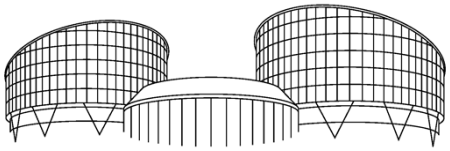

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FOURTH SECTION

# CASE OF LINDHOLM AND THE ESTATE AFTER LEIF LINDHOLM v. DENMARK

*(Application no. 25636/22)*

JUDGMENT

Art 8 read in light of Art 9 • Private life • Medical treatment in the form of a blood transfusion administered to unconscious Jehovah's witness, for his survival in an emergency situation, despite his advanced medical directive refusing such a measure • Interference clearly defined in domestic law and fulfilled accessibility and foreseeability requirements • No indication domestic law applied in an arbitrary or manifestly unreasonable way • Application of criteria set out in *Pindo Mulla v. Spain* [GC] • Limited binding effect of "advance directive on medical treatment" under domestic law and requirements concerning refusal of blood transfusions within the State's margin of appreciation • Legal requirement that blood transfusion be made on an informed basis in the context of the current course of illness, not met in the present case • Relevant and sufficient reasons • Interference "necessary in a democratic society" and proportionate to pursued legitimate aim of protection of health • Domestic authorities acted within margin of appreciation

Prepared by the Registry. Does not bind the Court.

STRASBOURG

5 November 2024

*This judgment will become final in the circumstances set out in Article 44 § 2 of the Convention. It may be subject to editorial revision.*

**In the case of Lindholm and the Estate after Leif Lindholm v. Denmark,**

The European Court of Human Rights (Fourth Section), sitting as a Chamber composed of:

Gabriele Kucsko-Stadlmayer*, President*,
Tim Eicke,
Armen Harutyunyan,
Ana Maria Guerra Martins,
Anne Louise Bormann,
Sebastian Răduleţu,
Mateja Đurović*, judges*,
and Andrea Tamietti, *Section Registrar,*

Having regard to:

the application (no. 25636/22) against the Kingdom of Denmark lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Danish national, Ms Lilian Elisabeth Lindholm (the first applicant), and the estate of her deceased husband, Mr Leif Ingolf Lindholm (the second applicant, henceforth L), also a Danish national, on 18 May 2022;

the decision to give notice to the Danish Government ("the Government") of the application;

the parties' observations;

Having deliberated in private on 15 October 2024,

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

# INTRODUCTION

1. This case concerns a member of the religious community of the Jehovah's Witnesses, who was admitted to hospital as an emergency patient and was given a blood transfusion, despite having previously stated his refusal of this procedure, a principle which was part of his religious beliefs. The applicants complained under Articles 8, 9 and 14 of the Convention.

# THE FACTS

2. The first applicant was born in 1953 and lives in Randers. Her late husband, L, was born in 1947 and died on 21 October 2014.

3. The applicants were represented by Mr Shane Heath Brady, Mr Petr Muzny, and Mr Tyge Trier, lawyers practising in respectively London, Switzerland and Copenhagen.

4. The Government were represented by their Agent, Ms Vibeke Pasternak Jørgensen, of the Ministry of Foreign Affairs, and their co-Agent, Ms Nina Holst-Christensen, of the Ministry of Justice.

5. The facts of the case may be summarised as follows.

## I. THE HOSPITALISATION

6. L had been a Jehovah's Witness since he was fifteen years old. In 1970 he married his wife, the first applicant, who was also a Jehovah's Witness. They had five children.

7. On 19 September 2014, in the afternoon, L, aged 67, was admitted to the emergency unit of a local hospital (*Odense Universitetshospital, medicinsk afdeling Ærø)* having fallen about two metres through a roof. The medical records showed that he was admitted at 3.28 p.m. and was then conscious. The first applicant estimated that L might have been lying unconscious for up to an hour before he was found. He was transported by helicopter from the local hospital to the main hospital, it was noted in the medical records at 10.22 p.m. that on his arrival at the hospital L had been awake and could give his name but that he was disoriented and had no recollection of the fall. All information came from the first applicant. A CT scan was carried out and showed a small subarachnoid haemorrhage (bleeding between the membranes that surround the brain) and bleeding on the left side of the thorax (chest) and on the left side of the gluteal muscles (buttock muscles).

8. Prior to his hospital admission, L had been taking blood thinners in the form of warfarin (Marevan 2.5mg) on prescription to reduce the risk of cerebral thrombosis from atrial fibrillation. One of the known side effects of warfarin is that it generally increases a patient's tendency to bleed. Any bumps, blows or jolts to the body will therefore have a risk of increased bleeding.

9. During the night of 19 - 20 September 2014, L began to have difficulty breathing. A new CT scan revealed that a massive accumulation of blood had developed by his left lung. A drain was inserted into the lung late in the morning of 20 September 2014. L's medical records show that his condition at that time did not indicate a need for a blood transfusion.

10. An entry in L's medical records on 20 September 2014 at 9.05 a.m. stated that L was able to give his name and date of birth and that he understood that he was in hospital, but that he otherwise seemed disoriented.

11. According to entries in the medical records made on 20 September 2014 at 2.08 p.m. and 2.38 p.m., L's daughter had informed the healthcare staff that L, as a Jehovah's Witness, did not wish to receive a blood transfusion. In the afternoon of the same day, the healthcare staff were presented with an advance medical directive and a Health Care Power of Attorney (*forhåndsdirektiv og fuldmagt angående lægebehandling*), which were entered into L's medical records. L had been carrying the document on his person when the accident happened. The advance medical directive had been signed by L on 11 February 2012 and stated as follows (emphasis in the original):

> "I, L ... am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if healthcare providers believe that they are necessary to preserve my life. I refuse to pre-donate and store my blood for later infusion."

12. According to the medical records, a doctor was called at 4.33 p.m. because L had lost consciousness. L was transferred to the hospital's neurosurgical intensive care unit and a new CT scan was carried out.

13. At 6.15 p.m. a note was added that L's haemoglobin level (blood cell count) had dropped from 10.0 to 6.1. and that "[t]he patient may not be given blood products because of his religious beliefs".

14. A further note at 7.40 p.m. recorded that "the patient is still not fully conscious".

15. From the medical records of 20 September 2014 at 11.42 p.m. it appeared that the unit's healthcare staff had had a conversation with L's family (the first applicant and some of the children). The family repeated that L was a Jehovah's Witness and did not wish to receive any transfusions of blood or blood components. The healthcare staff informed them that L was being treated in accordance with their wishes, but that he was in a very serious condition because of the atrial fibrillation, the blood accumulation near his lungs, and the added strain on his circulation. The family understood the gravity of his condition.

16. In the afternoon of 21 September 2014, L was transferred to the intensive care unit because the condition of his lungs was very poor. An entry in L's medical records at 5.45 p.m. said that he was deeply unconscious by then and connected to a ventilator. By that point, L's haemoglobin level had dropped to 4.2, but the assessment was that the "patient has no acute transfusion needs". The medical records further stated that it had not been possible to obtain L's own position on receiving a blood transfusion in the current potentially life-threatening situation and that L had probably not changed his opinion since 2012, when he had signed the advance medical directive (see paragraph 11 above), but that the healthcare staff had been unable to verify that assumption.

17. In the evening of 21 September 2014, the healthcare staff had a conversation with the L's wife (the first applicant), their daughter, and a support person, about the "problematic legal situation". The family referred to the advance medical directive and requested that it be respected. They also referred to the fact that in 2010 L had been admitted to hospital because of serious gastrointestinal bleeding in his duodenum and that during that hospitalisation he had been conscious and had decided to refuse a blood transfusion, against the doctors' recommendations. The doctor emphasised that following the incident on 19 September 2014 (see paragraph 7 above) L had lacked the capacity to confirm his decision to refuse blood products and that the situation was potentially life-threatening. The doctor explained that the situation might escalate quickly so that the need for a transfusion

might arise, and that the healthcare staff had a duty to treat L if they had had no confirmation directly from him about his decision to refuse blood products. At that time, L was still not in current need of a blood transfusion. The healthcare staff informed the family that the treatment with Konakion (vitamin K) and tranexamic acid (a synthetic amino acid used to treat and prevent blood loss) would be continued, and that treatment with erythropoietin (EPO) would be initiated.

