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Abdyusheva and Others v. Russia: a Sadly Missed Opportunity

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By Valérie Junod and Olivier Simon

On November 26, 2019, the ECtHR issued a 6 to 1 judgment finding that Russia had not breached the right of the complainants when it denied them access to methadone and buprenorphine (these two medicines are hereafter abbreviated to M/B) for treating their duly diagnosed opioid dependence syndrome (ODS).

Out of the three applicants, only the complaint of Mrs. Abdyusheva was analyzed in full. Since the other two were no longer consuming opioids and were no longer in active treatment; the Court declared their complaint inadmissible, disregarding their risk to relapse in the future.[1]

Since Mrs. Abdyusheva was still using opioids, her lack of access to M/B indeed interfered in her right to respect for private life (Article 8 ECHR), as private life has received a broad definition. However, the Court found it unnecessary to decide whether this interference had to be analyzed as an actual action by the State (negative obligation) or a failure of the State to meet its positive obligations.

Furthermore, the Russian ban had an explicit legal basis and pursued a public interest, which according to the Russian government, was the protection of health[115].

Turning to the third and final step, that is proportionality, the Court’s majority began by assessing the State’s margin of appreciation. It chose to grant a broad margin, because at its heart, the matter dealt with both technical medical issues and public health issues. For public health matters, the State, and not the Court, is considered best positioned to assess the actual needs of the population, the resources to be expended and the priorities to be set[112].

For the Court, the key question was whether Russia was obliged to let this specific patient access her “preferred” treatment – and not which medical approach against ODS was the safest and the most effective in general. As explained below, the Court’s choice as to the question to be answered had a clear impact on the answer ultimately provided.

Whilst the Court did seem to concede a consensus among Council of Europe’s nations to make M/B available to ODS patients, it did not go into actual numbers (compare with the now 3 year-old judgment of Wenner v. Germany, para 36). On the contrary, it suggested that there is still controversy among Member States as to the overall benefit-risk balance of M/B treatments[125-126]. Moreover, according to the majority, even a broad consensus as to the effectiveness of M/B treatments should not be decisive[124]. In his concurring opinion, Judge Dedov was even more explicit: in his view, establishing the (in)existence of a
consensus among Member States is unnecessary because this would be equivalent to a technical analysis of the risk-benefit balance of various medical treatments.

Given the wide margin of appreciation, the Court concluded that Russia could decide which medical approach to favor and which one to forbid.[2] Both the “conventional” approach (in the words of the ECtHR; actually an approach based on abstinence) and the opioid agonist treatment approach had their own medical and social benefits and risks. As a consequence, the Court held that balancing these benefits and risks and reaching the proper conclusion was best achieved by Russian authorities. As long as patients in Russia were offered a medical treatment (the so-called “conventional” approach) as long as there were no medical grounds to continue in Russia a long-standing M/B treatment (see the Wenner judgment of 2016), and as long as medical treatment was not imposed without patients’ consent [129], the State was entitled to select one medical approach and to ban the others entirely [130]. Moreover, for the majority, the Russian ban on M/B did not reveal a State’s will to humiliate or denigrate patients suffering from ODS [163, 166].

Three other arguments are noteworthy.

First, the Court found that because Ms. Abdyusheva was already infected with HIV, it was no longer necessary to decide whether access to M/B can reduce the likelihood of infections and should be allowed on this ground [123]. The Court chose to only focus on the applicant’s present situation, rejecting her argument that earlier access to M/B could have prevented her infection. This narrow outlook may appear unduly harsh.

Second, the Court refused to rule whether other international conventions forbid or force Russia to make M/B accessible to patients in need. Verifying compliance with other international texts is beyond its purview (however, compare with Molla Sali v. Greece of 2018). Yet it did suggest that no enforceable compulsory international obligations force Russia to make these medications legal [122]. Judge Dedov’s concurring opinion was even more explicit. Unfortunately, the Court’s analysis of the legal framework resulting from other texts was superficial – to say the least (compare with the analysis in the Hristozov judgment).

