The COVID-19 pandemic raises important ethical issues, especially regarding the potential need for rationing health care in the context of scarce resources and crisis capacity. Many clinicians and the public at large rarely perceive shortage of medical capacity so bad that maximal care cannot be provided due to overwhelming numbers of patients with severe illness. In a pandemic there is the added risk of healthcare workers becoming infected and sick and unable to provide care. In implementing crisis standards of care, the needs of individual patients have to be reconciled with the need to save as many lives with meaningful quality of life as possible for the resources available, and the need to protect the healthcare workforce.

In such circumstances, we need to be mindful of the distinction between care decisions for individuals made on the basis of potential clinical benefit, irrespective of resource constraints, and rationing decisions where a potentially beneficial treatment is withheld on the basis of resource constraints. In the setting of a pandemic where critical care resources are truly overwhelmed, decisions based primarily on beneficence and patient autonomy are not possible, and the principle of distributive justice becomes central.

This document from the Statewide General Medicine Clinical Network (SGMCN) aims to provide guidance to general physicians involved in the process of making decisions about the appropriateness of withholding or withdrawing life support interventions to patients with COVID-19. The document has been reviewed and endorsed by the SGMCN Steering Committee as of 23/4/20.

**Ethical principles**

In developing a framework to guide ethical decision-making, recent systematic reviews and consensus statements were reviewed. Discussions and literature reviews featured in recent multi-stakeholder workshops convened by the Clinical Senate, and involving consumers and representatives from all clinical networks, and which feature in the Queensland Health Ethical framework to guide clinical decision-making in the COVID-19 pandemic statement and the Queensland Clinical Senate ICU COVID-19 Tier 2 Pandemic Admission Guideline, both released on 20/4/20, have fed into this document.

Ethical decision-making must be reasonable (clinically credible and objective), open and transparent, inclusive of the views of various stakeholders, responsive to changing circumstances, accountable and consistent. It is not realistic to aim for perfect consensus in every decision, but what we can aim for is that each decision is legitimate by virtue of being made via a legitimate process. A major focus on

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6. Available at: www.thehastingscenter.org/ethicalframeworkcovid19
ethical decision-making relates to the need for mechanical ventilation in the advent of COVID-19 induced acute respiratory distress syndrome (ARDS). Admission rates to intensive care units (ICU) varies between 6-26% of hospitalised COVID-19 confirmed patients, with ICU length of stay (LOS) for such patients varying between 10-21 days, based on currently available epidemiological data (Appendix 1).

It is hoped that the considerable preventive public health efforts in Queensland and nationally that are reducing transmission and the numbers of COVID-19 cases, combined with the expansion of critical care capacity, will avoid the situation where critical care capacity is insufficient to meet demand. However, there remains the possibility that despite these efforts the numbers of critically ill patients could exceed the expanded capacity. Consequently, it may become necessary for clinicians to make difficult decisions regarding the allocation of critical care resources. These decisions can and will be ethically challenging, hence the need to carefully consider decision-making processes prior to a widespread pandemic overwhelming critical care capacity. The Toronto experience of SARS in 2003 indicates that if ethical frameworks had been more widely used to guide decision-making, this would have increased trust and solidarity within and between healthcare organisations.8

In the current pandemic in which critical care resources may be severely limited, certain overarching ethical principles can be articulated.

1. Triage and allocation of limited resources

- Triage and allocation processes must consider: equity of access; current and future organisational capacity to provide treatment; projected length of proposed treatment as a proxy for resource utilisation; impact of individual care on the health and care of other patients; and duty of care in ensuring safety of the healthcare workers.

- Triage decisions should be made in collaboration with patients and family wherever possible.

- Policies and procedures should reflect broad consensus that there is no ethical difference between withholding and withdrawing care, and that prolongation of life ‘at all costs’ is ethically inappropriate and leads to harm.

