

Denial of Pain Treatment and the Prohibition of Torture, Cruel, Inhuman or Degrading Treatment or Punishment

Joseph Amon and
Diederik Lohman

We must all die. But that I can save him from days of torture, that is what I feel as my great and ever new privilege. Pain is a more terrible lord of mankind than even death himself.

Albert Schweitzer¹

‘I have two of these,’ says Artur as he pulls a handgun from under his pillow. ‘I keep it to shoot myself when the pain gets too strong...’² Artur, a decorated former KGB agent, is dying of prostate cancer in his home in a village in central Ukraine. He experiences severe pain but the medications he receives from Ukraine’s healthcare system offer him little relief. Under World Health Organization recommendations, he should be receiving morphine six times per day but Ukraine’s antiquated drug laws require that a nurse visit him at home for each dose he gets. It’s an impossible task for the local nurse who is already overstretched. So Artur receives two doses per day instead. The rest of the time he is alone with his pain. The gun is his insurance policy for when life becomes unbearable.

There should be no need for a gun. Artur’s suffering from pain is almost entirely preventable. According to the World Health Organization (WHO), ‘most, if not all, pain due to cancer could be relieved if we implemented existing medical knowledge and treatments.’³ Indeed, if Ukraine’s drug regulations did not make proper treatment of his pain impossible, Artur would not have to contemplate and plan his own death. He could spend the last months of his life with his family. Instead, he lives his last months isolated in a world of pain and suffering, having moved away from his family because he doesn’t want them to hear him scream at night. Eventually, three months after the

interview, Artur died of natural causes.

Sadly, Artur’s suffering is hardly an exception. Millions of people worldwide suffer from severe pain without access to adequate treatment each year. Although morphine and other strong pain medications are inexpensive, safe and highly effective, they are virtually unavailable in more than 150 countries around the world.⁴ WHO estimates that tens of millions of people worldwide suffer from moderate to severe pain without access to treatment every year, including 5.5 million people with terminal cancer.⁵ Medications like morphine are often simply not available, drug regulations interfere with their accessibility, or doctors do not know how to prescribe them.⁶

The failure of governments in many countries to ensure the adequate availability of pain treatment services clearly raises questions of whether these countries live up to their obligations under the right to health, which requires states to ensure the availability and accessibility of health services, including, of course, treatment for pain.⁷ But could this failure, which condemns patients to what Albert Schweitzer, the great Swiss medical doctor and humanist, called ‘days of torture...more terrible than death itself,’ also constitute a violation of the prohibition of torture, cruel, inhuman or degrading treatment (hereinafter: torture or ill-treatment)?

At present, no international legal mechanism, whether judicial or quasi-judicial, has settled this question. In some countries, national courts have ruled that pain treatment must be available to patients but these rulings are not based on the prohibition of torture but on the right to health or life.⁸ In this article, we explore the

legal basis for the argument that denial of pain treatment can indeed constitute torture and ill-treatment and examine existing case-law to see how judicial mechanisms might approach the question.

Applicability of the Prohibition of Torture and Ill-treatment to Denial of Pain Treatment

A first question to answer is whether the prohibition of torture and ill-treatment can be applicable to denial of pain treatment. After all, denial of pain treatment generally involves acts of omission rather than commission (the active infliction of suffering by a state official on the victim).⁹ Moreover, in these cases the victim’s suffering is caused not by some external source but by the patient’s own body.

Article 7 of the International Covenant on Civil and Political Rights (ICCPR) articulates the prohibition of torture as follows: ‘No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment...’ While in the ICCPR and other international human rights instruments the right is formulated as a negative obligation – a prohibition for states to inflict such treatment – jurisprudence has clearly established that the provision also imposes a positive obligation on states: To protect people in their jurisdiction from such treatment as well as to investigate credible allegations of torture or ill-treatment.¹⁰ In other words, when a state fails to take steps to protect people from torture or ill-treatment – an act of omission – it can still be guilty of a violation of the prohibition of torture and ill-treatment.

A review of jurisprudence and authoritative interpretations shows that international human rights bodies and courts have found a great variety of

different types of suffering of different origins to potentially constitute torture or ill-treatment. For example, the European Court of Human Rights (ECtHR) has accepted that suffering due to the military burning someone's house;¹¹ a failure to protect someone from environmental pollution;¹² a failure by a government to adequately investigate a reported disappearance;¹³ a failure to protect someone from domestic violence;¹⁴ and a failure to address mistreatment and neglect of children by their parents¹⁵ can all give rise to a violation of the prohibition of torture or ill-treatment.

