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The Human Rights Act 1998—why should it matter for medical practice?

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A momentous event in British legal history was the introduction of the Human Rights Act 1998.[1] Doctors need to understand its scope and consider its implications for medical practice.[2] The Act has already made a substantial impact on medical law and will have a continuing effect on healthcare practice. It incorporates most, although not all, of the European Convention for the Protection of Human Rights and Fundamental Freedoms. The Articles of the Convention that have had major impact on healthcare are Articles 2 (the right to life), 3 (the prohibition on torture and inhuman or degrading treatment), 5 (the right to liberty and security), and 8 (the right to respect for private and family life). None of these rights is absolute but Article 3 represents an absolute prohibition and cannot be interfered with by the State under any circumstances. Articles 2 and 5 are subject to limited exceptions. Article 8 is a qualified obligation that requires a balance to be struck between the interests of the individual and the wider interests of society.[3] Any limitation or constraint imposed by a public body must be justified as being 'proportionate to the legitimate aim pursued'.[4]

This paper examines the background and scope of the Act, the interaction of the Articles of the Convention, and the impact on medical practice through engagement in life-and-death issues, mental health, confidentiality and access to treatment.

BACKGROUND AND SCOPE

The Act, which came into force on 2 October 2000, incorporates most of the provisions of the Convention into the law of England, Scotland, Wales and Northern Ireland. The immediate effect of implementation into domestic law was to allow 'victims' to claim their rights under the Convention in domestic courts instead of by referral to the European Court of Human Rights in Strasbourg.

The overarching purpose of the Convention is to safeguard human rights and fundamental freedoms and to maintain and promote the values of a democratic society. The UK was one of the first to ratify the Convention, in 1951, and individuals were extended the right of petition in 1966. However, before October 2000 the Convention had no legal effect, and instead was used as part of the wider political armamentarium, as an aid to the interpretation of ambiguous legislation and as a persuasive influence in judicial discretion when establishing the scope of the common law. The Act, however, created a constitutional instrument for a cooperative endeavour between the legislature, the executive and the judiciary to protect human rights, and has done so in an effective and positive manner.[5]

Section 3(1) of the Act requires all 'public authorities' to act in compliance with the Convention unless prevented from doing so by primary legislation. Section 6(3) describes a public authority as including a court or tribunal and 'any person certain of whose functions are functions of a public nature'. In the context of medical practice this clearly encompasses such bodies as National Health Service hospital trusts, primary care trusts, professional regulatory bodies when acting as a disciplinary body, NHS institutions and agencies, and NHS research ethics committees. Furthermore, doctors acting as NHS clinicians are likely to be construed as public authorities, although not when acting in relation to their private patients.[6] The term also applies to bodies that have a quasi-public function included within their remit, and may extend the potential liability of private organizations entering into target-driven cooperative schemes with NHS providers. Any interference with a Convention right by a public authority must be legitimate and directed towards an identifiable aim such as the interests of the public or national safety, the protection of health and morals, the economic wellbeing of the country or the promotion of the rights and freedom of others. In addition, such interference must be proportional in relation to what is necessary in a democratic society.

By section 3(1) of the Act, all legislation must, where possible, be 'read and given effect in a way which is compatible with Convention Rights'. In the context of medical practice this means that all healthcare statutes must be interpreted in a manner that accords with the sentiment and intention of the Act. Where this cannot be achieved the

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court may grant a declaration of incompatibility, pursuant to section 4 of the Act. The effect of the interplay between sections 3 and 4 can be seen to be given substance in mental health practice. In *R(H) v MHRT*[7] it was held that continued compulsory detention of a patient would be contrary to Convention rights unless reliable evidence showed that the patient had a mental disorder that warranted detention. The interpretive obligation pursuant to section 3 led the Court of Appeal to find that the onus of proof before a patient could be discharged from hospital under sections 72 and 73 of the Mental Health Act 1983 was irreconcilably incompatible with the right to liberty under Article 5 of the Convention. The burden of proof for continued detention must rest with the detaining authority and not with the patient. This case prompted the first declaration of incompatibility in healthcare law, and as a result, Parliament has now legislated[8] with the effect of amending s73 of the Mental Health Act 1983.

Under section 7 of the Human Rights Act, wronged individuals may rely on their Convention rights provided that they are 'victims' of the allegedly unlawful act, and that their claim is pursued within a year of the act complained of, or for such longer period as the court considers equitable. By way of redress the court may order any remedy it considers just and appropriate, provided that this power is within the court's jurisdiction. This may include ordering a public body not to take a proposed unlawful action, quashing an unlawful decision, conviction, or the award of damages or compensation.

