

Impact of the European Convention on Human Rights on medical law

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Not only is the right to life protected by law but the state should take steps to safeguard life

This article focuses on the interplay between the right to life enshrined in Article 2 of the European Convention on Human Rights (ECHR)* and the prohibition on torture and inhuman or degrading treatment contained in Article 3 and the practice of medicine.

ACCESS TO TREATMENT

The concept that everyone's right to life shall be protected by law enjoins the state not only to refrain from taking life intentionally but, further, to take appropriate steps to safeguard life.¹

The domestic courts have not made a finding on the funding of treatment since incorporation. In 1995 the Court of Appeal held that the Cambridgeshire Health Authority was entitled not to fund very expensive medical treatment for a young child which was unlikely to prolong her life for more than a few months.² The courts are unlikely to reach a different view today. It is clear that to interpret the state's duty to safeguard life as imposing an unqualified obligation to meet health care needs would be wholly unrealistic.³ It is likely to be enough that the state can show that it has acted reasonably in the allocation of resources, acting in good faith to strike a rational balance between competing needs.⁴

It might be more profitable to argue that to withhold expensive treatment which would demonstrably improve the quality of an individual's life would amount to inhuman or degrading treatment for the purposes of Article 3. However, to succeed the differential in the quality of life would have to meet the "minimum level of severity"—that is, result in severe suffering or gross humiliation.⁵ This is a difficult standard to satisfy.

Two further issues arise: the effect of incorporation on regional and continental variations in the availability of treatment.

*Articles 2–12 and 14–18 together with the First and Sixth Protocols of the European Convention on Human Rights were incorporated into domestic law by the Human Rights Act 1998 which came into force on 2 October 2000.

In 1999 the government set up the National Institute for Clinical Excellence (NICE) with a view to helping to end the lottery of "postcode prescribing" (see www.nice.org.uk) and to promote a more uniform national standard of care. Such an initiative would assist the government in arguing that it acts reasonably in allocating resources.

NICE is also charged with the task of identifying the most cost effective treatments. Thus the situation may arise in which a type of medication has been approved and is widely used in Europe but is not considered as clinically cost effective for use in the NHS. Unless it can be shown that the decision making process is flawed,⁶ the domestic courts are unlikely to find a human rights violation.

WITHHOLDING AND WITHDRAWING LIFE PROLONGING MEDICAL TREATMENT

The manner in which the state complies with its obligation to safeguard life should not result in the erosion of human dignity. Although the right to life is expressed as an unqualified or absolute right, the ECHR must be read as a whole. It is not difficult to envisage a situation where to continue to prolong a life via artificial means would be considered as inhuman and degrading for the purposes of Article 3. In such circumstances, it will be imperative for doctors to be in close consultation with the patient or the relatives.

The recent case of Ms B,⁷ the tetraplegic social worker who won the right to have the ventilator keeping her alive switched off, highlights the dilemma facing many doctors and nurses. Although the law was clear that a patient with the mental capacity to take decisions has an absolute right to refuse treatment,⁸ Ms B was deprived of the facility to exercise this right because no doctor within the NHS trust caring for her was willing to carry out her wishes and the trust had failed to take steps to find a doctor outside the trust who was prepared to do so. Dame Elizabeth Butler-Sloss highlighted the "serious danger, exemplified in this case, of a

benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient". Dame Elizabeth found that the NHS trust had been guilty of trespass to the person in treating Ms B unlawfully since the date she had been assessed by an independent clinical psychologist as competent to make the decision to discontinue her treatment. Dame Elizabeth set down clear guidelines for the conduct of similar cases in the future, emphasising that if there is no disagreement about competence but doctors are for any reason unable to carry out the wishes of the patient, their duty is to find other doctors who will do so. Considerations as to what would be in the best interests of the patient are irrelevant.

These guidelines are equally applicable to cases of terminal illness.

It should be noted that only nominal damages were awarded to Ms B in respect of the unlawful trespass arising out of treatment against her will (although this may have been because only nominal damages were sought). Larger awards of damages may well be made in the future, particularly if the guidelines are not followed†.

In another high profile case, Diane Pretty, who had motor neurone disease, sought the assurance of the Director of Public Prosecutions (DPP) that her husband would not be prosecuted if he assisted her to commit suicide. The DPP refused to give such an undertaking. Mrs Pretty applied for judicial review of the decision seeking a declaration that the DPP's refusal to give the undertaking was incompatible with Articles 2, 3, 8, 9, and 14 (the prohibition of discrimination) of the ECHR. Both the Divisional Court and the House of Lords held that the DPP had no power to give such an undertaking and was not in any event obliged to do so in order to comply with his obligations under the ECHR. Mrs Pretty complained to the European Court of Human Rights ("the ECtHR") in the first case to come before that court which had already been adjudicated in national courts under the Human Rights Act 1998. The ECtHR held that:

(1) The right to die could not be read into the right to life protected by Article 2.

