BELGIAN ADVISORY COMMITTEE ON
Bioethics

Opinion no 85 of 17 April 2023 on the ethical legitimacy of prioritisation in healthcare

Contents

1. Request for an opinion

The Belgian Advisory Committee on Bioethics was addressed by letter of 18 November 2021 from Dr. Luc Harlet, chairman of the Medical Ethics Committee at AH Delta in Roeselare, with the following request for opinion "regarding the increase in capacity of beds reserved for Covid patients":

"What we two years ago considered as inconceivable is now a reality: the corona pandemic is constantly challenging us to deal equitably with the persistent bed pressure in hospitals. Right from the very first wave, we sat down with doctors in our hospital to think about addressing prioritisation in Emergency and IC. What we included in it was the statement that we do not distinguish between Covid and non-Covid patients; that we look primarily at need and urgency. To date, each wave has required hospitals to retain a percentage of IC beds free for Covid patients. This requirement raises questions regarding the reasoning behind it. We understand the practical concern for anticipating an influx of Covid patients so that as much urgent care is provided as possible. We also understand we need to need to postpone other, non-urgent care for this purpose. The question, however, is what is the ethical basis for the request to keep a percentage of beds free for a specific condition, namely Covid. Does this approach not discriminate against other, urgent conditions that are equally entitled to a percentage of beds? In our opinion, whether someone needs care because of Covid or some other condition should not matter. Given the fluctuating infection waves, how can we ensure equitable distribution of access to hospital beds in a sustainable manner?"

On 03 December 2021, Dr. Olivier Descamps and Dr. Sébastien Loix, chairman and vice-chairman respectively of the Ethics Committee of Jolimont Hospital Group (Jolimont-Lobbes-Nivelles-Tubize) submitted the following request for opinion to the Belgian Advisory Committee on Bioethics:

"We *hereby wish to submit an important ethical issue for discussion by the Advisory Committee on Bioethics.*
All hospitals in the country are currently facing what is described as the fourth wave of Covid-19 infection. As you are well aware, each hospital is required to set aside a certain percentage of its intensive care resources in order to care for these Covid-19 patients.
This percentage is determined by the hospital and Hospital and Transport Surge Capacity Committee (HTSC) a consultative body that depends on the FPS Health.
Since 19 November, the HTSC Committee has ordered scaling up to phase 1B. This means that 50% of the available ICU capacity should be reserved for Covid-19 patients.

As with all others, the hospitals in our hospital group have responded to this demand, which has been prompted by the current increase in the number of patients requiring treatment.

Our intensive care units have currently reached a saturation level both in terms of Covid-19 and non-Covid-19 beds. We are currently unable to provide care for certain elective conditions requiring resuscitation. Operation schedules have to be constantly adjusted and some operations, although relatively urgent, are postponed indefinitely. Patients requiring intensive care are referred to less suitable facilities.

After several weeks of providing the necessary care following this fourth wave, we can observe the following: currently, beds for the care of Covid-19 patients are almost entirely (more than 95%) occupied by non-vaccinated patients.

It is by no means the intention of this letter to question the admittance of these patients or their choice not to be vaccinated. On the other hand, this situation presents us with a major ethical dilemma.

- *The current vaccination rate is 77%*
- *Virtually all Covid-19 beds were occupied by non-vaccinated patients*

"Is it ethically acceptable to allocate 50% of available intensive care beds to 23% of the population ?"[1] ***with significant consequences for the entire population? Can we not talk about a lack of proportionality here?***

Notwithstanding the fact that these "Covid-19" beds are intended for the entire population without distinction of vaccination status, in reality they are almost taken up exclusively by patients belonging to the non-vaccinated minority. This potential disproportion is likely to intensify if it proves necessary to scale up to phase 2A (60%), which is unfortunately very likely given current developments.

Requisitioning of beds has major implications for the proper functioning of usual care chains, with repercussions for the whole population (postponement of diagnosis and care, postponement of interventions with pathological or psychological consequences). This amounts to a "loss of opportunity" for every patient involved.

Regardless of any value judgement, we have to admit that denial of vaccination by a small percentage of the population limits the chances of optimal care to which everyone is entitled.

Doesn't respect for the autonomy of a minority violate the principle of distributive justice?

Can the conscious choice of a minority negatively affect the entire population without any accountability?

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[1] The use of bold font in this presentation corresponds to that of the original request for opinion.

In recent weeks, there have been several testimonials pointing to this disproportionality. Early November, De Morgen published an opinion letter by two VLD members in which they concluded the following: "The hard core who choose not to be vaccinated have the freedom to make this choice, but do not have the freedom to hold the rest of society hostage..." More recently, there was the open letter from a VRT journalist lamenting the indefinite postponement of his treatment for prostate neoplasia, and the most recent is common for the hospitals of Namur. Within our own walls, considerable concern has been expressed and there is the growing fear that in the second instance an influx of patients who have received their vaccine early and are no longer adequately protected can be expected. Will we be able to admit these patients in good conditions, knowing that the average length of stay of our Covid-19 patients in intensive car is several weeks?

We reiterate that the intention of this letter is not to open a debate on the legitimacy or otherwise of refusing a vaccine, but rather to reflect on this lack of proportionality and the consequences for the entire in the context of the health crisis.

We are convinced that this issue will be even more important in the coming weeks, and there is a danger of a huge divide in public opinion between the vaccinated and non-vaccinated.

We consider it imperative to examine the extent to which current and future requisitions directives respect the principle of proportionality at the level of the entire population."

These two requests for opinion were declared admissible by the Advisory Committee at its plenary session on 13 December 2021. These raise more questions regarding the legitimacy, even the judicial legality, of the decisions of the '*Hospital and Transport Surge Capacity* Committee', a body active within the FPS Public Health, than on the ethical issues raised by a shortage of available care for too many patients, leading to the eminently ethical question of possible prioritisation. However, it is not the task of the Advisory Committee to advise on purely legal issues. The Committee is not an appellate body for settlement of disputes regarding the legality of decisions of administrative authorities raised by litigants, which public hospitals certainly are. The Council of State is competent for this.

On the other hand, the ethical questions regarding the possible prioritisation of care and its criteria need to be answered and thus reformulated. The Advisory Committee can do this because of its right to investigate on its own initiative. The Advisory Committee on Bioethics has issued several opinions in the context of the pandemic, including the opinion 'Ethical aspects concerning the prioritisation of care in times of Covid-19' dated 21 December 2020. This recommendation, endorsed by the Order of Doctors and the Superior Health Council, is included in the annex as it partially answers the above questions.

Due to circumstances, including the Covid-19 pandemic and an excessive workload, the Advisory Committee could not address these requests for opinion within the desired time frame. Its plenary session on 22 September 2022 ruled that "the questions formulated are no longer as acute today". However, current demands resurfaced in the late autumn of 2022, following a resurgence of the Covid-19 pandemic accompanied by an epidemic of bronchiolitis causing respiratory distress in a large number of very young children, as well as the seasonal flu epidemic, prompting Belgian hospitals to "sound the alarm"[2]. In addition, other problems of scarcity also arise. For instance, several hospitals are currently forced to close wards (temporarily) due to a lack of nursing staff.