The Committee against Torture, an independent body that monitors the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, has stated that member states must prevent torture and ill-treatment in 'all context of custody or control...as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.'¹⁶

The UN Special Rapporteur on Torture, Cruel, Inhuman or Degrading Treatment or Punishment has specifically addressed the issue of pain treatment and argued that denial of such treatment can constitute torture and ill-treatment. In a 2009 report to the Human Rights Council, Professor Manfred Nowak, the then-rapporteur, specified that, in his expert opinion, 'the de facto denial of access to pain relief, if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment.'¹⁷

Minimum Level of Severity

The next question to examine is whether the suffering caused by untreated pain meets the required minimum level of severity, which most international human rights mechanisms use, to qualify as torture or ill-treatment. This determination is made on a case-by-case basis. The ECtHR, for example, has held that 'the assessment of this minimum is, in the nature of things, relative; it depends on

all circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim.'¹⁸

As Artur's case clearly shows, the physical and mental suffering of persons with untreated pain can, like that of victims of traditional forms of torture and ill-treatment, be very severe:

Physical Suffering: Not only can pain due to cancer or other illnesses be very severe, it often extends to many parts of the body, may be constant and without reprieve, and can last over long periods of time. Experts estimate that, on average, a person dying of cancer or AIDS will suffer from moderate to severe pain for a period of three months, far longer than most victims of traditional forms of torture or ill-treatment are subjected to abuse.¹⁹ In interviews with Human Rights Watch in half a dozen countries around the world, people with severe pain often expressed a sentiment similar to that of traditional torture victims: They would do anything to stop the pain.²⁰ We have documented numerous cases of suicidal ideation among such patients, as well as various cases of suicides and attempted suicides.

Mental suffering: Severe pain causes significant mental suffering. Patients often experience a profound sense of loss of control, fear, anxiety and isolation. Severe pain tends to render patients bedridden and incapable of being active or even making decisions about their own lives. Frequently, they become completely dependent on relatives while at the same time being unable to interact with them in a meaningful way. Human Rights Watch interviewed various patients who said that they could no longer tolerate having their children around them or became abusive to their spouses as a result of the pain. Finally, pain frequently causes acute sleep deprivation that builds over time and has a profound impact on patients' mental state.²¹ According to a WHO study, people who live with chronic

pain are four times more likely to suffer from depression or anxiety than people who do not have chronic pain.²²

Long-term consequences: Finally, untreated pain can have serious long-term consequences for patients. According to WHO, the physical effect of pain can influence the course of the diseases and even result in death.²³ Pain frequently causes immobility, which can result in permanent loss of function in patients.²⁴

It is important to keep in mind that a certain degree of suffering, both physical and mental, is inherent in having a life-threatening disease like cancer. In assessing whether the minimum level of severity is met, one therefore needs to examine not the totality of the patient's suffering but the severity of the suffering that may not be regarded as inevitably experienced by a person with a serious, life-threatening health condition.²⁵ The question is the extent to which the lack of treatment for severe pain unnecessarily prolonged or exacerbated the suffering.

Torture or Ill-Treatment?

A subsequent question is whether denial of pain treatment would qualify as torture or ill-treatment. Schweitzer uses the word torture to convey the severity of the suffering of patients. But in a legal sense torture requires intent to cause severe suffering and state officials must be directly or indirectly responsible for inflicting the suffering.²⁶ Typically, however, denial of pain treatment results from neglect, poor government policies, and a lack of knowledge, rather than from an intention to inflict suffering and would therefore constitute ill-treatment and not torture. Theoretically, of course, a healthcare worker or official who deliberately withholds treatment from someone in severe pain with the intent to cause severe suffering could be guilty of torture but this is not a situation we have come across in our work.²⁷

The Scope of the Positive Obligation

If we accept that the severe suffering of many patients with pain due to cancer and other health conditions can constitute ill-treatment, the next question to examine is the scope of the positive obligation to prevent such suffering. What steps do states have to take to ensure that these patients do not have to suffer from severe pain without being able to access treatment? Below, we first discuss the positive obligation states have in individual cases of pain treatment denial and then the obligations states may have to protect persons more generally from such unnecessary suffering.

