was greatly diminished. It also severely limited the possibilities open to the duty judge to undertake any further inquiries into the facts of the situation brought before her. This made it all the more important to give the decision-maker an adequate factual basis for a decision that, either way, was of very great consequence for the applicant.

177. With respect to the urgent threat to the applicant's life, it is clear that the judge was sufficiently apprised on this vital matter. On the other hand, with respect to the applicant's autonomy, the information regarding her refusal of treatment was incorrect (see paragraph 159 above) and incomplete, and referred neither to the informed consent document nor to the advance medical directive. The Court has noted the Government's argument that the applicant's decision of the day before could not automatically be taken to be her final word on the matter, as that decision had been taken when an alternative treatment in the receiving hospital, La Paz, was considered possible. It was stated by the Government at the hearing that practice showed that some La Paz patients changed their minds about refusing treatment when they realised that they were in a life-or-death situation. For her part, the applicant stated that she would not have wavered in her fidelity to her

religion's teaching, whatever the consequences. The Court would make the point that what is at issue in this case is the right of the competent patient to decide autonomously on their health care. That evidently includes the freedom to change one's decision as much as to maintain it. The question whether the applicant had the capacity to do so was a crucial one, given that there was an advance medical directive on record to ensure that her refusal of blood transfusion would remain operative in the event of her being unable to take such a decision at the relevant point in time according to Spanish law. Yet that issue was not put to the judge at the outset. While it was alluded to by the forensic doctor during the consideration of the application, it was not expressly addressed in the decision that was given. Rather, it was implicitly answered in the negative with the authorisation that was given to proceed directly with the necessary treatment without needing to obtain consent. The Court further observes that nothing was said regarding the safeguard provided for in domestic law where the patient's consent cannot be obtained, i.e., consultation when circumstances permit of relatives or of persons with *de facto* ties to the patient (Article 9.2b) of Act No. 41/2002). Nor was any such step taken following the notification of the decision to La Paz.

178. Coming to the review of the decision at the appellate stage, the Court observes that this was the first opportunity for the applicant to be heard by the judicial authorities and, as set out above, she contested both the factual basis and the legality of the contested decision (see paragraphs 37-39 above). Two key elements of the ruling of the *Audiencia Provincial* have been noted above, concerning the applicant's capacity and the unsigned version of the informed consent document (see paragraphs 170-171 above).

179. Regarding the first element, for the Court the position adopted by the appellate court that the applicant had been in a position to freely decide whether or not to accept a blood transfusion seems to beg the question why the authorisation to proceed with treatment was given in unqualified terms, as if there had been reason to consider – or at least to doubt – that she had by then lost the capacity to make a decision. As already noted, the effect of the decision was to transfer away from her, and without her knowing it, the power of consent in relation to medical treatment. It is not clear to the Court that this sits well with a domestic framework, such as that applicable in Spain, which gives great importance to respecting the wishes of a competent patient.

180. On the second element, the *Audiencia Provincial* considered that the missing signature had not been accounted for by the applicant. It did not further inquire into the matter, which was therefore left unresolved. Even now, and despite the parties' further submissions, it remains unexplained how it came about that the version obtained by the applicant, from a public hospital that had treated her, for the appellate proceedings lacked her signature. That she signed the document on the date in question is affirmed by both parties, by the contemporaneous medical notes, and by the regional health authority. Since, under the domestic framework, it is required that refusal of treatment

be expressed in writing, and the review of the duty judge's decision ultimately turned on it, the Court has difficulty understanding why such a central issue ultimately remained unelucidated by the competent court. Furthermore, it appears to the Court that it should follow from the position taken by the appellate court on the applicant's capacity to decide on her treatment that she should have been given the opportunity to do so in the required written form. This point was not pursued, however. In view of the Constitutional Court's rejection of the *amparo* appeal, both of the abovementioned matters remained unaddressed by the end of the domestic proceedings.

181. The Court fully appreciates that the actions taken in relation to the applicant on the day in question by the staff of both hospitals were motivated by the overriding concern to ensure the effective treatment of a patient who was under their care, in keeping with the most fundamental norm of the medical profession. It does not question their assessments regarding the severity of the applicant's condition at the time, the urgency of the need to treat her, the medical options available in the circumstances, or that the applicant's life was saved that day.

182. However, the authorisation by the duty judge to proceed with whatever treatment was considered necessary resulted from a decision-making process that was affected by the omission of essential information about the documenting of the applicant's wishes, which had been recorded in various forms and at various times in writing. Since neither the applicant nor anyone connected with her was aware of the decision taken by the duty judge, it was not possible, even in theory, to make good that omission. Neither this issue, nor the issue of her capacity to take a decision, were addressed in an adequate manner in the subsequent proceedings. In light of this, it cannot be said that the domestic system adequately responded to the applicant's complaint that her wishes had been wrongly overruled (see *Reyes Jimenez*, cited above, §§ 37-38; see also paragraph 138 above).

