DISCUSSING THE CASE OF "STERILIZATION OF PREGNANT HIV WOMEN IN OROSIA" SUBMISSIONS FOR THE *HUMAN RIGHTS MOOT COURT COMPETITION (2012/2013)*

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I — INTRODUCTION

The Human Rights Moot Court Competition is a simulated hearing of the European Court of Human Rights. The competition is open to all students from ELSA (European Law Student Association) countries as well as from countries that are members of the Council of Europe http://www.humanrightsmootcourt.org/

The first edition took place in 2012/2013 discussing the following case:

"Sterilization of pregnant HIV women in Orosia"

1. A young woman, referred to only as A.A. to protect her privacy, lives in Mangonia, the capital of the country of Orosia. The Republic of Orosia became a member of the Council of Europe and ratified the European Convention on Human Rights in 1995. Since then, it has also ratified all the Protocols to the Convention.

2. In order to address the spread of the human immunodeficiency virus (HIV) in Orosia and, more specifically, to avoid the transmission

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of HIV from mother to child during birth, the Orosian government has started a campaign encouraging the sterilization of HIV-positive women and offering the procedure for free through the National Health Service, the governmental agency that bears the financial costs of sanctioned medical treatments for citizens. The campaign was deemed by the Orosian Prime Minister as crucial in order to combat the increasing rate of people infected with HIV in the country and to raise awareness. The government based this decision on their responsibility to protect their citizens and especially vulnerable groups such as infants from HIV. A study conducted by "Victims of Sterilization", an Orosian NGO with the purpose of advancing women's reproductive health, self-determination, and dignity as basic human rights, claims that, since the starting of the campaign, 12.9% of sterilized HIV-positive women underwent the procedure without prior consent. Moreover, the same study affirms that 29% had agreed to be sterilized only after being coerced to by the doctors or nurses.

3. A.A. has lived for all her life in one of the poorest neighbourhoods of the capital city. Because of the financial strains of her family, she had to leave school at a very early age to seek work in a textile factory. She is not able to write and can read only very simple texts with much difficulty. In 2002, a few months after getting married A.A. found out that she was pregnant. Shortly after, during a routine test performed on all pregnant women as part of the campaign, she was diagnosed with HIV. She sought antiretroviral therapy (HIV treatment) and pregnancy services at the public Mangonia General Hospital. Due to financial issues, therapy in public facilities was the only possibility for A.A. in order to avoid transmitting the virus to her unborn child. HIV treatment is included between the therapies covered by the National Health Service.

As agreed with the medical staff during one of the previous visits, A.A.'s husband brought her to the Mangonia General Hospital few days before the expected date of delivery. As practice with illiterate patients, Priscilla Bantward, a member of the nursing staff, materially filled in A.A.'s admission form reporting in writing her verbal answers. During the admission procedure, Ms. Bantward, informed her about the campaign and the HIV-related risks for her child's health. As reported by the admission form, A.A. agreed to have a meeting with Dr. Graham Sylvester, coordinator for the campaign in the Mangonia General Hospital.

During the second day of A.A.'s stay in the hospital, Dr. Sylvester visited her in her room to discuss the sterilization. During this discussion, her husband was not present for work reasons. According to the doctor, in that occasion the patient had been informed of all aspects of the operation and had given her consent to the sterilization. A.A. eventually delivered a healthy baby through Caesarian section. While A.A was still under general anesthesia, Dr. Sylvester performed a tubal ligation procedure on her. When she woke up, she and her husband were given a short notice about the sterilization.

4. As a consequence of the sterilization, A.A.'s husband divorced her and her family and local community estranged her. Such "expulsion" is common social practice and strong cultural and religious belief in certain Orosian communities since women submitted to sterilization would not be able to continue the tradition of motherhood. The tradition and most important role of a woman in the social context of the villagers, is to be fertile and to bear offspring to ensure the continued existence of the community. Due to these circumstances A.A. is now suffering from psychological problems, has been forced by the community to move to the neighbouring city of Tibula and is currently raising her child without any support. "Victims of Sterilization" is providing A.A. with legal counselling and representation.

5. A.A. is claiming that she was not consulted or informed about the sterilization procedure and never gave her consent to do it. In relation to the meeting with Dr. Sylvester, she declared: "I just wanted to protect my baby's health and I trusted the doctors. When Dr. Sylvester came to my room, he talked to me using medical terms I could not understand. So I just told him to do what was best for the wellbeing of my child and mine. After I said that, he left the room and I did not see him again until the day I went into labour". The Hospital relies on the fact that they had fully informed her and that it was a voluntary decision. Nevertheless, doctor Sylvester concedes on the fact that A.A. might not have understood the result of her decision due to her lack of education, but submits that she was explained the circumstances in understandable terms and was asked more than once if she wanted to proceed with tubal ligation, always giving a positive answer.

6. "Victims of Sterilization" brought A.A.'s case to the Orosian District Court of Mangonia as a domestic complaint. The Court ruled that the medical staff had obtained valid consent from the complainant

for the surgery as Orosian law requires just verbal acceptance of the procedure in case the patient is illiterate. The lack of registration of the consent in the hospital records was considered "a mere administrative irregularity not bearing effects on the validity of consent according to relevant legal rules". The decision was confirmed in all the following domestic instances.

"Victims of Sterilization" also brought a formal complaint before the Orosian government, notwithstanding the recent drafting of a detailed national pilot plan for the treatment of HIV-positive pregnant women in cooperation with specialized experts. It seeks to better promote voluntary counseling and testing as well as to raise awareness of the risks that HIV poses on the mother as well as the unborn child.

7. After the exhaustion of all available domestic remedies "Victims of Sterilization" filed a complaint on behalf of A. A. at the European Court of Human Rights (ECtHR). The advocates have asked the ECtHR to recognize the violation of A.A.'s rights as protected by the European Convention for the Protection of Human Rights and Fundamental Freedoms.

II — WRITTEN SUBMISSIONS BY THE TEAM

The teams were obliged to send two written submissions: one for the applicant and one written submission for the respondent within the given deadline [2]. Hereby follow the written submissions pleaded by the FDUP team.

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[2] list of abbreviations: Art. — Article; CAI — Consultancy African Intelligence; CEDHBIO — Convention for the protection of Human Rights and Dignity of the human being with regard to the application of biology and medicine (Oviedo); GA — General Assessments, CRP — Constitution of the Portuguese Republic; DCMS — Portuguese Deontological Code for Medical Staff; ECHR — European Convention on Human Rights; ECtHR — European Court of Human Rights; FAP — Familial Amyloidosis Polyneuropathy; FIGO — International Federation of Gynecology and Obstetrics; IUD — Intrauterine Device; HIV — Human immunodeficiency virus; IMF — International Monetary Found; NGO — Non-Governmental Organization; SRHR — Sexual and reproductive health rights; UDHR — Universal Declaration of Human Rights; USA — United States of America; VCvSL — Case of "V.C. v. Slovakia" (application no. 18968/07), European Court to Human Rights; VS — Victims of Sterilization; WB — World Bank.

