The Constitution Unit

The Human Rights Act 1998 and Access to NHS Treatments and Services: A Practical Guide

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"...if you are ill or injured, there will be a national health service there to help; and access to it will be based on need and need alone - not on your ability to pay, or on who your GP happens to be or on where you live." - *The New NHS: Modern, Dependable - Government White Paper, December 1997.*

"If the right to health is considered as a fundamental human right, significant differences in access to health care and the health status of individuals must be seen as violations of the principle of equality" - *Implications of a Right to Health - Virginia A. Leary, 1993.*

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INTRODUCTION

Despite the preparation and anticipation by health care organisations, the numerous training courses offered to those with an interest in health and human rights, and despite the ever increasing number of publications on human rights, the Human Rights Act 1998 (the HRA) has had, to date, little visible impact on the field of health care provision, since it came fully into force on 2 October 2000.

The indications are that the judiciary has shown little tolerance for human rights arguments in court, preferring instead to rely on the existing provisions of domestic law, rather than dipping their toes into the largely uncharted waters of the Human Rights Act.

In general, preparations for the implementation of the HRA acknowledged and anticipated the unpredictability of the judicial response, so the reliance on existing domestic law has come as no great surprise. It is important to recognise however that even one successful challenge could have significant ramifications across the whole range of government activities. In this climate of uncertainty, what is needed is clear guidance for service users and health care professional as to the rights and responsibilities under the Human Rights Act 1998, and an awareness of the arguments that may be employed to support or refute allegations of breaches of fundamental human rights in the context of treatment decisions.

The aim of this guide is not to provide a substitute for legal advice. In such a new and developing area of law, readers are advised to seek help from qualified individuals or organisations, should they be uncertain as to their rights, or should they be contemplating litigation. What this guide aims to do is to highlight issues that may be relevant in the context of health and human rights and to illustrate how human rights considerations can provide a solid foundation for the provision of health care, how using human rights can underpin the reasons that many people enter the health care professions in the first place – to improve the quality of life of people wherever possible, to ensure that individuals are treated with respect and dignity and to do the best that they can within a framework of finite resources.

This guide sets out the legal framework within which the HRA is, in theory, to operate, before exploring the application of human rights considerations to decisions regarding access to NHS treatment and services. The final section of the guide comprises a series of case studies and commentaries as an aid to understanding the practical implications of the Human Rights Act for a field that is often beset with ethical conflict, scarce resources and the ever-increasing expectations of service users.

PART I: THE LEGAL FRAMEWORK

"Bringing Rights Home"

Surprising as it may seem, given the degree of preparation for the implementation of the Human Rights Act on 2 October 2000, the concept of human rights is not new to this country. The Human Rights Act 1998 incorporates most of the existing rights contained in the European Convention on Human Rights (the ECHR) into domestic law (see Annex B). The European Convention on Human Rights was drafted largely as a response to the atrocities committed in the Second World War. The ECHR was ratified by the United Kingdom in 1951 and individuals have been able to take cases alleging breach of the rights enshrined in the European Convention on Human Rights to the European Court of Human Rights in Strasbourg since 1966. Health and social policy should, in theory, therefore already respect the rights contained in the ECHR, but this is not necessarily the case. The ECHR is a dynamic living instrument, drafted so that it is capable of responding to changes in social attitudes and moral values. The fact that health care policy may have been compliant with the ECHR in the 50s, is no guarantee of compliance today. Issues that did not arise in the 50s and 60s are now the subject of litigation in the 21st century. Judgments of the court in relation to treatment decisions which are contested may very well have different applications following the implementation of the Human Rights Act 1998 on 2nd October 2000.

The 'living instrument' concept is very laudable, ensuring as it does the continuing relevance of legislation drafted over half a century ago, but the difficulty with the system prior to 2 October 2000 was that, in order to enforce their Convention rights, individuals in the United Kingdom had to incur the expense of taking their case to the European Court of Human Rights in Strasbourg, with the inevitable years of delay that this entailed. The Human Rights Act 1998 has not expanded the range of rights available to United Kingdom citizens, but has made it easier, quicker and less expensive for those same litigants to enforce the rights protected by the ECHR.

Who is covered by the Human Rights Act 1998?

All 'public authorities' are required to act compatibly with the HRA1, whether through their acts or their omissions. The term 'public authorities' is intentionally given a broad definition in the HRA 'so as to provide as much protection as possible to those who claim that their rights have been infringed.'2 Section 6(3) of the HRA provides:
'In this section 'public authority' includes –

- a court or tribunal, and
- any person certain of whose functions are functions of a public nature…'

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[1] Section 6(1) of the Human Rights Act 1998

[2] The Lord Chancellor, Hansard HL, 16 November 1997, col. 1231

The HRA therefore applies not only to obvious public authorities, such as government departments, but also to bodies which may be private, and which undertake certain public functions, for example, the privatised utilities (known as 'hybrid bodies'). Such hybrid bodies will only be covered by the HRA in relation to their public functions. There is little doubt that NHS Trusts and their employees (whilst carrying out NHS work) are public authorities for the purpose of the HRA. Private hospitals, or NHS doctors carrying out work under private health insurance schemes are unlikely to be covered by the HRA. However, in the context of the NHS Plan, private hospitals that are paid by the NHS to carry out work that the NHS cannot provide are likely to find themselves considered as undertaking a public function (and consequently be considered a public authority in relation to that work) for the purpose of the HRA.

Who can bring proceedings under the Act?

Claims under the HRA can only be brought by an individual who is or would be a 'victim' of the unlawful act.[3] Strasbourg has interpreted 'victim' to mean someone who is directly affected by the act or omission of the public authority that is alleged to have breached a Convention right, or who is at a real risk of potentially being so affected.[4] The interpretation prevents public interest groups from bringing proceedings under the Convention in their own name[5], unless they can establish that they are a group of victims, but there is nothing to prevent any such group supporting an individual litigant if they so wish, whether the litigant approaches them, or vice versa. The support from a public interest group may range from financial backing and the provision of legal advice to written or oral interventions in court. In the case of a deceased person, a relative may bring proceedings under the HRA, where a complaint is made about his or her death.

In the context of access to NHS treatment and services, a service user will have to prove that he or she is a 'victim' for the purposes of the HRA. This may not be as straightforward as it sounds. For example, suppose that an individual is denied a life-saving operation. An argument under Article 2 (right to life) may be appropriate, but in order to raise a successful challenge, the individual will need to go behind the decision of the health care professionals involved in his or her case and establish the reasons for the decision. Was the decision based purely on clinical considerations? Were resources a factor? And if resources were a factor, how can the individual concerned prove that had there been £x available, they would then have been given to fund his or her the operation? Would the individual concerned have been given the operation had it not been for the fact that he or she had other disabilities? Would

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[3] Section 7(1) of the Human Rights Act 1998.

[4] *Campbell v United Kingdom* (1982) 4 EHRR 293

[5] *Klass v Germany* (1978) 2 EHRR 214

the individual concerned have been given the operation had it not been for the fact that the health authority had decided to target its budget at reducing the incidence of teenage pregnancy in the area? Would the individual concerned have been given the operation had it not been for the fact that there was a patient some years younger who had the same clinical need for the operation? These are the types of questions that will need to be asked before a challenge to a decision refusing treatment can be mounted.

How readily available this information is will vary between health authorities, but service users should be aware that this may be the first in a series of hurdles that they will have to overcome in order to challenge a decision refusing treatment, using arguments based on Convention points.

How to bring a case under the Act

Cases based on human rights arguments can now be brought in the courts of the United Kingdom, either as stand-alone proceedings[6], or in conjunction with proceedings based on an existing cause of action[7]. Examples of the application of the HRA were given during the course of the Parliamentary debates on the bill:

> 'If people believe that their convention rights have been infringed by a public authority, what can they do about it? Under [s.7] they will be able to rely on convention points in any legal proceedings involving a public authority; for example as part of a defence to criminal or civil proceedings, or when acting as plaintiff in civil proceedings, or in seeking judicial review, or on appeal. They will also be able to bring proceedings against public authorities purely on convention grounds even if no other cause of action is open to them.'[8]

Stand-alone proceedings

The HRA has introduced a new cause of action into UK law by virtue of section 7(1)(a) which provides that:

> 7. Proceedings
>
> 1. A person who claims that a public authority has acted (or proposes to act) in a way which is unlawful by section 6(1) may -
>
> (a) bring proceedings against the authority under this Act in the appropriate court or tribunal…

[6] Section 7(1)(a) of the Human Rights Act 1998.