Obligation to Adequately Respond to Complaints

It is well established that states have a legal obligation to respond to credible allegations of serious ill-treatment, must take steps to stop the abuse and investigate and, if necessary, prosecute the perpetrators.²⁸ Failure to do so in itself constitutes a violation of the prohibition of torture and ill-treatment. Human Rights Watch believes that this obligation applies to cases where state authorities receive complaints from patients who are unable to get access to pain treatment, or the authorities have other reasonable grounds to believe a patient is suffering ill-treatment due to lack of access to pain treatment.²⁹ In such situations, states should take expedient steps to examine these complaints and, if it is found that a healthcare institution arbitrarily denied treatment causing severe suffering, it should take all reasonable steps to ensure that the patient gains access to appropriate treatment.³⁰ It should also examine whether legal steps, such as disciplinary measures, against the clinic or doctor are appropriate.³¹

The Case of Oleg Malinovsky

Oleg Malinovsky is a 35-year-old man from Kiev who has been diagnosed with chronic hepatitis C and a range of other illnesses. He developed severe pain in various joints shortly after he began treatment for hepatitis C in 2008. As any movement of his hip and knee joints caused severe pain,

Malinovsky was forced to lie completely still in his bed throughout the day. His wife told Human Rights Watch:

The pain was intolerable with any movement and became more severe with every day because of the pathological process in his hip joints. The pain affected his sleep, appetite, and his psychological condition. He became irritable and nothing could make him happy anymore. A normal sneeze or cough caused him terrible pain ... You could knock on the wall, and if he was lying over there, he would scream [in pain]...³²

For a period in late 2008 and early 2009, Malinovsky received a small dose of morphine every day which allowed him to sleep at night. Following surgery in March 2009, his pain temporarily subsided. When it came back in September 2009, Malinovsky asked his doctors for adequate pain treatment, expecting to once again receive morphine.

But the government clinic responded without any sense of urgency. It took weeks before examining Malinovsky and then repeatedly ordered new examinations, often after significant intervals, some of which appeared to simply repeat earlier examinations. Ultimately, it determined that Malinovsky suffered from persistent pain syndrome but failed to prescribe anything stronger than basic over-the-counter pain medications. Instead of viewing Malinovsky's request for stronger pain medications as a legitimate request for a medication that had helped control his pain before, it interpreted it as evidence of drug dependence. As a result, Malinovsky suffered from debilitating pain for six months. Eventually, Malinovsky's condition improved on its own.

Obligation to Ensure Availability and Accessibility of Pain Treatment

Given how severe and extended the suffering is that many patients with cancer and other severe chronic pain face, the large numbers of people affected each year and the fact that this

pain can be treated easily with inexpensive and safe medications, Human Rights Watch believes that the state's positive obligation requires reasonable steps to ensure that patients with severe pain can gain access to adequate treatment. This does not mean that every case where a patient with severe pain is unable to get access to pain medications constitutes ill-treatment. Where a country has taken all steps that can reasonably be expected of it to improve access to pain treatment but some patients still do not have adequate access because of the general weakness of the healthcare system or objective difficulties in making services available for people who live far from health centres, there would be no violation of the prohibition of torture or ill-treatment. (Of course, if a state became aware of such patients, it would still have to take adequate steps to remedy their situation where it is reasonable to do so.) But there may be a violation of the prohibition of torture and ill-treatment where states fail to take even basic steps to protect people in their jurisdiction from preventable suffering from pain.

The ECtHR has used a 'reasonable steps' test in some cases regarding the positive obligation under the prohibition of torture and ill-treatment. For example, in *Opuz v Turkey*, a case that concerned domestic violence, it examined whether the national authorities had taken 'all reasonable measures to prevent the recurrence of violent attacks against the applicant's physical integrity.' It found that although the national authorities had 'not remained totally passive' they had not 'displayed the required diligence to prevent the recurrence of violent attacks against the applicant...'³³

While this jurisprudence emanates from cases related to suffering caused by violence, the reasonable-steps test could be applied by analogy to cases of denial of pain treatment. Indeed, the UN Special Rapporteur on Torture has said explicitly that:

*Governments also have an obligation to take measures to protect people under their jurisdiction from inhuman and degrading treatment. Failure of governments to take reasonable measures to ensure accessibility of pain treatment, which leaves millions of people to suffer needlessly from severe and often prolonged pain, raises questions whether they have adequately discharged this obligation.*³⁴

The European Court of Human Rights has held that vulnerable individuals, such as children, are particularly entitled to state protection.³⁵ In an authoritative interpretation of the Convention against Torture, the Committee against Torture specifically cites the protection of ‘marginalized individuals or populations’ against torture or ill-treatment as an obligation for state parties and identifies health status as a category for vulnerability.³⁶ A strong case can be made for considering patients with incurable illnesses vulnerable individuals as well.

