

# Article 3 of the Human Rights Act 1998: implications for clinical practice

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**Abstract** The Human Rights Act 1998 was introduced into UK law in 2000. It must be considered in all clinical cases, including mental health review tribunals. The number of mental health cases brought to the European Court of Human Rights that breach Article 3 has been very few. However, Article 3 will need to be considered in the clinical setting in complaints arising from conditions of detention, seclusion, control and restraint. This article analyses the case law, illustrating its evolution and also demonstrating the fundamental and core concepts that underpin the Act that can be used in clinical practice.

The widespread use of torture has been documented for at least 2000 years (Mannix, 2003). Early Greek and Roman laws specified that only slaves could be tortured, but later they allowed the torture of free-men in cases of treason. In Roman law the right to torture slaves was abolished in AD 240. In the Middle Ages, torture was included in the proceedings of the Catholic Church in the 'Spanish Inquisition', which employed it to obtain confessions. In Elizabethan times 'torture warrants' were legally issued (Langbein, 1977). Examination by torture was last used in England in 1640 (see *A and others (Appellants) v. Secretary of State for the Home Department* [2004]: para. 412). 'Judicial torture' was abolished by way of the Treason Act 1709: this was the first formal abolition of torture in any European state. In a review of the history of secret torture and torture training by the US Central Intelligence Agency (CIA), McCoy (2006) describes how CIA-funded experiments on psychiatric patients and prisoners in the 1950s developed into 'no-touch torture' based primarily on sensory deprivation. For over two centuries, from Enlightenment philosophers such as the Marquis of Beccaria-Bonesana (Bonesana, 1764) and Voltaire (1764) to modern-day Amnesty International, there have been sustained campaigns against state-sponsored torture, culminating in the United Nation's 1984 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (ratified by the UK in 1988).

## The Human Rights Act 1998

The Human Rights Act 1998 came into force in the UK in October 2000. It incorporates into domestic

law most of the European Convention on Human Rights. It is now UK statute enforceable by UK courts (including mental health review tribunals) and sets out fundamental rights that all people are entitled to enjoy.

All public authorities have a statutory duty to act compatibly with the European Convention on Human Rights (and hence the Human Rights Act). The National Health Service (NHS) is a public authority and therefore NHS practices, trusts and health authorities come under the Human Rights Act. Domestic courts are obliged to interpret all laws consistently with the Act. If this proves impossible, a judge can make a declaration of incompatibility which needs to be remedied by the offending state.

Article 3 of the Human Rights Act is the only absolute European Convention right (other articles are 'limited' or 'qualified') and it states that:

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

Although Article 3 is an absolute right, allowing no derogations, it can be interpreted in various ways. Whether an act constitutes inhuman or degrading treatment depends on a range of factors and the individual circumstances of each case. In psychiatric practice Article 3 is most likely to be relevant to complaints arising from the conditions of detention, seclusion, control and restraint.

The following cases demonstrate how case law has evolved in relation to Article 3 and issues of psychiatric treatment. They also help to illustrate core judicial and clinical (Box 1) concepts of the Human Rights Act, to which I return later.

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## European Court of Human Rights and domestic case law

### *Ireland v. The United Kingdom [1978]*

In an effort to combat the escalating terrorist threat in Northern Ireland between 1971 and 1975 the UK government implemented extrajudicial powers of arrest, detention and (unlimited) internment. Those being held underwent interrogation involving a combination of five particular techniques – wall-standing, hooding, subjection to white noise, deprivation of sleep and deprivation of food and drink. The European Court of Human Rights ruled unanimously that the five techniques constituted an inhuman and degrading treatment and practice of torture which violated Article 3.

This case is very important in that the judgment emphasised that ‘ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3’, i.e. it sets a threshold. It further adds that ‘... assessment of this minimum is, in the nature of things, relative; it depends on the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim, etc.’ (*Ireland v. The United Kingdom [1978]*).