LIFE-AND-DEATH ISSUES

The area in which the Act has engaged most actively is in issues pertaining to life and death. This is not surprising since medical practice is fundamentally preoccupied with such matters. End-of-life decisions regarding withholding and withdrawing medical treatment evoke a strong moral resonance. Central to such questions lie a cluster of ethical principles, which include the concept of the sanctity of life, individual autonomy, the right of self determination, and respect for the dignity of individuals. These core ethical values are now reinforced through the Act, in particular by Articles 2, 8 and 3.

Article 2(1) states that 'Everyone's rights to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which the penalty is provided by the law.' Article 2 might impose a *positive duty*[9] to safeguard life as well as a *negative duty*, which is not to deliberately take life. This issue was addressed in the conjoined twin case[10] (although the Act was not in force at that stage). The Court of Appeal took the view that Article 2 imposed a duty to protect the stronger twin and not just a negative duty of preventing death for the weaker twin. The court interpreted 'intentionally' through a natural construction of the language meaning 'specific purpose' (in this case, to cause death). This was narrower than the 'virtually certain' that is applied to intention in criminal law.[11] By applying the ordinary meaning of 'intentionally', the court justified the conclusion that the operation was performed to save the life of the stronger twin and not with the intention of depriving the weaker twin of life (although the proposed operation made this a virtual certainty). Within the context of euthanasia, Article 2 has been interpreted and stated to protect the sanctity of life and to protect the individual from third parties, thereby ruling out active voluntary euthanasia. In *Pretty*, the argument that the prohibition regarding assistance with committing suicide under s2 of the Suicide Act 1961 contravened, *inter alia*, Article 2 of the Convention was unsuccessful.[12]

The positive obligation to conserve life under Article 2, however, does not trump the negative obligation. Article 2 has been considered in the context of withdrawal of artificial nutrition and hydration from patients in a persistent vegetative state.[13] As Dame Elizabeth Butler-Sloss explained: 'Although the intention in withdrawing artificial nutrition and hydration in PVS cases is to hasten death, in my judgement the phrase ''deprivation of life'' must [import] a deliberate act, as opposed to an omission, by someone acting on behalf of the state, which results in death . . . The death of the patient is the result of the illness or injury from which he suffered and cannot be described as a deprivation'. It was further held that the withdrawal of feeding and hydration from severely incapacitated patients can be justified as being in their best interests, and if so, would not be in contravention of Article 3. It has been suggested that it may be incumbent upon NHS trusts to actively consider the withdrawal of artificial nutrition and hydration at the very end of life in order to provide a dignified death for the patient in compliance with Article 3.[14]

In the context of choosing how to end one's days, Article 8 gives effect to the right of self-determination and autonomy in the competent patient, even if such a choice hastens death. In *Ms B*, the court affirmed the right of a tetraplegic social worker to have the ventilator that was maintaining her life switched off.[15] Butler-Sloss emphasized that there was a serious danger 'exemplified in this case of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient'. Likewise, in *Pretty* it was recognized that the right to refuse treatment was within the ambit of Article 8. However, the right to die could not be read into the obligations under Article 2, nor could Article 3 be considered to include permitting actions designed to cause death pursuant to the obligation of the State to prevent degrading treatment, even if a competent person regards his life as 'degrading' on account of the underlying medical condition.

With regard to the incompetent patient, Articles 8 and 3 apply in reaching a decision about best interests. The law is settled that a decision about best interests should not be solely medically oriented, but must incorporate broader ethical, social, moral and welfare considerations and that in the event of dispute it is for the judge, not the doctor, to decide whether the proposed treatment (or non-treatment) is indeed in the best interests of the patient who lacks capacity.[16] Article 8 provides protection for an incompetent individual's personal autonomy and dignity. In *Glass*[17] the European Court of Human Rights found a violation of Article 8 where doctors had administered diamorphine to a disabled boy against the express objections of his mother. The doctors' decision to override the mother's objections in the absence of court authorization resulted in an unjustifiable interference with the boy's right to respect for his private life and, in particular, his right to physical integrity, under Article 8. Further, the onus was upon the hospital trust to obtain a declaration from the court. In establishing best interests, the rights under Article 8 are protected by the Act, and arguably *Glass* puts an end to the sense that a medical assessment by itself would be determinative in law.