18. During the night between 21 and 22 September 2014, a pressure gauge was inserted into L's brain to monitor the pressure in his brain in case it became elevated as a consequence of the subarachnoid haemorrhage (intracranial pressure monitoring). Around noon on 22 September 2014, L's haemoglobin level was at 3.7, the pressure in his brain had built up, and he had a suspected swelling of the brain tissue (oedema). An immediate CT scan was ordered. The healthcare staff were concerned that the decreasing haemoglobin level might cause an oxygen deficiency in the brain and an increased risk of bleeding.

19. On 22 September 2014, the chief physician, X, consulted the medical health officer (*ombudslægen*) regarding L's immediate need for treatment. His decreasing haemoglobin level, the swelling in his brain and the subarachnoid haemorrhage made it necessary to increase his haemoglobin to a level between 4.3 and 4.5. L was unconscious and unable to give consent. In an e-mail send at 12.19 p.m., the medical health officer gave the following reply:

> "... Advice given:
>
> The chief physician, X, was reminded (*guidet)* of sections 19 and 24 of the Health Act (*sundhedsloven*)
>
> [a]s the patient is not competent and has not expressed his wishes in the current situation (but did so in 2012 in another context), there may be a need to give blood according to section 19 (if, however, there may be any possible way to avoid giving him blood, this should be sought in the light of the hospital's knowledge of the patient). For the sake of the patient, his relatives and the staff (including a potential subsequent complaint), it is important that record keeping is done with great care and conscientiousness."

20. According to the medical records of 22 September 2014 at 2.20 p.m., L's haemoglobin level had dropped to 3.4, and increasing intracranial pressure (elevated pressure in the brain) had been observed.

21. The healthcare staff discussed the situation with L's family again and explained the risk of suboptimal brain perfusion (marginally reduced oxygenation and a reduction in the supply of blood to the brain) and an increased risk of bleeding in the brain. The family maintained that L did not wish to receive a blood transfusion.

22. On 22 September 2014 at 3.28 p.m., the chief physician X decided to increase the haemoglobin level to between 4.3 and 4.5 by administering a

blood transfusion. L was given one bag of blood which was prescribed on 22 September 2014 at 4.44 p.m. His haemoglobin level rose to 4.5.

23. Seven days later, L showed no signs of returning to consciousness, for which there was no neurosurgical explanation.

24. On 9 October 2014, L was transferred to the intensive care unit at another hospital (*Svendborg Hospital*).

25. On 20 October 2014, the healthcare staff had a conversation with L's wife and daughter about L's condition and explained that permanent damage seemed unavoidable. In consultation with the family, active treatment was discontinued later that day, after which L received only palliative care.

26. L died on 21 October 2014. It is not in dispute that the cause of death was not linked to the blood transfusion administered on 22 September 2014 (see paragraph 22 above).

## II. THE ENSUING LEGAL PROCEEDINGS

27. On 7 December 2014, the first applicant filed a complaint with the Patient Ombudsman (*Patientombuddet*) claiming that the blood transfusion had been administered against L's will.

28. On 8 October 2015, the Patient Ombudsman became part of the newly established Patient Safety Authority (*Styrelsen for Patientsikkerhed*), which was established to examine complaints against treatment facilities and healthcare professionals.

29. On 17 December 2015, the Patient Safety Authority found no basis for criticising Odense University Hospital and concluded that the treatment provided to L had met the generally accepted professional standards and had complied with the Health Act.

30. On 16 December 2016, the applicants, instituted proceedings in the Svendborg District Court (*Retten i Svendborg*) against the Patient Safety Authority (now the Patient Complaints Agency) relying on, *inter alia,* Articles 3, 8 and 9 of the Convention, alone and read in conjunction with Article 14 of the Convention.

31. On 10 August 2018, the District Court referred the case to the High Court of Eastern Denmark (*Østre Landsret*) (henceforth "the High Court").

32. By a judgment of 7 December 2020, the High Court found partly for the applicants. The majority (two out of three judges) found, on the one hand, that previous information, such as an advance medical directive, could not be conclusive when doctors had to decide whether a blood transfusion was required under section 19 of the Health Act (see paragraph 39 below). On the other hand, making an unconditional, formal requirement of informed refusal "in the current course of illness" a condition for not administering a blood transfusion would mean that a person who was hospitalised in an unconscious state could not object to the treatment, no matter how unambiguous and well-documented their previous refusal of blood might be.

Moreover, in the present case, the doctors had had no doubt about L's absolute refusal of blood transfusion. Accordingly, there had been a violation of Articles 8 and 9 of the Convention. The wording of the reasoning was as follows:

> "All the essential evidence in the case – in particular L's advance directive of 11 February 2012, his refusal of a possible blood transfusion during his hospitalisation in 2010, the available medical records, the statements given by [the first applicant and her daughter] and the statement by chief physician X – points unequivocally to the fact that L's refusal to receive blood was a personal, religious decision. In particular, it is noted that at no time during the hospitalisation or afterwards has there been any doubt at all that the advance directive was completed and signed by L of his own free will on 11 February 2012, and that he was at that time capable of acting rationally. It must also be stressed that L decided to renew his advance directive after his hospitalisation in 2010. This is information which was essentially available when chief physician X decided that a blood transfusion should be carried out. He has explained, among other things, that he "at no time [doubted] the family's statements about the patient's wishes, but he had to do the right thing and follow the medical rules."
>
> There was therefore no doubt about L's decision, apart from the – in the light of the other evidence – theoretical doubt connected with the fact that L was unconscious when it first appeared advisable to carry out a blood transfusion, and that the doctors were therefore unable at that time to follow the procedure laid down in section 24, subsection 2 of the Health Act. Moreover, L was not found to have had an opportunity to make it known at the time of his admission, when he was still conscious, that he did not want blood. We note here that he was at that point dazed [*omtåget*] and suffering from amnesia, that it does not appear that he was questioned by the health professionals, and that he was carrying the advance directive on his person, which in itself indicates that he stood by his decision to refuse blood.
>
> After an overall assessment of the information available, we therefore find that at the time of the decision to give blood to L there was no reasonably justified doubt that he did not wish to receive blood even in the current situation of illness. There is no evidence of such special circumstances that chief physician ... otherwise had grounds for disregarding the wish.
>
> In these circumstances, we consider that it has been established that the decision to allow blood transfusion on 22 September 2014 was not necessary for reasons of critical social need, see Article 8, paragraph 2, and Article 9, paragraph 2, of the European Convention on Human Rights."

33. On appeal, in a judgment of 1 February 2022 a seven-judge panel of the Supreme Court (*Højesteret*) unanimously found against the applicants for the following reasons:

> "Background to the Case and the Issues
>
> Following a fall, L was admitted to Odense University Hospital for emergency care on 19 September 2014. During his stay in hospital, he received a blood transfusion on 22 September 2014, while he was unconscious. The health personnel were aware of his declaration *inter alia* in his "Advance Medical Directive and Health Care Power of Attorney " of 2012, stating that, as a member of the religious community the Jehovah's Witnesses, he did not want to be given blood under any circumstances, even if it was necessary in order to preserve his life. On 21 October 2014 he passed away without

having regained consciousness. The cause of death was unrelated to the blood transfusion.

On 17 December 2015, the Patient Safety Authority (now The Agency for Patient Complaints) decided that there were no grounds for criticising Odense University Hospital for giving L the blood transfusion.

The main issue in the case is whether the Patient Safety Authority's decision should be set aside (*tilsidesættes som ugyldig*) because the blood transfusion given on 22 September 2014 was administered in breach of the Health Act, in particular sections 19 and 24, or in violation of Articles 8, 9, and 14 of the Convention.

The Health Act

Under section 15 of the Health Act, no treatment may be initiated or continued without the patient's informed consent, unless otherwise prescribed by law or provisions laid down pursuant to law or by sections 17-19 of the Act. The exception in section 19 includes, *inter alia,* cases where a patient who is temporarily incapable of giving informed consent is in a situation where immediate treatment is required for the patient's survival.