### *Herczegfalvy v. Austria [1992]*

Mr Herczegfalvy was a Hungarian citizen living in Austria. He served two prison sentences in succession from 1972 to 1977 for assaults on his wife, public officials and customers of his television repair business. While in prison he underwent several psychiatric assessments and carried out physical assaults on prison warders and fellow prisoners. At this time he was diagnosed with the mental disorder *paranoia querulans* and deemed not responsible for his acts.

Following a month-long assessment in the Vienna psychiatric hospital he was returned to prison. As a protest against his detention he began a hunger strike and 4 weeks later collapsed needing intensive medical care. On his return to the psychiatric hospital he was in an extremely weak state and he was forced pursuant to Austrian hospital law. He refused all medical treatment and was given intramuscular sedation against his will. At this time he was attached to a security bed, ‘the net and straps of which he succeeded in cutting through’. He again went on hunger strike, which caused further deterioration in his physical and mental state and because of this he was sedated to bring about a state of ‘somnolence’ so that it was possible to treat him with ‘perfusions’. He continued to decline physically and was transferred to an intensive care unit. After 2 weeks he was returned

#### Box 1 The Human Rights Act: concepts for clinical practice

*Capacity* Patients with and without capacity remain under the protection of Article 3. Current jurisprudence suggests that capacity is not crucial when making decisions that may engage Article 3 as long as medical necessity is convincingly demonstrated.

*Degrading treatment* Treatment in which the object is to humiliate and/or debase the patient, which could adversely affect their personality. Treatment that arouses feelings of fear, anguish, inferiority and/or that shows lack of respect for or diminishes the patient’s dignity may be considered degrading.

*Inhuman treatment* Treatment could be construed as inhuman if it causes intense physical or mental suffering in the patient.

*Level of suffering* Inhuman or degrading treatment must go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment such as force-feeding or electroconvulsive therapy.

*Margin of appreciation* Domestic states have different accepted clinical practices and standards; the margin of appreciation is accepted as being very wide to reflect this. Consequently, clinical decisions that are proportional, therapeutically necessary and in keeping with accepted clinical practice are very unlikely to be outside this margin.

*Medical care* Authorities are obliged to provide adequate and requisite medical care. A delay in providing care may engage Article 3. Good documentation in medical notes is vital both clinically and legally.

*Proportionality* Clinical intervention needs to balance the severity of the effect of the intervention with the severity of the presenting clinical problem, i.e. be a proportionate response to a clinical scenario.

*Threshold of severity to engage Article 3* Ill-treatment must attain a minimum level of severity; assessment of this minimum is relative. All circumstances of the case need to be considered.

*Therapeutic necessity* A treatment or intervention that is convincingly shown to be a therapeutic or medical necessity in general will not be regarded as inhuman or degrading.

*Torture* The willful (criminal) infliction of severe physical or mental pain as a punishment or a forcible means of persuasion.

to the psychiatric hospital. He was handcuffed and a belt was placed about his ankles because of the continued risk of aggression (physical resistance to previous forced administrations of antipsychotics had resulted in injuries to him, including loss of teeth, broken ribs and bruises). He remained in these restraints for 15 days, although they were regularly changed. Throughout this period he continued his hunger strike but was force-fed. His behaviour settled and he consented to being fed in this way twice weekly. Over the ensuing months his behaviour improved and he ceased his hunger strike following a discussion with a doctor, who explained that it was endangering his life.

Mr Herczegfalvy subsequently took the Austrian government to the European Court of Human Rights, alleging that violent and excessively prolonged measures were used to treat, in violation of Article 3 of the Human Rights Act. He also argued that these measures contributed to the worsening of his condition. The government responded that the measures had been necessary, because of Mr Herczegfalvy's behaviour, his lack of capacity at the time and his refusal of urgent medical treatment, and that their sole aim had always been therapeutic.

The judgment noted,

'...the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is necessary for the medical authorities to decide, on the basis of the recognised rules of medical science, 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... such patients nevertheless remain under the protection of Article 3' (*Herczegfalvy v. Austria* [1992]).

