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The Right to Health Care in the United States

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The Allocation of Healthcare Resources in the National Health Service in England: Professional and Legal Issues*

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The main objective of this article is to discuss how English courts have responded to legal actions brought by patients against a number of health authorities[1] for failure or refusal to provide healthcare resources under the present allocation scheme. Patients also alleged negligence in the provision of healthcare resources. This article will also discuss how healthcare professionals and their professional bodies are responding to the issue of allocating scarce healthcare resources. For contextual purposes, the article begins with a brief initial discussion of England's healthcare system and the current state of healthcare litigation.

Generally speaking, healthcare services under the National Health Service ("NHS") are provided free of charge to persons who are "ordinarily resident" in the United Kingdom.[2] In 1946, Parliament enacted the National Health Service Act, which created the basic healthcare structure that exists today; its underlying principle is the free provision of quality healthcare services to all who need those services. Some charges are levied for certain re-

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1. The term "health authority" is used to describe an organisation that manages health services locally. There are a variety of health authorities. These health authorities include District Health Authorities, Regional Health Authorities, Special Health Authorities, NHS Trusts, and Family Health Service Authorities. CENTRAL OFFICE OF INFORMATION, THE HEALTH SERVICE OMBUDSMAN FOR ENGLAND 6 (1991). For a discussion of the increasingly complex NHS management and organisational structure, see *Lost in the NHS Maze: Tony Travers on a Most Unhealthy Bureaucracy*, THE TIMES (London), Feb. 17, 1993, Features Section.

2. *See generally* DEPARTMENT OF HEALTH AND SOCIAL SECURITY, NHS TREATMENT OF OVERSEAS VISITORS (1988); NATIONAL HEALTH SERVICES, FAMILY PRACTITIONERS SERVICES: FAMILY PRACTITIONER SERVICES FOR OVERSEAS VISITORS, HEALTH NOTICE FOR FAMILY PRACTITIONERS, Doc. No. HN (FP)(84) 7 (DHHS 1984).

lated services, such as the filling of prescriptions, subject to exceptions.

Britain's main hospital structure centres around the National Health Service. The major hospitals in the country in terms of number, facilities, and specialties are NHS hospitals. There are, however, a number of private hospitals as well, some of which are large.

The NHS has been the subject of a number of recent reforms.[3] David Green, in a study for the Journal of Economic Affairs, summarizes the nature of these reforms:

> The Government's approach was to introduce a measure of market discipline in the hope of securing better value for money, while continuing to rely on taxation for finance. It was expected that competition within an internal market would force bad hospitals and unsatisfactory GP's to raise their standards closer to the best. The most important elements of the reform strategy were:
> - Dividing purchasing from delivery.
> - The introduction of self-governing hospitals or NHS Trusts.
> - The introduction of budget-holding for GP's.
> - Continued funding of health care predominantly from taxation.[4]

The government organisation that manages the NHS, the NHS Management Executive, reported that the changes in the NHS organisation led to improvements in the quality of care, greater provider responsiveness to individual patients, and better value for the money from the NHS budget.[5] Despite their reported success, the

3. *See generally* IAN HOLLIDAY, THE NHS TRANSFORMED (1992).

4. David Green, *The NHS Reforms: From Ration-Book Collectivism to Market Socialism*, ECONOMIC AFFAIRS, Apr. 1992, at 12. The NHS reform strategy of dividing purchasing from delivery facilitated the operation of an internal market in the NHS. General practitioner ("GP") fundholders, or as they are sometimes termed GP budgetholders, and NHS Trusts have key roles in the market and enjoy a number of freedoms. Fundholding practices control their own budgets, and they can provide and buy a range of health care for their registered patients in the internal market. NHS Trusts operate in a similar fashion to GP fundholders in the acute sector of the NHS.

5. Duncan Nichol, *NHS Reforms: The First Six Months*, NHS MANAGEMENT EXECUTIVE, Dec. 1991, at 2. More recent support for this reform improvement proposition can be found in *Reaffirming Freedoms*, NHS MANAGEMENT EXECUTIVE NEWS, Oct. 1992, at 1, and *Recording Real Achievement: Duncan Nichol's Annual Report 1991/2*, NHS MANAGEMENT EXECUTIVE NEWS, Oct. 1992, at 16. The Report is discussed, and it is noted that the number of acute patients treated by NHS Trusts have risen from 7.2 per cent to 8.2 per cent. The Health Secretary (government health minister), Virginia Bottomley, comments on these figures: " 'This increase is not just a statistic,' . . . . 'It represents thousands of patients who have benefited from the practical implementation of the reforms.' " *Id.* at 1.

reforms remain controversial, and there are many differing views on their overall effectiveness. Risk Management and quality assurance initiatives are being increasingly introduced by hospitals in order to avoid complaints and litigation and to produce a safer clinical care environment.

