The impact of the Human Rights Act 1998 on medical decision-making
Guidance from the BMA’s Medical Ethics Department

How the HRA is relevant to medical treatment
- Article 2 – right to life
- Article 3 – prohibition of torture
- Article 5 – right to liberty and security
- Article 6 – right to a fair trial
- Article 8 – right to respect for private and family life
- Article 9 – freedom of thought, conscience and religion
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- Article 12 – right to marry and found a family
- Article 14 – prohibition of discrimination

How the HRA affects medical decision-making
The Human Rights Act 1998 came fully into force throughout the UK in October 2000. The Act requires all public authorities, including healthcare professionals working for the NHS, to act in accordance with the rights set out in the Act.

Whilst the implementation of the Human Rights Act has not created a major change in practice for health professionals, the Act has been used to challenge some medical decisions. It is therefore essential that decisions taken, both about individual patients and in terms of medical policy, take account of the Act, are transparent and can withstand scrutiny. Accurate and detailed recording of both the decision and the decision-making process also take on added importance.

This guidance aims to illustrate the way in which Human Rights are relevant to some common medical decisions and shows how a rights-based approach can be incorporated into medical decision-making. As UK case law develops additional information will be provided on the BMA’s website. A useful resources guide is also provided at the end of this document.

This guidance does not attempt to offer definitive advice in all circumstances and it should be remembered that many aspects of the Act have not been tested in the courts. Where serious doubt arises over duties under the Act, legal advice, or guidance from the courts, should be sought.

1. Why is guidance needed?

1.1 What is the Human Rights Act?

Human rights are legal instruments which represent fundamental human interests and are therefore closely aligned with ethical practice. As part of the general ethical treatment of patients, all health professionals should be familiar with their obligations under the Act.

The Human Rights Act incorporates into UK law the bulk of the substantive rights set out in the European Convention on Human Rights and applies to all health professionals working in the NHS.

The following articles are the most relevant to health professionals:

- right to life (Article 2)
- prohibition of torture, inhuman or degrading treatment or punishment (Article 3)
- right to liberty and security (Article 5)
- right to a fair trial (Article 6)
- right to respect for private and family life (Article 8)
- freedom of thought, conscience and religion (Article 9)
- freedom of expression (Article 10)
- right to marry and found a family (Article 12)
- prohibition of discrimination (Article 14)

Convention rights can be divided into three types:

- **absolute rights** (Article 3), from which no derogation is permitted although even these rights are open to interpretation;
- **limited rights** (Article 2, 5 and 6) where the limitations are explicitly stated in the wording of the Article; and
- **qualified rights** (Articles 8, 9, 10 and 12) where derogation is permitted but any action must: be based in law, meet Convention aims, be non-discriminatory, necessary in a democratic society and proportionate.

When a right permits no derogation, this means that the right must be respected in all circumstances, without exception. Both limited and qualified rights, however, do permit exceptions. Limited rights are more straightforward than qualified rights, as the exceptions which they permit are laid out in the wording of the Act. For example Article 5 – the right to liberty and security – permits the lawful detention of people who have committed criminal offences. The exceptions permitted to qualified rights, however, are not explicitly laid out in the Act, although some guidance is given. Exceptions to qualified rights must be “in accordance with law” and the restriction must accord with one of the aims or objectives of the Convention. It is for the public authority that has interfered with the right to identify the aim or objective in question. It must also show that any interference with a qualified right is “necessary in a democratic society”. This has been interpreted as meaning that interference must correspond to a pressing social need and must be proportionate to the aim pursued.

Article 14 is different in nature to the other rights laid out in the Act. It is not a free-standing right, and may only be invoked in a claim for some other Convention right. The prohibition of discrimination is a fundamental tenet of the Act, and to a human rights approach to decision-making.

Discrimination constitutes a bias against a person on the basis of one defining feature – such as their age, sex, race, sexual or religious orientation - regardless of other factors such as ability, experience, cultural and social background. Discrimination can be a major barrier to wellbeing and can violate a person’s human rights.

Those who believe their rights have been violated by a public authority have recourse to the UK courts. In addition, UK courts and tribunals (including those considering applications for court declarations) are required to take account of the Human Rights Act and to ensure that the development of the common law is compatible with the Convention rights.

1.2 Why is the Human Rights Act relevant to medical treatment?

The Human Rights Act is relevant to health care providers since it regulates the relationship between individuals and public authorities. It is unlawful for public authorities “to act in a way which is incompatible with a Convention right”. The NHS is a public authority and doctors fulfilling functions on behalf of the NHS have obligations...
under the Act. This means that doctors working within the NHS throughout the UK are required to observe the Convention rights in reaching decisions and must be able to demonstrate that they have done so.

Doctors who are providing a wholly private service (and not providing services on behalf of the NHS) are not bound by its terms. Given that the Act reflects good medical practice, however, we believe that all health professionals and health teams, howsoever constituted, should practise as though they are bound by the terms of the Human Rights Act.

Many doctors are not accustomed to thinking in terms of "rights" but one of the purposes of this guidance is to show the way in which accepted good practice, focused on patients' wishes and interests, closely echoes the requirements of the Human Rights Act. In many cases, considering Convention rights does not alter the final decision, but the way in which the decision is reached differs (by specifically considering human rights issues) resulting in greater transparency and scrutiny of the decision-making process.

1.3 How does the Human Rights Act affect decision-making?

Decision-making by all public authorities must be approached from a Human Rights perspective. Two questions need to be considered whilst making decisions:

- are someone's human rights affected by the decision?
- And, if so,
- is it legitimate to interfere with them?

Doctors need to be sufficiently familiar with these requirements for them to become a standard and routine part of the decision-making process. The dilemmas doctors are confronted with have not changed as a result of the Act, but the terms within which they must address them have. Many aspects of good practice – such as careful assessment of patients' best interests, balancing conflicting rights and consulting with patients and, as appropriate, their relatives – take on added importance as a result of the Human Rights Act, which makes them a required part of the decision-making process. Doctors are accustomed to taking into account the duties owed to patients and so the Human Rights Act does not involve major changes for them. The duties incurred through the Act are not something doctors can opt out of and all their medical decisions are potentially open to challenge.

2 Relevant articles

2.1 Article 2 – right 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.

The introduction of a "right to life" in the Human Rights Act does not mean that doctors must always strive to prolong life but that specific consideration must be given to this right as part of the medical decision-making process. Article 2 imposes positive and negative obligations on public authorities. They have positive duties to take adequate and appropriate steps to protect the life of individuals in their care, as well the negative duty not to take life intentionally.