- Clinicians are under no legal or ethical obligation to offer or provide non-beneficial or futile care,9 as supported by documents from Queensland Health10 and the Queensland Coroner.11

  o In regard to any civil litigation, plaintiffs would need to persuade a jury, among other things, that clinicians violated the applicable standard of care and, in so doing, caused the patient harm. Adherence to well-recognized triage guidelines (see below) will likely constitute strong evidence that the standard of care was satisfied.12

- Triage systems based even on limited evidence are ethically preferable to those based on clinical judgment alone. Decision makers need to demonstrate reasonableness and fairness in their decisions, and clear guidelines and processes will facilitate consistency and accountability of

9 We define futile care as the lack of any measurable reversal of the patient’s disease or return to reasonable functional status.
10 End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients. Available at: https://www.health.qld.gov.au/careatendoflife
11 The Coroner Court of Queensland has issued a statement stating that a death known or suspected to most likely to be from COVID-19 will generally NOT need to be reported to the coroner. This is because the death is from a natural cause and the probable cause of death is known. The fact that COVID-19 is a notifiable condition under the Public Health Act 2005 does not of itself make the death reportable to the coroner. Doctors are encouraged to issue a cause of death certificate in these cases. A COVID-19 death will only be reportable to the coroner if: a) the death is a death in custody or a death in care; or b) the person died as a result of the care they received or did not receive, for example, a missed diagnosis or failure to treat COVID-19. However a COVID-19 death will NOT be reportable for failure to provide health care because of inadequate resourcing in the event of an overwhelming demand for critical care services provided clinical decision-making for the person is consistent with the Australian and New Zealand Intensive Care Society (ANZICS) COVID-19 Guidelines of 16 March 2020 (available at: https://www.anzics.com.au/wp-content/uploads/2020/03/ANZICS-COVID-19-Guidelines-Version-1.pdf)
12 Cohen et al. Potential legal liability for withdrawing or withholding ventilators during COVID-19 assessing the risks and identifying needed reforms. JAMA Published online April 1, 2020.
decision-making and lessen the moral distress of clinicians associated with this decision making. Explicit triage criteria also improve outcomes overall for the group involved.\textsuperscript{13}

- Care resources should be allocated based on specific triage criteria, irrespective of whether the need for care is related to COVID-19 or an unrelated critical illness or injury.
- It is not ethically permissible to allocate care resources on the basis of place of residence, ethnicity, disability or age alone, socioeconomic status, sexual orientation or other demographic characteristics. It is also ethically inappropriate to allocate care according to ‘first come, first served’, or the ‘life cycle’ or ‘good innings’ principle, without consideration of other issues (see below), or on perceptions of ‘social worth.’
- It may be ethically permissible to use explicit exclusion criteria for critical care resources (mechanical ventilation, non-invasive ventilation, admission to intensive care unit [ICU]) since the advantages of objectivity, equity, and transparency generally outweigh potential disadvantages.
- It is ethically permissible to identify certain resource intensive therapies, procedures or diagnostic tests that should be limited or excluded during crisis standards of care.
- It may be ethically permissible to have policies that permit the withholding or withdrawal of critical care treatment to reallocate to someone else based on higher likelihood of benefit.
  - This depends on resource consumption and projected length of care in that some patients may be likely to respond to treatment with a lower consumption of scarce resources than other patients who are very likely to require more resources committed to their treatment to survive.
  - These resources may include the level of nursing care, a longer length of stay, or more drugs.
  - The greater the consumption of resource by one patient, the less the resource available for others with a higher likelihood of survival.
  - A decision not to provide a critical care is not a decision to withhold care and support of any kind. Options will be identified to manage patients’ symptoms in ensuring each person is treated with dignity and respect.
- Patients in whom a life support protocol such as cardiopulmonary resuscitation or emergent mechanical ventilation is deemed to be futile should receive do not resuscitate orders.

