THE UK HUMAN RIGHTS ACT 1998: IMPLICATIONS FOR NURSES

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In this article we consider some of the implications of the UK Human Rights Act 1998 for nurses in practice. The Act has implications for all aspects of social life in Britain, particularly for health care. We provide an introduction to the discourse of rights in health care and discuss some aspects of four articles from the Act. The reciprocal relationship between rights and obligations prompted us to consider also the relationship between guidelines in the United Kingdom Central Council's *Code of professional conduct* and the requirements of the Human Rights Act 1998. We conclude with the recommendation that the new legislation should be welcomed for its potential to support good practice and to urge critical and reflective practice rather than as yet another burdensome bureaucratic imposition.

Introduction

The Human Rights Act 1998, which came into effect on 2 October 2000, has been hailed by some as the most significant legal development since the Magna Carta. In contrast to the situation in other jurisdictions such as the USA and Ireland, nursing practice in the UK has not so far been supported by specific human rights legislation. The Human Rights Act 1998 has the effect that English courts will be able to take direct note of the application of the European Convention on Human Rights' (full title: Convention for the Protection of Human Rights and Fundamental Freedoms; see below, page 273) and of the interpretation of the Convention that has been made in the English courts. The potential of the Act for nurses is obvious. Patients may become more assertive of their rights in a whole range of areas. Where such rights are perceived to have been denied or curtailed then this may result in litigation. Nurses may find that they have new legal obligations. At the same time, they may also have new rights themselves, for example, broader rights in the context of conscientious objection. In this article we consider the scope and effect of the Human Rights Act 1998. We discuss the impact that the Act may have upon nursing practice with reference to a number of articles, namely article 2 (Right to life), article 8 (Right to respect for private

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and family life), article 9 (Freedom of thought, conscience and religion) and article 10 (Freedom of expression). We will also consider how the Act relates to the obligations specified in the current (United Kingdom Central Council) *Code of professional conduct*.[2]

Rights

The importance of rights in health care has been the subject of much debate in recent years: is there a 'right to health' and/or a 'right to health care', for example? Health care rights have been recognized through initiatives such as the Patient's Charter. Although the latter may have raised staff awareness of the rights and needs of patients,[3] it is not directly enforceable in the courts.

Rights can be defined as claims or entitlements that deserve respect. Distinctions are made between legal and moral rights; and between negative and positive rights. A legal right is defined as a claim 'justified by legal principles and rules' and a moral right as a claim 'justified by moral principles and rules'.[4] When a legal right is violated, an individual can seek compensation in the courts. There is overlap between these categories and more moral rights are claimed than can be legally supported. A distinction is also made between rights that demand or require noninterference or restrain others from inflicting harm (negative right) and those that demand or require that others furnish the right-holder with some good or service (positive right). The Act sets out our legal rights and contains both negative and positive nights.

The relationship between rights and obligations requires some mention. The correlativity thesis, for example, states that there is a reciprocal relationship between rights and obligations. Cooney[5] claims 'that for every right of an individual or group, there exists a corresponding duty on the part of others to respect that right'. If a person has a right not to be harassed, others have a duty to refrain from harassing this person (negative right). For those who claim a right to education, others (the Government in this case) has a duty to provide that good (positive right).

It is in the interest of registered nurses, including those who function at a higher level, to consider how the rights in the new Act may be translated into obligations. UKCC guidelines, such as the *Code of professional conduct*,[3] which inform nursing practice, outline nurses' obligations without reference to patients' rights. The Patient's Charter[6] outlines patients' rights and expectations without explicit reference to professionals' obligations. In both cases it may be said that the correlative rights and obligations are implied. Neither document discusses nurses' rights or patients' obligations.

It has been argued that human rights are universal; everybody has them. They are not rights that someone acquires by doing certain work, enacting a certain role, or discharging certain duties; they belong to people simply because they are human beings.[7] Controversy exists about the status of human rights: Which rights are foundational? Which rights are implied? This is relevant to the articles in the new Act. Human rights are generally subdivided into two categories: civil and political rights, which include the right to life, security and liberty and the right not to be tortured; and economic, social and cultural rights,[8] which include claims

to education, health, food and access to benefits of scientific progress. These two categories are present in the new Act.

