

COVID-19 – ethical issues. A guidance note (As of 15.00 19/03/20)

In brief

During a pandemic, doctors will be working under extreme pressure. Many may be diverted into new and unfamiliar areas of work or find themselves working at or even beyond the ordinary limits of their competence or expertise. Retired doctors may return temporarily to practice, and medical students may be deployed in some front-line roles. Resources are likely to be restricted and choices of available care limited. The pandemic is likely to be fast-moving, relatively unpredictable and of uncertain duration. Providing care to existing standards is likely to be difficult. Prioritisation and triage decisions during the peak of a pandemic are likely to be professionally challenging. Doctors will understandably be concerned about their ability to provide safe and ethical care, and their own health and safety as well as those of their family and friends. They will also be concerned about the possibility that their actions may attract criminal, civil or professional liability.

This guidance note addresses some of the main ethical challenges likely to arise during a COVID-19 pandemic. Wherever possible, links to other sources of advice are provided. From an ethical and professional regulatory perspective – which is also likely to govern the approach of the Courts if there are any legal challenges – doctors should be reassured that they are extremely unlikely to be criticised for the care they provide during a pandemic where decisions are:

- reasonable in the circumstances
- based on the best evidence available at the time
- made in accordance with government, NHS or employer guidance
- made as collaboratively as possible
- designed to promote safe and effective patient care as far as possible in the circumstances.

Should decisions be called into question at a later day, they ought to be judged by the facts available at the time of the decision, not with the benefit of hindsight.

Introduction and background

According to the World Health Organization (WHO), we are at the beginning of a pandemic outbreak of COVID-19, for which we currently have no effective vaccine and very little treatment.¹ Based on current – imperfect – knowledge, COVID-19 has a mortality per case ratio of somewhere between 0.5 and 3.4%,² although these figures are likely to be revised once more is known about background infection rates. An informed estimate by the English Chief Medical Officer (CMO) Professor Chris Whitty suggests a probable mortality rate in the region of 1% or less.³ Other commentators suggest it may be significantly higher than this, although it is too early to make definitive statements. (By comparison, seasonal flu has a mortality rate in the region of 0.1%.) Current data suggest that those

¹ <https://www.bbc.co.uk/news/world-51839944>. Accessed 12 Mar. 20.

² <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---3-march-2020>. Accessed 12 March 2020

³ <https://www.theguardian.com/world/2020/mar/06/uk-has-plans-to-deal-with-pandemic-causing-up-to-315000-deaths>. Accessed 12 Mar. 20.

emergency conditions, and flexible enough to respond to rapid changes in available resources during the development of the pandemic. As more resources become exhausted, so different decisions will need to be made.

Triage systems can also be modified depending upon the required outcome. 'Clinical' triage assesses patients based on need, prioritising those with greatest need. In traditional 'battlefield' triage, priority is sometimes given to those with minor wounds who can be rapidly returned to the field. In 'disaster' triage, which is akin to the scenario envisaged during a serious pandemic, priority will normally be given to those whose conditions are the most urgent, the least complex, and who are likely to live the longest, thereby maximising overall benefit in terms of reduced mortality and morbidity. Priority decisions will be dependent upon the relationship between the availability of resources and the demand. where there is serious depletion, consequently decisions about which patients should receive treatment will necessarily change over the course of the pandemic.

We know that current data about COVID-19 show a strong correlation between older age and mortality. Although work has not been done yet to establish whether this reflects an actual effect of age, or simply a correlation between age and co-morbidities that will affect survival rates, it is likely that the most challenging triage decisions will be made for these groups.

Protocols must ensure these decisions are not made solely based on age. Ethically, triage requires identification of clinically relevant facts about individual patients and their likelihood of benefiting from available resources. Younger patients will not automatically be prioritised over older ones.

A pandemic will obviously not prevent people being ill in other ways. Triage decisions will therefore not only relate to those patients directly suffering from COVID-19. Similar criteria will need to be applied to all varieties of medical need. Consequently, thresholds for granting access to, for example, intensive care or ventilation will have to be changed for all patients with all presenting criteria. By itself, infection with COVID-19 should not guarantee priority.

The presence of co-morbidity may exclude individuals from eligibility. In these circumstances, it may be necessary to discontinue treatment that has already been started as there are patients in need whose outcomes are likely to be more favourable. Difficult decisions will arise where strenuous intervention could reduce mortality significantly but would mean that individual patients use resources that could lead to better outcomes for a larger number of other patients.

The pandemic, and the restricted availability of intensive care, will influence other clinical decision-making within the hospital. For example, it will be important for clinicians to review and document the appropriateness of cardiopulmonary resuscitation for all inpatients (with or without COVID-19 associated illness) where there is a possibility of acute deterioration. If patients have sufficient background illness, co-morbidity and/or frailty that they would not be admitted to intensive care (because of the necessary restrictions on admissions), it is important that cardio-pulmonary resuscitation is *not* commenced in the event of a collapse. Performing advanced resuscitation for a patient for whom post-resuscitation intensive care cannot be provided would potentially cause harm to the patient, consume limited resources at a time of considerable strain, and potentially put the resuscitation team at unnecessary personal risk.