Chapter 6 (sections 22-27) of the Health Act contain rules about patient autonomy in special cases, including section 24, which deals with the right to refuse blood transfusions. Section 24, subsection 1, establishes that treatment involving a blood transfusion or blood products may not be initiated or continued without the patient's informed consent. According to section 24, subsection 2, a patient's refusal to receive blood or blood products must be given within the context of the current course of illness and must be based on information from the healthcare professional about the health consequences of blood or blood products not being administered during the treatment.

Section 22 of the Act establishes that section 19 does not apply to *inter alia* section 24. This means that administering treatment without consent in, *inter alia*, situations where it is required for an unconscious patient's survival under the ordinary rule in section 19 does not apply if the patient has refused blood transfusions in the context of the current course of illness. In such a situation, the patient's refusal must therefore be respected, even if a blood transfusion is vital.

If a person's refusal to receive blood is stated before the current illness, it follows from section 20 of the Health Act and the preparatory notes to the Act (*Folketingstidende* 1997-98, 2nd Compilation, Appendix A, Bill no. L 15. p. 533), that such an advance directive shall be treated as relevant and taken into account in the health staff's treatment decisions if the directive can still be assumed to be current and relevant. However, according to section 24 compared with section 19 of the Health Act, an advance directive does not prevent doctors from administering a blood transfusion without consent, *inter alia* in situations where an unconscious patient has not made an informed refusal of blood transfusion in the context of the current course of illness and is in a condition where a blood transfusion is required for the patient's survival.

Hereafter, the Supreme Court finds that there was a legal basis in the Health Act for the blood transfusion given to L when he was unconscious on 22 September 2014, regardless of his advance directives that he refused blood. Emphasis is placed here on the circumstances that it is undisputed that following the accident he was unable to state his own wishes. The fact that during his fall and admission to hospital he carried his Advance Medical Directive refusing blood on his person does not meet the requirement in section 24, subsection 2 of the Health Act that a refusal of blood transfusions must be given on an informed basis and in the context of the current course of illness. Furthermore, according to the medical information in the case, it definitely appears that

at the time when the blood transfusion was administered, he was in a condition where blood transfusion was required for his survival.

The European Convention on Human Rights

The court will deal secondly with whether the blood transfusion was a violation of the Convention on Human Rights.

Under Article 8, paragraph 1, of the Convention on Human Rights, everyone has the right to private life, and according to paragraph 2 there can be interference with this right only where it is necessary for the protection of the health or of the rights of others etc. Article 9, paragraph 1 establishes that everyone has the right to freedom of religion and to manifest his religion, and under Article 9, paragraph 2 this freedom can only be subject to such limitations as are prescribed by law and are necessary in a democratic society in the interests of for example health or for the protection of the rights and freedom of others. Article 14 of the Convention contains a prohibition on discrimination on the grounds of, *inter alia,* religion.

In its judgment of 10 June 2019 in case 302/02 (*Jehovah 's Witnesses of Moscow and Others v. Russia*), the Court found that the Russian authorities had violated the Convention on Human Rights by dissolving the association the Jehovah's Witnesses of Moscow and banning the association's activities, *inter alia*, with reference to the association's encouragement of its members to refuse certain forms of medical treatment, such as blood transfusions. The judgment states that refusing potentially life-saving medical treatment on religious grounds is a problem of considerable legal complexity, involving a conflict between, on the one hand, the State's interest in protecting the lives and health of its citizens and, on the other, the individual's right to personal autonomy in the sphere of physical integrity and religious beliefs, cf. paragraph 134. Furthermore, it is stated that the genuineness of a patient's refusal of medical treatment constitutes "a legitimate concern", given that health and possibly life itself are at stake in such situations, see paragraph 138.

The Supreme Court thirdly finds that the judgment does not provide a basis for holding that the national legislature is precluded from establishing, as part of a combined balancing of different considerations, further conditions under which directives from members of Jehovah's Witnesses refusing blood transfusions would be binding on health personnel.

The requirement in section 24, subsection 2 of the Health Act that a refusal of blood transfusions must be given in the context of a current course of illness in order to be binding on health staff is further supported in a reply from the Minister of Health at the time, during Parliament's consideration of the bill about the corresponding rule in section 15 of the previous Patients' Legal Status Act (the Minister of Health's reply to question number 4 of 2 April 1998 from the Parliament's Health Committee, Bill no. L 15 annex 25). It is stated in the reply that an advance medical directive setting out that the patient – who by then is unconscious or otherwise incapable – refuses treatment that involves blood transfusion is not binding on the physician, but shall obviously be taken seriously and be included in the considerations to be taken into account when deciding on treatment. In that connection, it is mentioned that both the Council of Europe's Convention on Human Rights and Biomedicine and a number of other declarations only make it obligatory to take advance directives into consideration, and do not require that they are binding on treating staff. It is then stated in the reply that whether the issue is a refusal of blood transfusions or directions about psychiatric treatment or other medical intervention, introducing rules that advance directives shall be binding on treating personnel, including in situations where the patient's situation is

not hopeless, would give rise to serious concerns about patient safety and would involve immeasurable problems with the documentation needed in order to reasonably determine that those were indeed the patient's settled wishes. Furthermore, the Minister said in his reply that it could not be ruled out that in the current situation the patient, had he or she been conscious, would have preferred to go on living.

The present position is that an advance directive refusing blood transfusions or other medical treatment has a persuasive influence but is not binding if it is a matter of life-saving treatment of for example an unconscious patient. The requirement in section 24, subsection 2 of the Health Act that a refusal of a blood transfusion must be made in the context of the current course of illness in order to be binding on health staff is, as described, there to enable the balancing of personal autonomy, patient safety, and the documentation of a patient's settled wishes. The legislature has found it proper to have a regulation that can prevent the risk that for example an unconscious patient dies because of insufficient vital treatment which, in the context of the current course of illness, he or she would have consented to.

During the first days after L's admission to hospital, he was treated with, *inter alia,* blood-forming medication in order to take into account his previous directives about not wanting a blood transfusion. It was not until it was thought to be required for his survival that a blood transfusion was given. Against that background, the Supreme Court finds that there are no grounds for determining that the blood transfusion that was given to L on the basis of the provisions of section 24 of the Health Act in conjunction with section 19 was a violation of Articles 8 or 9 of the Convention on Human Rights.

As stated, section 19 of the Health Act allows life-saving treatment to be administered to an unconscious patient regardless of any advance directive from him or her about not wanting to be treated. The rule is general and is not restricted to blood transfusions. Therefore, the blood transfusion that was given to L was not a violation of Article 14 of the Convention on Human Rights, read in conjunction with Articles 8 and 9.

Conclusion and legal costs ...."

# RELEVANT LEGAL FRAMEWORK AND PRACTICE

## I. DOMESTIC LAW AND PRACTICE

34. The Patients' Rights Act (*Lov om patienters retsstilling,* no. 498 of 1 July 1998) was replaced by the Health Act (*Sundhedsloven,* no. 546 of 24 June 2005*,* which entered into force on 1 January 2007).

35. At the time of the events in the present case, the relevant law was section 15 of the Health Act, which read as follows:

**Section 15**

"(1) No treatment may be initiated or continued without a patient's informed consent, unless otherwise provided by law or by provisions laid down in pursuance of the law or by sections 17 to 19.

(2) A patient may, at any time, withdraw his or her consent given under subsection (1).

(3) For the purpose of this act, informed consent means consent given on the basis of adequate information provided by a healthcare professional: see section 16.

(4) Informed consent ... may be written, oral or, in certain circumstances, implied. ..."

36. The corresponding preparatory notes to the former section 6 of the Patients' Rights Act read as follows:

"The provision includes the basic rule about informed consent. No examination, treatment or care may be initiated or continued without the patient's informed consent. This does not apply to cases where the patient is under 15 years of age or incapable of giving consent as described in sections 8 to 10 of the Act [now sections 17 to 19 of the Health Act], nor does it apply to exceptional cases where special legislation provides for compulsory treatment.

Under subsection (2), a patient may withdraw his or her consent to treatment at any time. The subsection emphasises that consent must be freely given and that the patient can withdraw that consent at any time and decline any further treatment. That may be important in cases where, because of religious or other beliefs, a patient does not wish to receive certain types of treatment, such as a blood transfusion. Refusal to receive blood or blood products is a practice of the members of the religious community of Jehovah's Witnesses.