I. INCREASED HEALTHCARE LITIGATION IN THE UNITED KINGDOM

England as a nation appears increasingly prepared to hold its healthcare professionals accountable. Over the last ten years, both negligence actions and the level of damage awards against doctors increased.[6] Awards of over £1 Million[7] are not uncommon, although at the time of this writing none exceeded £2 Million. Patients seem less deferential and more confident. More complaints about healthcare providers are being made to the Health Service Commissioner, or Ombudsman,[8] than ever before. During the period 1991-1992, the number of complaints filed with the Health Service Commissioner increased by nineteen percent.[9]

The increase in the number of negligence suits and the size of damage awards resulted in a corresponding increase in the cost of doctors' indemnity insurance.[10] In 1960, when negligence suits against physicians were relatively rare, the cost of an annual subscription to the Medical Defence Union (MDU)[11] insurance was

6. Chris Ham et al., Medical Negligence: Compensation and Accountability, Briefing Paper No. 6, Centre for Socio-Legal Studies, Oxford & Kings Fund Institute, London, at 8 (1988) (on file with the author). *See generally* ROBERT DINGWALL, MEDICAL NEGLIGENCE (1991).

7. At the time this article was published, the British pound was equivalent to $1.50 in United States currency.

8. The Health Service Commissioner can investigate certain types of patient complaints about the NHS and operates in England, Scotland, and Wales. Past complaints featured such matters as nursing and medical staff attitudes, nursing maltreatment, failures in hospital administration, and failures in ambulance service. *See generally* HEALTH SERVICE COMMISSIONER FOR ENGLAND, FOR SCOTLAND & FOR WALES ANNUAL REP. 43 (1991-1992) [hereinafter HSC ANNUAL REPORT]. The Office of Health Service Commissioner was created in England and Wales by the National Health Service Act, 1977, ch. 49, and in Scotland by the National Health Service (Scotland) Act, 1978, ch. 29. The Commissioner makes reports to Parliament about his work. At the end of an investigation, he sends a report of his findings to the responsible health authority and to the patient. If the patient's complaint has been upheld, the report states any action that the responsible health authority has agreed to take, such as an apology or agreement to change procedures.

9. HSC ANNUAL REPORT, *supra* note 8, at 1.

10. Ham, *supra* note 6.

11. The Medical Defence Union ("MDU") is a medical defence organisation with headquarters in London, England. The other major medical defence organisation is The Medical Protection Society ("MPS"), with headquarters also in London, England. Both

only £2.[12] In 1978, doctors paid £40 to their defence organisations in annual subscriptions. By 1988, the cost of an annual subscription rose to £1080, an increase of 87% annually.[13]

II. THE COST OF HEALTHCARE LITIGATION

Many health authorities and hospital trusts have expressed concern at the magnitude of damage awards, which threaten some health authorities with bankruptsy.[14] Mike Horah of the NHS Management Executive provides a different perspective on the issue and gives an indication of the costs of clinical negligence claims to the NHS:

> The Department receives returns from the NHS of its expenditure on negligence and in 1990/1 it estimated that the NHS spent between £40 and £45 million in England. . . . While costs are undoubtedly rising, perhaps as fast as 20 per cent a year, estimates based on assessments of the total number of claims in the pipeline inevitably give a distorted and overly pessimistic picture. . . . The data shows that about 98 per cent of claims are settled for under £100,000 and that such claims represent about 60 per cent of the expenditure.[15]

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organisations operate in England and in a number of other countries, excluding the United States and Canada. They are mutual aid associations providing a wide range of discretionary benefits to their members including advice on ethical and legal problems and indemnity (payment of damages and legal costs in professional negligence claims). Both organisations maintain an accumulated wealth of knowledge and experience in dealing with medicolegal matters. Although the MPS and MDU appear to operate as insurance companies, they are not legally classified as such. The MDU is the longest established and largest defence organisation in the world; the MDU was founded in 1885, the MPS in 1892. For the current status of medical NHS indemnity arrangements, see John Tingle, *Who Pays for Clinical Negligence?*, 141 NEW L.J. 630, 650 (1991).

12. John Wall, M.D., *Is Litigation Bad for Your Health*, 7 J. MED. DEFENCE UNION 54 (1991).

13. Ham, *supra* note 6.

14. Jenny Sims, *When Planning Ahead Avoids Costly Claims*, 21 HEALTH SERVICE J., Feb. 1991, at 16.

15. Mike Horah, *Clinical Negligence—Mountains & Molehills*, NHS MANAGEMENT EXECUTIVE NEWS, May 1991, at 15. More recent figures on the cost of medical negligence claims to the NHS were revealed in a written answer to a member of Parliament's question in the House of Commons:

> Dr. Liam Fox: To ask the Secretary of State for Health what was the cost to regional health authorities in 1991-92 of legal claims against (a) doctors and (b) dentists in the NHS for medical negligence.
>
> Mr. Sackville: Figures for 1991-92 are not yet available. In 1990-91 medical negligence claims cost the national health service an estimated £53 million (including legal costs and damages). Figures are not collected separately on claims against doctors and dentists.

