

UK: Legal action highlights social-Darwinist policies against the disabled during COVID-19 pandemic

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16 June 2020

Disability rights campaigners have launched legal action opposing the UK government's "discriminatory" actions toward disabled people during the coronavirus pandemic—including its suppression of data and the use of a "scoring" system to deny ventilator treatment to the sick, disabled and elderly.

This month, the Care Quality Commission revealed more than twice as many individuals with learning disabilities died during the peak of the coronavirus pandemic than in the same period last year.

In just five weeks, between April 10 and May 15, 386 people with learning disabilities who were receiving residential or community-based care lost their lives, compared with 165 in the same period in 2019—a 134 percent increase. Of these, 206 died from COVID-19.

The figures only came to light after legal action by Dr. George Julian, Mark Neary, Dr. Sarah Ryan and Simone Aspis. On May 18, they filed a claim for judicial review against the National Health Service (NHS), Care Quality Commission, NHS Digital, UK Statistics Authority and Health Secretary Matt Hancock over their failure to publish figures on the number of COVID-19 deaths among people with a mental disability or autism.

The Care Quality Commission figures—which include deaths among those with learning disabilities in care homes, independent hospitals and those receiving care in the community—show 53 percent of deaths were linked to coronavirus. According to the Office for National Statistics (ONS), this figure stood at 34 percent for the population as a whole in the same period.

Disabled people have "become cannon fodder," said chief executive of charity Disability Rights UK, Kamran Mallick, in response to the findings. "It is horrifying that there is such a discrepancy in the relative number of deaths of people with learning disabilities and autism compared to the rest of the population," he stated.

The COVID-19 death rate among disabled people is a result of deliberate policies by the British ruling class. A barely concealed agenda of social euthanasia has found expression in numerous medical guidance documents published during the pandemic, which suggest that coronavirus patients can be denied or deprioritised for medical care solely on the basis of their age or existing mental or physical disabilities.

NHS "Decision Support Tool"

In mid-April, the *Financial Times* revealed a "COVID-19 Decision Support Tool" was being used by the NHS. The "tool" claims to help medical workers decide which patients should receive life-saving

intensive-care treatment if hospitals are overwhelmed.

The document, which bears the NHS logo, advises doctors to use a numerical scoring system to assess whether a patient should be admitted to an intensive care unit (ICU). A patient's "score" is calculated using three different metrics: the age of the patient, their score on a Clinical Frailty Scale (CFS) and any co-morbidities.

Only those patients having a combined score under eight points are considered for admission to an ICU. Those scoring above eight would only be considered for "ward-based" care or "Facemask oxygen."

The "Decision Support Tool" allocates patients a score from zero to six for their age, with individuals under 50 years old receiving zero, and with the score going up to five points for 76- to 80-year-olds and six points for those aged over 80. Points are also allocated for health conditions such as hypertension (one point), for a "Severe and irreversible neurological condition including dementia" (one point), and for a "cardiac arrest for any cause" within the last three years (two points).

Patients would also be assessed for "frailty" using the CFS, a nine-point ranking system which ranges from "Very Fit" at number one to "Terminally Ill" at number nine. Vast swathes of the population would automatically receive at least three points ("Managing Well")—indicating that any medical conditions are "well controlled" but the individual is "not regularly active"—or even four points ("Vulnerable"), which describes a patient who is independent but has "symptoms [which] limit activities." Combined with age and co-morbidity criteria, most disabled and elderly people would receive a score well above the eight-point threshold.

A score of seven ("Severely Frail") on the CFS, which would immediately put a patient just one point away from being denied ICU treatment, indicates that an individual is "Completely dependent for personal care from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months)." This definition clearly discriminates against disabled people, many of whom may have significant care needs but are otherwise healthy and could expect to live for decades more.

Medical experts and disability campaigners have noted that the arbitrary CFS scoring system, initially developed to assess the health of elderly people—particularly those suffering from dementia—is entirely inappropriate for use with disabled people.

Chris Hatton, an academic from the Centre for Disability Research at Lancaster University, said of the CFS, "I think anyone with profound and multiple learning disabilities would at best be rated 7 (Severely Frail) ... And perhaps pretty much any adult with learning disabilities who has jumped the eligibility hurdle for long-term adult social care support (around 150,000 people in England alone)—and maybe all children with severe or profound multiple learning difficulties with an EHCP

[Education, Health and Care Plan] (around 40,000 children in England)—would be rated at best as 5 (Mildly Frail) ...”

Disabilities charity Mencap says approximately 1.5 million people with a learning disability would be directly affected by the guidance.

The NHS and National Institute for Health and Care Excellence (NICE)—a government-sponsored health care body—both claimed the guidance was not officially sanctioned and had been drafted by clinicians acting independently. But the document was far from being the work of rogue doctors acting against official advice.

“Clinical Frailty Scale” and the BMA

Prior to publication of the COVID-19 Decision Support Tool, NICE had issued its own guidance to the NHS, which differed from the first document only in the number of metrics used to assess a patient. NICE’s initial guidance instructed medical workers to “assess all adults for frailty” on admission to hospital, “irrespective of age and COVID-19 status. Consider comorbidities and underlying health conditions.”

Using the same Clinical Frailty Scale (CFS) (but this time without assigning “points” for age or co-morbidities), NICE guidance claims that for those scoring above five, there “is uncertainty regarding the likely benefit of critical care organ support ...” These patients would receive “ward-based” care if their condition improves, or “end-of-life care” if it deteriorates—but would not be admitted to intensive-care facilities.