2. Responding to Ethical Concerns of Patients and Families

- Hospitals and health services should publicise to all external clinicians and the public at large the ethical framework which will guide clinical decision-making and make transparent the underlying justifications and norms for crisis standards of care.
  - Include commitments to achieve highest standard of care within contextual constraints and duty to plan.
- Hospital and health services should communicate the definition of crisis standards of care to patients and families both on admission to the hospital and when triage decisions are being communicated.
- In cases where decisions have been made to withdraw life support, this should be done by a palliative care team with skills and expertise in palliative care and emotional support of patients and families.

- Patients triaged to palliative care should be notified of their right to discuss concerns and receive support from hospital personnel, including palliative care, social work, or ethics consultants.
- Hospitals and health services should include ethics resources in planning for crisis care and anticipate a need for ethics consultative services during the pandemic.
  - Decisions around withdrawing life support such as mechanical ventilation should involve a team of respected clinicians and ethicists who are not directly involved in a patient’s care.
  - As circumstances change and the availability of ventilators increases or decreases, the team can adjust its rationing criteria to produce the best outcomes.
  - Institutions may also include appeals processes, but appeals should be limited to concerns about procedural mistakes, given time and resource constraints.

3. Responsibilities to Healthcare Workers

- Hospitals and health services should make plans to assist with moral distress in healthcare workers involved in providing critical care, including ethically appropriate liability protections.
- Healthcare workers unable to accept implementation of crisis standards of care be transferred into support or non-clinical roles during pandemic response, if possible, but not be absolved of their obligation to participate in the response.
- Hospitals and health services plan to protect worker safety and should not expose vulnerable workers (eg those with medical conditions) to undue risk of harm.
- Hospitals and health services should encourage workers to create personal/family disaster preparedness plans.

Advance care planning

Even if capacity to provide care is sufficient, one priority is addressing goals of care in the setting of acute life-threatening illness, especially for older patients with chronic, life-limiting disease. The importance of goal-concordant care is not new or even substantially different in the context of this pandemic, but is heightened in several ways. Patients most likely to develop severe illness will be older and have greater burden of chronic illness (hypertension, cardiovascular disease, diabetes, chronic lung disease) and frailty. Mortality rates for COVID-19 increase with age, from around 4% in the age group 60-69 years, to 8% in those aged 70-79 years, and to 15% or higher in those aged 80 years or more. Residents of aged care facilities are at particular high risk with case fatality rates due to COVID-19 as high as 33%.

Patients like these may wish to forgo prolonged life support and who may find their quality of life unacceptable after prolonged life support. In addition, survival appears much less likely when acute respiratory distress syndrome (ARDS) is associated with COVID-19 than when it is associated with other aetiologies. Patients over the age of 65 with COVID-19 related ARDS who are placed on a ventilator have an approximate 80% mortality. On the other hand, there is also a significant proportion of younger and

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14 Based on direct and indirect evidence, workers with significant chronic lung disease, cardiovascular disease, hypertension, diabetes, renal disease or neuromuscular disease, or marked obesity or taking immunosuppressive medications (e.g. TNF-inhibitors, prednisone > 20 mg/day), or pregnant women (especially after 28 weeks gestation) and anyone aged 70 and over are regarded as vulnerable. A worker who identifies with any of the above and who works in an environment where they are likely to have contact with patients with suspected or confirmed COVID-19 infection, should talk to their line manager about alternative work options. Both employers and employees have a right to refuse or restrict work in a situation of unacceptable risk.
pre-morbidly healthy patients who also develop severe respiratory failure, in whom critical care interventions are likely to be life-saving with good functionality.