[7] For example, in a case involving clinical negligence resulting in the death of a patient, arguments based on Article 2 (the right to life) may be utilised in the course of the proceedings.

[8] The Lord Chancellor, Hansard HL, 3 November 1997, col. 1232

The effect of section 7(1)(a) is that a case can be brought on Convention grounds alone, i.e. it does not have to be tied in with any other proceedings. So for example, an individual could bring a case for inhuman and degrading treatment under Article 3 or for a breach of the right to private life under Article 8, without having to prove that the public authority was negligent or in breach of a public law duty in any respect.

Using the HRA in conjunction with another cause of action

Section 7(1)(b) of the HRA provides that an individual may:

> '…rely on the Convention right or rights concerned in any legal proceedings…'

Cases under section 7(1)(b) are likely to be more usual than cases under section 7(1)(a) and this has proved to be the case so far in the six months since implementation, where human rights points have been raised in conjunction with existing causes of action, for example judicial review, criminal proceedings, appeals against planning decisions, etc.

The practical steps of bringing a human rights claim

The conduct of civil cases is governed by the Civil Procedure Rules (the CPR) which have been updated to reflect the implementation of the HRA.[9] CPR Part 7 explains how to bring a case in general, while the Part 16 Practice Direction explains what needs to be included in a claim where Convention rights are being relied upon. Whether a free-standing claim is brought, or whether human rights points are raised in conjunction with an existing cause of action, certain information must be included in the claim. CPR Part 16 Practice Direction provides:

16.1 A party who seeks to rely on any provision of or right arising under the Human Rights Act 1998 or seeks a remedy available under that Act-

1. must state that fact in his statement of case; and
2. must in his statement of case-
    a. give precise details of the Convention right which it is alleged has been infringed and details of the alleged infringement;
    b. specify the relief sought;
    c. state if the relief sought includes-
        i. a declaration of incompatibility in accordance with section 4 of that Act, or

[9] An electronic version of the CPR is available on the Lord Chancellor's Department website at www.open.gov.uk/lcd

ii. damages in respect of a judicial act to which section 9(3) of that Act applies;

d. where the relief sought includes a declaration of incompatibility in accordance with section 4 of that Act, give precise details of the legislative provision alleged to be incompatible and details of the alleged incompatibility;

e. where the claim is founded on a finding of unlawfulness by another court or tribunal, give details of the finding; and

f. where the claim is founded on a judicial act which is alleged to have infringed a Convention right of the party as provided by section 9 of the Human Rights Act 1998, the judicial act complained of and the court or tribunal which is alleged to have made it. [10]

The continuing role of the European Court of Human Rights in Strasbourg

The implementation of the HRA does not mean that the European Court of Human Rights in Strasbourg has lost all relevance to the UK litigant. Individuals still have recourse to the Strasbourg court, but only once all domestic remedies have been exhausted.

[10] www.open.gov.uk/lcd/civil/procrules_fin/cseaf.htm

PART II: THE HUMAN RIGHTS ACT 1998 and ACCESS TO NHS TREATMENT AND SERVICES

Described as "one of the defining events in British constitutional history"[11], the HRA will have wide-ranging implications for all public authorities and their employees, not least for those making policy for, or working in the National Health Service. The HRA will consequently provide service users with a tool through which they can ensure that their human rights are fully taken into account when decisions regarding access to NHS treatment and services are taken. The difficulties facing both health care providers and service users were described by the Royal College of Nursing in a 1999 Congress Report:

> "When the NHS was founded in 1948, it was believed that the demand for health care would reduce once the backlog of problems caused by lack of access to health care were cleared. But, in practice, as the population increases and new technologies extend infinitely the possibilities for care and cure, and with budgets which are finite, demand for health care will always exceed supply. This has led to a situation of rationing, which is rarely explicit and often inequitable."[12]

High profile developments in technology and the pharmaceutical industry, coupled with the promise of extra funding for the NHS, have increased the range of health care that could be provided free of charge at point of access. Such developments have also greatly increased the expectations of service users. No sooner is a new treatment available, than the demand threatens to outstrip both supply and NHS resources, as evidenced when the drug Viagra became available in the United Kingdom. There is a clear read-across from the provisions of the Human Rights Act 1998 to the continuing rationing debate. The extent to which the HRA will impose a duty upon the NHS to provide certain types of medical treatment or service is, as yet, largely untested in the courts and consequently unclear.

This part of the Guide aims to examine:

- how the HRA can be used by service users to ensure that access to treatment and service is based upon need and need alone, and not one of the numerous considerations currently taken into account, and;
- how health care professionals can ensure that human rights considerations are taken into account as far as resources allow.

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[11] Building a Human Rights Culture - Address by the Home Secretary to the Civil Service College Seminar, 9th December 1999

[12] RCN Congress 99 Daily Report - 11th March 1999

There is inevitably an element of speculation - much depends on the attitudes of the courts to future challenges brought under the HRA, and it is likely that the full effects on the provision of health care will only become apparent over the next few years. Certainly, from 2 October 2000 to date, the courts appear to have been reluctant to entertain human rights arguments, contending that the domestic law is sufficient to deal with the majority of situations. Such judicial reticence was most evident recently in the case of the Siamese twins, Jodie and Mary[13], in which 'right to life' arguments based on Article 2 of the ECHR were given short shrift in the judgment and held to add little or nothing to current domestic law:

> "…despite Mr Owen Q.C.'s submission that Article 2 of the European Human Rights Convention will require us to recast the definition, I do not propose to do so. Law which has long needed to be settled should be left to settle."

A cautious initial approach to the Human Rights Act on the part of the judiciary is understandable and prudent, given the very real risk of the courts being overwhelmed by human rights cases. Even in those cases where human rights arguments are entertained, not all challenges will be successful. It therefore remains to be seen whether human rights really have been 'brought home', but with increasing pressures on the NHS, it is imperative that any mechanism capable of equalising access to treatment is fully explored and utilised, and the Human Rights Act could be one such mechanism.

Convention Articles relevant to health

The Human Rights Act 1998 was drafted primarily to protect civil and political rights and, as such, does not provide directly for a right to health care[14], but it is likely that where social provision, or lack of, impinges upon an individual's human rights, the Act will be brought into play. Hence, if for example, a patient is denied potentially life-saving treatment, the Act may well provide a domestic remedy. The following Convention Articles are particularly relevant to the provision of NHS treatment and services:

- Article 2 - Right to life
- Article 3 – Prohibition of torture
- Article 8 - Right to respect for private and family life
- Article 12 - Right to marry
- Article 14 – Prohibition of discrimination

[13] A (Children) 22 September 2000

[14] Unlike other international instruments, e.g. European Social Charter and the proposed EU Charter of Fundamental Rights.

Article 2 - R*ight to life*

1. *Everyone's right 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 this penalty is provided by law.*
2. *Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:*
   a) *in defence of any person from unlawful violence;*
   b) *in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;*
   c) *in action lawfully taken for the purpose of quelling a riot or insurrection.*

In broad terms, Article 2 means that public authorities must not cause the death of any person. Article 2 also imposes positive obligations upon public authorities. This means that public authorities must take steps, in certain circumstances, to preserve life, but not if this would impose a 'disproportionate burden' upon them.[15] Article 2 may have implications for policy on access to life-saving treatment and various end-of-life decisions, including abortion and 'do not resuscitate' notices;

Article 3 – Prohibition of torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

The aim of Article 3 is to protect and individual from both physical and mental ill-treatment. Whether Article 3 has been breached will depend upon the circumstances of the individual case, but factors that may be taken into account include the severity and duration of the treatment and the vulnerability of the victim. Article 3 may have implications for access to and consent to treatment, and for hospital conditions during treatment.