In this context a further issue concerns 'living wills' or advance directives. An advance directive in respect of refusal of treatment or resuscitation, made while a person was competent, will apply, at common law, at a future date should the person become incompetent, provided that the directive remains valid and relevant to the new circumstances.[18] The mentally competent person's right to refuse medical intervention is well established in law, and advance decisions for refusal represent an extension of this rule.[19] Following *Burke*,[20] however, an advance directive *requiring* that artificial nutrition and hydration be continued, will also be legally binding on the basis of the Act. Existing legal principle holds that there is no obligation to provide a form of treatment if doctors in the exercise of their clinical judgment do not consider this to be appropriate medical intervention. In *Burke* extensive judicial analysis in relation to the Act led to a different conclusion. On the basis that self-determination and dignity are fundamental rights protected by Articles 3 and 8, and that personal autonomy includes how one chooses to pass the closing days and moments of one's life, it was reasoned that this would support an entitlement to the provision of life-prolonging treatment, if so required by a competent person or if stated in an advance directive. Practicalities dictate that the person would be in a vulnerable position at the time such treatment would need to be administered. The Act provides an enhanced degree of protection for the vulnerable and would *a fortiori* give substance to such a requirement for treatment. *Burke* represents a bold interpretation of the Act and one that is firmly weighted towards autonomy, self-determination and the dignity of the individual, to the extent of stating that the withdrawal of such treatment could be degrading under Article 3, even in the unconscious patient, and such treatment should be continued until the very final stages of life. As trusts are public authorities for the purpose of the Act, they are under a duty to act in a manner that is compatible with the patient's Convention rights.[21] It falls upon trusts to provide such life-prolonging treatment if required, and to apply to the High Court as to when this treatment may be lawfully withdrawn. The precise implications of this decision (which has been appealed) are as yet unclear, but it is envisaged that it may have far-reaching consequences in terms of clinical practice.[22] [*Editor's note:* On 28 July 2005 the General Medical Council was successful in appealing against this ruling.]

In contrast to end-of-life decisions, ethicolegal questions pertaining to the beginning of life have had little recourse to the Act. In *Evans*[23] a vigorous court battle ensued between a woman and her ex-partner when she sought implantation of cryopreserved embryos created by *in vitro* fertilization with his sperm. His strenuous opposition powerfully illustrates the tension that exists between the competing human rights of parties involved in reproductive decision-making. Having exhausted all domestic remedies, she has now applied to the European Court of Human Rights pleading, *inter alia*, that her rights to privacy and family life under Article 8 have been 'breached', and that under Article 2 the embryos may have a right to life. The outcome is pending. The recent decision in *Quintavalle*[24] indicates a limited application of the Act as far as embryos are concerned. The case relates to the assisted conception of a tissue-compatible child who would not have the same genetic disorder as an existing sibling, whose stem cells could thus be transplanted for the treatment of the sibling. It was argued that allowing a mother to select an embryo might be undesirable on ethical grounds. However, the House of Lords held that such preimplantation genetic diagnosis could be lawfully authorized by the Human Fertilisation and Embryology Authority, in order to provide information about the embryo's characteristics which were relevant to the mother's decision whether or not to carry the child.

There has been an indirect effect on healthcare law through an action brought by mothers giving birth who had conceived with the assistance of medical technology after the death of the husband or partner.[25] Their contention was for the child's birth certificate to contain the name of the deceased father, founded on the right of the child to ascertain his or her genetic identity—a right that was argued to be inherent in Article 8. This was never tested in court, since the lawyers for the Government capitulated on the first day of the hearing, and subsequently the Human Fertilisation and Embryology Deceased Fathers Act 2003 was passed.

MENTAL HEALTH

Human rights arguments have featured prominently in the area of mental health law disputes, and were of influence even before the implementation of the Act. Article 5 delineates the right to liberty and security of the person, specifying that no one shall be deprived of liberty except in accordance with a procedure prescribed by law, which includes the lawful detention of persons of, *inter alia*, unsound mind. According to *Winterwerp*[26] the minimum criteria for the legitimate continued detention of a person of unsound mind are that: except in an emergency, the individual can be reliably proved on objective medical evidence to warrant compulsory detention; *and*, that the validity of the continued confinement depends upon the persistence of the condition. This requires that the patient's condition is regularly reviewed and that mechanisms are in place for the person's release as soon as the individual no longer satisfies the criteria. More recently in *Johnson*,[27] a convicted patient with schizophrenia was detained under a hospital order. On review before a mental health tribunal he was conditionally discharged subject to securing alternative supervised accommodation. Since no suitable accommodation could be found the patient remained and languished in hospital. The European Court of Human Rights, relying on *Winterwerp*, held that the duty remained with the tribunal, as a public body, to find suitable alternative accommodation. Taken together, *Winterwerp* and *Johnson* demonstrate that mental health trusts need to be vigilant about reassessing their detainees and justifying any imposed restriction on liberty.