It was therefore decided to follow the normal working procedure, including setting up a select committee to submit a draft opinion to the plenary meeting based on a reformulated question.

2. Previous opinion of the Committee on the question or shortage of available care in times of Covid-19

The Advisory Committee on Bioethics addressed this question in its recommendation of 21 December 2020 on 'Ethical aspects regarding the prioritisation of care in times of Covid-19', endorsed by the National Council of the Order of Doctors and the Superior Health Council. The considerations contained and conclusions drawn therein remain entirely valid. The present opinion aims to supplement it in light of the new elements in the question reformulated below. Accordingly, the recommendation of 21 December 2020 is attached to this opinion and forms an integral part of it.

3. Reformulating the question

One of the doctors at one of the two institutions heard by the Committee explained the lessons he had learned from the practical situations his hospital faced, specifically during the first wave of the Covid-19 epidemic:

- even before the epidemic, there was a shortage of nurses. The first wave of the epidemic brought about a redistribution of nursing staff in favour of emergency departments. However,

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[2] For France, see for example the digital *L'Obs* of Wednesday morning, 30 November 2022 (L'Obs newsletters@redaction.nouvelobs.com - Covid: Borne calls for makes to be put on again in transport (nouvelobs.com)) on Prime Minister ELISABETH Borne's statements the day before in the National Assembly and, for Belgium, *Le Soir* of the same day.

working in an emergency department requires specific skills and training that other nurses do not have, even if they have different skills. Moreover, many staff soon experienced health problems themselves, either through infection or extreme fatigue. As a result, some patients at that time did not receive the same quality of care as others. It is well known that a significant number of nurses left the hospital world after this period. As a result, there is still a shortage, even indefinitely, in all nursing sectors. This weighs heavily on the organisation of care in all hospitals. How will we tackle the next epidemic of similar magnitude - the recent history of global health shows that we will certainly face this situation - when the situation of our hospitals is more fragile today than before the first Covid-19 wave;

- the hospitals were completely saturated quickly and there was a shortage of machines. Some hospitals were forced to refuse admission of specific patients. Doctors were faced with the choice of which patient to prioritise and eventually they were unable to admit even a single patient. The organisation of compliance monitoring, which is community-based in Flanders and Brussels and regional in Wallonia, has encouraged networking. Hospital doctors who belong to the same network know each other. They therefore turn to these colleagues when transferring patients and not to those belonging to another network. As a result, some patients could not be transferred even though a hospital belonging to a different network, near the community and regional border, might have been a possibility;

- this condition has led to the death of an unknown number of inadequately treated patients.

Committee's interlocutor added that all shortages are threatening. The current shortage of certain drugs intended for treatment of stroke patients means that drugs still available in stock are only given to patients for whom there is certainty of an 'effective recovery'.

This finding raises the question of the ethical legitimacy of establishing criteria for the prioritisation of care by an authority, be it public or private.

All these considerations have led the Committee to reformulate the questions raised into a single question, which reads as follows:

"Is it ethically permissible for the government or public or private healthcare organisations to impose rules that prioritise certain care over others if the supply of care is insufficient to meet the demand for care, for example in an epidemic?"

The Committee is aware that several other perspectives are of great importance, such as bioethical theories on the right to healthcare, the efficient allocation of resources and the results obtained through the organisation of a healthcare system. The next Advisory Committee on Bioethics of the seventh mandate will address this issue if it so decides.

4. Challenges for a healthcare system in a resource-constrained environment

There is usually a good match between supply and demand in our healthcare system. This mainly concerns how our healthcare system is organised, which allows a significant amount of freedom on the supply side. There are waiting times in many places but this has more to do with specialised supply or the use of high-tech techniques. The care supply is flexible as we observed during the Covid-19 pandemic, where hospitals showed great flexibility in reallocating resources and people. The cessation of regular care has allowed maximum care for individuals with Covid-19.

When the demand for healthcare more or less matches supply, healthcare is prioritized based on good medical practice. In some circumstances, however, the supply of healthcare may not be adapted to the demand. This is the rule rather than the exception in developing countries where healthcare is organised with limited resources. Even though developing countries strive for universal access to healthcare, there are still substantial inequalities. The inequality in access is often based on socio-economic differences in the population. This leads to two-tier medicine, often a private medicine for the wealthy versus public medicine for the less fortunate.

Every health system should be prepared for unusual challenges. Moreover, the distribution of public health resources should be based on principles of justice and equal treatment. The World Health Organisation (WHO) has publishedseveral papers since 2015 on inequality of access to and unjust distribution of health care[3]. First and foremost, WHO argues that unequal access and inequity in supply is contextual. The context is influenced by human biology, the nature of pathogens and the vulnerability of a population group. Moreover, existing equilibria may be significantly disrupted during a pandemic. Depending on the health problem that occurs in a population group, indicators can show whether healthcare resources were distributed fairly (e.g. the proportion of children <5 years with fever treated for malaria in a malaria endemic area). According to the WHO, even in socio-economically prosperous regions,

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[3] https://www.who.int/data/inequality-monitor

resources to provide healthcare are often unevenly distributed. This leads to inequality in access to healthcare.

The healthcare sector is at risk of facing other shortages now and in the future. At the moment, there is a significant staff shortage due to the absenteeism of doctors and nurses. Numerous medications are temporarily unavailable due to production or other logistical problems. Innovative treatments cost more and more money while the gain in lives won or quality of life is not always assured. Along these lines, our healthcare system is also in danger of reaching its limits.

In disaster medicine or times of war, healthcare capacity is overstretched and supply and demand are no longer matched. The circumstances make it difficult to guarantee supply and its continuity. Demand also varies to the extent that at times large groups of victims need to be treated simultaneously. Rapid triage and prioritisation must be applied, sometimes based on simple criteria that can determine the patient's medical prognosis.

The recent corona pandemic put our healthcare system to the test. There were concerns that the number of intensive care beds would prove to be insufficient and that there would be a shortage of ventilators. In the context of a pandemic, different interests need to be weighed up: interest of the individual, protection of society as a whole, equal justice, trust in healthcare, solidarity and good governance. This has led to maximising the deployment of health workers, restricting citizens' freedom, setting priorities in terms of allocation of resources such as vaccines and antivirals, and restricting travel and tourism. Thanks to sweeping government measures, the limits of capacity have rarely been reached in our country.

Prioritisation may become necessary when healthcare supply and demand are mismatched. The term prioritisation presupposes prioritising one population group over another or one individual over another. For example, the Belgian Advisory Committee on Bioethics recommended in an opinion that certain population groups should be given priority for vaccination against Covid-19.

This opinion no 75 on the ethical standards for the roll-out of anti-Covid-19 vaccination for the benefit of the Belgian population stated that prioritisation is never based on purely medical criteria, but should be combined with principles such as solidarity, reciprocity, justice and other ethical principles[4]. The concept of prioritisation in the context of vaccination for Covid-19 has generated a lot of discussion.