If a patient refuses any examination or treatment offered, an entry to that effect must be made in the patient's medical records. ...

The right to personal autonomy applies to the greatest extent possible, that is, in all cases where a patient is able to understand and assess his or her specific medical situation. ...

The provision in subsection (3) defines the concept of 'informed consent', which is well-established within healthcare throughout the developed world and is used, *inter alia*, in international conventions. It is therefore considered appropriate to use this concept in the Act.

The advantage of using this concept is that it combines in one concept two elements that are key to patients' rights, namely information and consent, and makes it clear that consent depends on having full information about the state of health, treatment options, etc. Consent based on an insufficient level of information is inadequate when dealing with a matter as intrusive as medical treatment. If a patient has declined information under section 7(2) [now section 16 (2) of the Health Act], informed consent will still be considered to have been given, even if the amount and level of information may have been limited at the request of the patient.

The information that must form the basis for voluntary and effective consent must contain the appropriate information on the nature of the medical condition, treatment options, risks and side effects, etc., to enable the patient to decide on the matter of treatment. In the provision, this is expressed by the wording that information must be adequate. The information must also be based on currently accepted professional standards in the field. The provision of information from a healthcare professional to a patient must be tailored to the individual patient so that, to the greatest extent possible, he or she understands the situation, etc. The key is to provide the patient with a basis for giving consent freely, that is, consent without any pressure.

It is important that the healthcare professional ensures that informed consent is obtained at a point in the course of examination and treatment when the patient is best equipped to take a considered position on treatment and that the physical setting – the environment – will allow the patient to consider and decide on the issue of treatment. Where a patient is, *inter alia*, in a state of confusion because of medication or for other

reasons, consideration should be given to whether it is possible to postpone giving the information and treatment until the patient is better able to take a considered position on treatment. However, informed consent should always be obtained well in advance of invasive treatment. ...

Subsection (4) covers the form of consent, which may be written, oral or, in certain circumstances, implied. ...

Consequently, the general rule in health law is that oral consent is sufficient for healthcare professionals to initiate or continue treatment, etc. ..."

37. At the relevant time, the wording of section 16 of the Health Act read as follows:

**Section 16**

"(1) A patient has the right to be informed about his or her state of health and treatment options, including about the risk of complications and side effects.

(2) A patient has the right to decline any information under subsection (1).

(3) The information must be provided on an ongoing basis and offer a comprehensible explanation of the condition, examination and planned treatment. The information must be provided in a considerate manner and be adapted to the individual circumstances of the recipient in terms of age, maturity, experience, etc. ..."

38. The corresponding preparatory notes to the former section 7 of the Patients' Rights Act read as follows:

"This provision governs patients' right to receive information on their state of health, treatment options, etc. ...

Under subsection (1), every patient has the right to be fully informed about his or her state of health and about treatment options. The concepts of state of the patient's health and treatment options are to be understood as including all information of relevance to the patient on health, diseases, methods of examination, prevention and treatment options, prognoses for the patient's condition, risks, side effects, complications, care options, etc. The risk of complications or side effects is included specifically in the wording of the Act as it is often a very important factor for patients when considering a treatment option. ...

The provision in subsection (3) describes how healthcare professionals must provide information under subsection (1). The information must be provided on an ongoing basis as needed and in clear and comprehensible language so that the patient is able to understand the situation, that is, his or her state of health, the treatment options available, the risks of complications and side effects involved in various interventions, etc. The information must be provided in a considerate manner and must be adapted to the individual circumstances of the recipient in terms of age, maturity, experience, etc. This includes a particular obligation for healthcare professionals to show consideration and care for patients who are not used to claiming their rights from authorities and healthcare professionals. ..."

39. At the relevant time, the wording of section 19 of the Health Act read as follows:

**Section 19**

"If a patient who temporarily or permanently lacks the capacity to give informed consent, or who is under 15 years of age, is in a situation where immediate treatment is required for the patient's survival or to improve the patient's chances of survival in the long term or for a significantly better outcome of the treatment, a healthcare professional may initiate or continue treatment without obtaining consent from the patient or from the person with custody of the patient, the patient's closest relative or the patient's guardian."

40. The corresponding preparatory notes to former section 10 of the Patients' Rights Act read as follows:

"This provision allows the healthcare professional to provide treatment without consent where such treatment is urgent and typically life-saving.

If a patient is in a situation where immediate treatment is required for the patient's survival or to improve the patient's chances of survival in the long term or for a significantly better outcome of the treatment, the healthcare professional may initiate or continue treatment without obtaining consent from the patient or a representative.

The provision is based on the principle of necessity: the lesser good (the patient's right to personal autonomy) must give way to achieve a greater good (preservation of the patient's life and mobility).

The main point of the provision lies in the immediate need for treatment. Such a need exists where 'immediate treatment is required for the patient's survival', that is, immediate life-saving treatment, or where treatment is urgently needed to improve the patient's chances of survival in the long term or for a significantly better outcome of the treatment.

Where the patient is a fully conscious adult, informed consent must be obtained in compliance with the rules in sections 6 and 7 [now sections 15 to 16 of the Health Act]. Where the patient is a fully conscious person aged 15 to 17, informed consent must be obtained in compliance with the rule in section 8 [now section 17 of the Health Act]. In both cases, consent must be obtained in a manner appropriate to the urgency of the situation. ..."

41. At the relevant time, the wording of section 20 of the Health Act read as follows:

**Section 20**

"A patient who is unable to give informed consent must be given full information and must be involved in discussing the treatment to the extent that the patient understands the treatment, unless this may harm the patient. The patient's views must be taken into account, in so far as they are current and relevant."

42. The corresponding preparatory notes to former section 11 of the Patients' Rights Act read as follows (*Folketingstidende* 1997-98, 2nd Compilation, Appendix A, Bill no. L 15. p. 533):

"This provision applies in all cases where a patient does not have the capacity to give informed consent, that is, it applies to children and adolescents under 15 years of age, to immature children and adolescents aged 15 to 17 years (section 8(2)) and to patients who permanently lack the capacity to give informed consent (section 9).

... Patients who permanently lack the capacity to give informed consent constitute a very broad and heterogeneous group, covering wide variations of the inability to give consent. Often, a patient falling within this group will be able to understand some of the medical issues, in which case his or her views should be taken into account to the extent possible in the legal representative's decision-making process. Reference is also made to the explanatory notes on section 9.

The Council of Europe's Convention on Human Rights and Biomedicine contains the following provision:

**'Article 9 – Previously expressed wishes**

Wishes relating to a medical intervention previously expressed 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.'

Similar provisions can be found elsewhere - in, *inter alia*, *A Declaration on the Promotion of Patients' Rights in Europe* issued by the World Health Organisation (WHO) in March 1994, and in the Finnish Legal Status Act (Act No. 785 of 17 August 1992).

This general provision also applies to the relationship between patients and healthcare professionals under the Legal Rights of Patients Act. Where such previously expressed wishes are considered to be up to date and relevant, they must be given weight and must be taken into account by healthcare professionals when they take decisions on treatment."

43. At the relevant time, the wording of section 22 of the Health Act read as follows:

**Section 22**

"Sections 15 to 16 on informed consent, section 17 on minors, section 20 on the involvement of patients and section 21 on the responsibility of healthcare professionals apply with the necessary modifications to the provisions of this chapter. However, section 17 on minors does not apply to section 26 on living wills."

44. The corresponding preparatory notes to former section 13 of the Patients' Rights Act read as follows:

"The provision in section 13 [now section 22 of the Health Act] entails that the fundamental rules on informed consent in sections 6 to 7 [now sections 15 to 16 of the Health Act] also apply to the special cases falling within chapter 3 [of the Act].

The rule on the independent decision-making capacity of minors in section 8 [now section 17 of the Health Act] also applies in respect of the issues of hunger strikes, refusals of blood transfusions and the treatment of terminally ill patients. ...

The rule on immediate need for treatment, see section 10 [now section 19 of the Health Act], has also been left out of chapter 3 [of the Act]. A patient's right of autonomy in special cases falling within chapter 3 [of the Act] must be respected even if, during the course of treatment, a situation arises where section 10 [now section 19 of the Health Act] could in principle apply, that is, a situation where the patient has become unconscious and his or her condition has become life-threatening. Accordingly,

healthcare professionals are barred from carrying out treatment in such situation. Patient autonomy must be respected. ..."