The majority of hospital admissions for treatment of mental disorders are classified as 'informal admissions'.[28] The legal status of the informal patient equates with that of other informal patients who are admitted for physical conditions, inasmuch as the patient can refuse treatment and discharge himself or herself. Section 131 fails to provide for the compulsory treatment or detention of patients with mental health problems should the need for this arise during an informal admission, and enforced detention could be in breach of Article 5. In dealing with this problematic statutory deficiency at common law in *Bournewood*,[29] the Court of Appeal was asked to determine whether it was lawful to detain a mentally incapacitated man who was incapable of giving valid consent to medical treatment, following an event at the day centre where he had been an informal patient. His attending psychiatrist had assessed him as being in need of inpatient care, but judged compulsory admission under the Mental Health Act 1983 unnecessary since he did not resist admission. His carers sought judicial review of the decision to detain him. The trust argued that the patient had not been detained, since he had been accommodated on an unlocked ward, and in any event, his detention had been lawful under the doctrine of necessity. In considering the applicant's human rights *vis-à-vis* the restriction on his liberty, the Court of Appeal found that the patient had been unlawfully detained. The House of Lords reversed this decision and held that, in the instant case, all steps had been taken in the patient's best interest and were justified on the basis of necessity, although Lord Steyn acknowledged that the general effect of this verdict was to leave the compliant incapacitated patient without the safeguards enshrined in the 1983 Act, and to place effective and unqualified control in the hands of the hospital psychiatrist and other healthcare professionals.[30] An application to the European Court of Human Rights was successfully sustained and it was held that the patient had been deprived of his liberty in contravention of Article 5 of the Convention.[31] The effect of this ruling is that the lawful detention of patients under these circumstances requires that formal admission procedures are adhered to. The practical implications are yet to materialize.

The new rights culture has indirectly impacted on patients with mental health problems in respect of cases concerning enforced sterilization. There is a growing awareness of the force of Article 8 and the rights-based arguments that protect the individual. Recent jurisprudence demonstrates a more circumspect judicial approach to the abrogation of fundamental reproductive rights, whereas formerly sterilization might have been authorized purely on medical grounds.[32]

CONFIDENTIALITY

The respect for patient confidentiality has been an intrinsic part of medical practice. In the complexity of modern medicine, confidentiality is no longer confined to the doctor/patient relationship, and the maintenance of confidentiality requires healthcare organizations to recognize their responsibilities. The burgeoning intricacies of electronic patient and health records, and information technology, have led to the appointment of senior clinicians, known as Caldicott guardians, to oversee and protect confidentiality in their organizations.[33] Furthermore, the rules surrounding issues of data protection in respect of information that is held on computers or manually, the patient's rights of access to medical records and the obligation of confidence have all been assimilated into a single framework under the Data Protection Act 1998, which incorporates the law on confidentiality and imposes a duty on organizations to ensure that data are used only for authorized purposes and that it is properly protected.

Despite the agreement regarding the importance of confidentiality, there has been much debate as to the justification, as well as the functions, of such an obligation.[34] One reason that has been put forward is the patient's rights to privacy. The Act now reinforces this justification through Article 8 of the Convention. Confidentiality is an aspect of the right to privacy under Article 8 in human rights jurisprudence[35] and there is an enhanced degree of protection depending upon the sensitivity and intermittent nature of the issue in question.[36] This jurisdiction is increasingly prepared to recognize that private interests form the principal foundation of confidentiality,[37] and that the common law should cover the full scope of privacy protected under Article 8 of the Convention.[38] However, the rights protected under Article 8 are qualified by derogations, and the disclosure of confidential information must be balanced against the public interest.

Disclosure of confidential data that concerns a person's medical records is protected by Article 8, being an aspect of a person's 'right to respect for private and family life'. As such its disclosure must be required for a stated and specific purpose that satisfies the test of being 'proportionate to the legitimate aim pursued'.[4] *Z v Finland*[39] provides an illustration of the application of Article 8 in the context of medical confidentiality where police seized the hospital records of an HIV-positive patient during their investigations of her husband who had been charged with sexual assault and attempted manslaughter. At trial, the patient's doctors were required to produce her medical records as part of the factual evidence. The court found no breach of Article 8 since the interference with the patient's right to confidentiality was considered to be in accordance with the law and necessary in a democratic society, thereby satisfying the test of proportionality.