II.1. Legal Pleading for the applicant

1. General Assessments

There is no more important regulation that the one that relates to our body, the physical substract of the human being. The sanctity of our body's life must be harmonized with men's liberty to take decisions that affect it [3]. For these reasons, we must take into account the following GA:

1.1. About sterilization

A. Sterilization is the surgical or non surgical act that can be performed to men or women, namely to prevent fecundation;

B. Any type of sterilization (chemical, chirurgical, etc.) may raise several psychological and psychosexual consequences. Thereafter the person submitted to the treatment becomes infertile and looses the freedom to choose between procreation and no procreation;

C. Sterilization can present itself in many types: can be voluntary, if freely decided by the patient; can be coercive, if imposed on the patients against his/her will (which is considered a physical and freedom offence); and can also be compulsive. The last one reaches scientific and political community in 1883 with Francis Galton's eugenic studies and in the beginning of the 20th century we assist to a eugenic movement. In the state of Indiana it's voted in 1907 the first American law that establishes compulsive sterilization. Eugenic sterilization was only changed in 1980 in California and still survives in 20 states of USA. In the decade of the 80's a strong fight was taken to end this violent procedures, fight that culminated with the approval of Beijing Platform (1995) that in its 115 paragraph considers this a type of violence against women;

D. Sterilization can also be therapeutic or not therapeutic. In this case A.A. was submitted to a non therapeutic sterilization, since it was used as a contraceptive method. Because there are currently a wide variety of contraceptive methods not as radical as sterilization, this should be the option of last resort. And even if allowed by law,

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[3] Neto (2010), p. 114.

sterilization should be exhaustively regulated. For example, in Portugal sterilization is permitted but with restrictions: it can be performed to patients with more than 25 years old, their consent must be valid, unequivocal and it must be registered that the doctor informed the patient about its consequences;

E. Furthermore there are other ways to prevent the transmission of HIV to children, as effective treatments that can be done during pregnancy. A.A. was submitted to one of these treatments: an antiretroviral treatment. While the chance of transmitting HIV from mother to children (vertical transmission) rounds 15% to 20%, with these treatments the probability decreases to between 6% and 8% [4]. Hence the risk of transmission is not so high, as it was proved by the born of her healthy son;

F. For example, in Portugal, *Familial Amyloidosis Polyneuropathy* (FAP) is common in Northern and Central fish areas. This is an illness where a protein called *amyloid* is deposited in tissues and organs. Amyloidosis may cause the degeneration and dysfunction of the peripheral sensory, motor or autonomic nerves. Symptoms appear around 20-30 years old and the disease causes several pain, dependence on other people and even death. The disease has no cure and the only way to retard it is through a liver transplant. This form of amyloidosis is hereditary, which means that it is transmitted from parents to children and the probability of the child to have FAP is about 50% [5], much higher than the probability of vertical transmission of HIV. But never in Portugal was implemented a campaign encouraging the sterilization of women with FAP in order to control the disease. On the contrary, sanitary authorities make these women aware of the risks of getting pregnant and of transmitting the disease to their babies. Besides the government supports [6] the financial costs of medically assisted procreation in order to allow these women to constitute a family, decreasing the probabilities of their child being born with FAP. Furthermore it has been done a huge effort to intro-

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[4] Manuel da Costa Andrade (2004) pp. 38-39.

[5] http://www.paramiloidose.com/sm20.15567/pag4935.html

[6] Administrative Decree 29/90, 14th September: access to health care public services concerning FAP patients (Portugal).

duce a drug, Tafamidis, which in an early stage of the disease has the same effect than a liver transplant and avoids invasive treatments.

1.2. Valid Consent

G. The informed consent is a legal institute that translates a dynamic process of inter-relationships between the agents involved. Although the relationship is usually simple as it involves only the patient and the doctor, under specific circumstances it may also involve the medical team, family or legal representatives, case in which it becomes a multilateral relationship. To obtain a valid consent it is necessary that the patient has the legal capacity to make decisions for himself. Also the patient must have received all the necessary information by the doctor. Consent can only be obtained when we are talking about disposable juridical goods. The consent for medical interventions affects liberties, self-determination, physical and psychological integrity;

H. According to the British Medical Association and Law Society [7] the patient is considered capable if he/she understands in what the treatment consists, its goals, nature and why it was advised to him. He also has to understand the benefits, risks, alternatives, costs and the consequences of not doing it. Finally the consent is only valid if the patient is able to make free decisions without pressures and after an adequate period of reflection;

I. Furthermore, the new ethic guidelines regarding female contraceptive sterilization by The International Federation of Gynecology and Obstetrics (FIGO) also corroborate this concept of informed consent. FIGO states that "Fears remain that ethnic and racial minority, HIV-positive, low-income and drug-using women, women with disabilities and other vulnerable women around the world, are still being sterilized without their own freely-given, adequately informed consent" [8];

J. According to a report by the Consultancy Africa Intelligence (CAI), based on a study of Loveness Tapiwa Satande [9]

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[7] British Medical Association and Law Society (1995), p. 15.

[8] http://www.figo.org/files/figo-corp/FIGO%20-%20Female%20contraceptive%20sterilization.pdf

[9] http://www.tigweb.org/resources/toolkits/view.html?ToolkitID=2649

dedicated to Namibia and South Africa regarding Sexual and reproductive health rights threatened through forced sterilization of women with AIDS:

> "The reason for the intervention, any foreseeable consequences of accepting or rejecting, existence and nature of available alternatives and the fact that an individual is free to accept or reject the intervention should all be made clear in the informed consent document. Valid informed consent therefore incorporates five elements: voluntarism, capacity, disclosure, understanding, and decision making (De Carmen and Joffe, 2005)";
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> "Freedom of decision-making is integrally linked to informed consent. It requires informed decision-making and consent when permanent procedures such as sterilisation are being performed";
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> "Informed consent is not merely saying «yes» to a procedure. Informed consent is a discussion and most importantly involves communication between a patient and a healthcare provider" — This principle pulls down the medical staff argument.

K. In some legal systems, the medical staff has the legal duty of documentation — ex. 112.º CDOM "the doctor has the right and the duty to carefully record the results that considers relevant about the patient". This is understood as a lateral duty of the relationship between the doctor and patient. Besides that, this is also a doctor's duty of care and it has been recently analysed as an altogether personality right;

L. General Recommendation No. 24 adopted by the Committee on the Elimination of Discrimination against Women (CEDAW) in 1999 includes the following recommendations:

> *"20. Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives.*
>
> *21. States parties should report on measures taken to eliminate barriers that women face in gaining access to health care services and what measures they have taken to ensure women timely and affordable access to such services.*

22. States parties should also report on measures taken to ensure access to quality health care services, for example, by making them acceptable to women. Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilization, that violate women's rights to informed consent and dignity.

31. States parties should also, in particular:

(e) *Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;*

(f) *Ensure that the training curricula of health workers includes comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence."*

M. The World Health Organisation (WHO), in March 1994, endorsed a document entitled "Principles of the rights of patients in Europe" [10], in which the following principle were established:

"2.2 Patients have the right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment.

2.4 Information must be communicated to the patient in a way appropriate to the latter's capacity for understanding, minimizing the use of unfamiliar technical terminology.

