Royal College of Physicians

Setting higher standards

Ethical dimensions of COVID-19 for frontline staff

Appendix 2

Ethical dilemma scenarios for ambulance-based clinical assessments during COVID-19

8 February 2021

As the NHS weathers the second, considerably larger wave of COVID-19, patients are unfortunately needing clinical assessment by hospital staff in waiting ambulances. To help clarify the best, most ethical course of action, the following common scenarios and advice have been developed, to guide hospital staff with making decisions in the event of having to assess patients in ambulances or immediately outside the boundaries/walls of existing healthcare facilities.

The assessment and management of patients in waiting ambulances by acute medical teams should occur only if the alternative is no medical review for patients at all. Other than individual patient emergencies, this should only occur following the involvement of hospital management teams who also work within an ethical framework on ambulance assessment. Any clinical assessment made by a doctor on behalf of an organisation should be recorded on that organisation's clinical noting systems. This guidance is not intended to normalise clinical assessment by acute medical teams of patients in waiting ambulances outside of *in extremis*, such as the current COVID-19 pandemic.

It is not possible to generalise all responses and approaches, and each patient should be assessed and cared for as an individual with differing needs.

In line with the guidelines for frontline staff, the advice of the Royal College of Physicians (RCP) remains to assess and treat those most in need, regardless of COVID-19 diagnosis. While often difficult for families and patients, healthcare staff can make valid and appropriate decisions about treatment, escalation and palliation for patients who are assessed in an ambulance, when all other measures to prevent this have been exhausted. As with all clinical decisions, the views of the patient/carer/family must be solicited in line with General Medical Council (GMC) guidance and professional standards of ethical communication and person-centred care.

In the current circumstances it is incumbent on healthcare staff to uphold their duty of care, which may include:

- making a decision to de-escalate a patient or send for palliation or home care if that is most clinically appropriate
- providing treatment for a patient in an ambulance or outside the boundary of a healthcare facility, prior to admission or discharge.

Healthcare staff, and especially senior and expert decision makers, must treat patients as individuals according to their presentation. After assessing patient, family and carer views, the risks, benefits and broad likelihood of success or failure of treatment must be weighed up together with the patient's wishes. Some patients, for example those approaching the end of their life or with multiple medical conditions, may be very unlikely to survive a severe infection or benefit from invasive ventilation, as they will have no meaningful functional recovery. Deciding the best location of care must take many factors into account and it will not infrequently be the case that return to home, a long-term facility (eg a care home), community care or same-day emergency care (SDEC) is the most compassionate, patient-centred and safest option, rather than bringing highly vulnerable individuals into a hospital ward or emergency department.

In each of these scenarios, the ethical response is not new and is covered in already existing clinical and ethical guidance – most of which falls either under patient autonomy, informed consent or a duty of care to patients. In line with the RCP's guidance that all decisions in the pandemic be accountable, inclusive, transparent, reasonable and responsive, we recommend that all treatment

be appropriately and compassionately allocated based on the needs of individual patients as they present for care. For each scenario, an ethical response has been provided that corresponds to the appropriate clinical response. Each patient will be different, and it is not possible to provide advice that covers all scenarios. The individual circumstances of the patient, the clinical presentation and the capacity of the hospital and other services must be considered.

Scenarios

The hospital is at full capacity and as ambulances continue to arrive, the acute medicine team are asked to go outside and assess the patients in ambulances.

1

In the first ambulance you find Betty, aged 90. She lives in a nursing home that is known to have recently had an outbreak of COVID-19.

Betty is rousable only to pain and her oxygen saturations are 86% on a non-rebreather mask. The crew inform you that she has a temperature of 39.9°C and her respiratory rate is 30. She has a community DNACPR which the crew have brought with them, along with Betty's medications. They state that she has a background of dementia and is reliant on others for all her care needs. She has a daughter and a son.

When you examine Betty, you notice her respiratory distress. There are crackles throughout her lungs.

There are absolutely no beds available in the hospital. What can you do? You believe that Betty is actively dying and needs palliative treatment.

Response

In this scenario, the patient Betty has been identified as actively dying and therefore should be treated using a palliative approach to care. In order to identify whether Betty requires care in hospital or in the home/care home, it would be clinically and ethically advisable to do the following.

- If possible, speak to Betty to explain that she is very unwell and dying, and ask her what her wishes are. Betty has a label of dementia, but do not make assumptions as to the lack or presence of her mental capacity without talking to her and assessing capacity at the time. (Respect patient autonomy: it is likely that Betty is not competent, but she may understand that she is dying.)
- Contact the care home to ascertain whether Betty has an advance care plan, patient passport or other indication about her wishes regarding resuscitation and escalation status. (Again, this will respect the patient's wishes if she has made it clear where she would like to die, eg at her care home.)
- Consider discussion with the palliative care team for those with complex needs in order to best meet and anticipate the care required, whatever decision is made about admission. (Ensuring duty of care to the patient by establishing where she can be best cared for, hospital vs community.)
- Contact Betty's daughter and son to understand whether Betty has any wishes about her own death. It is important to have an open and honest discussion with family and carers to understand Betty's wishes, which she cannot articulate for herself in this scenario.