Background to the Human Rights Act 1998

The Human Rights Act 1998 is the first comprehensive bill of rights to be enacted in the UK. It incorporates rights contained in the European Convention of Human Rights[1] into English law. Individuals have already been able to bring claims directly to the European Court of Human Rights in Strasbourg, but this is a protracted process. Bringing such a claim can take several years and, ultimately, although the UK Government might decide to act upon the findings of the Court, this has not invariably been the case. In contrast, from October 2000, when an English court is determining a matter 'in connection with' a right under the Convention, then it must, as far as is applicable, take account of Strasbourg case law (section 2, Human Rights Act 1998). All primary and secondary legislation must be construed consistently with the Act. When legislation is inconsistent, the court may disapply subordinate legislation. This applies as long as the legislation does not expressly debar this. What the court cannot do is strike down primary legislation, that is, in effect act as a 'supreme court' in that situation. The sovereignty of Parliament, as expressed through statute, ultimately prevails. Certain courts, such as the House of Lords, the High Court and county courts have the power to make what is called a 'declaration of incompatibility' (section 4, Human Rights Act 1998). As a consequence of such a declaration of incompatibility, a government minister may make a 'remedial order' in relation to a particular piece of legislation which may also lead to remedial action in a particular case, although this is not automatic. There is also a new right of action provided against a public body acting in a public capacity, such as a National Health Service (NHS) body that acts in a manner that is incompatible with a right under the European Convention of Human Rights.

Relationship between law and codes

In everyday decision making, nurses in practice can derive guidance from a number of sources, which include UKCC guidelines, government policy, research findings, the law, ethical theory and, indeed, experience. All registered nurses are obliged to follow the guidelines in the UKCC *Code of professional conduct*[2] and in documents such as *Guidelines for professional practice*[9] and the *Scope of professional practice*.[10] The boundaries of professional practice continue to change and nurses are undertaking an increasingly wide range of clinical activities. It is estimated in *The NHS Plan*,[11] for example, that, by the year 2001, 23 000 nurses will have 'the right to prescribe a limited range of medicines'. Those who work at an advanced level can obtain additional guidance from the UKCC regarding a higher level of practice.[12]

The usefulness or otherwise of professional codes has long been debated.[13] It can be said that professional codes set out the behavioural and ethical aspirations of a particular professional group. As professionals have to work within the law,

a code should not contradict the law if, indeed, the law is deemed just. It has been pointed out that 'morality is not reducible to law'[14] and that 'finding out what the law permits or requires is not necessarily to find out what is morally right'. In the case of codes it may be that their requirements are more demanding than legal requirements. If it is agreed that the UKCC *Code of professional conduct*[2] is an assertion of the ethics of the profession, it is clear that it requires more from professionals than English law. For example, nurses do not have a legal duty to stop and give care to a person injured in a road traffic accident but they do have a professional (and it might be said moral) duty because the *Code* places a professional duty upon them at all times.[9]

Professional codes should at least be compatible with the law. Rights theory straddles the discourses of moral and legal philosophy. The UKCC is currently undergoing radical change, so it seems timely and appropriate to discuss the implications of legislative, professional and policy change for existing professional guidelines. A review of the 1992 *Code* in the light of the new legislation (and also in relation to *The NHS Plan*[11] proposing, for example, a new patient advocacy service) seems appropriate. Although it may not be necessary or even desirable that the ethical underpinning of a new code is solely based on rights and obligations, it *is* necessary that the profession considers and discusses the implications of the Act. It is interesting that the consultation document *Modernising regulation*[15] does not discuss a review of the Code.

Article 2: the right to life

> 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.

This is a foundational human right. The implications of this article for health care practice are many, most notably at the beginning and end of life. The question of abortion and the availability of contraceptive services come immediately to mind. Nurses who work in these areas may have some concerns that this right compromises their work. Although it is important that nurses reflect on and discuss what the right to life involves (for example, questions of sanctity of life, quality of life and the principle of double effect), it is not the case that this right is absolute, wiping out existing legislation and requiring nurses to engage in aggressive interventions or, indeed, to withhold interventions against a patient's wishes or best interests. Litigation on this topic, while inevitable, may in practice not lead to any fundamental legal change. There have already been challenges taken to the European Court of Human Rights in relation to the provisions of the Abortion Act 1967 in *Paton* v. *UK*.[16] These did not lead to any fundamental change to our legal position. Indeed in many respects it could be argued that this issue was itself sidestepped in the courts.