3.1 The informed consent of the patient is a prerequisite for any medical intervention.

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[10] http://www.who.int/genomics/public/eu_declaration1994.pdf

3.2 A patient has the right to refuse or to halt a medical intervention. The implications of refusing or halting such an intervention must be carefully explained to the patient."

N. Moreover, Articles 5th and 6th of the Universal Declaration on Bioethics and Human Rights [11] found:

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."

O. According to the dominant doctrine and jurisprudence, the onus of the proof lies on the doctor. The doctor's duty of obtaining a free and clear consent comes from the principle of good faith that characterizes the therapeutic relationship and also from the doctor's accompaniment duty that raises form the *legis artis* of this profession.

1.3. The cultural issue

P. Belonging to a culture is extremely important to develop a person's personality. Rainer Baudöck [12] explains that acquiring value systems, traditions and beliefs occurs in the first socialization within the family. This acquisition remains in our cognitive processes and our own perception of the world and conduction of life is always made by reference to those values. As Catherine Lalumière stressed, identity "help us all to know ourselves better and position ourselves in relation to others" [13]; and Will Kymlicka adds that membership "is a high

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[11] http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html

[12] *Apud* Patrícia Jerónimo (2011) p. 361.

[13] Catherine Lalumiére (2005) *in* Colloquy on: "European Culture: *Identity and Diversity*" Strasbourg, France 8-9 September 2005.

social profile in the sense that it affects how other perceive and respond to us, which in turn shapes our self-identity" [14].

1.4. Remembrance of relevant rights

Q. We must remember Articles 3rd, 5th, 8th, 12th, 14th and 17th of the European Convention on Human Rights establish:

Article 3 — Prohibition of torture: "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

Article 5 — Right to liberty and security: "Everyone has the right to liberty and security of person."

Article 8 — Right to respect for private and family life: "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 in accordance with the law and is necessary in a democratic society (...) for the protection of health or morals, or for the protection of rights and freedom of others."

Article 12 — Right to marry: "Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right."

Article 14 — Prohibition of Discrimination: "The enjoyment of the rights and freedoms shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

Article 17 — Prohibition of Abuse of Rights: "Nothing in this Convention may be interpreted as implying for any State, group or person any right to engage in an activity or to perform any act aimed at the destruction of any rights and freedoms set forth herein or at their limitation to a greater extent than is provided for in the Convention."

R. All these rights must be now vindicated by this Court. And let us remember that the Commissioner for Human Rights in a report from 17 October 2003, regarding certain aspects of law and practice

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[14] Will Kymlicka (1996) p. 89.

related to sterilization in the Slovak Republic, recommended, in accordance with Article 8 paragraph 1 of Resolution (99) 50 of the Committee of Ministers of the Council of Europe, that "rapid adoption of new legislation introducing and sufficiently specifying the requirement of free and informed consent for medical acts, including sterilizations, in line with the requirements of international law". The recommendations can be transported to Orosia because the objectives are the same for every European Country;

S. Finally it is important to remark that the issues relating third world countries and sterilization are not anything new. In fact, we recall on this matter the 1984 World Development Report [15] by the WB following a proclivity that started in the 60's when sterilization started being used as a contraceptive method. Although the incomes of some African countries and Orosia are similar, in line with the WB "classification by income does not necessarily reflect development status" [16]. So we wouldn't be able to establish a parallel between them. However, based on the data provided on the case, we find that there are plenty of circumstances which allow us to relate Orosia with some countries in Africa. On this report, in order to execute its population reduction program, WB suggested the use of "sterilization vans" and "camps", which threatens nations who are slow in implementing the bank's population policies with "drastic steps, less compatible with individual choice and freedom." This sort of measures and threats generated a high level of controversy because, among other effects, they could lead to cases of malpractice in third world countries as they would be pressured to reach WB's goals. This polemic managed indeed to affect WB's credibility and led this organisation to abandon the proposal.

2. Conclusions

Given the arguments previously expended, it becomes clear that:

I. The campaign implemented in Orosia collides with fundamental rights that must be protected by the Rule of Law, as they directly affect human dignity. For this reason most countries in Europe incor-

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[15] http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2000/12/13/000178830_98101903341963/Rendered/PDF/multi0page.pdf

[16] http://data.worldbank.org/about/country-classifications.

porate fundamental rights on the reserve of law of the Parliament. Yet the campaign was created by the Government by an administrative decree, obviously violating the principle of the separation of powers and the rule of law. Because the European Court of Human Rights reiterates that the Rule of Law is implicit to all the ECHR, the campaign should have been deemed by a legislative decree (see case V.C. v Slovakia, application no 18968/07, § 1 40);

II. If the purpose was not allowing A.A. to get pregnant again, the national service should have opted for other methods, as the pill, the diaphragm or the Intrauterine Device (IUD). These are all effective and reversible methods that do not cause physical and psychological damage. Clearly this campaign didn't respect the principle of proportionality required by the article 8, paragraph 2 of the ECHR (see about the necessity VCvSL, § 139, ECtHR). Sterilisation is a "major interference with a person's health status" and since it concerns an essential bodily function, it "bears manifold aspects of (...) personal integrity including (...) physical and mental well-being and emotional, spiritual and family life". (VCvSL, § 106);

III. It is said in point 6, paragraph 1 of the A.A.'s case that *"(...) during a routine test performed in all pregnant women as a part of the campaign, she was diagnosed with HIV"*. Hereupon it is clear that A.A. wasn't provided with the necessary information and she wasn't asked for consent about the blood test, as it was required in the legal provision. The relevant paragraph of the legal provision on which the Orosian campaign was based states that:

> *"Health personnel providing care to pregnant women are required to inform the latter, in a comprehensible manner, of the risks to run by their offspring if the mother is HIV-infected, and to* ***advise*** *them to undergo testing and,* ***with their consent****, to have the blood withdraw subjected to a test for the detection of syphilis and HIV infection";*

IV. According to FIGO's recommendation no.7, the medical staff behaved unethically and illegally when accepting passively these directives from the Ministry of Health, since "At a public policy level, the medical profession has a duty to be a voice of reason and compassion, pointing out when legislative, regulatory or legal measures interfere with personal choice and appropriate medical care.";

V. In addition, Dr. Sylvester performed the sterilization while A.A. was still under general anaesthesia right after the caesarean. Since epidural is the normal procedure in c-sections, which allows patients to stay awake and conscious, the doctor acted clearly in bad faith. This violates the orientations of CAI once they don't recommend the practise of a sterilization right after a c-section. The successive realization of these procedures may also restrain the achievement of a correct and informed consent;

VI. On the no. 3 of the case it is stated that A.A was informed about the campaign of sterilization of HIV-positive women and about the HIV-related risks for her child's health, which she discussed later with Dr. Sylvester. Because during this process no other alternatives were presented, A.A was misled into thinking that sterilization was the only possible way to prevent the transmission of HIV;

VII. Notwithstanding, sterilization fails to prevent the transmission of the virus between sexual partners. According to FIGO's guideline no. 11 — "(...) it must also be emphasized that sterilization does not provide protection from sexually transmitted infections";