In this context, advance care planning (ACP) prior to the onset of serious acute illness and discussions about goals and ceilings of care at the onset of serious acute illness should be a high priority for several reasons:

- Clinicians should always strive to avoid intensive life-sustaining treatments that are unwanted by patients.
- Avoiding nonbeneficial or unwanted high-intensity care becomes especially important in times of stress on health care capacity. Even in the absence of the current pandemic, about 1 in 10 end of life admissions to hospital involve futile treatment, with a third of hospital days spent in ICUs. Such futile care in ICU also has backflow effects manifesting as increased waiting times in the emergency department and at peripheral hospitals for ICU admission which result in poorer outcomes.
- Provision of nonbeneficial or unwanted high-intensity care may put other patients, family members, and health care workers at higher risk of transmission of SARS-CoV-2.
- Admitting patients to ICU in order to give families time to come to terms with their relative’s pending death, or using ICU as a location for palliative care, will not be possible in a pandemic setting.

Now is the time to implement ACP to ensure patients do not receive care they would not want if they become too severely ill to make their own decisions. Evidence suggests clinicians are also more likely to expedite discussions about ACP and goals of care when ICU capacity is limited.

Many of these discussions need to be undertaken NOW in pre-hospital settings involving general practitioners, senior nurse managers caring for residents of aged care facilities, and specialists in outreach services or outpatient clinics. Decisions around what may constitute inappropriate or futile care in the event of serious illness need to be made NOW at a time and in a place where people’s values, preferences and expectations can be fully disclosed and information about what clinicians can and cannot do in various scenarios can be fully shared. The situation where patients and their relatives are forced to rapidly make hard and potentially uninformed decisions during a clinical crisis must be avoided.

During this pandemic when non-essential medical visits may become more limited, these conversations may need to occur via telemedicine (either as a stand-alone appointment or in combination with an appointment designated or scheduled for another purpose). The outcomes of these conversations must be recorded, preferably as a completed Statement of Choices form or as an advance care directive, which should be sent (faxed, e-mailed or posted) to the Metro South ACP Office so that it can be uploaded to the statewide Viewer platform and thereby be accessible to any future clinician (hospital doctor, general practitioner, ambulance officer) in guiding care decisions. Various resources that can assist in providing ACP and end of life care are freely available from Queensland Health websites.

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21 Fax: (07) 3710 2291; Email: acp@health.qld.gov.au; Post: PO Box 2274, Runcorn, Qld 4113. Statement of Choices forms can be downloaded from: www.mycaremychoices.com.au
Cardiopulmonary resuscitation

For hospitalized patients, one focal point for goal-concordant care is related to discussions around the use of cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS). Discussing CPR and do-not-resuscitate (DNR) orders with patients as the first step of a goals-of-care discussion, before adequate discussion around values and goals, and benefits and harms of invasive care, should be avoided as much as possible. But decisions around CPR status must, in the end, be made in avoiding inappropriate CPR for these reasons. First, although unwanted or nonbeneficial CPR under any circumstance may risk increasing psychological distress for patients’ family members at any time, inappropriate CPR during a pandemic is especially stressful and, being a highly aerosol generating procedure, potentially dangerous for health care workers in terms of virus transmission. Second, nonbeneficial or unwanted CPR and ACLS will strain available resources for personal protective equipment (PPE) because multiple health care workers are needed for effective intervention. Third, patients who may regain cardiorespiratory function following resuscitation will likely require transfer to ICU and mechanical ventilation or other forms of life support, which strains limited ICU resources when, despite immediate survival from CPR, the patient still has a very low chance of long-term survival with any reasonable quality of life. The COVID-19 pandemic heightens the importance of implementing DNR orders for appropriate hospitalized patients.

The implementation of DNR orders can occur in 3 ways. First, patients or their surrogate decision makers (SDMs) may clearly understand and communicate that the patient would not want CPR if the heart were to stop and communicate this as part of the ACP and which is formalised in an acute resuscitation plan. This is the most preferable option. Second, in the absence of either an ACP or ARP that explicitly states patient preferences, patients or their SDMs may follow the recommendation of a clinician to forgo CPR as a process of informed assent (see Appendix 2). Third, in extreme situations in which CPR and other life support measures such as mechanical ventilation are clearly deemed futile (see below), clinicians may unilaterally decide to withhold CPR and write a DNR order, irrespective of patient or SDM wishes. This latter approach is clearly the least preferred option but has to be considered in situations such as a patient with severe underlying chronic illness and acute cardiopulmonary failure who is getting worse despite maximal supportive care.

