Human Rights Act

This month, October, the Human Rights Act 1998 comes into force, bringing the rights and freedoms enshrined in the European Convention on Human Rights' into domestic law. The act applies to the whole of the United Kingdom, although to some extent the convention has already been incorporated into the law in Scotland, Wales and Northern Ireland. Under 1998 legislation, neither the Scottish Parliament, nor the Welsh and Northern Ireland Assemblies, may act in contravention of the European Convention on Human Rights. It has been possible for some time, therefore, for the exercise of a function by one of those bodies to be challenged as not being within its powers, by virtue of that function being incompatible with the convention rights.

Under the Human Rights Act, all action by "public authorities" must be compatible with the convention rights. National Health Service (NHS) trusts and health authorities are public authorities in this context and it is possible that individual NHS doctors will also fall within that definition. Whilst hospital doctors may appear to be more affected than general practitioners, who are independent contractors, other doctors may also be caught within the terms of the act. Acting in accordance with the Human Rights Act is also a matter of good practice. All doctors, therefore, need to be aware of their obligations and would be well advised to take account of the new legislation in making treatment decisions.

One of the primary changes that will occur, in practical terms, is that, in addition to considering whether a proposed action would be lawful, it will be necessary also to consider whether someone's human rights are involved and, if so, whether it would be legitimate to interfere with them.

It is envisaged that the introduction of the convention rights into domestic law will lead to an increasing number of challenges to medical decisions. The articles most likely to be used in such cases include: article 2—right to life; article 3—prohibition of torture and of inhuman or degrading treatment; 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—right to freedom of thought, conscience and religion; and article 14—prohibition of discrimination.

The type of decisions that may, potentially, be open to challenge using the Human Rights Act include the cessation of life-prolonging treatment, rationing decisions, particularly where these are made on the basis of age (as is often the case with the provision of fertility treatment) and do-not-resuscitate (DNR) orders. The courts began to bring discussion of convention rights into their deliberations in the months leading up to October, considering specifically whether, and if so how, an individual's human rights were involved in the cases being considered. An example of this is in the case of "I" which was considered in July 2000. "I" was 19 months old and suffered from a severe, chronic, irreversible and worsening lung disease. A declaration was sought, by the NHS trust, that "I" could be treated as suffering and to permit his life to end peacefully and with dignity. "I"s parents opposed the application. The application was granted and, referring specifically to the convention rights, it was held that there was no infringement of article 2 (right to life) in making the declaration as the decision was in "I"s best interests. Furthermore, under article 3, which requires that a person not be subjected to inhuman or degrading treatment, it was held that a person had a right to die with dignity.

In many cases, as with that described above, rights may conflict and arguments can be made both in support of and against a particular course of action using convention rights. The situation is further complicated by the fact that not all articles have the same weight. Some, such as article 3, are absolute rights allowing no derogation by the state. It is therefore helpful that the court has made clear that this does not entail prolongation of life in all circumstances. Other articles, such as article 8, are qualified rights. A government task force has produced general guidance on the Human Rights Act and many individual trusts are currently making their existing guidance to ensure compatibility with the Human Rights Act and to include reference to convention rights.

The level of impact the Human Rights Act will have on medical practice is impossible to predict. The process by which decisions are currently made, involving a balancing of benefits and burdens and of conflicting duties and rights, will take on greater importance because the concept of proportionality is one of the key principles underpinning the act. What is now good practice will, in some areas, become obligatory and decisions are likely to be open to far greater scrutiny. Whilst the outcomes of many cases will be the same, the way in which they are argued and decided will be different. There will be a steep learning curve and, until a body of case law develops, a lot of uncertainty but one thing is clear: doctors simply cannot afford to ignore the new legislation.

Confidentiality

The General Medical Council (GMC) has published new guidelines on confidentiality to replace those issued in October 1993. The new guidelines have been the subject of intense debate and controversy during their many months’ gestation. The basic principles have not changed: all patients are entitled to expect that information about them will be kept confidential, to be asked about its disclosure or use, and that confidentiality
published its report into controversial
In May 2000, the Gri
guidelines
New research
its guidelines if the Appeal Court
matter to the House of Lords. The
Department of Health may seek to take the
commercial company, but the Depart-
ment of Health, which advised
health data from pharmacists, and the
case between a commercial organis-
in UK law. There is an ongoing legal
interaction was how valid
consent could be obtained for the
involvement in research or innovative
treatment of vulnerable subjects, such
as young seriously ill children, when
parents were likely to be severely psy-
chologically or emotionally stressed.
The same point had been made
earlier in the year by the Royal
College of Paediatrics and Child
Health which published in January
2000 specific guidance on Safeguard-
ing Informed Parental Involvement in
Clinical Research involving Newborn
Babies and Infants. (The college sub-
sequently also issued its revised gen-
eral Guidelines on the Ethical Conduct
of Medical Research involving Children.)
In July 2000, the Department of
Health announced that it would be
establishing a group to look at some
aspects of Griffith's recommenda-
tions, namely the need for guidance
about the use of covert video surveil-
ance in the care of children. The
Royal College of Psychiatrists has also
prepared new Guidelines for Research-
ers and for Ethics Committees on Psychi-
atric Research Involving Human Par-
icipants (in press).

New research guidelines
In May 2000, the Griffiths Inquiry
published its report into controversial
research carried out at North Staf-
fordshire Hospital. The inquiry con-
sidered the use of two procedures
involving babies and children: con-
tinuous negative extrathoracic pres-
sure as a technique for respiratory
support and the use of covert video
surveillance to detect Munchausen
syndrome by proxy in carers. Consid-
ering the research framework within
which the procedures had been car-
rried out, the inquiry concluded that
"considerable clarification is now
urgently required of the roles and
accountabilities of the different bod-
ies involved in research and its
management—in short, a framework
of research governance". A central
concern of the inquiry was how valid
consent could be obtained for the
involvement in research or innovative
treatment of vulnerable subjects, such
as young seriously ill children, when
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Helsinki Declaration
The World Medical Association's
(WMA) consultation is progressing on
the Declaration of Helsinki, which
provides international guidance on
research on humans. The latest draft
removes references to a distinction
between "therapeutic" and "non-
therapeutic" research and provides a
glossary of terms to avoid ambiguity
about what is intended by frequently
used words such as "benefit" and
"risk". A final revised text will be sub-
mitted for agreement at the WMA's
October meeting in Edinburgh.

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