The judgment further opined that 'the established principles of medicine are admittedly decisive in such cases' but concluded, 'as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading' and the Court must satisfy itself that such medical necessity has been convincingly shown to exist.

Although the length of time in restraints was 'worrying', the Court accepted that according to psychiatric principles generally accepted at the time, medical necessity justified the treatment at issue and hence there had been no violation of Article 3.

### ***Kudla v. Poland* [2000]**

In 1991 the applicant was charged with fraud and forgery and detained on remand. During the detention he suffered from depression, twice tried to take his own life and also went on hunger strike. He complained that while on remand he had not

been given adequate psychiatric treatment, which was contrary to Article 3.

The complaint was rejected by the European Court of Human Rights on the grounds that Article 3 requires proof of severe ill treatment and that failure to alleviate chronic depression, even where authorities are aware of the vulnerability of the individual in question, cannot amount to inhuman or degrading treatment. The Court said that inhuman or degrading treatment must 'go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment' to be deemed a violation of Article 3.

### ***Keenan v. UK* [2001]**

While serving a prison sentence for assault, Mr Keenan, who was known to have paranoid schizophrenia and a personality disorder, took his own life. During his detention he showed episodes of disturbed behaviour involving the demonstration of suicidal tendencies, possible paranoid-type fears, and aggressive and violent outbursts. Despite being monitored by the prison doctor he had found the means to hang himself. A complaint was lodged with the European Court of Human Rights by the mother of the deceased for violation of Article 3. It was submitted in the complaint that,

'while segregation of persons in detention did not in itself breach Article 3..., the State had to examine carefully whether the personality of a prisoner and his mental vulnerability might cause otherwise justifiable treatment to bring about suffering and a breakdown of physical and mental resistance'.

The Court recalled that 'ill-treatment must attain a minimum level of severity' to fall within the scope of Article 3 and that such assessment of this minimum is relative and depends on 'all circumstances of the case' (*Keenan v. UK* [2001]).

In considering the issue of whether a punishment or treatment is 'degrading' within the meaning of Article 3, the Court noted that it would also have to take into account whether its object 'is to humiliate and debase the person concerned and whether, as far as the consequences are concerned, it adversely affected his or her personality in a manner incompatible with Article 3'. The Court cited *Ireland v. The United Kingdom* [1978], where 'degrading' is described as,

'involving treatment such as to arouse feelings of fear, anguish and inferiority capable of humiliating or debasing the victim and possibly breaking their physical or moral resistance'.

The Court also noted that authorities are under an obligation to protect the health of persons deprived of liberty by providing requisite medical

care (see *Hurtado v. Switzerland* [1994] – during his arrest Mr Hurtado incurred various injuries which were not assessed for 6 days. Because ‘he was not given immediate medical treatment’ it was found that Article 3 had been violated). The Court specifically commented that in the case of mentally ill persons, the assessment of whether the treatment concerned is incompatible with Article 3 has to take into consideration ‘their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment’ (see *Herczegfalvy v. Austria* [1992]; *Aerts v. Belgium* [1998]).

The Court was ‘struck by the lack of medical notes’ about the monitoring of the deceased prisoner and evidence that he had received insufficient psychiatric assessment. There were no entries in his medical notes for the 10 days prior to his death and the Court did not accept ‘that an absence of notes indicates there was nothing to record’ (see also *Khudobin v. Russia* [2006], where poor documentation was criticised especially for illegible writing and no information relating to treatment plans).

The Court ruled that this treatment of a mentally ill person was not compatible with the standard required to avoid a violation of Article 3. It was found that Mr Keenan had been subjected to inhuman treatment and hence a violation of Article 3, for which the Court ordered £10 000 damages.

### *Pretty v. UK [2002]*

The European Court of Human Rights has further clarified and defined inhuman and degrading treatment following the case involving Diane Pretty, a woman with terminal motor neurone disease, who claimed that the refusal of the Director of Public Prosecutions to grant immunity from prosecution to her husband if he assisted her in taking her own life and the prohibition of assisted suicide in domestic law infringed various rights, including Article 3.