Determining indications for initiation of life support interventions

During a pandemic, thresholds for initiating life support interventions such as CPR and mechanical ventilation may need to differ according to resource availability. Clinicians have to consider patients’ expressed wishes and preferences for care, the burden and potential harms of life support treatment to the individual patient, their underlying co-morbidities and level of frailty, their probability of response to intervention, and the length of time they may consume limited resources which are then unavailable to other patients with a greater probability of a favourable response. These considerations underpin an evidence-based approach to decision-making in managing patients with COVID-19. (Appendix 3).

It is important that all clinicians understand (and can communicate appropriately with patients and families) that any decision not to provide life support interventions will be made in accordance with good clinical practice and does not constitute a rationing decision. When considering eligibility for ICU admission, consultation should be sought with intensivists to discuss a patient’s status. Intensivists are committed to providing outreach and support to their colleagues, even if a patient is ultimately not accepted for ICU. In those patients for whom significant comorbidities and/or frailty would preclude admission to ICU, advanced resuscitation should not be commenced in the event of a collapse. To do
otherwise will cause harm to the patient, consume limited resources at a time of considerable strain, and potentially put the resuscitation team at unnecessary personal risk.

The principles that will guide the provision of life support interventions are:

- Decisions around life support interventions will consider the likelihood of response to intervention, the burden of interventions for the patient and their family, patients’ comorbidities and pre-morbid function, and patients expressed wishes and preferences.
- Life support interventions (which includes admission to a critical care unit) will be prioritised to those patients with the highest chance of meaningful survival and will not be provided to those patients who have very little or no chance of benefit.
- Trials of life support interventions will be limited in time (and patients and their family need to be made aware of this if they were to deteriorate) and response to interventions will be regularly reviewed to guide decisions on withdrawal of therapy.
- Any uncertainty or disagreement regarding suitability for initiation or cessation of life support interventions will involve at least 2 senior clinicians who will apply an agreed criteria-based decision-making process and provide a final decision.
- The decision-making process will be open, transparent, reasonable and inclusive of patients, their families, and all involved clinical staff.
- Criteria for providing life support interventions will apply to all patients across all jurisdictions, and equally to patients with COVID and non-COVID illness.

An evidence-based objective assessment (or threshold test) of the risk of death with and without life support interventions needs to be made in the context of the likely long term (12 month) survival with a quality of life concordant with what patients regard as tolerable. In regard to mortality in the absence of COVID-19 infection, the surprise question has reasonable (~70%) predictive accuracy: ‘Knowing all I know about this patient, would I be surprised if he/she were to die within the next 12 months?’ Various scoring systems are used by emergency physicians and intensivists (such as the Sequential Organ Failure Assessment [SOFA]) to estimate the short-term (<30 days) probability of survival which can also inform life support decisions. However, there are no validated scoring systems that can accurately define which patients should receive life support interventions in an overwhelming pandemic situation.

Patients with certain characteristics (Appendix 4) are likely to have a poor outcome with life support interventions and are therefore likely to be ineligible for such intervention. Most will generate an answer of ‘no’ to the surprise question. Deciding not to embark upon life support in such patients is not a rationing decision, but a decision made on the basis of individual clinical benefit. In such situations, the final triage decision to initiate or withhold life support interventions should involve at least one senior clinician (which may be an intensivist and/or ethicist) not involved in direct care of the patients, with expertise in ethical decision-making, working in consultation with the referring team (Appendix 5).

