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Sanctioning Chile's Public Health Care System for Not Providing Basic Services to the Elderly: The Inter-American Court's *Poblete Vilches* Ruling

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Abstract

This paper analyzes the Inter-American Court of Human Rights' ruling in the case of *Poblete Vilches et al. v. Chile*. Poblete Vilches, a senior citizen, died in February 2001 due to septic shock and bilateral bronchopneumonia after being treated in a public hospital in Chile. The ruling held the state of Chile responsible for a number of human rights violations. The paper evaluates the interpretation of the American Convention on Human Rights as carried out by the Inter-American Court of Human Rights. It concludes that the sentence explicitly developed criteria in relation to informed consent as a derivation of the right to health and implicitly recognized, from a gerontological perspective, a manifestation of structural abuse toward older persons and their supportive environments. The gerontological gaze brings new challenges for the development of older persons' rights. The ruling is unique in the inter-American human rights system, as recognized by the court itself.

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Introduction

This paper analyzes the reasoning of the Inter-American Court of Human Rights in its judgment in *Poblete Vilches et al. v. Chile*, issued on March 8, 2018, which interpreted the human rights of older persons in the context of medical and social care.[1] The court pronounced on the right to life and personal integrity and the right to health for older persons based on the recognition of economic, social, cultural, and environmental rights, invoking for the first time the Inter-American Convention on Protecting the Human Rights of Older Persons.

The Inter-American Court of Human Rights is an autonomous judicial institution tasked with the application and interpretation of the American Convention on Human Rights (ACHR). Decisions of the court are justified and final, and they may not be appealed. States parties to the convention—as in the European human rights system—are obligated to comply with the court's judgments.[2] The ACHR establishes and limits the jurisdiction of the Inter-American Court. According to the facts of the case, Mr. Vinicio Poblete Vilches (hereinafter Poblete) was admitted to the Sótero del Río public hospital on January 17, 2001, due to severe respiratory failure. On January 22, he was moved to the surgical intensive care unit. A surgical intervention was performed while he was unconscious, without the prior consent of his relatives. Nevertheless, doctors performed a surgical intervention while he was unconscious, without the prior consent of his relatives. On February 2, Poblete was discharged without further instructions.[3]

Three days later, on February 5, Poblete was admitted for a second time to the same hospital, where he remained in the intermediate care unit due to lack of available beds, despite the clinical record specifying his admission to the intensive care unit. Poblete died on February 7, 2001, at the age of 76, due to septic shock and bilateral bronchopneumonia.[4] According to the sequence of events, there was a failure to comply with medical care standards regarding to informed consent required under *lex artis*.

Unlike the European and universal human rights systems, the inter-American human rights system has a binding instrument for the protection of the human rights of older persons (the Inter-American Convention on Protecting the Human Rights of Older Persons). Therefore, the Inter-American Court's references to the European Court of Human Rights in this ruling can only be partial, because the reference frame is different.

The objective of this paper is to analyze the arguments used by the Inter-American Court in its application of the Inter-American Convention on Protecting the Human Rights of Older Persons, identifying the gerontological elements in the *Poblete* case.

Experts in gerontology have increasingly turned to the courts in their battles to protect the human rights and health of older persons. Yet while a significant literature analyzes legal mobilization on these issues, it tends to focus predominantly on domestic legislation and cases. This paper analyzes the effect of these issues when they reach the Inter-American Court. It begins by describing the court's ruling in *Poblete Vilches et al. v. Chile*, which offers an authoritative interpretation of older persons' rights to life, personal integrity, health, and autonomy. As our analysis demonstrates, the court balanced medical, ethical, and legal considerations in its judgment. The paper then considers how rulings such as this one can drive legal reforms to protect and promote the rights of older persons on the American continent.

To date, *Poblete Vilches et al. v. Chile* is the only case concerning the rights of older persons to reach the Inter-American Court, and it shows the trajectory from domestic jurisdiction to the regional human rights system, and vice versa.[5] On October 1, 2012, through Law 20.584, Chile changed its domestic legislation on the rights of the patient; this was before the Inter-American Court issued its ruling in *Poblete*.

Development of the topic

In its ruling, the Inter-American Court developed two rights. The first of these is the right to life and personal integrity of older persons, and the second is the right to health, which encompasses the right to health of older persons and the right to informed

consent of older persons and their relatives in the field of health care.

