**Concerns about the BMA Document:**

**Covid-19 Ethical Issues – A Guidance note**

We welcome BMA publishing ethical guidance for their members in relation to Covid-19. Difficult decisions will be necessary as healthcare resources come under strain through increased demand over the coming weeks and months. However, Learning Disability England are seriously concerned that the current document is flawed, and that it is discriminatory towards disabled people (including people with learning disabilities).

We believe that these problems arise largely from the document’s failure to address a conflict between two of its own sets of principles, namely:

1. (Page 2) “In dangerous pandemics the ethical balance of all doctors and healthcare workers must shift towards the utilitarian objective of **equitable concern for all**” (*our emphasis)* and “Equal Respect: everyone matters and everyone matters equally, but this does not mean that everyone will be treated the same”
2. (Page5) “The focus of health professionals …… will be on delivering the greatest medical benefit to the greatest number of people”

This is a conflict because many disabled people will require additional time and intervention to address the same health challenge (such as Covid-19) as faced by a non-disabled person and to achieve the same health outcome as that for a non-disabled person. This will vary between individuals but might (for example) require additional time around communication or additional aspects to medical intervention to allow for the complicating factors arising from that disability.

These additional factors are not only needed, but could be **required by law** in the form of ‘reasonable adjustments’. This means service providers taking reasonable steps to change their policies so as to remove any substantial disadvantage they are causing to disabled people, so as to avoid that disadvantage. i.e. A reasonable adjustment operationalises the first principle outlined above – the achievement of equitable concern for all - and (by treating some disabled people differently) achieves showing that they matter equally. A reasonable adjust does, however, challenge the second principle above.

The current BMA document totally fails to acknowledge this legal imperative and instead clearly falls down on the side of the second principle above i.e. it advises its members to use resources to treat the greatest number of people (e.g. the penultimate paragraph of page 4) - rather than (in some cases) make reasonable adjustments to ensure equitable concern for all.

In this context we welcome the NHS England’s Chief Nursing Officer writing to all NHS bodies on April 7th reminding them that:

“We should be cognisant of the principle of equity of access for those who could benefit from treatment escalation, and the principle of support for autonomy for those who want to be involved in decisions. Even under pressure we strive for the delivery of personalised care and high standards of patient experience.”

Recent NICE guidance (NG159) also recognises additional effort still has to be made for patients with a learning disability – noting they should receive an individualised assessment and not have the standard CFS ‘clinical frailty’ decision making processes applied to them.

Whilst the BMA document does acknowledge the issue of discriminatory practice, and we welcome the document stating (for example) “a simple cut-off policy with regard to age or disability would be unlawful as it would constitute direct discrimination”, it then proceeds to offer BMA members a way out of that through linking age or disability with co-morbidity factors and denying or withdrawing treatment on those grounds. Furthermore, it states that, in the opinion of the BMA, the recommended ‘capacity to benefit quickly’ test would not constitute indirect discrimination because pursuing a “greatest medical benefit to the greatest number of people” approach is a “proportionate means to achieve a legitimate aim” under the Equalities Act.

We fundamentally challenge that assertion for three reasons. Firstly, the NHS constitution states that, the NHS has “a wider social duty to promote equality”, and that the NHS “accept(s) that some people need more help”. Thus, “proportionate means to achieve a legitimate aim” must include these two things in its definition of a legitimate aim. Secondly, it fails to address the duties in relation to reasonable adjustments. Finally, there is now widespread evidence, accepted by the NHS itself, that the poor health of many people with learning disabilities which necessitates some of these reasonable adjustments during the Covid-19 pandemic, has been caused by the NHS’s own failure to deliver equitable services in the past. To deny learning disabled people access to healthcare now because of poor health that was partly created by past NHS failure would, we suggest, be immoral.

We fully recognise the challenges that the NHS and health professionals are facing in the coming weeks and months. We have the greatest respect and admiration for healthcare staff (and social care staff) working in these situations. We understand that some people may not get the healthcare treatment they would have done under normal circumstances and that, for some, this may be a matter of life and death. However, what we cannot accept are guidelines that will discriminate against disabled people. This BMA document will be understood and interpreted by many as being permission to deprioritise healthcare for those who either (i) may take more time to support and treat (which will include many people with learning disabilities), and (ii) who may have additional healthcare needs connected with their disability, including untreated conditions because of past healthcare system failures.

We urge that the BMA immediately review this Guidance note. A few comparatively small changes would address the conflicts we identify here, such as:

* Adding a sixth bullet point under ‘In Brief’ on page one to include reference to people’s human and legal rights
* Including specific statements about the importance of continuing to make reasonable adjustments to allow for a person’s disability, as required under equalities legislation, covering involvement in decision making (as per the Chief Nurse’s letter), communication and treatment of comorbidity.
* Make a specific statement that having a disability (including a learning disability) is not, in itself, a co-morbidity.
* Making a specific statement to note that the ‘capacity to benefit quickly’ test and the principle of ‘greatest medical benefit to the greatest number of people’ will have a flexible boundary in order to allow for actions arising from the making of reasonable adjustments for disabled people.

We would welcome the opportunity to discuss this further with you and assist in the making of these changes if that would be helpful.

**Learning Disability England**