– *Conclusion*

183. In the Court's view, the shortcomings identified above (see paragraphs 172-182) indicate that the interference complained of was the result of a decision-making process which, as it operated in this case, did not afford sufficient respect for the applicant's autonomy as protected by Article 8, which autonomy she wished to exercise in order to observe an important teaching of her religion.

184. It follows that in the applicant's case her right to respect for private life under Article 8 of the Convention, read in the light of Article 9, has been violated.

II. APPLICATION OF ARTICLE 41 OF THE CONVENTION

185. Article 41 of the Convention provides:

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

A. Damage

186. The applicant claimed 45,000 euros (EUR) in respect of non-pecuniary damage that she considered she had suffered on account of the hysterectomy performed on her without her consent and the blood transfusions given to her contrary to her wishes and profound religious beliefs. She considered that these acts represented egregious breaches of her Convention rights, contrary to her dignity, self-determination and religious conscience, and that she had experienced intense feelings of humiliation as a result.

187. The Government objected to the applicant's reference in this context to the hysterectomy, arguing that she had not in fact challenged this during the domestic proceedings, and that her position in those proceedings had been that the surgical procedures performed on her were of lesser importance than the fact that the doctors had been authorised to save her life. Given the circumstances, the Government considered that in the event the Court found a violation, that would constitute in itself sufficient reparation for any non-pecuniary damage suffered by the applicant. They further submitted that without the medical interventions that had been performed, the applicant would certainly have died and no application could have been made to the Court. The fact that her life had been saved should be treated as sufficient to compensate for any failure to respect her rights.

188. The Court reiterates that the awarding of sums of money to applicants by way of just satisfaction is not one of its main duties but is incidental to its task under Article 19 of the Convention of ensuring the observance by States of their obligations under the Convention (see *Nagmetov v. Russia* [GC], no. 35589/08, § 64, 30 March 2017). The Court enjoys a certain discretion in the exercise of that power, as the adjective "just" and the phrase "if necessary" attest (see *Yüksel Yalçınkaya v. Türkiye* [GC], no. 15669/20, § 422, 26 September 2023; and *Molla Sali v. Greece* (just satisfaction) [GC], no. 20452/14, § 32, 18 June 2020, with further references). Depending on the circumstances, the Court may also consider that a finding of a violation constitutes sufficient just satisfaction and thus dismiss related claims (see *Nagmetov*, cited above, § 70, and the cases cited therein). The Court's guiding principle as regards just satisfaction on account of non-pecuniary damage is equity, which involves flexibility and an objective consideration of what is just, fair and reasonable in all the circumstances of

the case, including not only the position of the applicant but the overall context in which the breach occurred (see *Yüksel Yalçınkaya*, cited above, § 423; *Varnava and Others v. Turkey* [GC], nos. 16064/90 and 8 others, § 224, ECHR 2009; *Al-Jedda v. the United Kingdom* [GC], no. 27021/08, § 114, ECHR 2011; and *Nagmetov*, cited above, § 73).

189. The Court would clarify that its finding of a violation in relation to the applicant's complaint rests on its assessment that the decision-making process followed in her case did not afford sufficient respect for her autonomy. As emerges from her submissions in support of her claim for just satisfaction, what occurred in this case has caused the applicant significant distress. The Court therefore considers it appropriate to make an award of compensation for non-pecuniary damage.

190. In the light of the above, making its assessment on an equitable basis, the Court awards the applicant EUR 12,000 in respect of non-pecuniary damage, plus any tax that may be chargeable.

B. Costs and expenses

191. The applicant submitted a claim for EUR 14,000 plus any applicable tax for the costs and expenses that she had incurred before the Court. In support of this she submitted a legal services agreement dated 20 December 2019 concluded between herself and her two legal representatives at that time, Messrs. Muzny and García Martín. Under that agreement, she undertook to pay her representatives EUR 1,500 each for preparing her application to the Court, and EUR 1,000 each for preparing her response to the Government's submissions before the Chamber. The agreement became binding when signed by the applicant and her legal representatives, with payment due within three months of the Court's ruling on the case. Following relinquishment of the case to the Grand Chamber, the applicant entered into a supplementary agreement, dated 9 August 2023, with Messrs. Muzny, García Martín and Brady. This provided for a payment of EUR 3,000 to each representative for the preparation of her written submissions to the Grand Chamber and participation in the hearing.

192. As regards the claim for costs and expenses incurred before the Chamber, the Government considered that the applicant had not proved that she had effectively incurred them. They did not submit any observations concerning the applicant's additional request for reimbursement of costs and expenses before the Grand Chamber.