2.1.1 Withholding and withdrawing life-prolonging treatment

It is arguable that a health care provider is obliged to make adequate provision for medical care in all cases where the right to life of a patient could be at risk, and that withholding or withdrawing any life prolonging treatment could be in breach of Article 2. In one of the first cases considered under the Act, the court made clear that Article 2 does not require the prolongation of life in all circumstances. In that case, concerning non-resuscitation of a 19-month-old child ("I") who had severe disabilities and a very short life-expectancy, it was held that withholding life-prolonging treatment did not breach Article 2 because the decision was made on the basis of the child's best interests.

"I" was born in November 1998 and suffered from a severe, chronic, irreversible and worsening lung disease giving him a very short life expectancy. He also had heart failure, hepatic dysfunction and renal dysfunction with a background of severe developmental delay. When "I" was 19 months old, the hospital applied to the court to be permitted to treat him as advised by his paediatrician; this would include non-resuscitation in the event of a respiratory and/or cardiac failure and the provision of palliative care to ease his suffering and to permit his life to end peacefully and with dignity. The parents strongly opposed the application considering it to be premature. Given the conflicting views that could not be resolved by discussion, or by seeking further medical opinions, a "best interests" application was made to the court.

Reports were considered from three consultant paediatricians, all of whom agreed that it was in the best interests of "I" that he should not be further subjected to resuscitation involving the provision of artificial ventilation and admission to paediatric intensive care. These decisions were reached on grounds of the invasive nature and risks of artificial ventilation and the distress, discomfort and pain caused by the treatment. In reaching his judgement, Mr Justice Cazalet stated that the court's clear respect for the sanctity of human life imposed a strong obligation in favour of taking all steps capable of preserving life, save in the most exceptional circumstances. In this case, however, he held that there could be no Article 2 infringement because the treatment authorised (non-resuscitation) was made in the best interests of "I".

A National Health Service Trust v D & Ors

Withdrawing or withholding treatment, including artificial nutrition and hydration, does not breach Article 2 where doing so is deemed to be in the patient's best interest. This was confirmed in a subsequent case involving two patients in a persistent vegetative state (PVS).

Under the Human Rights Act, patients' best interests remain at the heart of medical decision-making; this
reinforces existing good practice. Since the introduction of the Act, however, the way in which best interests are assessed and the factors taken into account in reaching those decisions are open to far greater scrutiny. Doctors must be able to show that the patient’s right to life was specifically considered and, where treatment is not provided, to demonstrate legitimate grounds for not taking steps to enforce that right.

Article 2 is also constrained by the concept of futility. There is a lack of consensus about the meaning of “futility”, but it is generally thought that if treatment cannot achieve its physiological aims or the burdens of the treatment are considered to outweigh the benefits for that particular individual – then withholding it would not breach Article 2.

Although people cannot generally waive their right to life by consenting to be killed, a competent adult may effectively waive his or her right to have life prolonged by making an informed refusal of life-prolonging treatment. Individuals may not, however, waive the right to have someone else’s life prolonged, such as a dangerously ill child or an incompetent adult, if treatment is considered to be in their best interests. Under the Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000 competent adults can, however, appoint a proxy decision maker to make decisions on their behalf, once they lose capacity, including the power to refuse life-prolonging treatment. All decisions made on behalf of a person without capacity are regulated by best interests; if there is a serious dispute as to whether a decision made by a proxy would be in the patient’s best interests, the court would be the final arbiter.

In the case of Burke v General Medical Council (GMC) the Court of Appeal stated that where a patient with capacity requests artificial nutrition and hydration to be provided when they lose capacity, this must be provided. The Court was careful to explain that this did not mean that the patient’s wish will merely be kept alive by ANH … the patient’s wish will merely underscore that duty” Mr Burke was denied leave to appeal to the House of Lords and his application to the European Court of Human Rights was rejected.

Mr Burke was a 45-year-old man who suffered from cerebellar ataxia with peripheral neuropathy, a progressively degenerative condition that follows a similar course to multiple sclerosis. As his condition worsened he would lose the ability to swallow, requiring artificial nutrition and hydration (ANH). Medical evidence indicated that he would retain mental capacity until very close to his death. Mr Burke was concerned that the GMC’s guidance on withholding and withdrawing life-prolonging treatment gave doctors the discretion to decide whether ANH should be provided and allowed them to withdraw ANH even if his death was not imminent. He challenged the guidance, claiming that it was incompatible with the Human Rights Act.

In July 2004 Mr Justice Munby upheld the challenge, ruling that some parts of the GMC’s guidance were not compatible with the Human Rights Act. This decision was subsequently overturned by the Court of Appeal. The Appeal Court made clear that there was never any question of ANH being withdrawn before the final stages of Mr Burke’s disease and that he did not need to go to court to ensure this. This is because he had always made it clear that he would want to receive this treatment when his health deteriorated and when he was no longer able to express his wishes. The Appeal Court added however that “autonomy and the right to self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. However, “where ANH is necessary to keep the patient alive, the duty of care will normally require the doctors to supply ANH … Where the competent patient makes it plain that he or she wishes to be kept alive by ANH … the patient’s wish will merely underscore that duty”

2.1.2 Duty to protect life

The positive duty on a public authority to protect life, under Article 2, requires it to take steps to prevent life-threatening conditions by, for example, vaccination programmes. It also includes a duty to inform the public of threats to life which could include the effects of pollution, epidemics and perhaps risks such as BSE. This duty could extend to situations where a doctor knows that an individual patient is putting another identifiable individual at risk. For example, if a doctor is aware that a patient is knowingly exposing his or her partner to HIV infection, or has refused to inform close relatives that they are at risk of a serious, life-threatening genetic disorder for which avoiding action could be taken. People who are harmed by a doctor’s failure to warn in such cases could claim that this breached their Article 2 right.

In deciding whether to breach confidentiality in these circumstances, however, the doctor needs to consider the patient’s right to privacy, including under Article 8 (see section 2.5). The two conflicting rights need to be weighed up: if a doctor is aware that a patient is putting another identifiable individual at risk, the doctor must be able to justify choosing one over the other. In practice the same type of analysis is required as before the Act came into force although the decision-making process and the reasonableness of the decision may now be open to greater scrutiny. If in doubt, doctors should seek legal advice.

