Key COVID-19 legal developments in the health sector: Critical Care – Clinical Decision making and Ethics

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BMA Guidance has sought to provide assistance and clarity for the challenging decisions for frontline critical care (and other) staff as the volume of patients with COVID 19 requiring inpatient treatment rises, and the available resources in terms of critical care beds, ventilators and staff are pushed to their limits as the pandemic evolves in the UK.

Key headlines from the **BMA guidance** includes:

- The need for NHS Trusts to allocate responsibility for policy making around triage of patients, clinical prioritisation and the allocation of limited clinical resources, in line with BMA ethical guidance;

- In planning for these issues, Trusts will need to urgently formulate policies and protocols with regard to:

    - Triaging of patients
    - Allocation of limited clinical resources at points of pressure
    - Involvement (or creation) of clinical ethics committees wherever possible
    - Always having regard to the potential availability of additional resource elsewhere
    - Ensuring that policies and protocols are:

        - Clear
        - Kept under regular review
        - Revised promptly as circumstances change
        - Communicated clearly and promptly to clinical teams

- In relation to triaging patients, these decisions relate not only to the question of whether to escalate care into a critical care/ventilator setting, but also when to stop that line of treatment.

- The essential criteria must consider which patients have the greater capacity to benefit from the escalation to critical care, or who may benefit more rapidly from that escalation. Considerations may include the severity or impact of COVID 19 for the individual patient, and may take account of underlying comorbidities and other underlying factors *where they are clinically relevant*. Blanket rules around age or medical conditions or disabilities must *not* be created, however the analysis of capacity to benefit from escalation of care to critical care settings, may include age if this is a *relevant clinical factor* to the individual patient's capacity to benefit from escalation of care.

- All resource allocation decisions must be:

    - reasonable in the circumstances
    - based on the best available clinical data and opinion
    - based on coherent ethical principles and reasoning
    - agreed on in advance where practicable, while recognising that decisions may need to be rapidly revised in changing circumstances
    - consistent between different professionals as far as possible
    - communicated openly and transparently
    - subject to modification and review as the situation develops

- On PPE, the BMA make clear that if there is insufficient or inadequate PPE available for a healthcare professional to provide treatment to a COVID 19 patient, there should be no obligation on the healthcare professional to provide that treatment, but instead urgent discussion about how treatment can be given in alternative ways.

NICE Guidance

NICE guidance published on 20 March and updated on 31 march supports clinical decision making for those making challenging decisions around which patients to escalate to critical care units, how to manage those who are not admitted to CCUs, and

review of outcome goals per patient in order to make appropriate decisions as to the likely achievement of those goals day by day. Compliance with the guidance is not mandated, and the content does not seek to usurp reasonable clinical decision making, or the evolving local and national priorities. This guidance is however intended to assist and support robust clinical

decision making, and having regard to its content will assist with risk management of such difficult decisions, supporting staff, patients and their families and carers at such a challenging time.

Key headlines:

- All adults should be assessed for frailty upon admission to hospital, irrespective of COVID-19 status.

- Reference to, and use of the Clinical Frailty Scale (CFS) as a reference point for considering clinical pathways for patients being admitted to hospital, and specifically part of the application of a Clinical Care Admission algorithm.

- Both tools provide clinical decision makers making escalation of care decisions, with a frailty indicator point of below or above 5 on CFS as a suggested benchmark. This remains subject to taking advice from experienced CCU staff, more used to making such clinical decisions than the extended staff pool that will be necessary under COVID 19 resourcing.

- The CFS should not be used in younger people, people with stable long-term disabilities (for example, cerebral palsy), learning disabilities or autism. An individualised assessment is recommended in all cases where the CFS is not appropriate.

- As ever, clinicians must also consider underlying pathologies, comorbidities and the severity of the patient's acute illness. This includes an assessment of whether the patient is likely to benefit from critical care intervention, with an assessment of "likelihood of recovery" from CCU, with an outcome that is acceptable to the patient (our emphasis).

- The requirement to discuss the above with the patient (if possible), and/or their family and carers, continues. This can be simply summarised as a discussion as to the benefits and risks of critical care, plus a realistic discussion as to the likely outcome for that patient.

- For patients accepted to CCU, the guidance encourages very regular reviews of progress against planned 'goals' of the escalated critical care, to realistically assess whether those goals remain realistically achievable. The expectation is that CCU intervention should then stop, if those goals no longer appear achievable. Full documentation of discussions with families and carers (or an IMCA) regarding that decision, is of course essential.

At a practical level, the guidance suggests:

- a review of a hospital's Management of the Deteriorating Patient strategy, noting NEWS2 has been endorsed by NHSE and NHSI.

- Such strategy should also include advice and assessment by CCU staff by telephone rather than face to face, where clinically indicated.

- Proactive exploration of resources in local networks to achieve transfers to optimise use of CCU beds.

- Access for CCU to bed data to assist with management of patient flow decisions.

- Establishment of level 2 or level 3 capacity across the hospital

- Consideration of an enhanced care facility being created.

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