

**Position statement of the C.N.E.**  
on the  
**essential ethical benchmarks when guiding patients**  
**in a context of limited available therapeutic resources**  
**due to the pandemic crisis of COVID-19**  
**(31 March 2020)**

## **Introduction**

The COVID-19 pandemic is proving to be a major threat to global public health and puts the lives of such a high number of patients at risk<sup>1</sup> that health systems are pushed to their absolute limits. This shortage situation has already become a reality in many parts of the world. A similar situation of overrunning and submersion, where care needs exceed the available means, may not be excluded in Luxembourg.

True to its mission of making recommendations on policy and legislative measures, more specifically in health matters, the Commission Nationale d'Éthique (National Ethics Commission), hereinafter the C.N.E., issues the present position statement, which is limited, given the extreme emergency, to setting out the **main challenges** of the crisis and to specifying, by way of proposals, **guidelines**, which may

- serve as references for hospital ethics committees and
- contribute in the same way to providing members of care, hospital, medical and other services, with guidelines for action, argumentation and protection.

The benchmarks provided in the present statement are neither new nor are they specific to our country. In particular emergency care, intensive care or the distribution of organs for transplantation have always led to similar issues and reflections. The C.N.E. is however of the opinion, that it is necessary to

- recall some **of the essential principles of medical ethics**,
- advise the **public who is entitled to be informed**,
- call for **reason** and common **sense**.

The absence of information and misinformation generate a risk of panic while there is no justification for this, despite the undeniable seriousness of the situation. It is essential to avoid any arbitrary reaction to the potential shortage of therapeutic resources due to the collapse of democratic rules of conduct not justified by the state of crisis.

Measures taken by European governments to restrict activity and exchange (lockdown, quarantine, testing, travel monitoring, etc.) obviously affect public freedoms, and, as such,

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<sup>1</sup> The male grammatical form used in this text includes all genders

are also raising major ethical issues, but, it must be admitted, less urgent right now than the issue of prioritization when it comes to deciding about life and death. The C.N.E. may come back to these other issues but will, in the present document, only deal with the problem of a possible shortage of therapeutic resources and the issues of prioritization resulting therefrom.

### **Specific problems linked to the COVID-19 pandemic**

The COVID-19 pandemic is potentially life-threatening for elderly or otherwise vulnerable people, and even for some young people it requires intensive care measures with uncertain outcomes. It may, in some cases, cause severe respiratory failure, with no chance of recovery without respiratory treatment in intensive care. A treatment will, from a statistical point of view, be longer (and, worse, resulting in potential permanent after-effects) the older the patient.

No country in the world has unlimited supply of equipment or of specialized human resources to simultaneously deal with a large influx of patients in respiratory distress as is caused by SARS-CoV-2.

This limitation of resources leads to the requirement to make choices based on the characteristics (i.e. the criteria) of the groups of patients for whom intensive care should be considered as a priority, or even to merely admit them to the hospital. The identification of argumentative, transparent therapeutic benchmarks, relying on constantly updated medical knowledge and justifiable in public is necessary to avoid the dissemination by certain media or social networks of such preoccupying news as randomly taken medical decisions in the manner of a lottery without concern for the actual interest of patients.

### **What are the ethical principles that must guide difficult choices?**

- *Prerequisites*

The **Hippocratic Oath** imposes the care of the sick as an obligation of means (best-efforts obligation). This requires the availability of material and human resources and the avoidance of shortages. The first moral obligation is to avoid a limitation of resources, which would subsequently lead to making choices based on priorities (« prioritization », « sorting » (term partly rejected), « selection » (term used but widely rejected)). Alternative solutions to avoid congestion, such as international mutual aid, must be considered.

- *The dignity of each person is intangible*

**Every human life is absolute, of equal value and has no price.** Every sick human has the elementary right to receive care, which implies the ambition to do good and the absence of malfeasance on the part of the caregivers. This obligation is determined by the intangible dignity of every human being in all circumstances.

- *All patients must be treated fairly and equally*

In the context of the disease, the human being is called a patient. Equality of human rights implies the following fundamental principle: **All patients are equal**. They can only be distinguished by medical criteria. Any discrimination on the basis of age, gender, disability, origin, nationality, ethnicity, religion, social status, insurance covered by the social security and residence is therefore absolutely prohibited.

Each patient is treated as a special case and is thus entitled to the consideration of his specific medical situation. Criteria applied for making decisions are therefore strictly objective and scientifically sound. **The assessment of the patient's overall state of health as well as the individual prognosis for short and medium-term survival and health are key criteria for treatment choices**, particularly if limited resources are available. Considering the state of health on a medium-term basis includes assessing the risks of any after-effects of intensive care treatment.