HOUSE OF COMMONS OFFICIAL REPORT, WRITTEN ANSWERS ON MEDICAL NEGLIGENCE 184 (Dec. 15, 1992).

The current trend is towards settlement rather than prolonged litigation. However the figures are viewed, the law can increasingly be seen as a mechanism for holding healthcare providers accountable for negligence in care.

III. HEALTHCARE RESOURCE ALLOCATION ISSUES

The law is clearly not the only relevant factor in the debate over the allocation of healthcare resources; political, social, and economic factors play a large role as well. Health authority organisations have limited resources and must work within constraints. If a dispute arises over resources, political, social, and economic factors cannot be ignored. To an extent, these factors feature in reported cases.

Another increasingly important factor in the healthcare resource allocation debate is the attitudes of healthcare providers themselves. A doctor or nurse may have very strong personal feelings about a resource issue and may challenge the employer publicly by "whistleblowing" to the press. The doctor or nurse may then be subject to employer disciplinary proceedings for breaching a "gagging clause" in their contract of employment, which a number of the NHS Hospital trusts have recently inserted in staff contracts.[16]

16. The effect of gagging clauses on employees is a matter of conjecture. A view could be advanced that they operate to deter employees from making public pronouncements on employment-related matters that concern them. Such clauses would also appear to encourage, foster, and perhaps even force on the employee a much more cautious strategy toward this issue. The government organisation that manages the NHS, the NHS Management Executive, recently produced and circulated for comment draft guidance on freedom of speech for NHS staff. Letter from B A J Bennett, Personnel Directorate, NHS Management Executive, to NHS Staff (Oct. 16, 1992) (on file with the Institute for Health Law). The Department of Health has now considered the replies to their consultation paper and has now produced formal advice which was issued under cover of Executive Letter EL (93) 51, by the NHS Management Executive on June 8th, 1993.

Clause 20 of the guidance states the legal position in which well-meaning whistleblowers may find themselves:

> Because the relationship of an employer and an employee is one established on the principles of confidentiality and fidelity . . . any disclosure to the media of a matter which is relevant to the employer's work and responsibilities, without the consent of the employer, might be seen by the employer as damaging the relationship of mutual trust and would therefore represent a potentially serious breach of contract. The employee will therefore need to realise that such action may lay him/her open to the possibility of disciplinary action by the employer, depending on the facts of the case.

See Jean V. McHale, *Whistleblowing in the NHS Revisited*, 1993 J. SOC. WELFARE & FAM. L. 52 (for a discussion of the draft guidance); Jean V. McHale, *Whistleblowing in the NHS*, 1992 J. SOC. WELFARE & FAM. L. 363 (for a discussion on whistleblowing in the NHS).

There are already a number of well-publicized "whistleblowing" cases.[17]

The Royal College of Nursing ("RCN")[18] established a whistleblow scheme in 1991.[19] Under this scheme, nurses, midwives, and health visitors can write directly and confidentially to the General Secretary of the RCN. The General Secretary can request the complainant's permission to investigate the case further.

The resource debate has become an issue for many healthcare providers. Some doctors and nurses work in environments where healthcare resources are severely limited and their patients' safety may be compromised as a result. Some of the responses to the RCN Whistleblow scheme provide evidence of resourcing problems:

> If nothing else, the RCN Whistleblow mailbag revealed just how stressful the jobs of some nurses have become.
>
> Many letters recounted similar stories of being asked to do more and more with fewer and fewer resources, and of a management style which was, at best, unsympathetic and at worst belligerent and inflexible. . . . Many correspondents cited examples of wards being staffed by too few nurses of insufficient experience. Commonly the picture was one of nursing skills being diluted by managers replacing senior nurses with more junior and unqualified staff.[20]

Depending on the severity of the resource problem, it is not unreasonable to suppose that many patients would expect their healthcare providers to inform their line managers of the situation. For a healthcare professional to fail to do so could be viewed as unprofessional and, in some circumstances, even negligent. Legal action could result against the individual healthcare provider and the employing health authority. The advice of the English doctors' defence organisations, the MDU and The Medical Protection Society ("MPS"), and of the nurses' professional regulatory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting ("UKCC"), is instructive on this point. This advice can be seen to represent important perspectives on the legal and professional issues involved in allocating healthcare resources.

17. Jackie Cresswell & Peter Davies, *Give a little whistle?*, HEALTH SERVICE J., Aug. 13, 1992, at 14; Toni Turner, *The Indomitable Mr. Pink*, 88 NURSING TIMES 26 (1992).

18. The Royal College of Nursing is the professional and trade union organisation of nurses. The college provides a wide range of services for nurses including education courses and professional negligence insurance.

19. ROYAL COLLEGE OF NURSING, NURSES SPEAK OUT: A REPORT ON THE WORK OF THE RCN WHISTLEBLOW SCHEME (1992).

20. *Id.* at 7.