The Court dismissed the case, stating in its judgment,

‘case-law refers to “ill-treatment” that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering. Where treatment humiliates or debases an individual, showing lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual’s moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3. The suffering that naturally flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible’ (*Pretty v. UK* [2002]).

### *McGlinchey v. UK [2003]*

In this case it was found that medical treatment of a heroin addict in prison was inadequate and of sufficient severity for her to suffer inhuman and degrading treatment. It was held that the prison had not provided the requisite healthcare and had breached Article 3.

Ms McGlinchey, who had chronic heroin addiction and asthma, had been sentenced to 4 months in prison. On admission she developed severe opiate withdrawal symptoms, including repeated vomiting which led to dehydration and weight loss (assessed to be 20% in a week). A doctor advised nurses to monitor her symptoms. She deteriorated over a weekend but a doctor was not called to review nor was she transferred to hospital. On the Monday morning she collapsed and despite immediate admission to hospital she died.

The Court confirmed that the state has a duty to ensure that detainees are held in conditions compatible with respect for human dignity, which includes proper health provision and the necessary medical attention to secure their well-being. This echoes *Riviere v. France* (2006), *Holomiov v. Moldova* [2006] and *Tanko v. Finland* (1994), the last of which concluded that ‘a lack of proper care in a case where someone is suffering from a serious illness could in certain circumstances amount to treatment contrary to Article 3’.

### *Sentges v. Netherlands [2003]*

Although this case involved Article 8 (respect for private and family life, home and correspondence), it emphasises that there is no guarantee of a specific level of care, which may be influenced by lack of resources.

The applicant had Duchenne muscular dystrophy, a progressive degenerative muscle disease. The Dutch health authorities refused to fund an expensive robotic arm which would have enabled him to live at home for longer and with much greater autonomy. The applicant submitted that the refusal to be provided with a robotic arm infringed his Article 8 rights.

The complaint was rejected by the European Court of Human Rights, which noted that regard must be had to the fair balance that has to be struck between the competing interests of the individual and those of the community as a whole and to the wide margin of appreciation enjoyed by states in this respect in determining the steps to be taken to ensure compliance with the European Convention on Human Rights. This margin of appreciation is even wider when the issues involve an assessment of priorities in the context of the allocation of limited

state resources, i.e. there is no guarantee of a specific level of care, and lack of resources may influence this (see also *Matencio v. France* [2004]).

### ***R (on the application of A) ... [2000]***

This case, brought before the domestic courts, concerned the refusal of a health authority to allocate NHS funds to the treatment, including surgery, of transsexualism because of its policy not to do so in the absence of 'overriding clinical need' or other exceptional circumstances. The Court of Appeal commented 'It is plain ... that Article 3 was not designed for circumstances of this sort of case where the challenge is as to a health authority's allocation of finite funds between competing demands' (*R (on the application of A) v. North West Lancashire Health Authority* [2000]).

### ***Naumenko v. Ukraine [2004]***

This case is the modern-day 'Herczegfalvy'. The applicant was convicted of murder, attempted murder and rape. He was initially sentenced to death but this was later commuted to life imprisonment. Medical assessments identified psychopathy and suicidal tendencies, and the man made several attempts to hang himself while in prison. He was placed under psychiatric supervision and administered psychotropic medication both orally and by injection. He alleged that he was subjected to radiation from a 'psychoactive drugs generator', had received repeated beatings and had been handcuffed for days on end. Such treatment, he claimed, breached Article 3.

From the evidence of witnesses and the medical file it was clear that the applicant had serious mental disorder and had twice tried to hang himself. He had been put on medication to relieve his symptoms. The European Court of Human Rights saw no reason to question the dosages of medication administered or to suspect that he was given other substances. The Court therefore did not find sufficient evidence to establish beyond reasonable doubt that the applicant had been forced to take medication in contravention of Article 3.