Nurses caring for patients in all areas of practice should be aware that there are also likely to be a considerable number of challenges in relation to a decision to withdraw or withhold treatment from patients who are regarded as being at the end of life. Such actions were heard in the very first week that the Act was in force. The whole question of the relationship between act and omission in

English law and the failure of English law to recognize active euthanasia is inevitably going to come under renewed scrutiny. Whether this leads to a fundamental alteration to the fabric of English law may be questioned. Such cases frequently have implications that are far broader than any individual case before the courts. It should be noted that in the landmark case of *Airedale NHS Trust* v. *Bland*[17] concerning the withdrawal of artificial nutrition and hydration from the young man Tony Bland, the English courts emphasized first that this was very much a one-off decision and that future decisions of this type would require judicial consideration. Secondly, while commenting on the fact that English law sanctioned the withdrawal of treatment while not sanctioning active euthanasia, they stated that these were matters for Parliament and not for the courts. The Human Rights Act 1998 does not make the House of Lords into a supreme court. The House cannot override legislation. The courts may make a declaration of incompatibility but this is as far as they can go. To expect that the courts will enact radical change on such fundamental issues may thus be considerably premature.

Nonetheless, the Human Rights Act 1998 requires that nurses reflect on their practice, considering the implications of a right to life and ensuring that their practice is safe and evidence based as far as possible, and that patients' welfare and autonomy are paramount. This is particularly important for specialist nurses as they expand their practice to achieve a balance between innovation and patient safety.[18] Unlike the Irish nursing code,[19] which states that 'the nurse must at all times maintain the principle that every effort should be made to preserve human life, both born and unborn', the UKCC *Code of Professional Conduct*[2] does not state explicitly that nurses have an obligation to preserve life. Rather, it states that they have an obligation to 'safeguard and promote the interests of individual patients and clients', to ensure that patients or clients are not harmed, and to attempt to remedy any situation in which patients' welfare is jeopardized.

Rights to life and resources

The right to life is also likely to be used in challenges regarding the limited expenditure on NHS resources. An attempt was made to use rights in such a way in the context of the 'Child B' case in 1995. B was a 10-year-old child who suffered from leukaemia. Treatment was undertaken involving chemotherapy and a bone marrow transplant, which was initially successful; however, the condition recurred. Cambridgeshire Health Authority refused to authorize a further course of treatment. Doctors stated that a third course of chemotherapy and a further transplant would not be in the child's best interests. It was noted that the overall success rate of the procedure was 1–4%. The child's father sought to challenge in the courts the decision to refuse treatment.[20] At first, in the High Court, Judge Laws said that, in determining whether to give treatment, the Health Authority must act reasonably and, in making the decision, the Authority should have regard to all relevant considerations. In this case, he said, the Health Authority had not taken into consideration the views of B's family. He commented that in a situation where, as here, a patient was at risk of death, the Health Authority had to explain why it had decided not to fund the treatment.

However, his judgement was overturned in the Court of Appeal. Sir Thomas Bingham, the Master of the Rolls, held that, although the Finance Director of the Health Authority had not spoken directly to the family, he had noted the family's interests. Difficult issues concerning resource allocation had to be weighed in the balance. He stated that:

> 'Difficult and agonising judgements had to be made as to how a limited budget could best be allocated for the maximum advantage of the maximum number of patients. That was not a judgement for the court'.[20]

Bingham held that, in reaching their decision, the Health Authority had weighed up the various factors and had not acted unreasonably. Relevant factors were that the treatment was untested and that it could almost be regarded as being experimental in its nature because the success rate was only 1–4%. In addition, the Court noted the fact that there were potentially debilitating side-effects. Overall, the decision of the health authority was not considered to be unreasonable.

With the coming into force of the 1998 Act, the English courts are almost certain to be asked to consider a whole raft of cases concerning treatments that have been restricted because it has been argued that resources are finite and the demand is potentially infinite for new technologies such as assisted reproduction, and for drugs considered to be expensive, such as resperidone (treatment of schizophrenia), aricept (treatment of Alzheimer's disease), and beta interferon (treatment of multiple sclerosis). Whether this makes a radical difference in practice can be questioned. Such resource issues have implications in many situations beyond individual cases. It is unlikely that the House of Lords will enter into what is in effect the prioritization of health care resources.