So what are the reasonable steps a government should take to protect patients with severe pain from unnecessary suffering? We can look for guidance at the right to health. A key duty under the right to health is the obligation to respect which requires countries to ‘refrain from interfering directly or indirectly with the enjoyment of the right to health.’³⁷ In Artur’s case, Ukraine’s drug control policies made it practically impossible for healthcare workers to properly manage his pain. As the legal requirement that a healthcare worker administer every dose of morphine is unnecessary from both a medical and drug control perspective – it is standard practice worldwide that patients who are at home or their families administer morphine themselves – there is no justification for a regulation that so severely impedes appropriate pain care, which thus violates the obligation to respect. Another example: In Guatemala, drug control regulations require that every

prescription for morphine be validated at a government office in Guatemala City before a pharmacy can fill it. This requirement, again unnecessary from a drug control or medical perspective, for all practical purposes makes morphine inaccessible for many patients, particularly those in rural areas.

The Committee on Economic, Social and Cultural Rights, the body that monitors the implementation of the right to health as articulated in the International Covenant on Economic, Social and Cultural Rights (ICESCR),³⁸ has identified a number of core obligations under the right to health, which it holds all countries must meet regardless of resource availability. First, the Committee articulates the general principle that ‘the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups’.³⁹

A crucial core obligation for this topic holds that states must ensure the availability and accessibility of medications included in the WHO Model List of Essential Medicines, which includes morphine. In fact, countries also have an obligation to ensure the availability of morphine under the 1961 Single Convention on Narcotic Drugs, to which 184 countries are party and which ‘establishes a dual drug control obligation: to ensure adequate availability of narcotic drugs, including opiates, for medical and scientific purposes, while at the same time preventing illicit production of, trafficking in and use of such drugs.’⁴⁰ Thus, ensuring the accessibility of morphine is not just a reasonable step toward preventing unnecessary suffering from pain, it actually is a legal obligation.

A second core obligation holds that states must adopt and implement a national public health strategy and plan of action.⁴¹ This core obligation is closely aligned with a recommendation by the WHO that countries adopt national or state policies that support pain relief and palliative care.⁴² A

second reasonable step to prevent unnecessary suffering from pain is therefore the adoption of health policies that address the palliative care needs of the population. If national health policies fail to do so, the state will fall foul of this core obligation.

Finally, the Committee has held that providing appropriate training for health personnel is an obligation of ‘comparable priority.’⁴³ Again, this obligation coincides with WHO’s recommendation that countries ensure healthcare workers are trained in provision of palliative care.⁴⁴ Thus, a third reasonable step toward preventing unnecessary suffering from pain therefore involves ensuring that healthcare personnel, particularly those likely to regularly encounter patients who need such health services, such as oncologists, have at least basic training in palliative care provision.

When the failure of states to take these positive steps or to refrain from interfering with healthcare services condemn large number of patients to unnecessary suffering from pain, they will not only fall foul of the right to health but may also violate the positive obligation under the prohibition of torture and ill-treatment. In an example of this in India we found that more than half of the country’s regional cancer centres, which see tens of thousands of cancer patients per year, do not offer adequate palliative care services. In fact, many do not even have morphine or doctors trained in using it, despite the fact that 70 per cent or more of their patients have advanced cancer and are likely to require pain treatment. Although the Indian government bestows the prestigious designation of regional cancer centre on hospitals and provides some financial support, it has not used its leverage with these hospitals to ensure that they offer palliative care and pain treatment services. As a result, tens of thousands of patients of these cancer centres suffer unnecessarily from severe pain every year. A doctor at a regional cancer

centre that does offer palliative care recalled how he and his colleagues dealt with patients in pain when they did not have morphine:

We used some drugs ... For example, weak opioids... But our patients' pain was [often] much beyond [those medications]. So we tried to avoid the patients: "Don't come to us. Go and take treatment at your local [doctor]." That was the attitude. "Our treatment is exhausted. We completed radiation, chemotherapy. We did everything we could for you. Nothing more is possible. You need not come here. You go and show to your local doctor." The local doctor says, "This is not my specialty. Cancer is like a super-specialty. I don't know anything about this cancer. So go back to your treating doctor." So in between the patient suffers and they die with suffering.⁴⁵

This kind of gross neglect of the needs of large numbers of patients who face severe suffering as a result violates the prohibition of torture and ill-treatment and states should be held accountable accordingly.

Joseph Amon is director and Diederik Lohman is senior researcher at the Health and Human Rights division of Human Rights Watch.

The authors would like to acknowledge the contributions to this article of three former interns or externs with HRW's HHR division: Florian Kastler, Jimmy Pan and a third person who requested to remain anonymous.

¹ Albert Schweitzer, 'On the Edge of the Primeval Forest,' 1924.

² Al Jazeera, Freedom from Pain, <<http://www.internationalreporting.org/pain/al-jazeera/>>.

³ WHO, 'Achieving Balance in Opioid Control Policy,' 2000, p. 1.

⁴ Statement by Professor Sevil Atasoy, President of the International Narcotics Control Board, at the Economic and Social Council Substantive Session for 2009, 30 July 2009, <http://www.incb.org/documents/President_statements_09/2009_ECOSOC_Substantive_Session_published.pdf>, (accessed 12 March 2010).

⁵ 'Briefing Note: Access to Controlled Medicines Program,' World Health Organisation Briefing Note, February 2009, <<http://www.who.int/medicines/areas/>

quality_safety/ACMP_BrNoteGenrL_EN_Feb09.pdf>, (accessed 6 August 2010).

⁶ Human Rights Watch, "Please Do Not Make Us Suffer Any More...": Access to Pain Treatment as a Human Right, March 2009, <<http://www.hrw.org/reports/2009/03/02/please-do-not-make-us-suffer-any-more>>, (accessed 10 June 2011).

⁷ UN Committee on Economic, Social and Cultural Rights, 'Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights,' General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), <[http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/40d009901358boe2c125691500509obe?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/40d009901358boe2c125691500509obe?OpenDocument)>, (accessed 4 November 2010).

⁸ See, for example, *All India Lawyers' Forum for Civil Liberties v Union of India*, (1998), WP 942/98.

⁹ See, for example, *Sadykov v Russian Federation*, judgment of 7 October 2010.

¹⁰ UN Human Rights Committee, General Comment 20, para. 8, <[http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/6924291970754969c12563ed004c8a5?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/6924291970754969c12563ed004c8a5?OpenDocument)>, (accessed 29 August 2009). See also the judgment of the European Court of Human Rights in *Z v United Kingdom* (2001) 34 EHHR 97.

¹¹ *Selçuk and Asker v Turkey*, judgment of 24 April 1998, para. 80.

¹² *Lopez Ostra v Spain*, judgment of 9 December 1994, para. 60.

¹³ *Kurt v Turkey*, judgment of 25 May 1998, para. 134.

¹⁴ *Opuz v Turkey*, judgment of 9 June 2009, para. 176.

¹⁵ *Z. v UK*, judgment of 10 May 2001, para. 75.

¹⁶ UN Committee Against Torture, 'Implementation of article 2 by States parties,' General Comment No. 2, The Absolute Prohibition Against Torture, UN Doc CAT/C/GC/ (2008), <<http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/402/62/PDF/G0840262.pdf?OpenElement>> (accessed 27 October 2011), para. 15.

¹⁷ Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, A/HRC/10/44, January 14, 2009, <<http://daccessdds.un.org/doc/UNDOC/GEN/G09/103/12/PDF/G0910312.pdf?OpenElement>>, (accessed 4 August 2009), para. 72.

¹⁸ *Ireland v the United Kingdom*, judgment of 18 January 1978, para. 162.

¹⁹ K. M. Foley, et al., 'Pain Control for People with Cancer and AIDS,' in *Disease Control Priorities in Developing Countries*, 2nd ed., New York: Oxford University Press, 2003, pp. 981-994.