45. By Act no. 618 of 8 June 2016, and therefore after the incident giving rise to the present case, section 22 was amended by the addition of a sentence to the section, so it then read as follows:

"Sections 15 to 16 on informed consent, section 17 on minors, section 20 on the involvement of patients and section 21 on the responsibility of healthcare professionals apply with the necessary modifications to the provisions of this chapter. Sections 18 and 19 do not apply to the provisions in this chapter [chapter 6 about patient autonomy in special cases]. Section 17 on minors does not apply to section 26 on living wills."

46. At the relevant time, the wording of section 24 of the Health Act read as follows:

**Section 24**

"(1) Treatment involving the transfusion of blood or blood products may not be initiated or continued without the patient's informed consent.

(2) A patient's refusal of blood transfusions or blood products must be given in the context of his or her current course of illness [*den aktuelle sygdomssituation*] and must be based on information provided by the healthcare professional about the consequences to the patient's health of not administering a blood transfusion or blood products in connection with the treatment.

(3) If carrying out treatment without the use of blood or blood products is contrary to a healthcare professional's ethical standpoint, that healthcare professional is not obliged to carry out that treatment, and the patient must be referred to another healthcare professional, unless there is a need for urgent medical care, see section 42 of the Authorisation of Healthcare Professionals and Medical Activities Act."

47. The corresponding preparatory notes to former section 15 of the Patients' Rights Act read as follows:

"The provision is unamended and follows of section 14 of the Circular on Information and Consent issued by the Health Authority.

The rules were originally introduced to accommodate the wishes of members of the religious community of Jehovah's Witnesses who do not, for religious reasons, wish to receive blood or blood products in connection with surgery or other procedures. The provision also reflects that, in such situations, the integrity and autonomy of the individual are considered more important than the preservation of life.

It should be observed that a decision not to use blood or blood products in connection with surgery may be entirely medically justifiable. However, significant risks may be involved. It is presumed that the relevant patient will be thoroughly informed about such risks.

The provisions in subsections (1) and (2) mean that a healthcare professional (doctor) may not use blood where the patient has refused blood, not even if it transpires during surgery that the use of blood is necessary to a greater extent than initially assumed.

Subsection (3) clarifies that a healthcare professional (doctor) is only obliged to initiate surgery or other procedures without the use of blood or blood products where

urgent medical care is needed, see section 7(1) of the Medical Profession Act [now section 42 of the Authorisation of Healthcare Professionals and Medical Activities Act]. In this situation, the doctor must provide the best possible treatment while respecting the patient's refusal of blood. The doctor must accept the patient's right to autonomy and treat the patient even if this means that, in the doctor's opinion, the patient does not receive the best treatment available but treatment which may ultimately lead to the patient's death.

Where treatment can be delayed, the doctor must decide whether he or she is willing to treat the patient despite the patient's refusal of blood transfusions. If the doctor is willing to provide treatment, he or she must not give blood or blood products to the patient, even where there is a risk that the patient may die from unreplaced blood loss. If the doctor finds it unacceptable to provide treatment on those conditions, no duty to provide that treatment can be imposed on the doctor, and in that situation the patient must be referred to another doctor.

It is further observed that the above refers only to situations where the patient himself or herself refuses blood. ..."

48. Sections 15, 19 and 24 of the Health Act set out how to balance the saving of a patient's life or enabling a significantly better outcome of treatment against patient autonomy and the right to make a binding advance directive, such as an advance medical directive refusing blood transfusions. When balancing these considerations, the legislature made a choice in favour of the protection of citizens' lives and health and in favour of patient safety, to the effect that advance medical directives are not legally binding for healthcare staff, except for directives on the medical treatment of, *inter alia*, terminally ill patients.

49. The balancing of considerations was reflected, *inter alia*, in Parliament's reading of Bill no. L 15 of 26 March 1998 on the Legal Rights of Patients. The former Minister of Health was asked by a member of Parliament to comment on a letter from the Watch Tower Bible and Tract Society, which recommended that advance medical directives be binding for healthcare staff. The Minister's written reply of 21 April 1998 read as follows:

"Advance declarations are of no independent significance when the patient has the capacity to give informed consent because informed consent can and must be obtained directly from the patient in such situations, see section 6 of the Bill [now section 15 of the Health Act].

Only in cases where the patient is unable to safeguard his or her own interests because of unconsciousness or another form of incapacity will it become relevant to discuss what weight healthcare staff must attach to any advance directive made by the patient.

In the Bill, sections ... concern advance directives in the form of living wills [now directives on medical treatment]. A living will is binding for the doctor where the patient is terminally ill, that is, where the patient will very likely die within days or weeks regardless of any healthcare interventions. Where the patient is not terminally ill, an advance declaration (living will) serves as guidance to the doctor and must be taken into account in the doctor's treatment decisions.…

Patients' refusals of blood transfusions are governed by section 15 of the Bill [now section 24 of the Health Act]. The provision requires the patient's refusal of blood or blood products to be given in the context of the current course of illness and to be based on information provided by the healthcare staff about the consequences of not administering a blood transfusion or blood products in connection with the treatment, see section 15 (2) [now section 24 (2) of the Health Act]. Consequently, an advance directive to the effect that – in the event of unconsciousness or other forms of incapacity – the patient does not wish to receive treatment that includes a blood transfusion is not binding on the doctor but must be taken into account in the doctor's treatment decisions. ...

Bringing in rules making advance directives binding on healthcare staff, even in situations where the patient is not terminally ill – whether the matter concerns a refusal to receive blood, directions for psychiatric treatment ('psychiatric wills') or otherwise – will give rise to serious concerns about patient safety and would entail unmanageable issues with the documentation needed to determine that the advance directive does in fact represent the patient's settled wishes. Furthermore, it cannot be ruled out that the patient, had he or she been conscious, would have preferred at that point to go on living, or that new treatment methods developed after the advance directive could have so improved the patient's life that the patient would have accepted the treatment.

Therefore, I find that advance directives should continue to be binding only for the living wills [now directives on medical treatment] of terminally ill patients. Needless to say, all other advance directives must be taken seriously, but they should only serve as guidance to healthcare staff, so that healthcare staff take advance directives into account in making their decisions on treatment."

## II. RELEVANT INTERNATIONAL MATERIALS

50. The relevant international materials were recently set out in *Pinda Mulla v. Spain* ([GC], no. 15541/20, §§ 71 to 80, 17 September 2024). In particular, the following was stated in respect of the Convention on Human Rights and Biomedicine (the Oviedo Convention) (ratified by Denmark on 10 August 1999. It entered into force on 1 December 1999):

"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).

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

"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."

## III. COMPARATIVE LAW

51. The relevant comparative law was recently set out in *Pindo Mulla* (cited above, §§ 81 to 86) as follows:

"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, Hungary, Germany, Ireland, Italy, Liechtenstein, Portugal, 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). 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."

52. In addition, the Danish Government consulted several Member States about their legislation and how patients could refuse blood transfusions in advance of a specific course of treatment. In respect of Iceland and Norway, which were not part of the comparative survey carried out in *Pindo Mulla* the following can be added.

53. Iceland has no specific regulation on refusal of blood transfusions. Patients may decide to refuse treatment. Where a patient refuses treatment, a doctor must inform the patient of the potential consequences of such a refusal. If a patient is unconscious, implied consent may be assumed, unless it is known with certainty that the patient would refuse the treatment.

54. In Norway, a patient of 18 years or older who has the capacity to give consent may refuse a blood transfusion in special situations on the basis of genuine beliefs. Where the refusal is of treatment involving blood, Norwegian law makes no distinction between courses of treatment already initiated and future treatment. In connection with a refusal, the healthcare staff must ensure that the patient is provided with sufficient information and understands the potential health consequences of such a refusal.

