



# Ethical dimensions of COVID-19 for frontline staff

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In response to the growing urgency of the COVID-19 pandemic, the Committee on Ethical Issues in Medicine of the Royal College of Physicians (RCP) has developed the following guidance for frontline staff.

Presently there is no specific treatment or prophylaxis option for COVID-19. As seen with previous pandemics, this can change over time. The practical ethics will change as such options emerge. This should be taken into account when reviewing this document and making ethical decisions based on the advice presented here. This guidance has benefited from multiple stakeholder input, including the General Medical Council (GMC), the Faculty of Intensive Care Medicine, the Intensive Care Society, royal colleges and faculties. It provides guidance for the difficult ethical issues that frontline staff will face while caring for their patients during the pandemic. The Committee on Ethical Issues in Medicine reserves the right to change this advice at any time to reflect the current situation with the COVID-19 pandemic.

## Ethical framework that informs the guidance

Pandemics present difficult logistical, medical and ethical challenges to the medical workforce. Pandemics require incorporating public health ethics with clinical ethics. Distributive justice is the most often cited ethical principle during a pandemic; however, we suggest that, for the clinical workforce in particular, fairness is a better way of understanding and approaching the ethical problems that the workforce will encounter and are encountering. Fairness is often part of disaster or emergency medicine ethics, and presents a useful ethical approach for clinicians to COVID-19. The principal values that inform this guidance are that any guidance should be accountable, inclusive, transparent, reasonable and responsive.<sup>1</sup>

By these we mean:

Value	Description
<b>Accountability</b>	Measures are needed to ensure that ethical decision-making is sustained throughout the crisis, ideally nationally.
<b>Inclusivity</b>	Decisions should be taken with stakeholders and their views in mind.
<b>Transparency</b>	Decisions should be publicly defensible.
<b>Reasonableness</b>	Decisions should be based on evidence, principles and values that stakeholders can agree are relevant to health needs, and these decisions should be made by credible and accountable members of staff.
<b>Responsiveness</b>	Flexibility in a pandemic is key. There should be opportunities to revisit and revise decisions as new information emerges throughout the crisis, as well as mechanisms to address disputes and complaints.

Good stewardship, guided by a doctor's duty to care is key to good ethical practice in a pandemic. The above values promote action and decisions that are fair, reciprocal, respectful, and equitable.<sup>2,3</sup> Adopting this approach will support the workforce as they cope with the increased demand, while maintaining good ethical processes in their care, and continuing to promote the ethical values they already maintain in their current practice.

# Specific recommendations for ethical practice and decision-making during the pandemic

Developed from the above values and principles, the following offers specific guidance for the kinds of situations that frontline staff may find themselves in as the pandemic progresses. This advice takes into consideration the recent joint statements released by the GMC, the NHS and the chief medical officers in the UK. We hope that this practical advice will be of use to the workforce if and when they are faced with difficult situations. This advice will be added to and adjusted, in accordance with the value of responsiveness, as more is learned about the pandemic.

With all the guidance below, the usual principles of good care still apply:

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*Any decisions made to begin, withdraw or withhold care must also comply with the shared decision-making policies of the NHS. This means that these decisions should include the patient and their wishes (as much as is feasible for the given situation) and, if appropriate, the patient's carers. This is true regardless of whether the patient has COVID-19.*

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## Ensuring fair and equitable care

Frontline staff, policymakers, management and government have a responsibility to patients to ensure that any system used to assess patients for escalation or de-escalation of care does not disadvantage any one group disproportionately. Treatment should be provided, irrespective of the individual's background (eg disability), where it is considered that it will help the patient survive and not harm their long-term health and wellbeing.

## Caring for COVID-19 vs non-COVID-19 patients

Decision-making should not be disease specific – ie the presence or absence of COVID-19 should not be a limiting factor in treatment decisions. Where care between a COVID-19 patient and another patient in need of care is in question, care should be prioritised based on national guidance. Resources will be inevitably stretched, with doctors having to make decisions about whether patients can or cannot receive necessary treatment.

However, efforts must be made to ensure that the public (patients, carers and those not yet ill) understand the purpose of any treatment guidelines being used. Patients and their families must understand how the guidance is applied, so they are able to trust that it is consistently and fairly applied. This will help to avoid fears in the public that doctors and nurses are allowed to 'ignore' certain patients, which is not and will not be the case.