VIII. Nowadays, medical practice is no longer seen as *ars muta.* But in this case, A.A. didn't understand the risks of the treatment that she was going to be submitted, no one presented her other alternatives, no one gave her time to reflect and, as a result, she was practically forced to do the sterilization. It is indicated that "*According to the doctor, in that occasion the patient had been informed of all aspects of the operation and had given her consent to the sterilization*" and that A.A "*was asked more than once if she wanted to proceed with tubal ligation, always giving a positive answer*". It is never mentioned that A.A. chose this specific treatment among other possible alternatives, which is part of an ethical proceeding's explanation — guideline no. 11, by FIGO: "As for all non-emergency medical procedures, women should be adequately informed of the risks and benefits of any proposed procedure and of its alternatives. It must be explained that sterilization must be considered a permanent, irreversible procedure that prevents future pregnancy, and that nonpermanent alternative treatments exist (...)". In fact, Dr. Sylvester based his defence on the constant positive answers given by A.A, which is not the correct way to obtain an informed consent;

IX. Attending to the high risks of irreversibility, we claim that it was equally necessary the consent of her husband, who would reject

the treatment and avoid all the social consequences that A.A. suffered. In fact her husband was not even present and for that reason the consent shouldn't be valid — N.B. v Slovakia, § 78, ECtHR;

X. A.A's judgment and decision making capacity were compromised due to the imminence of having a child. She was induced to believe sterilization was the best for her child, not knowing that the treatment would have no influence on her baby's health. It's important to emphasize that the consent is nowadays seen as a fundamental right, which was violated according to articles 5th and 6th of CEDHBIO;

XI. The doctor should have attended to the peculiarities of A.A., as he knew she was illiterate. It was his obligation to ensure that A.A. understood all the information by communicating in an understandable and simple language adequate to the social-economic and professional level of the patient [17]. Yet A.A. says she didn't understand the doctor because he talked with a complex language. Without this extra care nothing guarantees that the consent was really enlightened. In this sense, Hottois and Parizeau advised "The request of consent obliges the doctor to a few complementary initiatives: verify if the information was understood, asking some questions; evoking complementary questions by the patient; evaluating the anxiety state of the patient; obtaining the verbal agreement of the patient to initiate the treatment". In this case, the doctor didn't check if A.A. had really understood the information, otherwise he would have realized that A.A. was not aware of the consequences of the procedure, violating this way the Recommendation no. 24 of the CEDAW, the "Principles of the rights of patients in Europe" of the WHO as well as articles 5th and 6th of the Universal Declaration on Bioethics and Human Rights;

XII. Besides, due to the consequences of irreversibility, it is frequently required a written consent. According to CEDHBIO — 19.º/2 — "the consent must be provided in an express and specific way, written and before an official entity". And despite the fact that A.A. was illiterate, she could at least be accompanied by a relative or someone of her confidence who would be able to explain the intervention and sign the document on her behalf. Clearly the present nurse hadn't done that;

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[17] Pereira (2004), pp. 472-475.

XIII. As it is said in GA C), in some juridical orderings the medical has the legal duty of documentation. Here, the doctor didn't fulfil his duty, because he didn't record A.A.'s alleged consent;

XIV. "(...) The Court reiterates that the very essence of the Convention is respect for human dignity and human freedom. It has held that in the sphere of medical assistance, even where the refusal to accept a particular treatment might lead to a fatal outcome, the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with his or her right to physical integrity"(VCvSL, § 105);

XV. A.A. was a young woman at an early stage of her reproductive life (VCvSL, § 106) who suffered psychological, emotional and social after-effects (VCvSL, § 118) due to the sterilisation that was performed with "gross disregard for her right to autonomy and choice as a patient". She was submitted to a treatment that attained to the minimum level of severity condemn by the art. 3 of ECHR and thus she suffered inhuman and degrading treatment. Misleading the victim to act against her will or conscience (VCvSL, § 102) may be considered a violation of the Article 3 of the EHCR;

XVI. After doing sterilization the probability of getting pregnant is less than 1% in the particular case of tubal ligation, which was the method implemented in A.A's intervention. It also has a high tax of irreversibility: in women it has an average rate of 60%. So in 40% of the cases sterilization can be reverted. Among these 40%, only 80% of the women will succeed to get pregnant again [18]. Although A.A. could try a reversible surgery, she doesn't have economic resources to do it as she's raising her child without any support;

XVII. The possibility of a future pregnancy is not a fundament to impose sterilization.[19] A.A. is self-determined to make her own choices regardless the risk of transmitting the virus to her children;

XVIII. According to the Court (VCvSL, § 138), "«Private life» is a broad term, encompassing, *inter alia*, aspects of an individual's physical, psychological and social identity such as the right to personal autonomy and personal development, the right to establish and develop relationships with other human beings and the right to res-

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[18] Sgreccia (2009), p. 706.

[19] Sgreccia (2009), p. 720.

pect for both the decisions to have and not to have a child". Just like the applicant in the case V.C. v Slovakia, A.A.'s sterilisation affected "her reproductive health status and had repercussions on various aspects of her private and family life". She is unable to exercise her right to found a family due to sterilisation. The Court is clear, "(...) article 12 of the Convention secures the fundamental right of a man and woman to marry and to found a family. Its exercise is subject to the national laws of the Contracting States but the limitations thereby introduced must not restrict or reduce the right in such a way or to such an extent that the very essence of the right is impaired"(V.C. v Slovakia, § 159). Hence the sterilization procedure constituted an interference with A.A.'s right under art. 8 read in conjunction with art. 12 of the ECHR. (V.C. v Slovakia, § 143). Like John Mills [20] said "Privacy is an integral part of the (...) values that define a healthy society";

XIX. Let us also highlight that A.A. was discriminated on ground of her sex and health status. All the campaign is a pure discrimination against HIV infected women and the behaviour of the medical staff corroborates this, since Dr. Sylvester, as a coordinator of the campaign in Mangonia Hospital, performed an unethical and illegal sterilisation on A.A., violating article 14 of the ECHR (*a contrario*, VCvSL, § 177);

XX. So, if verified the assumptions of responsibility — fact, illegality, damage, guilt and causal nexus — the doctor should be punished by his conduct both from a civil and criminal perspective;

XXI. It is also extremely important the analysis of A.A.'s emotional state after sterilisation, who became psychologically ill. Such traumatic events probably led to an Adjustment Disorder which is a type of mental disorder resulting from maladaptive or unhealthy responses to stressful or psychologically distressing life events. Experts underline that adjustment disorders are triggered by external stressors, but the symptoms result from the individual's interpretation of the stressful event or circumstances. They recognize the influence of beliefs, perceptions, fears and expectations in the development of an Adjustment Disorder. The symptoms are listed in Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) and the applicant meets the following criterion: "*the*

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[20] *Apud* Chate (2010), p. 14.

patient experiences significant impairment in social relationships or in occupational or academic settings" [21]. And experts alert this condition can be extremely serious in patients who already suffer from a disease, as A.A., which is HIV infected [22];

