

Covid-19: Refracting Decision-Making Through the Prism of Resource Allocation

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Abstract

Medical decision-making has, across the history of the NHS, made a transitional journey from a model characterised by paternalism to one which places emphasis on partnership and patient autonomy. This article assesses the extent to which the circumstances generated by the Covid-19 pandemic affect the mode of critical care decision-making. It observes that clinical judgment influenced by protocols, algorithms and resource constraints do not lend themselves to full identification with either of the two frameworks familiar to the NHS. The unique mode of decision-making engendered can only be understood on its own terms.

I. Introduction

When the Covid-19 pandemic resulted in high hospital admission rates, concern understandably arose over how limited intensive care resources are to be made available to all patients who could potentially benefit from them. Responding to the urgency of the unprecedented situation, the National Institute for Health and Clinical Excellence (NICE), and NHS England and NHS Improvement issued guidelines¹ for the management of critical care for adults infected with the coronavirus SAR2-CoV-2. Following these, intensive care decision-making is to be conducted in line with prescribed protocols and algorithms, whilst being “consistent with normal ethical and

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¹NICE, ‘Covid-19 Rapid Guideline: Critical Care in Adults’ (20 March 2020, updated 29 April 2020); NHS, ‘Clinical Guide for the Management of Critical Care for Adults with Covid-19 During the Coronavirus Pandemic’ (8 April 2020).

legal frameworks”.² However, when treatment choices are protocolised and algorithm-based, not only is the latter difficult to achieve, it is also not possible for decision-making to proceed solely with the individual patients’ best medical interests in contemplation. To the extent that this decision-making model does not fully resonate with the paternalistic tendencies during the early days of the NHS nor with the modern expectation to respect patient autonomy, its unique character needs to be, and can only be, understood through a pandemic-ridden resource allocation prism.

II. The Doctor-Patient Relationship: From Paternalism to Partnership

At its inception in 1948, the NHS committed itself to the provision of a comprehensive healthcare delivery and universal medical coverage irrespective of the ability of an individual patient to pay for treatment.³ While this objective has remained unchanged, there has since been a marked shift in the ethico-legal frameworks which govern medical decision-making.

In the early days of the NHS, patients were expected, and indeed had seemed content, to view doctors as the sole expert in their relationship. As the party with esoteric medical knowledge, doctors were deemed to know what was best for their patients. They would unilaterally recommend a treatment strategy which they judged to be beneficial, and enforced that opinion on the patient.⁴ Medical decision-making

²NHS, *ibid.*, paragraph 3.

³M. Gorsky, ‘The British National Health Service 1948-2008: A Review of the Historiography’ (2008) 21(3) *Social History of Medicine* 437-460; R. Kaba & P. Sooriakumaran, ‘The Evolution of the Doctor-Patient Relationship’ (2007) 5(1) *International Journal of Surgery* 57-65.

⁴E. Gefenas, *et. al.*, ‘New Ethical Paradigm in Preventive, Predictive and Personalised Medicine’ in V. Costigliola (ed), *Healthcare Overview: New Perspectives* (Dordrecht: Springer, 2012) pp. 471-484 at 473; P. Lepping, T. Palmstierna & B.N. Raveesh, ‘Paternalism v

therefore revolved around the principle of beneficence, and patients played a passive, subordinate and dependent role within a hierarchical relationship.⁵ This paternalistic stance was also condoned by the courts through a refusal to impose liability for failures to redress the power imbalance by closing the information asymmetry gap. The judiciary made it clear that the law would not censure doctors who did not draw known risks to their patients' attention when they were of a strong belief that a proposed treatment would benefit the patients.⁶ Neither would they criticise doctors who deliberately withheld information about risks from patients who specifically asked if these were present.⁷ Indeed it was emphasised that whether and how much information was divulged were matters to be decided by doctors themselves following a standard of practice recognised as proper by a responsible body of medical opinion (i.e. in accordance with the Bolam test).