2.1.3 Resource constraints

Treatment that could prolong life may sometimes be withheld on the grounds of scarce resources. Whilst it is open to a patient to argue that economic factors should not be taken into consideration in making treatment decisions, any claim under Article 2 would need to show that failing to provide treatment would lead to a real, perhaps inevitable, and immediate risk of death and that providing treatment was likely to avert that risk. Even if this case could be made, for example with some new expensive drugs for cancer patients, public authorities are only required to take those steps to avoid death that are “appropriate” and it appears that a shortage of resources may be a valid constraint to providing life-prolonging treatment.

Ann Rogers was refused the drug Herceptin by Swindon PCT, for the treatment of breast cancer. At the time Herceptin was not licensed for the treatment of early-stage breast cancer. The trust’s policy, with regard to the
treatment, was that it should only be given to patient’s in ‘exceptional’ circumstances, although considerations of cost should be disregarded.

The court ruled that Swindon PCT’s policy was irrational and therefore unlawful. Given government guidance that Herceptin should not be turned down on cost alone, it was deemed impossible to demonstrate an ‘exceptional’ need for Herceptin on either clinical or personal grounds. Once the trust had decided to fund Herceptin for some patients, the only reasonable course would be to provide the drug to all those who were clinically eligible.

The court did not order the trust to fund the treatment, but the trust were required to re-evaluate their policy.

The court came to the conclusion on grounds of domestic law and it was not deemed necessary to consider further argument under Articles 2 and 14. However the court suggested that, because of the relevance of Article 2, the trust’s policy should come under closer scrutiny.

R v Swindon National Health Service Primary Care Trust and another

In reaching policy decisions about the allocation of resources, NHS bodies must be able to show that they have considered their patients’ Article 2 right, and must be able to justify interfering with that right. Such decisions must be transparent, logical and able to withstand scrutiny. The decision must also be non-discriminatory; a blanket age restriction on treatment such as cardiopulmonary resuscitation, for example, is likely to contravene Article 14 (see section 2.9). The court is unlikely to interfere with a Health Service Body’s decision on allocation of resources, provided the appropriate procedures have been followed.

2.1.4 Right to life does not extend to the unborn

Until 2004, the European Court had avoided making a decision as to whether the right to life extended to the unborn child. It addressed this issue in the case of Vo v France in which the European Court of Human Rights clearly stated that the Article 2 right to life does not extend to an unborn fetus but, rather, the protection to clearly stated that the Article 2 right to life does not extend to an unborn fetus but, rather, the protection to an unborn child. It addressed this issue in the case of Vo v France in which the European Court of Human Rights. Mrs Vo argued that the “term ‘everyone’ (‘toute personne’) in Article 2 of the Convention was to be taken to mean human beings rather than individuals with the attributes of legal personality”; unborn children, therefore, should come under the scope of Article 2.

The European Court held that it was not possible to decide in the abstract whether an unborn child is classed as a person under Article 2 of the Convention and concluded that the issue of when the right to life begins is up to individual states to decide and it is not possible for the Court to decide whether the unborn child is a person under Article 2 of the Convention.

Vo v France

Article 2 – Summary

1. The patient’s right to life under Article 2 should be specifically considered in any decision to withhold or withdraw life-prolonging treatment but this does not mean that treatment must always be provided. Treatment may be withdrawn if:
   - providing treatment would not be in the patient’s best interests;
   - the treatment is considered futile; or
   - the patient has effectively waived his or her right to have life prolonged by making an informed refusal of life-prolonging treatment.

2. Article 2 may impose a duty on doctors to take steps to prevent life-threatening conditions and a duty to inform the public, or individuals, of threats to their life. Where this would involve a breach of confidentiality, this should be balanced against the patient’s right to confidentiality.

3. Article 2 must be taken into account where potentially life-prolonging treatment is not provided on economic grounds. Any such decisions must be made in a non-discriminatory way and must hold up to scrutiny.

4. Article 2 does not extend to the unborn.

2.2 Article 3 – prohibition of torture

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

Article 3 is an absolute right, allowing no exceptions but it can be interpreted in various ways. Violations of Article 3 can result from the failure to treat, they can also result from treating patients against their wishes.

2.2.1 Access to medical treatment

Whether an act constitutes inhuman or degrading treatment depends upon a range of factors and the individual circumstances of each case. Withholding proper medical care in a case where someone is suffering from a serious illness could, in certain circumstances, amount to treatment contrary to Article 3. ‘Undue delay’ in providing treatment can also constitute a breach of Article 3.

In October 2003 the High Court confirmed that where treatment cannot be provided without “undue delay” in the UK, patients have the right to seek treatment in
another member state and receive reimbursement of the cost from the NHS.

Mrs Yvonne Watts was 72 years old and had osteoarthritis in both hips. She was originally told she would have to wait for one year for the treatment she needed. She made enquiries about receiving the treatment in another country under the established procedures but was informed that this was not possible because, as her waiting time was within the government’s target, she had not suffered “undue delay”. Mrs Watts subsequently arranged her operation privately in France and claimed reimbursement from the NHS. Mrs Watts argued that her human rights were relevant to the case in terms of Article 3 and 8.

The court concluded that the authorities’ refusal to fund treatment did not infringe her Article 3 or 8 rights. The “ill-treatment” in question was not severe enough to engage her Article 3 rights.

Nevertheless the court confirmed that “undue delay” does not mean the same as being outside the government’s waiting list targets and, although relevant, waiting lists are not determinative. In assessing what amounts to “undue delay” all the circumstances of the individual case, including the patient’s medical condition and, where appropriate, the degree of pain and the nature and extent of the person’s disabilities, must be taken into consideration.

Yvonne Watts v (1) Bedford Primary Care Trust (2) Secretary of State for Health

2.2.2 Dignity in death

The courts have made clear that Article 3 provides the right to “dignity in death”. This was established in a case heard shortly before the implementation of the Human Rights Act, in which a health care team sought approval to withhold artificial ventilation from a baby boy despite the objection of his parents. Referring back to previous cases in which non-treatment had been found to be in the best interests of the child, the High Court held that it would be lawful for artificial ventilation to be withheld if, in the opinion of the treating paediatrician, it was clinically inappropriate. The judge was of the view that this was not possible because, as her waiting time was within the government’s target, she had not suffered “undue delay”. Mrs Watts subsequently arranged her operation privately in France and claimed reimbursement from the NHS. Mrs Watts argued that her human rights were relevant to the case in terms of Article 3 and 8.

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From 1972 to 1984 Mr Herczegfalvy was compulsorily detained in Austria, some of the time in prison and intermittently, in a psychiatric hospital after he was diagnosed as suffering from paranoia querulans. On a number of occasions during this period he went on hunger strike and was force-fed. Mr Herczegfalvy also refused to consent to any medical examination or treatment but was given sedatives and other medication against his will. In order to administer the treatment in the face of his aggression and death threats, he was attached to a security bed or was handcuffed with a belt around his ankles. After his release in 1984, Mr Herczegfalvy made a number of complaints about his treatment, including a claim under Article 3 that the forcible administration of food and neuroleptics and the use of handcuffs and the security bed to administer the treatment constituted inhuman or degrading treatment.