Priority choices must apply to all patients without discrimination. **Hence, there is no need to distinguish between a COVID-19 patient and a non-COVID-19 patient** other than for therapeutic and hygienic considerations and for reasons of good hospital organization.

- *The ambition for the survival of as many people as possible*

Under conditions of severe restriction, all measures are aimed at **saving as many lives as possible** and keeping the number of deaths to a minimum.

- *The patient's will must be sought and followed*

The **will of the patient** must be obtained from the patient or else his relatives or the person of trust he will have designated. Existing end-of-life provisions must be complied with. The patient's intentions for the end of his life are essential. Decisions taken in the light of informed and thoughtful choices by the independent patient are of great help for the patient, his family and his caregivers. A choice is deemed to be « informed » when it involved the consideration of any available information on the likely evolution of the clinical state and, if necessary, on the access to palliative care.

- *The right to palliative care is equivalent to the right to other care*

**Palliative care** is essential in justifying the absence of care for lack of resources or therapeutic de-escalation. The patient has the right to receive, if necessary, palliative care that alleviates all suffering and mitigates the symptoms that are most difficult to live with.

- *Ensure that decisions are taken in an appropriate way and that clear and accepted criteria are applied*

Any renouncing decision due to shortage must be based on objective arguments and be documented by the people in charge of such decision.

**Therapeutic de-escalation involves** reducing, on a thoughtful and intentional basis, the level of therapeutic care in the absence of clinical progress and this in a palliative perspective. It is conceivable :

- if the patient's therapeutic response does not correspond to the expected goal,
- in case of serious complications, or multi-systemic decompensation (multi-organ failure),
- if there is an acute need for respiratory assistance to another person in danger whose prognosis of survival is rated as more favourable.

In such situations, to relieve healthcare workers and with a view to greater responsiveness, relying on national or international **decision tree diagrams** in the decision-making process is allowed and even recommended. Reviews from an ethical perspective and ongoing improvements contributed by hospital ethics committees are highly recommended.

Taking decisions for de-escalation must, as far as possible, also rely on a continuous collegial discussion, conducted ideally at the level of the entire care team, conceived as a « **peer panel** » where hierarchical reporting lines are suspended. To the extent possible, taking decisions and actions at the actual care level should not be left exclusively to caregivers, who are in direct contact with the patients so as to :

- not put too much strain on the same individuals,
- allow for concomitant opinions to arise,
- reduce the risk of misjudgements to the best possible extent.

In the event of dilemmas in the context of therapeutic de-escalation, the association of an external **ethical crisis cell** appointed/designated/constituted according to objective and traceable criteria would allow to relieve the burden weighting on healthcare teams.

For therapeutic de-escalation or the occurrence of major complications, palliative sedation, the transfer to the non-intensive sector for palliative care in a stage of prolonged agony are indispensable.

- *Contact with the family or relatives (partner), as well as the person of trust designated by the patient, should be sought and cultivated as much as possible*

Relatives that are separated from their loved-ones due to the confinement have the right to be **kept informed** on the evolution through the use of existing telecommunications means, if the patient still manages to use them, or else through correct, personalized information adapted to the possibilities of the recipient to understand them.

The contact with the patient's family and/or person of trust is also a means of collecting information about the patient's history, preferences and end-of-life intentions.

Finally, in the event of an unfortunate outcome, family members and/or the partner and/or the person of trust designated by the patient have **the right to an understandable explanation** of the circumstances of the death.

- *The duty of caregivers and its limitations*

The duty to provide care is an obligation of means that is assessed in the light of the available human and material resources.

In the absence of resources and with regard to the individual patient, healthcare workers cannot be required to achieve the impossible.

It is essential **to spare the psychological and physical forces of healthcare workers** and **protect them from any sense of abandonment and loneliness**. They must be able to count on the constant solidarity, support and benevolence of everyone.

- *Protecting healthcare workers is essential*

**Preserving the health of caregivers is in the primary interest of the patients**, which makes their protection a priority for both ethical and practical reasons. Caregivers are entitled to the solidarity of non-caregivers when it comes to

- the availability of protective gear (masks, protective suits, goggles, gloves,...),
- psychological support to deal with increased and multiplied professional pressure in the event of a shortage of material and human resources.

The C.N.E. sees the current pandemic as a major challenge, which requires greater solidarity between those who are sick, those who are healthy, the healthcare workers and the entire population. We are *all* in this together.