[15] *Osman v United Kingdom* (2000) 29 EHRR 245

Article 8 - Right to respect for private and family life

1. *Everyone has the right to respect for his private and family life, his home and his correspondence.*
2. *There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention or disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

Article 8 covers a wide range of issues and may have implications for priority setting, for example, if the refusal of treatment is likely to have an adverse impact upon the individual's private or family life. A public authority may not interfere with the rights protected by Article 8, unless the interference:

- is in accordance with the law;
- is necessary in a democratic society (this means that the measure must fulfil a pressing social need and be proportionate to the aim pursued) in the interests of national security, public safety, the economic well-being of the country, for the prevention of disorder or crime for the protection of health or morals, or for the protection of the rights and freedoms of others.

Article 12 - Right to marry

Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

Article 12 may have implications for the provision of fertility treatment, particularly when the criteria or the funding for the provision of such treatment varies from health authority to health authority, as it currently does.[16]

[16] 'Fertility Treatment guidelines sought', BBC News OnLine 30 November 2000

Article 14 – Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Article 14 is what is known as the 'parasitic Article'. Article 14 is not a free-standing right to freedom from discrimination and acts only to prevent discrimination in the enjoyment of the rights and freedoms set forth in the Convention. This means that it is not possible to bring a case on Article 14 grounds alone, but it must be linked to another Convention Article. Nevertheless, this Article may be relevant to the provision of health care (see below under 'Postcode Prescribing').

The Effect of the Convention Articles

Articles 2, 3, 8 and 14 of the ECHR could potentially, either singly, or in different combinations, be used as a lever to access the treatment of choice on demand in the following types of situation (the list is speculative rather than definitive):

Postcode prescribing: where different treatments and services are available in different areas of the country

"Postcode prescribing", where different health authorities fund different levels of treatment for people with the same degree of need, will be vulnerable to challenge under Article 2, the right to life, and Article 14, freedom from discrimination. Legal argument could be based on the premise that there is a breach of Article 14 because an individual has been discriminated against in the provision of treatment because of where he/she lives. Article 12, the right to marry and found a family, could also be raised in this context, if the treatment which is subject to geographical differences in availability, concerns fertility/methods of assisted conception.

A similar situation could arise where health care facilities in rural areas are limited, thus restricting access to necessary treatment, although the practicability of providing medical cover for remote areas of the country would be one of the factors taken into account by the court when making a decision as to whether a breach of the Human Rights Act had taken place.

Postponed operations: where operations are postponed due to lack of available staff

Where an operation is postponed, for reasons unconnected with the individual, and the delay means that the condition then becomes inoperable, it is likely that Article 2, the right to life, will come into play.

In such cases, the court will also most likely explore the nature of the obligations upon the Secretary of State for Health regarding the provision of health care imposed by section 3 of the NHS Act 1977 and also the extent to which Article 2 places positive obligations on the State to safeguard life[17].

Discriminatory decisions: where treatment decisions are taken on the basis of a patient's lifestyle, pre-existing disabilities or age.

Whilst treatment decisions taken on the basis of a patient's lifestyle, pre-existing disabilities or age may have groundings in clinical effectiveness, it is important to recognise that Article 14 issues (freedom from discrimination) may be raised in conjunction with Article 2. Such an argument would be most likely to find favour with the courts if the only difference between an individual offered treatment and an individual refused treatment was their lifestyle, pre-existing disability, age or some other potentially discriminatory reason. There are inevitable difficulties for the service user in establishing that this is the case, but such a conclusion may emerge during the course of proceedings and should be fully utilised to support the case.

Safeguarding Resources: where less expensive and less effective drugs/treatment are used in order to safeguard NHS resources.

Where less expensive and less effective drugs/treatment are used in order to safeguard NHS resources (see for example, the recent debate surrounding the availability of Taxol), it is likely that Article 2 will be brought into play, particularly if loss of life is involved.

The courts will be likely to take into account, inter alia, whether the savings made were proportionate to the risk to the life of the individual concerned.

End of life decisions: the withdrawal of life-support systems/life-saving treatment

The "human rights card" could be played both ways in the context of end-of-life decisions, for example in decisions regarding life-support machines. If the relatives of the individual concerned dispute a decision to withdraw life support, they could engage Article 2, the right to life[18].

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[17] See *Osman v United Kingdom* (2000) 29 EHRR 245

[18] Disabled boy "should die with dignity" - BBC News OnLine, 12th July 2000.

Conversely, if the relatives wished life support to be withdrawn, they could engage Article 3 by alleging that continuing medical intervention would amount to inhuman and degrading treatment[19]. For an argument to succeed under Article 3 however, the patient would have to be aware of the treatment in question.[20] This limits the use of the HRA in cases where a patient is in a persistent vegetative state.

Article 3 has also been brought into play successfully where the extradition of an individual would result in the withdrawal of life-saving treatment.[21]

Article 9 (freedom of thought, conscience and religion) could also be engaged in this context, for example, where brain stem death is not recognised by a religion as the death of an individual,[22] and consequently where medical opinion is at odds with the wishes of the patient's family.

With the dual nature of human rights in this context, it will be particularly important to have evidence that human rights considerations were taken into account before a particular decision was reached.

The use of "Do Not Resuscitate" (DNR) Notices

The use of DNR notices without the consent of the individual (or next of kin) concerned, as recently reported in the national media, could potentially engage Articles 2 and 14, particularly if the criteria for using such notices is based upon the individual's age, rather than upon clinical considerations. Due to such concerns, the NHS Plan, published by the Government at the end of July 2000, specifically prohibits DNR policies based on age alone. In addition to a review of how consent is currently obtained, every hospital is required to have in place a local resuscitation policy by April 2001. With such intense focus upon the use of DNR notices, the courts would be extremely likely to uphold a challenge if such a notice were implemented without the individual's consent.

Euthanasia

The courts could become engaged in legal argument over whether the failure of the State to provide a mechanism for physician-assisted euthanasia constituted inhuman and degrading treatment for the purposes of Article 3. It is likely however that the court would reach the

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[19] *Airedale NHS Trust v Bland* [1993] AC 789.

[20] *NHS Trust A v M, NHS Trust B v H* November 29, 2000

[21] *D v United Kingdom* (1997) 24 EHRR 423

[22] Brain stem death: managing care when accepted medical guidelines and religious beliefs are in conflict - David Inwald, Immanuel Jakobovits, Andy Petros, BMJ Volume 320 6 May 2000

conclusion that the existing provisions of domestic law are sufficient for dealing with this situation, and that there is therefore no need for consideration of the HRA.

Where misdiagnosis has resulted in incorrect treatment

Misdiagnosis resulting in the incorrect treatment being given could possibly be construed by the courts as a breach of Article 8, if the treatment that was in fact given had a significant impact upon the private or family life of the individual concerned. Legal argument could also be based upon Article 3 if the misdiagnosis resulted in inhuman and degrading treatment, for example, a misdiagnosis of mental illness for an individual with autism, resulting in that individual being sent to a psychiatric unit or prison.[23]

As more stories hit the headlines, it is apparent that human rights considerations could be used in a variety of ways to attempt to secure access to NHS treatment and services. Some are listed above, but some will be entirely unpredictable and hitherto unthought of, except by the individuals who find themselves in the unfortunate situation of having to find arguments in support of their request for a particular form of treatment.

The impact of Article 3

The wording may seem far removed from the NHS, but Article 3 (freedom from torture and inhuman and degrading treatment) could be brought into play in all of the above situations if the refusal of treatment either had the effect of inflicting physical and mental pain and suffering, combined with the arousal of feelings of fear, anguish and inferiority, capable of humiliation and debasement.[24]

The right to life or quality of life?