XXII. A.A. suffered emotional and social life consequences, psychological problems and she is currently being ostracised. To calculate her damage we must attend to her specific situation and cultural experience. As seen supra in GA C) is clear that, if she belongs to a community where the main role of women is reproduction, her damage is increased comparing to other situations. These damages may cause relational dysfunctions and changes of behaviour (relational damage). A.A. suffered physical, psychic and social damages that should be repaired. Since Orosian law doesn't provide liability of public entities, Dr. Sylvester should be liable to respond before the courts. Also A.A. must be compensated because the doctor broke the relationship of trust between a doctor and a patient, thereby violating a lateral duty that should have been respected. Attending to these considerations, under article 41 of the ECHR, A.A. should be provided with a fair indemnization for non-pecuniary damage (VCvSL, § 184);

XXIII. Given the illiteracy and the psychological and monetary conditions of A.A, she wouldn't be able to prepare a proper legal defence; therefore, VS filed the complaints on her behalf. According to 34th article ECHR — 'Individual applications': AA, as an individual, and 'Victims of Sterilization' as a NGO could apply for a trial in the European Court of Human Rights, against an 'High Contracting Part', in this case, the Republic of Orosia which became a member of the Council of Europe and ratified the ECHR in 1995;

XXIV. For all the described facts, we are compelled to say that Orosian Government abusively interpreted the possibility to restrict fundamental rights present in the Convention, since sterilisation is neither a necessary or appropriate mean to "address the spread of the human immunodeficiency virus" nor to "avoid the transmission of HIV from mother to child during birth". In fact it is an excessive

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[21] American Psychiatric Association (2006), pp. 679-683.

[22] http://www.minddisorders.com/A-Br/Adjustment-disorder.html.

procedure given all available options which falls in the scope of article 17 of the Convention;

XXV. That's why we appeal for the most severe condemnation of Orosia's Government, so that human rights and human dignity may prevail above all.

II.2. Legal Pleading for the respondent

1. General Assessments

From now on the government of Orosia will present its arguments in defense of the accusation submitted by a legal representative of Victims of Sterilization:

A. Firstly the government wants to leave it clear that it had competence to do the pilot plan executed in Orosia. The campaign was done by an Administrative Decree by the Ministry of Health;

B. The Government was the competent organ and there is no such rule in Orosia that demands the intervention of the Parliament. Comparing to other European countries, it is a governmental task to promote health and security to the citizens. These norms are normally executed by the ordinary legislator, but also often by the government, like in this case. So it's not seasonable to question the competence of the government since it came from superior legislation that was legally approved. Attending to this competence, the government decided to promote a campaign that verifies the presence of HIV in the population and offers a free sterilization procedure throughout the NHS in order to prevent its transmission. We want to underline that no one was forced to do the diagnostic tests and the results were only known by the responsible doctors. If the results were positive, treatment was advised but not imposed. As it was said in the clarification available:

> *"Any citizen may request to undergo Human immunodeficiency virus (HIV) testing in a clinic for sexually transmitted diseases within a dermato-venerology department. The identity of the person undergoing testing is confidential. Health personnel providing care to pregnant women are required to inform the latter, in a comprehensible manner, of the risks run by their offs-*

pring if the mother is HIV-infected, and to advise them to undergo testing and, with their consent, to have the blood withdrawn subjected to a test for the detection of syphilis and HIV infection. The health personnel are required to suggest and recommend to persons recognized as being HIV-infected that they undergo sterilization free of charge at a health department of their choice."

1.1. "Right to privacy"

C. So it is secured that the privacy of the patients was respected by the medical staff involved and that the results were not disclosed to anyone except the patient. If the results provoked consequences in patients' social life it is not responsibility of the hospital. The Mangonia General Hospital action, in the special case of A.A., respected indeed all legal and fundamental conditions and requirements, for instance demanded by 4thart. of CEDHBIO [23];

D. A.A. can't claim that the results were reported to others, since doctors always respected the right of privacy and the right to "informational self-determination" [24] of the patients. Much more than a professional duty, it is a legal obligation for doctors to respect the privacy of their patients as stated in art. 12th of the UDHR [25], in art. 8th and 9th of the ECHR, in art. 10th of the CEDHBIO and in art. 17th of the ICCPR;

E. According to the ECHR, a document of Europe Council ratified by Orosia in 1995, public authorities are allowed to interfere in the private life of their citizens "in accordance with the law" and if it 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" [26].

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[23] Article 4 — "Any intervention in the health field, including research, must be carried out in accordance with relevant professional obligations and standards."

[24] Costa Andrade (2004), p. 22.

[25] 12.º: "One shall be subjected to arbitrary interference with his privacy, family, in your home or correspondence, nor to attacks upon his honor and reputation. Against such interference or attacks any person is entitled to protection of the law."

[26] 8tharticle of the ECHR

Thus the campaign created and promoted by the Orosian government was legal, since it aims to protect the health and the fundamental rights of the citizens by combating the increasing rate of people infected with HIV. The Court has admitted this argument in the "V.C. vs. Slovakia" case (application no. 18968/07) when it says in paragraph 145 "the respondent State complied with its positive obligation under Article 8 to secure through its legal system the rights guaranteed by that Article, by putting in place effective legal safeguards to protect the reproductive health of women of Roma origin in particular." and also in paragraph 139 "Any interference under the first paragraph of Article 8 must be justified in terms of the second paragraph, namely as being "in accordance with the law" and "necessary in a democratic society" for one or more of the legitimate aims listed therein.". Also the same is said in "A.B. and C. vs. Ireland" (application no. 25579/05).

1.2. The intervention's legitimacy

F. The Orosian government also recalls the "EuroNGOs" work towards a higher level of protection of human rights, specially sexual and reproductive health rights. It is also important to consider what has been their *modus operandi* in Europe: "[it] is a platform of cooperation between NGO's in Europe which put in common their work and collaborates to find the best ways to promote their values". Its members "aim to ensure that the European Countries as well as the European Union are committed to implement comprehensive and progressive SRHR policies";

G. Besides the Orosian government recalls the Commissioner of Human Rights in accordance with Article 8 paragraph 1 of Resolution (99) 50 of the Committee of Ministers of the Council of Europe that made several recommendations, which can be transported to Orosia as the objectives are the same for every European Country. "The Commissioner recommends that adequate resources be allocated for measures aimed at improving the health care system, including gynecological and obstetrical medical services and counseling, and that equal access to health care be ensured for everybody", and that justifies the campaign developed by the Orosian public authorities to promote public health;

H. The respondent also evokes the 1984 World Development Report by WB [27] and IMF [28]. Although the incomes of some African countries and Orosia are similar, in line with the WB "classification by income does not necessarily reflect development status" [29]. So we wouldn't be able to establish a parallel between them. However, based on the data provided on the case, we find that there are plenty of circumstances which allow us to relate Orosia with some countries in Africa. On this report the WB suggests the use of "sterilization vans" and "camps", and that's what the government decided to do when creating this campaign: building infrastructures that can reach all the country's population in order to permit the access to health services. If the campaign wasn't created, the majority of the population wouldn't have financial conditions to access these diagnostic tests or to antiretroviral therapy;

I. After doing the diagnostic tests, A.A. sought antiretroviral therapy (HIV treatment) and pregnancy services at the public Mangonia General Hospital. Due to financial issues, therapy in public facilities was the only possibility for A.A. in order to avoid transmitting the virus to her unborn child;

