What next?

Withdrawal of Clinically Assisted Nutrition and Hydration

Review by **Rick Thomas**
CMF Public Policy Researcher

The Supreme Court has ruled[1] that clinically-assisted nutrition and hydration (CANH) may be withdrawn from patients in prolonged disorders of consciousness (PDOC) without court approval, where the family and the clinicians agree it would be in the 'best interests' of the patient and the legal requirements of the 2005 Mental Capacity Act (MCA)[2] have been followed. This will apply to:

- Patients with progressive neurodegenerative conditions (eg. Parkinson's or Huntington's disease).
- Patients with multiple comorbidities and/or frailty that are likely to shorten life expectancy, or who have suffered a brain injury (eg. a catastrophic stroke).
- Previously healthy patients with PDOC who are in a vegetative state (VS) or minimally conscious state (MCS) following a sudden-onset brain injury (eg. a traumatic brain injury after a road traffic accident).

The British Medical Association and Royal College of Physicians (RCP) have issued joint guidance[3] in response to this ruling.

The guidance addresses some, bu no means all, of the conerns raised. So, how shall we now respond?

CMF is forming a working group of clinicians and lawyers:

- To monitor the effect of the new guidance in practice: how many patients will have their lives ended in this way? How will their deaths be recorded? Will the ruling open the door to 'euthanasia by stealth' for other categories of patient?[4]
- To consider whether 'consensus' between family and clinicians that CANH be withdrawn truly meets the purpose of the MCA in protecting the rights of the incapacitated person. For example, is it within the boundaries of their professional responsibilities, competencies and resources for clinicians to evaluate conflicts of interest between the incapacitated patient and their family?
- To consider whether to press for an amendment to Section 4 of the MCA to provide that decisions to withhold or withdraw CANH from patients who are not at the end of life must be subject to application to the court for a declaration of lawfulness, irrespective of whether family and clinicians are in agreement.

For more information on CANH see *CMF File*: 69, No water, no life.

references

1. An NHS Trust and others (Respondents) v Y [2018] UKSC 46
2. Mental Capacity Act 2005. *bit.ly/2MtLqkx*
3. Clinically-assisted nutrition and hydration (CANH): New guidance to support doctors making decisions about CANH for adults who lack capacity in England and Wales. BMA 24 May 2019. *bit.ly/2C5XSkC*
4. CMF Files. *cmf.li/CMF_Files*

New abortion statistics published

Alarming trends emerge as rates of abortion increase

Review by **Philippa Taylor**
CMF Head of Public Policy

The latest abortion statistics from the year 2018[1] show that abortion numbers have hit a ten-year high, with 205,295 abortions in England and Wales, an increase of 7,762 abortions from the previous year.

A breakdown of the figures shows some particularly disturbing developments. For example, there has been a steady rise in repeat abortions, reaching 78,998 in 2018. This means that 39% of women undergoing abortions had one or more previous abortions, compared to 33% in 2008. For women aged 30 and over having an abortion in 2018, almost half (48%) had previously had one or more abortions.

Can we really just blame this level of repeat abortions on poor contraception advice or lack of availability of contraceptives? It seems that abortion is being used as a form of contraception now. One young woman, who had her first abortion at the age of 18 and then another three by age 22, was interviewed a few years ago about how she felt having several abortions, she said: 'It does get easier, the more you have. I know that sounds really bad but that's how it is... I just think I was really careless...it was down to me, but I should have been more responsible because I've killed a life now, and it wasn't that baby's fault...'[2]

Another trend in the statistics is the sharp increase in abortions carried out using pills – medical abortions. In 2008, 37% of abortions were medical. By 2018, the proportion was 71%. The use of abortion pills is advocated by abortion providers as a safe and simple procedure. However, a large Finnish study of 42,600 women found that women had four times as many serious complications after medical abortions than surgical abortions: 20% compared to 5.6%. Rates of surgery after medical abortion can be up to 33% for later abortions. These are costs borne by hospitals, not abortion clinics.

Abortion providers (with obvious financial and ideological vested interests in increasing numbers of abortions) are now driving campaigns to make obtaining a medical abortion as easy as possible, removing the administration of the abortion pill misoprostol from medical oversight and removing legal restrictions on abortion. This is likely to cause these statistics to get even worse.

There has also been an increase in disability-selective abortions up to 3,269.[3] This figure includes abortions carried out after 24 weeks gestation; a number that has increased for babies diagnosed with Down's syndrome. This is likely to be partly attributed to the private availability of non-invasive prenatal tests (NIPT) and is a situation that will become worse as the government moves ahead with their proposals to implement NIPT testing into the Fetal Anomaly Screening Programme.

Every one of these abortions represents a failure of our society to protect the lives of babies in the womb and a failure to offer full support to women with unplanned pregnancies.

references

1. Abortion Statistics, England and Wales: 2018. *Department of Health and Social Care* 13 June 2019. bit.ly/2IeC8pM
2. Taylor P. The number of women having several repeat abortions is shockingly high, and increasing. *CMF Blogs* 29 April 2014. cmf.li/2RjULLR
3. Abortion Statistics *Art.cit*