## Making difficult decisions

For reasons of practical and moral support, it is advisable that assessment and prioritisation decisions are carried out by more than one clinician colleague, where feasible. Decisions to escalate care to ITU should have input from ITU doctors. As is normally the case it is recommended that, where appropriate, decisions within ITU involve the multidisciplinary team. This is particularly so if a decision is taken to withdraw treatment from existing patients in critical care. While it is ethically equivalent to withdraw treatment instead of withholding treatment, the stakes will undoubtedly be seen and felt by all to be very much higher when it comes to withdrawing treatment. These decisions must be made with the patient and, if appropriate, their carers.

All decisions must be appropriately documented, to ensure accountability and for the legal protection of frontline staff. Again, any decision to start, withdraw or withhold treatment must be made in accordance with existing national guidance.

## Accountability for decision-making

During a pandemic, all accountability for decisions still holds. While doctors may have to work outside their usual location or specialty, they will still be held accountable for their decisions, just as they would during their regular practice. Decisions, regardless of whether they are COVID-19 related, should be made according to protocol and justified where required, as per good clinical practice. To provide accountability across the pandemic, documentation of the decision-making process is very important. As far as possible, conclusions should be in writing, and the reasons for any decision should be clearly set out.

## Support with difficult decisions

Medical ethicists (sometimes referred to as bioethicists) can help frontline staff with difficult decisions, particularly where there is significant disagreement or a stakeholder might wish some form of external appeal other than a second opinion. Hospitals may wish to engage medical ethicists, or form clinical ethics committees to help with such situations.

Teamwork and mutual support across the whole healthcare team are essential to making difficult decisions. Working together and consulting colleagues regularly, including MDTs where appropriate, recognises that everyone is working in very stressful situations, in different ways and may be exhausted. Support and solidarity with all our colleagues is so important in this time.

## Discussing care wishes with patients

Many frontline staff will already be caring for patients for whom any escalation of care, regardless of the current pandemic, would be inappropriate, and must be properly managed. We strongly encourage that all frontline staff have discussions with those relevant patients for whom an advance care plan is appropriate, so as to be clear in advance the wishes of their patients should their condition deteriorate during the pandemic.

## Prioritising ITU beds and resources

ITU beds, in fact all hospital beds and resources, should continue to be allocated based on appropriate assessment methods. This assessment should be continual as new cases present, to ensure that those patients in most need of care are continually prioritised and cared for. As is always the case in critical care, there will be some patients (with or without confirmed COVID-19) for whom admission to ITU would be inappropriate. National Institute for Health and Care (NICE) guidance on how to assess these patients for care during the pandemic has been issued and can be found [here](#).

## Working outside of specialty

Doctors are bound by their duty of care for patients in the pandemic. In a pandemic, this duty of care is part of equitable, reciprocal practice that shows solidarity while protecting the public from harm. To uphold this duty of care, doctors will need to be flexible, and may need to work in locations or clinical areas outside their usual practice. This will be especially true for those doctors who find their elective clinics and procedures cancelled during the COVID-19 crisis. Doctors should be prepared and supported to work outside their normal practice, but not obligated to work outside their competency. There should be overt support of the clinicians – preferably by the government,

but at the very least by the trusts/health boards employing the clinicians. Doctors working out of remit should be provided with appropriate training and personal protective equipment (PPE) to work competently in their new role.

## Doctors with pre-existing conditions or over the age of 70

The government has advised that there is an increased risk of severe illness from COVID-19 in those aged over 70 or under 70 with certain underlying health conditions. Some of our workforce will come under one or both of these categories, and should consider these risks if they choose to continue working.

Doctors have a duty to protect the public from harm, an extension of which is the right to protect themselves from harm so they can continue to care effectively. In this respect, it is ethical for those doctors who would be harmed by contracting the virus to refrain from treating patients with (or suspected) COVID-19. In line with the above recommendation that doctors need to be flexible during a pandemic, it may be necessary to reassign these doctors to roles that do not involve contact with these patients (eg as NHS 111 responders or teleconsultation services), so that their expertise can help with the pandemic, while keeping these individuals safe. In addition, those doctors with care responsibilities for vulnerable family members should also be given the option of stepping back from frontline care of patients with COVID-19, as part of their duty of care to that family.

## PPE for frontline staff

In order to fulfil their duty of care to their patients, frontline staff must be appropriately shielded from harm, regardless of the source of that harm. Caring for patients with or suspected COVID-19 requires appropriate PPE, and all frontline staff should have constant access to PPE during the pandemic, as specified in the current Public Health England guidance. If asked to care without appropriate PPE, doctors should immediately report this to the relevant director of that clinical service. If possible, please also report it via the RCP reporting system.