At the level of the individual care relationship, healthcare providers adapt their care according to the guidelines of good medical practice and the patient's needs. The Advisory Committee does not regard this as prioritisation as defined in this opinion. After all, scientific guidelines are meant to support doctors in making the right choices and carry out prioritisation rationally. By way of example, it is not necessarily because the patient asks for an antibiotic that the doctor prescribes it. When choosing the right antibiotic, consideration should be given to developing potential resistance, method of administration and cost. Good medical practice often considers reasonable steps and sequence in treatment programmes, for a given individual or between individuals. Patients eligible for kidney transplantation are asked to quit smoking, as the use of certain immuno-suppressants gives rise to accelerated atherosclerosis. If patients do not respect this measure, they risk waiting longer for a transplant or being removed from the waiting list. Here, prioritisation comes into conflict with personal freedom, even if it remains based on the medical choices that are scientifically supported.

Thus, prioritisation based on science-based criteria and guidelines generally does not lead to a public debate but scientific and ethical discussions among professionals. An ethical social debate arises when prioritisation threatens equal access to healthcare. This can be either a true inequality of access or a perceived one. There may also be uncertainty about what doctors consider a reasonable outcome for a specific patient population.

Prioritisation results from decisions at the macroeconomic level regarding the allocation of resources that can be used for health care. The programming of heavy equipment and specialised care means that residents of one region have easier access than those in another region. Subsidising a specific type of care over another puts emphasis on the supply and thus the accessibility of care. A similar phenomenon occurs at the macroeconomic level through oversupply in certain medical specialities at the expense of others. Resource scarcity is thus partly created by the government, but equally by interest groups, universities, insurance companies and other stakeholders.

Prioritisation based on age, co-morbidity, chances of improvement and survival are rational parameters used not only in the context of a pandemic but also in healthcare in general. The ethical question is whether prioritisation should be left solely to doctors or whether

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[4] Opinion no 75 of 11 December 2020 of the Belgian Advisory Committee on Bioethics on the ethical standards for the roll-out of anti-Covid-19 vaccination for the benefit of the Belgian population, www.health.belgium.be/bioeth.

government guidelines should be drafted. This concerns not only making the decisions themselves but also communicating about them. In this case, the government must be careful not to discriminate against vulnerable groups such as children, people with disabilities, the elderly, refugees, etc.

Experience during the Covid-19 pandemic showed that applying prioritisation was a significant burden for healthcare providers. Some caregivers considered it normal, while others perceived it as very stressful. Support for healthcare providers in applying prioritisation is thus necessary. At a minimum, hospitals should have multidisciplinary teams that can be a sounding board for individual healthcare providers. Moral support should help minimise potential contradictions and conflicts in practice. Thus, support initially comes from peer groups but support through government regulation is also possible. Decision-making arising from law enforcement or regulation relieves healthcare providers in part by providing them with a framework and protects them from external influences, but it creates other difficulties in the process: according to Put and Van Assche, it has advantages and disadvantages[5]. Among other things, this can result in decontextualisation, with increased conflict and soured human relations.

5. Legal considerations

5.1. International texts

Article 2 of the Convention for the Protection of Human Rights and Fundamental Freedoms, signed in Rome on 4 November 1950, is entitled 'Right to life'; in its first sentence, paragraph 1 provides that 'everyone's right to life shall be protected by law'; it follows from this provision that every State is obliged to frame its legislation in such a way as to protect its inhabitants against loss of life.

The International Covenant on Civil and Political Rights, concluded in New York on 16 December 1966 and ratified by Belgium on 21 April 1983, contains a similar provision in Article 6(1): ' Every human being has the inherent right to life. This right shall be protected by law'; it follows that no law of a State party to the Convention can alter this right[6].

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[5] J. Van Put and L. Van Assche. (2013) Legalisation of the healthcare sector. An exploratory concept and phenomenon study. Welfare, Public Health and Family Support Centre.

[6] Subject to the death penalty referred to in the following paragraphs of the same article.

The International Covenant on Economic, Social and Cultural Rights, concluded in New York on 16 December 1966 and ratified by Belgium on 21 April 1983, provides:

- in Article 11(1), that 'the States Parties to the present Covenant recognize the right of everyone [...] to the continuous improvement of living conditions' and 'will take appropriate steps to ensure the realization of this right'; failure to take such measures implies that a State party to the Covenant is in breach of its international obligations;

- in Article 12(1), that 'the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; in paragraph 2 of this article, the following addition is made: 'The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: [...] c) prevention, treatment and control of epidemic and endemic diseases, as well as occupational and other diseases'.

The Committee on Economic, Social and Cultural Rights adopted a General Comment on the Right to Health on 11 May 2000. (General Comment no 14: The right to the highest attainable standard of health under Article 12 of the Convention). This Comment recalls in particular the general legal obligations of the States. While the State must be able to fulfil its obligations progressively, it must not fail to give them real substance. It must implement the measures referred to in Article 12 as quickly and effectively as possible. Its obligations are thus as follows: to comply, to protect and to implement. Compliance by not directly or indirectly impeding its exercise. Protect by taking measures to prevent third parties from affecting them. Implement by taking appropriate legislative, administrative, budgetary, judicial measures to ensure implementation.

5.2. Charter of Fundamental Rights of the European Union

Article 35 of the Charter of Fundamental Rights of the European Union is entitled 'Healthcare' and reads as follows:
'Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.'

5.3. Texts of Belgian domestic law

We limit ourselves to two examples of provisions of Belgian domestic law:

(1) According to article 23 of the coordinated constitution of 17 February 1994,

"Everyone has the right to live a dignified life.
To this end, the law, decree or rule referred to in Article 134, taking into account the corresponding duties, guarantees the economic, social and cultural rights, the conditions for the exercise of which they define.
Those rights include in particular:
1° [...];
2° the right to social security, health protection and social, medical and legal assistance;
[…]".

Recognising the existence of a right to health protection for citizens implies an obligation for the State to ensure that this right is not compromised by lack of foresight or precaution. ALSO, this affirmation of health protection has the effect of consolidating this recognition through the so-called standstill effect, which provides for maintaining, in principle, an equivalent level of protection. The adoption by the authorities of measures that result in these rights being affected requires that they justify this on grounds of public interest. Note 14 also points out that: "In the case of a measure that constitutes a deliberate step backwards, the State party to the convention must demonstrate that it was taken after careful consideration of all other possible solutions and that it is fully justified in the light of all the rights envisaged in the Convention and all available means."

(2) The Law of 22 August 2002 on Patients' Rights stipulates the following in article 5: "The patient, with respect for his human dignity and self-determination and without any discrimination on any ground, entitled vis-à-vis the professional, to quality services that meet his needs." It is the State's responsibility to enable the patient to actually exercise this right and to enable the practitioner to carry it out, otherwise it would only be theoretical.

5.4. Conclusion on the State's obligations

Even if some of the above obligations can be described as a resource rather than result obligations, the State must at least do everything reasonably possible to comply with them. However, its policies on health care and the training of health personnel, especially doctors and nurses, have for many years ignored the risk of epidemics, especially respiratory diseases, which epidemiologists nevertheless rate highly (e.g. by not replenishing the strategic stock of masks, by not providing for pandemic preparedness in the training of health workers).

6. Ethical concerns

Legal discourses on fundamental rights relating to health during health crises cannot always prevent fundamental rights and human rights from being neglected or even violated.[7] Therefore, the recommendation is to combine legal discourse with a philosophical discourse on human rights. Human rights discourse has an ethical and critical capacity that points even further than positive law. The ethics of human rights allow us to continue to critically test legitimate political decision-making regarding the granting and curtailing fundamental rights against essential moral values.