It could be argued that the Human Rights Act 1998 provides not only a mechanism for demanding life-saving treatment, under Article 2, but also for non-life-saving treatment where the denial of such would have a severe impact upon the quality of that individual's life or upon his private relationships, under Article 8 (right to respect for private and family life). If the courts adopted this approach, Article 8 could be brought into play in all of the above situations. It is not beyond the realms of possibility that the courts could interpret "life" in this broader sense and hold that an individual has been deprived of his life because, in the absence of a particular form of treatment, for example, beta interferon for an individual suffering from the relapsing-remitting form of MS, the quality of life is significantly reduced.

This would involve a substantial shift in judicial attitude, but it is an argument that could be employed to challenge the refusal of a particular form of treatment. If the courts were to

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[23] Autism misdiagnosis "ruined a life" - BBC News OnLine, 27th June 2000

[24] *Selmouni v France* (1999) 29 EHRR 403

follow this line of argument, this would be a much more effective tool for service users to employ, than arguments based upon Article 2, which are likely to succeed only in those isolated cases where refusal of treatment is likely to result in the loss of life. Article 8 arguments, if successful, are likely to have significant implications for NHS resources, given that there are many more patients awaiting treatment that will improve their quality of life, than those awaiting life-saving treatment. It is likely, that if the courts accepted this approach, a significant degree of impact upon the private or family life of the individual concerned would have to be demonstrated.

It is therefore important to appreciate that the Act may not be used solely to secure the provision of life-saving treatment, but also for life-enhancing treatment, although, as a matter of public policy, it may be more difficult to succeed in securing access to the latter. The following diagram shows where the majority of the successful legal challenges are likely to fall:

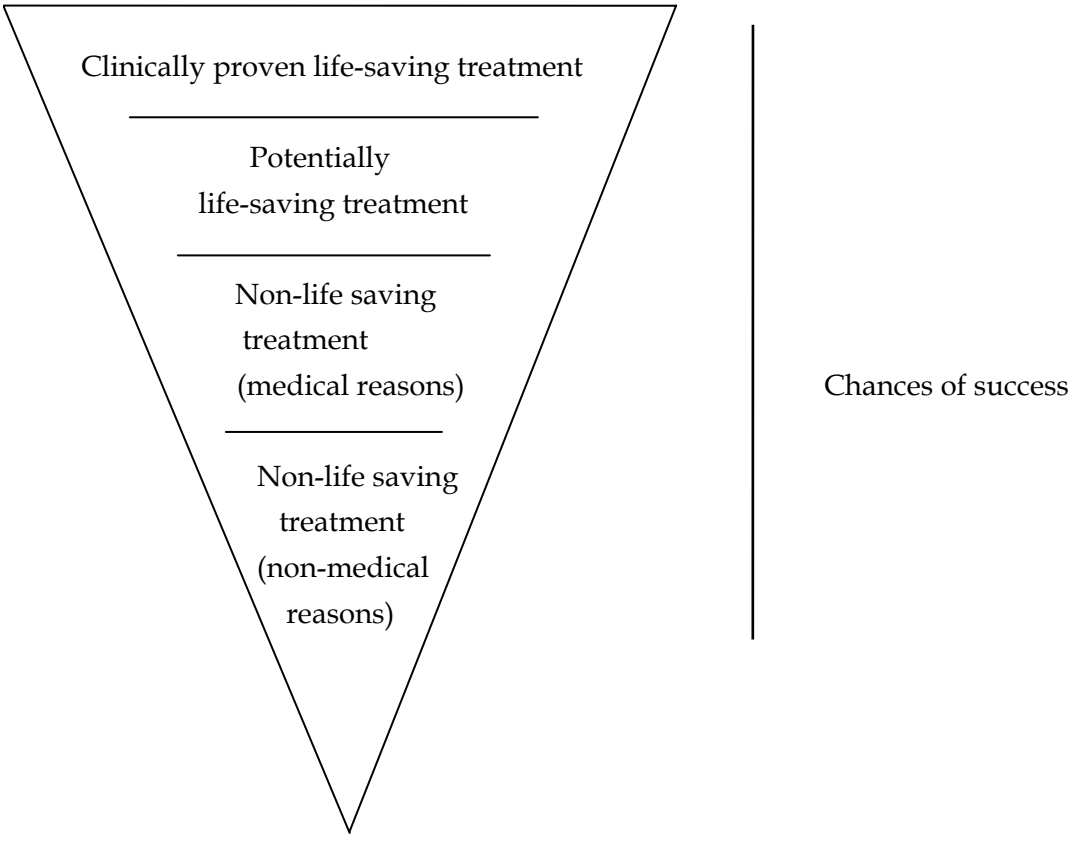

Figure 1. Likelihood of successful legal challenges to refusal of treatment

Previous Judicial Attitudes to Clinical Judgment and the Right to Treatment

> 'Inequities in access to services have always been a feature of the NHS, and the courts have never upheld the view that the principle of 'comprehensiveness' implies any substantive rights to a specific treatment or service.'[25]

In the European Court of Human Rights, it has so far been held that Article 2, the right to life, does not confer a right to treatment. The case of Osman v United Kingdom26 examined the extent to which there were positive obligations on the state to preserve life. In this case, a teacher shot a pupil's father, following a period of harassment of the pupil. The harassment was known to the police, and the family of the victim argued that the police were negligent in not taking steps to protect the pupil or his family. The court held that there was a duty on the state to take adequate and appropriate steps, but that the obligation to preserve life was not absolute.

In domestic law, the courts have considered the scope of the obligation upon the state to provide NHS treatment, but have consistently shown reluctance to usurp the role of the medical profession in making decisions regarding the allocation of treatment and resources.

> '...the courts are not, contrary to what is sometimes believed, arbiters as to the merits of cases of this kind. Were we to express opinions as to the likelihood of the effectiveness of medical treatment, or as to the merits of medical judgment, then we should be straying far from the sphere which under our constitution is accorded to us.'[27]

Whether such reluctance on the part of the judiciary persists after 2 October 2000 is still a matter of conjecture, six months after implementation of the HRA (there were previously indications that the courts are becoming more receptive to challenges to the provision of social services28) but uncertainty should be no bar to ensuring that the decision-making process reflects human rights as far as is possible.

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[25] A Future for the NHS: Health Care for the Millennium - Wendy Ramade, 2nd ed., (Longman)

[26] (2000) 29 EHRR 245

[27] *R v Cambridge Health Authority, ex parte B* [1995] WLR 898 at 904.

[28] *R v North East Devon Health Authority, ex parte Coughlan* [1999] Lloyds L.R. 305

Judicial attitudes post 2nd October 2000

A legal challenge to the refusal of treatment may fail, in line with the judicial precedent outlined above, but the court may still find the NHS in breach of the HRA, if the decision-making process is lacking in terms of transparency and use of evidence.

Another factor that the court is likely to take into account is that of proportionality, i.e. is the interference with the Convention right(s) proportionate to the intended aim? This could have implications in the individual case. For example, would the safeguarding of the national health budget justify the refusal of treatment likely to substantially improve the quality of an individual's life? In such circumstances, service users should expect and health care professionals should endeavour to provide that a balancing of national and individual priorities is clearly evidenced in the decision-making process.

The Human Rights Act 1998 will prove fertile ground for testing the extent of the obligations on the state regarding the provision of health care. Instances are already being reported in the media, e.g. the litigation pending regarding "dehumanising" treatment of patients in Ashworth hospital.[29] Areas specifically regarding access to NHS treatment or services that have recently received much media attention include:

- the availability of Beta Interferon for patients with MS;[30]
- the use of "Do Not Resuscitate" notices on elderly patients without the consent of the patient or their next of kin;[31]
- the availability of fertility treatment;[32]
- the repeated postponement of surgery, due to staff shortages, leading to operable conditions becoming inoperable;[33]
- the availability of cardiac surgery for patients with Down's syndrome;
- the availability of cancer services in rural areas;[34]
- the use of less effective/expensive treatments to safeguard NHS resources, e.g. the debate surrounding the availability of Taxol.[35]
- the misdiagnosis of autism as mental illness.[36]

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[29] Hospital to face civil cases in court - The Times, 12th June 2000.

