



**Centre of Biomedical Ethics and Culture**  
**Sindh Institute of Urology and Transplantation**

**COVID-19 Pandemic:**  
**Guidelines for Ethical Healthcare Decision-Making in Pakistan**

**Prepared by Centre of Biomedical Ethics and Culture, SIUT  
Karachi, Pakistan**

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## **Process for Developing the Guidelines**

The Center of Biomedical Ethics and Culture (CBEC), Sindh Institute of Urology and Transplantation (SIUT), Karachi offers these guidelines to assist healthcare institutions and professionals who are in the front lines for making critical and morally challenging decisions while caring for patients during the COVID-19 pandemic in Pakistan. These challenges will be accentuated as the number of infected patients is likely to rise exponentially and clinical care will have to be provided in situations of severely limited resources. The primary aim of these guidelines therefore is to provide an ethical framework for institutions and physicians to formulate Standard Operating Procedures that will maximize benefit to the public while minimizing risks to healthcare providers.

The initial draft of the guidelines document was prepared by a committee of CBEC-SIUT faculty consisting of Chairperson Dr. Farhat Moazam, Dr. Aamir M. Jafarey, Dr. Ali A. Lanewala and Ms. Sualeha S. Shekhani. Relevant literature and existing international guidelines were reviewed and several online meetings undertaken in this process. The draft was circulated to several key stakeholders in medical institutions within the public and private sectors in Pakistan and members of civil society. Their valuable input was reviewed by the committee and incorporated into the document where needed

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## Preamble

- A. The aim of these guidelines is to provide a broad ethical framework to help healthcare professionals (HCPs) and their organizations/institutions in making difficult decisions that will become inevitable in this pandemic situation.
- B. This framework will allow institutions to develop their own Standard Operating Procedures (SOPs) for COVID-19 induced strains on healthcare resources.
  - i. HCPs must be made fully aware of the SOPs in force within their institutions.
  - ii. Institutions should make their COVID-19 SOP easily accessible to the public. This may be through use of institutional notice boards or websites to ensure public awareness and transparency.
- C. These guidelines are not meant to serve as alternative to responsibilities and obligations of governments, healthcare facilities and other relevant bodies with respect to increasing the pool of available resources.
- D. COVID-19 pandemic poses a catastrophic health emergency which necessitates prudent use of scarce resources while safeguarding ethical values and professional virtues that form the core of humanistic health care for patients.
- E. Dire circumstances of the pandemic necessitate shifting to a public health approach that requires distribution of scarce resources for the benefit and protection of the larger society often times at the expense of benefits to individual patients. In such situations conflicts arise for clinicians who must balance norms of primary duty of care towards individual patients with the necessity to focus on public health good.
- F. As a developing country, healthcare systems in Pakistan function in a state of chronic scarcity of resources even during times of normalcy. The pandemic will serve to amplify this problem several folds as has also been demonstrated in many developed countries with far better healthcare systems in place.
- G. Scarce resources include but are not limited to Intensive Care Unit (ICU) beds, mechanical ventilation, ward beds, provision of diagnostic tests/kits, as well as prophylactic interventions (like vaccines) and therapeutic options (like medications) when these become available.
- H. Scarce resources also include available HCPs and ancillary staff. They must be protected and deployed appropriately. It is essential that appropriate Personal Protective Equipment (PPE), proper masks and gloves are made available for all HCPs and others involved in patient care.
- I. Pandemic induced scarcity will not only affect the treatment of COVID-19 patients but also impact care of those with other dire medical conditions who are not infected with the virus. The allocation of scarce resources must take into account urgent medical needs of all patients including those already admitted, and not exclusively those of COVID-19 patients.
- J. While planning for COVID-19 related influx, as far as possible, institutions should take steps for provision of medical care for non COVID-19 patients.
- K. Decision-making for the allocation of resources must rest on agreed upon medical criteria.
  - i. Decisions of resource allocation must be free from all forms of bias and discrimination.
  - ii. Decisions should be made to maximize the utility of available resources.
  - iii. Decisions for treatment of infected HCPs and ancillary staff should give importance to the principle of reciprocity.

- L. Institutional demands on resources and personnel can change on a daily basis requiring revision in the criteria for allocation of available resources. HCPs must be made aware of the resource allocation criteria in force at a given time.
- M. Healthcare professionals must be provided with indemnity against prosecution and penalization for decisions taken connected to the COVID-19 pandemic crisis.

# Guidelines

## 1. Criteria for allocation of scarce resources

- a. The “first come, first served” basis for allocating scarce resources is not recommended in COVID-19 pandemic. Experience from other countries in managing COVID-19 patients reveals that use of Triage System serves as an ethically justifiable approach for resource allocation decisions. A combination of the following factors should be taken into consideration in making allocation decisions:
  - i. **Age:** Experience indicates that older age patients suffering from COVID-19 generally tend to have significantly worse outcomes. However age limits should take into account other health variables when making allocation decisions.
  - ii. **Probability of survival:** There is convincing evidence that COVID-19 patients with pre-existing comorbid conditions such as cardiovascular disease, diabetes and pulmonary disease have lower survival rates than those who do not. These factors should also be taken into consideration.
  - iii. **Expected outcome:** Medical determination of poor functional status of a patient should s/he survive treatment may also be taken into consideration when making resource allocation decisions.
- b. The above factors should be clearly reflected in the institutional SOPs and made well known to HCPs.
- c. These criteria may require adjustment by each institution depending on the availability of resources and severity levels of the pandemic at a given time.

