Judicial Review Of Health Care Decisions

‘Success in using the law to gain access to medical treatment is often limited and typically likely to be unproductive. The law should have a greater role in determining the availability and distribution of health care resources.’

Critically evaluate this statement taking into consideration legal challenge by way of public law. Your answer should take into account challenge using the Human Rights Act 1998 and European law.

Since its inception the National Health Service has met the needs of its users free at the point of use. This concept is enshrined in the NHS constitution but must be balanced against a huge demand for its services with limited funds from the public purse. Further challenges are faced when patients have health conditions with complicated and expensive clinical needs; the population is becoming older, and there are more long-term health conditions including obesity and diabetes. Health care commissioners have a limited amount of money to fund treatments and they face a year on year dilemma on how to allocate funds. It is hardly surprising that there is conflict between how funds are allocated and how some patients would like funds to be distributed. This essay will not be focusing on resource rationing but instead will examine how patients can use the courts to gain access to and change clinical decisions.

The courts allow a patient or his representative to bring actions in both public and common law, including judicial review where a decision made by any public body can be challenged as unlawful. According to Byrne, public law “deals with the state, either by itself or in it’s relations with individuals.” On the other hand, Private law (also known as Civil law) “deals with those relations between individuals with which the state is not directly concerned; as in the relations between husband and wife, parent and child… contracts, torts, trusts and legacies.”

The first stage in challenging a decision is through the complaint’s procedure pertinent to the particular trust or commissioning body. If the outcome is not satisfactory, the patient can escalate the complaint. A patient has the right to argue in court that being denied access to a certain treatment breaches a statutory duty. Section 1 (i) of the National Health Service Act 2006 says the Secretary of State is obliged to ‘continue the promotion in England of a comprehensive health service.’ Patients can argue that those who have the task of providing a health service are in breach of that statutory duty if they refuse to fund a particular treatment.

In R v Secretary of State for Social Services ex parte Hincks , a rationing decision about orthopaedic treatment was upheld. It was deemed lawful to take financial considerations into account when deciding about whether to offer treatment to a particular patient or group of patients. A similar decision was reached in R v Central Birmingham HA ex parte Walker where the Court of Appeal refused a claim by a mother that heart surgery should be performed on her child. The planned surgery had been postponed due to nursing shortages and it was held that those responsible for the allocation of resources had not acted unreasonably . In both cases, patient lives were not at immediate risk, questioning whether the court would have reached a different decision it that were the case. This arose in R v Central Birmingham HA ex parte Collier where lifesaving surgery on a child was postponed due to a lack of intensive care beds.

The child was in ‘desperate need and would probably die without it’. Stephen Brown LJ said, “the courts of this country cannot arrange the list in the hospital…and should not be asked to intervene. ” Ralph Gibson LJ added that the courts “have no role of general investigation of social policy and of allocation of resources.” Newdick criticized this decision as “one of the most unsatisfactory cases ever to have emanated from the court of Appeal in England’. Furthermore, Newdick questioned “how could any reasonable system of priorities sensibly have abandoned such a deserving case? ” Newdick said Collier identified the fact that some care “may fall into a category in which clinical assessment is necessary. It says nothing however, about the components of such a decision, who is responsible for making it, or where the line should be drawn.”

The case of R v North Devon Health Authority ex parte Coughlan tested a breach of statutory duty. Lord Woolf ruled “promotion of a comprehensive health service does not equate to the guaranteed provision of a comprehensive health service. The Secretary of State is allowed to withhold the provision of treatments that he deemed unreasonable and that this did not contravene Section 1 (i) of the Act.”

There will always difficult decisions regarding how funds are allocated for treatment. In R v Cambridge Health Authority ex parte B, at the first instance, Laws J, focused on B’s right to life under Article 2 of the European Convention on Human Rights. This meant persuasive reasons were necessary to explain why the needs of other patients should take precedence over B. Using the argument of limited resources was not enough and “the health authority had to state explicitly which other calls on its funds meant that it was not able to offer her treatment.” At Appeal, (heard the same day), Lord Bingham MR said “it is common knowledge that health authorities of all kinds are constantly pressed to make ends meet….Difficult and agonising judgements have to be made as to how a limited budget is best allocated to the maximum advantage to the maximum advantage of the maximum number of patients. This is not a judgement a court can make.” Judicial Review was sought on the following grounds: the wishes of the patient had not been considered by the decision maker. Describing the treatment as ‘experimental’ was both unfair and inaccurate as success was estimated. The evidence given by the Trust regarding resources consisted of only grave generalities. Lord Bingham stated:

“where the question is whether the life of a 10 year old child might be saved by however slim a chance, the responsible authority… must do more than toll the bell of right resources… it must explain the priorities that have led it to decline to fund the treatment.”