[30] MS drug not worth the money - BBC News OnLine, 6th March 2000.

[31] Too old to care - Caroline Gilchrist, The Guardian, 17th May 2000.

[32] Age limit for NHS fertility treatment - BBC News OnLine, 23rd August 1999.

[33] Cancer surgery postponed four times - BBC News OnLine, 11th January 2000.

[34] Rural cancer deaths higher - BBC News OnLine, 5th May 2000.

[35] Debate on the Health Bill - Hansard, 29th April 1999.

[36] See 7 above.

The above list is not exhaustive, but indicative of the areas where service users may wish to bring human rights considerations into play.

A large number of cases were expected following 2 October 2000, although few cases brought under the Human Rights Act were expected to succeed37, or to result in changes having to be made. In the main, changes in overall access to NHS treatment and services were not expected, but changes in the process by which those decisions are reached were. These expectations have certainly been borne out by the few cases concerning access to NHS treatment and services.

In NHS Trust A v M and NHS Trust B v H38, it was held that the law as stated in Airedale National Health Trust v Bland[39] was not contrary to the provisions of the HRA. The cases concerned the withdrawal of treatment of patients in persistent vegetative states. Dame Elizabeth Butler-Sloss decided that Article 2 (right to life) did not apply as it was accepted that there was no obligation upon the state to take steps to prolong a person's life if they were in a persistent vegetative state. It was also held that Article 3 (prohibition of torture and inhuman and degrading treatment) did not apply as this required the victim to be aware of the treatment in question. As the relatives were in agreement with the withdrawal of treatment, the court did not have to consider whether Article 8 (the right to private and family life) was engaged.

In the Siamese twins case,[40] it was held that arguments based on Article 2 (right to life) did not need to be considered as the situation was catered for by the existing provisions of domestic law.
One can see therefore that the expectations preceding the HRA were accurate in that the decision remains the same as it would have been before the implementation of the HRA, although the process by which the outcome is reached now takes human rights considerations into account.

[37] This assumption is based upon the experience of Scotland where the Scottish Executive and all its agencies (including the NHS) have had to comply with the ECHR since 1st July 1999.
[38] November 29, 2000, Family Division
[39] [1993] AC 789
[40] see page 17

PART III: DECISION MAKING and the REQUIREMENTS OF THE HUMAN RIGHTS ACT 1998: THE PRACTICAL IMPLICATIONS

Individual responsibility

Will the fact that an individual has contributed to the condition for which he requests treatment justify, in whole or in part, the denial of that treatment? Currently, clinical considerations are supposed to take precedence in treatment decisions. The emphasis has not changed following 2 October 2000, but some of those considerations relating to individual responsibility could be interpreted as discriminatory for the purposes of Article 14 (the freedom from discrimination).

For example, the decision not to offer heart surgery to a patient who smokes may still be clinically justifiable, but because the underlying reason could be considered discriminatory, there should be objective criteria that indicate that:

- the case was looked at on an individual basis, and was not subject to an overarching policy that prevents patients who smoke from being offered this type of surgery.
- the fact that the patient smokes is a factor that was taken into account amongst other clinical considerations, but was not the main factor influencing the decision.

Resources

Will a lack of resources provide a defence to a claim that adequate medical provision was not made? The courts have long since recognised that the budget for the National Health Service is finite. However, in the context of life-saving treatment, the courts have also recognised the value of human life:

> 'Our society is one which a very high value is put on human life. No decision affecting human life is one that can be regarded with other than the greatest seriousness.'[41]

Therefore, the health authority in question would have to ensure that every avenue of funding had been explored before refusing life-saving treatment on the grounds of cost.[42]

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[41] Sir Thomas Bingham M.R. in *R v Cambridge Health Authority, ex parte B* [1995] 1WLR 898 at 905

[42] It is important to note that the case referred to in 18 above, concerned treatment that had such a small risk of success that it could be considered experimental. In cases where the treatment has a higher chance of saving the patient's life, the courts will no doubt require a higher degree of justification for the refusal of the treatment.

Evidence-based decision-making

Now, more than ever, health care professionals must be able to show why a particular decision has been reached. The National Institute for Clinical Excellence will provide the scientific justification for the use of a particular treatment, and may well provide one justification but this is only one of many factors that should be taken into account in treatment allocation decisions. The indications upon which treatment decisions are based may not necessarily change, following the implementation of the Human Rights Act on 2nd October 2000, but justification for a particular decision should be expressed in a way that is clear to the service user.

Transparency

How can the decision-making process be made more accessible and transparent?

Article 6 of the European Convention on Human Rights guarantees the right to a fair trial, but is likely to have implications that extend beyond "trial" in the criminal or civil courts. A possible interpretation is that decisions which determine an individual's civil rights and obligations (of which health care is arguably one[43]) should be subject to independent scrutiny. In order for this scrutiny to be effective, decisions will necessarily need to specify clearly the reasons for a particular course of action.

The courts will not expect a health authority to "demonstrate its funding priorities by reference to specific evidence"[44], but in the context of treatment decisions, the courts are likely to expect the following information to be given as a minimum:

- a summary of the evidence that was taken into account when making the decision;
- an explanation which relates the evidence used to the circumstances of the individual's case;
- an evaluation of any alternative treatment options;
- an explanation of what the patient should do next, if he/she is still unhappy with the decision in question. (You may wish to ask for a face to face discussion about the decision with a health care professional to clarify any areas of which you are unclear).

[43] See for example, *Gaygasuz v Austria* (1996) which concerned entitlement to state benefits.

[44] See 18 above

National guidelines and priorities

The aim of the Act is to place the individual at the heart of the decision-making process; blanket bans are anathema to the rights enshrined in the Convention[45] and increasingly, the focus will be upon decisions taken at the individual level, rather than at the national level. The Human Rights Act 1998 should therefore not be viewed as a threat to clinical autonomy, but as its safeguard, protecting service users and clinicians from national policies that undermine professional judgment. In this sense, the Act may be viewed as a positive force, both for service users and health care professionals, in the field of health care provision. If an individual feels that their individual circumstances have not been taken into account when a treatment decision has been reached, this will be a clear indication that human rights considerations have been neglected in the decision-making process.

Decisions of health authorities to exclude certain forms of treatment may consequently be brought into question. For example, Article 12 (the right to marry and found a family) may be invoked in the context of a refusal to offer methods of assisted conception. Article 8 (the right to respect for private and family life) may be invoked where tattoo removal has been refused and the individual concerned feels that the tattoo is hindering his or her prospects of employment. In terms of the Human Rights Act 1998, it will be advisable for health authorities to offer a full range of treatments, but to allow/restrict access according to the merits of each individual case. It will be useful for the service user who has been refused a particular form of treatment to establish whether the treatment in question has been specifically excluded by the health authority or whether it is the GP, in the exercise of his discretion that has made the decision. A blanket ban would be an indication that human rights considerations have been neglected in the decision-making process.

