RESTORATION OF SERVICES – AN ETHICAL APPROACH

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I am a senior leader at an ICS or STP responsible for leading the restoration of clinical services following their suspension. What are the ethical issues that I need to consider and what are the specific issues related to COVID?

INTRODUCTION

It is very unlikely that all clinical services that were provided before the COVID pandemic can or will be provided in the same way, with the same capacity in the near future. Choices about which services can or should be restarted will have to be made. Choices will also have to me made about which patients should have priority for treatment – particularly those affected by the suspension of services because of COVID. These decisions should be made ethically on the basis of fairness, equity and justice; however, conflicts may arise as a result of trying to address these principles, particularly between egalitarian and utilitarian approaches. The decisions that are made must explicitly confront these conflicts and systems must be open about the basis on which decisions have been made. As far as possible there should be consistency of service provision and access across the Region to avoid the development of post-code lotteries. Proposals must also take account of social care restoration.

The following points highlight ethical issues that should be considered by clinical leaders when making these decisions

CONSIDER THE IMPACT ON THE MAIN GROUPS AFFECTED BY COVID

As well as considering the needs of the population as a whole it is important to consider the needs of those who are specifically affected by the COVID pandemic.

- Those waiting for treatment at time services were stopped because of COVID.
- Those newly assessed as needing treatment during and after suspension of services because of COVID.
- Those who cannot be assessed (e.g. needing a CT Scan) to determine need for treatment during and after suspension of services because of COVID.
- Those who cannot be assessed (e.g. needing an endoscopy) to determine need for treatment because continuing issues with infection control risks because of COVID.
- Those whose treatment would put them at excess risk of poor outcomes from COVID e.g. those requiring immunosuppressive chemotherapy.
- Those unable to meet self-isolation criteria prior to treatment/investigation.

APPROACHES TO PRIORITISATION OF PATIENTS AND RESTORATION OF SERVICES AND THEIR ETHICAL BASIS

As national ethical guidance notes, the principle of justice requires (*inter alia*) that people are treated fairly and equally, processes are fair, and that decision-making is consistent. Legal rights should also be respected, including those in human rights instruments and in the Equality Act 2010. However, different approaches may potentially be taken to the prioritisation of the restoration of services and the needs of patients in the groups above. National bodies, including professional associations and the Royal Colleges, as well as local ethical groups have given guidance on these issues. SWERG has made the following observations on approaches to prioritisation:

- **First come, first served.** SWERG notes that in the UK first come first served plus queuing is a widely accepted social norm which is largely **egalitarian**; jumping the queue is widely regarded as unacceptable. Thus, using existing queues for assessment and treatment as a basis for prioritisation offers simplicity and acceptability, but it may not achieve the best overall use of resources or achieve the most equitable and desirable health gains (i.e. is not a **utilitarian** solution). However, in some cases it may also be an unfair approach as some may not be able to join the queue (e.g. because of difficulty accessing the queue because of issues with location or technology, or because of disability) and thus it is not completely **egalitarian**.
- **Prioritisation criteria**
  - **Need.** To each according to need is a founding principle of the NHS. Restoration of services could mirror these needs. SWERG notes that priority should, wherever possible, be given to those in greatest need, for example, to those who are suffering more or at risk of suffering more. **Egalitarian** approaches suggest that those with equal clinical needs should have equal rights of access. However, SWERG also appreciates that assessment of need is often problematic and there may be situations where other approaches to prioritisation are required.
  - **Risk of delay.** SWERG notes that priority may need to be given to those patients where a delay in their treatment may lead to significantly worse outcomes e.g. many cancer treatments. Priority may need to be given to those services providing such treatment.
  - **"Status".** SWERG notes that "status" may sometimes be relevant: for example, it may be appropriate to seek to address existing inequalities, by offering priority for sub-groups of the population who currently have poorer than average health outcomes. Restoration of services could be planned in a way that attempts to address these inequalities.
  - **Ability to benefit.** Some guidance promotes a **utilitarian** approach, aimed at "delivering the greatest medical benefit to the greatest number of people",[1] which would direct resources to those most likely to benefit. SWERG notes that assessment of the benefit of treatment is problematic and that tools for assessing benefit, e.g. QALYs, may have intrinsic weakness. Restoration of services could be sequenced in a way that prioritised those services giving the greatest benefit to the community as a whole. Some guidance