J. A.A. was interned at the hospital a few days before deliver and Ms. Bantward informed her about the campaign and the HIV-related risks for her child's health. As reported by the admission form, A.A. agreed to have a meeting with Dr. Graham Sylvester, coordinator for the campaign in the Mangonia General Hospital, who visited her at the second day to discuss the sterilization;

K. According to the campaign of the government and to the opinion of the medical staff sterilization is the adequate method to prevent the transmission of HIV;

L. Since the 60's of the 20th century it is common to do this procedure as a contraceptive method, which was encouraged by the European governments due to the demographic explosion that occurred in this period. In the 70's, persuasive techniques were used to increase this type of sterilization by appealing to the more harmful consequences of abortion. In Western Europe sterilization procedures

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[27] http://www.imf.org/external/pubs/ft/weo/2010/02/weodata/index.aspx

[28] http://data.worldbank.org/indicator/NY.GDP.PCAP.CD

[29] http://data.worldbank.org/about/country-classifications

were not punished anymore and in England they became free. In Sweden, 230 thousand women did this procedure between 1935 and 1996 [30]. So attending to this historical context the initiative of the government and the choice of the sterilization as the right method to prevent the transmission of HIV can't be a scandal. Quite the contrary, the government was correct in creating these free procedures, without which several women wouldn't have the choice to avoid the transmission of HIV. This shows that the government is attentive to Orosian's problems;

M. The government and medical staff know that the sterilization is most of the times performed in the tubal area and can be done by different methods: excision and suture, use of clips or rings or use of chemical substances, tubal ligation, etc.[31]Notwithstanding, there are other more radical techniques like the removal of the ovaries or the uterus, that are usually done due to the existence of tumors or bleedings and not as a contraceptive method. But when promoting this initiative the government ensured that the techniques used were the most appropriate and the less harmful. The procedure applied to A.A., the method of the tubal ligation, was practiced with all the hygienic and security conditions. This is sustained by the fact that A.A. didn't claim any health problem, but only psychological consequences that were provoked by her community and not by the hospital;

N. Furthermore sterilization can be practiced in many ways:

i. Can be voluntary — if freely decided by the patient;
ii. Can be coercive — if imposed on the patient against his/her will;
iii. Can be compulsive [32] — if we go back to the distant past we found in *The Republic of Plato*, Book V, a reference to this type of sterilization. But it is only in 1883 with Francis Galton's studies that eugenics reaches scientific and political community. In the beginning of the twentieth century we assist to a eugenic movement in the USA,

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[30] Sgreccia (2009), pp. 701-702.

[31] Hottois and Parizeau (1993), p. 202; Sgreccia (2009), p. 705.

[32] Nissa (2001), pp. 9-39; for further development check Berg and Roll-Hansen (1997).

> Canada and in the north countries of Europe like Denmark, Sweden and Norway. In the state of Indiana it is voted in 1907 the first American law that establishes the compulsive sterilization. In 1931 it is raised to 33 the number of states that have the power to impose sterilization to criminals convicted of rape, sexual offenses, epileptics, mentally disable and alcoholics. Eugenic sterilization was only changed in 1980 in California and it stills survives nowadays in 20 states. The Nazi Germany promoted also a eugenic program since 1933 and the rest of the story we already know. In the decade of the eighties a strong fight was taken to end these violent procedures, a fight that culminate with the approval of Beijing Platform (1995), whose 115th paragraph considers this a type of violence against women.

O. The national service has only practiced voluntary sterilization, once A.A. met with a doctor that explained the procedure and asked for her consent. In other words the sterilization procedure was not coercive, as it wasn't done against her will;

P. Furthermore A.A. can't claim that this was a eugenic program, since its goals are to promote health and to prevent the transmission of HIV. Not for a second did the government thought to create such an inhuman initiative, which would violate the art. 3 of ECHR. Besides, in order to benefit from this program the person in question needed to attend the campaign and to decide to do the tests and the other procedures by her own. No one was forced to do sterilization and the Orosian Government didn't imposed the procedure to any "type" of people;

Q. Sterilization can also be therapeutic or not therapeutic[12]. The first one is practiced when pregnancy is highly contraindicated for the women's health or when it may cause serious problems to the baby. The second one is used to prevent fecundation not for medical reasons but as a contraceptive method;

R. A.A. wasn't submitted to a therapeutic sterilization, but her procedure was not only practiced to prevent reproduction, but also to prevent vertical transmission of HIV;

S. The government recognizes that sterilization may scare patients, because the procedure reduces the probability of getting pregnant to less than 1% in the particular case of tubal ligation. Also,

it has a high tax of irreversibility in women, which rounds the 60%. Hence in 40% of the cases it is possible to women to reverse the situation — among these 40%, 80% will be succeed and will be able to get pregnant again. Obviously, these percentages may depend on how the surgery is done and on the size of the lesion [33]. But in this case of A.A. where getting pregnant may bring devastating consequences, sterilization is the most appropriate procedure to do. Nevertheless if A.A. regrets her own decision she can always try to reverse the tubal ligation, which seems possible since the procedure was done with all the needed care and all the necessary hygienic and security conditions;

T. Let us clarify that the government knows how important the reproductive role is for some communities in Orosia and is almost sure that if A.A. wasn't submitted to sterilization she would became pregnant in the future. Certainly, if contraceptives were recommended, she would not use them. Attending to this, the promotion of sterilization was considered appropriate according to her style of life;

U. The government also believes sterilization is a necessary procedure when women have HIV, because the chance of transmitting the virus from mother to children (vertical transmission) rounds 15% to 20%. Even when A.A. started doing the antiviral treatments (offered by the NHS) during the pregnancy, the rate only decreased to between 6% and 8%, which is still a relevant percentage when talking about the life of an innocent baby [34]. If she decided not to be submitted to sterilization and get pregnant again in the future, her baby could born with HIV and in the upcoming blame A.A. for having decided to proceed with the pregnancy even knowing the chances of transmitting the virus — this has already happen and it is called the *wrongful life* in the EUA. In the polemic Perruche [35] case (presented to the Court the Cassation in France) a child with a deficiency interposed an action for being born instead of being subjected to an abortion. The lawyer Jerry Saint-Rose invoked the *wrongful birth action* that claims an indemnization for the parents and the *wrongful life action* that pretends to repair the damage of the life that a child was

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[33] Sgreccia (2009), p. 706.

[34] Costa Andrade (2004), p.p. 38-39.

[35] http://pt.scribd.com/doc/49575379/Caso-Perruche-e-o-Direito-de-nao-nascer

forced to live [36]. So A.A.'s future son could interpose a *wrongful life* action to be compensated for the birth life sentenced that the HIV would bring to him/her, since A.A. knew during the pregnancy that there was a probability of transmitting this virus to her baby and she decided to pursue the pregnancy anyway;

V. Since the mentality of the communities of Orosia is not so developed as it should be, the government pretended to draw the attention to this epidemic by helping moms to take the best decision disregarding them from the influences of their community. In this case the law was created before a change of mentality happen. This law will have the task to change it — appealing for the role of woman not only as a reproductive human being.