As the Advisory Committee on Bioethics, we must therefore conclude that

1. The probability and risk of the occurrence of a new pandemic is real: mutation of existing viruses or the combination of different infectious diseases can very quickly clog up the IC and emergency services.
2. The scarcity of healthcare workers such as doctors and also nurses poses a threat. Hospital beds and wards have already been closed due to a lack of staff.
3. The population is ageing quickly and the need for care is increasing. It is clear that staff shortages will also occur in elderly care and that more and more people will be transferred to the hospital from the home situation.

From an ethical point of view, all measures taken will be tested against the principles of solidarity and of justice, such as distributive justice and procedural justice. There are many questions and specific answers regarding the equitable distribution of risks and benefits and potential harms, as well as the equitable working method for realising values such as freedom, equality and care for the most vulnerable. These questions arise both at the level of society as a whole (national, European, international) and at the level of national politics (macro), healthcare organisations (meso) and the healthcare provider-patient relationship (micro). The hearing with a health sociologist revealed that people's cultural, social and family contexts leave their mark on the precarious living conditions associated with their specific needs and

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[7] Opinion of Deutscher Ethikrat, 4 April 2022, "Vulnerability and Resilience in a Crisis - Ethical Criteria for Decision-Making in a Pandemic", p. 185-189, https://www.ethikrat.org/en/publications/.

requirements towards healthcare. Equitable healthcare is based on the needs and requirements of the individual patient.
A comprehensive and global healthcare crisis also raises issues regarding (inter)generational justice. Will the intended measures be fair to the various age groups? Example: Protecting older people should not result in a one-sided burden on young people (generational). Given the high costs of the pandemic, the future generation will bear a higher debt burden (intergenerational).

When the government reserves a certain number of beds for intensive care, it implicitly or explicitly invokes a solidarity obligation. Solidarity is an altruistic moral value. During the pandemic, many healthcare providers acted not only based on their professional ethics but also from altruism towards their fellow human beings.

We live in a complex society where people are dependent on the judgements, decisions and actions of others. In times of uncertainty, people put their confidence in the correct working methods of other people, organisations and institutions. In a crisis situation, trust plays a prominent role in interpersonal and social interaction. In the absence of confidence, there is an increase in uncertainty, both social and individual. Trust already decreases when relevant persons or groups are not or are insufficiently informed regarding decisions taken, or when they are not or insufficiently involved in the decision-making process. Therefore, it is important for the government and international organisations active in the health field to thoroughly consult, define and justify their policies and adequately inform the public. Stable social cooperation is possible only if there is sufficient trust at and between the three levels (government, healthcare organisation, healthcare provider-patient/relationship).

7. Conclusions

The Belgian Advisory Committee on Bioethics believes that the competent public authorities have the responsibility to guarantee the population health and to do so following the legal rules they have established for themselves and in accordance with the international obligations entered into. To fulfil this obligation, public policies must be aimed at a social organisation that provides the necessary care staff, equipment and medication and provides the necessary procedures. This will allow them to anticipate better any reasonably foreseeable events that could put pressure on the healthcare system and avoid a shortfall in healthcare supply. It is not ethically permissible for the government to impose rules on healthcare providers to address shortages for which the government itself is responsible, especially when applying these rules results in certain patients not being treated or being treated less well. By introducing such rules, the government could shift its responsibility to healthcare providers by leaving health policy choices to them even though it is not their responsibility. The government must ensure that healthcare providers can make decisions based on their knowledge and based on the latest state of science.

The Committee believes it to be ethical for public or private healthcare organisations such as hospitals, clinics, nursing homes, etc., to draw up a framework of general guidelines to be applied when they are unable to meet the influx of healthcare requests. These institutions must work to optimise care and medical treatments so that scarce resources can be optimised for the benefit of patients and based on demonstrated expertise. Moral stress the care providers are subject to should be avoided or at least alleviated as much as possible. The contribution made by scientific institutions such as the Federal Knowledge Centre for Health, the Superior Health Council and others is indispensable for this purpose.

The opinion was prepared in the select committee 2020/4, consisting of:

Joint chairpersons	Joint reporters	Members	Member of the Bureau
Patrick Cras	P. Cras	Vera De vleeschauwer	Jan De Lepeleire
Thérèse Locoge	T. Locoge	Ignaas Devisch	
	J. Libbrecht	Martine Dumont	
	J. Messinne	Julien Libbrecht	
	J. Stuy	Jules Messinne	
		Johan Stuy	
		Nele Van Den Noortgate	

Members of the secretariat
Dominique Dugois and Bea Deseyn

Representatives of applicants heard
Sébastien Loix, Chairman of the Medical Ethics Committee of the Jolimont - Lobbes - Nivelles - Tubeke hospitals
Natasha Cornelis, Chairwoman of AZ Delta's medical ethics committee
An Ravelingien, ethics and patient experience policy coordinator at AZ Delta
Jan Hebbrecht, nursing-paramedic director at AZ Delta

Experts heard
Marcus Leys, Sociologist, Professor at the Free University of Brussels - Department of Health Sciences
Philippe Leroy, director general of the CHU Saint-Pierre
Michelle Dusart, Head of medical services, general management at CHU Saint-Pierre

This opinion is available on the website www.health.belgium.be/bioeth, under the “opinions” section.

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Attachment

Recommendation of 21 December 2020 of the Belgian Advisory Committee on Bioethics, endorsed by the Order of Doctors and the Superior Health Council: "Ethical aspects regarding prioritisation of care in times of Covid-19"

Introduction

The Covid-19 pandemic is putting our healthcare system under pressure in a manner never seen before. Increases in infection rates and hospital admissions are putting increasing pressure on care, making if necessary to reflect on deployment of resources and temporary reorganisation of care delivery. Caregivers, patients, policy-makers and the general public are thereby faced with complex organisational issues that often also have an ethical dimension: how do we safeguard the capacity of care, how do we guarantee the accessibility of care, how do we maintain the quality of care, what about the continuity of care and the equitable distribution of resources?

The ethical issues that arise in the current crisis span the entire healthcare landscape: from the citizen who does everything to stay healthy and is subjected to special measures as a result of the epidemic, to primary care and the various healthcare centres, to intensive care provided in specialised hospital wards. In addition, several scenarios are conceivable, each of which poses specific ethical challenges. These range from scenarios where the corona virus is still present in society, but manageable, to *worst-case scenarios* where a spike in infections would acutely exceed healthcare capacity and as a result of which decisions would have to be taken regarding which patients could access scarce resources and which could not.

When discussing care overload, special attention has for logical reasons so far been paid to Intensive Care Units:

- These wards often represent the last resort for patients who experience severe consequences of Covid infection;
- Because of their need for specialised personnel and high-tech equipment, these wards are limited in size and therefore also restrict the possibilities of creating additional capacity;
- Once these wards are overloaded, it is no longer possible to base decisions on initiating or continuing care solely on the wishes, needs and prognosis of the individual patient, as would be the case under normal circumstances, but as resources have become scarce, it becomes unavoidable to make tough choices between individual patients becomes unavoidable;
- Examples from abroad illustrate that such a scenario can suddenly become a reality.

