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ACUTE PERSPECTIVE

David Oliver: Covid shows the need for transparency in prioritising acute care

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As the covid-19 pandemic has exceeded last spring's peak, many NHS leaders are warning that the NHS is overwhelmed. What we really mean is that hospitals are overwhelmed—that people who could benefit from admission or treatment may be denied it because there's no room. In extremis, that may mean battlefield-type triage: deciding who gets to live or die, with intensive care units already running at twice their normal bed base, on borrowed staff and borrowed beds, and with capacity for surgery compromised.

The Medical Protection Society and other medical organisations recently called for emergency legislation to protect doctors from legal action if they have to decide how limited resources are allocated.[1 2] With oxygen delivery systems under pressure and record numbers of patients on non-invasive ventilation, it may prove necessary—as happened in northern Italy last spring—to choose between patients, or groups of patients, who might benefit from potentially lifesaving treatment. In Italy some fairly crude cut-offs based on age were reportedly used.

This is different from what we routinely do when not facing a pandemic emergency—prioritising treatment depending on whether that individual patient has much chance of benefit or whether the risk of harm is greater. We also take patients' and families' views into account. And even that scenario can prove problematic with a media and public not always ready for an open discussion of these realities. So, when it comes to deciding who gets the ventilator, the CPAP, the ICU, or the HDU bed—the "who gets to live or die" scenario—I do wonder whether our society is ready for a realistic public conversation. Still, surely it's better to have it openly rather than using some system with no chance for discussion, public engagement, or consultation, with no explicit local or national guidance or decision support tools.

The *Daily Telegraph* recently ran the headline "Crisis triage protocol is a brave attempt to ensure what happened in northern Italy is not repeated in Britain,"[3] saying that "doctors need an ethical system for rationing critical care if hospitals are overwhelmed . . . currently there is no national guidance." On the same day it reported, "Covid rationing plan tells doctors to pick patients to save by lottery,"[4] next to a story on "twice as many critically ill patients in hospitals as at the peak of the first wave."[5]

The meat of the story was a paper entitled "Ethical decision making when demand for intensive care exceeds available resources,"[6] first published in the *Journal of Medical Ethics* in November 2020. The original paper had described the iterative, multidisciplinary process and consultation in developing a local document for "fair allocation of critical care resources in the setting of insufficient capacity." The authors, based at the Royal United Hospital in Bath, had argued that it was better to have a transparent, standard decision tool, with strong ethical and legal components, than to leave such decisions ad hoc to clinical teams on the day. This never became official policy in Bath, let alone the wider NHS. Bath hospitals responded to the *Telegraph* that "it is a research document for purposes of wider discussion . . . when resources are sufficient, decisions are based solely on what is best for each individual patient."[4]

But the perceived need for such a hasty public rebuttal, as well as the tone of a newspaper report, risked undermining a brave and clinically led attempt by staff in one hospital to do the right thing, to foster transparency and honesty about prioritisation or rationing of scarce care. It left me wondering whether the press and public were ready for a frank discussion about prioritising acute care, especially in a pandemic when we're all emotionally spent and uncertain about what's to come.

It reminded me of a line from the film *A Few Good Men*: "You can't handle the truth."

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