The Court considered that the position of inferiority and powerlessness which was typical of patients confined in psychiatric hospitals called for increased vigilance in reviewing whether the Convention had been complied with. It held, however, that it was for the medical authorities to decide, on the basis of the recognised rules of medical science, and on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves. The court went on to say that, as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading but that medical necessity must be convincingly shown to exist. In the case of Mr Herczegfalvy, it was held that the evidence was not sufficient to disprove that the medical necessity justified the treatment and that there had not been a violation of Article 3.

Herczegfalvy v Austria

2.2.4 Prohibition on discrimination

Refusing to provide treatment for a patient because of some personal characteristic, such as age, sexual orientation or physical or mental handicap, might also be considered a breach of Article 3, amounting to inhuman or degrading treatment. This Article prohibits treatments that “lower the individual in rank, position, reputation or character, whether in his own eyes or the eyes of other people”. In a 1994 case before the European Court it was held that not providing medical treatment to patients in custody was a breach of Article 3. The same may be true if treatment that would clearly benefit them is
could include, for example: the court. Such cases are likely to be exceptional but whether it reaches the high threshold of gravity set by individual circumstances of the case, in particular, treatment is “inhuman or degrading” depends upon the patients have a right under article 3 to be protected from article 3 – summary patients have a right under article 3 to be protected from

D was born and spent most of his life in St Kitts. On arrival in the UK in 1993, seeking permission to enter for two weeks, he was found to be in possession of a substantial quantity of cocaine and was sentenced to six years’ imprisonment. While in prison D was found to be HIV positive and developed AIDS for which he was receiving medical treatment. On his release from prison on licence, D applied to remain in the UK on compassionate grounds so that he could continue to receive the level of medical care he needed. This request was turned down and D took his case to the European Court of Human Rights.

D’s solicitor argued that removal to St Kitts would entail the loss of the medical treatment D was currently receiving, thereby shortening his life expectancy. Furthermore such action would condemn him to spend the rest of his remaining days in pain and suffering in conditions of isolation, squalor and destitution. The Court held that, although it could not be said that the conditions which would confront him in the receiving country were themselves a breach of the standards of article 3, D’s removal to St Kitts would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment in violation of article 3.

D v United Kingdom

Subsequent cases have attempted to show that the deportation of failed asylum seekers receiving treatment for HIV to their country of origin would breach article 3. At the time of writing, however, none have succeeded. As stated above, it is clear that there is no general right to treatment under article 3 and it was the exceptional nature of D’s case which constituted a potential breach of his article 3 rights.

2.2.5 Treatment of asylum seekers

The courts have established that there is no general right to medical treatment under article 3. In the UK, where a person has been formally refused asylum they are not entitled to routine free NHS care. There are some exceptions, including emergency treatment and treatment for sexually transmitted diseases and some infectious diseases (with the exception of HIV/AIDS).

As the below case shows, in exceptional circumstances the removal of a failed asylum seeker, who is receiving treatment under the NHS, to a country where they will not be able to continue treatment, can result in a breach of article 3.

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2.3 Article 5 – right to liberty and security

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons unsound mind, alcoholics or drug addicts or vagrants ...

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

The right to liberty does not mean that individuals must never be detained against their will and article 5 provides specific exceptions to permit the lawful detention of those who have committed a criminal offence and to detain those who may pose a risk to themselves or others.

2.3.1 “Unsoundness of mind”

“Unsoundness of mind” is one of the exceptions allowed by article 5(1)(e) although the European Court has taken the view that the meaning of that phrase is not susceptible to a definitive interpretation since it will continually evolve. As a minimum, however, the Court has emphasised that “unsoundness of mind” cannot be used to detain an individual merely because his or her views or behaviour deviate from the norms prevailing in a particular society. Detention under article 5(1)(e) is only justified where appropriate procedures have been followed. The European Court has specified that in order for such detention to be lawful, in all but emergency cases, there must be reliable evidence before a competent authority:

1. that a true mental disorder has been established by objective medical expertise;
2. that the mental disorder is of a kind or degree warranting compulsory confinement; and
3. the validity of continued confinement depends upon the persistence of such a disorder.

Article 3 – Summary

Patients have a right under article 3 to be protected from inhuman or degrading treatment. Whether the treatment is “inhuman or degrading” depends upon the individual circumstances of the case, in particular, whether it reaches the high threshold of gravity set by the court. Such cases are likely to be exceptional but could include, for example:

- withholding proper medical care in a case where someone is suffering from a serious illness;
- providing invasive treatment contrary to the patient’s best interests - where, for example, the burdens outweigh the benefit;
- denying the patient the right to be allowed to die with dignity;
- treatment without consent except where treatment is provided to an incompetent patient in his or her best interests;
- providing treatment against the wishes of a competent patient;
- providing treatment to an incompetent patient when it is known that he or she would not have given consent to the treatment, or had specifically refused the treatment by means of an advance directive;
- refusing to provide treatment for a patient because of some personal characteristic, such as age, sexual orientation or physical or mental handicap.

The individual factors of the case need to be assessed to decide how “inhuman or degrading treatment” should be interpreted.

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1. that a true mental disorder has been established by objective medical expertise;
2. that the mental disorder is of a kind or degree warranting compulsory confinement; and
3. the validity of continued confinement depends upon the persistence of such a disorder.
In addition, patients who are detained are entitled to seek review of the lawfulness of the detention and of the continued need for detention.

2.3.2 Protection from arbitrary detention

Article 5 is not an absolute right to freedom of movement, rather it protects people from arbitrary detention. Article 5 has been used to challenge unjustified detention under mental health legislation or informal treatment for a mental disorder regarding the restraint of an incapacitated adult. In 2004 the European Court of Human Rights confirmed that restraint of an incapacitated patient under common law, without recourse to statutory mental health legislation, was arbitrary and unlawful. HL, an autistic man with severe learning disabilities, was informally admitted to Bournewood Hospital under common law. Whilst HL was compliant in the treatment, it was clear that he did not have the capacity to consent to treatment. HL was subject to continuous supervision and was not free to leave the hospital.