Based on the findings of those actions, it would be ethically correct for Betty to be cared for out of hospital if the care home and her GP were best able to facilitate the necessary palliative care and it is Betty's wish not to die in hospital. If appropriate palliative care can only be administered in

hospital, and not admitting Betty would cause unnecessary pain and suffering, it would be unethical not to admit her and withhold basic palliative care. Documentation on the ceiling of treatments and interventions for Betty would be necessary at this stage. However, if Betty wishes to die in hospital, but her palliative care could be correctly managed in the care home or another non-hospital location (eg her son's house), then it is ethically acceptable to not admit her to hospital owing to capacity issues, as her care is not compromised. It is not always possible for the NHS to offer patients and families exactly what they have asked for, but the NHS is often able to provide a clinically comparable alternative, such as care at Betty's son's house with appropriate community palliative care support, thus enabling a frail, dying person to return to their home and place of care comfortably.

2

In the second ambulance, you find Sunil. He is a 28-year-old who tested positive in the community 10 days ago and has been isolating since then. He called an ambulance himself as he was struggling to breathe. He has a history of mild asthma, using a blue inhaler only occasionally. He works as a personal trainer and doesn't smoke.

His respiratory rate is 22. His oxygen saturations were 94% on room air, and are currently 100% on 2 L oxygen via nasal cannulae. There is no wheeze on his chest, but he is very anxious.

He wants to be admitted to hospital to 'be safe', but you wonder whether he would be suitable for outpatient management, community or ambulatory care instead.

Response

In this scenario, the patient has been identified as potentially having no clinical concerns that require admission to hospital. A period of observation is recommended before making a decision on admission. If there is doubt of the need for admission or safety of discharge, there is a duty of care, and it would be appropriate and advisable, to ask a respiratory colleague for an opinion. While patients have autonomous agency over their health, this does not extend to being admitted to hospital just because they desire to be admitted. Clinical and practical judgement allows doctors to make clinical decisions about who is admitted for hospital care. If hospital admission is not required, there still exists a duty of care to explain and reassure the patient, and also (if required) offer potential ways of self-monitoring (pulse oximeter), COVID-19 virtual ward or appropriate safety netting for the clinical scenario. It is appropriate to explore his anxieties briefly and to explain that you are balancing the significant risks of hospital admission to him and the wider hospital versus the benefits of ambulatory care treatment. If the hospital has an ambulatory care unit that can review patients with COVID-19 infection or a COVID-19 virtual ward, a review should be organised for the following day if indicated. Again, patients may not be able to receive what they ask for, but a clinically equivalent and safe alternative is provided.

3

The third ambulance contains Steven, a 54-year-old. He is a heavy smoker, and tells you he called an ambulance because he was short of breath. He states that he knows he doesn't have COVID-19, because he doesn't believe COVID-19 is any worse than the flu and this seems serious. He hasn't had a test in the community and hasn't been isolating.

His respiratory rate is 30 and his oxygen saturations are 93% on air. He appears to have 'air hunger' but says he feels quite well. He has been waiting in the ambulance for an hour already and is quite

frustrated. He wants you to give him a course of antibiotics as he believes he has ‘a chest infection’. If you will prescribe the antibiotics, he wants to go home.

Response

In this scenario, the doctor has a duty of care to try their best to diagnose this patient appropriately, regardless of the patient’s opinions on COVID-19-related illnesses. Appropriate steps to take would include the following.

- Assess the patient’s capacity, mindful that confusion is a presenting feature of many pneumonias.
- In this scenario, there is a balance of risk of unknowns (eg diagnosis without being able to do a chest X-ray or blood tests) with risk of antibiotic issues and the patient’s own beliefs. It would not be unethical to offer observations, offer a COVID-19 test and/or prescribe antibiotics if it were felt to be either clinically necessary, or provided appropriate safety netting for the patient.
- Briefly explore the patient’s ideas, concerns and expectations, given he has called an ambulance. Doctors have a duty of care to the public and, if possible, the patient needs to be assessed to determine whether he is a public health risk if he does indeed have COVID-19. The doctor should communicate to him what the thinking is to make sure that he, as well as the rest of the population, is safely managed and how he describes the reason he is being seen in an ambulance rather than the hospital.
- As with the scenario above, there is a duty of care to this patient, even if he refuses, to attempt to put into place safety netting with (for example) oximetry, observations or appropriate self-monitoring for the patient’s clinical context.

However, even if the doctor diagnoses a condition that requires admission of the patient to hospital, it is the patient’s autonomous decision to agree to be admitted. In fact, the patient has the right to refuse any tests that may aid in diagnosis too, regardless of how dangerous that may be to their own health. Duty of care and the principles behind patient-centred care and shared decision-making require the doctor to be clear about the risks of refusing tests, treatment and/or admission, so that the patient can make an informed decision and consent (whether that is to treatment or to say they have refused it). Only where a patient is incompetent (lacks capacity) can a decision regarding admission and treatment be made in the patient’s best interest. Therefore, if the doctor feels the patient has COVID-19 or some other lung distress that needs to be treated in hospital, they cannot force the patient to be admitted if the patient refuses and prefers to go home. It is ethically defensible not to give the patient antibiotics if this is an inappropriate treatment for the patient.