It should be noted that this case represents the court's first-ever recognition of the right to health as an autonomous right.[6] The ruling also represents the court's first decision on the rights of older persons in matters of health.[7]

Right to life and personal integrity of older persons

The court held that the right to life constitutes a "prerequisite for the enjoyment of all other rights."[8] The court used a systematic argument (whereby laws regarding the same matter must be construed with a reference to each other; what is clear in one statute may be called in aid to explain what is doubtful) and referred to a previous ruling of the European Court of Human Rights.[9] According to the court, a state holds international responsibility for death in a medical context when the following conditions are met: (1) a treatment is denied to a patient in a situation of medical emergency or essential medical care, despite the risk that this denial poses for the life of the patient; (2) there is serious medical negligence; and (3) there is a causal link between the act and the damage suffered by the patient. Verification of the state's international responsibility must also consider any situation of special vulnerability of the affected person (in this case, the patient's status as an older person) and any measures taken to avoid that situation.[10]

The court also quoted article 5(1) of the ACHR, noting that the protection of the right to personal integrity requires the regulation and implementation of health services. It further noted that states "must establish an adequate regulatory framework that regulates the provision of health services, establishing standards of quality for both public and private institutions."[11] In the particular case at hand, the court held that repeated omissions in the care provided to Poblete and the failure to treat his specific health conditions contributed to the deterioration of his health.[12]

Right to health of older persons

The court argued that civil and political rights and economic, social, cultural, and environmental rights are interdependent and without hierarchy and that they must be understood integrally.[13] It made direct reference to the observations made by Chile in 1969, during the drafting of the ACHR, in which the state considered that a certain legal obligation must exist with regard to economic, social, and cultural rights.[14] On this same point, the court ended with a comment of a teleological nature, referring to the international and national *corpus iuris*.[15]

The court also argued that article 26 of the ACHR creates two types of obligations: progressive and immediate. Progressive obligations mean that states have a concrete and constant obligation to proceed as expeditiously and efficiently as possible toward the full effectiveness of economic, social, cultural, and environmental rights; they also imply an obligation of non-retrogressivity with regard to the rights that have been realized. Meanwhile, immediate obligations "consist [of] adopting effective measures in order to guarantee access, without discrimination, to the benefits recognized for each right."[16]

The court cited several international tools, such as the Charter of the Organization of American States, the American Declaration, and the international *corpus iuris* on the right to health.[17]

With regard to situations of medical emergency, the court referred to General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights, noting the minimum standards of quality, accessibility, availability, and acceptability.[18] Quality is understood as the "adequate infrastructure required to meet basic and emergency needs," including life support devices and qualified human resources.[19] Accessibility is understood in its "overlapping dimensions of non-discrimination, physical accessibility, economic accessibility, and information accessibility."[20] Availability implies sufficient material and human resources and the coordination of facilities and networks.[21] Acceptability refers to the fact that health services "must respect medical ethics and culturally appropriate criteria … [and] include a gender perspective, as well as the conditions of the patient's life cycle. The patient must be informed of

his diagnosis and treatment and, in this regard, his wishes must be respected."[22]

Lastly, the court held that "older persons have the right to increased protection, [which] requires the adoption of differentiated measures." It upheld "the right to a dignified old age and consequently the measures required to this end."[23] Again, with a systematic argument, the court quoted the Committee on Economic, Social and Cultural Rights, namely its General Comment 6 and General Comment 14, which guide states to maintain measures of prevention and rehabilitation in order to preserve the functional capacities of older persons, thereby reducing costs in health care and social services.[24] In the ruling, some relevant concepts—such as functionality, autonomy, care, chronic patients, and patients in the terminal stage of life—appeared but were not defined.

Right to informed consent of older persons and their family members

Regarding older persons in the health care context, the court noted the existence of several factors that increase their vulnerability, such as physical limitations, limited mobility, economic status, and severity of a disease. It further noted that due to frequent imbalances in the doctor-patient relationship, it is essential that the patient be provided with the information needed to understand their diagnosis and possible treatments.[25] In this regard, it pointed out that "informed consent forms part of the accessibility of information … and, therefore, of the right to health (Article 26 [of the ACHR])," establishing the right to information in article 13 of the ACHR as an instrument to ensure and to respect the right to health.[26]

The court interpreted informed consent according to international standards in health care.[27] It noted that health providers must, at a minimum, provide information to the patient on the following: (1) "an evaluation of the diagnosis"; (2) "the purpose, method, probable duration, and expected benefits and risks of the proposed treatment"; (3) "the possible adverse effects"; (4) "treatment alternatives"; and (5) the progression of the treatments.[28] In addition, the court held that informed consent by representation is granted when the patient is unable to make a decision regarding their own health.[29]

The court concluded with a teleological element, "dignity" (article 11 of the ACHR), which is linked to autonomy, stating that dignity consists of "the possibility of all human beings for self-determination and to freely choose the options and circumstances that give a meaning to their existence, based on their own choices and convictions."[30] This is related to the protection of the family (article 17 of the ACHR), which plays a central role in the existence of a person and in society in general.