With regard to the use of handcuffs the Court opined that the prison authorities had 'not restrained the applicant more than was necessary to calm him down and prevent him from using violence against himself and others' (*Naumenko v. Ukraine* [2004]). The measure could not therefore be termed inhuman or degrading.

The Court noted that it was regrettable that the applicant's medical file contained only general statements which made it difficult to assess whether he had consented to treatment. However,

the applicant had not produced sufficient detailed and credible evidence to show that, even without his consent, the authorities had acted wrongfully in making him take the medication.

### ***Nevmerzhitsky v. Ukraine [2005]***

Mr Nevmerzhitsky was a bank manager, arrested and subsequently convicted of a variety of forgery and fraud offences. During his time in detention he went on hunger strike on a number of occasions and was subjected to force-feeding.

Relying on Article 3, he applied to the European Court of Human Rights, complaining that he had been denied adequate medical treatment and that he had been force-fed (which included the use of handcuffs, a mouth-widener and a rubber tube inserted into the oesophagus) while on hunger strike. The Ukrainian government failed to produce a number of important documents concerning the applicant's health and decisions to force-feed him.

The crux of the case centred on the fact that the government had not provided a written medical report or evidence that it had followed a domestic decree setting out the procedure to be followed on force-feeding detainees. Because the government had not demonstrated that force-feeding was medically necessary, it could only be assumed that it was arbitrary and not in the applicant's best interests. The Court concluded that the force-feeding of the applicant without medical justification and against his will (i.e. he had capacity) constituted severe treatment above the minimum level and therefore warranting the characterisation of torture and in violation of Article 3.

### ***R (on the application of B) ... [2005]***

In the domestic case of *R (on the application of B) v. (1) Dr SS (Responsible Medical Officer, Broadmoor Hospital) (2) D G (Second Opinion Appointed Doctor) (3) Secretary of State for the Department of Health* [2005] it was found that neither Article 3 nor Article 8 entitled the patient to refuse compulsory medical treatment under section 58 of the Mental Health Act 1983 as (a) he lacked capacity to consent to treatment and (b) in any event his doctor had convincingly shown that treatment was a therapeutic necessity. This judgment suggests that the 'necessity' test for the non-consensual treatment of mental health patients is determined according to the views of the medical practitioners involved.

The applicant was detained in Broadmoor Hospital in the UK and diagnosed with bipolar affective disorder. He sought judicial review of the decision of his treating doctors to administer medication pursuant to their powers under the Mental Health

Act without his consent. Part IV of this Act empowers compulsory treatment of both capable and incapable detained patients. The applicant argued that this would breach his Article 3 and 8 rights.

The judgment reiterated that in order for Article 3 to be engaged a minimum level of severity has actually to be reached – it is not sufficient that it is capable of being reached. Once the level of severity is reached treatment can still be administered if it is convincingly shown that it is a therapeutic or medical necessity (the ‘Herzcegfalvy test’).

The judgment noted that a number of factors must be considered when determining whether a treatment is of sufficient severity to engage Article 3. These include the nature and context of the treatment, the manner in which it is administered, its duration, its physical and mental effects, and whether it is intended to humiliate or debase. Capacity is also a relevant factor. If treatment under the Mental Health Act is demonstrated as being therapeutically necessary it will not generally amount to a breach of Article 3 even when a patient has capacity.

Under section 63 of the Mental Health Act it is permissible to administer treatment without a patient’s consent even when they do have capacity (for a review of section 63 of the Mental Health Act and force-feeding see Curtice, 2002). Although the issue of capacity is a relevant factor, the judgment opined that whether or not a patient has capacity ‘does not carry significant weight’ because that difficult question is not the trigger or gateway to the decision-making process. The judgment felt that the correct approach is to take account of the wishes of the patient against the background of their understanding and appreciation of whether they are being forced to accept treatment. In this case it was found that the claimant was able to comprehend and retain the relevant information, but owing to lack of insight into his mental disorder he was unable to weigh and balance the information: he therefore lacked capacity to consent to treatment.