However, the focus on the Intensive Care Units should not make us forget that there are also significant and acute decisions to be made as to whether or not to start care elsewhere in the healthcare landscape e,g, in primary care referrals, interventions by the MUG [Mobile Emergency Group], after admission through the Emergency Department, in residential care centres and rest and care homes.

It should also be noted that the different domains within the healthcare landscape can act as communicating vessels: patients not treated in an Intensive Care Unit need to have their healthcare needs met elsewhere. This also applies to resource allocation: centralisation of resources and people in hospital care often impacts primary care and residential care centres, which may find access to tests, protective equipment or oxygen more difficult. Furthermore, the postponement of non-urgent care in hospitals to free up space to care for Covid patients significantly impacts the continuity and outcome of non-Covid related care. The postponement of surgical procedures because the infrastructure and staff required for this purpose are used to care for Covid patients, can have far-reaching consequences for the patients concerned. The postponement of care also has profound implications outside of hospitals.

Thus, when the healthcare landscape is viewed as a whole, it becomes clear that decisions on prioritisation in healthcare can be situated in different places and with different actors: decisions on the organisation of healthcare, decisions by the patient, decisions by health professionals, decisions at the level of institutions and, ultimately, decisions by citizens, who can actively contribute to limiting the spread of the virus through behavioural modification and prevention. Any decision on prioritisation, at any level, has consequences.

In keeping with the structure of this complex healthcare landscape, the present recommendations are structured in four topics: (1) the organisation of care; (2) the patient; (3) caregivers; (4) coordination of care in hospital, primary care and residential care.

The Committee believes that it is not its place to define and rank criteria for patient selection or "triage". Indeed, these concern medical decisions regarding individual patients made by a doctor and his team, in which diagnostic and prognostic elements should always be central, considering the patient's wishes and preferences. However, these decisions have an ethical and deontological dimension. In addition, the Committee recognises that these decisions weigh heavily on caregivers exposed to moral stress.

In response to this situation, the Committee formulates recommendations designed to support caregivers in making the difficult decisions they currently face. These recommendations should not be considered direct obligations.

The present recommendations draw on ethical principles that have strong presence in the national and international debate and have been the subject of in-depth reflection in the literature. Some of these principles deserve to be explicitly mentioned. Thus, the Committee stresses the importance of reconciling the pursuit of saving as many lives as possible with the ethical principles of beneficence and respect for the dignity and autonomy of each person. When making choices between different patients prove to be unavoidable, the principles of equal access to care and equity are paramount. Furthermore, the Committee points out some aspects that are less present in the literature. Thus, it is important that medical criteria do not completely overshadow physical, psychological and social vulnerabilities.

With these recommendations, endorsed by the Order of Physicians and the Superior Health Council, the Belgian Advisory Committee on Bioethics aims to provide an initial response to the urgent need for an ethical framework as institutions, caregivers and patients face the challenging situation posed by the pandemic. In doing so, it intends to support existing efforts to deal with current ethical issues (cf. the guidelines, advice, protocols, and flow charts developed from within the field) and encourage the further development of new initiatives.

While the fundamental principles on which these recommendations are based are permanent, their translation into clinical practice requires ongoing reflection and debate. In a rapidly changing context with a constantly evolving pandemic situation, it is therefore necessary for the Committee and the bodies endorsing this text to reflect more in-depth on these principles in the future.

This recommendation was developed by the Belgian Advisory Committee on Bioethics. The text was prepared in a select committee and then presented to all members of the Committee in plenary session for discussion and approval. This recommendation is endorsed by the Order of Physicians and the Superior Health Council.

1. The organisation of the care

The Covid-19 pandemic represents a stress test for the public health sector, both in terms of performance, and ethical and legal aspects. At the organisation of care level, the challenge posed is how to safeguard or increase the capacity of care in the face of an increasing number of infections to provide both care for Covid patients and continuity of essential care for other patients. This can be done, for example, by expanding the capacity of Intensive Care Units or postponing non-urgent care to free up staff and infrastructure to build Covid units.

In striking the right balance between availability, accessibility, and quality of care during the pandemic, it is vital to strive for the best possible care for the patient within the exceptional constraints that the context may pose in this pandemic. This can be based on the criterion of achievable care, distinguishing three stages according to the pressures posed by the pandemic:

- Conventional care: with a mild increase in demand for care (e.g. up to 120% of normal capacity), the aim is to treat all patients according to the normal standards. Thanks to the additional deployment of people and resources, the availability, accessibility and quality of care can be maintained at the usual level;
- 'Contingency' care: when normal care capacity is considerably exceeded, care provision needs to be redesigned to match current needs as much as possible. For example, operating theatres can be transformed into Intensive Care Units and OR personnel can be used as staff. Care quality is maintained, but availability and accessibility is restricted by postponing non-urgent care. The pressure on healthcare staff increases significantly. In this phase, the balance between continuing regular care and care in crisis is disrupted;
- Crisis care: if normal care capacity is significantly exceeded, complete maintenance of availability, accessibility and quality of care can no longer be guaranteed. In this case, the situation forces prioritisation and optimal distribution of patients and carers across the healthcare landscape. Solidarity between healthcare institutions, regions and countries comes into effect.

At the organisation of care level, the available personnel and equipment must be deployed to provide the highest possible degree of achievable care. Only after human and logistical capacity is exhausted can a decision be taken to move to a lower level of realisable care for the shortest possible period. In anticipation of a sharply rising need for care, it may be justifiable for healthcare institutions to switch to a reduced level of achievable care shortly before the absolute limits are reached.

Organising care based on the criterion of achievable care creates maximum clarity regarding the possibilities and limitations to which care is subject at a given stage. This allows caregivers to focus decisions maximally on the patient's care demand, care needs and prognosis within the limits of the respective level without worrying about safeguarding capacity. These criteria also clarify that caregivers have to choose between patients with similar care demands, care needs and prognosis only in the highly exceptional circumstances of complete saturation of wards at the crisis care level.

The following ethical considerations are important here:

- Access to care should be maximally safeguarded for all patients, with or without Covid infection, by optimising and increasing capacity where possible and, if necessary, distributing patients across institutions, regions and national borders;
- Efforts and resources to maintain quality of care in times of scarcity, including protective equipment, testing capacity and medication and oxygen, should be distributed fairly across the entire healthcare landscape: primary care, home care, specialised care in hospitals and various forms of residential care should all be reinforced to be able to provide the care in the highest quality possible;

- Because residential care in residential care centres and other facilities does not have similar infrastructure and capacity to manage infection prevention and treatment as in hospitals, there is a need for appropriate support. For example, residents often have a fixed room, making it more challenging to distinguish spatially between a Covid and non-Covid ward. As a result, staff also experience a significant additional workload. The Coordinating and Advisory Physicians (CRA) and GP district associations can play a crucial role in this support;
- Where non-urgent care is postponed, this period should be kept as short as possible and sufficient attention should be paid to the impact of this interruption on the quality and outcome of care. An exercise is also needed to determine which care can be postponed. Here, however, it is difficult to formulate general principles because, on the one hand, the interpretation of the notion of non-urgent care is vague and rapidly evolving and, on the other hand, the extent to which care is postponed and the constraints experienced within a hospital depend significantly on the specific situation;
- The availability of materials and care providers play a vital role in decisions on what level of care is achievable. Therefore, this availability and, above all, the burden and well-being of care staff must be closely monitored.