Conclusions from the interpretative argumentation

Recent decades have seen profound transformations in international human rights law, motivated by considerations of international *ordre public*, and which confirm that human rights are applicable to all people irrespective of where they live. At the beginning of the 21st century, the "reason of humanity" took primacy over the reason of the state, inspiring the historical process of *humanization* of international law.[31] As a consequence, we can see explicit ethical guidelines, improved domestic laws, and international legal norms.[32] In addition, the Inter-American Court's ruling reflects the constant process of improvement in interpretive legal techniques. The establishment of human rights in societies does not occur automatically; rather, it implies states' acceptance of the restriction of the power they exercise over citizens, as well as the acceptance of jurisdiction of international institutions in a very sensitive area.[33]

Most of the arguments embraced in the court's ruling were systematic. But the court also used precedent and theological elements.

Concerning the right to health, the court used precedents from other rulings, as well as a genetic argument in relation to Chile's position regarding the legal applicability of the right to health, which the state had expressed during the drafting of the ACHR.

Finally, the ruling held the Chilean state responsible for the violation of Poblete's rights to

health, to life, and to personal integrity; the violation of Poblete's and his family members' right to informed consent and access to information on health-related matters; and the violation of his family members' right to personal integrity.[34]

Issues from a gerontological perspective

Among the many issues relevant to gerontology, the Inter-American Court's ruling proposed overcoming stereotypes and stigma against older persons in the social and health care spheres. It is clear that a cultural and social structural change, as well as a new way of relating to and with elderly people, is required.[35] It is necessary to undertake a paradigm change toward older persons, who have the right to assistance benefits, that views such persons as subjects of law who can make demands of the state.[36] In this sense, a person's age is not an indicator of medical diagnosis or prognosis, unlike other areas, such as functionality, to which the ruling did not refer.[37]

The Inter-American Convention on Protecting the Human Rights of Older Persons refers to prejudices and stereotypes, requiring state parties to "create and strengthen mechanisms for the participation and social inclusion of older persons in an environment of equality that serves to eradicate the prejudices and stereotypes that prevent them from fully enjoying those rights."[38] It is worth noting that the *Poblete* case is an example of structural abuse, where social stereotypes form the basis of abuse and directly affect the rights to life and to integrity. According to the National Service for the Elderly in Chile, structural abuse is "that which occurs from and within the structures of society through legal, social, cultural, [and] economic norms that act as a background for all other forms of existing abuse."[39]

The court's ruling referred to events that occurred in Chile in 2001, when the national and international normative standard was lower in matters of health care for older persons.[40] Today, a similar case would likely be resolved with a more demanding standard. At the time of the events, the World Health Organization had not coined the term "healthy aging," which is based on the pillars of health, safety, and participation, and there was no recognition of older persons' autonomy in health-related matters.[41] On the other hand, the Madrid International Plan on Action on Ageing promotes the idea of considering the increase in life expectancy as an opportunity.[42] According to the plan of action, older persons should enjoy the right to security, including health benefits and care; it also recognizes older persons' rights to participation, autonomy, and informed consent. These standards were not implemented by the court because they are not mandatory.

The aforementioned instruments generate changes at the level of sociocultural and legal standards. At the international level, this includes guidelines on good clinical practices in geriatrics that encourage integrated care for older persons and the Inter-American Convention on Protecting the Human Rights of Older Persons, among others.[43] At the national level, it includes Chile's Universal Access Plan to Explicit Guarantees in Health, in force since 2005, which promotes the enactment of Law 20.584 on the rights and duties that people have concerning actions related to their health care, replacing the paradigm of biomedical paternalist care with a model of autonomy.[44]

In this sense, an evaluation of the clinical situation of health care for older persons should incorporate a comprehensive view of the individual that considers not just biomedical aspects but also the person's social, biographical, functional, affective, and cognitive characteristics. Care for older persons should be continuous and integrated and should seek to enhance their functionality and prevent iatrogenesis, regardless of the level of care at which they are being treated. This care must pay special attention to the prevention of risks associated with hospitalization, particularly for those who are frail. The opinion of older persons must be incorporated into decision-making; to this end, a competence evaluation must be performed, and advance care planning should be a priority. Good communication tools among the different actors are encouraged, benefitting not only the relationship between patient, family, and medical team but also the patient's transitions between types of

care. Regarding the communication and delivery of information, special attention should be paid to the level of health literacy of those involved, and communication strategies should be adapted so that people can actively participate in their health care. This requires a commitment from states both in the training of human resources at the undergraduate and postgraduate level and in the continuous review and adjustment of existing practices and resources, all of which are key for the nonrepetition of violations.[45]