Where it is claimed that a particular medical treatment will violate Article 3, unless it can be convincingly shown that it is a medical or therapeutic necessity, the court must decide whether such necessity has been shown to the appropriate standard. It is, however, quite proper for the court to place appropriate weight on the opinions of the treating clinicians.

The standard of proof formulated in Article 3 as ‘convincingly shown’ is a high standard that lies between the two English standards of proof laid down in civil (‘the balance of probabilities’) and criminal law (‘beyond reasonable doubt’).

On the facts it was found that the claimant had lacked capacity. It was also found that there had been ‘sound and compelling reasons to conclude

the administration of the medication would be of considerable benefit’. It was therefore considered that the requirement of medical or therapeutic necessity had been met. It was found that Article 3 had not been engaged as the treatment had been unlikely to reach the required level of severity – it had been felt that the claimant would not suffer unduly from the administration of medication and, furthermore, that the object of administration of the medication had not been to humiliate or debase. Treatment was found also to have been justified under Article 8(2) and in the best interests of the claimant.

The judgment in this case does not consider capacity to be crucial when making decisions about the engagement of Article 3. It also implies that far more weight will be placed on the opinions of the treating clinicians about the necessity of the treatment than on the fact that a person with capacity has refused it (see also *R (on the application of Wilkinson) v. (1) The RMO Broadmoor Hospital, (2) The Mental Health Act Commission Second Opinion Appointed Doctor & Secretary of State for Health* [2001], where ‘... the decision to impose treatment without consent upon a protesting patient is a potential for invasion of his rights under Article 3 or 8’ and the role of the courts should be to undertake a ‘full merits review’ of the appropriateness of the treatment, including cross-examination of the doctors involved).

## The Human Rights Act 1998: key concepts

### *Obligation of states to comply with judgments*

The European Court of Human Rights notes that domestic states ‘undertake to abide by the final judgment of the Court in any case to which they are parties’. This undertaking entails precise obligations for respondent states (although, contrary to popular belief, a declaration of incompatibility with the European Convention on Human Rights has no legal effect and does not actually bind Parliament or other European state authorities). Since the Human Rights Act came into force, the courts in the UK have made only 20 declarations of incompatibility, of which 6 were overturned on appeal to the Court of Appeal or the House of Lords (Department for Constitutional Affairs, 2006).

A first obligation is the ‘payment of just satisfaction’, which is normally a sum of money that is clearly defined in the judgment. Sometimes the adverse consequences of the violation are not always adequately remedied by this payment. The execution of the judgment may also require the respondent state to take ‘individual measures’ (e.g.

the re-opening of unfair proceedings) or 'general measures' (e.g. a review of legislation or judicial practice, to prevent new and similar violations).

### Margin of appreciation

The doctrine of a margin of appreciation in the application of the Human Rights Act enables domestic states to have a degree of discretion in setting the boundaries of rights of individuals and obligations of states.

This doctrine was expounded in *Handyside v. UK* [1976], where it was eloquently stated that:

'...it is not possible to find in the domestic law of the various Contracting States a uniform European conception of morals. The view taken by their respective laws of the requirements of morals varies from time to time and from place to place, especially in our era which is characterised by a rapid and far-reaching evolution of opinions on the subject',

but that this margin of appreciation was not unlimited and the

'domestic margin of appreciation thus goes hand in hand with a European supervision. Such supervision concerns both the aim of the measure challenged and its "necessity"'.

### Necessity

If an interference with a Convention right is to be justifiable, it must be shown to be 'necessary in a democratic society'. This requirement protects against arbitrariness, including the excessive use of public powers. In *Handyside v. UK* [1976], the following features were said to be signifiers or core values of a democratic society: pluralism, toleration and broadmindedness. It was considered that 'necessity' lay somewhere between 'indispensable' and 'useful'. This definition was developed in *Olsson v. Sweden* [1988], where the European Court of Human Rights stated that 'the notion of necessity implies that an interference corresponds to a pressing social need and, in particular, that it is proportionate to the legitimate aim pursued'.