193. According to the Court's case-law, an applicant is entitled to the reimbursement of costs and expenses only in so far as it has been shown that these have been actually and necessarily incurred and are reasonable as to quantum. In accordance with Rule 60 §§ 2 and 3 of the Rules of Court, itemised particulars of all claims must be submitted, failing which the Court may reject the claim in whole or in part (see *Yüksel Yalçınkaya*, cited above,

§ 429; and *Karácsony and Others v. Hungary* [GC], nos. 42461/13 and 44357/13, § 189, 17 May 2016). A representative's fees are actually incurred if the applicant has paid them or is liable to pay them pursuant to a legal or contractual obligation (see *Merabishvili v. Georgia* [GC], no. 72508/13, § 371, 28 November 2017 and the cases cited therein). As for the number of representatives necessitated by the case, and the rates charged, those are matters taken into consideration by the Court as relevant within the framework of its assessment as to whether the costs and expenses have been reasonably incurred (see, for instance, *Yüksel Yalçınkaya*, cited above, § 429; and *Iatridis v. Greece* (just satisfaction) [GC], no. 31107/96, § 55, ECHR 2000-XI).

194. In the present case, the Court is satisfied that, in view of the legal services agreement and the supplementary agreement, the applicant was under a legal obligation to pay the fees charged by her lawyers (see, among many examples, *Yüksel Yalçınkaya*, cited above, § 430; *Toptanış v. Turkey*, no. 61170/09, §§ 60-62, 30 August 2016; and *Bilgen v. Turkey*, no. 1571/07, §§ 104-06, 9 March 2021 for a similar finding). The Court further considers that the amount claimed is not excessive, having regard to the legal work that was required at the level of the Chamber and then of the Grand Chamber. In the light of the documents in its possession and of its case-law, the Court considers it reasonable to award the applicant the amount claimed in full in respect of costs and expenses, EUR 14,000.

FOR THESE REASONS, THE COURT

1. *Declares*, unanimously, the application admissible;

2. *Holds,* unanimously, that there has been a violation of Article 8 of the Convention read in the light of Article 9;

3. *Holds*, by nine votes to eight, that the respondent State is to pay the applicant, within three months, EUR 12,000 (twelve thousand euros), plus any tax that may be chargeable, in respect of non-pecuniary damage;

4. *Holds*, unanimously, that the respondent State is to pay the applicant, within three months, EUR 14,000 (fourteen thousand euros), plus any tax that may be chargeable to the applicant, in respect of costs and expenses;

5. *Holds*, unanimously, that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amounts at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;

6. *Dismisses*, unanimously, the remainder of the applicant's claim for just satisfaction.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 17 September 2024, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Marialena Tsirli Registrar	Síofra O'Leary President

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

(a) Concurring opinion of Judge Elósegui;
(b) Concurring opinion of Judge Ktistakis, joined by Judge Mourou-Vikström;
(c) Partly concurring and partly dissenting opinion of Judge Seibert-Fohr, joined by Judges Kucsko-Stadlmayer, Pastor Vilanova, Ravarani, Kūris, Lubarda, Koskelo and Bormann.

S.O.L.
M.T.

CONCURRING OPINION OF JUDGE ELÓSEGUI

1. At the outset, I wish to emphasise my full agreement with the unanimous conclusion reached by the Grand Chamber in this case. The objective of this concurring opinion is to highlight some of the elements derived from the judgment that I consider important in preventing such violations from reoccurring, at least in Spain.

I. SPANISH LAW ON PATIENTS' RIGHTS

2. As is clear from the judgment, Spain has extensive and detailed legislation on the protection of patients' rights. In 2002, an important piece of legislation, namely Act no. 41/2002, was enacted, regulating patient autonomy and the rights and obligations in respect of clinical information and documentation. It regulates both informed consent and the refusal of treatment, including through advance medical directives. Furthermore, the National Register of Advance Medical Directives envisaged by Article 11.5 of Act no. 41/2002 was established by Royal Decree no. 124/2007, of 2 February 2007.

II. EQUALITY IN THE EXERCISE OF RIGHTS THROUGHOUT THE NATIONAL TERRITORY, INCLUDING THE RIGHT TO HEALTH CARE

3. More importantly, the Constitution establishes the principle that patients' rights are identical throughout the national territory. As stated in paragraph 56 of the present judgment:

> "The Spanish Constitution provides that the Autonomous Communities may assume competence over health care (Article 148). All Autonomous Communities in Spain, including Castile and Leon, and Madrid, have done so. However, the State retains exclusive competence for the general coordination of health care, that is to say, setting minimum standards to be met by public health care services, establishing the means and systems to facilitate the exchange of information, and overseeing the coordination of the State and Autonomous health authorities in the exercise of their respective functions (see generally Article 149)."

III. BETTER COORDINATION AMONG HOSPITALS IS DESIRABLE

4. Spain has enacted legislation and regulations on informed consent and the use of advance medical directives. In practice, better coordination among hospitals in the different Autonomous Communities would be desirable. As is clear from the judgment, the applicant used all the avenues afforded to her by the law, but, having done so, her wishes as set out in the documents signed by her were nonetheless ignored, as a result of various errors that are attributable to the authorities involved in her case. The national authorities,

and the doctors and judges involved, cannot hide behind mistakes made by others, much less accuse the applicant of failing to fulfil her obligations; lessons must be learned for the future.