As the pandemic progresses and despite the implementation of these triage criteria, critical care resources may become overwhelmed although recent modelling in Australia suggests that if current stringent public health measures are maintained, this stage may not eventuate. But if and when it was to occur, the criteria will need to become more stringent, but will still take into account patient age, number of co-morbidities, frailty, reversibility of acute presentation, severity of illness, and likelihood of response to intervention. In this scenario, clinician judgement will be paramount and needs to be trusted. For patients judged to have similar prognoses, equality should be invoked and operationalized through random allocation.
Determining indications for cessation of life support interventions

There will also be patients who, after being admitted to hospital and to ICU, do not have the predicted response to therapy, or who develop progressive multiorgan failure, and in whom life-support interventions should be withdrawn. Given the demand for critical care resources from people who have a higher chance of recovery, it would be unethical to deprive them of access to these resources by continuing to treat someone with negligible chance of recovery. Patients and their families should be made aware of this possibility at admission. The decision to withdraw a scarce resource to save others is not an act of killing and does not require the patient’s consent. A time limited trial of therapy can be justified ethically in the event of a COVID-19 pandemic with the potential to overwhelm critical care resources because it allows a determination of the patient with the best chance of recovery.

There are no validated criteria for determining in whom and when life support interventions should be withdrawn, and such decisions should be based on independent second opinions of two senior clinicians who are not directly involved in care. The same decision-making process used to initiate life support interventions should also be applied to ceasing such interventions (Appendix 5). When life support is discontinued, expert comprehensive palliative care is imperative. Providing comfort at the end of life is difficult when patients with COVID-19 are in isolation precautions to prevent virus transmission. Family members of patients near death should be granted compassionate use of PPE if possible so that they can be with the dying patient. If this is not possible, hospitals should help families use videoconferencing technology to hold bedside vigils at a distance. Health care workers will also need emotional support.
Appendix 1. Progression of COVID-19 disease

References:
Appendix 2. Process of informed assent*

Informed assent may be a more acceptable approach to CPR status discussions than medical futility and may be useful for patients in whom CPR is exceedingly unlikely to allow a successful return to a quality of life they would find acceptable. The advantage of informed assent over a more traditional informed consent approach is that the clinician does not ask the patient or designated SDM to take responsibility for the decision but rather asks them to allow the clinician to assume responsibility. Some family members may be willing to permit clinicians to make this decision while simultaneously being unable to accept responsibility themselves, even if they agree, because of the psychological burden it places on them. In this setting, informed assent may provide family members a way to agree with the clinician’s determination without assuming responsibility. Importantly, this approach places great responsibility on clinicians to enact careful prognostication and thoughtful, respectful, open communication with family members.

1. Assess patient’s values and goals
   • Elicit values and preferences for therapies and outcomes from the patient or designated SDM and formulate overall therapeutic goals
   “Is it important to your mother to live as long as possible, no matter what her quality of life, or are there circumstances in which she would not want to receive life support, such as a prolonged nursing home stay?”

   Is survival the patient’s primary goal above all else, including quality of life?
   If yes, then do not proceed further

2. Discuss cardiopulmonary resuscitation (CPR)
   • Briefly describe CPR explaining how, when, and why it is performed
   “We want to be sure we are taking the best possible care of your mother, so I would like to talk to you about CPR.”

3. Summarize the role of CPR
   • Provide a personalized explanation about the lack of ability of CPR to achieve the previously assessed patient goals
   “Given what you have told me about your mother and her goals, CPR will not help her reach her goals.”

4. Present a definitive assent statement
   • Inform the patient or the patient’s family that CPR will not be offered
   “Since CPR will not work to achieve your mother’s goals in this situation, we will not be providing it.”

5. Assess understanding and allow for objection
   • Discuss the patient’s or family’s understanding of the assent statement, the decisions made, and any objections they may have
   “I want to make sure you understand. Do you have any questions?”