### Proportionality

Proportionality requires that interference with a Convention right by a public authority must be in accordance with law, must not be arbitrary or unfair, and must go no further than is necessary to 'meet a pressing social need'. The principle of proportionality requires that decision-makers considering an interference with a Convention right must balance the severity of the interference

with the intensity of the social need for action. In a complex clinical case this often requires choosing the least worst option. The state's measure or act must interfere with the right in question no more than is reasonably necessary to achieve the legitimate aim, i.e. public authorities must not use a 'sledgehammer to crack a nut'. Under the Human Rights Act, the domestic courts need to consider proportionality by looking with 'anxious scrutiny' at decisions that impinge on human rights. It is this concept of proportionality that provides the Act with its dynamism as a 'living instrument'.

### A living instrument

It is settled case law that the European Convention on Human Rights (and hence the Human Rights Act) is 'a living instrument which must be interpreted in light of present-day conditions' (*Tyrer v. United Kingdom* [1978]). So as society and attitudes change, the Convention will change and develop. Nevertheless, it will still tend to follow the precedents set by earlier cases; and where it does not it will make clear the reason for the departure.

### Clinical negligence

Case law suggests that a case of clinical negligence does not automatically translate into a violation (and hence financial recompense) under the Human Rights Act: 'Clinical negligence, no matter how gross, could not found a claim under Article 3' (Justice Scott Baker, in *R (Howard) v. Health Secretary* [2002]). This suggests that victims of clinical negligence are unlikely to successfully pursue a claim under the Human Rights Act and hence receive financial compensation from such a legal route. However, remedy may still come from the domestic civil courts: victims may be entitled to compensation if their medical care is judged to have failed to meet the 'Bolam' principle – that a doctor is not negligent if he or she acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion (*Bolam v. Friern Hospital Management Committee* [1957]).

### The future of Article 3

The number of mental health cases brought to the European Court of Human Rights that have actually breached Article 3 has been very few. This may be in part because the standard of proof needed in Article 3 cases is 'beyond reasonable doubt', an extremely high standard. As already mentioned, the Human Rights Act is a 'living instrument' which changes its interpretation over time and will adapt

to future advances in medical knowledge and treatment. Future case law will inevitably nibble away at, and define more precisely, what is and is not medically acceptable under Article 3. This may affect treatments such as electroconvulsive therapy (ECT) and force-feeding, which are still currently regarded as acceptable forms of treatment for certain disorders. The law regarding the use of ECT has already evolved in England and Wales: under section 58A of the new Mental Health Act 2007 it cannot be given in the face of capacitous refusal (Office of Public Sector Information, 2007). There are also indications that case law may decide that, if treatment is forced on people with capacity to make their own decisions (see *R (on the application of Wilkinson) ...* [2001]) when they do not present a serious threat to others, then Article 3 (and 8) could be engaged. The Bar Council (2004) suggests that inadequate protection may be given to the residual rights of detained patients in relation to issues such as seclusion, searching, visiting and access to personal possessions (e.g. computers) that might breach Article 3 (and 8).

The definition of what constitutes degrading and inhuman treatment will similarly no doubt become more refined, and case law already hints at future implications:

‘...in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct (i.e. disproportionate) diminishes human dignity and is in principle an infringement of the right set forth in Article 3. Similarly treatment of mentally ill persons may be incompatible with the standards imposed by Article 3 in the protection of human dignity, even though that person may not be capable of pointing to any specific ill-effects’ (*Keenan v. UK* (2001)).