A. Resource Shortfalls: The Advice of Medical Professional Bodies

The MPS offers the following advice to its members:

> The Society remains concerned about the effects on patient care of economies imposed in response to limitation in funds, facilities and resources. . . . [W]here these are considered by members to impose unacceptable risks to patient care, representations should be made, at once, to those responsible for managing the service.
>
> Whilst the law requires the exercise of a reasonable standard of care and cannot expect doctors to do more than their reasonable best, the standard is a high one and deviations from it may result in findings of negligence. Threats to the standard of care which members can provide for their patients should be discussed carefully between colleagues. Where shortfalls are considered to impose an unacceptable risk to safe care of patients, representations should be made to those responsible for managing the service, for example the appropriate administrators in the National Health Service. Whilst verbal discussions are most helpful, members' concern should be confirmed in writing as should their professional advice for appropriate action. . . .
>
> An acquiescence (often by silence) in cuts harmful to standards of patient care may leave members vulnerable to criticism because health authority managers and administrators are not slow to point out that professional staff raised no objection to cuts, and so may be taken to have agreed to them and to have accepted the professional consequences thereof.[21]

The possibility of a negligence court action and the need to speak out on dangerous healthcare resource shortfalls are key issues in the MPS's advice to members.

The Medical Defence Union notes the following:

> An increasing number of members seek advice on the problems which arise from shortfalls in resources, both human and material. A note of desperation is creeping into many letters and some members have considered threatening withdrawal of services as one way of persuading their managers to provide either manpower or equipment.[22]

There is clear evidence that some doctors recognise a moral and perhaps a professional duty to make known shortfalls in resources.

21. 1990 ANNUAL REPORT & ACCOUNTS OF THE MEDICAL PROTECTION SOCIETY 19.

22. Kathleen Allsopp, *Shortfalls in Resources*, 7 J. MED. DEFENCE UNION 73 (1991).

B. *The Nurse as Patient Advocate*

While much would depend on the facts of an individual case, it is possible that nurses who fail to report to their managers' serious resource deficiencies in their working area could well find themselves subject to UKCC professional disciplinary proceedings and discipline such as termination of the nurse's right to practice. Because the disciplinary systems[23] of the medical and nursing professions are very different in terms of what is regarded as professional misconduct, nurses, midwives, and health visitors can be disciplined by the UKCC for conduct which, if committed by a doctor, would not result in General Medical Council ("GMC") disciplinary sanctions.[24] Therefore, nurses, midwives, and health visitors can be seen as more professionally accountable to their patients and the public than their medical colleagues. They are under a direct professional duty to act as patient advocates.

According to the UKCC, a frequent ground for removing nurses from the professional register has been "failure to protect or promote the interests of patients/clients."[25] The UKCC Code of Professional Conduct also provides:

> As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must: . . . report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice; . . . [and] report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided . . . .[26]

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23. On General Medical Council disciplinary procedures generally, see GENERAL MEDICAL COUNCIL, PROFESSIONAL CONDUCT AND DISCIPLINE: FITNESS TO PRACTISE (Jan. 1993); Roy Palmer, *Accountability and Discipline*, *in* DOCTORS, PATIENTS AND THE LAW 180 (Clare Dyer ed., 1992); GENERAL MEDICAL COUNCIL, PROPOSALS FOR NEW PERFORMANCE PROCEDURES (1992); Margaret Stacey, *Medical Accountability: A Background Paper*, *in* CHALLENGES IN MEDICAL CARE 109 (A. Grubb ed., 1992); Arnold Simanowitz, *Standards, Attitudes and Accountability in the Medical Profession*, THE LANCET, Sept. 7, 1985, at 546, 547.

24. On United Kingdom Central Council disciplinary procedures generally, see UNITED KINGDOM CENTRAL COUNCIL FOR NURSING, MIDWIFERY AND HEALTH VISITING, '. . . WITH A VIEW TO REMOVAL FROM THE REGISTER . . .'? (1990); Reginald H. Pyne, *Professional Discipline*, *in* NURSING, MIDWIFERY AND HEALTH VISITING (2nd ed. 1992). *See also* Nina Fletcher, *The Nurses, Midwives and Health Visitors Act 1992*, 8 PROF. NEGL. 94 (1992).

25. UNITED KINGDOM CENTRAL COUNCIL, *supra* note 24, at 7.

26. UNITED KINGDOM CENTRAL COUNCIL FOR NURSING, MIDWIFERY AND HEALTH VISITING, CODE OF PROFESSIONAL CONDUCT (3rd ed. 1992).

An advisory document further provides:

> [T]he registered nurse, midwife and health visitor must make appropriate representations about the environment of care:
>
> (a) where patients or clients seem likely to be placed in jeopardy and/or standards of practice endangered;
>
> (b) where the staff in such settings are at risk because of the pressure of work and/or inadequacy of resources (which again places patients at risk); and
>
> (c) where valuable resources are being used inappropriately.[27]

The UKCC expects nurses in the United Kingdom to take proactive steps in poor resource situations. A nurse who says nothing can be charged with professional misconduct and subject to disciplinary action. Doctors in the same situation would not, generally speaking, face such disciplinary action from their regulatory body.