IV. SHORTCOMINGS IN THE DECISION-MAKING PROCESS REGARDING THE APPLICANT'S RIGHT TO AUTONOMY

5. It should be noted at the outset that during the public hearing in this case (which was recorded and is available on the Court's website), it was established beyond any doubt that the applicant went to Soria Hospital in 2018 to request a copy of her medical records, including a copy of the informed consent document that she had signed on 6 June 2018, confirming her refusal of blood transfusions on religious grounds ("the ICD"). She wished to present this document as evidence in judicial proceedings. Surprisingly, the hospital gave her a document that did not contain her signature, although she had certainly signed it. It would be absurd and contrary to all logic had she not done so. That error, attributable to the hospital administration, (whether in good or bad faith, we do not know), was relied on to her detriment by the Madrid *Audiencia Provincial*. However, when on 4 February 2020 (by which date her application was already pending before this Court), the applicant returned to Soria Hospital, again requesting a copy of the ICD, she was provided with a copy that bore her signature and that of the doctor. It remains unclear why in 2018 Soria Hospital gave her a document showing only the doctor's signature.

6. Even prior to the hearing before the Grand Chamber, it was shown (and accepted by the Government) that on 18 October 2021 the managing director of the Ministry of Health of Castile and Leon (*Consejería de Sanidad, Junta de Castilla y León*), which has responsibility for Soria Hospital, had issued a report at the Government's request, which reads as follows:

> "1. Document 11. 'Application for registration in the Register of Advance Directives of Castille and Leon', dated 4 August 2017, although not formally included in the medical records of the interested party, it can be accessed through a link from the *Jimena* electronic clinical history application to the Register of Advance Directives.
>
> 2. The informed consent document dated 6 June 2018, signed by the patient and a doctor, can be found in the patient's medical records and is available to the patient at all times.
>
> 3. The 'Do not Accept Blood' document dated 4 August 2017 is not in the patient's medical records".

I wonder why this document, which is so crucial, was not included in the applicant's medical records.

V. TRANSPORT OF THE APPLICANT'S MEDICAL RECORDS WITH HER IN THE AMBULANCE

7. The errors had already multiplied. In Spain, ambulances are required to have a copy of the medical records of the patient they are transporting. In contrast to the practice now established in many of the Autonomous Communities, at the relevant time there was no direct electronic access from an ambulance to a patient's hospital medical records. However, as the Grand Chamber established, a copy of the applicant's medical records was taken with her in the ambulance (see paragraph 22 of the present judgment). The Court prudently makes no finding as to the content of those medical records.

8. That does not prevent me from finding, on the facts, that it has been proven that the reason for the applicant's transfer from Soria Hospital to La Paz Hospital in Madrid was her refusal, as a Jehovah's Witness, to accept blood transfusions. The documents presented by the Government clearly state that there had been prior communication between the two hospitals on this point, with a view to her undergoing a scheduled operation. Thus, this was not a situation of urgency in which, for example, the name of the injured party in an accident might not even be known to the medical staff.

9. What is different in the applicant's case is that an operation which could have been undertaken without the use of a blood transfusion, was planned, but the applicant's condition subsequently deteriorated. However, that situation by no means excuses the fact that the receiving hospital ignored the informed consent documents and the applicant's advance medical directive.

VI. SHORTCOMINGS IN COMMUNICATION BETWEEN THE TWO HOSPITALS AND BETWEEN THE DOCTORS AND THE DUTY JUDGE

10. That the two hospitals are in different Autonomous Communities cannot in any way serve as an excuse for the shortcomings in communication between them, as the Government have argued. That submission is both concerning and perplexing. The question arises: do the rights enshrined in the Constitution and provided for in binding State legislation applicable throughout the national territory, and the use of a regulated framework for the protection of patients' rights, cease to exist when a patient is transferred to another region two hours away by road?

11. Next we must consider all the absurd submissions concerning the relationship between the doctors at La Paz Hospital and the duty judge. My long experience in patients' rights in Spain leads me to focus on a number of facts in that regard. As already noted in other concurring opinions on the right to informed consent, I was a member of the Bioethics Committee of Aragón from its creation in 2013 until 2018, when I was elected as a judge of this Court. I was also a member of the Ethics Committee of the Lozano Blesa

Hospital, attached to the University of Zaragoza, for fifteen years. I understand that in an emergency situation, where a patient's life is in danger, where there is uncertainty regarding that patient's wishes, and in the absence of information (attributable to a lack of coordination between hospitals, as in the applicant's case, rather than to an unexpected emergency), the duty judge will be consulted.

12. Where the wishes of a patient are unclear, there are no previous advance medical directives in place, or where that patient's life is at risk and she or he is under the control of a hospital, then doctors must be certain of and seek consent when the patient is conscious, or, if the patient is unconscious, consult the family. In cases of doubt, safeguarding life is paramount. Life is a constitutional value, and the State (represented by judges and doctors) is under an obligation to preserve life. Judges and doctors also have civil, administrative and criminal liability. For instance, Article 142 § 1 of the Spanish Criminal Code establishes the crime of causing death by serious negligence.