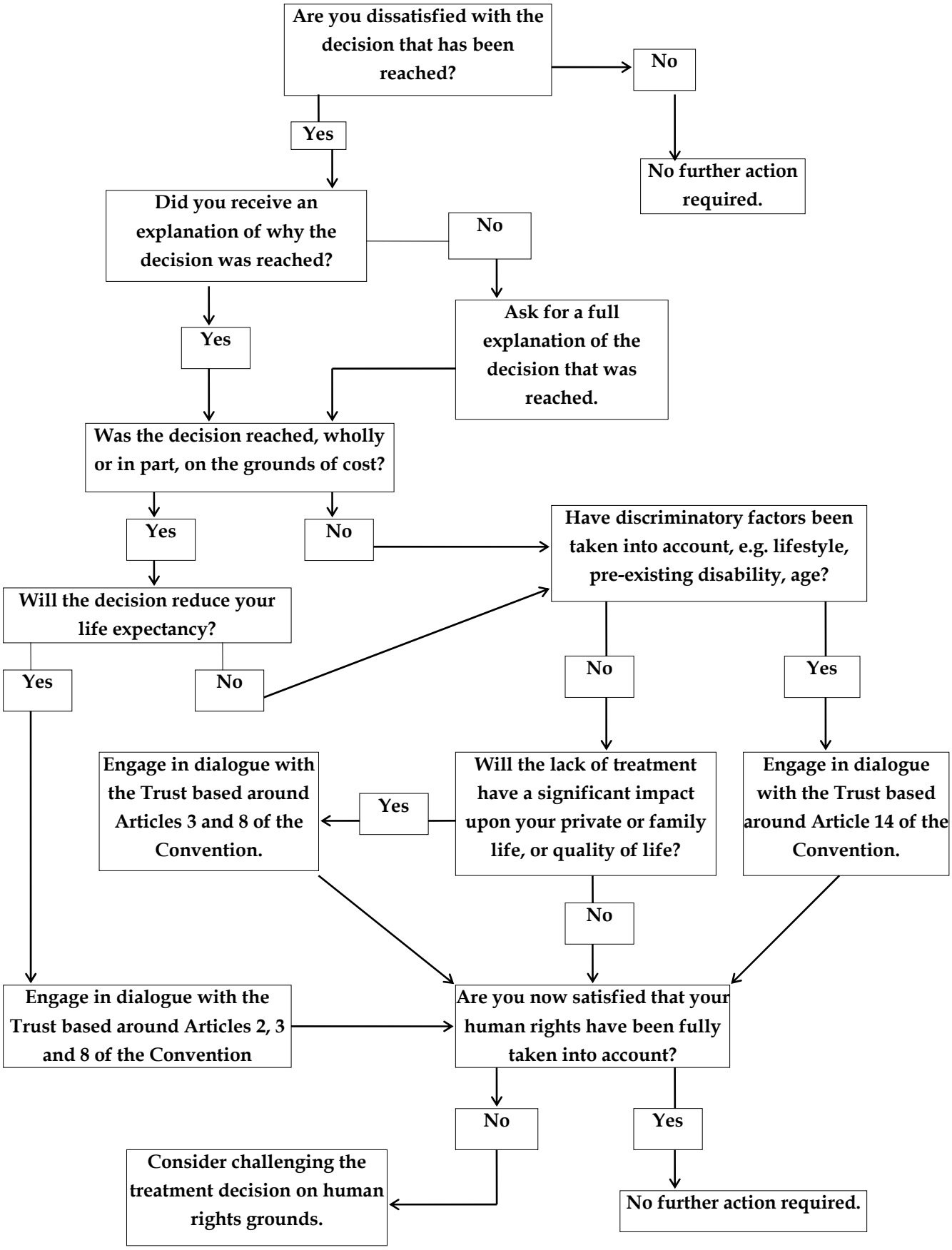
[45] See for example, *Regina v North East Devon Health Authority, ex parte Coughlan* [1999] Lloyds L.R. 305

PART IV: HUMAN RIGHTS IN PRACTICE

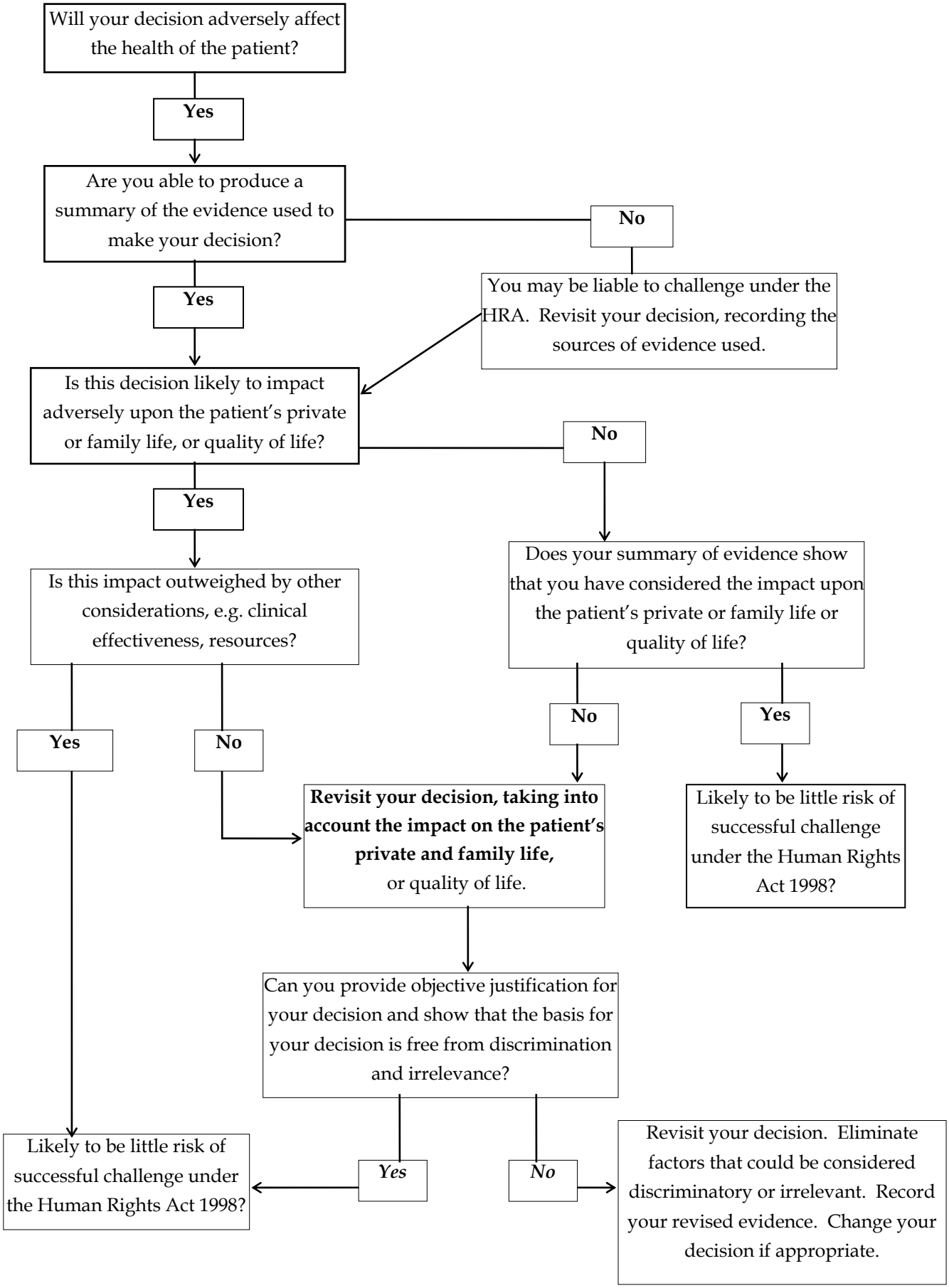
The following section comprises two flow-charts, a series of case studies and a commentary on each case study. The first flow-chart is designed for service users; the second is designed for health care professionals. The aim of both charts is to act as a preliminary guide to examining the decision-making process as a whole from a human rights perspective. As with the rest of this Guide, the charts are not definitive and are no substitute for formal legal advice, but may give the concerned individual an indication of the kinds of issues that may arise following the implementation of the HRA on 2 October 2000. The HRA may be viewed as an additional weapon in their armoury, but individuals considering taking action to challenge a particular decision should also be aware of existing remedies such as NHS complaints procedures and public law provisions.

The case studies which follow the flow-charts demonstrate the type of situations in the context of the provision of health care and services that could engage one or more Convention rights. It is important to note that the case studies cover areas that have not, for the most part, been tested in the courts. As such, the case studies do not provide the answers to a particular situation, but give an indication of the type of human rights arguments that *could* arise. The names in the case studies are fictional, but all have occurred, or are likely to occur, in the NHS in its present format. It is hoped that the flow-charts and case studies will provide a useful starting point for those individuals – either service users of health care professionals – who may be concerned as the human rights dimension of a particular decision.