C. Resource Allocation and the Provider: A Summary

Medical litigation over the last ten years in the UK has increased significantly. Record numbers of complaints are being made against healthcare providers. Patients appear less deferential and more confident. The attitudes of individual healthcare providers are a factor in the healthcare resource allocation debate, since they may feel that it is both their moral and professional duty to press for a resource allocation. Their actions can have legal implications for themselves and for their employing organisations. Furthermore, nurses, midwives, and health visitors are, in certain circumstances, under a direct professional regulatory body duty to take action over resource issues.

Many healthcare providers are actively pressing for healthcare resource allocations in appropriate cases. If this course is unsuccessful, the patient has the choice of either paying for the treatment privately or waiting. Patients who grew tired of waiting and who tried unsuccessfully to compel a resource allocation then turned to the courts.

IV. Litigation Over Healthcare Resources

The cases in which patients challenged resource allocation show that under the National Health Service patients do not have a legal right to immediate treatment. Relevant parts of Section One of the

27. United Kingdom Central Council for Nursing, Midwifery and Health Visiting, Exercising Accountability: A Framework to Assist Nurses, Midwives and Health Visitors to Consider Ethical Aspects of Professional Practice (1989).

National Health Service Act 1977,[28] provide:

> (1) It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement—
>
> (a) in the physical and mental health of the people of those countries, and
>
> (b) in the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with this Act.
>
> (2) The services so provided shall be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.

Section 3(1) provides:

> It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements—
>
> (a) hospital accommodation;
>
> (b) other accommodation for the purpose of any service provided under this Act;
>
> (c) medical, dental, nursing and ambulance services;
>
> (d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;
>
> (e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;
>
> (f) such other services as are required for the diagnosis and treatment of illness.

The case of *R. v. Secretary of State for Social Services and Others, Ex parte Hincks and Others*[29] tested the nature of the Secretary of State's duties under the Act. In *Hincks*, orthopaedic patients at a hospital in Birmingham had to wait for periods of time longer than was medically advisable for hip replacement surgery because of a shortage of facilities. The patients sought declarations that the respondents—the Secretary of State, the Regional Health Authority, and the Area Health Authority—were in breach of their duties

28. National Health Service Act, 1977, ch. 49 (applying to England and Wales; some provisions extend to Northern Ireland). The long title of the National Health Service Act explains its goal: "to consolidate certain provisions relating to the health service for England and Wales; and to repeal certain enactments relating to the health service which have ceased to have any effect." *Id.*

29. Unreported (Q.B.), 123 SOL. J. 436 (June 29, 1979); JOHN D. FINCH, HEALTH SERVICES LAW 38 (1981).

under Sections One and Three of the National Health Service Act of 1977. These actions failed because the courts found that no right of action exists on the part of an individual aggrieved patient to sue for a declaration and damages in respect of protracted pain and suffering caused by a failure to provide more hospital services. Lord Denning stated that the Minister, or Secretary of State, could be considered to have failed in his or her statutory duty only if his or her exercise of discretion was so thoroughly unreasonable that no reasonable Minister could have reached the same conclusion. The court also recognised that Ministers face long term financial planning and constraints. The public purse was not to be viewed as a bottomless pit.[30]

In *Medicine, Patients and the Law*, Margaret Brazier comments on this case, discussing the possibility of a future claim in this area:

> [T]he courts did not entirely abdicate control over the Minister. A public-spirited patient, resigned to getting no damages himself, might try again for an order against any Minister who he alleged had totally subverted the health service, for example, a Minister using his position and powers exclusively to benefit private medicine at the expense of the NHS. Chances of success are not high, and, of course, the government of the day could always change the law, but they can be made to do it openly and not permitted to pay lip service to a duty to a health service which might have been abandoned.[31]

While aggrieved patients have also sued health authorities for failure to provide a particular treatment, such claims have not met with much success. In the case of *In re Walker's application*,[32] the Court of Appeal dismissed a mother's application for judicial review of the Central Birmingham Health Authority's decision to postpone carrying out necessary heart surgery on her baby. The operation had been postponed on five previous occasions because of the lack of specially trained nurses and accompanying facilities, which did not allow the expansion of the intensive care unit. The baby was not in any immediate danger, and other more urgent cases were being treated.

