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Citation: Germain, S. (2021). The Role of Medical Professionals in Shaping Healthcare Law During COVID-19. *Amicus Curiae*, 3(1), pp. 33-55. doi: 10.14296/ac.v3i1.5351

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THE ROLE OF MEDICAL PROFESSIONALS IN SHAPING HEALTHCARE LAW DURING COVID-19

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Abstract

This article explores the changing nature of the allocation of healthcare resources during the Covid-19 crisis and how it may have shaped a new role for medical professionals in healthcare law and policymaking. It contrasts the traditional input of medical professionals in systemic healthcare reforms (1946, 1990 and 2012) with their role in the elaboration of ethical emergency guidance published by the British Medical Association and the Royal College of Physicians in March–April 2020, using a discourse analysis methodology and concepts borrowed from political philosophy.

Keywords: Covid-19; medical professionals; healthcare law and policy; ethics; justice; emergency guidance.

[A] INTRODUCTION

During the spring of 2020, the first peak of Covid-19 infections in England led to an immediate reorganization of healthcare services (Propper & Ors 2020). As the entire system came under pressure, the reality of triage changed. Clinicians were told that decisions could no longer be based solely on the best interests of their patients but had to account for crucially limited healthcare resources (British Medical Association (BMA) 2020a; Royal College of Physicians (RCP) 2020). Medical needs became a secondary consideration after assessing how a proposed treatment might affect resources and impact on a patient's chances of survival (Sokol 2020).

Medical professionals were thus put at the centre of the systemic healthcare rationing process, a role traditionally fulfilled by the Government when dictating the allocation of resources for the National Health Service (NHS) (Baggott 2015). Although the raging crisis did

not allow for the traditional law and policy process to take its course, frontline workers were still in urgent need of rules to manage patients and allocate human resources and personal protective equipment (PPE). Decisions were therefore taken at an organizational level (Royal Colleges of Medicine and BMA) to support the difficult decision-making process at the ‘bedside level’ in primary and secondary care settings.

This article considers whether the unusual circumstances of the pandemic have substantially changed the way in which medical professionals shape healthcare law. It will do so using a discourse analysis methodology and concepts borrowed from political philosophy to compare the traditional role of medical professionals in healthcare reforms with their role in formulating ethical emergency guidance.

The first part of the article looks at tools used in healthcare law and policy to allocate scarce resources, in theory (models of distributive justice) and in practice (rhetoric and discourses). This is drawn from the theoretical framework used by the author in her prior research to analyse the role played by medical professionals in healthcare reforms (Germain 2019). The second part of the article presents these findings and exposes how medical professionals have used an egalitarian rhetoric to halt or modify governments’ ambitions and to protect their professional autonomy during three major systemic reforms (1946, 1990 and 2012) (Germain 2019). The third part of the article analyses the more recent role played by medical professionals in healthcare law and policy-making by paying attention to written discourses and the rhetoric of justice enclosed in the ethical emergency guidance documents published by the BMA and RCP in March–April 2020. This portion of the analysis aims to determine whether the unusual circumstances of the pandemic created an opportunity for medical professionals to change their role in healthcare lawmaking. The article concludes that, although the first wave of the pandemic was unprecedented in the history of the NHS, it has not shaped a substantially new role for medical professionals in the law and policy arena.

[B] ALLOCATING SCARCE RESOURCES

Healthcare law and policy formalizes rationing patterns as demands put on healthcare systems are often infinite and resources greatly limited (Mallia 2020: 1). The Covid-19 pandemic exemplifies the importance of this process. The fear of not having sufficient resources to meet the needs of the population in the first months of lockdown in England mandated that allocation rules be put in place swiftly.

The distributive justice models presented in this section theorize the allocation of scarce resources and to a greater or lesser extent underpin systemic and institutional healthcare laws and policies (Fleischacker 2009: 1-17). More specifically, the egalitarian, utilitarian and libertarian models have provided principles to ration healthcare resources. This section discusses the fact that, in practice, these models are part of oral or written discourses and rhetoric used by actors in the healthcare law and policy arena to shape allocation rules. Together they form the basis of a theoretical framework that can be used to analyse the role of medical professionals in healthcare law and policymaking (Germain 2019).