The European Court of Human Rights found that he had been deprived of his liberty unlawfully, violating Article 5(1) and 5(4) of the Convention. HL had been detained without a legal procedure and without procedural safeguards and did not have rapid access to a court or tribunal. Detention without such safeguards was deemed to fail to protect individuals against arbitrary deprivations of liberty. The Court made it clear that the question of whether someone has, in fact, been deprived of liberty depends on the particular circumstances of the case. HL v United Kingdom

The implications of the ‘Bournewood’ case are wide-ranging, potentially effecting all compliant incapacitated patients who are currently detained under the common law. It is likely, therefore, to apply to many older people, and people with learning disabilities, in residential settings. At the time of writing the English government is planning to clarify the law around the treatment of such patients and to ensure the law and practice is compliant with the Human Rights Act.

In cases where the risk of harm is to the patient him or herself, it might be considered that the suicidal patient has effectively waived his or her Article 2 right to life and thus should not be detained. It is considered very unlikely, however, that such a claim would be upheld since society does not generally accept that people have an unambiguous right to die when they choose. In most cases there will be an initial assumption that suicidal tendencies are a symptom of mental disorder and the patient is likely to be detained using emergency powers for assessment.

2.3.3 Preventing the spread of infectious diseases

Article 5 permits the lawful detention of individuals for the prevention of the spreading of infectious diseases, in the public interest. This does not, however, mean that individuals who represent a risk to others can be detained in the absence of any legal authority to do so. The detention of the infected person should always be the "last resort"; meaning that less restrictive measures should have been considered first and found insufficient.

The Human Rights Act does not provide that authority, it simply states that one exception to the right to be free from detention is where the law has decided that individuals should be detained for the prevention of the spreading of disease. Any statute relied upon in these circumstances must be specific and accessible.

2.4 Article 6 – right to a fair trial

In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

At the time the Act came into force it had been suggested that one of the effects of Article 6 would be to make it more common for Trusts to apply to the courts for declarations about the provision or withholding of treatment. There is no evidence yet that Article 6 has had this effect.

Article 6 is most relevant to health professionals with regard to staff disciplinary proceedings, compensation claims and independence of tribunals, for example mental health tribunals.

2.5 Article 8 – right to respect for private and family life

Everyone has the right to respect for his private and family life, his home and his correspondence.

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.

This Article is very broad but its relevance to medical
decisions relates, primarily, to the rights of individuals
to privacy and to be involved in decision-making about their
treatment. Other relevant issues include considerations
such as single-sex wards, and respecting people’s sexual
and other relationships in residential care settings.
Access to assisted reproduction also comes within the
ambit of Article 8.

2.5.1 Privacy and access to medical records

The right to privacy, under Article 8, closely reflects
the legal duty of confidentiality and the professional
obligations of health professionals.

In a 1989 case before the European Court, it was held
that public authorities have a positive obligation to allow
an individual access to files containing information about
him or her. Although this case related to files held by the
local authority, it is likely that a failure to allow individuals
access to their medical records, without good reason,
may also breach Article 8. As before the Human Rights
Act, information should only be disclosed without the
patient’s consent, where there is a legal obligation to do
so or where it is decided that there is an overriding public
interest in disclosure.

Since the Data Protection Act 1998 came into force in
March 2000, individuals have had a statutory right of
access to the whole of their medical record (with limited,
specific exceptions) and so Article 8 reflects existing
access legislation in the UK.

2.5.2 Informed consent

Article 8 may also impact on the amount of information
to be provided for consent to be valid and informed.
It could be argued, for example, that informed consent had
not been obtained where a particular piece of
information about the treatment was withheld. This does
not mean that doctors must tell patients about every
possible complication of the treatment, however small,
but that they must be able to show that they have taken
into account the patient’s Article 8 rights and be able to
justify withholding information. Some forms of
experimental or innovative treatment could also violate
Article 8 unless the patient has been given sufficient
information and has given a valid consent.

2.5.3 Children and young people

The Court has taken the view that parents have the right
under Article 8 to be involved in important decisions
concerning their children. When fundamental disputes
arise between the medical team and the parents,
regarding the treatment of a minor, failure to seek a
court declaration to resolve the dispute can breach the
minor’s Article 8 rights. Other than in an emergency
situation, treatment must not be provided for a child or
young person who lacks capacity without the consent of
someone with parental responsibility or the court.

In March 2004, the European Court of Human Rights
(ECHR) awarded Carol Glass and her son David
compensation after doctors treated David contrary to his
mother’s wishes, without a court order.

Born in 1986, David Glass was severely mentally and
physically disabled, requiring 24-hour care. In July 1998
after surgery to alleviate an upper respiratory tract
obstruction, David became critically ill and was put on a
ventilator. Doctors thought he was dying. His condition
improved briefly and he returned home only to be
readmitted a few days later when doctors discussed the
option of morphine to alleviate his distress. His mother
refused, believing it would compromise his chance of
recovery. She also made clear that she wanted David
resuscitated if his heart stopped. Relations between the
family and the health care team had completely broken
down. Although the doctor managing David’s care
noted the possible need for a court order in such cases of
total disagreement, no order was sought and the
morphine was provided without consent.

The Glass family argued that, when the dispute arose, the
hospital should have involved the courts to clarify
whether, despite his mother’s objections, the treatment
proposed was in David’s best interests and that the
doctors were wrong in believing the urgency of the case
made that unnecessary. Although dismissed by UK
Courts, the ECHR held that David’s Article 8 right to
privacy, and in particular his right to physical integrity,
had been breached. The Court said it was clear that the
UK courts should have been used to settle the dispute
before an emergency situation arose.

Those with parental responsibility for a young child have
clear rights and responsibilities in respect of their child. It
is also possible that an unmarried father who does not
have parental responsibility, could use Article 8 to claim a
right to be involved in decisions about medical treatment.

Competent minors may be able to invoke their rights
under the Act to challenge a decision to provide
treatment against their wishes. In England, Wales and
Northern Ireland legal cases heard before the
implementation of the Human Rights Act made clear that
Courts and parents may give consent to treatment
notwithstanding refusal by a competent person under
18. (This does not appear to be the case in Scotland,
although the law there cannot be considered to be
settled.) It is possible that a young person could use the
Convention rights (in Articles 5, 8, 9 or 14) to appeal
against a decision to provide treatment against his or her
wishes.

The law is clear, however, that people under 18 can give
valid consent to treatment, providing they have sufficient
understanding of the proposed treatment.

Sue Axon, the mother of a teenage girl who had
undergone an abortion, sought to challenge the legality
of the Department of Health’s guidance to health
professionals, under Article 8 of the Human Rights Act.
Axon argued, unsuccessfully, that she had a right to
know if her daughter sought an abortion.