1.3. The "medical-patient" relationship

W. In this case it is important to analyze the relationship between the doctor and the patient. The patient has the duty of ensure and promote his own health and the doctor is a professional called and freely chosen by the patient to help him [37]. The doctor shows up as a provider of a qualified service; however, the patient is considered the principal agent of the relationship. According to the Professional Letter of Health [38] this relationship is a meeting between confidence and conscience: the confidence of the man reached by pain, disease and the need of help; and the conscience of other person capable of cure him.

This hasn't always been the understanding of this relationship. In 1803 Thomas Percival in Medical Ethics starts talking about the obligation to inform the patient, but only when extremely necessary. In 1912 it is consecrated in Principles of Medical Ethics (due to American Medical Association) that the doctor should inform the patient of the benefits of the procedure. In 1969, the same association obliges the doctors to obtain informed consent every time they were using new medicines. With the Nuremberg and Helsinki code the consent becomes necessary in experiences. According to Lobato's

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[36] http://pt.scribd.com/doc/49575379/Caso-Perruche-e-o-Direito-de-nao-nascer

[37] Sgreccia (2009), pp. 275.

[38] Sgreccia (2009), p. 276.

theory [39] this relation is built in a set of phases: (meeting, diagnosis, operative moment, historical-social moment, a constitutive moment that appeals to an ethic dimension).

This relationship developed all over the years [40]. It started with the paternalistic model where the doctor only needed to assure the patient that he would have all the interventions he needed to promote his health. The doctor informed the patient in an authoritarian way presuming that he was the best person to determine what the best intervention was, leaving to the patient a reduced participation in this process. Later emerges the informative or scientific model that presupposes interaction with the patient. Assuming that the patient has his own values competes to the doctor to inform only about the facts, so that the patient can decide by himself. This model was criticized because it was considered an impersonal relationship with lack of support by the doctor. Then it progressed to the interpretative method where the doctor's role is to help the patient to reflect about his own values attributing a meaning to his choices and choosing the treatment according to that meaning. The patient here doesn't have pre-determined values, but builds them with the help of the doctor. This model was criticized because the doctor could influence the patient. Finally we can found the deliberative model where the doctor acts like an old professor, informing the patient about the procedure and helping him to make a moral path that will guide him to the final decision. This has been the most accepted model. We evolve from a vertically and demanding bilateral relationship to a horizontally, democratic and multilateral relationship (since involves all the medical staff, the family, etc.).

X. Having analyzed those arguments we can affirm that Dr. Sylvester fulfilled his duties. Indeed he came to A.A.'s room, explained the procedure in understandable terms and was available to respond to any doubts. He tried to build a relationship based in confidence asking for her consent more than twice. He acted like an old professor, teaching, informing and helping A.A. to make a moral path that would guide her to the final decision. He let her decide accor-

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[39] Neto (2004), pp. 718.

[40] Sgreccia (2009), pp. 281-284; Emanuel and Emanuel (1992), pp. 2221-2226.

ding to her own values but at the same time he was near her and closely followed every step that she took.

1.4. Valid Consent

Y. To obtain a valid consent it is necessary in first place that the patient has the capacity to make decisions. Secondly he must receive all the necessary information. Also consent only can be obtained when we are talking about personal and juridical available goods. However this availability has limits: law [41] and morality [42]. In this case, it's obvious that the limits were not extravasated;

Z. The procedure is not immoral since it is a common practice done everywhere. And if we appeal to immorality, we must consider that it is immoral to get pregnant knowing that there are chances of transmitting HIV to innocent children. By submitting herself to this procedure, A.A. was being responsible, showing that she didn't want to transmit HIV to a baby, condemning him to a life of suffering;

AA. A.A. can't claim either that she isn't capable of consent. According to the facts, the doctor affirms that he explained the procedure to A.A, so she was able to consent. The doctor also attended to certain criteria to make sure the patient received all the necessary information. He attended to the reasonable doctor's criterion that considers that the information given is enough when other reasonable doctor would have given the same information. This is, for instance, the dominant criteria in the UK [43]. The doctor also used the reasonable patient's criteria, according to which the relevant information is, at least, the one that an average person, in the same clinical state of the patient, needed to take a decision (dominant criteria in EUA [44] and Australia). The German courts demand a subjective criterion that attends to the concrete patient. Every patient has different needs due to his peculiarities and idiosyncrasies [45]. This criterion is based on what the concrete patient would like and should know;

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[41] Pereira (2004), pp. 129-147; Beauchamp and Childress (2001), p. 80.
[42] Pereira (2004), pp. 129-147; Mota Pinto (1985) p. 551.
[43] Smith and Smith (2005), p. 280.
[44] In EUA — Beauchamp and Childress (2001), p. 82.
[45] Glatz (1998), p. 247

BB. In this case, the doctor tried to explain in reasonable terms attending exactly to the concrete patient since he knew A.A. was illiterate. That's why he asked for her consent twice. If she wasn't certain about the consequences of sterilization, A.A. also had the duty to ask the doctor to explain her one more time the procedure, in a more current language. But she didn't and now she expects to charge doctor Sylvester for her own acts. We must not forget that the procedure was in the best interest of A.A., and if A.A. didn't care to know in what the procedure consisted, anyone else can be responsible for that;

CC. When asking her consent twice the doctor also fulfilled the duty to verify if the patient has understood the explanations that he gave. Without this extra care nothing guarantees that the consent was really enlightened. In this sense, Hottois and Parizeau said "The request of consent obliges the doctor to a few complementary initiatives: verify if the information was understood, asking some questions; evoking complementary questions by the patient; evaluating the anxiety state of the patient; obtaining the verbal agreement of the patient to initiate the treatment" [46];

DD. It wasn't necessary the consent of the father. In most countries it is only necessary the mother's consent, since is she who is going to be submitted to the procedure. The Orosian's law was respected since it didn't provide any requirements on this matter. Attending analogically to the abortion, the European Commission of Human Rights said in Petition 8416/76 that "the potential husband-father don't have the right to be consulted and to going to court because of the abortion that his wife is considering to do because the wife is the main interested in the continuation or interruption of the pregnancy." In a few words the relationship between doctor-patient is strictly personal and doesn't involve anyone else. Like it is said in the decision of the Spain Court STS 24/05/95 — "the consent is of a personal nature and can't be supplied or provided by a private family, even by the spouse" [47] and also in Câmara Nacional de Apelaciones en lo Civil in 25/10/1990 (Spain) "Health is a personal right

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[46] Pereira (2004), pp. 472-475.

[47] GalánCortés (2001), p. 260.

relatively unavailable, whose owner is the only one entitled to accept certain therapies" [48];

EE. Normally, in these procedures, the consent is written. But in this case, a written consent was impossible to obtain, since A.A. was illiterate — she can't read or write. In these cases Orosian law is clear: when the patient is illiterate it's only necessary verbal acceptance. The Spanish doctrine has been accepting other means instead of the written consent because believes that the consent is a verbal process and should be treated this way — law 41/2002, 14th November. Freedom of shape is the main rule and it is not removed even in invasive surgeries [49];

FF. Besides we are also aware that the hospital wants to avoid the written forms that are nowadays criticized for departing the relationship between the doctor and the patient, which is supposed to be personal and close. These written forms consist in general clauses that are transmitted to all patients in the same way. So they don't attend to the particularities of each patient, which may lead to fault of information more easily;

GG. A.A. claims that due to her state of labor she was not able to consent about the procedure. She says she was accidentally and temporarily disabled to give consent. The truth is that the doctor didn't realize that the patient was altered. In addition it is convenient to say that A.A. went to the hospital a few days before the delivery, so when she gave her consent to the doctor she wasn't in labor. Her stay in the hospital in the first days was just a measure of security and a way to provide a better accompaniment to A.A. Then when the visit occurred A.A. was in perfect conditions to consent. We must also highlight that the consent is revocable at any time, thus if A.A. was having second thoughts she could have stopped the procedure. Of course the law could impose more limits like France's law that enforces a period of reflection of 4 months, but it doesn't, and it is not less legitimate than the others. For example, when comparing to the Portuguese law, it is not imposed a reflection period. Moreover, most of the doctrine accepts a time of reflection of 24 hours.