### **The Human Rights Act in clinical practice**

The cases analysed in this article, however complex, serve to reiterate that good note-keeping remains essential for both clinical (General Medical Council, 2006) and legal reasons (European Convention on Human Rights judgments often quote verbatim from medical notes: see, for example, *Keenan v. UK* [2001], *McGlinchey v. UK* [2003], *Nevmerzhitsky v. Ukraine* [2005]). They similarly show how the fundamental concepts of the Human Rights Act, particularly proportionality and necessity, but also margin of appreciation, can easily be applied in routine clinical practice (Box 1). Case law also demonstrates common areas where clinical care may potentially fall foul of Article 3 (Box 2). Knowledge of these should be protective for both clinicians and patients alike.

#### **Box 2 Areas that may fall foul of Article 3**

- Not considering all aspects and circumstances of the case, e.g. the patient’s age, disability, physical frailty or illness, or vulnerable personality, and the nature, duration and route of administration of treatment
- Not adequately demonstrating therapeutic or medical necessity
- Not adequately documenting therapeutic management plans, e.g. absence or lack of documentation, illegible writing
- Providing inadequate or substandard treatment
- Not providing treatment or interventions quickly enough
- Excessive restraint or force disproportionate to the risk being posed
- Not considering capacity to consent to treatment
- Using treatment intentionally to humiliate or debase the patient

Baroness Hale (2007), a leading Law Lord, suggests the ‘short and gloomy answer’ as to whether the Human Rights Act has helped mental health law ‘... must be – not very much’. A recent report by the Joint Committee on Human Rights (House of Lords House of Commons, 2007) assessed the impact of the Act since its inception and revealed widespread poor knowledge, training and implementation of the Act. The report noted the ‘transformative purpose of the HRA [Human Rights Act] to help develop a culture of respect for human rights’ and as a ‘tool that can and should be used in law, policy and practice to enable ... social justice goals to be achieved’. Further extensive training in the Act for both organisations and individual clinicians alike needs to be proactively implemented if a human rights-based approach is to embed itself in both the collective and individual consciousness.

#### **Declaration of interest**

None.

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## MCQs

### 1 With regard to the Human Rights Act:

- a it was introduced into UK law in 1998
- b it incorporates all the Convention rights into UK law
- c it does not apply to the NHS as a public authority
- d it applies to Mental Health Review Tribunals
- e domestic courts are not obliged to interpret UK law in conjunction with the HRA.

### 2 With regard to Article 3 of the HRA:

- a it is a limited Convention right
- b it is a qualified Convention right
- c it is an absolute Convention right
- d to be violated must demonstrate both inhuman and degrading treatment
- e applies only to patients who are unable to consent to treatment.

### 3 Article 3 case law has demonstrated:

- a that ill-treatment need not attain a minimum level of severity
- b that reasonable force cannot be used in treatment
- c force-feeding cannot be given to a patient unable to consent
- d victims are not entitled to financial compensation as part of the judgment
- e that a measure which is therapeutically necessary cannot be regarded as inhuman or degrading.

### 4 With regard to concepts underpinning the Human Rights Act:

- a the standard of proof in Article 3 cases is of a low threshold
- b treatment must be proportional and not arbitrary or unfair
- c following a violation of Article 3, respondent states are not obliged to implement individual or group measures in the execution of a judgment
- d domestic states have little discretion or leeway in applying the Act to domestic laws
- e to justify an interference under the Act it does not need to be shown that it is necessary in a democratic society.

### 5 Article 3 case law has also demonstrated that:

- a treatment could be inhuman if it arouses a feeling of anguish, fear and inferiority in the victim capable of humiliating and debasing the victim
- b treatment could be construed as degrading if it causes intense physical or mental suffering in the victim
- c current case law suggests that clinical negligence can found a claim under Article 3
- d Article 3 violations can still be assessed as negligent under the 'Bolam' principle in UK civil law
- e to determine whether there has been a breach of Article 3 only some of the circumstances of the case need be considered.

### MCQ answers

1	2	3	4	5
a F	a F	a F	a F	a F
b F	b F	b F	b T	b F
c F	c T	c F	c F	c F
d T	d F	d F	d F	d T
e F	e F	e T	e F	e F