Frequently asked questions

Where the serious health needs of patients exceed our ability to provide life-sustaining treatment, is it legal and ethical to prioritise some patients over others?

Although everything is being done to maximise resources and to limit demand, during the pandemic it is possible that, at times, the need for medical treatment, including, in some cases, for life-saving interventions, will exceed the resources available. This includes the availability of ICU places and mechanical ventilation.

All patients should, to the greatest extent possible in the circumstance, receive compassionate and dedicated medical care including appropriate symptom management and, where patients are dying, the best available end-of-life care. Nevertheless, in these circumstances, in the BMA's view it would be both lawful and ethical to refuse someone potentially life-saving treatment where another current or anticipated patient has a higher priority for the available treatment.

In making these decisions doctors should follow accepted local guidance and protocols. Decisions about how resources are allocated must be:

- reasonable in the circumstances, including being based on coherent ethical principles and reasoning
- based on the best available clinical data and opinion
- 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.

What criteria should be used when making these treatment allocation decisions?

During the peak of the pandemic, it is possible that doctors may be required to assess a person's eligibility for treatment based on a 'capacity to benefit quickly' basis. As such, doctors may be called on to deny some of the most unwell patients access to life-sustaining treatment such as cardio-pulmonary resuscitation, intensive care or artificial ventilation. To ensure maximum benefit from admission to intensive care, it will be necessary to adopt a threshold for admission to intensive care or use of scarce intensive treatments such as mechanical ventilation or extracorporeal membrane oxygenation. Such decisions should be made using local policies and guidance. Relevant factors predicting survival from COVID-19 include severity of acute illness, presence and severity of co-morbidity and, to the extent that it is a clinically reliable indicator, patient age.[1] Those patients whose probability of dying, or of requiring a prolonged duration of intensive support, exceeds a threshold level would not be considered for intensive treatment, though of course they should still receive other forms of medical care. These decisions must be made on the best available clinical evidence, including clinical triage advice from appropriate clinical bodies.

1 1. Zhou, Fei, Ting Yu, Ronghui Du, Guohui Fan, Ying Liu, Zhibo Liu, Jie Xiang et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. The Lancet. doi:10.1016/S0140-6736(20)30566-3.

These decisions will not only relate to those patients with COVID-19. Similar criteria will need to be applied to all varieties of medical need. Consequently, thresholds for granting access to, for example, intensive care or ventilation should be similar for all patients regardless of presentation. By itself, infection with COVID-19 should not guarantee priority for treatment.

Do these treatment allocation decisions extend to withdrawing treatment from patients who are currently being treated but are not responding?

Yes. In our view there is no intrinsic ethical difference between decisions to withhold life-sustaining treatment and decisions to withdraw it, provided other clinically relevant factors are equal – although health professionals may find decisions to withdraw treatment more challenging.[2] There may be a need to make admission to intensive care or commencement of advanced life-support conditional upon response to treatment, such as in a time-limited trial of therapy.

Should withholding or (particularly) withdrawal decisions be any different in the context of patients with lasting power of attorney or with personal religious views opposed to withholding/withdrawal of therapy?

It is important to involve families and to take account of patient wishes in the context of 'best interests' decision-making for patients. However, the ethical basis for decisions to restrict ICU admission or to withdraw treatment because of critically short supply are **not** best interests decisions. These are decisions made on the basis of distributive justice and the ethical importance of trying to benefit as many patients as possible. If there is a need to limit the availability of intensive care for patients because of the COVID-19 pandemic and a critical shortfall in ICU capacity, it would be unethical to apply those limits differently to patients with or without appointed surrogate decision-makers or those with or without particular religious views.

Will I be at risk of breaching equality legislation when making these decisions?