*Adapted from Curtis et al. The importance of addressing advance care planning and decisions about Do-Not-Resuscitate orders during novel coronavirus 2019 (COVID-19). JAMA Published online March 27, 2020.
Appendix 3. Decision guide for patients presenting with COVID-19*

*Excerpt from the Queensland ethical framework to guide clinical decision making in the COVID-19 pandemic April 20, 2020, p. 18
Appendix 4. Triage criteria for life support interventions*

- Age > 75 years with pre-morbid clinical frailty score of 6 or more (scale 1 [very fit] – 9 [terminally ill])
- Prolonged cardiac arrest > 40 mins irrespective of cause with ongoing cardiovascular collapse and/or poor neurological progress
- Severe chronic cognitive and physical impairment with limited chance of return to baseline function
- Severe and irreversible neurologic event or deterioration
- Advanced, metastatic malignant disease
- Advanced and irreversible immunocompromise with poor prognosis

- Pre-morbid end-stage organ failure with the following criteria:
  - **Cardiac**
    - NYHA class IV heart failure or
    - Housebound and/or with significantly restricted activities of daily living (ADL)
  - **Respiratory**
    - Oxygen dependent or
    - Housebound and/or with significantly restricted ADL
  - **Liver**
    - Child–Pugh C cirrhosis or
    - Concurrent chronic renal failure and/or hepatorenal-syndrome or
    - Housebound and/or with significantly restricted ADL
  - **Renal**
    - > 65 years on long term renal replacement therapy (RRT) with pre-morbid clinical frailty score of 6 or more or
    - Housebound and/or with significantly restricted ADL

*Source: Queensland Clinical Senate ICU COVID-19 Tier 2 Pandemic Admission Guideline

As the pandemic progresses, despite the implementation of the above criteria and expanded critical care capacity, critical care resources may become overwhelmed. This should be anticipated by regular reviews of the triage criteria by Queensland Health. Progression of a hospital to a higher capacity response will also trigger criteria review which may need to become more stringent. Patients will be assessed in accordance with the same ethical principles as applied to the current criteria, with consideration given to degree of co-morbidities, reversibility of acute presentation, severity of illness, likelihood of response to intervention, frailty and age.
Appendix 5. Decision making process for initiating and ceasing life support interventions

1. Assemble appropriate team for decision making:
A minimum of two senior clinicians should meet, with further input from experienced external clinicians or senior nursing colleagues as required. It is recommended that at least one of these senior clinicians should not be directly involved in the patient’s care. This team should work through the following process and document their considerations.

2. Consider criteria for initiation of life support interventions
Refer to the patient’s advance care plan or acute resuscitation plan in the first instance to see if the patient or SDM has clearly stated they do not wish such interventions. In those instances where they do, or no clear statement of preferences have been stated, then refer to the criteria listed in appendix 2.

3. Consider other issues relevant to the decision to initiate or cease life support interventions
The following principles should be considered that apply to a particular patient at a particular point in time within the constraints imposed on the particular hospital to which the patient has been admitted:
• Equity of access to care - each person to be assessed on their individual health characteristics and not on other characteristics such as place of residence, ethnicity, other demographics.
• Current and future capacity of the hospital to provide interventions, including its capacity to provide care to others presenting in subsequent days who may be more likely to survive
• Resource consumption and projected length of care - some patients may be likely to respond to treatment with a lower consumption of scarce resources than other patients who are very likely to require more resources committed to their treatment to survive. This may include the level of nursing care, a longer length of stay, or more medications. The greater the consumption of resource by one patient, the less the resource available for others.
• Impact on health and care of other patients - Assessment of the risk that interventions for one patient creates for other patients.
• Impact on health care providers – There is a duty to care for and ensure safety of all health care providers who should not be expected to provide interventions to patients that place them at unreasonable risk of harm.

4. Document decision and reasoning
The responses to each of the above considerations and the reasoning behind them should be fully documented.

5. Review decision at multidisciplinary morbidity and mortality meeting
All decisions and the associated documentation should be reviewed at subsequent departmental mortality and morbidity meetings to ensure they have adhered to the ethical principles previously described.