13. Since the fax sent by the doctors at La Paz Hospital to the duty judge refers to the applicant as an adult Jehovah's Witness patient who was refusing blood transfusion (see paragraph 25 of the present judgment), it is difficult to understand why the judge chose in her reasoning to apply the nationally well-known Constitutional Court judgment of 27 June 1990. That case concerned the obligation to feed prisoners from a specific terrorist group who had started a hunger strike to put pressure on the administration and protest the fact that they had been placed in different Spanish prisons. However, subsequent to that case, as described in the present judgment, the Spanish Constitutional Court had developed a consolidated case-law on the obligation to respect the informed consent of a competent adult when that consent was formulated in a clear way; this also corresponds to the case-law of this Court.

VII. SHORTCOMINGS IN INFORMING THE APPLICANT OF THE INVOLVEMENT OF THE DUTY JUDGE

14. What is more, when the applicant arrived at the hospital she was conscious. However, she was not asked any questions, nor was she informed of the duty judge's order permitting the doctors to use any treatment they considered necessary to save her life. When a patient is conscious, a low haemoglobin level does not exempt doctors from the obligation to consult her or him. It is perfectly possible, and it is not for this Court to come to a conclusion on this point, that there was effectively no alternative in treating the applicant but to use blood and, had a blood transfusion not been carried out, she would have died. As the applicant's representative stated in her presence at the public hearing, the applicant did not wish to die.

VIII. SHORTCOMINGS IN COMMUNICATION WITH THE APPLICANT AT LA PAZ HOSPITAL

15. Precisely for this reason, however, the applicant has not complained that there was a lack of *lex artis* on the part of the doctors, but rather that she was excluded from making decisions about her own health and/or life. In fact, this was her main argument in her *amparo* appeal before the Constitutional Court and it also explains why she did not file administrative proceedings against the La Paz Hospital or a claim for medical negligence against the doctors involved. Her complaint was that she was not consulted about her treatment in spite of the fact that she had previously made use of all the means available to her under Spanish law to ensure that her wishes were known.

IX. SHORTCOMINGS IN THE CONSTITUTIONAL COURT PROCEEDINGS

16. The final episode in this series of failures in legal protection is the fact that the Constitutional Court declared the applicant's *amparo* appeal inadmissible on the grounds that there was "a clear absence of a violation of a fundamental right protected under the *amparo* appeal", as the Constitutional Court judgment of 27 June 1990 had been the leading case in establishing the constitutional guarantees on informed consent. Perhaps it would have been more understandable had the case been declared inadmissible on the basis that there was already consolidated jurisprudence, and that the applicant's case was not of special constitutional importance. However, declaring it inadmissible because it did not affect a fundamental right provided for in the Constitution is illogical. Furthermore, the 30-page submissions were well-argued.

X. SHORTCOMINGS IN THE ABILITY TO ACCESS ADVANCE MEDICAL DIRECTIVES

17. Spain must ensure that access to advance medical directives through computer systems is possible from all hospitals to which a patient might be transferred. It is nonsensical that access to the National Register of Advance Medical Directives, in which all patients who have made use of this right have placed their trust, is not readily available throughout the entire national territory. In the applicant's case, for example, given that access to her advance medical directive was possible through the *Jimena* system in the Community of Castile and Leon, then the relevant access keys could have been provided to La Paz Hospital, or could have been included in the applicant's medical records, which were transported with her.

XI. REGULATION OF ADVANCE MEDICAL DIRECTIVES IN THE AUTONOMOUS COMMUNITY OF CASTILE AND LEON AND ACCESS TO THOSE DIRECTIVES BY DOCTORS

18. The relevant provisions of Decree no. 30/2007 of the Government of Castile and Leon of 22 March 2007 regulating advance medical directives and creating the Castile and Leon Register of Advance Medical Directives, reads (emphasis added):

Article 14. Incorporation of data

"The data contained in advance medical directives shall be incorporated into the automated data file, known as the Register of Advance Medical Directives, by the administrative unit responsible for this function".

Article 15. Transmission of advance medical directives to healthcare centres

"1. **If, after registration in the Register of Advance Medical Directives, the person concerned wishes to have her or his advance medical directive included in her or his medical records, the person in charge of the Register shall issue a certificate of registration, which shall be sent, together with the advance medical directive, to the healthcare centre indicated by the person making the application for registration**, which shall adopt the necessary measures to ensure confidentiality, in accordance with the provisions of the regulations in force.

2. If the advance medical directive has not been registered in the Castile and Leon Register of Advance Medical Directives, and the person concerned wishes it to be included in her or his medical records, it shall be for her or him to deliver it to the healthcare centre, or if she or he is unable to do so, it shall be delivered by a relative, legal representative or the representative designated in the advance medical directive itself."

Article 20. Retention of advance medical directives recorded in the Register

"1. The Castile and Leon Register of Advance Medical Directives shall file and keep a paper copy of the advance medical directives that are registered.