He found that the Trust had not adequately done so. Finally, the authority claimed the problem was the spending of £75,000 but in reality, the treatment cost £15,000. Had Laws’ judgement not been appealed there was the risk of the floodgates opening to patients bringing cases that challenged treatment decisions. Each health care authority would have to explain fund allocation in all cases which would be costly and time consuming.

Therefore, the courts are not likely to be helpful to a patient who tries to challenge a treatment decision on statutory duty grounds. Caution must be exercised to prevent arbitrary rationing of resources being disguised on the grounds of futile treatment. Instead, the onus is to prove that the Secretary of State, or the Health Commissioner have failed to provide treatment that they deemed reasonable . However, a problem arises around the issue of proof, due to the number of valid defences that could be raised in court. Also, patients have recourse to Judicial Review to dispute the decision-making process by claiming it is unlawful. In R v North West Lancashire

Health Authority ex parte A and Others a challenge was successful. Auld LJ criticised the Health Authority for not considering each case on its own merit and applying policy generically. This effectively led to a blanket ban that was unlawful. In an earlier case, R v Derbyshire Health Authority, ex parte Fisher the likely success of relevant treatments was found in NICE guidelines and it would be wrong not to follow them without explanation. In R (Ross) v West Sussex Primary Care Trust medical evidence had not been considered properly so a challenge was successful.

Therefore, any policy about funding that does not explain what is meant by ‘exceptional’ circumstances is likely to be found unlawful if this forms the basis of a refusal. In Rogers, it was held that treating one person who required the anti-cancer drug Herceptin differently from another was irrational due to too much emphasis on personal characteristics. This means that funding policies can be challenged for either not being considered on individual merit and therefore too rigid, or for being irrational. Also, exceptional cases should be defined. Sir Anthony Clark MR said, “if the clinical needs are equal, and resources are not an issue, discrimination between patients in the same eligible group cannot be justified on the basis of personal characteristics not based on health care.” Also, treating patients with the same clinical needs differently is contrary to section 4 of the Equality Act 2010. However, Herceptin has no effect at all on certain types of the disease, adding further weight to the argument to judge each case on its own individual clinical need. Patients are likely to find that the courts can assist them to access medical treatments on the grounds of failing to define what is an exceptional case. The realisation that resources are rationed is relatively new. Syrett says rationing took place under the ‘cover of clinical judgement’. Therefore, it was implicit rather than explicit. Mechanic, on the other hand claims implicit rationing works ‘because patients trust that doctors are their agents and have their interests at heart.’

An ‘exceptional case’ was tested again in AC v Berkshire West Primary Care Trust. A male to female transsexual challenged a decision made by the Trust who refused breast augmentation, stating it is a “low priority treatment due to the limited evidence of clinical effectiveness and is not routinely funded.” The claim for judicial review failed. Bean J, held that not treating the patient’s claim as exceptional because the symptoms are not severe was lawful. The Trusts gender dysphoria policy had been carefully written, factoring in both extensive research and consultation. Also, there was a conscious decision by the Trust to promote equal opportunities of accessing treatment between transsexuals and non-transsexuals in order to be perceived as non-discriminatory .

Sometimes, a decision has already been made before patients have the opportunity to state why they should be eligible for and receive a certain treatment. In R v Ethical Committee of St Mary’s Hospital (Manchester) ex parte H, the consultant failing to provide treatment was criticised by Schieman J, for not giving the patient the opportunity to put her side of the case and say why it was exceptional. Herring comments that the “patients views need to be properly and seriously considered.” Therefore, it can be established that the courts can assist patients to challenge decisions made on these grounds.

Next, this essay will look at is a ‘funding expectations.’ These have been challenged in court and a leading case is R v North and East Devon Health Authority ex parte Coughlan. A group of severely disabled patients had been promised funding to pay for life long accommodation in a particular care setting that was especially designed to cater for their additional needs. The decision of the Department of Health to close this residential centre was challenged and ruled

unlawful. The court upheld the “legitimate expectation” of a home for life brought by the claimants, finding the decision to close this facility was unfair and a gross abuse of power.

As well as challenging funding decisions about access to treatment through the courts and invoking the NHS Act 2006 and Equality Act 2010, patients have also used the Human Rights Act 1998, especially articles 2, 6 and 7 to contest treatment decisions. These articles will now be considered individually regarding their success or otherwise when used to challenge a treatment decision.