In the seven decades which have elapsed since the NHS was launched, profound changes have taken place in the doctor-patient relationship. Doctors are now expected by their professional regulator, the General Medical Council, to work in partnership with patients in an egalitarian non-hierarchical fashion based on openness, trust and good communication.⁸ Whilst doctors are still acknowledged as the expert on matters like diagnostic techniques, aetiology, prognosis and treatment

Autonomy – Are We Barking Up the Wrong Tree?' (2016) 209(2) *British Journal of Psychiatry* 95-96.

⁵ T. Nys, Y. Denier & T. Vandevælde (eds.), *Autonomy and Paternalism: Reflections of the Theory and Practice of Health Care* (Leuven: Peeters, 2007), p. 3.

⁶ *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582, per McNair J. at 590.

⁷ *Hatcher v. Black* (1954) *The Times*, 2 July, per Lord Denning.

⁸ GMC, *Good Medical Practice* (2013)(updated 29 April 2019) paragraph 49; GMC, *Consent: Patients and Doctors Making Decisions Together* (2008) paragraph 3.

options that are supported by clinical guidelines, weight is today given to patients' knowledge, experiences of illness, social circumstances, values, preferences and attitudes to risks.⁹ It is recognised that inasmuch as both types of knowledge are indispensable in the effort to effectively manage illnesses, it is important for patients to participate in the decision-making process. For this to take place in a meaningful way, the NHS requires doctors to ensure that patients are acquainted with "all the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead".¹⁰ Based on these, patients are to decide whether to accept any of the options available, and to do so even for reasons which may seem irrational to others or for no reason at all.¹¹ All these signaled a shift towards an ethical and professional approach which not only treats them as partners, but allows them to assume primary decision-making responsibilities in determining the treatment option to follow. The courts too emphasised that "in modern law medical paternalism no longer rules."¹² They therefore pulled the plug on the Bolam test in respect of pre-treatment information disclosure. Doctors can now be held negligent if they fail to disclose risks which a reasonable person in the patient's position or the particular

⁹S.W. Chan, W. Wojcik & J.E. Norman, 'Montgomery and Informed Consent: Where Are We Now?' (2017) 357:j2224 *British Medical Journal*; A. Coulter, 'Paternalism or Partnership? Patients Have Grown Up – and There's No Going Back' (1999) 319(7212) *British Medical Journal* 719-720.

¹⁰NHS, 'Consent to Treatment', available at <https://www.nhs.uk/conditions/consent-to-treatment/> (accessed on 19 May 2020).

¹¹GMC, Consent, *op. cit.*, paragraph 5(c).

¹²*Chester v. Afshar* [2004] UKHL 41 *per* Lord Steyn at paragraph 16.

patient before them, would find significant in the decision-making process, and the undisclosed risks subsequently materialised.¹³

As can be seen, medical decision-making across the history of the NHS has undergone a transition from a model characterised by paternalism to one which places emphasis on respect for patient autonomy. The next section will explore the extent and manner in which resource allocation considerations generated by Covid-19 impact on these modes of decision-making.¹⁴

III. Covid-19 and Clinical Decision-Making

Resource allocation and decisions concerning the prioritisation of medical treatments are no strangers to the NHS. How resources are best utilised to achieve a comprehensive and universal healthcare system creates the imperative to be fair, just, efficient, and cost effective.¹⁵ In a public health emergency, resource considerations may simply extend beyond money. Factors such as hospital bed capacity (space), clinical workforce (people and time), equipment and treatment (commodity), and organisational planning may all be heavily stretched.¹⁶ The Covid-19 pandemic has inherently created high numbers of patients who are admitted to hospital, each with similar clinical needs, who are competing for access to the very same medically

¹³ *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11 at paragraph 87; *Chester v. Afshar, ibid.*, paragraphs 87 and 101.

¹⁴ The focus would be on the critical care of Covid-19 patients. Although the pandemic has led to the deprioritisation of most other areas of healthcare, any potential impact this would have on decision-making in those areas is not within the scope of this article.