# THE LAW

## I. ALLEGED VIOLATION OF ARTICLES 8 AND 9 OF THE CONVENTION

55. The applicants complained that the Supreme Court judgment of 1 February 2022 (see paragraph 33 above), approving the lawfulness of administering the blood transfusion to L despite his previously expressed refusal of this form of treatment, was in violation of Articles 8 and 9 of the Convention, which in so far as relevant provide as follows:

**Article 8**

"1. Everyone has the right to respect for his private ... 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."

**Article 9**

"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

56. The Government submitted that the applicants' complaint should be declared manifestly ill-founded within the meaning of Article 35 § 3 of the Convention.

57. The applicants disagreed. They also submitted that both applicants have victim status under Article 34 of the Convention; the first applicant in her personal capacity as being directly affected by the blood transfusion

imposed on her deceased husband, and as being authorised by his Health Care Power of Attorney (see paragraph 11 above) to bring "legal action" to uphold his decision to refuse blood transfusion.

58. The Court observes that both applicants had legal standing before the domestic courts. Having examined this issue *ex officio* (see, *Buzadji v. the Republic of Moldova* [GC], no. 23755/07, § 70, ECHR 2016 (extracts)), the Court further observes that the instant case concerns fundamental questions concerning a patient's right to self-determination and the State's duty to protect life which are of general interest transcending the person and the interest of both the first applicant and her late husband. The Court also notes that the first applicant was married to L for forty-four years, shared his religious beliefs, and was with him in the hospital where she explained what she sincerely believed her husband would want and objected to the blood transfusion on his behalf. Her personal commitment is further demonstrated by the fact that she pursued the domestic proceedings in her own name after her husband's death. Under these exceptional circumstances, the Court accepts that the first applicant was so personally affected by the interference at issue that she can be considered a victim within the meaning of Article 34 of the Convention (see *mutatis mutandis*, *Koch v. Germany*, no. 497/09, §§ 43-50, 19 July 2012).

59. The Court has not been made aware of any exceptional circumstances which could lead it to accept that the estate of L can be considered a victim within the meaning of Article 34 of the Convention. The Court is not even in possession of any information, as to whether the estate of the first applicant's deceased husband, L, is indeed still a legal entity, and whether, or how, it has been settled. In these circumstances, the Court is not convinced that the estate of L can be accorded standing as an applicant within the meaning of Article 34 of the Convention.

60. Accordingly, the application must be declared inadmissible as regard the second applicant. Further, in respect of the first applicant the complaint is neither manifestly ill-founded nor inadmissible on any other grounds listed in Article 35 of the Convention. It must therefore be declared admissible.

## B. Merits

### *1. Legal characterisation of the case*

61. The Court observes that the two distinct rights relied on by the first applicant, the right to respect for private life and the right to freedom of conscience and religion, are very closely intertwined here; L's previously expressed wishes not to receive blood were rooted in his fidelity to the teachings of his religious community.

62. The Court considers that the issue in this case, which principally pertains to the autonomy and personal integrity 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". The religious aspect of the first applicant's complaint can be adequately accommodated by interpreting and applying Article 8 in the light of Article 9 (see, for a similar approach, *Pindo Mulla v. Spain* [GC], 15541/20, § 98, 17 September 2024, with further reference).

*2. Arguments by the parties*

**(a) The first applicant**

63. The first applicant maintained that the interference had not been in accordance with the law, and that the Supreme Court finding to the contrary erred on two points. Firstly, the Supreme Court had ignored the importance of section 20 of the Health Act (see paragraph 41 above), which required that a patient's previous views should be taken into account, and given weight, particularly where they were likely to remain current and relevant. Secondly, the Supreme Court had an unrealistic, unduly technical and unforeseeable interpretation of section 24, subsection 2 of the Health Act (see paragraph 46 above).

64. She also found that that neither the blood transfusion itself nor the Supreme Court's judgment pursued any of the aims recognised in Article 8 § 2, including the protection of "the lives and health of ... citizens" since there was no reasonably justified doubt in the present case that L had unconditionally rejected blood transfusion.

65. As to the proportionality test, the first applicant submitted that given the fundamental importance of respecting patient autonomy and personal integrity, any margin of appreciation for the domestic authorities in this respect would have to be very narrow. Moreover, referring to, among other things, the Oviedo Convention, and the Court's finding in *Jehovah's Witnesses of Moscow and Others v. Russia* (no. 302/02, §§ 135, 136, 139 and 142, 10 June 2010), the interference had not been necessary in a democratic society. The State's interest in the preservation of life or health under Article 2 of the Convention must yield to the patient's Article 8 right to personal integrity and autonomy, unless there is sufficient evidence to prove that the patient's will was "overborne" or was the product of "improper pressure or influence". In the present case, referring particularly to the conclusion of the High Court in its judgment of 7 December 2020 (see paragraph 32 above), there was no doubt about the genuineness of L's refusal of blood transfusions. It was clear on the facts of the case that there had been no reason whatsoever to doubt the validity of L's 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 his right to respect for his private life.

**(b) The Government**

66. The Government submitted that that there had been no violation of the provisions relied on. The interference had been "in accordance with the law", had "a legitimate aim" and "was necessary in a democratic society".

67. The Danish legislation was founded on the fundamental principle of self-determination based on informed consent in the context of current medical treatment, only yielding for situations, such as that in the present case, where a refusal of potentially life-saving treatment could not be immediately obtained due to the patient's condition.

68. The Danish legislation only gave binding effect to a so-called "advance directive on medical treatment" or "living will" (*behandlingstestamenter*) in which a terminally ill patient wanted to decline life-prolonging treatment.

69. Other advance medical directives, for example about not wishing to receive blood transfusions or psychiatric treatment, had no binding effect under Danish law, but had to be included in decisions on medical treatment.

70. In 1998, and again in 2005, when the provisions from the Patients' Rights Act were repeated in the Health Act (see paragraph 34 above), the Danish legislature had properly balanced the State's interest in protecting the lives and health of its citizens against the individual's right to personal autonomy in the sphere of physical integrity and religious beliefs. It took account of the Convention and the Oviedo Convention, and the legislature had given reasons for not making advance medical directives binding, including that it would give rise to serious concerns about patient safety and would entail unmanageable issues with the documentation needed to determine that the advance directive did indeed represent what the patient wanted. Furthermore, it could not be ruled out that in a given situation a patient, had he or she been conscious, would have preferred to go on living. The Government referred, among other things, to the Supreme Court judgment of 1 February 2022 (see paragraph 33 above), and the written reply of 21 April 1998 from the former Minister of Health to Parliament about advance medical directives (see paragraph 49 above).

*3. The Court's assessment*

**(a) Relevant case-law principles**

71. In a recent case, *Pindo Mulla* (cited above) the Court summarised the relevant case-law and principles under Article 8 of the Convention in the light of Article 9 in respect of a complaint that, in a medical emergency, a blood transfusion had been given to a Jehovah's Witness who in the course of her medical treatment had refused such treatment both in writing and orally. Beforehand, she had also made an advance medical directive refusing blood transfusions in "all healthcare situations". Spain had chosen to confer binding effect on advance medical directives and had made specific practical

arrangements in order to ensure that the instructions given by patients were known and followed in the health care system throughout the national territory (ibid., § 156).

72. In that case the Court gave its ruling under the following headings:

(a) its preliminary observations (ibid., §§ 125-28);

(b) the interference with the applicant's right to respect for private life (ibid., §§ 129-30);

(c) the justification for the interference, including

(i) the lawfulness of the interference (ibid., §§ 131-33);

(ii) the aims of the interference (ibid., §§ 134-36);

(iii) the necessity of the interference (ibid., §§ 137-82).

Under the heading of necessity, the Court examined:

(α) the relevant case-law principles on personal autonomy in the sphere of health care, on the duty of the State to protect the life and health on patients, and on procedural safeguards, and

(β) the reconciliation of the Convention rights and duties at stake.

The Court stated as follows (ibid., §§ 146-53):

> "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* [*v. the United Kingdom*, no. 2346/02], § 70[, ECHR 2002-III]).
>
> 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* [*v. Portugal* [GC], no. 56080/13], § 164[, ECHR 2017], and also *Lambert and Others* [*v. France* [GC], no. 46043/14], § 117[, ECHR 2015 (extracts)]).
>
> 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 ... *Arskaya* [*v. Ukraine*, no. 45076/05, 5 December 2013], 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."