The court found that under the circumstances, the health authority's decision was legal. There were no procedural defects and the health authority's decision was not unreasonable to the point of irrationality. Mr. Justice MacPherson, the trial judge, deprecated any suggestion that patients should be encouraged to think that the

30. FINCH, *supra* note 29, at 38.
31. MARGARET BRAZIER, MEDICINE, PATIENTS AND THE LAW 22 (2d ed. 1992).
32. THE TIMES (London), Nov. 26, 1987.

court had a role in such cases. The Court of Appeal also dismissed the application. Sir John Donaldson, Master of the Rolls, the senior appeal judge, stated

> that it was not for the court to interfere and substitute its own judgment for that of those responsible for the allocation of resources. It would only interfere if there had been a failure to allocate funds in a way which was "unreasonable" in the *Wednesbury* sense, (1948) 1KB 223 (*Associated Provincial Picture Houses v. Wednesbury Corporation*) or where there were breaches of public-law duties.[33]

On similar facts, the Court of Appeal in *R. v. Central Birmingham Health Authority Ex parte Collier*[34] dismissed a similar application. The court followed the reasoning of *In Re Walker*. Lord Justice Stephen Brown stated that the principles were the same even if there was an immediate danger to health. Lord Justice Ralph Gibson stated: "[T]his court and the High Court have no role of general investigator of social policy and of the allocation of resources."[35]

It is evident from the cases discussed that the courts are very reluctant to intervene in the organising of hospital treatment lists. This exercise would turn the courts into arbitrators of social policy and healthcare resource allocators. The cases indicate, however, that the door of judicial review is not completely closed.

V. Challenging a Medical Decision Not to Treat

The resource issue has also arisen in English law in the context of a doctor's decision not to give medical treatment and a doctor's refusal to admit a patient to a programme of treatment. A doctor's discretion to refuse to treat a patient can be challenged in court if appropriate circumstances exist. The following two cases are relevant to this issue.

In the case of *R. v. Ethical Committee of St. Mary's Hospital (Manchester) Ex parte Harriot*,[36] the court refused to review a decision of an ethical committee and a hospital consultant. The applicant was having difficulty conceiving a child. She had applied on a number of occasions to foster or adopt a child. Her applications were refused on grounds that included her past criminal record of

33. *Id.*

34. Unreported (C.A.) Jan. 6, 1988 (LEXIS, Butterworths, London; on file with the Institute for Health Law) (case discussed by Michael McCarthy, *Heart Boy's Parents Receive Three Offers for Private Surgery*, THE TIMES (London), July 1, 1988, at 3.).

35. *Id.*

36. 1 F.L.R. 512 (1987).

allowing premises to be used as a brothel and soliciting for prostitution. She had sought in vitro-fertilization (IVF) and was placed on the waiting list of the regional IVF unit. Later, a consultant decided to remove the applicant from the IVF list in part because of the adoption agencies' refusal to consider child placement. The applicant was not given the true reason for the consultant's refusal for some period of time. The applicant complained to the court about being removed from the list and the refusal of the hospital infertility service's ethical committee to intervene. The committee felt that the decision was for the consultant to make. The applicant also contended that the consultant was under a duty to act fairly when basing a decision of whether to remove a woman from the IVF list on social grounds involving issues of contested fact.

The applicant lost her case. The trial judge, Mr. Justice Schiemann, felt that in some circumstances the court could review an ethical committee's decision "[i]f the committee had advised, for instance, that the IVF unit should in principle refuse all such treatment to anyone who was a jew [sic] or coloured, then I think the courts might well grant a declaration that such a policy was illegal . . . ."[37] In the present case, however, the court found the committee's advice unobjectionable. It was held that judicial review does not lie to compel the committee to give advice or to embark on a particular investigation. If the court had the power to force the committee to receive representations before deciding not to give advice, it should be slow to do so.

The judge left unanswered the question of whether the court could review the decision of a hospital consultant. The matter did not need to be decided in the case. The judge stated: "It is not, and could not be, suggested that no reasonable consultant could have come to the decision to refuse treatment to the applicant."[38] The argument can therefore be advanced that a court could review a consultant's decision to refuse treatment if that decision was unreasonable, in the sense that no reasonable consultant in the circumstances of the case would have come to that decision.

A more recent case dealing with the issues of healthcare resources and a consultant's discretion is *In re J (a Minor) (Medical Treatment)*.[39] This case concerned Baby J, who was born in January of 1991 and was profoundly handicapped, both mentally and physically, as a result of an accidental fall when he was one month

37. *Id.* at 518-19.
38. *Id.* at 519.
39. THE TIMES (London), June 12, 1992.

old. He was severely microcephalic and had cortical blindness and severe cerebral palsy and epilepsy. Medical opinion was unanimous that the baby was unlikely to develop much beyond his present level of functioning. It was also possible that his condition might deteriorate. He was not expected to live long. A paediatrician caring for the baby felt that mechanical ventilation procedures would not be in the baby's best interests if he were to suffer a life-threatening event. The local authority sought to uphold an order of the trial judge, Mr. Justice Waite, in the High Court, granting the local authority and the mother an interlocutory injunction, pending a full hearing, and ordering the health authority to cause such measures to be applied to J. for so long as they were capable of prolonging his life *if* (i) J's medical condition changed so that his life were threatened but was capable of being prolonged by, inter alia, artificial ventilation, (ii) he was at the time in the care of the health authority, and (iii) the required drugs and equipment could reasonably be made available.[40]