TREATMENT DECISION CHECKLIST FOR SERVICE USERS



TREATMENT DECISION CHECKLIST FOR HEALTH CARE PROFESSIONALS



Case Study A

A new study of the NHS in England and Wales has revealed that a patient's chances of survival can be affected by where they live. A survey carried out on behalf of ConRel, the interest group which represents concerned relatives of those affected by the crisis in the NHS, found that 24 patients in Dunmoor in the north of the country were dying for every 10 patients who died in Southpool.

The survey, which analysed 50 million hospital admissions over a period of five years found that the lowest death rates were to be found in the south of the country where hospitals on average employ more than six times the number of doctors per bed than the worst performing hospitals. The low doctor/bed ratio in Dunmoor was explained by a Ministry of Health and Fitness spokesperson as 'due to the decision of Dunmoor health authority to concentrate its resources on tackling the area's escalating heroin problem.'

Mrs Blatt was taken by her son to the Accident and Emergency Department at Dunmoor General Hospital at 3 a.m. on Saturday morning, following a fall at her home. She was seen by a nurse upon arrival, but was not attended by a doctor until 7 a.m., by which time, Mrs Blatt was complaining of persistent abdominal pain. Mrs Blatt died at 7.30 a.m. as a result of internal bleeding. Mrs Blatt's son is considering taking action against the Trust in respect of the death of his mother.

Commentary

Mr Blatt may be able to utilise both Article 2 and Article 14 of the Convention in this situation. Article 2 (right to life) could potentially be brought into play because the delay in attendance by a doctor could have been a significant factor in Mrs Blatt's death (medical evidence on this point would be needed, as required for clinical negligence cases currently). Article 14 (prohibition of discrimination) could be brought into play if the delay in being attended by a doctor was as a result of the lower doctor/bed ratio, and consequently such delay would not have occurred elsewhere in the country. Mr Blatt could therefore argue that Article 2 had been breached in respect of his mother as a result of where she lived, which could be held to be a discriminatory reason.

Case Study B

A patient died from pneumonia following a ten hour wait on a trolley in a busy hospital. Mr March was admitted to the Accident and Emergency Department before 7 a.m. on 3 March 2001, but was not given a bed on a ward until 5 p.m. that day.

Mr March, who was in his seventies, had been suffering from a severe chest infection and died the following day. A spokesperson for the Trust has apologised for the delay, but maintains that Mr March's death was not linked to the shortage of beds. He said that Mr

March received all the nursing and medical care in the A&E Department that he would have done on the ward.

Mr March's daughter said: 'I am absolutely disgusted at the way in which my father has been treated by the hospital and am convinced that the delay in finding him a bed contributed to his death. He waited on the trolley for ten hours, during which time I saw other people, who were younger and fitter than my dad, being found beds. He was in the busiest part of the hospital and found the noise, constant interruptions and lack of privacy extremely distressing.'
Miss March says that she is now considering taking action against the hospital.

Commentary
There are potentially three Convention Articles that Miss March could utilise if she chose to bring an action against the hospital. Article 2 (right to life) could be used if the delay in finding Mr March a bed caused or contributed towards his death. Article 3 could be used if the noise, interruptions and lack of privacy suffered by Mr March were of sufficient severity and duration to constitute degrading treatment (in this respect, the court would also take into account the fact that Mr March was in his seventies and was vulnerable due to illness). Article 14 could be brought into play if Miss March were able to prove that younger, fitter patients were given preferential treatment over her father, for no reason other than age, or other such discriminatory factors.

Case Study C

One in seven couples is affected by infertility, with 45,000 seeking help each year. As a result, 12,000 explore methods of assisted conception such as in-vitro fertilisation (IVF).[46]

Mr and Mrs Harper currently have no children and have been trying to conceive for the past twelve months, without success. The couple live in the area covered by Dunmoor Health Authority and have just been told by their consultant that they have been accepted on the IVF programme, during the course of which they will be offered three cycles of IVF treatment.

Jack Fowler and his partner of ten years, Samantha Mitchell have a daughter aged five years and have been trying to conceive a sibling for her for the past fourteen months without success. The couple live in the area covered by Southpool Health Authority and have just been told by their consultant that they will not be offered IVF treatment. When Mr Fowler asks why they have been turned down, he is told that it is because of the policy of Southpool Health Authority.
Jack Fowler and Samantha Mitchell wish to challenge the policy of the health authority.

[46] "Fertility treatment guidelines sought" BBC News OnLine, 30 November 2000

Commentary

In this type of situation, Article 12 (right to marry and found a family) and Article 14 (freedom from discrimination) could be brought into play. The European Court of Human Rights has not yet ruled on whether the provision of fertility treatment falls within the ambit of Article 12, but it is likely to only be a matter if time before such a challenge is mounted – either in this country under the HRA, or in another Member State under the Convention. In this case study, should the provision of fertility treatment be held to be within the ambit of Article 12, Jack and Samantha could then rely on Article 14 to show that they have been discriminated against in the following respects:

- the area in which they live;
- the fact that they are not married;
- the fact that they appear to have been the subject of a blanket ban;
- the fact that they already have a child.

Without objective justification on the part of the health authority, any or all of these factors could be held to be a breach of Article 14 in conjunction with Article 12.

Case Study D

Malcom Bennett has been suffering from schizophrenia for three years. He has been prescribed conventional antipsychotic medication, chlorpromazine, but has a history of non-compliance in taking the medication. When Malcolm fails to take the medication as prescribed, he relapses quickly and is often compulsorily admitted to hospital under the provisions of the Mental Health Act 1983.

When questioned as to why he refuses to take chlorpromazine, Malcolm explains that he finds the side effects of the medication, such as uncontrollable shaking and depression, too distressing.

Malcolm's Community Psychiatric Nurse has heard about a new atypical antipsychotic which causes considerably fewer side effects than conventional antipsychotics. The new drug however is twice as expensive as the medication Malcolm is currently prescribed. Malcolm's psychiatrist has received guidance from the local health authority, emphasising the resource implications of prescribing the new type of medication. Malcolm requests that he be given the atypical antipsychotic medication, but his request is refused. Malcolm decides to stop taking chlorpromazine and relapses. He is re-admitted to hospital under the provisions of the Mental Health Act 1983.

Commentary

Articles 3 (freedom from torture and inhuman and degrading treatment), 8 (right to respect for private and family life) and Article 14 (freedom from discrimination) are potentially

engaged in this situation. The side effects of Malcolm's current medication could fall within the ambit of Article 3, as could the fact that the decision of the health authority has, in effect, stopped him from taking any medication at all and has resulted in his compulsory admission to hospital. Article 14 could be brought into play if GPs are permitted to prescribe atypical anti-psychotics under other health authorities for cases such as Malcolm's.

Case Study E

Mr. Carter has been diagnosed with a progressive neurological disease. He has mild symptoms at present and his life expectancy is somewhere in the region of three to five years. The progress of the disease is such that Mr Carter's physical abilities will leave him long before his mental faculties show any signs of deterioration. Mr Carter is married with two young children. He is anxious that his family do not witness his physical deterioration.

Mr Carter discusses the end stages of the disease with both his lawyer and his GP and states that he would like his GP's help to commit suicide when he is no longer able to communicate. At the very minimum, Mr Carter makes it known that he would wish treatment to be withdrawn or withheld when he is no longer able to survive without medical intervention. The lawyer advises that the GP would be acting illegally if he acceded to Mr Carter's request. However, Mr Carter insists that the lawyer record his wishes in the form of a living will, also known as an advance directive. In any event, Mr Carter's GP refuses Mr Carter's request and records his refusal in the medical notes recording the consultation.

Commentary

A BMJ survey[47] indicated that this type of situation is more common than might at first be thought. 424 general practitioners and hospital consultants were surveyed. Out of the 273 who replied, 163 had been asked by a patient to hasten death, with 124 of these being asked by the patient to take *active* steps to hasten death.