¹⁵ F. Mosley & S. Lockwood, 'Prioritizing Clinical Care in the Cash-Strapped NHS' (2018) 36(9) *Surgery* 491; M. Luchetti, 'Intensive Care Resource Allocation: When Difficult Choices Have to be Made' (2013) 6 *British Journal of Medical Practitioners* 633.

¹⁶ V.B. Satkoske, D.A. Kappel & M.A. DeVita, 'Disaster Ethics, Shifting Priorities in an Unstable and Dangerous Environment' (2019) 35 *Critical Care Clinics* 717-725.

valuable resources at the same time. Generally, patients ill with the SARS-CoV-2 coronavirus would be triaged for clinical assessment on the severity of symptoms. Following this, a decision is made on whether hospitalisation is required. Dependent on any findings revealed by physical assessment, a clinical management plan would be formulated with the aim to formally diagnose, treat, and manage any potential deterioration in the patient's clinical condition as the illness progresses.¹⁷ At each stage of the process from diagnosis to management, clinical decisions are made and enacted to facilitate subsequent patient recovery. Moreover, each patient requiring hospital treatment may present with different chronic diseases and thus would have varying chances of survival. Similarly, patients critically ill with the condition would vary in the anticipated lengths of stay on the intensive care unit should such a clinical intervention be warranted.

To mount an effective organisational response to the emergency, it is important that clinical protocols on how to manage the critical care of patients infected by the novel coronavirus are established. To this end, NICE and NHS England and NHS Improvement have issued guidelines which prescribe a clinical approach that places strong emphasis on the doctor's assessment of two issues: the patients' frailty, and their suitability to receive life-sustaining treatment. Together, the guidelines allude that patients with a capacity to benefit faster from intensive care, should be prioritised. However, as mentioned previously, they also instruct that decision-making should be

¹⁷NICE, 'NG159 Critical Care Referral Algorithm' (27 March 2020); E. Persson, *et. al.*, 'Discrepancy Between Health Care Rationing at the Bedside and Policy Level' (2018) 38 *Medical Decision Making* 881-887.

consistent with ethico-legal norms. But, is this fully achievable when treatment choices are based upon protocols and algorithms?

It is relevant to note that although the capacity of critical care beds, ventilator equipment, and specialised medications are frequently in short supply even at the best of times, medical care and treatment still manage to keep within the partnership model outside a pandemic situation.¹⁸ By contrast, clinical decisions that are based on prescribed algorithms would inevitably place a physician's clinical judgment over the patients' autonomy. After all, decisions that are made on a case-by-case basis, as expected by the contemporary ethico-legal frameworks, not only risks the perception of clinical inconsistency, but may also threaten the fair distribution of limited resources during the Covid-19 pandemic.¹⁹ Therefore, a return to some degree of traditional clinical practices based on a paradigm that adopts a paternalistic view of the doctor-patient relationship is inexorable. However, since doctors may be compelled to triage patients in order to attain the utilitarian objective of benefiting the greatest number of patients, not only is their judgment not made on the basis of shared decision-making, it is also removed from sole consideration of the patients' best medical interests as per the paternalistic practices of the early NHS days. This can result in some patients having critical care withheld from them even if they stand to benefit.²⁰ An illustrative

¹⁸A. McGuire & P.C. McConnell, 'Resource Allocation in ICU: Ethical Considerations' (2019) 32(2) *Current Opinion in Anaesthesiology* 190-194.

¹⁹Royal College of Physicians, 'Ethical Dimensions of Covid-19 for Front-Line Staff' (31 March 2020); BMA, 'Statement/Briefing About the Use of Age and/or Disability in Our Guidance' (2020).