2. The patient

All patients are fundamentally equal. Patients are entitled to quality and accessible care without distinction based on gender, origin, socio-economic status, religion, age, culture or other grounds for unlawful discrimination[1]. Therefore, the individual patient and his care demand and/or care need are the *ultimate concern* of healthcare provision. A commitment to equal treatment of every patient in need should always be the central concern.

Patient rights

The law of 22 August 2002 on patients' rights guarantees respect for several ethical foundations of good patient care, in particular autonomy and transparency. The starting point is that patients are active interlocutors in the decisions made about their care, even when it comes to delicate decisions such as reducing care, without prejudicing the right to quality care (see below). The right to quality services (Art. 5), the right to information on the patient's state of health and its probable evolution (Art. 7), the right to informed consent and the right to refuse treatment (Art. 8), the right to a carefully maintained and securely stored patient record (Art. 9) and the right to complain (Art. 11) deserve special attention and respect in this context.

Patients capable of informed consent are entitled to make autonomous decisions about the care they wish to receive, ad hoc or by prior declaration of intent, whether or not as part of advance care planning. It is of key importance to know the patient's wishes and preferences, particularly when complex choices about whether or not to start invasive treatments have to be made. However, the right to make autonomous decisions in no way implies that patients have the right to demand treatments that the physician would consider pointless or futile.

Many patients are entrenched in a relational network of family and loved ones they may wish to consult when making these decisions, especially their confidant if they appointed one. This must be recognised.

The Covid-19 pandemic sometimes complicates the respect for patients' rights. For example, there may be an inability to treat patients in a facility of their choice or they may be unable to choose to which hospital they are transferred[2]. Current circumstances may also complicate the

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[1] See (*inter alia*) Law of 10 May 2007 on combating certain forms of discrimination.

[2] Besides the Law of 22 August 2002 on patients' rights, see also the Law of 4 November 2020 on various social measures following the Covid-19 pandemic.

decision-making process because e.g. consultation with family members on these major decisions is not possible due to restrictions in (physical) contact possibilities. Finally, the patient's condition, especially if they are seriously ill and/or experiencing respiratory distress, can impede communication or even make it impossible. In these exceptional circumstances, however, the law on patients' rights remains unaffected.

Transparency principle

The right to information about the patient's state of health, as well as the right to informed consent and the right of access to a patient file implies that caregivers and healthcare institutions must be transparent towards the patient and, if the patient so wishes, also towards their relatives or their confidant, more specifically regarding the patient's state of health and health problems, the evolution of the condition, the way these health problems are handled and the (medical) decisions taken in this respect[3]. In this respect, it is important to record decisions to withhold or withdraw treatments in the patient file. The patient or his/her representative and, if the patient wishes, their confidant must be informed of these decisions. A quality patient file also contributes to transparency as a necessary guarantee of continuity of care. Indeed, an integrated patient file can serve as a communication tool in case of referrals between caregivers and healthcare institutions.

Advance care planning

The right to informed consent includes the right to record preferences regarding care so that when a patient is temporarily or no longer capable of express his/her preferences, the patient's wishes and what quality of life the patient wishes to enjoy in the future are known. This can for example be done by means of an advance will in which the patient explicitly refuses a transfer to a hospital or admission to an Intensive Care Unit. In addition, future care can be anticipated when elaborating an Advance Care Planning (hereinafter ACP). In the case of ACP, the initiative need not necessarily be taken by the patient as drafting an ACP can be integrated into routine care processes, e.g. at the time of admission to a residential care center. It should be emphasised, however, that in the process of ACP, determining the content of the care plan is entirely up to the patient in question. Preferences regarding the end-of-life can also be clearly recorded in the ACP.

Currently, the practice of ACP is not implemented uniformly in all healthcare facilities and hospitals. It is, however, essential in the present circumstances to ascertain whether an ACP has been or can be drawn up. When, however, taking new initiatives to establish an ACP, it should be assessed whether the concrete circumstances provide the right psychosocial and emotional context to do so according to good practice. It is therefore strongly recommended for care planning be carried out at a time when treatment decisions are not acutely pressing.

The Belgian Society for Intensive Medicine recommends specifying in advance in an ACP which interventions will be considered or which interventions would be undesirable for a particular patient, including:

- Cardiopulmonary resuscitation;
- Admission to the hospital;
- Admission to an intensive care unit;
- Endotracheal intubation;
- Non-invasive mechanical ventilation;
- Pharmacological hemodynamic support;

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[3] See *inter alia*: Principles of European Medical Ethics adopted by the European Conference of Medical Chambers (CEOM):http://www.ceom-ecmo.eu/view/principes-d-ethique-medicale-europeenne.

- The initiation of renal replacement therapy[4].

Here, it is advisable that the duration and circumstances of these therapy restrictions be specified.

Representation

Even when a patient is no longer capable of informed consent, the patient's interests and wishes should be respected to the extent possible. If there is no record of a patients advance will, nor a documented ACP, decisions about the care must be made by the patient's legal representative. The Patients' Rights Act has provided for a cascade arrangement for the designation of representatives, so that the patient's relatives can often act as representatives, thus articulating the patient's wishes and making informed decisions on his behalf. Either way, the (presumed) interests of the patient are always at the centre of the decision-making process.

3. Caregivers

Medical decisions

Making decisions about initiating, continuing, or withholding or withdrawing care are inherently part of medical practice in any context.

In such decisions, medical criteria are considered in the light of major ethical principles, such as equality, beneficence, non maleficence, autonomy and respect for the person's dignity. Doctors and other caregivers have extensive experience in this decision-making process. These decisions will take into account, among other things:

- The care demand and the care needs of the patient;
- The general state of health of the patient, in which, for example, fragility and co-morbidities are relevant parameters;
- The patient's prognosis in the light of his/her current condition;
- The proportionality of care in relation to the above elements;
- The person of the patient, who is not reduced merely to his medical condition in these decisions, but whose personal preferences and wishes regarding treatment and outcome are considered;
- The fundamental equality of all patients and their right to quality care.

Under normal circumstances, care decisions should never take into account:

- Gender, origin, sexual orientation, religion, physical or mental health, disability, age, colour, culture, socio-economic status or other grounds of unjust discrimination;
- The deployment of equipment and personnel, insofar as they are not redundant or medically useless.

Medical decisions are made taking into account ethical issues significant to this decision. They are, wherever possible, an outcome of *shared decision-making* in which all stakeholders are each maximally engaged in their own roles.

Therapy restrictions

Setting therapy restrictions is also part of normal medical practice. It is part of doctors' judgement to assess which care is medically appropriate and which does not provide sufficient

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[4] Geert Meyfroidt, Erika Vlieghe, Patrick Biston, Koen De Decker, Xavier Wittebole, Vincent Collin, Pieter Depuydt, Nguyen Duc Nam, Greet Hermans, Philippe Jorens, Didier Ledoux, Fabio Taccone, Ignaas Devisch (2020). *Ethical principles concerning proportionality of critical care during the 2020 Covid-19 pandemic in Belgium: advice by the Belgian Society of Intensive care medicine*.

therapeutic benefit to the patient. When making such medical decisions, the individual patient's condition, evolution and preferences, available scientific evidence and good practice are naturally taken into account. Although doctors and medical teams essentially make medical decisions regarding therapy restrictions, patients should be fully involved in these decisions.