## Specialty-specific advice

We recognise that other colleges have developed more tailored advice on ethical issues for their members. When made available, links to this advice will be available here.

The Royal College of General Practitioners is producing specific GP guidance that is forthcoming.

## References

- 1 Daniels N. Accountability for reasonableness. *BMJ* 2000;321: 1300–1. <https://doi.org/10.1136/bmj.321.7272.1300>
- 2 Thompson AK, Faith K, Gibson JL *et al.* Pandemic influenza preparedness: an ethical framework to guide decision-making. *BMC Med Ethics* 2006;7:12. <https://doi.org/10.1186/1472-6939-7-12>
- 3 UK Government. *Guidance: Pandemic flu*. 2017. [www.gov.uk/guidance/pandemic-flu#ethical-framework](http://www.gov.uk/guidance/pandemic-flu#ethical-framework). [Accessed 29 March 2020].

## Further reading

Badano G. If you're a Rawlsian, how come you're so close to utilitarianism and intuitionism? A critique of Daniels's *Accountability for reasonableness*. *Health Care Anal* 2018;26:1–16. <https://doi.org/10.1007/s10728-017-0343-9>

Bensimon CM, Smith MJ, Pisartchik D, Sahni S, Upshur RE. The duty to care in an influenza pandemic: A qualitative study of Canadian public perspectives. *Soc Sci Med* 2012;75:2425–30. <https://doi.org/10.1016/j.socscimed.2012.09.021>

Daniels N, Sabin JE. Accountability for reasonableness: an update. *BMJ* 2008;337:a1850. <https://doi.org/10.1136/bmj.a1850>

Daugherty Biddison EL, Faden R, Gwon HS *et al*. Too many patients...a framework to guide statewide allocation of scarce mechanical ventilation during disasters. *Chest* 2019;155:848–54. <https://doi.org/10.1016/j.chest.2018.09.025>

Faden R. Social justice and pandemic planning and response. In *Institute of Medicine (US) Forum on Microbial Threats. Ethical and Legal Considerations in Mitigating Pandemic Disease: Workshop Summary*. Ethical Issues in Pandemic Planning and Response: Washington (DC): National Academies Press (US) 2007, p172. [www.ncbi.nlm.nih.gov/books/NBK54169/](http://www.ncbi.nlm.nih.gov/books/NBK54169/) [Accessed 30 March 2020].

Kinlaw K, Barrett DH, Levine RJ. Ethical guidelines in pandemic influenza: recommendations of the Ethics Subcommittee of the Advisory Committee of the Director, Centers for Disease Control and Prevention. *Disaster Med Public Health Prep* 2009;3 Suppl 2:S185–92. <https://doi.org/10.1097/DMP.0b013e3181ac194f>

Lor A, Thomas JC, Barrett DH *et al*. Key ethical issues discussed at CDC-sponsored international, regional meetings to explore cultural perspectives and contexts on pandemic influenza preparedness and response. *Int J Health Policy Manag* 2016;5:653–62. <https://doi.org/10.15171/ijhpm.2016.55>

General Medical Council. Joint statement: Supporting doctors in the event of a Covid-19 epidemic in the UK, 11 March 2020. [www.gmc-uk.org/news/news-archive/supporting-doctors-in-the-event-of-a-covid19-epidemic-in-the-uk](http://www.gmc-uk.org/news/news-archive/supporting-doctors-in-the-event-of-a-covid19-epidemic-in-the-uk) [Accessed 13 March 2020].

Sokol DK. Ethics and epidemics. *Am J Bioeth* 2008;8:28–9. <https://doi.org/10.1080/15265160802318121>

Upshur REG, Faith K, Gibson JL *et al*. *Stand on guard for thee: Ethical considerations in preparedness planning for pandemic influenza*. A report of the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group. November 2005. [www.jcb.utoronto.ca/people/documents/upshur\\_stand\\_guard.pdf](http://www.jcb.utoronto.ca/people/documents/upshur_stand_guard.pdf) [Accessed 31 March 2020].

WHO. *Ethical considerations in developing a public health response to pandemic influenza*. 2007. [www.who.int/csr/resources/publications/WHO\\_CDS\\_EPR\\_GIP\\_2007\\_2/en](http://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2/en)