²⁰BMA, 'Covid-19 – Ethical Issues: A Guidance Note' (2020) p. 3; M. Magelssen, P. Nortvedt & J. H. Solbakk, 'Rationing at the Bedside: Immoral or Unavoidable?' (2016) 11(4) *Clinical Ethics* 112-121.

example would be in relation to patients with co-existing chronic disease requiring life-sustaining treatment as a result of severe lung infection. In circumstances outside Covid-19, such a patient might be trialed with critical care on the basis that the lung infection is treatable and that the intensive care treatment ought to improve the patient's clinical condition somewhat.²¹ However, the difference with the pandemic is the acuity of the effect it has on existing shortages of resources and the capacity to deliver critical care to all who require it. In the uncertainty of how this pandemic would progress, it is foreseeable that critical care would be prioritised to those clinically judged to benefit most and quickly.²² Patients clinically anticipated to require prolonged courses of critical care may have this treatment option withheld especially in cases where it is unclear to the clinician that the benefits outweigh the risks of intensive therapy.²³ Similarly, doctors may also withdraw treatments from patients in order to make way for those considered to have better chances of survival.²⁴ Thus, what has emerged is a decision-making method which is neither fully reminiscent of the early paternalistic days of the NHS nor reflective of the contemporary concern on partnership and patient autonomy. To the extent that it seems to integrate a unique blend of "what the doctor knows best" and prescriptive clinical guidance, critical care decision-making in times of Covid-19 is truly unprecedented.

²¹ E.E. Vink, *et. al.*, 'Time-Limited Trial of Intensive Care Treatment: An Overview of Current Literature' (2018) 44 *Intensive Care Medicine* 1369-1377.

²² M. Pruski, 'Experience Adjusted Life Years and Critical Medical Allocations Within the British Context: Which Patient Should Live?' (2018) 21 *Medicine, Health Care and Philosophy* 561-568.

²³ T. M. John & J. Millum, 'First Come, First Served?' (2020) 130 *Ethics* 179-207.

²⁴ BMA, 'Covid-19', *op. cit.*, p.3.

IV. Conclusion

On the evening of 23rd March 2020, the UK government imposed lockdown restrictions in an effort to limit the spread of the Covid-19 global pandemic. In doing so, members of the public were compelled to stay at home. This was to ensure that the NHS can adapt to the challenges presented by the pandemic without being overwhelmed. With potentially large numbers of patients requiring critical care, clinical guidelines issued by NICE and the NHS gained prominence in the management of such patients. Although the use of clinical guidelines to facilitate medical decision-making is an established phenomenon, there are observable differences in the context of Covid-19. Broadly speaking, guidelines for other conditions have a more solid clinical evidence base and were produced over a longer time frame. By contrast, the guidelines for the management of Covid-19 have an evolving clinical evidence base and are synthesised at a fraction of the time taken for the former. The reasons for this are: the urgency of the public health emergency; the need to be clinically consistent in the management of patients with Covid-19 infection; and the imperative to maximise utility of scarce critical care resources.²⁵ As a consequence, decision-making power lies far more in the hands of doctors than patients. For this reason, it is difficult to reconcile this evolving reality with the demand that critical care decision-making be made in line with current ethico-legal norms which revolve around autonomy and partnership. At the same time, it does not identify fully with the paternalistic model of the early days of the NHS because doctors are instructed on the likely treatment options appropriate for the patient's condition. Since doctors are expected to follow guidance issued by authorities

²⁵ *Ibid.*, pp. 3 & 5.

such as NICE and the NHS,²⁶ they have less scope for decision-making. Moreover, when doctors are commending treatment choices to their patients, they are not only considering the individual patient's interests. They would also have to balance these against the welfare of others who are similarly ill and who are competing for the same resources.

Thus, by refracting clinical decision-making through the prism of pandemic-ridden resource allocation, this article has observed a mode of decision making that is neither fully reminiscent of the past nor an expression of present expectations. Its uniqueness needs to be understood on its own terms. However, with so many imponderables surrounding this pandemic, it is a matter of speculation how long this approach will need to be in place. And, would it lead to a new normal for intensive care decision-making in general?

²⁶GMC, 'Joint Statement: Supporting Doctors in the Event of a Covid-19 Epidemic in the UK' (11 March 2020); Royal College of Surgeons of England, 'Covid-19: Good Practice for Surgeons and Surgical Teams (31 March 2020, updated 3 April 2020), paragraph B4.