Third, the Court drew a parallel to the Hristozov case of 2012 [128] and distinguished the present situation from the Wenner judgment of 2016. In Hristozov, the Court held that patients cannot force the State to permit terminally-ill patients to access experimental drugs whose safety and effectiveness is presently unproven. In Wenner, the Court found a violation of Article 3 when Germany made it impossible to a detainee to continue in prison a methadone treatment he had begun several years earlier. In the present judgment, Mrs. Abdyusheva was not in prison and had not been receiving methadone. Moreover, for the Court, the overall risk-benefit balance of M/B was as debatable as that of an experimental treatment currently in clinical trials – even though both methadone and buprenorphine are listed the in the WHO’s list of essential medicines, a fact duly acknowledged.[3]

The lone dissent

Judge Keller issued a strongly worded dissenting opinion. First, she highlighted the importance of the disputed issue, since many individuals in Russia suffer from ODS. [4]
Regrettably in her view, the majority’s judgment did not take into consideration the general situation of ODS patients in Russia. She found it particularly objectionable that the M/B ban was absolute, i.e. with no exceptions even in case of long-standing prior M/B treatments. She was especially critical of the majority’s refusal to study the actual practices of most Member States. She underlined the factual errors in the majority judgment, errors due to overreliance on the statements of the Russian government. Rightfully, Judge Keller underscored that M/B treatments are not experimental, making the comparison with the Hristozov case misplaced. She emphasized the pain that ODS patients go through during withdrawal, and disputed the findings of the majority, in holding this pain to be due to lack of access to effective medications, and not to the ODS disease itself.

For these various reasons, Judge Keller would have reached the conclusion that the applicants had suffered a violation of their rights guaranteed under Articles 8, 3 and 14.

Comment

As is frequent, the outcome of this case largely rested on the margin of appreciation argument. However, this margin should be inferred from more reliable criteria that the ones mentioned in this judgment. That technical, scientific or more broadly factual issues influence the legal outcome should not automatically open the door to a broad margin. Not only are technical issues often intertwined with social, political and legal considerations, but they may be important per se. Moreover, there are many ways to disguise a public interest issue as a technical issue. If such loopholes are tolerated too easily, the Convention may lose its power as a living instrument, protecting actual rights. One thinks of access to many medical technologies (e.g., genetic in vivo analyses, preimplantation in vitro diagnostic, or even more sensitive topics such as abortion services).

In the present case, in Russia, people suffering from ODS who wish to receive treatment go through a period of intense pain, because they receive no effective medication to alleviate their withdrawal symptoms and/or to treat their concurring disorders. Ordinary (i.e. non-opioid) pain relievers are insufficient. The pain of withdrawal has been rated as among the most intense. This was accepted by both the majority (in its analysis of a possible violation of Article 3 ECDH [156]) and Judge Keller [11 of the dissent]. However, the majority ultimately dismissed this pain, claiming that withdrawal pain results from the disease [161, 165] and not State action and that the conventional medical approach did not leave the patients without treatment [162][5]. However, the specific medications that ODS patients receive in Russia to alleviate was not described, whereas it is known that patients in Russia receive inadequate pain control medications and incur a high mortality.

Even after this acute phase is over, maintaining abstinence without opioid agonist treatment is very difficult. Studies have shown that over half of patients relapse,[6] meaning that they will have to endure the same acute pain again. Relapses are associated with a high risk of overdoses. Whenever in the acute phase of ODS, people are at increased risks to acquire other transmissible diseases (e.g., HIV, hepatitis) and to commit criminal offenses, if only to acquire the substances they intend to consume. The constant pressure and risk borne by ODS patients represents a very real obstacle to their employability and social insertion. In turn, this creates a climate of hostility and contempt against these individuals, which make it even harder to reach this population.
Comparison between abstinence programs and opioid agonist treatments show that patients enrolled in the latter incur significantly less pain, remain abstinent longer, live longer, maintain a better social and professional network. There are hundreds of studies and reports documenting the issue spanning several decades[7]. None of them has shown that abstinence works better to produce overall better outcomes. While it is not claimed that M/B treatment leads to immediate or permanent abstinence, that they make concurrent drug consumption impossible, or that they entirely block drug trafficking, they still produce overall better outcomes than the alternative, mainly abstinence-based, approaches. When the studies are that clear in their results, holding that this represents a technical issue that each State can decide however it wants is fully unconvincing.