## 2. Setting limits to provision of care

- a. When despite aggressive treatment it is determined that the outcome will not be favorable, a medical decision may be taken not to pursue further aggressive treatment.
- b. In such cases, patients may be placed on a Do Not Resuscitate (DNR) status.
- c. In extreme situations of limitation of space and equipment, ventilatory support may be withdrawn from a patient assessed to have little or no chance of survival for use to help another patient judged to have greater possibility for survival.
- d. For these difficult decisions it is recommended:
  - i. Colleagues, peers, including hospital administration must be involved.
  - ii. Decision and process used for making it must be documented in the patient’s medical record.
  - iii. Efforts should be made to take decisions in consultation with the members of the immediate family.
  - iv. The final decision in the case of disagreements will be taken by the hospital administration.
  - v. These decisions should be made swiftly so that resources become available for patients medically assessed to benefit from them.

### **3. Provision of supportive care**

- a. When ICU care and other interventions are not available it is essential that patients are not abandoned. Professional values of compassion, empathy and respect for persons must be maintained and patients provided necessary supportive and palliative care.
  - i. Such patients should be shifted to non-intensive care facilities within the same hospital or to other hospitals where such care is available.
  - ii. It is the responsibility of institutions and government to ensure the availability of compassionate end of life care and appropriate personnel.

### **4. Collaborative process for decision making**

- a. Allocation of limited resources can be morally distressing and emotionally draining for clinicians. These decisions should therefore not be made alone but through a collaborative process which will help to share and lessen the burden.
  - i. The collaborative process should involve a team which includes at least two healthcare professionals.
  - ii. When possible, the team should include healthcare professionals who are not involved in direct management of the patient.
  - iii. Where available, Institutional Hospital Ethics Committees should assist in this process.
- b. Such decisions and the process employed in making them should be documented in patients' medical charts.

### **5. Communication with patients/families**

- a. Trust is the core of ethical physician-patient relationships. Establishing trust in the initial encounter with patients and families can facilitate difficult decisions that may have to be made later.
  - i. Compassionate, honest and direct communication with patients or surrogates is important beginning from the time of admission to the hospital.
  - ii. ICU admission criteria and the possibility of withdrawing of ventilation must be made known to the patient and/or the surrogate at the time of admission.
- b. All communications regarding medical decisions with patients and families must be documented in the patient file.

### **6. Obligations towards HCPs and ancillary staff**

- a. It is the duty of institutions and relevant government authorities to provide standard Personal Protective Equipment (PPE) to HCPs and ancillary staff who are working in the frontlines and at maximum risk of acquiring the infection.
- b. They should be provided the standard protection recommended for the nature of their work and expected risk of exposure.
- c. The principle of reciprocity requires that those who risk their lives for the good of others should receive first priority for available treatment modalities if they contract COVID-19 infection. However, the same medical criteria will be applicable to them as for others.

- d. HCPs should also receive priority for COVID-19 screening tests that are available.
- e. Priority screening and treatment of HCPs will ensure that they can resume their duties for the benefit of the larger society following recovery.
- f. HCPs and ancillary staff should also be given priority in treatment for other serious illnesses they may develop.
- g. Institutions should make provisions for mental healthcare support to HCPs and ancillary staff in view of the immense psychological burden that they will inevitably carry.
- h. Immediate family members of HCPs who acquire COVID-19 infection should also be prioritized if they fit the medical criteria for resource allocation. This will help HCPs to better fulfill their duties by removing additional worry about their families.

## **7. Benefiting research participants**

- a. Physicians should make sure that COVID-19 patients under their care are enrolled in a research only if the study has been cleared by the relevant Ethical Review Committees and, when applicable, the National Bioethics Committee of Pakistan.
- b. Research participants should be prioritized for access to scarce resources. They should also be provided preferential access to products of the research in which they participate.

## Additional Reading Materials

- Berlinger, N., Wynia, M., Powell, T., Hester, M., Milliken, A., & Fabi, R. et al. (2020). Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic - *The Hastings Center*. Retrieved 30 March 2020, from <https://www.thehastingscenter.org/ethicalframeworkcovid19/>
- Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A. & Phillips, J. P. (2020). Fair allocation of scarce medical resources in the time of Covid-19. *New England Journal Of Medicine*. Retrieved 30 March 2020 from: <https://www.nejm.org/doi/full/10.1056/NEJMsb2005114>
- Vergano, M., Bertolini, G., Giannini, A., Gristina, G., Livigni, S., Mistraletti, G., & Petrin, F. (2020). Clinical Ethics Recommendations for the allocation of intensive care treatments in exceptional resource-limited circumstances. *Società Italiana di Anestesia Analgesia Rianimazione e Terapia Intensiva (SIAARTI)* Retrieved 30 March 2020, from <http://www.siaarti.it/SiteAssets/News/COVID19%20-%20documenti%20SIAARTI/SIAARTI%20-%20Covid-19%20-%20Clinical%20Ethics%20Reccomendations.pdf>