2. Advance medical directives which have been entered in the Castile and Leon Register of Advance Medical Directives, as well as any accompanying documentation, shall be kept and stored until they are revoked or until five years have elapsed since the death of the person concerned, unless they [constitute] documentary evidence in a judicial process or administrative procedure, in which case they shall be kept until a final judicial or administrative decision has been issued."

Article 21. Access

"1. A person who has made an advance medical directive that has been registered, as well as the representative or representatives designated in that advance medical directive, may at any time access the Castile and Leon Register of Advance Medical Directives in order to consult the directive.

2. In order to ensure that advance medical directives made by patients and registered in accordance with the provisions of this Decree are complied with, in situations where

it is necessary to make relevant clinical decisions and the patient is unable to express her or his will, **the doctor** responsible for the [patient's] care **shall consult the Castile and Leon Register of Advance Medical Directives to verify whether the patient has made an advance medical directive and, if so, to consult its content.**

3. Access by the doctor responsible for the care [of the person in question], both in publicly and privately owned medical centres, shall be by electronic means that guarantee the confidentiality of the data and the identification of both the person requesting the information and the information provided, so that there is a record of the access. **The necessary measures shall be taken to ensure that the information is available twenty-four hours a day on every day of the year**".

CONCURRING OPINION OF JUDGE KTISTAKIS, JOINED BY JUDGE MOUROU-VIKSTRÖM

1. I voted in favour of finding a violation of Article 8 of the Convention, read in the light of Article 9. Nevertheless, I believe that the present case presented the Grand Chamber with an opportunity to affirm with clarity the principles of self-determination and personal autonomy, and I regret that it chose not to do so.

2. These are principles (a) which the Court articulated comprehensively in 2010 (see *Jehovah's Witnesses of Moscow and Others v. Russia*, no. 302/02, 10 June 2010, §§ 135-136) and more recently in 2022 (see *Taganrog LRO and Others v. Russia* (nos. 32401/10 and 19 others, 7 June 2022, § 162); (b) which are reflected clearly in the Convention on Human Rights and Biomedicine (the Oviedo Convention, Articles 5 and 9; see paragraphs 71-72 of the present judgment); (c) which are also reflected in the International Covenant on Economic, Social and Cultural Rights (General Comment no. 14 – right to health; see paragraph 79 of the present judgment) and in the Convention on the Rights of Persons with Disabilities (General Comment no. 1 – Article 12: Equal recognition before the law, § 42 of the Comment); (d) which are recognised (explicitly or not) by 24 (out of 39) of the States Parties to the Convention surveyed, including the respondent State (see paragraphs 81-86 of the present judgment); and, most importantly, (e) have been recommended by the Parliamentary Assembly of the Council of Europe [Resolution 1859(2012)], in paragraph 1, as follows:

> "There is a general consensus based on Article 8 of the European Convention on Human Rights on the right to privacy, that there can be no intervention affecting a person without his or her consent. From this human right flow the principles of personal autonomy and the principle of consent. These principles hold that a capable adult patient must not be manipulated and that his or her will, when clearly expressed, must prevail even if it signifies refusal of treatment: no one can be compelled to undergo a medical treatment against his or her will." (see paragraph 74 of the present judgment).

3. It would thus be reasonable to posit that the judgment should be founded upon the principles of self-determination and personal autonomy, and that the duty judge should have been held accountable for any failure to respect these principles. In contrast, the judgment avoids promoting the principles of self-determination and personal autonomy. I do not concur with this approach, and here I would borrow the Court's formulation in *Taganrog LRO and Others* (cited above, § 162):

> "Freedom of choice and self-determination are fundamental elements of life and [...], in the absence of any indication of the need to protect public health, the State must refrain from interfering with individual freedom of choice in the field of health care, since such interference can only diminish, not increase, the value of life".

It is notable that the applicant's position does not compromise public health in any way. This will be discussed in more detail below.

4. A pivotal aspect of the (rather paternalistic) perspective in the present assessment is the "appearance" of Article 2 of the Convention and the positive obligations on States. On the one hand, the judgment isolates the two previous – specific – judgments, *Jehovah's Witnesses of Moscow and Others* and *Taganrog LRO and Others*, which recognise the right of Jehovah's Witnesses to refuse blood transfusions in the light of the principles of self-determination and personal autonomy (see paragraph 140 of the present judgment). On the other hand, it gives unjustified prominence to the *Lopes de Sousa Fernandes v. Portugal* [GC] judgment (no. 56080/13, 19 December 2017; see paragraphs 130, 141, 145 and 147 of the present judgment).

