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Postcode prescribing and the Human Rights Act 1998

The Human Rights Act 1998 is one of the most important developments in English Law for many years. The Act, which came into force in October 2000, effectively incorporates the European Convention on Human Rights into English law. Under the new legislation, a public body cannot proceed in a way that is incompatible with any of the 'convention rights' that will now form part of the law; thus health authorities and National Health Service trusts will have to be aware of their responsibilities with regard to human rights. The Act imposes a 'positive rights' approach on English law, which had previously acknowledged only 'negative rights'—i.e. the rights of individuals not to be subject to interference. We can expect that, increasingly, individuals will demand that public bodies make provision to uphold their human rights; thus greater demands are likely to be made on the resources of all such public authorities. One area particularly relevant to clinical practice is 'postcode prescribing'.

Postcode prescribing arises from the decisions of individual NHS health authorities and trusts on whether they can afford to supply a specific drug for a particular condition. Access to a drug can thus depend on where you live. One purpose of the National Institute for Clinical Excellence (NICE) is to make judgments on controversial treatments, which will then be prescribable in all areas or none. The Human Rights Act 1998 will enable individuals to seek to challenge future decisions of health authorities and trusts who refuse to fund drug treatment on the basis of cost. Article 2 provides that 'everyone's right to life should be protected by law'; this is an absolute right and, as such, allows no scope for exemptions on grounds such as lack of funds. The Strasbourg Court has stressed that Article 2 does not simply require an authority to refrain from the taking of life but also requires appropriate action to safeguard life. Where a patient who has been refused a drug for reasons of cost takes steps to challenge the decision, he or she can now do so by claiming that the body making the decision has acted in a manner incompatible with Article 2—if the refusal of drug treatment might lead to an earlier death. A patient may also rely on Article 14, which protects against discrimination in the enjoyment of convention rights, to support such a claim. Similarly, the patient might rely upon the Act in connection with a Judicial Review application against the authority or trust when challenging the decision to refuse such drug treatment.

Whilst patients have always been able to challenge funding decisions made by trusts or health authorities, the courts have to date made clear that their role is to determine whether the body has followed the correct procedure and acted reasonably. The courts have emphasized that it is not their role to consider the merits of the decision as to whether treatment should be funded. However, the requirement to interpret the law in accordance with Article 2 (the right to life) may cause the courts to adopt a new approach. They might, for example, be obliged to examine data relating to the efficacy of a drug, particularly where it is claimed to be life-saving. In defence of their decisions health authorities are likely to use the NICE guidelines, and the courts will have to familiarize themselves with the approach of evidence-based medicine.

What weight the courts will give to the 'right to life' remains unclear. Will they require the decisions of authorities and trusts to be reviewed only when there is a clear case that the drug in question might improve the patient's health and increase life expectancy, or will they also allow claims where the chances of increasing life expectancy are relatively low? The case of 'Child B', in which the Cambridge Health Authority decided to refuse further treatment for a 10-year-old child with leukaemia, illustrates the different approaches that the courts might take. In the original hearing the judge quashed the health authority's decision not to fund the treatment on the grounds that, however slim the chances of the child's survival, the responsibility of the authority was 'to do more than toll the bell of tight resources'. It is noteworthy that this judge, hearing the case in 1995 (well before the new Act had been debated for legislation), specifically referred to the European Convention on Human Rights in reaching his judgment. The Court of Appeal took a very different view, holding that the authority could choose to use funds for the benefit of patients in general rather than for the treatment of one particular individual. In the light of the new Act and the positive rights approach, the demands of an individual patient are likely to be greater.

Article 3, which provides that 'no-one should be subjected to torture or to inhuman or degrading treatment' might also provide some ammunition for patients who have been denied a drug. The refusal to fund a therapy,

particularly where the patient would be able to receive it if located in a different area of the country, can be regarded as 'degrading' and thus the body who refuses the treatment might be in breach of the convention right. Again, it should be noted that Article 3 is an absolute right and the authority or trust cannot rely on any exemption.

Under the new human rights legislation patients have gained practical and effective means for challenging decisions in various areas of medical practice. Whilst we cannot be certain at this stage about the manner in which the courts will interpret the Act, there is little doubt that it will have great impact.