Article 2 – the right to life – means “individuals have the right to have their life protected by law and the state has positive duties to protect life.” If a public body such as the NHS, penal system or Police fail to protect life they can be in breach of Article 2. In Osman v United Kingdom (which was not a medical case) it was held that failing to take necessary measures to protect life can, in some circumstances, breach Article 2 (1). Bernhardt P said “[I]t is sufficient for an applicant to show that the authorities did not do all that could reasonably be expected of them to avoid a real and immediate risk to life of which they ought to have knowledge.” Examples of a potential breach in a health and social care setting are failing to protect vulnerable patients from abuse; maladministration of medications by unqualified staff; failure to provide adequate nutrition and hydration and assist a patient to feed himself where necessary; failing to check on service users at regular intervals; failure to investigate a sudden or unexplained death and failure to reduce the risk of infections in any health and social care setting.

Health care organisations need robust health and safety policies and procedures to manage and reduce risk. These should be made known to staff during their induction training and on-going personal development to prevent the care setting facing challenges brought under Article 2 . If treatment to prolong life is withheld due to lack of funding, then following Osman, patients will find it extremely difficult to bring a challenge to court using Article 2.

On the other hand, in Savage v South Essex Partnership NHS foundation Trust, Article 2 was used successfully on the ground that “where there is a real and immediate risk to life of which it could be reasonably expected was known – or should be known about at the time” . This case, however, is exceptional as most challenges to decisions citing Article 2 regarding access to medical treatments are unsuccessful.

Article 3 - the freedom from inhumane and degrading treatment. Patients have tried to argue that being denied a certain treatment could indeed lead to degradation or be inhumane. This was argued in R (on the application of Watts) v Bedford Primary Care Trust. Munby J, ruled that the degrading treatment must involve “actual bodily injury or intense physical or mental suffering.” In other words, if a condition causes a patient severe pain, according to Munby J this is not an adequate ground to bring a challenge using Article 3.

In Price v United Kingdom, a female with severe physical disabilities was kept by Police in a totally unsuitable cell, was held that there must be a minimum level of basic care. If that is not met, then it can be classed as a breach of Article 3. The Care Quality Commission produces guidelines detailing the ‘fundamental standards’ of a care package a patient can expect to receive. Using these standards as a benchmark, levels of care that fall short, may well breach Article 3. As minimum standards are laid down to safeguard dignity and prevent inhumane treatment, it remains difficult for patients to use Article 3 to challenge a treatment decision in court.

Article 8 – respect for private and family life was tested in R (on the application of Condliff v North Staffordshire Primary Care Trust when a request for judicial review failed. Mr Condliff applied to receive a gastric band under the Trust's Individual Funding Request Policy but treatment was refused as his BMI was under 50. By using clinical needs to decide how resources are allocated to provide health care services, it was, according to Toulson LJ, applying "the resources for the purpose for which they are provided without giving preferential treatment to one patient over another on non-medical grounds." The court did not agree that failing to provide treatment in this case was a breach of Article 8. Similarly, in R v North West Lancashire Health Authority ex Parte A and Others, the courts did not recognise Article 8 as a valid challenge.

Those cases demonstrate that the Human Rights Act 1998 is unlikely to facilitate patient access to medical treatments. In addition, there is also some reluctance from the courts to allow challenges brought to them on the grounds of the Act for fear of opening the floodgates and being swamped by huge numbers of cases.

Another way of bringing a challenge to court regarding decisions not to fund certain treatments is through the tort of negligence. The patient would need to prove there was a breach of the duty of care owed to the patient by either the medical staff or the NHS Trust. However, this is not favourable with the courts who are reluctant to make judgements about allocating treatment through the laws of tort. Mustill J, in Bull and Another v Devon Area Health Authority said, "it is unnecessary to go further into these matters which raise important issues of social policy, which the courts may one day have to address." This case shows that unsafe practices are not always due to a lack of resources. Ruling the prevention of not providing access to medical treatment as negligent is very doubtful if patient safety is not jeopardised.

Sometimes, to circumnavigate long waiting list times, patients have elected to have treatment abroad then tried to force the NHS to refund the costs. This was tested in R (on the application of Watts) v Bedford Primary Care Trust and Another where the issue arose as to whether the NHS could refuse a refund. The European Court of Justice ruled that there must be an objective assessment of medical needs and if the waiting list for treatment was disproportionately long, then the NHS was not allowed to refuse funding. In such cases, the courts have proved helpful to patients accessing medical treatment through challenges brought under European Community Law under Articles 49 and 22.

In conclusion, patients cannot demand treatment, nor is the right to treatment unconditional. However, if a funding policy is illogical, discriminatory, neglectful of the patient's viewpoint or are contrary to a legitimate expectation then the courts can be of assistance in enabling a patient to access treatment. It seems to be that the courts are cautious about 'opening the floodgates' and their decisions often reflect this. As the culture of litigation becomes more widespread, it seems obvious that more cases about access to treatment will come before the courts, whether there is an increase in successful outcomes for patients remains to be seen.