An established manner of setting therapy restrictions are DNR ("*Do Not Reanimate*" or "*Do Not Resuscitate*") codes. DNR codes record in advance in the patient file which treatments will not be started or phased out. They are particularly relevant for avoiding disproportionate when it comes to caring for patients with a Covid infection.

It is important to note that ACP and DNR codes are not automatically linked. If, however, the content of the ACP bears a strong resemblance to a DNR code, it is advisable to record the corresponding DNR code in the patient file to ensure maximum respect for the patient's wishes.

Therapy restrictions can also be taken in the context of non-referral of patients to hospital. Similarly, the Belgian Society for Gerontology and Geriatrics also states that for some older persons, a palliative approach is medically preferable over hospitalisation, for example in cases of high frailty or respiratory failure[5].

Ethical recommendations for prioritising care

In normal practice, patients who would benefit from the Intensive Care Unit admission are carefully considered. Medical parameters as well as the patient's personal and ethical issues are taken into account when making such decisions. Ethically, the principles of beneficence, non maleficence, autonomy and justice deserve due attention. This can help avoid therapeutic obstinacy, insufficient consideration of patients' wishes or unlawful discrimination.

In the crisis care scenario, a complete saturation of the Intensive Care Units should occur that cannot be overcome by a transfer of patients to other hospitals (cf. the crisis care scenario described above), doctors are forced to select a limited number of patients from all those normally eligible for intensive care. The medical criteria and ethical standards in the context of normal practice may not help make these choices. Complex questions can arise in this context, particularly regarding applying the principle of justice.

There is no procedural way out of this impasse: none of the numerous triage criteria being defined, considered and/or used[6], for example in the historical context of the allocation of the (at the time) scarce kidney dialysis, offer a *miracle solution* to this selection problem. It is also impossible to replace human decisions with an algorithm. Caregivers in wards facing such shortages are well aware of this problem. The painful choices to be made are difficult to bear for those having to make them.

When prioritisation becomes necessary, it is logical that considerations about the efficient use of resources should come to the fore. With these considerations in mind, the aim is to ensure that as many people as possible can receive care, or that as many health gains can be achieved

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[5] Guideline for doctors Hospitalisation of WZC resident with proven/strongly suspected Covid-19 infection Version 2.0 dated 21 October 2020, https://geriatrie.be/media/2020/10/Leidraad-voor-artsen-ziekenhuisopname-bij-WZC-bewoner-met-Covid-19-23092020-1.pdf.

[6] Historically, numerous criteria were defined, considered and/or used, including Medical benefit, Quality of benefit, Length of benefit, Likelihood of benefit, Imminent death, Ability to pay, Willingness to be treated, Random selection (First come first served, Lottery), Social value, Special responsibilities, Favoured group, Resources required, Age, Psychological ability, Supportive environment. See, for example, Kilner JF, *Who Lives? Who Dies? Ethical Criteria in Patient Selection*, London, Yale University Press, 1990.

as possible with the limited resources available. Here, a particular concern is that scarce resources are not wasted unnecessarily, e.g., using them to treat patients whose treatment outcome and/or chance of survival would be expected to be substandard. Attention must be paid to the number of lives saved and number of quality years of life gained[7]. From an ethical perspective, this enters the realm of utilitarianism, where decisions seek the 'greatest good for the greatest number'.

This aspiration is at odds with other ethical principles considered fundamental in normal circumstances, such as the refusal to discriminate based on age or special consideration for the most vulnerable. This can also contrast with specific interpretations of the principle of justice and cause moral stress. Reconciling such conflicting values in practice is not easy, especially since there are neither criteria nor decisions that are *a priori* indisputable. It is for the Advisory Committee on Bio-Ethics to point out that a utilitarian approach is only one of many options and puts considerable pressure on the principle of equal treatment or equality of opportunity.

In the ethical debate, professional literature, guidelines and opinions and effective practice, there is no uniformity as to which criteria apply. Certain considerations are, however, cited in the majority of these documents, albeit in different variants. Other criteria are the source of greater controversy. Against the background of this ongoing discussion on the applicable grounds for selection, the Committee recommends, without being exhaustive, that the following aspects be considered in the decision-making:

- Medical criteria, which are part of the normal medical decision-making process, should be fully exploited to consider any relevant distinction between patients. These criteria assess the medical usefulness, duration and outcome of treatment. In this respect, standardised measurement tools including the Clinical Frailty Scale can be helpful. Vigilant remains necessary, however, to ensure that patients are not reduced to available medical parameters;

- Existing guidelines also regularly refer to the quality of life. It is important here to limit the use of the concept of quality of life to the estimation of whether or not the treatment outcome is favourable. The ethical principles of beneficience, non maleficence and equality of treatment should always be paramount. Under no circumstances should the medical consideration of quality of life be extended to an assessment regarding the value of the patient's life or person;

- The principle of equality must be thoroughly considered in any decision. Unlawful grounds of discrimination, including discrimination based on gender, origin, sexual orientation, religion, mental health, disability, age, skin colour, culture, or socio-economic status should never be used. When the situation does not allow for everyone to be treated equally and prioritisation decisions have to be made, these elements should not play a role. In addition, more implicit forms of discrimination also deserve attention. For example, there are correlations between socioeconomic status and health, and in this case too, the principle of equality should always be prominent in making decisions so that social justice is not unduly harmed. In this context, the Committee believes that social vulnerability should not be used as a ground for exclusion, even if it impacts the expected outcome. When a patient's socio-economic situation threatens to complicate rehabilitation, this should not be considered a medical evaluation. The focus must be on the opportunities available for providing appropriate support to this patient;

- As in normal practice, therapeutic obstinacy is avoided and the proportionality of care is constantly monitored. Medical evaluation of patients should carefully assess whether, with reasonable use of resources, patients can achieve a hopeful outcome. Here, consideration

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[7] In the second indent we specify the meaning of this notion from a medical point of view: when considering an intervention, the doctor must ensure that the patient will benefit from the treatment, i.e. that his/her state of health will improve and not deteriorate.

should be given not only to the admission to the Intensive Care Unit but also to the whole healing process;

- Pursuant to respect for the principle of equality, criteria that evaluate personal merit or responsibility are excluded. Healthcare is not the appropriate place to reward or punish personal choices. Therefore, risky behaviour that may give rise to infection with or spread of Covid-19 does not warrant exclusion from care. Conversely, including special commitments, such as care provision, does not give rise to priority access to care. However, priority access for healthcare workers may be justified if they may have experienced high exposure to the virus in the course of their work;

- Age limits, wholly disconnected from medical grounds, are never considered. With increasing age, the incidence of chronic pathology, multi-morbidity and fragility admittedly increase. Age, as related to age-related disease burden, can be part of the medical evaluation. The Committee does not find sufficient ethical justification for the exclusion of the elderly based on intergenerational solidarity, where older generations are denied access to intensive care in favour of the access of younger generations, or the exclusion of the elderly on similar grounds;