The Department of Health’s guidance on the provision of
advice and treatment of contraception and sexual and
reproductive health, to under 16 year olds, \(^{26}\) is based on the English case-law precedent laid out in the landmark Gillick\(^ {27}\) case. In the Gillick case the majority opinion of the House of Lords was that it would be lawful to provide contraceptive advice and treatment to a patient who was under 16, without her parents’ knowledge, provided that the young woman had sufficient understanding and intelligence for her to comprehend fully what was being proposed.

Axon claimed that the Gillick ruling should be re-considered in light of the Article 8 rights of parents. High Court Judge Silber J, rejected Axon’s argument. He was “unable to agree that there should be any exception to the duty of confidence along the lines advocated”.

Silber J ruled that Article 8 was not engaged and, even if it was, any interference with parents’ rights under Article 8(1) would be justified by 8(2). Sibler J described parents’ right to control their child as a “dwindling” right which yields to young peoples’ right to make their own decisions, once they have sufficient understanding to do so. Moreover, the nature of sexual health information meant that it deserved the “highest degree of confidentiality”.

R (on the application of Axon) v Secretary of State for Health\(^ {38}\)

2.5.4 Patients who lack capacity

Where a patient has expressed a specific wish that their condition should not be discussed with relatives and friends this should be respected even if he or she loses capacity to participate in treatment decisions. In the absence of such an expressed wish Article 8 may give those close to a patient who lacks capacity the right to be consulted about treatment decisions. In such cases a balance must be sought between preserving patient confidentiality and obtaining enough information to make an informed assessment of the patient’s best interests. A patient’s best interests encompass a persons’ past and present wishes and their broader beliefs and values, where they would have an impact on the decision. Discussion with those close to the individual may be necessary to build up this profile of a patient who lacks capacity. Whilst the views of relatives cannot be determinative (since they may conflict with the patient’s interests), the doctor must be able to show that these views have been taken fully into account. As has always been the case, medical decisions should reflect the patient’s best interests but doctors should be ready to show why they cannot comply with relatives’ wishes in some cases.

The Mental Capacity Act 2005 and the Adults with Incapacity (Scotland) Act 2000 clarify the law around the treatment of adults who lack capacity. Health professionals who work with adults without capacity, or who may lose capacity, should be aware of the implications of this legislation. Separate BMA guidance on this legislation is available.

2.5.5 Assisted reproduction

The European Court of Human Rights has recognised that access to assisted reproduction comes within the ambit of Article 8. However the right to assisted reproduction is not absolute and states have a wide “margin of appreciation” when setting their policy in this area.\(^ {37}\) Nor can the right to such treatment override other considerations such as the need for consent from another party.

In 2000, Natallie Evans was diagnosed as having ovarian cancer so she and her partner, Howard Johnston, agreed to create embryos for their future use. Six embryos were created and frozen but when the couple separated in 2002, Mr Johnston withdrew his consent for Ms Evans to use these embryos. He wrote to the clinic to notify it of the separation and requested that the embryos be destroyed. The Human Fertilisation and Embryology Act 1990 requires the consent of both gamete donors at each stage for the storage or use of human embryos. Natallie Evans went to the High Court and Appeal Court asking to be allowed to use the embryos without the consent of her estranged partner. She sought an injunction requiring her ex partner to restore his consent to storage and she argued that destruction of the embryos would be incompatible with her own Convention rights under Article 8 and that the embryos too were entitled to protection under Article 2. Her case was rejected. The judge ruled that an embryo was not a person with rights under the human rights Convention and that Ms Evans’ human rights were not engaged. In November 2004, she was also refused permission to appeal to the House of Lords against the ruling that she could not use the frozen embryos for treatment. As embryos cannot be used or stored without the consent of both parties, Ms Evans argued that under the law she was losing her only chance of having a child of her own. In 2005, Ms Evans lodged an application with the European Court of Human Rights. She asked the court to consider whether the UK law which required her six stored embryos to be destroyed was a breach of her human rights. The European Court decision was given in March 2006 and ruled that there was no violation of human rights.

In April 2007 Ms Evans lost her final appeal to the Grand Chamber of the European Court of Human Rights, again, the Chamber ruled there was no violations of human rights.

Evans v United Kingdom\(^ {40}\)

Article 8 – Summary

Under Article 8 the patient has a right to privacy and also a right to family life. This means that:

- particularly careful attention should be paid to the amount of information to be provided for consent to be considered informed and valid;
- the patient should be involved with the treatment decision to the greatest extent possible;
- the parents of a child patient should be consulted about treatment and their views should be taken into account (this could include unmarried fathers who do not have parental responsibility for the child);
- a competent young person could use the Human Rights Act to challenge the provision of treatment against his or her wishes although it is unclear whether such a challenge would succeed;
- those close to an incompetent adult should be consulted about treatment and their views should be taken into account;
• if it is decided that the wishes of those close to the patient cannot be complied with in a particular case, the doctor must still show that these views have been taken fully into account and must be prepared to explain his or her reasons for adopting a different position;
• the protection of personal and, particularly, medical information is of fundamental importance to a person’s enjoyment of his or her right to respect for private and family life;
• access to assisted reproduction comes within the ambit of Article 8.

2.6 Article 9 – freedom of thought, conscience and religion
1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

Article 9 is absolute so far as the right to belief is concerned, but qualified in respect of the right to act on one’s beliefs or oblige others to comply with them. Under Article 9 a competent patient may object to treatment on religious grounds, even where withholding treatment may lead to death.

2.6.1 Conscientious objection

It is possible that Article 9 could be used to claim a legal right to conscientious objection. Currently the only areas where doctors have a legal right to claim a conscientious objection are to participation in abortion and activities licensed under the Human Fertilisation and Embryology Act. The BMA, and other professional bodies, however, recognise an ethical right to claim a conscientious objection to a broader range of activities: prescribing contraception including emergency contraception, for example, and decisions to withhold or withdraw treatment, including artificial nutrition and hydration. It is possible that Article 9 could be used to strengthen such a claim and to challenge an employer’s insistence upon involvement in such activities. It is necessary for a doctor claiming a conscientious objection to refer the patient to another practitioner and to provide treatment in an emergency situation.

2.7 Article 10 – freedom of expression

1. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.

At the time of writing, there is little case law which engages Article 10. It could, however, be called upon by patients in support of their right to receive information considered by their doctor to be appropriate and necessary.