According to the CFS, a score of five (“Mildly Frail”) indicates that a patient needs “help in high order IADLs [Instrumental Activities of Daily Living] (finances, transportation, heavy housework, medications),” a description that is likely to include most individuals with learning disabilities, even if they are physically fit and whose condition has no bearing on their likelihood of surviving COVID-19.

Law firm Hodge Jones & Allen (HJA) issued a legal challenge to the NICE guidance on behalf of a disabled client. Its lawyers explained that many healthy adults with autism and learning difficulties would be classified as a six or seven on the CFS, automatically disqualifying them from ICU treatment. Disabled individuals are far more likely than non-disabled to receive a high score on this scale, HJA explained, “as it is only disabled people who will generally have total dependency for personal care.”

Only after threats of legal action from HJA did NICE later add a caveat that the CFS was not suitable for use with patients “under 65, or [a] patient of any age with stable long-term disabilities (for example, cerebral palsy), learning disabilities or autism.” These individuals should instead have an “individualised assessment of frailty,” a qualification which still leaves disabled people at risk of being denied care.

Only a couple of weeks after the NICE guidelines were released, the British Medical Association (BMA) doctors’ union published advice to its members on how to “maximise overall benefit” of treatment if “demand outstrips the ability to deliver to existing standards.”

Its guidelines state that if hospitals become overwhelmed, doctors “may be obliged to withdraw treatment from some patients to enable treatment of other patients with a higher survival probability.”

The BMA declared that this “may involve withdrawing treatment from an individual who is stable or even improving but whose objective assessment indicates a worse prognosis than another patient who requires the same resource.” The presence of other health conditions may exclude some patients from eligibility for intensive care or ventilation, and it may even be necessary to “discontinue treatment that has already been started.”

Disability campaigners protested the BMA’s guidelines, forcing the

union to issue a clarification document, which stated that being elderly or having existing medical conditions or disabilities should not be “used by itself as a reason to withhold treatments, unless it is associated with worse outcomes and a lower chance of survival.”

At least three separate legal cases are challenging the advice. In addition to the HJA case, law firms Rook Irwin Sweeney and Bindmans sent legal letters to the government and NHS England challenging their failure to issue standardised national protocols and referring directly to the BMA guidance, the “COVID-19 Decision Support Tool” and the NICE guidelines.

Lawyers argue these documents are discriminatory and a breach of the fundamental human rights of disabled people to have equal access to health care.

In a press release, Rook Irwin Sweeney stated on behalf of its clients: “The campaigners [their clients] are concerned that there is no explanation about how patients will be prioritised and that value judgements will be made about disabled people’s quality of life which will lead them to be placed at the back of the queue for treatment.”

The “COVID-19 Decision Support Tool,” Rook Irwin Sweeney argues, “would lead directly to direct age discrimination and indirect discrimination on the grounds of disability.”

Government lies and cover-up

Despite these legal challenges, the government has dismissed any calls for clear and standardised national advice as “fundamentally misconceived.” Responding to the legal letters, Health Secretary Matt Hancock claimed there was enough capacity in the NHS to treat all patients, and therefore national guidance was unnecessary.

This is a malicious falsehood. The argument that the NHS has “coped” is belied by the tens of thousands of lives avoidably claimed by the pandemic. The Office for National Statistics (ONS) has reported that “excess deaths”—considered by many to be the best indication of the actual impact of the pandemic—reached over 63,000 by the end of May.

Public Health England ordered that thousands of people be cleared from hospital beds as the NHS struggled to cope with the influx of seriously ill patients, with many sent to their deaths in care homes. ONS figures show 13,454 people died in care homes across the UK during the COVID-19 pandemic up to May 29. The real figure is far higher—at least 20,000 according to modelling published by the *Financial Times* and the *Times*.

At the same time, “Do not attempt resuscitation” (DNAR) notices were added en masse to the medical records of elderly and disabled people in care homes, without proper consultation with either the individuals or their families:

* At the end of March, three care facilities for adults with learning disabilities in Somerset, Derbyshire and East Sussex were contacted by General Practitioners (GPs) to inform them that all the adults they support should be deemed DNAR.

* Residents at care homes for the elderly in South Wales and Hove had blanket DNAR notices imposed on their care plans, without consultation with the residents or their families.

* In Leeds, staff at care homes reported that district nurses had asked them to “revisit do not resuscitate conversations with people who said they didn’t want them.”

* Turning Point, a care provider for adults with learning disabilities, received 13 “unlawful” DNAR orders from hospitals in April, the same number it would normally receive in a whole year.

The United Nations Special Rapporteur on poverty and human rights, Philip Alston, has roundly condemned these policies, stating that they

“reflect a Social Darwinism philosophy that prioritises the economic interests of the wealthiest while doing little for those who are hard at work providing essential services or unable to support themselves.”

“In a moral failing of epic proportions,” Alston continued, “most states are doing all too little to protect those most vulnerable to this pandemic.”

The normalisation of health care rationing and the wholesale abandonment of the most vulnerable in society is only possible because the NHS has been systematically starved of funds for decades. While private equity funds and other financial parasites have raked in billions from the privatisation of the NHS, the disabled, the frail and elderly are being treated as a burden, blocked from ICU beds and denied the right to live.



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