BELGIAN ADVISORY COMMITTEE ON
Bioethics

Ethical aspects regarding prioritisation of care in times of Covid-19

Recommendation of 21 December 2020 of the Belgian Advisory Committee on Bioethics, endorsed by the Order of Physicians and the Superior Health Council

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

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

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 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

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[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.

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;

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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.

- Pharmacological hemodynamic support;
- 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.

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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.*

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 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

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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.

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 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

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[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.

[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.

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 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.

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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.

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 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.

Editing

This text was edited by: Wim Pinxten and Tom Goffin
Revision in limited committee (Florence Caeymaex, Paul Cosyns, Gilles Genicot, Tom Goffin, Guy Lebeer, Wim Pinxten) and discussion with all members in plenary debate.
Endorsed by the Superior Health Council and the Order of Physicians.

Sources consulted

Guidelines and Reports

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