(2) The state's obligation to prevent ill treatment pursuant to Article 3 could not be considered to include permitting actions designed to cause death. The state was not required to undertake not to prosecute the applicant's husband if he helped her to commit suicide.

†The General Medical Council are expected to issue guidelines following the promulgation of the decision in Ms B entitled "Withholding and Withdrawing Life Prolonging Treatment: Good Practice in Decision-making" shortly.

(3) The right to refuse treatment was within the ambit of Article 8(1). The failure of the English law to allow Mrs Pretty the assistance of her husband to end her life constituted an interference with her private life and it was necessary to consider whether this interference was in accordance with Article 8(2). It was clear that the interference was prescribed by law and pursued a legitimate aim. A blanket ban on assisted suicide was not disproportionate. The interference complained of was necessary in a democratic society.

(4) Article 9 did not protect all convictions or beliefs. While strongly held, Mrs Pretty's beliefs about assisted suicide did not fall within the ambit of Article 9.

(5) The state had a reasonable and objective justification for not distinguishing in law between individuals who were and were not capable of committing suicide. There had been no violation of Article 14.

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 ‡Article 8 is a qualified right. Article 8(1) secures the right to respect for private and family life, home and correspondence. Article 8(2) contains the following qualification: there shall be no interference by a public authority with the exercise of this right except such as is 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 of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others. Articles 2 and 3 contain no express qualification.

§Article 9 protects the right to freedom of thought, conscience, and religion. This right is qualified in similar terms to Article 8.

ADVANCE STATEMENTS

Advance statements or living wills are a valuable tool in facilitating self determination. Through an advance statement a mentally competent patient may authorise or decline specific treatments, including blood transfusions, feeding, and hydration. As the case of Ms B demonstrates the mentally competent patient's right to refuse medical intervention is well established in the domestic common law. In the case of an individual who is mentally incapacitated, an unambiguous advance directive, completed when competent, should be valid. Compliance with an unambiguous request to facilitate an individual's death should not be considered to be in violation of Articles 2 or 3.

The same applies to "do not resuscitate" directives.

CONCLUSIONS

Practitioners should also bear in mind the impact of the incorporation of the ECHR on the following situations:

First, doctors should be aware of the necessity to secure a patient's fully informed consent where he wishes to administer treatment which might be considered to be of an experimental character, otherwise a patient may argue that he had been subjected to treatment contrary to Article 3.

Secondly, when responding to a request for disclosure of medical records from a third party, a practitioner must bear in mind a patient's right to privacy enshrined in Article 8 and any detriment to the patient's mental or physical health which might result from disclosure.

Finally, some comfort may be drawn from the fact that Article 6 (right to a fair hearing within a reasonable time) applies to proceedings before the General Medical Council (GMC v Rogers, unreported). Practitioners are entitled to a fair and public hearing within a reasonable time where proceedings might

result in the removal of the right to practise. If a treating clinician decides to withhold medical records as suggested above in the context of proceedings before the General Medical Council, the council will be obliged to perform a balancing act between Article 6 and Article 8 weighing the relevance of the contents of the medical records to charges brought by the General Medical Council against the detriment to a patient's mental or physical health that might result from disclosure. To this end the clinician is likely to be called upon to explain the content of the medical records and his concerns in camera to the General Medical Council.

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REFERENCES

- 1 Association X v United Kingdom Application 7154/75 14 DR 31 (1978) at p 32.
- 2 R v Cambridgeshire Health Authority, ex parte B [1995] 1 WLR 898.
- 3 An impossible or disproportionate burden must not be imposed upon authorities in the interpretation of Article 2 *Osman v UK* (1999) 29 EHRR 245 at para 116.
- 4 Compare the approach of the Constitutional Court of South Africa in *Soobramoney v Minister of Health* (1997) 4 BHR 308.
- 5 *Ireland v UK* (1979–1980) 2 EHRR 25.
- 6 For an example from pre-incorporation domestic law see *North West Lancashire Health Authority v A, D and G* (2000) 1 WLR 977.
- 7 [2002] 2 All ER 449.
- 8 *Airedale Trust v Bland* [1993] AC 789 at 864 (per Lord Goff of Chieveley); *St George Healthcare NHS Trust v S* (1998) 44 BMLR 160. It was expressly stated in *An NHS Trust "A" v Mrs "M"* (2001) 58 BMLR 87 that Lord Goff's analysis of the issues in *Bland* was entirely in accordance with the ECHR case law on Article 2.