73. The Court found a violation of Article 8 of the Convention, read in light of Article 9, because of various shortcomings (ibid., §§ 172 to 183) in the decision-making process, which as it was carried out in the specific case had not given sufficient respect to the applicant's autonomy.

**(b) Application of these principles to the present case**

*(i) In accordance with the law*

74. The Danish legislation provided a general rule on patient autonomy in section 15 of the Health Act (see paragraph 35 above). This also included specific rules on patient autonomy, including the right to refuse blood transfusion. The former section 15 of the Patients' Rights Act of 1 July 1998, which was replaced by section 24 of the Health Act of 24 June 2005 (see paragraph 46 above), said that treatment involving the transfusion of blood or blood products could not be initiated or continued without the patient's informed consent. It was however a requirement (see section 24, subsection 2) that a patient's refusal to receive blood or blood products had to be given in the context of his or her current course of illness and had to be based on information provided by the healthcare professional about the consequences for the patient's health of not giving a blood transfusion or blood products.

75. It was not disputed in the Supreme Court proceedings that because of L's disorientation when he was admitted to hospital as an emergency patient on 19 September 2014 (see paragraph 7 above), and his later unconsciousness, he had been unable to express or confirm "in the current course of his illness" that he was refusing to have a blood transfusion.

76. Nor was it in dispute that when the blood transfusion was administered on 22 September 2014 (see paragraph 22 above), L's condition was such that a blood transfusion was required for his survival.

77. The decision to administer a blood transfusion to L without his consent on 22 September 2014 was taken in accordance with section 19 of

the Health Act, which sets out that if a patient, who temporarily or permanently lacks the capacity to give informed consent, is in a situation where immediate treatment is required for the patient's survival or to improve the patient's chances of survival in the long term or for a significantly better outcome of the treatment, a healthcare professional may initiate or continue treatment without obtaining the patient's consent (see paragraph 39 above). In its judgment of 1 February 2022 (see paragraph 33 above), the Supreme Court emphasised that the process set out in section 19 for administering treatment without consent in situations where, *inter alia*, the treatment is necessary for the survival of an unconscious patient does not apply if the patient has refused a blood transfusion in connection with the current course of illness. If a refusal has been given in the current medical situation, the patient's refusal must be respected, even if the blood transfusion is vital. However, since L had not fulfilled this requirement (which was not met by L carrying the advance medical directive on him), the Supreme Court found that the Health Act was a sufficient legal basis for the blood transfusion carried out on L without his consent on 22 September 2014.

78. The Court reiterates 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*, Pinda Mulla*, § 132, and *Sanchez v. France* [GC], no. 45581/15, § 128, 15 May 2023, with further references).

79. In respect of the first applicant's argument that the Supreme Court had ignored the importance of section 20 of the Health Act and had unforeseeably interpreted section 24, subsection 2 of the Health Act (see paragraph 63 above), the Court notes, that the former section 11 of the Patients' Rights Act (now section 20 of the Health Act), provided that patients who are unable to give informed consent must be given full information and involved in the discussion of their treatment to the extent that they understand their medical situation, unless this may cause them harm, and that patients' views must be taken into account in so far as they are current and relevant (see paragraph 41 above). It is visible from the preparatory notes to that provision (see paragraph 42 above) that the legislature had regard in particular to Article 9 of the Oviedo Convention, as the notes state: "This general provision also applies to the relationship between patients and healthcare professionals under the Patients' Rights Act. Where such previously expressed wishes are considered to be up-to-date and relevant, they must be given weight and must be taken into account by healthcare professionals when they take decisions on treatment".

80. The Supreme Court said (see paragraph 33 above) that if a person states their refusal of blood transfusions before a course of illness begins, it follows from section 20 of the Health Act and the preparatory notes to the

Act (see paragraphs 41-42 above) that such an advance directive is treated as relevant and must be taken into account in health staff's treatment decisions, if the declaration is still taken to be current and relevant. However, under section 24 in conjunction with section 19 of the Health Act (see paragraphs 46 and 39 above), an advance directive does not prevent doctors from administering a blood transfusion without consent in situations where, *inter alia,* an unconscious patient has not made an informed refusal of blood transfusions in the course of the current illness and that patient is in a condition where a blood transfusion is required for survival. Thus, "an advance directive refusing blood transfusions or other medical treatment has a persuasive influence but is not binding if it is a matter of life-saving treatment of for example an unconscious patient. The requirement in section 24, subsection 2 of the Health Act that a refusal of a blood transfusion must be made in the context of the current course of illness in order to be binding on health staff is there ... to enable the balancing of personal autonomy, patient safety, and the documentation of a patient's settled wishes. The legislature has found it proper to have a regulation that can prevent the risk that for example an unconscious patient dies because of insufficient vital treatment which, in the context of the current course of illness, he or she would have consented to".

81. The Court is satisfied, having regard to the wording of sections 19, 20 and 24 of the Health Act, and the preparatory notes, that the interference, in the form of administering a blood transfusion, was clearly defined in the law and fulfilled the requirements of accessibility and foreseeability, and that there are no elements indicating that the Supreme Court interpreted and applied domestic law in an arbitrary or manifestly unreasonable way.

*(ii) Aim of the interference*

82. The first applicant argued that both the blood transfusion administered to L without his consent and the Supreme Court's judgment had failed to pursue any of the aims recognised in Article 8 § 2, including "the lives and health of ... citizens" since there was no reasonably justified doubt that L had unconditionally rejected blood transfusion (see paragraph 64 above).

83. The Government argued that the legal aim was the State's interest in protecting the life and health of its citizens.

84. The Court accepts the Government's position on this point. It observes that the exception in domestic law for emergencies 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). All of these texts share the concern that vital medical treatment must be permitted in emergency situations, in order to save the lives of patients when their own wishes cannot be sufficiently established. Furthermore, the State's duty under Articles 2 and 8 to ensure the protection

of hospital patients 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" (see *Pindo Mulla*, cited above, §§ 135-36).

*(iii) Necessity of the interference*

(α) Non-binding effect of advance medical directives

85. The Court recently examined the issue of the "previously expressed wishes of the patient" in the light of the Convention, the Oviedo Convention, and a comparative survey undertaken for the purpose of the case in *Pindo Mulla* (cited above, §§ 151-53). The survey showed a diversity of practice in Europe when it came to the way the right to life and the right to respect for the autonomy of the patient were reconciled by taking account of the patient's previously expressed views.

86. The Court pointed out that both the principle of giving binding legal effect to advance directives and the formal and practical way of doing so come within the margin of appreciation of the Contracting States (ibid., §§ 153 and 156). In other words, the Member States are under no obligation under Article 8 of the Convention to give binding effect to advance directives, for example that signed by L on 11 February 2012 (see paragraph 11 above).

– *The legislative and policy framework*

87. As pointed out by the Supreme Court and the Government (see paragraphs 33 and 70 above), when the Danish legislature adopted the Patients' Rights Act in 1998, the former section 15 (now section 24 of the Health Act) was inserted specifically to accommodate the wishes of Jehovah's Witnesses, who do not, for religious reasons, wish to receive blood or blood products during surgery or other procedures. The provision reflected that the importance of the integrity and right to autonomy of the individual was considered more important than the preservation of life (see paragraph 47 above). It was however made conditional on the patient's refusal of blood or blood products being given in the context of his or her current course of illness and being based on information provided by the healthcare professional about the consequences to the patient's health of not administering blood or blood products as part of the treatment (see the current section 24, subsection 2 of the Health Act, cited in paragraph 46 above). During Parliament's reading of Bill no. L 15 of 26 March 1998 on the Legal Rights of Patients, the former Minister of Health was asked by a member of Parliament to comment on a letter from the Watch Tower Bible and Tract Society, which recommended that medical directives be binding on healthcare staff. The Minister's written reply of 21 April 1998 emphasised that the legislature did not want to give binding effect to advance medical directives, since it would "give rise to serious concerns about patient safety and would entail unmanageable issues with the documentation needed to

determine that the advance directive does in fact represent the patient's settled wishes. Furthermore, it cannot be ruled out that the patient, had he or she been conscious, would have preferred at that point to go on living, or that new treatment methods developed after the advance directive could have so improved the patient's life that the patient would have accepted the treatment" (see paragraph 49 above).