In a claim for social insurance benefit, copies of health records, including details of a previous abortion, were released,[40] and the applicant claimed that her rights under Article 8 had been breached. Her claim was rejected on the grounds that there was a legitimate aim in checking the data that had been submitted in order to ascertain its accuracy and that the intrusion into her privacy in this regard was not disproportionate to the legitimate aim pursued. The right to confidentiality under Article 8 has also been used to prevent a health authority from disclosing the identity of a health professional who was found to be positive for HIV.[34] The argument for this was that the risk of patients' contracting HIV from a health professional was so low as not to justify the level of intrusion on the individual's privacy that would ensue on disclosure of his identity. The effect of this ruling has been the emergence of new guidance from the Department of Health:[34] whereas previously it was thought that under such circumstances a patient should be contacted and offered an HIV test, this is no longer necessary.

ACCESS TO TREATMENT

Challenges to decisions about resource allocation and the financing of treatments have been argued as an infringement of the 'right to life', since Article 2 includes positive duties to preserve life as well as negative duties not to deprive another of life. In *Scialacqua*[41] the European Court of Human Rights held that it was prepared to assume that Article 2 imposed an obligation on the State to provide for the 'costs of certain medical treatments or medicines that are essential in order to save lives'. However, the duty to safeguard life is not absolute. Each State has the freedom to implement public policy with a certain measure of discretion,[42] and the extent of the obligation to safeguard life by resource allocation will generally be left to each individual State.[9] It seems unlikely therefore that Article 2 will provide an automatic entitlement to treatment. Article 8 has also been used to argue for the right to obtain certain forms of care, although this trend was constrained within this jurisdiction when, whilst allowing access to gender reassignment surgery in the instant case, the Court of Appeal added the general caveat that the right to privacy imposed no positive obligation to provide medical treatment.[43]

A further argument could be raised by invoking Article 3 of the Convention, in that the failure of the NHS to provide costly treatment that could demonstrably improve the quality of a patient's life would amount to inhuman or degrading treatment. However, *dicta* indicate that Article 3 'has never been applied merely to policy decisions or the allocation of resources'.[43] In *D v UK* the European Court of Human Rights determined that the deportation to St Kitts of a patient with AIDS who had been receiving antiviral treatment in the UK would amount to a violation of Article 3. Since there was no adequate treatment for the disease in St Kitts, deportation would amount to breach of the patient's human rights as he would be exposed to a real risk of dying under extreme and inhuman conditions. The facts in *D v UK* were unusual in as much as the State had already begun treatment that would subsequently have been withdrawn, and thus can be distinguished from situations that concern the refusal of an anticipatory treatment decision.

It has been suggested that the recent guidance issued by the Department of Health, 'Implementing the Overseas Visitors Hospital Charging Regulations', may be susceptible to challenge under the Act.[44] The regulations empower hospitals to apply charges for certain NHS care provided to specific patient groups such as failed asylum seekers, students on short courses, and persons visiting Britain specifically for medical treatment. Some professional groups have condemned these proposals as an infringement of the professional and ethical duty of doctors to assist those in need irrespective of their ability to pay. Implementation of the regulations has the potential to fall foul of the Act by being seen as discriminatory against specific groups and breaching the rights protected under the Articles of the Convention.

CONCLUSION

The Human Rights Act, now enshrined in domestic legislation, impinges on several areas of medical practice, including life-and-death issues, mental health, confidentiality, and access to treatment. Perhaps its greatest impact in clinical practice is in the area of end-of-life decision-making and the withholding and withdrawal of life-prolonging treatment. The law has recognized and upheld the autonomy of the individual and the right to self determination in a competent patient for the refusal of medical treatment. The parameters that reflect primacy of the individual have been broadened by the Act and the interaction between Articles 2, 3 and 8 of the Convention. There has been a large shift in the scope of advance directives, the determination of best interests, as well as the need for judicial resolution of disagreement in this area, with the emergence of an emphasis that promotes the human rights of the individual. Article 8 protects patient confidentiality, Article 3 and 8 may be invoked in issues regarding access to treatment, and Article 5 protects the right to liberty and security of the person, especially in the context of mental health where there might be the requirement for enforced detention of persons of unsound mind.

The Act has already had wide impact on several areas of medical practice. The resort to rights-based discourse has bolstered patients' rights of autonomy, dignity, privacy and self-determination. Some areas remain as yet uncharted, such as the clinician's right to conscientious objection, or the engagement of the Act in professional regulation. Certain other codes and declarations designed to safeguard human rights have not, as yet, been incorporated into domestic legislation. The Convention on Human Rights and Biomedicine extends to many matters relating to healthcare practice including consent, privacy and confidentiality and the protection of individuals unable to give a valid consent. The proposed new European Constitution includes the Charter of Fundamental Rights and Freedoms which resonates with healthcare law particularly in the requirement of respect for human dignity. The language of rights will continue to have a profound influence on healthcare law and medical practice.

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