ETHICS DURING THE COVID-19 PANDEMIC
May 2020

WORKING outside my usual area of competence or comfort zone

- What if I feel like I am working out with my scope?
  - All doctors have a duty to recognise and work within their competence. But in these exceptional circumstances, doctors at every level may be required to work at the limits of their comfort zone and in some cases beyond. See GMC website for further info: https://www.gmc-uk.org/ethical-guidance/ethical-hub/covid-19-questions-and-answers#Working-safely
  - Key recommendations:
    - consider what is within your knowledge and skills
    - healthcare is a team endeavour, be willing to seek advice and ask for clinical supervision from colleagues
    - seek additional training and guidance. See COVID-19 resources on MED website
    - make sure you know who go to for support and professional advice
    - in an emergency you should provide the safest care you can. If you think that patients are being exposed to avoidable risk, you should tell a senior colleague or manager and work with colleagues to find the best possible solution in the circumstances. Make sure to record any concerns about working outside of your competence and how this could impact on patient safety.

INDEMNITY

- Do I need special indemnity arrangements to treat COVID patients?
  - Doctors must have appropriate indemnity arrangements relevant to their practice.
  - No special provisions are required for treating COVID patients, unless you are working out with your usual scope
  - See https://www.themdu.com/guidance-and-advice/latest-updates-and-advice/coronavirus-medico-legal-update
  - If in doubt, speak with your defence union

The GMC recognise that these are extraordinary times and doctors may be understandably anxious about how context is considered, should any concerns or complaints be raised about their conduct, particularly if working out with scope.

‘Where a concern is raised about a registered professional, it will always be considered on the specific facts of the case, taking into account the factors relevant to the environment in which the professional is working. We would also take account of any relevant information about resource, guidelines or protocols in place at the time’.
GMC Joint statement:
https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

WELLBEING

Your own personal wellbeing is important for yourself, your family, the team you are working with and your patients.

- What should I do if I am feeling overwhelmed?
  - Firstly, these are very stressful and challenging times and work may feel overwhelming at times, particularly when you may be unable to access your usual support structure or coping mechanisms due to public health measures.
  - Recognise it is OK not to feel OK. You are not alone.
  - NES Stress, Coping and Resilience work is a fantastic source: https://learn.nes.nhs.scot/28257/quality-improvement-zone/learning-programmes/scottish-quality-and-safety-sqs-fellowship-programme/stress-coping-and-resilience
  - GMC website also has some useful signposting advice: https://www.gmc-uk.org/ethical-guidance/ethical-hub/covid-19-questions-and-answers#Your-health-and-wellbeing
  - There are also some very useful links to local support on the MED website: https://www.med.scot.nhs.uk/resources/covid-19#wellbeing-and-support
- Above all, talk to someone

GOOD MEDICAL PRACTICE

- Principles of GMC Good Medical Practice (GMP) remain the same, regardless of COVID-19. However, there are some areas in which unique challenges exist.

Confidentiality: Information disclosure to family/carers

- Most hospitals have placed restrictions on visiting. This makes it difficult to deliver face-to-face updates or collate a collateral history and conversations are taking place with families or caregivers over the phone
- In line with GMP: Confidentiality, you should always seek the patient’s permission (where possible) to discuss their care over the phone.
- Try to identify one family member to be the point of contact

- In the event you cannot seek a patient's consent to speak with relatives, information about relevant contacts or proxy decision-makers may be available on TRAK via the Key Information Summary (KIS)

Information disclosure in the public interest

- COVID-19 is a notifiable disease and information disclosure may be appropriate in the public interest where failure to do so may expose others to risk of harm
    - In this event, any disclosure should be proportionate and the benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential
    - See GMC guidance: https://www.gmc-uk.org/ethical-guidance/ethical-hub/covid-19-questions-and-answers#Decision-making-and-consent

Social media

- Social media can be a useful source of information and support for doctors, especially during this time.
- Arguably, doctors have a responsibility to engage with the general public about the virus and its impact.
- Without this, the void may be filled by soundbites from alternative, less reputable sources.
- Guidelines around use of social media remain the same and you should never share information where patients could be identified.
- You should also be prepared to publicly identify yourself when sharing opinions or links on social media.
- GMC guidance can be found here: https://www.gmc-uk.org/ethical-guidance/ethical-hub/covid-19-questions-and-answers#Confidentiality-and-social-media
- It may be fine to post videos on **NHS Lothian's social media feed** ONLY when patients leave our wards having recovered from COVID-19 when patients are happy for that to happen, but you **must obtain written consent** to do so. The consent form is available on the intranet: http://intranet.lothian.scot.nhs.uk/Directory/communications/Documents/CONSENT%20FORM%20FOR%20MEDIA%20AND%20IMAGES.pdf

ALLOCATION OF SCARCE RESOURCES

What is the concern?

One of the main issues dominating the media coverage of COVID-19 has been the concern that doctors will have to make very difficult choices about who to allocate scarce resources to in the event the UK's ICU capacity is breached, despite surge capacity. So far, this has not happened in the UK and we are not currently operating in a resource constrained setting.