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[48] Galán Cortés (2001), p. 260.

[49] For example, in Portugal the written consent in some cases is preferable, but it's not imposed — 66/1.º DCMS (such as the written forms).

2. Conclusions

Attending to what was previously explained, V.A. on behalf of A.A. intended to blame doctor Sylvester. It is however clear that this Court must not grant any sequence to this claim. In fact, from the arguments prior expended, it becomes self-evident that:

I. The conduct of the doctor was correct and responsible so he will not have to respond or compensate A.A. The responsibility assumptions (fact, illegality, damage, guilt, and causal nexus) are not fulfilled since there is no illegal fact that presupposes his guilt. He may be, maximum, disciplinary sanctioned because of the lack of registration of the consent (that is only considered a "mere administrative irregularitynot bearing effects on the validity of consent") that violates the duty of documentation. He can't respond civilly or criminally since he obtained the consent from A.A. twice and the intervention didn't cause any corporal damage and didn't bring any previous or subsequent health complications. Without damage the doctor doesn't have the obligation to compensate A.A. Like it was said in the decision of the Spain Court STS in 27/09/2001 "the lack of information by itself isn't enough to emerge a necessity of compensation — extra-contractual liability may exist without guilt, but not without damage." [50]. Or also in Sala de lo Civil y Penal del TSJ de Navarra in 27/10/01 where some conclusions have been taken:

- "Damage has to be certain and proved. Without damage there is no responsibility." In this case may only exist an infraction that will be sanctioned in other juridical orderings;
- "Damage has to be consequence of the medical intervention — a typical risk that should have been informed to the patient";
- Damage has to be a consequence of an arbitrary intervention (removing medical negligence or deficient functionality of the service)" [51].

II. The doctor didn't violate the lateral duty of information. He didn't frustrate the confidence that A.A. had deposited on him. Also

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[50] GalanCórtes (2001), p. 348.

[51] GalanCórtes (2001), pp. 348-349.

the hospital will not respond for the doctor's conduct: "*A public entity is not liable for an injury, whether such injury arises out of an act or omission of the public entity or a public employee or any other person*". Since the consent is a cause that excludes the illegality of the fact, and attending that A.A. gave a valid consent doctor Sylvester can't be blamed according to 5th art. of CEDHBIO;

III. A.A. claims damage to health [52] and wants the damage to be calculated attending to her specific cultural situation. Of course, if she belongs to a community that sees reproduction as the main role of women, her damage may increase. However, the doctor cannot be held responsible for the damage that the community caused to A.A. Nevertheless, the government will continue to support this type of legislation since it wants to change mentalities. As Karl Popper said: "we shouldn't accept without reservations the principle of tolerance with the intolerant ones. If we do so, we will be not only destroying ourselves, but the own attitude of tolerance". Clearly people can't be blamed just because communities believe in traditions that underestimate the role of women, who are considered mere reproduction objects. A.A. has autonomy to make her own decisions and by giving her consent she decided according to her conscience, so she should not be discriminated by that. The government is committed in fighting against this epidemic and this type of discrimination against women respecting this way the art. 14thCEDH. Besides CEDAW also blames all type of discrimination against women (1st) and according to art. 3th it is a state's task to "take in all fields, (...) all appropriate measures, including legislation, to ensure the full development and advancement of women" and it is also a task of any state "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women" (art. 5th). According to art. 16th/e) women and man have "the same rights to decide freely and responsibly on the number and spacing of their children";

IV. Culture isn't a static entity; it is dynamic and in constant evolution. It follows that although our personality is constructed in reference to certain values acquired in a cultural context, it doesn't

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[52] Dias (2001), p. 114.

mean that we cannot question, revise and fight them. The acceptance of its importance in the formation of personality doesn't imply a cultural fatalism [53]. Membership, as Kymlicka puts it, provides access to meaningful options which, in turns, allows individual to lead a "good life", but Jeremy Waldron alerts: meaningful options often come to us "(...) as items or fragments with a variety of cultural sources" and explains that what is important for individual is to have access to a range of "(...) stories and roles" not the access to "(...) a rich and secure culture structure" [54]. For all this we can't accept the cultural defense system (defended in the Common Law) that recognizes the determinant paper that culture have when performing certain acts but the cultural offense — where the normative and the cultural systems collide and the first one prevails [55];

V. We must attend to A.A.'s liberty and her liberty must be respected by everyone, including her community. In fact human liberty is an important principle and in this case it is clear that everyone respected A.A.'s liberty except her own community. Botturi believed that liberty could be divided in [56]: self-determination (subjecting to acts against her); self-realization (a path to the completeness of the agent); relation (the relations with the others; the recognition before others of her liberty). Evidently, A.A.'s community didn't accept her choice of submitting to the procedure. But that is not an issue for which the government must respond;

A.A. also claims the responsibility of the nurse. It is obvious that the information's debtor is the doctor. But nowadays, the medicine is exercised by multidisciplinary and hierarchical teams which give us two problems:

i) Who must tell the information and obtain the consent?
ii) Who is covered by that consent?

The doctrine admits that the assistants involved in the treatment can give information and the delegation of certain competences in the

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[53] Jerónimo (2011), p. 360.
[54] Kymlicka (1996), p. 83; p.102.
[55] Chate (2010), pp. 37-42.
[56] Sgreccia (2009), p. 201.

team assistant's is legal. But when it comes to the nurses, they can't by themselves transmit the information to the patient (the doctor can't delegate on them this duty) [57]. So in this case, the nurse had done her job completely by helping the doctor filling the admission form. Nevertheless, she may be important in this case, since she is the only witness that can prove the type of information given by the doctor.

VI. We also want to make clear that "the recent drafting of a detailed national pilot plan for the treatment of HIV-positive pregnant" is not a retreat of the government. It is just a way to improve this campaign and to achieve more effectively the results that the government pretends to;

VII. Once the ONG studies are not official, the government is not even going to comment them. Official data will arrive and then the government will evaluate the results.

Most of all, we cannot forget that patients with HIV have an increased responsibility and need to take precautions to avoid the transmission of the virus. Certainly sterilization is one of the best ways to prevent vertical transmission. By doing this patients act according to their disease. Like George Bernard Shaw said: "Liberty means responsibility. That's why so much people are afraid of it". And the government of Orosia contributed to stress this responsible liberty. That is what should prevail. And that is what this Court must state.

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