It can be argued that nurses are and should continue to be involved in resource allocation decisions at micro and macro levels. The UKCC highlights the role of nurses as patient advocates and their obligation to 'act in such a manner as to promote and safeguard the interests and well-being of patients and clients'.[2] It seems justifiable for nurses to provide patients with research-based information about best treatments for their particular condition, but a dilemma may arise when these treatments are deemed to be too expensive by a health authority. Specialist nurses who are in a position to prescribe drugs may be similarly constrained by resources. The UKCC also requires that nurses make their concerns known, should they be 'unable to provide good care because of a lack of adequate resources'.[9] Knowing that patients now have a legally enshrined right to life, as well as having to consider other statements of the right to health care based on need,[11] may provide an additional impetus for action. An awareness of such legislation can alert nurses to practices or policies that may be discriminatory, for example those that penalize vulnerable groups such as older people and those with mental illness. Reconciling the rights and needs of an individual with a group can also be challenging.

Conflicting rights

Article 8 of the Act is entitled 'Right to respect for private and family life' and states:

> 1 Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2 There shall be no interference by a public authority with the exercise of this right except 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.

Article 10 is entitled 'Freedom of expression' and reads:

> 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.
>
> 2 The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary'.

Another challenge is how the courts will deal with the question of conflicting rights and, indeed, whether or not rights can be effectively ranked. An example is the case of the English nurse Graham Pink. Pink was a night charge nurse who 'blew the whistle' on what he regarded as unacceptable care of elderly patients in a Stockport hospital.[21] It was alleged that Pink's disclosures had breached confidentiality. Confidentiality may be regarded as being safeguarded by article 8 of the European Convention: the right to privacy. The first point to note is that such rights are not absolute in nature themselves and indeed article 8 is subject to a caveat sanctioning limitations. Secondly, article 8 may in such a situation be regarded as being in conflict with another right, namely that of article 10 of the Convention, which recognizes the right to free speech. Someone like Pink could today argue that, even if article 8 may have been infringed (this is arguable because the disclosure may still be legitimate because it fell within the scope of article 8's exceptions), it is possible that disclosure was still justifiable because it fell within the right to freedom of expression, which has long been recognized as one of the most powerful of all human rights. Such tensions between rights are matters that will undoubtedly be the subject of judicial determination under the new rights jurisprudence. Article 3 ('No one shall be subjected to torture or degrading treatment or punishment') clearly also has relevance in this case.

In the Pink case, such conflicts also arose in relation to the UKCC *Code of Professional Conduct*.[2] Although Pink was exonerated, winning a case for wrongful dismissal, it can be said that similar cases result in a conflict of clauses in the *Code*. Clause 10 states that nurses must 'protect all confidential information concerning patients and clients' and clauses 11 to 13 state that nurses must report circumstances that are detrimental to patients and staff. As with article 8 of the Convention, clause 10 of the Code provides possible exceptions to the rule of confidentiality. Breaching confidentiality to remedy bad practice can be 'in the wider public interest'. Considering and discussing possible conflicts arising from the Human Rights Act 1998 and the UKCC *Code of Professional Practice*[2] is an impor-

tant part of reflective practice. Since the Pink case, legislation has been passed (Public Interest Disclosure Act 1998), providing some protection for those who draw attention to bad practice. However the question of conflicts of disclosure in the context of professional codes remains to be considered.

Rights and faith

Challenges are likely to arise in the context of claims surrounding faith and belief in relation to article 9 concerning 'Freedom of thought, conscience and religion'. This article states:

> 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 and in private, to manifest his religion or belief, in worship, teaching, practice and observance.
>
> 2 Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

At present the law recognizes faith choices. For example, competent adults may refuse treatment for themselves on 'faith' grounds even if the consequence of that refusal is that they will almost certainly die. However, in contrast are the cases of treatment decisions made by parents on behalf of their children that have not been upheld by the courts, for example, in *Re C* (a minor).[22] C was 16 months old and suffering from spinal muscular atrophy. The child was in what was known as a 'no-chance' condition according to the Royal College of Paediatricians guidelines. However, the child was conscious and was able to recognize the parents and smile. The child's parents, who were orthodox Jews, believed that life should be preserved. It was proposed to remove her from the ventilator. If she suffered a further relapse she would be left to die. Although the parents supported the decision to see if the child could survive without a ventilator, they wanted her to be re-attached to it if she relapsed. The courts indicated that observing the request made by the parents meant that doctors would have been compelled to undertake a course of treatment. They refused to compel the doctors to treat the child in the face of clinical opposition to such an approach. Similarly, in a case concerning conjointed twins born in Manchester in the summer of 2000, the Court of Appeal sanctioned surgery to separate them; the effect of this surgery was that one twin inevitably died.[23] The parents, committed Roman Catholics, were initially opposed to the operation being undertaken.