Withholding & withdrawing treatment

In countries, like Italy, where the reality of scarce resources has materialised, ventilators have been allocated based on maximising the number of lives saved – the principle of utilitarianism. This means prioritising those patients who are likely to benefit from treatment (medical need) and have the capacity to benefit quickly enough to be discharged so another patient can access that bed or ventilator.

But, doctors have a duty to 'do no harm'. So, how can this be reconciled with treatment decisions which are synonymous with allowing some patients, e.g the frail elderly or those with serious comorbidities who *might* not receive invasive treatment, to die? Such concerns have dominated headlines where statements such as 'doctors forced to play God' underscore the difficulties some of our colleagues across the world have already faced.

However, we must remember that whilst we are in the middle of a global pandemic, basic principles of good medical care and ethics still apply. Where there is a decision that a treatment may not provide any benefit to the patient, the appropriate clinical decision may be to withhold it, COVID-19 times or not. Doctors grapple with these decisions daily, that is not new, and doctors do not have a legal or moral duty to provide treatment which is felt to be clinically inappropriate.[1] But the rationale should always be explained and discussed with the patient and their families (if appropriate).

But these *are* new and challenging times. Doctors may be required to implement decision-making policies which mean some patients may be denied intensive forms of treatment that they may have received outside a pandemic. Doctors may also be required to withdraw treatment from some patients to enable treatment of other patients with a higher survival probability. This may involve withdrawing treatment from an

individual who is stable or even improving but whose objective assessment indicates a worse prognosis than another patient who requires the same resource.

The moral strain this can cause has been articulated in a moving article by a New York Emergency Medicine doctor working in the epicentre of the US COVID outbreak. See https://www.bbc.co.uk/news/world-us-canada-52137160 In this context, patients become commodities. None of us envy her position and desperately hope this scenario never plays out in our hospitals. Withdrawal of medical treatment intuitively always feels morally different from withholding it (never starting it) in the first place. However, legally they are recognised as the same entity – an omission as opposed to a deliberate act to shorten life - assuming that the treatment was no longer providing any benefit to the patient and the doctor's **intention was to alleviate the burdens of treatment not deliberately end their life.**[1]

Making treatment escalation decisions

But what does benefit in this context really mean? In its simplest form, it equates with survival. But COVID times are not that simple. Evidence is emerging from ICUs across the UK that this is not a straightforward disease and the burdens of treatment and lengths of ICU stay are significant.[2] This compounds the difficulty that our critical care colleagues will have to make in deciding how best to allocate scarce resources.

In these challenging times, 'burdens' of treatment will not just represent the burden to that patient, but the likely burden that using that treatment would impose on the current capacity of the hospital and region – as no hospital will be at capacity until all ICU beds are used.[3] In dangerous pandemics the ethical balance of all doctors and health care workers must shift towards the utilitarian objective of equitable concern for all – while maintaining respect for individuals as ends in themselves. Various scoring criteria have begun to emerge incorporating factors such as disease severity, comorbidities, frailty and where relevant, age, to help guide decision making.[4] These matrices are not new and arguably simply codify what already happens in clinical practice. But they are not without controversy as they suggest certain groups will be disadvantaged and on the face of it, remove the 'individual' aspect of decision making.

The lawyer and ethicist, Daniel Sokol has proposed another framework for making these decisions based predominantly on a patient's capacity to survive an ICU stay and the predicted length of stay. Where conflict still arises, he uses 'first come, first served' as well as the more controversial notion of utility to guide resource allocation decisions.

This framework is intended for information and discussion only and is not a legally binding document.[5]

Ultimately, however decisions to allocate scarce resources are made these decisions must be:

- **reasonable** – including based on sound principles
- based on the best available **evidence** and opinion
- **agreed** on in advance where practicable, while recognising that decisions may need to change rapidly
- **consistent** between different professionals as far as possible
- **communicated** openly and transparently
- subject to modification and **review** as the situation develops.

RCP Ethical guidance:
https://www.rcplondon.ac.uk/news/ethical-guidance-published-frontline-staff-dealing-pandemic

But where ICU is not an option, there is **always something we can do**. Aggressive ward level management may be appropriate. Where that fails, we can provide good end-of-life care and hold the patient's hand. Now more than ever, it is imperative we make clear and person-centred treatment escalation or anticipatory care plans (ACPs) for every patient.

See links to ACP resources and providing EOL care on the MED website
https://www.med.scot.nhs.uk/resources/covid-19#doctors-in-training

See links to Death certification in times of COVID-19 in MED resources
https://med-assets-docs.s3.eu-west-2.amazonaws.com/mccd---slides.pptx

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3. Intensive Care Society COVID-19
   https://www.ics.ac.uk/ICS/COVID-19/COVID19.aspx?hkey=d176e2cf-d3ba-4bc7-8435-49bc618c345a

4. NHS 'score' tool to decide which patients receive critical care:
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5. Daniel Sokol, Decision Making for Intensive Care Triage, A Practical Guide for Clinicians and Hospital Managers
   http://medicalethicist.net/wp-content/uploads/2016/06/v5-Sokol-ICU-Triage-April-2020.pdf