[1] BMA

refers to "the capacity to benefit quickly",[2] although other guidance omits "quickly".[3],[4],[5] Adopting this approach may mean indirectly discriminating against some individuals, since (for example) older individuals or those with disabilities might be disproportionately affected; the BMA nevertheless believes this may be justified in pandemic circumstances of overwhelming demand for life saving resources- circumstances where as the BMA guidance puts it, 'demand outstrips the ability to deliver to existing standards'.[6] Even guidance which adopts "capacity to benefit" notes that there may be situations when different individuals have equal chances of benefitting. Where this is the case, some guidance proposes for them an **egalitarian** system of "first come, first served".

- **Demands.** Demand alone should **not** determine whether (or not) someone receives particular resources. Harmful treatments, or those unlikely to work, should not be offered, regardless of demands.[7] Guidance for intensivists and anaesthetists adds that clinicians should not treat patients differently now because of anticipated future demands i.e. in view of resource constraints that might arise in the future.[8],[9],[10]

- **Rationing – stop offering some treatments**

  Limits on resources and overall capacity may mean that not all therapies/interventions that were previously provided can be restored. To be acceptable the criteria used to determine which services are not provided at all must also be acceptable to society as a whole and again not systematically disadvantage particular groups of individuals.

Whichever approach(es) to prioritisation are taken, SWERG emphasises the importance of not systematically disadvantaging particular groups of individuals, and of engaging with the public to determine what is acceptable.

SWERG emphasises the importance of **transparency** to underpin an ethical approach**.**

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[2] BMA

[3] Royal College of Paediatrics

[4] Royal Pharmaceutical Society

[5] UKCEN

[6] BMA

[7] RCN

[8] ICS

[9] FICM

[10] The Faculty of Intensive Care Medicine, Intensive Care Society, Association of Anaesthetists and Royal College of Anaesthetists

PARTICULAR ETHICAL ISSUES TO CONSIDER

- Restarting first those services which are convenient to do so doesn't seem morally appropriate.
- There is a need to openly consider health care rationing as a way to demand manage.
- There are many interventions of minimal benefit to the patient, either because of their intrinsic effect or because of the patients' overall health, that could be 'rationed' or not provided at all to optimise use of resources.
- There are a number of ways of assessing the value of interventions including potential life opportunity lost, but value is a difficult concept.
- A 14 day self-isolation period before and after treatment may not be possible for everyone and therefore may not be equitable.
- Policies on pre- and post-treatment isolation should be applied equally in hospitals throughout the health system to ensure equity.
- There must be public involvement in the debate, with perhaps a role for the Citizens Assembly.
- Patients views regarding the value of interventions should be taken into account both in regard to individual treatment decisions and in relation to provision of services by the system.
- Patient views re value can be driven by unrealistic and overly optimistic expectations of the offered intervention, as well as unfounded anxieties about the risks.
- The balance of immediate versus long-term harm.
- Ways to compare benefit between outcomes for conditions with different acuteness of need.
- Comparing conditions with different intensity of need.
- Comparing conditions across specialities.
- Capacity should as far as possible be seen as an issue across the whole system and not just in one sector or geographical location.
- Proposals must take account social care provision as well as medical services.

SPECIFIC QUESTIONS FOR CLINICAL LEADERS MANAGING THE RESTORATION OF SERVICES

- What service(s) can be provided?
- What do the public think should be provided?
- When should a service be provided?
    - What benefit might patients gain? (if small, not such a strong obligation?)
    - What perceived and objective risks (e.g. of contracting COVID or poor outcomes if treatment is delayed) might be posed to patients?
    - What risks (e.g of infecting others with SARS-CoV2) might patients pose to other patients, staff, members of the public?
    - What impact does provision have on ability to provide other services?
    - What should be prioritised?
- What and when should patients and the public be told about the background to decisions about restarting services, the risks and the fact that some service will not be restored at all whilst others may effectively not be restored because they will always be low priority?

Please send any comments to:

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