Such cases can place nurses in a very difficult position. Children's welfare is paramount and nurses are required to advocate on behalf of a child. In the case of 'Mary' and 'Jodie', the conjointed twins, difficulties were compounded by the fact that the infants had competing interests. When it is unclear what is in the best interest of the child and when there is a lack of consensus between parents and professionals, then the courts may have to decide. Decisions in such cases are never easy. In addition to the question of whether or not to adhere to article 9, othe case of *Re C* involved consideration of article 3 ('No one shall be subjected

to torture or degrading treatment or punishment') and necessitated a consideration of article 2. In the case of the conjoined twins there was the agonizing reality for the parents and professionals that saving one of the twins would inevitably lead to the death of the other.

The scope of conscientious objection by health care professionals requires reconsideration because the Human Rights Act 1998 could prompt nurses to opt out of more procedures than are currently supported by law. At present, there are only two situations in which there are statutory rights provided for conscientious objection: in relation to abortion (under section 4 of the Abortion Act 1967) and in relation to new reproductive technologies (under section 38 of the Human Fertilisation and Embryology Act 1990). What of those nurses who object to being involved in removing patients' nutrition or hydration, or taking them off a ventilator? Such issues have arisen in the Irish Republic after court decisions sanctioning treatment withdrawal. This has not yet, it appears, become an active issue in the UK, but if procedures of this nature become more common, it may well do. It may also arise in the context of specialist nurses who are in a position to prescribe and who object to providing emergency contraception, or psychiatric nurses who have reservations about electro-convulsive therapy. Clause 8 of the UKCC Code[2] states that nurses should report 'at the earliest possible time, any conscientious objection which may be relevant to [their] professional practice'. The *Guidelines for professional practice* specify the legal position and go on to point out that nurses do not 'have the right to refuse to take part in emergency treatment' or to refuse to 'be involved in the care of patients because of their condition or behaviour [which] is unacceptable'.[9]

Privacy and confidentiality

Article 8 makes provision for respect for the privacy of home and family life. This is widely regarded as legitimizing protection of the confidentiality of personal health information. Although the ethic of confidentiality is well recognized in clinical practice, its boundaries have long been uncertain. The need to safeguard electronic records was noted in the *Report on the review of patient-identifiable information* (the Calidicott Report),[24] and some statutory protection is afforded by the Data Protection Act 1998. However, there are a myriad of uncertain issues yet to be resolved.

The scope, nature and control of genetic information,[25] the availability of such information to employers and/or insurers, and the need for specific legal protection has been discussed at some length in recent years and comes under the remit of article 8. This is also linked to the need to avoid patient discrimination. At present, genetic conditions are not safeguarded under the Disability Discrimination Act 1995 until these conditions become manifest. These issues are particularly pertinent for those nurses who work as specialists in the field of genetics. As genetic counsellors they will need to be aware of what the law allows and disallows regarding the transfer of genetic information.

Conclusions

Much of what is claimed by the Human Rights Act 1998 has parallels with the obligations contained in the clauses of the UKCC *Code of professional practice*.[2] However, given this legislative change in the UK and other policy initiatives, it seems timely for UK nursing to review the Code. The profession needs to continue to reflect on and review its position on the ethical and legal aspects of such issues as the continuation and discontinuation of treatment, resource allocation, conscientious objection and conflicts regarding disclosure of information and freedom of thought.

We agree that human rights discourse is increasingly likely to form part of jurisprudence and to become a key part of the ethics, law and social policy curricula of preregistration and postregistration nurse education programmes. It is also likely to permeate clinical practice and health care policy. There is a danger that rights may be seen as yet another burdensome bureaucratic imposition and yet another legal consideration for nurses to bear in mind, as yet more responsibilities with the consequent fear of litigation. A more hopeful scenario, however, is that consideration of rights is something that is supportive of good practice and will form part of critical reflective nursing practice, with nurses working in partnership with patients and colleagues to maximize the efficacy and quality of health care. The advent of a human rights culture in English law should be welcomed for its potential rather than feared for the prospect of pitfalls.

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