The Court of Appeal held it would not order a medical practitioner to adopt a course of treatment after determining, based upon clinical judgment, that the treatment was contra-indicated because it was not in the patient's best interest. In discussing the errors of the trial judge's order, Lord Donaldson of Lymington, Master of the Rolls, the senior appeal court judge, stated that the order was "wholly inconsistent with the law as so stated and could not be justified on the basis of any known authority."[41] He further commented on Mr. Justice Waite's order:

> It was erroneous on two other grounds namely . . . (ii) its failure adequately to take account of the sad fact of life that health authorities might on occasion find that they had too few resources, either human or material or both, to treat all the patients whom they would like to treat in the way they would like to treat them. It was then their duty to make choices. The court would have no knowledge of competing claims to a health authority's resources and was in no position to express any view on their deployment.[42]

As is apparent from the line of cases discussed so far, the courts have shown a marked reluctance to get involved in reviewing healthcare resource allocation decisions. The attitude seems to be that doctors and health authorities should be left to get on with their jobs. However, judicial review of an allocation decision is not

40. *Id.*
41. *Id.*
42. *Id.*

impossible, and, in certain circumstances, it would be appropriate to bring an action.

VI. Allocation of Healthcare Resources and Negligence

In addition to the line of cases concerning judicial review of allocation decisions, there exists a second line of cases concerning the tort of negligence as it relates to resource allocation. Patients in these cases received a resource allocation: they were treated. Unfortunately, they suffered injury, allegedly because the care received was of poor quality.

These cases reveal a direct link between inadequate allocation of healthcare resources and the quality of treatment. Healthcare staff, care facilities, medical equipment, and hospital services are all "healthcare resources." A health professional may have performed the healthcare service negligently, or the patient may have suffered as a result of not being offered appropriate care facilities. Of course, organisational failures can result in poor patient treatment without any particular healthcare professional being negligent. Medical negligence causing injury is only one feature of this area of law. The negligence cases that follow reveal a more liberal judicial attitude toward resource allocation issues than the cases asking for judicial review of decisions to treat.

In *Wilsher v. Essex Area Health Authority*,[43] Martin Wilsher, who was born prematurely on the 15th of December, 1978 suffering from various illnesses, brought a negligence action seeking compensation for injuries he allegedly received in the hospital. A junior and inexperienced doctor occupying a key post in the defendant's twenty-four-hour special care baby unit mistakenly inserted a catheter into a vein rather than through an artery. The junior doctor asked a registrar to check his work. Unfortunately, the registrar failed to see the mistake and some hours later repeated the error. The catheter monitor in both instances failed to register correctly the amount of oxygen in the plaintiff's blood. As a result, the plaintiff was given excess oxygen. The plaintiff claimed damages, alleging that the excess oxygen in his bloodstream caused an incurable condition of the retina, which eventually resulted in his total blindness.

The case raises a number of important legal issues. The litigation continued for a number of years and was eventually settled for

43. [1986] 3 All E.R. 801 (C.A.).

£116,724.40 in January of 1991.[44] The Vice Chancellor, Sir Nicolas Browne-Wilkinson, a senior appeal judge, stated in his dissenting judgment in the case:

> [A] health authority which so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient. . . . I can see no reason why, in principle, the health authority should not be so liable if its organisation is at fault . . . .
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> * * *
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> Given limited resources, what balance is to be struck in the allocation of such resources between compensating those whose treatment is not wholly successful and the provision of required treatment for the world at large? These are questions for Parliament, not the courts. But I do not think the courts will do society a favour by distorting the existing law so as to conceal the real social questions which arise.[45]

The judge's statements reveal definite attitudes about healthcare resource accountability and responsibility. The judge appears to imply that hospital under-resourcing by the government will not result in judicial acceptance of a reduced standard of patient treatment and that the allocation of healthcare resources is a problem for Parliament and not the courts. Patients' legal rights will not be compromised by politics and issues of social policy.

Similar sentiments were expressed in the more recent unreported Court of Appeal decision of *Bull v. Devon Area Health Authority*.[46] Mrs. Bull went into the hospital in premature labor, carrying uniovular twins sharing the same placenta. The first twin was born at 7:27 p.m. and was normal. The second twin was delivered sixty-eight minutes later and was found to have brain damage. Delivery should have been made as soon as practicable after the first twin and, in any event, within twenty minutes. The maternity service was found to be negligently organised. Senior and specialised medical staff did not attend to Mrs. Bull in sufficient time.[47]

Lord Justice Dillon stated: "The Exeter City Hospital provides a maternity service for expectant mothers, and any hospital which provides such a service ought to be able to cope with the not particularly out of the way case of a healthy young mother in somewhat

44. D.G. Kerry, *Lawyer's Comment:* Martin Wilsher v. Essex Area Health Authority *and Causation*, AVMA MED. & LEGAL J., Oct. 1991, at 12.
45. 3 All E.R. at 833-834.
46. On file with the Institute for Health Law.
47. *Id.*

premature labor with twins."[48] The judge went on to say that there should have been a staff reasonably sufficient for the foreseeable requirements of the patient.[49] Lord Justice Slade applied the res ipsa loquitur principle. Lord Justice Mustill, who was also a judge in the *Wilsher* case, commented on the hypothetical argument that the hospital had done the best it could with limited resources:

> Again, I have some reservations about this contention, which are not allayed by the submission that hospital medicine is a public service. So it is, but there are other public services in respect of which it is not necessarily an answer to allegations of unsafety that there were insufficient resources to enable the administrators to do everything which they would like to do. . . . It is, however, unnecessary to go further into these matters, which raise important issues of social policy, which the courts may one day have to address.[50]

Lord Justice Slade further stated that the system operating at the hospital for multiple births was obviously operating on a knife edge.[51] The plaintiff was awarded £750,000 in damages.[52] Based upon the statements of Lord Justice Mustill and the Vice Chancellor, Sir Nicholas Browne-Wilkinson, in *Wilsher*, the argument could be advanced that the standard of treatment to be expected in a public hospital will not be discounted because of external funding problems over which the hospital has no control.

However, Michael Jones, in his text on medical negligence, offers a somewhat different perspective on this issue:

> An action in negligence against a hospital authority which alleges that the plaintiff sustained injury through an inadequate provision of resources, whether it be staff, equipment, or funds for drugs, would have to prove that the lack of resources was a consequence of negligence in the *organisation* of the hospital itself. It is not sufficient simply to point to the lack of resources, since this may well be a consequence of resource allocation decisions over which the hospital has no control.[53]

A reasonable standard of care is to be expected. Lord Justice Mustill took a bold stance on the resource issue and, furthermore, apparently reserved the right to adjudicate in the future issues of

48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.*
52. Keith Miles, *Health Authority Liable for Negligent Organisation of Maternity Services*—Bull v. Devon Health Authority, AVMA MED. & LEGAL J., Jan. 1990, at 11.
53. MICHAEL A. JONES, MEDICAL NEGLIGENCE 282 (1991).

social policy.[54] The *Bull* case is not widely known in the United Kingdom because it is not reported. It deserves wider exposure for its important implications.

A negligence case that displays a somewhat softening of judicial attitudes in this area is *Knight and others v. Home Office and another*.[55] Again, healthcare resources were an issue in this case. A mentally ill prisoner with known suicidal tendencies committed suicide by hanging at Brixton prison in London. His personal representatives sued for negligence, alleging that the general standard of care provided for him in the prison hospital was inadequate. They argued that the standard to be expected was the same as that in a psychiatric hospital outside prison.

The trial judge, Mr. Justice Pill, rejected this argument. Psychiatric and prison hospitals perform different functions, and the duty of care required must be tailored to the act and function to be performed.[56] Mr. Justice Pill stated:

> In making the decision as to the standard to be demanded, the court must, however, bear in mind as one factor that resources available for the public services are limited and that the allocation of resources is a matter for Parliament. . . . [I]n a medical situation outside prison, the standard of care required will vary with the context. The facilities available to deal with an emergency in a general practitioner's surgery cannot be expected to be as ample as those available in the casualty department of a general hospital, for example.[57]

The court found no negligence.

VII. Implications of the Knight Case

In his approximation of the standard of care to be expected, Mr. Justice Pill was apparently unduly influenced by the fact that Parliament allocates resources in the public sector and that these resources are limited. Lord Justice Mustill in the *Wilsher* and *Bull* cases was much bolder in his approach to this issue, as was Nicholas Browne-Wilkinson in *Wilsher*. It is possible, using Mr. Justice Pill's analysis, to argue for a lesser standard of care in public hospitals—an argument that does not serve the general public interest.

The legal standards of care in public hospitals should not be re-

54. *See also* Christopher Newdick, *Rights to NHS Resources After the 1990 Act*, 1 Med. L. Rev. 58 (1993).
55. [1990] 3 All E.R. 237 (Q.B.).
56. *Id.*
57. *Id.* at 243.

duced because they have limited funds or because Parliament controls resource allocation. Public expectations of standards should not be tailored to the reality of resource shortages. If the hospital holds itself out as providing a facility, a reasonable and safe standard of care should always operate. Mr. Justice Pill need not have even introduced the limited resources/parliamentary role issue at all. He need not have gone further than his argument that the standard of care in a prison hospital was different because its function was fundamentally different from that of a public hospital.[58]

VIII. CONCLUSION

There is clear evidence in certain English judicial decisions that judges are fully aware of the issues involved in allocating healthcare resources. Resource allocation problems are reaching the courts and judges respond differently. Medical decision making does not exist in splendid isolation. Unreasonable decisions can be challenged. Courts are prepared to take a hard line when the standards of patient care and treatment fall below reasonable levels and result in injury.

58. See further Re HIV Haemophiliac Litigation (C.A. 1990) (reported in *NLJ Law Reports*, 140 NEW L.J. 1349 (Sept. 28, 1990), for a discussion of negligent policy making and discretion exercised in healthcare resource allocation.