²⁰ Human Rights Watch, "Please Do Not Make Us Suffer Any More..." *supra* note 6; Human Rights Watch, Unbearable Pain: India's Obligation to Ensure Palliative Care, October 2009, <<http://www.hrw.org/reports/2009/10/28/unbearable-pain-o>>; Human Rights Watch, *Uncontrolled Pain: Ukraine's Obligation to Ensure Evidence-Based Palliative Care*, May 2011, <<http://www.hrw.org/reports/2011/05/12/uncontrolled-pain-o>>; Human Rights Watch, *Global State of Pain Treatment: Access to Medicines and Palliative Care*, June 2011, <<http://www.hrw.org/reports/2011/06/02/global-state-pain-treatment-o>>.

²¹ F. Brennan, D. B. Carr, M. J. Cousins, 'Pain Management: A Fundamental Human Rights,' *Anesthesia & Analgesia*, vol. 105, No. 1, July 2007, pp. 205-221.

²² O. Gureje, M. Von Korff, G. E. Simon, R. Gater, 'Persistent pain and well-being: a World Health Organization study in primary care,' *JAMA*, vol. 80, 1998, pp. 147-51. See also: B. Rosenfeld, et al., 'Pain in Ambulatory AIDS Patients. II: Impact of Pain on Psychological Functioning and Quality of Life,' *Pain*, vol. 68, 1996, pp. 2-3, 323-28.

²³ WHO, 'National Cancer Control Programme: Policies and Managerial Guidelines,' 2002, p. 83.

²⁴ *Supra* note 21.

²⁵ The ECtHR uses a similar approach in cases of enforced disappearances, where it examines whether the suffering caused to relatives of a disappeared person is exacerbated by the failure of the government to conduct an adequate investigation into the incident. See for example, *Kurt v Turkey*.

²⁶ Article 1 of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (hereinafter: Convention against Torture) stipulates that torture means 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.'

²⁷ In our research, we have found cases where police deliberately denied treatment to drug users, using resulting painful withdrawal symptoms to force them to sign confessions. See: Human Rights Watch, *Rhetoric and Risk: Human rights abuses impeding Ukraine's fight against HIV/AIDS*, March 2006.

²⁸ See, for example, Articles 12 and 16 of the Convention against Torture; *Assenov v Bulgaria*, ECtHR judgment of 15 July 2005.

²⁹ See Article 12 of the Convention against Torture.

³⁰ See, for example, complaint by the All-Ukrainian Council for the Rights and Safety of Patients and Human Rights Watch to the UN special rapporteurs on torture and health of 4 February 2011 in the case of Oleg Malinovsky, accessible at <<http://www.hrw.org/node/102693>> (accessed 31 October 2011).

³¹ *Ibid.*

³² Human Rights Watch, *Uncontrolled Pain*, *supra* note 20.

³³ *Opuz v Turkey*, para. 166. See also *Osman v United Kingdom*, judgment of 28 October 1998, pp. 115-122.

³⁴ Joint letter by the UN special rapporteur on the prevention of torture and cruel, inhuman or degrading treatment or punishment, Manfred Nowak, and the UN special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, to the Commission on Narcotic Drugs, December 2008. A copy of the letter is available at <http://www.ihra.net/Assets/1384/1/Special_Rapporteurs_Letter_to_CND_012009.pdf>, (accessed 16 January 2009).

³⁵ *Opuz v Turkey*, para. 159.

³⁶ *Supra* note 16, para. 21.

³⁷ *Supra* note 7, para. 33.

³⁸ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted 16 December 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force 3 January 1976, Art. 11; also in the Convention on the Rights of the Child (CRC), G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force 2 September 1990, Art. 12.

³⁹ *Supra* note 7, para. 43.

⁴⁰ INCB, 'Availability of Opiates for Medical Needs: Report of the International Narcotics Control Board for 1995,' <<http://www.incb.org/pdf/e/ar/1995/supplien.pdf>>, (accessed 15 January 2009), p.1.

⁴¹ *Ibid.*, para 44(f).

⁴² WHO, 'Cancer Pain Relief, Second Edition, With a guide to opioid availability,' 1996, p. 3.

⁴³ *Supra* note 7, para. 44f.

⁴⁴ *Supra* note 42, p. 3.

⁴⁵ Human Rights Watch, *Unbearable Pain*, *supra* note 20.