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Ethical Considerations Relating to Critical Care in the context of COVID-19

INTRODUCTION

The following guidance is directed to clinical staff who will be involved in making decisions regarding the prioritisation of critical care resources in the context of COVID-19. The guidance is applicable to the particular situation where resource scarcity arises and rationing decisions have to be made and are applicable to all patient categories. Patients with COVID-19 and other patients requiring intensive care are treated according to the same criteria. Available resources are to be allocated fairly and in a consistent manner.

In response to the COVID-19 pandemic and in anticipation of a significant increase in demand for resources, measures have been and are being taken to increase capacity in the Irish healthcare system, including in relation to intensive/critical care capacity. As part of the process of preparation for dealing with a pandemic and building "surge capacity" it is necessary to make difficult choices in terms of the availability of certain health services (e.g. deferring non-essential appointments, cancelling elective surgeries, transferring patients, etc) to ensure staff, space, and resources are available.

COVID-19 is associated with acute respiratory illness, and clinical evidence indicates that a substantial proportion of patients become seriously ill, requiring respiratory support (e.g. oxygen, ventilation, etc) and admission for intensive care treatment. Therefore, notwithstanding the measures taken to build surge capacity, as part of the pandemic preparedness process, it should be anticipated that healthcare resources, particularly in the context of intensive care, are likely to be severely limited and potentially overwhelmed as the impact of COVID-19 increases and the number of cases increases. In public health emergencies, clinicians will have to adapt their normal practice in order to appropriately respond to the needs of the population. Faced with unprecedented demands, clinicians may

need to replace normal standards of care with 'contingency standards of care'[1] until such point as the pandemic is determined to have been brought under control. This creates a tension between a healthcare professional's duty of care for individual patients and the broader public health consideration of maximising the number of lives saved, and overall health gain, of the population as a whole.

Where intensive care resources become limited, it is ethically necessary, justifiable and proportionate to have mechanisms/decision tools in place to enable healthcare professionals to triage and prioritise access to those resources. In line with the ethical principle of fairness there should be processes to guide the distribution of burdens and benefits across members of society so that no individuals or groups shoulder a disproportionate burden or benefit in a disproportionate way, relative to others. Healthcare planners, managers and clinical staff have a duty to use limited resources prudently and fairly to minimise the loss of life and suffering and produce the maximal benefit possible for individuals served by those interventions.

ADMISSION TO INTENSIVE CARE

In emergency and non-emergency situations, it is not ethically appropriate to offer intensive care to every patient, since intensive care will not provide benefit to some patients who are seriously ill or dying. Access to intensive care should generally be reserved for those patients in whom a good outcome may be expected (those who will most likely survive their acute illness with reasonable long-term status). In line with the principle of minimising harm, it may be necessary to impose stringent restrictions on ICU admission during a pandemic in order to ensure that the available resources are used to achieve the best possible outcome at a population level. The focus on population health in a pandemic situation means that resources which could under normal circumstances have been used to prolong lives will have to be redirected to saving the lives of those who will be most likely to recover. Any allocation procedure must be fair, clinically justified, transparent and documented.

Given the novel nature of COVID-19, decisions are being made on the basis of the best available information. Relevant evidence, as it evolves, will help to inform clinical decisions that have to be made for each individual patient, and will also serve to reassure patients, their

[1] Contingency standards of care involve providing the best possible care under the circumstances. This reflects the legal meaning of standard of care which speaks to what is reasonable in the circumstances.

families and the general public that decisions taken on their behalf are neither arbitrary nor subjective.

While the specific factors utilised within a prioritisation protocol may vary (e.g. Sequential Organ Failure Assessment [SOFA] scores, frailty scores), there are certain common and interconnected features, which should be considered as part of the decision-making process, including:

- the type and severity of the patient's illness;
- the presence of comorbidities and frailty;
- the impairment of other organs and systems; and whether that impairment can be alleviated with intensive care treatment;
- how long the patient is likely to require intensive care treatment for;
- consideration of the patient's capacity to withstand the physical impact of intensive treatment (including mechanical ventilation); and
- long-term functional status should they survive
- the patient's informed views on whether to undergo intensive therapies such as mechanical ventilation

Factors such as frailty or the existence of co-morbidities should only be considered relevant in triage decisions insofar as they will have an impact on the patient's potential to benefit from ICU admission and remaining survival time after discharge. No single factor (e.g. a person's age) should be taken, in isolation, as a determining factor and decisions should not be made arbitrarily or in such a way as to result in unfair discrimination. In the interest of fairness and to protect against unjustified discrimination, it is important that clinicians apply a consistent approach to considering the predictors of outcome for all ICU admissions, including patients with COVID-19 and patients without COVID-19.

Where it is decided that the provision of intensive care treatment is not beneficial or possible in light of the circumstances, patients will be provided with other available and potentially beneficial forms of treatment. For example, in the context of COVID-19, other respiratory supports may still be effective (e.g. non-invasive ventilation, oxygen). In cases where a patient is unlikely to recover, appropriate palliative and/or end-of-life care must be provided. Withholding of critical care does not mean a patient will no longer be cared for.