88. The legislation was re-assessed in 2005 (see paragraph 34 above). The legislature took account of the Convention and the Oviedo Convention (which had been in force since 1 December 1999) and decided to repeat the provisions from the Patients' Rights Act in the Health Act.

89. As described above the requirement under Section 24, subsection 2, of the Health act that a patient's refusal of blood products is only binding if given in the course of the patient's current illness and based on information provided by health care professionals on the consequences of this refusal aims to ensure that the patient's decision is current and informed and that an unconscious patient, who might want to live, is not denied lifesaving treatment. The Court finds that this requirement falls within the State's margin of appreciation when balancing the State's duty to protect life and the patient's right to autonomy.

– *L's individual case*

90. As already stated, (see paragraph 75 above), following the accident on 19 September 2014, L was unable to state his own wishes "in the context of his current course of illness".

91. The fact that during his fall and admission to hospital L carried on his person his advance medical directive of 11 February 2012, stating that he refused blood transfusions (see paragraph 11 above), did not meet the requirement in section 24, subsection 2 of the Health Act that a refusal of a blood transfusion must be given on an informed basis and in connection with the current course of illness (see paragraphs 33 and 46 above).

92. The question remains whether the advance medical directive was treated as relevant and taken into account in the health staff's treatment decisions as required by section 20 of the Health Act (see paragraph 41 above).

93. In this respect the Supreme Court gave weight to the fact that "during the first days after L's admission to hospital, he was treated with, *inter alia,* blood-forming medication in order to take into account his previous directives about not wanting a blood transfusion. It was not until it was thought to be required for his survival that a blood transfusion was given" (see paragraph 33 above).

94. The Court finds no reason to question that finding. It further notes the entry in L's medical records on 20 September 2014 at 6.15 p.m. (see paragraph 13 above) that L's haemoglobin level had dropped from 10.0 to 6.1

and that "the patient may not be given blood products because of his religious beliefs".

95. On 21 September 2014 at 5.45 p.m. L's haemoglobin level had dropped to 4.2 (see paragraph 16 above).

96. On 22 September 2014, L's haemoglobin level had dropped to 3.7 at around noon (see paragraph 18 above) and to 3.4 at 2.20 p.m. (see paragraph 20 above).

97. On 22 September 2014 the doctor treating L sought guidance from the medical health officer and was informed that there might be a need to give blood to save L's life but that if there were any possible way to avoid giving him blood, this should be sought in the light of the hospital's knowledge of the patient. The Court does not question that the doctors treating L acted in accordance with this guidance and sought to avoid giving blood until it was found necessary for L's survival.

98. In addition, every day from 20 to 22 September 2014 the healthcare staff met with the first applicant and some of her and L's children (see paragraphs 15, 17 and 21 above) and took note of L's expressed wishes, including those expressed in his advance medical directive. In keeping with that, the healthcare personnel tried to avoid allowing L's haemoglobin level to fall to a life-threatening level by using *inter alia* blood-forming medication (see paragraph 33 above).

99. It was not until 3.28 p.m. on 22 September 2014 that the healthcare staff found it necessary to administer a blood transfusion in order to save L's life (see paragraph 22 above).

#### *4. Overall conclusion*

100. In the light of all the above-mentioned considerations, the Court considers that the reasons relied upon by the Supreme Court in its judgment of 1 February 2022 (see paragraph 33 above) were both relevant and sufficient to establish that the interference complained about can be regarded as having been "necessary in a democratic society" and proportionate to the aims pursued, namely the protection of health, and that the authorities of the respondent State acted within their margin of appreciation, having taken into account the criteria set out in the Court's case-law, notably *Pindo Mulla* (cited above, §§ 146-53).

101. It therefore follows that there has been no violation of Article 8 of the Convention read in the light of Article 9.

## II. ALLEGED VIOLATION OF ARTICLE 14 READ IN CONJUNCTION WITH ARTICLES 8 AND 9 OF THE CONVENTION

102. The applicants also complained that the Supreme Court judgment of 1 February 2022 (see paragraph 33 above) was in contravention of Article 14

of the Convention, read in conjunction with Article 8 read in the light of Article 9. Article 14 reads as follows:

> "The enjoyment of the rights and freedoms set forth in [the] Convention 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."

103. The applicants maintained that the effect of the requirements in section 24, subsection 2 of the Health Act (see paragraph 46 above) is to disable the refusal of blood transfusions by Jehovah's Witnesses when the refusal is made during a medical emergency ("the current course of illness") during which the Witness cannot confirm that refusal. That disability has disproportionate effects on the rights of Jehovah's Witnesses to personal autonomy. It is only for Jehovah's Witnesses that a treating doctor therefore becomes the gatekeeper of their rights to personal integrity and autonomy and the satisfaction of their religious conscience. The State has not provided any justification for this difference in treatment.

104. The Government pointed out that section 19 of the Health Act (see paragraph 39 above) does not target Jehovah's Witnesses and blood transfusions. It is of a general nature. It does not establish a difference in treatment of persons in relevantly similar situations. Should the Court find that there is a difference in treatment, such a difference has an objective and reasonable justification.

105. From the outset, the Court recalls its finding above (see paragraph 60) that only the first applicant can claim to be victim within the meaning of Article 34 of the Convention.

106. The intervention complained about, namely the blood transfusion administered to L without his consent, had a legal basis in section 19 of the Health Act, which says that "If a patient who temporarily or permanently lacks the capacity to give informed consent, or who is under 15 years of age, is in a situation where immediate treatment is required for the patient's survival or to improve the patient's chances of survival in the long term or for a significantly better outcome of the treatment, a healthcare professional may initiate or continue treatment without obtaining consent from the patient or from the person with custody of the patient, the patient's closest relative or the patient's guardian".

107. The Supreme Court observed (see paragraph 33 above) that section 19 of the Health Act allowed for the life-saving treatment of an unconscious patient regardless of any advance directive from him or her about refusing treatment. The provision was general and was not restricted to blood transfusions. It therefore found that the blood transfusion administered to L was compliant with Article 14, read in conjunction with Articles 8 and 9 of the Convention.

108. The Court observes that the relevant general principles have been set out in, for example, *Biao v. Denmark* ([GC] no. 38590/10, §§ 88-94,

24 May 2016). In particular, it recalls that a general policy or measure that has disproportionately prejudicial effects on a particular group may be considered discriminatory even where it is not specifically aimed at that group and there is no discriminatory intent. This is only the case, however, if such policy or measure has no "objective and reasonable" justification (ibid., § 91).

109. Thus, even though section 19 and section 24, subsection 2, of the Health Act were general provisions, not aiming at Jehovah's Witnesses who wished to refuse blood transfusions, in the application of these provisions, members of Jehovah's Witnesses may have been more likely to be affected than other groups and thus be subject to a form of indirect discrimination. Thus, although the first applicant has not relied on any specific figures in this respect, the Court is willing to accept that the group of Jehovah's Witnesses, who were unable to comply with the criteria set out in section 24, subsection 2 of the Health Act to refuse blood transfusion "in the context of his or her current course of illness", may have been more affected than other groups, by blood transfusions authorised under section 19 of the Health Act.

110. Nevertheless, for the reasons set out under its finding regarding the complaint under Article 8 of the Convention, read in the light of Article 9 (see paragraph 100 above), the Court finds that such a possible indirect discrimination had "objective and reasonable" justification, as it pursued a legitimate aim, namely the protection of health, and there was a reasonable relationship of proportionality between the means employed and the aim sought to be realised.

111. It follows that this part of the application is manifestly ill-founded within the meaning of Article 35 § 3 (a) of the Convention and must be declared inadmissible in accordance with Article 35 § 4.

## FOR THESE REASONS, THE COURT, UNANIMOUSLY,

1. *Declares* the complaint under Article 8 read in the light of Article 9 of the Convention, brought by the first applicant, admissible and the remainder of the application inadmissible;

2. *Holds* that there has been no violation of Article 8 read in the light of Article 9 of the Convention.

Done in English, and notified in writing on 5 November 2024, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

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|---|---|
| Andrea Tamietti<br>Registrar | Gabriele Kucsko-Stadlmayer<br>President |