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Training for colonoscopy

Requests for colonoscopy continue to increase, with no prospect of a plateau now that the Department of Health is promoting better colorectal cancer services. There is even a possibility of national population screening if the pilot studies continue to show benefit[1,2]. For both diagnosis and surveillance, in most patients, colonoscopy is the best way to examine the large bowel. A possible alternative is 'virtual colonoscopy' or CT colography[3], in which spiral computed tomography is combined with graphic computerized reconstruction of the colonic lumen. This has yet to be adequately evaluated in clinical practice; but with any radiological method at least one-third of examinations would have to be followed by conventional colonoscopy for validation or therapy (polypectomy in particular).

Even if we could fund more colonoscopy sessions and even if a proportion of the increased work were shifted to nurse-endoscopists[4], how could we train the new endoscopists and at the same time raise the standards of existing practitioners? Colonoscopy is a skilled procedure which is not always well done. Many endoscopists have been trained through a patchy apprenticeship at best, augmented by an occasional demonstration by world experts beamed across the globe by satellite. Such diversity is no longer acceptable. A structured training programme is required, for both trainers and trainees.

A challenging solution is being developed by the Royal College of Surgeons of England (Raven Department of Education) and the British Society of Gastroenterology (Joint Advisory Group on Endoscopy Training). There are three major components. First, the trainers must be trained; an existing three-day course at the Royal College of Surgeons has now been modified to provide a training-the-trainers (colonoscopy) module. The hope is that aspirant local trainers will attend one such course and then disseminate the good practice and technique in their own locality. Each trainer will have learned the principles of good training—in particular, avoidance of teaching by humiliation and of excessive intervention ('let me show you'). In theory a good trainer does not have to be an expert, though, unlike a football coach, he or she must be able to take over as replacement and finish the game.

Secondly, the approved regional training centres (initially 6–8 in England), staffed by trained trainers, would run local courses, two or three times a year. The courses would be in standard format, lasting three days, and would target specialist registrars in medical or surgical gastroenterology (though other specialists and career grades might also wish to enrol). As well as enthusiastic local trainers with protected teaching time, such centres would need additional support—for example, high-quality instruments and technical backup from endoscope manufacturers. Each local centre would have a standard fixed closed-circuit television system in the endoscopy training room, with facilities for trainees to videotape their own performance. There should also be provision for early testing of manipulative skills and brain–hand–eye coordination, by use of simple mechanical colon models and perhaps the electronic simulators[5] that have just come on the market. The training principles of such simulators are well established in the airline industry but have yet to be adequately tested in clinical endoscopy. Another valuable training tool is the electromagnetic imager[6], which involves no ionizing radiation, has been refined over the past five years and may soon be commercially available. It may not help the expert much—except with the 'endless colon'—but in the learning phase of colonoscopy it provides real-time awareness of the type and location of the various colonic loops. In this context, fluoroscopy has largely been abandoned worldwide as unnecessary as well as potentially dangerous.

In summary, the basic training course aims to teach a technique of colonic intubation that achieves safe and accurate examination of the whole colon in over 90% of patients. Before attending, each trainee should read a short standard handbook, so that the course can concentrate on individual hands-on training.

So, the trainers have been trained and the trainees have been taught, but our third component is not yet in

place—audit and monitoring. The trainees should be able to continue developing their endoscopic skills by attending supervised colonoscopy lists in their own base hospital, but with ready access back to the training centre for specific progress reports, help and advice. Each training centre would need to demonstrate continuing quality control and performance standards—for example, by interchange of trainers and random assessment of videotaped procedures. Only if such initiatives are supported, funded and validated will we be able to provide satisfactory and safe colonoscopy throughout the National Health Service.

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Stepney Green clocktower: a medical memorial

A panel sculpted in *art nouveau* style at the base of the clocktower in Stepney Green represents *Benevolence*. The clocktower, perhaps unique as a memorial to a local doctor, was built in 1913. Dr Stanley B Atkinson (1873–1910) was born, lived and worked throughout his short life in the East End. Doubly qualified in law and medicine, Dr Atkinson worked tirelessly for his patients and in local public service, as Stepney Borough Councillor, Guardian of the Poor and Member of the Metropolitan Asylums Board. The memorial was funded by public subscription 'in recognition of his unselfish devotion to the public good.'

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