A case was brought before the European Court by two companies, Open Door Counselling Ltd. and Dublin Well Woman Centre, two counsellors working for the latter company and two women of child-bearing age. The applicants complained of an injunction imposed by the Irish courts restraining the companies or their employees from providing certain information to pregnant women concerning abortion facilities outside the jurisdiction of the Republic of Ireland.

The Court decided that the injunction constituted an interference with the right of the companies and the counsellors to impart information, as well as the rights of the other applicants to receive information. The Court recalled that freedom of expression is also applicable to “information” or “ideas” that offend, shock or disturb the State or any sector of the population. In this case it was important to note that the corporate applicants neither advocated nor encouraged abortion but solely explained available options.

This interference was considered to be disproportionate to the aims pursued. The protection of the right to life of the unborn was a legitimate aim and the Court acknowledged that the national authorities enjoyed a wide margin of appreciation in matters of morals. This power is however not unlimited. Taking into consideration the absolute nature of the injunction which imposed a “perpetual” and absolute restraint, as well as the fact that the injunction appeared to have been largely ineffective in protecting the right to life of the unborn, the Court held that the injunction was disproportionate and therefore there had been a breach of Article 10 of the Convention. Moreover it noted that the injunction
had actually created a risk to the health of women due to lack of proper counselling.

Open Door and Dublin Well Woman v Ireland

In the past doctors have been advised, by Health Authorities, not to inform patients that there is a course of treatment that could be beneficial for them because the treatment is not available on the NHS. Patients could challenge such instructions under Article 10 which gives them the right to receive information without unjustified interference by a public authority. If treatment cannot be funded by the NHS, patients should have access to information about the factors leading to the rationing decision and it should be made clear whether the treatment is unavailable because it is unproven or solely on the grounds of cost.

Positive obligations may arise under Article 10 although these have yet to be fully explored. It is possible, however, that patients could take action in such circumstances using Article 8 since failure to provide the information could mean that their consent was not valid and informed.

Article 10 – Summary

Article 10 could be used to challenge attempts by Health Authorities to restrict or influence the information provided to patients.

2.8 Article 12 – right to marry and found a family

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.

It has been suggested that Article 12 could be used to challenge decisions not to provide access to fertility treatment although the European Commission has stated that Article 12 does not give individuals a positive right to be provided with assistance to conceive.

2.8.1 Access to reproductive services

Article 12 may preclude placing arbitrary restrictions on access to reproductive services.

Gavin Mellor was serving a life sentence for murder when he met and married his wife. In 1997 he applied for permission to be allowed to inseminate his wife artificially arguing that Article 12 of the European Convention gave him the right to found a family. The Secretary of State refused the request on the grounds that artificial insemination was not needed for medical reasons but was sought in order to circumvent the normal consequences of imprisonment. Furthermore, he argued that there were serious concerns about the stability of the relationship which had not been tested under normal circumstances.

Mr Justice Forbes held that the Secretary of State’s decision did not contravene Mr Mellor’s Article 12 rights. It had been clearly established that the Article 12 right to found a family did not mean that a person must be given, at all times, the actual possibility of procreating his descendants. In reality, what Mr Mellor was seeking was to be granted the privilege or benefit of being afforded access to artificial insemination services because an inevitable consequence of his lawful detention in custody was that it was impossible for his wife to conceive a child by natural means. The Secretary of State was therefore entitled to formulate a policy for dealing with such requests by prisoners to decide whether the privilege should be made available in a particular case. The application was dismissed.

R v Secretary of State for the Home Department

2.8.2 Sterilisation of incompetent adults

Article 12 is also relevant to applications to court for the sterilisation of incompetent adults. In Re A, an application for the sterilisation of a 28-year-old man with Down syndrome was rejected. Reference was made in that case to A’s right to privacy and to found a family and it was suggested that the view of A that he did not want the operation ought not to be ignored even though he was unable to understand its implication. In the Court of Appeal, Lady Justice Butler-Sloss warned that with the direct application of the European Convention on Human Rights to English domestic law imminent, the courts should be slow to take any step which might infringe the rights of those unable to speak for themselves.

Article 12 – Summary

It is possible that Article 12 could be used to challenge arbitrary decisions not to give access to fertility treatment or applications for enforced sterilisation.

2.9 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 not give a free standing right, and can only be invoked in a claim for some other Convention right. A “blanket ban” on providing certain treatments on the grounds of age, for example, may contravene patients’ right to life (Article 2), their right to be free from torture, inhuman or degrading treatment (Article 3) and also their right to respect for private and family life (Article 8). Although Article 8(2) appears to allow derogation on the grounds of resources, such derogation must be applied without discrimination. An example of a breach of Article 14 could be rationing which appears solely based on age rather than evidence of effectiveness and benefit for the individual. Age discrimination falls within the ambit of Article 14, even though it is not mentioned explicitly, because the list in Article 14 is not exhaustive and includes “other status”. Clinical indicators demonstrating that older people in general benefit less from a certain treatment may not be accepted as a justification if such arguments are applied in a blanket way rather than treatment decisions being based on individual assessment. It is very unlikely, however, that health authorities and individual doctors could be seen as obliged to provide futile, ineffective or unproven treatment. It is important, therefore, that attention is paid to the individual circumstances of each case and the requirements of the individual patient. Any discrimination between patients or patient groups must be justified and able to withstand scrutiny.
Article 14 – Summary

Article 14 ensures that all individuals enjoy the Convention rights without discrimination. This means that “blanket” decisions - based on age or medical condition - instead of decisions based on an assessment of the individual factors of the case, could be challenged.

3 How can doctors show compliance with the Act?

3.1 How can doctors determine whether interference with a right is legitimate?

Many decisions in medical practice involve patients’ human rights. The rights that are affected need to be identified first. The next stage of the process is to consider whether it is legitimate, in the circumstances, to interfere with those rights. In order to assess this, it is necessary to be familiar with the concept of proportionality.

Any interference with a Convention right must be proportionate to the intended objective. This means that even if there is a legitimate reason for interfering with a particular right, the desired outcome must be sufficient to justify the level of interference proposed. This involves a similar thought process to that used by doctors in many contexts, for example, to decide whether a breach of confidentiality is justified in the public interest. In those cases, doctors must consider whether the legitimate aim in disclosing information (to prevent or detect a serious crime, for example) is sufficiently serious to justify breaching confidentiality. These decisions are made by balancing the competing interests and by careful assessment of the individual factors in the particular case. In some cases a breach of confidentiality will be justified and in others it will not and those making the decision may be called upon to justify their actions. Although the term “proportionality” may be new to doctors, the concept is not.

