UKCEN

CLINICAL ETHICS NETWORK

Registered with the Charity Commission (No 1120097)

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Dear Chairs of Clinical Ethics Committees,

Covid-19 Pandemic

The COVID 19 pandemic is a medical emergency, an extreme economic burden and a powerfully real clinical ethical challenge. I understand that many of you and your committees are involved in developing guidance and actually managing or planning to manage particular cases.

The UKCEN is looking to support you at this time. We would advocate consistency, transparency and justice in resource allocation across all cases. Justice includes fairness, formal justice and procedural justice amongst other dimensions.

To help with this:

1. There are some key resources below. these have been collected by work from the UKCEN Board as a whole. If there are additional resources please feel free to share these. The ethics resources are too numerous to list but a rapid literature review is being worked towards.
2. The UKCEN will be looking to provide updates through its twitter feed (@UKCEN) and its website (http://www.ukcen.net/covid-19). There have been administrative limitations as many of you know but with support from the Institute of Medical Ethics we are hoping be able to deliver this.
3. We are looking at developing a way to share cases across the network and provide additional views on cases to support CECs.
4. Can I ask CECs to seek to support those institutions without CECs if needed. If formal support is required then the institution hosting the supporting CEC will need to approve CEC involvement given the potential for legal ramifications.
5. Note that resource restrictions can impact upon all services not just critical care facilities and the same principles would apply.
6. The Parliamentary Select Committee on Human Rights is looking for submissions to see how Human Rights can be safeguarded in the context of this crisis. Please submit views if possible (10).

Points from these resources as areas to consider:

The Critical care triage statement, London and SE Coast (20 Nov 2009)(5) in part rests on the observation that that there is a difference between:

(a) resource unconstrained decision-making; and

(b) resource constrained decision-making.

The rapid NICE guidance (1) requires calculation of the clinical frailty scale and then moving to make decisions about admission to ITU. The details of particular case selection remain open. The New York ventilator allocation guidelines (7) make the following strong points:

> *p. 43: "decisions made at the bedside represent an individualized rather than collective approach to ventilator allocation, which result in inconsistencies and increase the potential for inequity, unintentional bias, and ineffectiveness. Without a consistent decision-making framework for physician clinical judgment, processes and outcomes will vary between physicians, hospitals, and locales."*
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> Their approach:
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> *p.33; "Patients for whom ventilator treatment would most likely be lifesaving are prioritized. Patients with the highest likelihood of survival without medical intervention, along with patients with the smallest likelihood of survival with medical intervention, have the lowest level of access to ventilator therapy. Allocating scarce resources in this manner utilizes them effectively and increases the number of survivors by providing ventilators to those who are most likely to survive with ventilator therapy."*

para 4.5 of the NICE guidance (1) states that:

> *"Decisions about the use of critical care resources should only be made by, or with the support of, healthcare professionals with expert knowledge and skills in critical care."*

Useful steps to consider include:

1. Transparent system level decisions about moves to and from resource unconstrained to resource constrained decision-making. (19)
2. if resource constrained decision-making is active then development of a dynamic system for monitoring supply of and demand upon critical facilities with this information fed back down to bedside decision-makers who can then allocate such resources as are available to those most able to benefit on objective criteria.

Additionally, note that clinical staff are potential patients too. Careful consideration should be given to the roles of clinical staff in high risk groups.