Mr Carter could potentially utilise Articles 3 and 8 to support his request. Article 3 could be engaged if Mr Carter took the approach that the continuing medical treatment was inflicting upon him torture or inhuman and degrading treatment. Article 8 could be engaged because this carries with it a degree of a right to physical and moral integrity, which Mr Carter could argue were being denied him. However, given the current domestic law, under which voluntary euthanasia/physician-assisted suicide is illegal, it is likely that Mr Carter would not succeed in his request for help with suicide. The courts could however draw a distinction between this and Mr Carter's request that treatment be withdrawn/withheld, and it is likely that in the latter, arguments based upon Articles 3 and 8 would hold more sway.

[47] 'Attitudes among NHS doctors to requests for euthanasia' – B J Ward, P A Tate, BMJ 1994; 308: 1332-4 (21 May)

Case Study F

Half of all health authorities are not funding drugs that can help slow the progress of Alzheimer's disease.[48] This is despite the fact that government experts have recommended that the drugs, known as cholinesterase inhibitors, should be prescribed for all patients with Alzheimer's.

Mr and Mrs Campbell are in their 70s. Mrs Campbell has been diagnosed with Alzheimer's. There are periods in which her memory deteriorates and she also experiences episodes of severe anxiety.

The Campbells' GP has told the couple that he is unable to prescribe a cholinesterase inhibitor, because the local health authority, although it funds the drug, restricts its use to specialists only.

The Campbells have now used their life savings to fund the treatment for Mrs Campbell privately. It is costing them £100 per month and their savings will soon run out. The drug has improved Mrs Campbell's quality of life enormously, and also that of her husband.

Commentary

As yet, there is no indication that Mrs Campbell's life expectancy has been reduced by the decision of the health authority, so Article 2 (right to life) is not yet relevant, although it may become so in the future. What is clear however is that the new drug is effective in Mrs Campbell's case and has improved her quality of life. In this type of situation, arguments based upon Article 8 may be appropriate (right to respect for private and family life). The decision of the health authority in restricting the prescribing of the drug with the result that some people in the area are being prescribed it, and others are not, could be held to be discriminatory if there is no objective reason for the policy, and so Article 14 could also be engaged. In the 'postcode prescribing' type of situation, the courts would be more likely to find in a patient's favour, if there was evidence that the restricted medication would be clinically effective for that *particular* individual.

[48] 'Chaos over funds for Alzheimer's drugs', BBC News OnLine, 11 October 2000

Case Study G

68 year old Mrs. Alexander has been admitted to hospital for cardiac surgery. On reading her in-patient notes, she notices 'DNR' written on her file. Mrs. Alexander has not discussed whether she would wish to be resuscitated with her consultant, or with any of the hospital staff, and does not know what 'DNR' stands for.

Commentary

This is a situation that is hopefully now in the past. The NHS Plan, published in July 2000, requires all hospitals to have in place a local resuscitation policy by April 2001 and it is likely that such policies will require consent to place a 'DNR' notice on a patient's records to be obtained in all cases either from the patient, or from the next of kin, if the patient is incapable of making the decision for his or herself.

Should consent not be obtained, as is the case with Mrs Alexander above, there are potential human rights arguments based upon Article 2 (right to life) and Article 8 (right to respect for private and family life) and its connotations of physical integrity. If the decision of the health care professionals to put a 'DNR' notice on Mrs Alexander's file related solely to her age, Article 14 (freedom from discrimination) could also be engaged.

CONCLUSION

The Human Rights Act 1998 is likely to have a far-reaching effect upon the way in which all public authorities act. This is no more apparent than in the field of health care provision where many of the rights enshrined in the ECHR are likely to be brought into play. Whilst overall access to NHS treatment and services may not change, the way in which treatment decisions are reached and recorded inevitably will change, increasing the evidence available to the service user, who will then be in a better position to decide whether or not to challenge that decision. The guidance acts as a starting point for establishing the action that needs to be taken (and by whom) in order to ensure that the Human Rights Act 1998 becomes a positive influence in the provision of health care.

This Guide forms part of an ongoing project on human rights and health currently being undertaken by the Constitution Unit of University College London, supported by the Nuffield Trust. Suggestions for update/inclusion are always welcome. Please contact us via our website at: http://www.ucl.ac.uk/constitution-unit with your feedback, or tel. 020 7679 4979, or email: jeremy.croft@ucl.ac.uk.

Human Rights and Health

Project dates: 11 Jan 2001 – 10 Jan 2002
Researchers: Jeremy Croft, Roger Masterman, Susan Kerrison
The coming into force of the Human Rights Act 1998 means that all public policy and health service provision needs to be evaluated against the standards and values set out by the Act. This project aims to build on Elizabeth Haggett's research and this guide, to provide further guidance for health policy makers and professionals on developing an approach to health care which reflects and incorporates a human rights culture and standards. It will examine the dilemmas involved in incorporating a human rights approach into health policy and provide practical advice, tailored to the needs of health service professionals.
Further details: Jeremy Croft, 020 7679 4979, jeremy.croft@ucl.ac.uk

Future dissemination:

- Manual for health professionals on implications for HRA on health care.
- Inserts to manual – user specific groups: including long-term care providers, care of mental patients, NHS Trusts and authorities, regulatory agencies, health care purchasers.
- Dedicated website: materials will be published on a dedicated website, to be used as a specialist training and educational resource.

Future events:

- Seminars to trial material with user groups in July, August and September 2001.
- Launch seminars in Jan 2002.

ANNEX A: Sources of Further Information

Websites

- www.homeoffice.gov.uk/hract - the Home Office website which contains guidance, speeches, law and information about the Human Rights Task Force
- www.echr.coe.fr - the website of the European Court of Human Rights which contains judgments, press releases and useful summaries
- www.beagle.org.uk - the website for lawyers which contains summaries of human rights cases
- www.news.bbc.co.uk - the BBC website which has a search function, enabling a search for all recent articles about human rights and health
- www.ucl.ac.uk - the website of University College London which contains information regarding the work of the Constitution Unit on health and human rights

Publications

- *Blackstone's Guide to the Human Rights Act 1998* – Wadham and Mountfield, Blackstone, 2000, 2nd ed.
- *Human Rights Law and Practice* – Lester and Pannick, Butterworths, 2000
- *The Human Rights Act: A practical guide for nurses* – Rosie Wilkinson, Helen Caulfield, Whurr Publishers.
- *Guide to the Human Rights Act* – Wendy Outhwaite, Marina Wheeler, Old Bailey Press
- *Healthcare Law: the impact of the Human Rights Act 1998* – John Tingle, Austen Garwood-Gowers, Cavendish Publishing, (May 2001)

Organisations

Liberty
21 Tabard Street
London SE1 4LA
Tel: 020 7403 3888

Justice
59 Carter Lane
London EC4V 5AQ
Tel: 020 7329 5100

Campaign for Effective and Rational Treatment
PO Box 22093
London SW2 4US
Tel: 020 8671 0620

The Patients' Association
PO Box 395
Harrow
Middlesex
Tel: 020 8423 9111

Age Concern
Astral House
1268 London Road
London SW16 4ER Tel: 020 8765 7379

Patient Concern
PO Box 23732
London SW5 9FY

ANNEX B: The Convention Rights

Article 2 - Right to life

Article 3 - Prohibition of torture

Article 4 - Prohibition of slavery and forced labour

Article 5 - Right to liberty and security

Article 6 - Right to a fair trial

Article 7 - No punishment without law

Article 8 - Right to respect for private and family life

Article 9 - Freedom of thought, conscience and religion

Article 10 - Freedom of expression

Article 11 - Freedom of assembly and association

Article 12 - Right to marry and found a family

Article 14 - Prohibition of discrimination

Article 16 - Restrictions on political activity of aliens

Article 17 - Prohibition of abuse of rights

Article 18 - Limitation on use of restrictions on rights

<u>The First Protocol</u>

Article 1 - Protection of property

Article 2 - Right to education

Article 3 - Right to free elections

<u>The Sixth Protocol</u>

Article 1 - Abolition of the death penalty

Article 2 - Death penalty in time of war

ANNEX C: The Human Rights Act 1998