3.2 The decision-making process

Deciding whether interference with a Convention right is legitimate requires consideration of the following:

a) Is an absolute right involved? If so, there can be no interference with it although there are issues of interpretation (see discussion of Article 3 above).

b) Is a limited or qualified right involved? If so, 
   - refer to existing guidance from professional bodies to identify how similar cases have been judged,
   - is the proposed interference justified by the aim pursued? (Does it meet the proportionality rule?) It must:
     - impair the right as little as possible;
     - meet the objectives in question;
     - not be arbitrary, unfair or irrational; and
     - balance the need against the severity of the effect of impairing the right.

The Human Rights Act allows judges to look at both the decision-making process and the merits of the decision. Therefore doctors’ decisions are likely to be open to greater scrutiny and must be more transparent and properly recorded. Existing good practice, emphasising the importance of consultation and of carefully documenting decisions and the reasons for them, takes on greater importance.

As can be seen, the rights-based assessment required since the introduction of the Human Rights Act echoes very closely the type of decision-making process promoted in existing good practice guidelines. The main difference is the language which is used to describe the decision-making process, with terms such as “rights” and “proportionality” gradually being introduced into the medical lexicon. Decision-making also needs to be approached and documented in an increasingly formal way so that doctors not only take account of the human rights aspects of the decisions they make but are also seen to have done so.

In every decision doctors must consider relevant Convention rights and must be able to demonstrate legitimate grounds for interfering with such rights. Where different rights come into conflict (such as Articles 2 and 3), the doctor must be able to justify choosing one over the other in a particular case. Any decision, either to provide or withhold treatment, could be open to challenge using the Human Rights Act. It is therefore essential to build into the decision-making process consideration of how the decision could be justified from a human rights perspective.

For further information about these guidelines, BMA members may contact:

askBMA on 0870 60 60 828 or
British Medical Association
Department of Medical Ethics, BMA House
Tavistock Square, London WC1H 9JP
Tel: 020 7383 6286
Fax: 020 7383 6233
Email: ethics@bma.org.uk

Non-members may contact:
British Medical Association
Public Affairs Department, BMA House
Tavistock Square, London WC1H 9JP
Tel: 020 7387 4499
Fax: 020 7383 6400
Email: info.public@bma.org.uk

Further resources

Guidance
Bournewood briefing sheet
Department of Health
London, 2006

Health and Human Rights
A guide to the Human Rights Act 1998
The Nuffield Trust
London, 2003

Health and Human Rights – 25 Questions and Answers
World Health Organisation
Geneva, 2002

Human Rights in Healthcare – A framework for local action
Department of Health and the British Institute of Human Rights
London, 2007
Mental Capacity Act 2005 – guidance for health professionals
British Medical Association
London, 2006

Medical treatment for adults with incapacity: guidance on ethical and medico-legal issues in Scotland
British Medical Association
London, 2002

Withholding and Withdrawing Life-Prolonging Medical Treatment – Guidance for decision-making. 3rd Edition
British Medical Association

Parental responsibility – guidance from the ethics department
British Medical Association
London, 2006

The right to health: a toolkit for health professionals
British Medical Association and the Commonwealth Medical Trust
London, 2007

Websites

British Institute of Human Rights
www.bhr.org.uk

British Medical Association, Medical Ethics section
www.bma.org.uk/ethics

Commission for Equality and Human Rights
www.cehr.org.uk

Department of Health
www.dh.gov.uk

European Court of Human Rights
www.echr.coe.int

Human Rights Division, Department of Constitutional Affairs
www.dca.gov.uk/peoples-rights/human-rights

Liberty
www.liberty-human-rights.org.uk

Mental Health Act Commission
www.mhac.org.uk

NHS Litigation Authority
www.nhsla.com

World Health Organisation
www.who.int/en/

References

2 X v FRG (1984) 7 EHR CD 152
3 X v UK (1978) 14 DR 31
4 A National Health Service Trust v D & Ors [2000] 2 FLR 677
5 NHS Trust A v M; NHS Trust B v H [2001] 1 All ER 801
6 Ibid
7 R (on the application of Burke) v General Medical Council [2005] 2 FLR 1223 at 69
8 Ibid
9 R v Swindon National Health Service Primary Care Trust and another [2006] EWCA Civ 392
10 Ibid
11 Ibid
12 Vo v France [2005] 40 EHR 12
13 Ibid
14 D v United Kingdom (1997) 24 EHR 423
15 R (on the application of Yvonne Watts) v (1) Bedford Primary Care Trust (2) Secretary of State for Health. [2003] EWHC 2228
16 A National Health Service Trust v D & Ors [2000] 2 FLR 677
17 Herczegfalvy v Austria [1992] 15 EHRR 437
18 Ibid
19 East African Asians v United Kingdom [1981] 3 EHRR 76
20 Hurtado v Switzerland 29 January 1994, Series A, No 280-A
21 N v Secretary of State for the Home Department [2005] UKHL 31
22 D v United Kingdom (1997) 24 EHR 423
23 R v Chief Immigration Officer (Re R) TLR 29/11/2000; Amegnigan v The Netherlands, LTL 2/2/2005, Document No. AG3000274; N v Secretary of State for the Home Department [2005] UKHL 31, TLR 09/05/05
24 N v Secretary of State for the Home Department [2005] UKHL 31, TLR 09/05/05
25 Winterwerp v The Netherlands (1979-80) 2 EHRR 387
26 HL v United Kingdom (2004) ECHR 761
27 Ibid
28 Enhorn v Sweden Court ECHR Application 56529/00
31 Gaskin v. United Kingdom (1989) 12 EHR 36
32 W v United Kingdom (1987) 10 EHR 29
33 Glass v United Kingdom (2004) (application no. 61827/00)
34 Ibid
35 Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 122; R (on the application of Axon) v Secretary of State for Health [2006] 2 WLR 1130
36 Department of Health. Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under sixteen on contraception, sexual and reproductive health. DH, London 2004
37 Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 122
38 R (on the application of Axon) v Secretary of State for Health [2006] 2 WLR 1130
39 Dickson v United Kingdom ECHR Application no. 44362/04
40 Evans v United Kingdom ECHR Application no. 6339/05
41 Open Door Counselling Ltd. and Dublin Well Woman Centre Ltd. v. Ireland [1992] 14 EHR 131
42 Briody v St Helen’s and Knowsley Area Health Authority [2001] EWCA Civ 1010
43 R v Secretary of State for the Home Department, (2001) 3 WLR 533
44 Re A (Male Sterilisation) [2000] 1 FLR 549
45 R v Ministry of Defence, ex parte Smith [1996] Q.B. 517