5. On the basis of the latter observation, I should like to emphasise that the *Lopes de Sousa Fernandes* judgment differs from the present case in terms of the facts and interests at stake. It concerned the State's substantive positive obligation in relation to deaths caused by alleged medical negligence. In contrast to *Lopes de Sousa Fernandes*, the applicant in the present case does not rely on Article 2, does not rely on the State's responsibility to take positive measures to protect life, does not rely on the civil liability of healthcare providers and, most importantly, does not rely at all on an allegation that Spain provides inadequate medical care. Instead, the applicant raises the same issues as those addressed in the *Jehovah's Witnesses of Moscow and Others* and *Taganrog LRO and Others* judgments. The key question in these two judgments is whether the protection of "health" justifies restricting the right of Jehovah's Witnesses to refuse blood transfusions on the basis of their individual (Article 9) and collective (Article 11) right to manifest their religion. Since only the applicant (and not the religious community) brought the present case before the Court, the Grand Chamber examined the application in the light of Articles 8 and 9 (excluding Article 11). However, the three cases undoubtedly have the same legal core: does the protection of "health" justify restrictions on the right of Jehovah's Witnesses to refuse blood transfusions?

6. The Grand Chamber was, of course, entitled to distance itself from the judgments in the cases of *Jehovah's Witnesses of Moscow and Others* and *Taganrog LRO and Others* and to adopt a more paternalistic position. But this ought to have been done in a convincing, methodologically sound manner. If the applicant in the present case had endangered the lives (or health) of third parties by her conduct, for example by refusing the COVID vaccine, then Article 2 (positive obligations) could have been taken into account when analysing the "rights of third parties" as set out the second paragraph of Article 8. However, the applicant has not endangered the life or health of third parties, or public health. Nor does she rely on her own health. On the contrary, she relies on her personal autonomy and her religious beliefs. Paragraphs 125-127 of the present judgment illustrate her situation very accurately. We have the classic schema of Article 8: recognition of the

patient's right to autonomy (paragraph 1) and (un)lawful restriction of health (paragraph 2) in a democratic society. Nowhere is Article 2 invoked.

7. In conclusion, the Grand Chamber had all the necessary elements in its favour (the case-law of the Sections, developments in the law of international treaties in the field of human rights, the encouragement of PACE, the legislation in the majority of the States Parties to the Convention, and the advanced legislation of the respondent (Spanish) State) to enable it to formulate with clarity and authority the principles of self-determination and personal autonomy.

PARTLY CONCURRING AND PARTLY DISSENTING OPINION OF JUDGE SEIBERT-FOHR, JOINED BY JUDGES KUCSKO-STADLMAYER, PASTOR VILANOVA, RAVARANI, KŪRIS, LUBARDA, KOSKELO AND BORMANN

1. We fully agree with the finding that there has been a violation of Article 8 of the Convention, read in the light of Article 9, for the reasons given in the judgment. The decision-making process leading to authorisation of the blood transfusion was flawed in several respects (see paragraphs 172-182 of the present judgment), so that it did not afford sufficient respect for the applicant's autonomy (see paragraph 183). The doctors from La Paz Hospital who contacted the duty judge to inquire how to proceed were apparently aware neither of the written refusal of a blood transfusion, signed at Soria Hospital on the day before the applicant's transfer, nor of her advance medical directive. Accordingly, the factual basis on which the duty judge had to reach a decision was incomplete (see paragraphs 175 and 177). Moreover, authorisation was granted in unqualified terms, despite uncertainty as to the applicant's capacity to refuse a blood transfusion, in the required form and in the time still available, while she was conscious of the implications of her decision (see paragraphs 25, 161, 165 and 177). Lastly, the subsequent proceedings failed to address these issues in an adequate manner and therefore to respond adequately to the applicant's complaint (see paragraphs 179 and 182).

2. While we firmly concur with these findings, our sole disagreement concerns the award for non-pecuniary damage. The applicant claimed EUR 45,000 in respect of the non-pecuniary damage which she considered she had suffered on account of the hysterectomy performed without her consent and the blood transfusions administered contrary to her wishes (see paragraph 186). However, the hysterectomy was by no means integral to the Court's finding of a violation (see paragraph 183, with references to paragraphs 172-182). It was the subject neither of her appeal to nor of the proceedings before the *Audiencia Provincial* (see paragraphs 36-39 and 43). As a matter of fact, the applicant stated before the *Audiencia Provincial* that she had not refused "any treatment" but had refused only blood transfusions (see paragraph 37). Moreover, the proceedings brought by her at the domestic level seeking a remedy did not involve calling into question any of the medical assessments or decisions taken in her case (see paragraphs 91 and 130). Furthermore, and to be more specific, the ground for finding a violation is not that blood transfusions were administered to the applicant contrary to her wishes, but rather that the decision-making process which led to authorisation for these blood transfusions did not afford sufficient respect for the applicant's autonomy (see paragraph 183).

3. In assessing the scope of the State's responsibility under Article 8, read in the light of Article 9, regard must also be had to the following context. If any blood transfusion in an emergency situation which later turns out to have been contrary to a patient's wishes were to constitute a violation of the Convention, this would have a chilling effect on emergency medical treatment. The decisive question under the Convention is therefore whether a patient's previously expressed wishes, in so far as these are known at the time of the intervention, were sufficiently taken into account (see paragraphs 149-150; see also Article 9 of the Oviedo Convention and paragraph 62 of the explanatory report in relation to that provision, set out at paragraph 72 of the present judgment). This cannot be assessed on an *ex post facto* basis but depends on each particular situation as it presents itself in the relevant circumstances. The fact that the applicant disagreed with the administered blood transfusions when informed about them the following day cannot therefore be decisive. For this reason, in relying on the decision-making process as the basis for its finding of a violation the Court has found an essentially procedural violation, without going into the question of how the request for authorisation should have been decided (see also paragraph 189).