Where patients are refused access to life-saving treatment as a result of triage or prioritisation decisions, it is possible that these decisions will be challenged by patients and relatives and that questions about possible discrimination may be raised. During the peak of a pandemic, doctors are likely to be required to assess a person's eligibility for treatment based on a 'capacity to benefit quickly' basis. As such, some of the most unwell patients may be denied access to treatment such as intensive care or artificial ventilation. This will inevitably be indirectly discriminatory against both the elderly and those with long-term health conditions relevant to their ability to benefit quickly, with the latter being denied access to life-saving treatment as a result of their pre-existing health problems. A simple 'age cut-off' policy would be unlawful as it would constitute direct age discrimination. A healthy 75-year-old cannot lawfully be denied access to treatment on the basis of age. However, older patients with severe respiratory failure secondary to COVID-19 may have a very high chance of dying despite intensive care, and consequently have a lower priority for admission to intensive care.

Although a 'capacity to benefit quickly' test would be indirect discrimination, in our view it would be lawful in the circumstances of a serious pandemic because it would amount to 'a proportionate means of achieving a legitimate aim', under s19 (1) of the Equalities Act – namely fulfilling the requirement to use limited NHS resources to their best effect.

Is it acceptable for me to work outside my usual areas of specialty during a pandemic?

2 1. Wilkinson, D., and J Savulescu. 2012. A costly separation between withdrawing and withholding treatment in intensive care. Bioethics 26 (1):32-48. doi:10.1111/j.1467-8519.2010.01811.x.

During the peak of the pandemic, it is likely to be necessary for health services to focus on providing care to large numbers of people suffering from COVID-19 and its complications. This may involve drafting doctors and other health professionals away from their usual roles to focus on large numbers of patients who are prioritised for treatment or offered supportive or palliative care. In these circumstances, doctors may be concerned about whether they are working within the limits of their usual competence in accordance with professional guidance. Where doctors are following the reasonable requests of employers, and have a reasonable belief they will be providing overall benefit to patients, the BMA considers it reasonable to expect doctors to work flexibly and to do their best outside their usual areas of practice. If doctors are asked to perform tasks they do not feel competent to carry out, they should explain their concerns immediately to managers and ask that other arrangements are made. In an emergency, where there is no alternative provider available, they should provide the safest care that they are able to provide in the circumstances, with the aim of providing overall benefit for the patient.

Do I have to work if my personal protective equipment is inadequate?

Obligations on health professionals to accept a degree of risk in providing treatment impose strong reciprocal obligations on employers. All employers have both a legal and ethical responsibility to protect their staff and must ensure that appropriate and adequate personal protective equipment is available, and that staff are trained in the use of it. Health staff, and other staff essential to the running of health services cannot be expected to expose themselves to unreasonable levels of risk where employers have not provided, or have been unable to provide, appropriate protective equipment.

Where health professionals have a reasonable belief that their protective equipment is insufficient – that it falls short of expected professional standards – they need to raise this as a matter of urgency with their managers. Risk assessments must be made based upon the specific facts of the case, and consideration should be given to finding alternative ways of providing the care and treatment needed. In the BMA's view, there are limits to the level of risks doctors can reasonably be expected to expose themselves to as part of their professional duties. Doctors would not be under a binding obligation to provide high-risk services where employers have failed to fulfil at least minimal obligations to provide appropriate safety and protection and to protect doctors and other health professionals from avoidable risks of serious harm.

If BMA members are concerned that they are being asked to see patients who are infected, or who are suspected to be infected, without adequate safeguards being in place, this should also be raised immediately with the BMA via local representatives or First Point of Contact, the BMA's telephone advice service.

Will the GMC take into consideration the circumstances of the pandemic should fitness to practise questions be raised?

Yes. The GMC has made it clear that it will consider:
- the facts of the case, including the environment in which the doctor is working;
- the pressure doctors are working under, the resources available, and the scale of the challenges in delivering safe care;
- relevant information, guidelines or protocols in place during the pandemic.

The primary requirement for all doctors is to respond responsibly and reasonably to the circumstances they face.