With regard to the right to life—in relation to the denial of emergency medical treatment by medical personnel—the Inter-American Court found that Chile did not adopt necessary, basic, and urgent measures to guarantee Poblete's right to life. The state could not justify its denial of basic emergency services. The court argued that such assistance would have at least prolonged Poblete's life and thus concluded that the omission of basic health benefits affected his right to life.[46] Health care teams must provide technically viable and justified alternatives in light of the clinical condition of older patients. Still, the court's decision does not constitute a vote in favor of therapeutic obstinacy, which would ultimately imply unnecessary suffering for the patient, as well as the misuse of health resources. In this sense, it is the duty of the health care team to consider death as a part of life, and, consequently, the team should offer appropriate support and consolation to relatives after the patient's death.[47] Chile embraced this orientation when it ratified the Inter-American Convention on Protecting the Human Rights of Older Persons, declaring:

> *the life-course approach will be understood as the continuity of a person's life, from the beginning of their existence to the last stage of life, which, conditioned by different family, social, economic, environmental and/or cultural factors, configure the life situation, with the state being in charge of developing this approach in its public policies, plans and programs, with a special emphasis on old age.*[48]

Regarding informed consent, such consent is part of the growing recognition of the autonomy of older persons. This implies considering informed consent as a principle that allows for existential and practical choices that arise from one's personal identity, life history, and environmental conditions. In general, the term "autonomy of the will" is understood as the ability of legal subjects to establish rules of conduct for themselves and in their relationships with others within the limits established by law.[49] And the term "autonomy and individual responsibility" is understood as the autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.[50] The Inter-American Convention on Protecting the Human Rights of Older Persons maintains that independence and autonomy constitute general principles for the interpretation of the convention.[51] An important dimension of autonomy occurs in the health field, where decision-making capacity and responsibility constitute guiding principles for the relationship between the patient and the health care team, in an effort to avoid verticalization and asymmetry of information. In technical terms, the Universal Declaration on Bioethics and Human Rights defines these concepts as the power to make decisions about one's own life, assuming responsibility for those decisions, and respecting others.[52] Regarding people who lack decision-making capacity, special measures must be taken to protect their rights and interests. This declaration unites the concept of autonomy and responsibility, moving away from a conception of freedom that exalts the individual. The obligation to take "special measures" does not fall exclusively on health service users but instead applies to other subjects as well, since these special measures must protect 'their rights and interests." At the same time, the autonomy of the subject is appreciated because it is essential for the integration of decision-making processes, such as informed consent. Consent (agreement of wills) relates not to the narcissist satisfaction and autonomy of the patient but to the realization of their possible therapeutic wellness.[53] Therefore, we must incorporate more demanding standards associated with clinical

protocols, including informed consent, into geriatrics, particularly in relation to hospitalization.[54]

The ruling of the Inter-American Court of Human Rights in *Poblete Vilches et al. v. Chile* marks an important milestone regarding the recognition of the rights of older persons, especially in the spheres of life and health. Further, it emphasizes the importance of ensuring that older patients' wishes are heard and that guidelines are in place concerning how to proceed in cases where a person is unable to express their wishes. The principle of informed consent is not irrelevant with regard to older people. Since the tragic events that happened to Poblete and his family, national and international legal instruments have taken a positive turn, moving toward greater recognition of the rights of older persons, with dignity as their guiding light.

Conclusion

First, the *Poblete* case is important for its effective application of the Inter-American Convention on Protecting the Human Rights of Older Persons. This is a critical development in the international context, since the Organization of American States differentiates the legal protection of older persons from that of disabled people. The ruling is a major step forward in terms of the promotion of positive stereotypes of older persons, as embraced by the World Health Organization—namely active aging, positive aging, and healthy aging.

Second, international public order and the Inter-American Court of Human Rights in particular have made efforts to move forward in the recognition of older persons' rights. The Inter-American Court declares this case as groundbreaking and, for this reason, a greater specialization in older persons' rights can be reasonably expected over time, in which a person's biographical identity is accepted as an ethical and gerontological core of reflection.[55]

Third, regarding the court's argument, specifically the systematic element, the inter-American human rights system requires that the arguments used by the Inter-American Court to interpret the ACHR be legal and within the framework of a previously enshrined right. Therefore, the Inter-American Court is not acting within its jurisdiction if it uses extra-systemic arguments, such as quoting the European Court of Human Rights. This bad practice of the Inter-American Court does not comply with the international standards of the system or with the cultural realities of the continent.

Finally, this ruling applies some of the same principles enshrined in the Inter-American Convention on Protecting the Human Rights of Older Persons, among them dignity, autonomy (expressed through informed consent), solidarity and empowerment of family and community protection, and effective judicial protection.[56] These legal principles will bring new perspectives in future trials in the region.

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