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Coronavirus and critical care

Ventilators and the number of critical care beds are a regular feature of the Government's daily briefings and the questions posed by the media. This newsflash explores the guidance currently available and which legal provisions apply. It concludes with some practical considerations to ease any legal difficulty in the provision of critical care in these extraordinary times.

Background

There have been whispers for some time that clinicians will be given guidance as to the potential rationing of limited resources during this pandemic. At the time of writing, there are no national directions or explicit instructions as to which patients clinicians will be expected to prioritise if the critical care saturation point is reached.

Interestingly, there is provision in the Coronavirus Act 2020 for the Secretary of State to issue guidance to local authorities as to the exercise of their functions which presumably will detail how to prioritise and ensure the best use of resources in a time of emergency. There is no equivalent provision in relation to healthcare.

Guidance

Guidance produced by NICE on 21 March provided an algorithm for referrals to critical care. At the core of this process was an assessment under the Clinical Frailty Score (CFS). On 25 March 2020 the algorithm was amended to take into account additional factors. Under this, the CFS is to be used only for patients over 65 without stable long-term disabilities, learning disabilities or autism. Comorbidities and underlying health conditions are to be considered in all cases as part of the frailty assessment. The algorithm can be found here.

On 1 April 2020, the BMA published a guidance note on ethical issues surrounding Covid-19 which can be found here. This guidance deals specifically with decision making where serious health needs have overtaken the resources required to treat them and the consequent need to provide the greatest medical benefit to the greatest number of people. The BMA guidance asserts that decisions to prioritise care (including withdrawing resources from Patient A to give them to Patient B because they have a better prognosis) are both lawful and ethical if carried out correctly. Such decisions will be made outside of the Mental Capacity Act 2005 and the "best interests" framework and clinicians must comply with the decision-making protocols rolled out by their employing or commissioning bodies.

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The guidance stresses that all decisions concerning resource allocation 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 7 April 2020 the Royal College of Physicians also provided an ethical dimensions document which can be found here. This guidance highlights the need for clinical decision-making during this time to be accountable, inclusive, transparent, reasonable and responsive. Decision making should not be disease specific and treatment should be provided irrespective of the patient's background where it will help the patient survive and not harm their long-term wellbeing. It stresses that the usual good care principles continue to apply including consideration of the patient's wishes as much as is feasible and, if appropriate, their carers'.

Legal Framework

We set out below the legal considerations which may go to a decision as to critical care provision and its withdrawal:

1) An act done, or decision made, on behalf on an adult lacking capacity must be in their best interests (Mental Capacity Act 2005)

2) Best interests have to be assessed from the particular patient's point of view. A treatment is not futile if it would provide an outcome which the patient would find acceptable (Aintree University Hospital NHS FT v James)

3) Neither a patient nor a family member can dictate what treatment is provided

4) The law does not require doctors to provide treatments or procedures that they have assessed as not being clinically appropriate or not of overall benefit to the patient.

5) The Court of Protection can only look at available options in order to decide which is in the patient's best interests (a CCG and another v MN and others)

6) The legal question is not whether it is lawful to withdraw treatment but whether it is lawful as being in a person's best interests to continue to give it (Aintree University Hospital NHS FT v James)

7) The doctrine of necessity may justify a balancing exercise between two patients to determine the least detrimental course of action (re A (conjoined twins))

8) It is not unlawful to set out guiding principles as to how to prioritise scarce resources (R(BA) v Secretary of State)

9) Health bodies have a duty to promote a comprehensive health service but what is necessary at any point is informed by the available resources (R v North and East Devon HA, Ex p Coughlan)

It is easy to envisage conflict between the provisions set out above. The law in relation to critical care to date has focussed on an individual's best interests and the Court of Protection deals only with the individual - resources have simply not been a factor in any court decision in relation to withholding/withdrawing critical care treatment of an individual. However, if we reach the point where national critical care is saturated, public law principles (8 and 9 above) will come into play – principles which, although applied regularly in relation to commissioning services, have not been seen before in critical care in this way.

What to do

The BMA guidance calls for public acceptance of rationing decisions and highlights that this is more likely with oversight by elected or other appropriate representatives. It may be that national rationing directions will be produced. Until this and/or there is a relevant court decision, we suggest the following practical considerations for those working in the field:

1) Robust care planning will be essential. This should set out:

- proposed treatment;
- the goals of such treatment;
- what will happen not only if these goals are reached but also if they are not reached;
- the timescales for review and a decision on continuing and what factors may result in those timescales being adjusted.

Whilst the legal provisions are clear that starting a treatment and continuing to provide it are to be considered as one, in practical terms, patients and families often consider that starting a treatment implies that it will be continued until a very definitive point (either recovery or death). It is this assumption that often results in the need for legal or court involvement. Robust care plans and goal setting are essential in order to prevent such assumptions.

2) Early and clear discussions with patients and families – this will be undoubtedly be tricky and may have to take place via technology but cannot be avoided.

3) Ensuring the correct people have the difficult conversations – this is not easy in a time where staff are pressed and there are a number of people acting outside their usual area of expertise. However, Trusts may wish to identify a core team of high level intensivists who can act as the first port of call for advice and input for tricky cases. We suggest any such team should support those most directly involved in care for joint decision making and not just take over the decision making.

4) Keeping full records of the decision-making process for individuals so that the position is clear if there is later scrutiny.

5) Drafting of or contribution to appropriate local guidance to ensure a consistent approach to assessing a patient's capacity to benefit quickly should the national saturation point be reached. This should take into account both the NICE and BMA guidance and include:

    - Severity of acute illness
    - Presence and severity of co-morbidity
    - Patient age in so far as it is clinically relevant

Any such guidance should steer clear of:

- Any blanket exclusions
- A strict age cut off – age will undoubtedly be a factor but must be considered in context
- Prioritisation on the basis of social factors, e.g. an NHS worker. It is an entirely understandable consideration and may indeed become a factor if the situation worsens further. However, this should be a nationally guided decision.

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If there is a dispute

Having a clear plan from the start and discussing it will help to avoid later disputes or may identify situations where a dispute is likely.

In any event, disputes need to be escalated at an early stage so that other interventions can be tried, including taking specific legal advice.

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