As the pandemic progresses and intensive care resources become even more limited it may be necessary to review and adapt the decision-making approach accordingly. For example, as pressure increases on intensive care capacity, it may be necessary for a higher threshold to be applied in relation to which patients can access intensive care treatment.

Given their role in referring patients to ICUs, it is essential that senior clinicians and the wider medical team in the hospital are:

- informed of amendments to admission criteria or decision tools so that they can apply them within their own practice and decision-making processes;
- where needed, they should be supported by senior ICU clinicians and hospital management;
- and be aware of their role in discussing critical care treatment options with patients and families and should be supported accordingly.

PROVIDING AND REVIEWING INTENSIVE CARE TREATMENT

It is essential that clinicians discuss the possible risks and benefits associated with intensive care with patients (where possible) and their families in advance of, or upon admission to the ICU. It is important that, at this time or preferably earlier in the illness, that the patient's wishes with regard to emergency treatment (e.g. CPR) and intensive care are ascertained and documented, especially for individuals belonging to a high-risk group. Not all patients will wish to be ventilated in an intensive care unit.

Part of the process of prioritising critical care in a pandemic involves the review of the effectiveness of care for patients who have already been admitted to an ICU. If a patient's condition or prognosis deteriorates, or if it does not improve following admission, decisions regarding the continuation or potential withdrawal of intensive treatment will need to be made. Where a patient is likely to be admitted to an ICU, this should be preceded by an explanation that, in a pandemic situation where resources are severely limited due to increased demand, critical care will be provided on the premise that continuation of treatment will be based on regular assessments of the patient's response to treatment.

It is important to recognise that the pressure arising in relation to the availability of intensive care resources during a pandemic could have a direct impact on other clinical decision-making

within a hospital for patients with or without COVID-19. For example, if, due to his/her condition and prognosis, a patient would not meet criteria to access intensive care during the pandemic, it may not be appropriate to provide that patient with cardiopulmonary resuscitation (should s/he collapse) since the required follow up care in the intensive care unit would not be available. As stated above, this should be discussed with patients and their families in advance. It would be important that any decisions taken in such scenarios are appropriately recorded, e.g. in a do not attempt resuscitation order, and communicated to the patient and/or their family.

Decisions in relation to the provision of cardiopulmonary resuscitation (CPR) to patients who have been admitted to ICU will be based on a consideration of factors including:

- the potential benefits of CPR;
- the potential risks; and
- the likely outcomes for the patient
- Expressed wishes of the patient
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COVID-19 raises specific safety concerns in relation to the provision of CPR. The serious risk of aerosol exposure for healthcare workers requires healthcare professionals to don personal protective equipment (PPE) which will result in a delay in initiating CPR (4 mins+). This delay could adversely affect the outcomes for patients, especially those who do not have COVID-19. Neither the provision of CPR without PPE nor the withholding of CPR (unless already agreed and documented) are considered viable practices, therefore some delay will be unavoidable. This is in line with the more general acknowledgment that in a pandemic situation, contingency standards of care will be necessary in some instances (e.g. the provision of compression-only CPR with early defibrillation).

DECISION-MAKING PROCESSES

It is vital that decisions relating to the allocation of life-saving equipment do not become the responsibility of single individuals. Decisions to prioritise or deny access to critical care interventions should ideally always be discussed by at least two senior clinicians with experience of respiratory failure in ICU (where possible). If circumstances dictate that decisions are being made by clinicians who are not experienced in ICU or where staff are more junior, every practicable effort should be made to consult e.g. through teleconsultation with experienced senior clinicians and this discussion documented in patient record. Intensive

care admission should not be offered to patient or relatives prior to consultation with Critical Care team.

Implementing critical care triage decision tools enables a consistent, more standardised and ethically justified approach to be taken to the decision-making process. While a clinical decision will still need to be made for each patient, a protocol helps to underpin the rationale for that decision. This will be particularly relevant where a multidisciplinary healthcare team is involved in the patient's care. In all cases it will be important for all healthcare professionals involved to document their decisions and the rationale for them and, therefore, it will be important for them to fully understand the criteria being used to arrive at prioritisation decisions. Implementing an intensive care protocol helps to provide clarity in communicating treatment decisions to relevant stakeholders, such as the patient, his/her family, hospital staff, and also to the general public. It is therefore, interlinked with a number of the procedural values and ethical principles set out in the broader ethical framework.

SUPPORT FOR STAFF

Triage is challenging both clinically and psychologically; those responsible for assessing patients and making triage decisions must have proper support in allocating scarce, lifesaving resources. While intensive care staff have considerable experience in making judgments around the withholding and withdrawing of life sustaining interventions, it must be recognised that the COVID-19 pandemic has created an exceptional set of circumstances. Healthcare professionals working in this environment will face unprecedented challenges, both from the scale of critical care resource demands, but also from being unable to provide critical intensive care to some patients who in normal circumstances would have received it. Data from other countries has documented the physical, psychological, emotional and moral burdens that these choices have placed on those working in intensive care. It is imperative that healthcare organisations, institutions and professionals recognise these demands and provide whatever supports are needed, and possible, at this time, and that healthcare professionals experiencing these burdens feel at liberty to discuss the effects of those burdens with employers and colleagues.