**Challenging times; challenging decisions**

**Claudia Carr (13th April 2020)**

It is now three weeks since the beginning of the national lockdown due to the Covid-19/Coronavirus pandemic and the recorded number of deaths, excluding those in the community and care homes exceeds 10,000[[1]](#footnote-1). During this period, many patients who develop severe symptoms will need mechanical ventilation to assist their breathing as the virus continues to attack the patient’s lungs. Whilst new hospitals are being built with impressive speed and creative innovating methods are developing ventilators to meet a potential upsurge in demand in these unpredictable times, attention has now turned to consider the situation where the demand for ventilation may outstrip supply. In these circumstances, the question to be addressed, is how these resources are to be allocated?

Historically, resource allocation has often been recognised by the courts[[2]](#footnote-2), but more usually in terms of potential unavailability of specific resources or services, rather than removal of a resource such as mechanical ventilation from one patient to give to another, more ‘worthy’ patient.

Decisions regarding resource allocation are always controversial but, it is difficult to identify who will make these decisions and what criteria will be taken into account. Whilst these decisions are not imminently required, perhaps we also need to reflect on the consequential effect on society these decisions might bring.

Various models attempt to justify how limited resources can be allocated. For example, a recent Australian publication[[3]](#footnote-3) , suggests different approaches. Whilst it states that all patients should be treated equally and not discriminated against due to personal characteristics such as age, gender and sex, an alternative suggestion would be to maximise resources by for example, allocating resources to health care workers, enabling them to return to work or giving priority to care providers or the young over the elderly or infirmed. A final approach would be to prioritise those in greater need, whether the need relates to clinical need or other aspects.

However, where there is a competing demand for available ITU resources due to the Coronavirus pandemic, it is suggested that patients who are ‘highly likely’ to recover would receive the highest priority. If this policy is adopted, it follows that the elderly and those vulnerable patients with pre-existing conditions would be directly discriminated, by not receiving life sustaining mechanical ventilation.

Here in the UK, guidance has been published from a range of professional bodies including the General Medical Council and NICE. Yet, none of it provides the clarity that clinicians need in these extraordinary times. The most recent guidance (updated 9th April) from the BMA[[4]](#footnote-4) states that clinicians ‘may be obliged to withdraw treatment from some patients to enable treatment of other patients with a higher survival probability’. This could mean that even where a patient is stable or their condition is improving; if their long-term prognosis is objectively worse than another patient, resources could be diverted to that patient [[5]](#footnote-5).

Whilst resource allocation has always been recognised in medical law, it has never previously been at the forefront of national consideration yet, a recent decision[[6]](#footnote-6) recognised there existed the possibility where a hospital may need to cease inpatient care which ‘will give rise to significant risks to the patient’s health or even life’[[7]](#footnote-7). Indeed, the BMA guidance confirms where ‘radically reduced capacity to meet all serious health needs, it is both lawful and ethical for a doctor, following appropriate prioritisation policies, to refuse someone potentially life-saving treatment where someone else has a higher priority for the available treatment.’

Of additional concern is how those with intellectual disabilities will fare during this pandemic. GP’s in Cambridgeshire have regrettably already sent letters to Mencap care homes, advising them that patients with intellectual disability who fall ill with Covid-19 are unlikely to receive mechanical ventilation as they are too ‘frail’[[8]](#footnote-8). It is already recognised that people with intellectual disability suffer health inequality[[9]](#footnote-9) and there is evidence they also receive poorer level of health care[[10]](#footnote-10). If it becomes necessary to allocate scarce mechanical ventilation according a policy of priority, it is unlikely people with intellectual disability will be first in line.

Never has the expression ‘survival of the fittest’[[11]](#footnote-11) been so apt.

1. <https://www.worldometers.info/coronavirus/country/uk/> [↑](#footnote-ref-1)
2. See for example, R v North and East Devon Health Authority, Ex p Coughlan [2001] QB 213 [↑](#footnote-ref-2)
3. <http://www.smer.se/wp-content/uploads/2020/03/she.-clinical-ethics.-resource-allocation-framework-v1-final-2-april-2020.pdf> [↑](#footnote-ref-3)
4. <https://www.bma.org.uk/advice-and-support/covid-19/ethics/covid-19-ethical-issues> [↑](#footnote-ref-4)
5. Ibid p3 [↑](#footnote-ref-5)
6. University College London Hospitals NHS Foundation Trust v MB 2020 EWHC 882 (QB) [↑](#footnote-ref-6)
7. Ibid at para 55 [↑](#footnote-ref-7)
8. <https://www.hsj.co.uk/coronavirus/learning-disabilities-patients-told-they-may-be-too-frail-for-mechanical-ventilation-if-they-get-covid-19/7027318.article#.XotqeKMaqZM.twitter> [↑](#footnote-ref-8)
9. Smith, MVA, Adams, D, Carr, C, Mengoni, SE. Do people with intellectual disabilities understand their prescription medication? A scoping review. J Appl Res Intellect Disabil. 2019; 32: 1375– 1388. https://doi.org/10.1111/jar.12643 [↑](#footnote-ref-9)
10. <https://theconversation.com/people-with-intellectual-disabilities-are-often-not-told-about-their-medicines-and-their-potential-side-effects-119415> [↑](#footnote-ref-10)
11. An expression first coined by Herbert Spencer after reading Charles Darwin’s ‘On the Origin of Species’ [↑](#footnote-ref-11)