- Appropriate attention is paid to health-related vulnerabilities that, independently of Covid infection, would give rise to additional care rather than restriction of care. This includes, for example, patients with fragile health due to an acute but treatable health problem or with a congenital disease or other chronic health problem. If, with proper care, these patients can expect a good long-term outcome, doctors must ensure that indiscriminate use of medical criteria does not affect these patients twice over: on the one hand, by the underlying condition, and on the other, by exclusion from care based on a worse score on medical criteria compared to patients who do not have an underlying condition;

- Decisions are made collegially by a team of caregivers. This involves at least two, preferably more, medical staff members. It is recommended to involve healthcare providers from different disciplines and domains, including the nursing team. It is further recommended that, where possible, a doctor independent from the patient and the services involved should also participate in this decision. The complementarity of insight and expertise increases the efficiency of the decision-making process. Team involvement also distributes the moral burden of these tough decisions over more shoulders. The same collegiality is appropriate in any evaluation involving patient referral: from the home or residential care facility to a hospital, or from one hospital to another, possibly in another region or country. The decision-making process should be transparent and based on explicit and justified criteria. Ethical guidelines from an internal or external body should always support it.

The Committee is acutely aware that debates on the above criteria are still in full swing and notes that there is currently no unanimity on them within the available guidelines and opinions. This is particularly the case for the "first come, first served" criterion, which is highly controversial. The Committee therefore stresses that the debate in the wake of this recommendation must be ongoing and thorough.

When making prioritisation decisions, medical and ethical aspects should be considered to the maximum extent possible and patients and their relatives should be involved as far as permitted by the circumstances.

Continuity of quality care

All patients, without discrimination on any grounds, are always entitled to quality care that meets their needs at all times, regardless of personal preferences (whether or not set out in advance will or an ACP), medical prognosis or triage decisions. This is guaranteed under Article 5 of the Patients' Rights Act. The quality care that can be offered to patients is not, however, always the same: the following types of care can be distinguished depending, on the one hand, on the needs and wishes of the patient and on the other on the medical indication of certain care for this patient:

- Palliative care: supportive care of the patient, such as pain relief, symptom management and other interventions to protect the dignity of the terminal patient;
- Ordinary nursing care: low-tech care aimed at improving or maintaining the patient's health status;
- Mediumcare ward: continuous monitoring and supervision of patients, for example when respiratory support is needed;
- Intensive Care: care for patients with acute life-threatening conditions and a reasonable chance of survival and acceptable quality of life after discharge from hospital.

Each of these types of care has its own quality standards and good practices for ensuring that patients receive quality care at all times. Attention to the patient's end-of-life wishes is very important at every level. Here, as in normal circumstances, it is important to pay attention to comfort, but also to the psychological, social, emotional and existential aspects.

4. Healthcare facilities and primary care

A role that should not be underestimated in making the pandemic manageable falls to healthcare facilities and primary care. They are faced with the complex task of managing care and supporting caregivers at their tasks.

Coordination cell

Each hospital should establish a coordination cell. as part of hospital emergency planning. It is recommended that a committee be established within this coordination cell or linked to it to administer, under the leadership of the chief medical officer, the management of care during this pandemic. This committee's task is to decide on the allocation of all bed capacity, manpower and support resources using a clear strategy, as well as care planning, which should also involve prioritising urgent and essential care and deferring other care. The commission for medical ethics can play an advisory role here.

When postponing regular care, the short and long-term consequences of these decisions should be carefully considered and clear criteria should be used to decide which care is deferred for how long and which care continues to be offered on an ongoing basis. Proper recording of decisions made in this regard, especially in the patient file, is of great importance in the context of transparency and critical evaluation.

The decisions made by the coordination cell or related bodies should be communicated transparently and clearly both within the hospital and to primary care providers so that all care providers can contribute to their consistent implementation.

Even outside hospitals, managing care during the pandemic presents complex challenges, both in residential care, primary care, and home care. These care settings are mostly not intended for organising Covid care. However, it is also necessary *extra muros* to determine the strategy that will best combat this pandemic from each healthcare setting. District associations of GPs, together with coordinating and advising doctors of residential care facilities, play a crucial role here.

Moreover, good cooperation and coordination with local hospitals are essential in these *extra-muros* strategies, including, where appropriate, palliative care teams. To this end, the committee within the hospital mentioned previously should also explicitly engage with *extra-muros* care settings in outlining this strategy.

Available and deployable care capacity

Thinking about available and deployable capacity is not just about having sufficient (protective) equipment and beds[8]. A very important aspect is the available staff.

Throughout the pandemic, much is expected of healthcare staff: staff from departments where Covid patients are treated, such as Intensive Care Units, are put under severe physical and mental pressure. Doctors and their healthcare team have to make ethically complex decisions. It is therefore necessary to pay increased attention to the mental and physical well-being of the staff, especially staff in heavily burdened care services.

When the existing care staff within a ward proves insufficient, flexible yet careful solutions should be sought: deploying care staff from other care departments and other health professions, deploying medical, surgical, midwifery, nursing and medical laboratory technology students, and involving non-healthcare staff are explicit possibilities for which the legislator has created the necessary legal frameworks in the context of this pandemic[9]. Here, it is important that opportunities to avoid a shortage of caregivers should be exhausted and quality and safety be maintained at the highest possible level.

Knowledge sharing

Since the outbreak of the Covid-19 pandemic, rapid response was provided by many. Meanwhile, the field can boast many good and inspiring initiatives. Various actors and institutions have performed original and quality work in organising and realising the best possible response to this crisis. Here, increasing attention was given to the patient's perspective and voice, complementary to scientific insights, organisational issues, and ethical and legal aspects.

Much of the information is now publicly available, including policy advice, professional group guidelines and scientific publications. Other information was initially developed within the confines of institutions. However, much of this information is not made public. However, the need to share knowledge and the opportunities to learn from this knowledge sharing are enormous. It is therefore recommended that information and procedures, even if their value is limited by, for example, *ad hoc* production, time constraints, incompleteness, and limited *uptake* of the scientific state of the art, to be shared securely. Knowledge sharing is therefore essential in a collective fight against Covid-19 pandemic.

Conclusion

These recommendations aim to provide an ethical framework to inform prioritisation decisions made by diverse actors across the healthcare landscape from a reflection on the key ethical, legal and organisational challenges in responding to the Covid-19 pandemic.

These recommendations are limited to ethical considerations. The elaboration of specific medical guidelines, the establishment of medical evaluation criteria, treatment standards or thresholds and the development of good practices remain at all times the preserve of the relevant professional groups and their professional associations, always recognising that the

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[8] Within the hospital, the chief medical officer has the legal obligation, after consultation with the federal health inspector, to take the necessary measures to reserve the Covid capacity determined by the special *ad hoc* committee under the auspices of the FPS Public Health, Food Chain Safety and Environment.

[9] Act of 4 November 2020 on various social measures arising from the Covid-19 pandemic; Act of 6 November 2020 to allow nursing activities to be carried out in the context of the corona virus-Covid-19 epidemic by persons who are not legally authorised to do so.

patient is the main stakeholder and co-player in the final decision. It is neither the mandate nor the assignment of the endorsing bodies to do so.