22nd March 2020

Ethical Dilemma:

The ethical dilemma is related to wandering older patients, who do so because of delirium/dementia or severe psychosis. In the current circumstances this risks spread of C19 either from or to these patients. Spread of infection is usually managed by allocating staff to do so, however this carries risk of infecting staff and this will add to the inevitable reduction in staff available as time goes on.

The ethical question is ***whether it would be ethical to sedate such patients.*** *On one hand it protects them and others from infection and may preserve staffing to look after them, but on the other it may increase respiratory risks with C19 and risks of falls*

This dilemma was circulated to the Oxford Health NHS FT ethics committee on 18th March 2020, and members of the UK Clinical Ethics Network. The below is a collation of responses received

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As you might expect with such a dilemma, there were a number of varying opinions. Some placed more weight on the current situation with a pragmatic utilitarian appraisal of the limitations around being able to do things as we might prefer, and some took a straightforward ideological view.

Of those who took a straightforward ideological view (to not use sedation), most did not appear to have acknowledged the wider ramifications of not using this possibility in their responses; I highlight this because it was the essence of the ethical dilemma. In other words, yes we can say that sedation should not be used because of the impact on the individual undergoing sedation (*primum non nocere*) however what of the potential harm to others, and even the secondary or tertiary harms which might affect the patient (for example becoming infected, or losing the staffing resource to support them regardless of whether COVID positive or not). Some balanced the potential harm of contracting COVID against the risks of sedation *within the individual*, and felt that the risks outweighed the benefits.

Of those who took a wider pragmatic approach taking into account the collective good as well as the individual, all agreed that if patients were sedated to prevent wandering, this should not be a blanket approach. If it were used, this would need to be a decision made in individual circumstances, and there were suggestions about what alternative options might be considered before sedation, and what aspects should be weighed up when making this decision.

These comments also placed emphasis on the current COVID pandemic situation, with a need to ration medical resources, for example ventilation or ITU beds, and how this was likely to have an impact on the non-COVID positive. By extension this might be another group whose care might be less than optimal, to divert resources to those with better prognosis. An inevitability of reducing staff/patient ratio was cited, and the importance of instituting a proper plan to mitigate against this for all patients, although a number did not feel it appropriate to pre-emptively consider sedation and only when staffing had collapsed or with positive cases.

The hypothetical question was raised of *whether sedation would be used (eg for agitation or wandering) if there was no COVID*? with a stress that COVID should be an *additional* (rather than a sole or significant) factor to be considered in this decision. Given the public health risk it was suggested as reasonable to change the threshold for using sedation; this was compared to the frequent use of sedation in situations to prevent patients from injuring themselves, or when they are violent and others are at risk. Some felt sedation should be considered only as a last resort.

Alternative options were suggested to limit wandering, with some discussion of the related physical and mental health risks (eg of patients injuring themselves) of such strategies. Options suggested as possibly preferable to sedation included:

1. Staffing
    a. Volunteers? might increase risks to themselves, patients and staff.
2. Increasing hygiene measures
3. Physical / mechanical restraint
4. Other patient-focused measures:
    a. Sleep promotion initiatives
    b. Use of pain assessment tools – presumably to manage pain-related agitation
5. Environment:
    a. Locked if not already
    b. installing (further?) locks on doors/ barriers
    c. Cohorting patients - (re)configuration of ward areas/ reorganisation of space / patient mix
    d. Can the patient be discharged to the community?

Considerations suggested in making the decision to use sedation included:

1. Capacity: do not assume any patient with inconvenient wandering behaviour lacks autonomy. Are there any previously expressed views from the patient? Regardless, can they work with measures to reduce risk?
2. The dose of sedative medication:
    a. it was highlighted that sedation need not be a binary option, and a lower dose might be a compromise option, aiming to use the lowest possible dose to reduce restlessness and to avoid making patients bedbound; would this necessarily increase the risks of concern of using sedation?
    b. One suggestion to mitigate this was a protocol to monitor level sedation and provide criteria for clinical escalation in the event of complications
3. How long? the COVID epidemic is likely to run for many months; will sedation be time-limited when patients are agitated or until longer-term solutions can be put in place?
4. What is current vs anticipated level of staffing? Should there be a staffing “trigger point”?
5. Whether a patient is symptomatic, and from this, whether they are COVID positive?
6. What is the risk to this individual from COVID or from sedation, with specific relation to age and co-morbidity? Is the risk of contracting this greater than the risks of sedation? International statistics suggest that the risks of COVID in the elderly are significant and carry a high mortality. Will we have a better/emerging idea of risks of COVID?

7. Nature of the environment: are the staff specifically skilled in managing dementia/psychosis and behavioural disturbance; is there an additional burden of other competing roles?
8. Current legal position and national directives, including powers to detain those who are COVID positive.
9. Of alternatives above, are they avoided because of social stigma, eg physical / mechanical restraint? Which of these alternatives is least restrictive / least harmful / least distressing?
10. Including the family transparently in such discussions: expectations would need to be managed.
11. How can such decisions be transparently and fairly made?
    a. in order to avoid unconscious bias about *quality of life* or an individual's social "value", or related to a clinician's direct therapeutic relationship with an individual
    b. possibly the use of double/second opinion decision-making to support;
    c. Should a senior team oversee any change in process at a system level and then regularly and transparently review the situation, until the decision to return to normal practice made transparently at system level?
12. How can we support staff in delivering sub-optimal care and negotiating difficult discussions with families? perhaps using a different person to make the decision than convey it?

In concluding, I must declare my own professional background / bias, inasmuch as being a Forensic Psychiatrist, making decisions that take into account risk to others against the benefit to the patient is something that we have to do on a daily basis; these decisions include detention of capacitous patients and prescribing medication coercively that may have risks and side-effects.

Overall, there was no clear consensus on this, however most agreed that using sedation in the current circumstances could be justifiable with careful consideration. The most salient considerations were that these decisions were made on an individual basis, taking into account the rapidly changing staffing status, the emerging COVID situation and how feasible/comparatively harmful other alternatives might be. Any use of sedation should be reviewed regularly, with the above factors in mind.

There was a divided view on whether it was ethical to pre-emptively sedate those who were not COVID positive (with some even highlighting that these were less vulnerable to the risks of sedation than the COVID positive) or to anticipate staff shortage.

In the time since the initiation of this exercise, the British Geriatrics Society,European Delirium Association and Old Age Psychiatry Faculty (Royal College of Psychiatrists) have issued guidance on "Coronavirus: Managing delirium in confirmed and suspected cases" as dated 19th March 2020

https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspected-cases

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