The Court should develop a better way to assess scientific facts so that its judgments can build on a strong factual basis. Indeed, a judgment based on misrepresented facts can only lead to unpersuasive results[8]. As our societies come to rely increasingly on highly technical tools and approaches, mastering the process of scientific assessment is ever more crucial. And this is not so difficult, as the task is immensely helped by scientific groups (e.g., Cochrane Library for medicine[9] or consensus statements[10]) engaging constantly in that effort. This is also the role of third parties appearing before the Courts. Yet, there should also be a process to assess the reliability and representativeness of such groups, especially if they claim to hold technical knowledge. In that respect, it is perplexing that the Abdyusheva judgment appears to weigh in the same way the opinions of four Russian groups and those of the Joint United Nations Programme on HIV/AIDS (UNAIDS), a U.N. Special Envoy or of a renowned NGO such as Human Rights Watch.

In a time where the basic human right to autonomy has come to largely prevail over outdated and dangerous medical practices, it is unfortunate that the ECtHR missed this opportunity to set the golden standard of effective and ethical medical treatment for ODS sufferers. As Judge Keller wrote:

“En conclusion, les autorités nationales ont interféré avec le choix des requérants de bénéficier d’un traitement de substitution aux opiacés, lequel est crucial puisqu’il leur permettrait de survivre. Ce choix touche au noyau dur de l’article 8 de la Convention et relève de la notion d’autonomie personnelle.”

[“In summary, the national authorities interfered with the applicants’ choice to benefit from an opioid substitution treatment, which is crucial to allow their survival. This choice touches the hard core of Article 8 and belongs to the notion of personal autonomy.”]

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Yet studies have shown that the odds of a relapse are very high in patients suffering from ODS. This was not commented upon by the Court. See Robin E. Clark et al., *Risk Factors for Relapse and Higher Costs Among Medicaid Members with Opioid Dependence or Abuse: Opioid Agonists, Comorbidities, and Treatment History*, Journal of substance abuse treatment, Vol. 57 (2015): p. 75-80.

Despite some confusion in the judgment, the issue was not whether to “legalize” or “depenalize” certain opioid drugs or medicines, but whether they should be made available to certain patients within a State-regulated framework.

For the Court, this list is not binding on Member States, in the sense that States are not forced to make the medicines on this list available to their patients. Yet, “the Committee on Economic, Social and Cultural Rights has elaborated that access to essential medicines is a minimum core obligation of the right, and States must comply immediately with this non-derogable obligation regardless of resource constraints.” United Nations, Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Note by the Secretary-General, August 6, 2010.

Judge Keller wrote of thousands of patients who were lacking effective treatment in Russia. Yet the scantily available statistics suggest that the actual numbers may be significantly higher: “Some researchers estimate that there are 4 million to 6 million regular users [of illegal drugs], whereas among young Russians, lifetime prevalence of illicit drug use is up to 40 percent. The healthcare system appears to be completely unprepared to intervene. The first problem is the absence of reliable data as well as tools for collecting the data. According to official statistics, Russia has 448,100 regular drug users and addicts. However, even health authorities admit that these data should be multiplied by 10 in order to approximate real figures.” U.S. National Institute on Drug Abuse, Lobodov, *Alcohol and Illicit Drug in Russia: Current Situation and Possible Solution*, 2004. The Russian mortality from ODS is also significantly higher than that of other countries. See AEGEE, *A Growing Problem: Drug Abuse in Russia*. Also Richard Hurley, At least 80 people have died in Crimea since Russian law banned opioid substitutes, says UN special envoy, *BMS, 2015;350:h390*. See also paragraph 86 of the Judgment.

But see paragraph 12 of the Judge Keller’s dissent.

DrugAbuse.com, *Drug Relapse*.

For an overview, see WHO, *Guidelines For The Psychosocially Assisted Pharmacological Treatment Of Opioid Dependence*, Annex I, p. 55 ss, 2009; Luis Sordo et al., Mortality risk during and after opioid substitution treatment:

systematic review and meta-analysis of cohort studies, *BMJ 2017;357:j1550*.

See inter alia paragraph 6 of the dissent.