Principles include:

- The aim to maximise benefit from the resources available.
- Proper documentation of the context and basis of such decisions made in the context of resource restricted decision-making.
- Recognising that the criterion of 'ability to benefit from therapy' rather than other criteria such as age, comorbidity or disability may be the most efficient way to maximise benefit overall. In regard to this patients suffering from COVID 19 and patients suffering from other diseases should be treated equally

Yours sincerely,

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	Guidance	
1	Rapid NICE guidance	https://www.nice.org.uk/news/article/nice-publishes-first-rapid-covid-19-guidelines
2	BMA guidance	
3	GMC guidance	https://www.gmc-uk.org/news/news-archive/supporting-doctors-in-the-event-of-a-covid19-epidemic-in-the-uk
4	Public Health England guidance	https://www.gov.uk/government/collections/wuhan-novel-coronavirus
	Ethics resources	
5	Critical care triage statement, London and SE Coast (20 Nov 2009)[1]	Attached – developed by St George's ethics committee in conjunction with the Depts of Infectious Diseases and Intensive Care, when the NHS was faced with a predicted H1N1 epidemic in 2010.
6	Some materials for clinicians from Warwick University	https://warwick.ac.uk/fac/sci/med/research/hscience/ssh/research/intensive/resourcesfornhstrusts/
7	New York department of health's ventilator allocation guidelines, published in November 2015 (see below).	https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf
8	Pandemic flu strategy ethical framework on line (2013 updated 2017). From: Cabinet Office, Department of Health and Social Care, Ministry of Housing, Communities & Local Government, Home Office, and Ministry of Justice	https://www.gov.uk/guidance/pandemic-flu#ethical-framework
	Law	
9	User friendly summary of the new Health Protection (Coronavirus) Regulations 2020 Warning – the law is rapidly changing so please check for updates https://www.hempsons.co.uk/services/covid-19-portal/	https://www.hempsons.co.uk/app/uploads/2020/03/Coronavirus-regulations-2020.pdf https://www.gmc-uk.org/-/media/documents/general-medical-council---coronavirus-bill.pdf

[1] Eastman N, Philips B, Rhodes A. Triaging for adult critical care in the event of overwhelming need. *Intensive Care Med* 2010;36(6):1076-82.

10	Parliamentary Select Committee on Human Rights - Inquiry: The Government's response to COVID-19: human rights implications – seeking evidence.	https://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/news-parliament-2017/covid-19-and-human-rights-19-21/ send submission: 1,500 wds max, asap
	Anaesthetics resources	
11	There is now a unified portal for anaesthetists, intensive care:	https://icmanaesthesiacovid-19.org/clinical-guidance
12	Page on current situation:	https://icmanaesthesiacovid-19.org/current-situation
	Webinars	
13	Pandemic ethics: achieving moral balance Dr Dan Harvey, Nottingham	https://attendee.gotowebinar.com/recording/7829962456189868556 (42:20 - 66:55 minutes) Please do complete the evaluation survey after you have viewed the recording: https://www.surveymonkey.co.uk/r/cov2webdel
14	Association of Anaesthetists COVID-19 webinar - 17.03.20	https://icmanaesthesiacovid-19.org/covid19-webinar
	Other resources	
15	COVID-19 guidance for paediatric services	https://www.rcpch.ac.uk/resources/covid-19-guidance-paediatric-services
16	Clinical guidance for use of ECHO during the COVID-19 pandemic (BSE) - 19/03/2020	https://www.bsecho.org/COVID19
17	Clinical Frailty	
18	John Hopkins Coronavirus map: https://coronavirus.jhu.edu/map.html UK Coronavirus case tracking: https://www.gov.uk/government/publications/covid-19-track-coronavirus-cases	

19	Intensive care society	https://www.ics.ac.uk/COVID19.aspx (accessed 23/03/2020) “In particular, on the topic of potential ‘triage by resource’ (declining a patient on the basis of capacity rather than the usual triage by likely outcome/benefit), the following apply: External: nobody should triage until everybody triages (which should be a national decision).We are a networked service and until the last bed in the last hospital is occupied, there are always options. Internal: no one should make capacity-related admission decisions alone. Trust systems such as ‘three wise people’ should be deployed for mutual multidisciplinary support.”
20	Centre of Law, Medicine and Life Sciences Cambridge University. COVID-19 Resources	https://www.lml.law.cam.ac.uk/news/lml-compilation-covid-19