4. This also has implications for the question whether non-pecuniary damage should be awarded under Article 41 of the Convention. The Court has explained in its previous case-law that, having regard to what is just, fair and reasonable in all the circumstances of the case, it may consider that the finding of a violation constitutes in itself sufficient just satisfaction and that no monetary award is to be made. This concerns, *inter alia*, cases such as the present one, in which the violation found is considered to relate to procedural deficiencies (compare, for instance, *Nikolova v. Bulgaria* [GC], no. 31195/96, § 76 *in fine*, ECHR 1999-II; *Öcalan v. Turkey (no. 2)*, nos. 24069/03 and 3 others, § 215, 18 March 2014; *Vinter and Others v. the United Kingdom* [GC], nos. 66069/09 and 2 others, § 136, ECHR 2013 (extracts); *Murray v. the Netherlands* [GC], no. 10511/10, § 131, ECHR 2016; *Janowiec and Others v. Russia* [GC], nos. 55508/07 and 29520/09, § 220, ECHR 2013; and *Stollenwerk v. Germany*, no. 8844/12, § 49, 7 September 2017).

5. Apart from the procedural nature of the violation found, which does not extend to the medical interventions as such, several additional aspects speak in favour of the conclusion that the finding of a violation would have constituted in itself just satisfaction in the circumstances of the present case. First, one must recognise the difficult situation which arose for the medical staff at La Paz Hospital and for the duty judge on 7 June 2018 when the applicant's health seriously deteriorated during her transfer so that, according to the medical assessment, the applicant's haemodynamic instability meant that alternative treatment, such as uterine artery embolization, the assessment of which the applicant had been transferred for, was no longer considered

feasible. When they learned about the applicant's orally expressed refusal the doctors at La Paz were faced with a dilemma and potentially faced criminal liability in the absence of clear evidence of a valid refusal (see paragraph 112). When the ambulance arrived, they judged that they had a serious clinical emergency to deal with, leaving them with no alternative, and that surgery had to commence without delay (see paragraph 109).

6. The Court has recognised therefore in the judgment that the actions taken by the doctors were motivated by the overriding concern to ensure the effective treatment of a patient who was under their care, in keeping with the most fundamental norm of the medical profession (see paragraph 181), that is, to save life and to protect health. The Court did not question their assessments regarding the severity of the applicant's condition at the material time, the urgency of the need to treat her and the medical options available in the circumstances. Moreover, the urgent threat to the applicant's life did not leave the duty judge with time to consider the matter further.

7. This is not to question that, overall, the decision-making process was flawed; under such circumstances, however, the blood transfusions cannot be equated with an act of "rape" as suggested by the applicant (see paragraph 35). There is no evidence of any bad faith, either on the part of the medical staff or the duty judge. In the absence of reliance on forms of remedy which would have allowed for relevant fact finding at the domestic level, anything else would be mere speculation. It is important to note that the alleged damage in question, namely the blood transfusions, was a direct consequence of the applicant's underlying pathology.

8. Moreover, we cannot but observe that the applicant's life was saved that day. She survived as a result of a medical intervention which, according to the doctor's medical assessment, was necessary to save her life – a fundamental value, protected by positive obligations under Article 2 of the Convention and an absolute precondition for the enjoyment of any other Convention right or freedom, including freedom of religion. While the applicant claims that she would have maintained her refusal had the question been put to her at the relevant time, when she was asked during the public hearing whether she would have been prepared to die in the absence of a blood transfusion, her representative answered that she wished and still wishes to live. Moreover, in her earlier submissions she had argued that what had been at stake was her freedom to live in accordance with her religious beliefs (see paragraph 49). It is difficult to see, however, how it would have been possible for her to continue living without blood transfusions. Though we recognise the dilemma that the applicant found herself in, we do not believe that it is the result of any of the shortcomings in the decision-making process that have led the Court to find a violation.

9. Lastly, the applicant has stated that, for her, the issue at stake was not one of possible medical negligence but essentially one of principle (see paragraph 91). She conceded that she could have attempted to bring civil

proceedings in order to claim compensation, but had decided against it. Given that the Court has ruled on a matter that was for the applicant a matter of principle, we therefore fail to perceive why compensation that was not claimed domestically should now be awarded by the Court in the context of the present application.

10. In the light of these considerations, having regard to what is just, fair and reasonable in all the circumstances of the case, including the nature of the violations found as well as the context of the case (see paragraph 4 of this opinion), we find convincing reasons to conclude that the finding of a violation would have constituted in itself sufficient just satisfaction, and that no monetary award ought to be made in respect of non-pecuniary damage.