The remainder of the article uses this framework to consider whether medical professionals have promoted a specific model to allocate resources during the elaboration of systemic reforms and whether they have promoted the same or an alternative model in the drafting of Covid-19 emergency guidance. This analysis will help reveal whether the medical profession's perspective on the rationing process was altered at the onset of the Covid-19 crisis. The analysis will also speak to its ability to shape healthcare law and policy if it transpires that their position was ultimately formalized into law.

In Theory

Even though healthcare resources do not possess any attributes that make them stand out from other health determinants in the contribution they make to good health, the article argues that their allocation should follow principles that focus on the attainment of justice. The seriousness of healthcare needs, especially in pandemic times, makes these resources stand out from mere consumer goods, and their potential to alleviate pain and help avoid absolute harm makes them a central component of our society (Segall 2007; Schramme 2009: 17).

Justice also requires that we treat equally those who are alike and that we balance individuals' needs with the claims of the community by providing rules to distribute resources and to structure human relationships (Joachim & Rees 1953). Therefore, both procedural and distributive justice are at play in rationing healthcare resources. To ensure fairness and consistency, procedural justice requires that the process of allocating resources accounts for three elements: accountability for reasonableness; transparency; and relevant decision criteria and regulatory frameworks (Michaels 2020: 1). Just allocation, on the other hand, is theorized differently under the egalitarian, utilitarian and libertarian models as presented herein.

The Egalitarian Model

Egalitarianism posits that justice in healthcare can be achieved through patterns of equality. Redistribution of resources is needed to help level up good health capabilities or life opportunities, since we have not all been provided with the same allotment of capabilities or potential for good health at birth. Even though no amount of resources can entirely eradicate inequalities in health, healthcare law and policy should focus on principles of equality to allocate resources fairly (Hoedemaekers & Dekkers 2003: 327-328). Liberal egalitarianism only tolerates an unequal distribution of resources to provide greater benefit to the least advantaged (Rawls 2005: 302-303).

Laws and policies that adopt a liberal egalitarian approach to allocate healthcare resources at a systemic level often prescribe a universal and equal access to services. The ambition set for the national system is to 'level the playing field' in healthcare which may result in dedicating more resources to the least favoured and have the most vulnerable patients guaranteed an equal access to care regardless of their income. Patients with equivalent healthcare needs would be treated alike, but may be treated differently from other patients (Gutmann 1983).

Ethical guidance taking an egalitarian approach would not give priority to Covid-19 positive patients over non-Covid patients suffering from similar health issues in accessing healthcare services. Instead, it may use a random process, such as a lottery system, to allocate resources (Persad & Ors 2009: 423).

The Utilitarian Model

Utilitarianism is preoccupied with utility (good health) maximization. Certain groups of patients may be prioritized if they have the potential to derive greater health outcomes from limited resources. Focus is set on consequences of actions and in the context of healthcare on treatment outcomes and chances of survival. This model of allocation, however, should aim to do the least harm to the fewest people and prevent most harm for the greatest number (Bentham 1879). Just utilitarian distribution does not imply fair distribution, and it is almost inevitable that resources will be distributed unequally (Kymlicka 2002: 27).

Governments tend to turn to utilitarian healthcare policies to rationalize limited healthcare resources. For example, treatments are compared and ranked and only the interventions that will do 'the greatest good' (increase life years and quality of life) are covered under the system's healthcare entitlements (Williams 1998: 29-97).

Guidance following a utilitarian approach prioritizes patients with the greatest likelihood of survival. Therefore, acutely sick Covid-19 patients or infected patients with survival-limiting comorbidities may be least favoured to receive treatment (Tolchin & Ors 2020: 1). Conversely, individuals in key roles such as medical professionals could also be given priority in treatment, regardless of their clinical state, as their recovery would indirectly improve society's aggregate health status as they become available again to treat patients (Persad & Ors 2009: 426). These instances of discrimination at the clinical level would be tolerated because of the extreme scarcity resulting from the pandemic.

The Libertarian Model

Libertarian justice does not recognize healthcare as an entitlement and posits that market forces are most optimal for the allocation of healthcare resources. A private, deregulated and decentralized allocation of healthcare resources is deemed to generate the best cost-efficient quality solutions for individuals' needs (McGregor 2001).

Healthcare law and policy adopting a libertarian and consumerist approach tends to focus on patients' autonomy and their liberty to choose. Resources are made available to support choices in healthcare and competition amongst providers is strongly encouraged (Terris 1999: 151-152).

Libertarian ethical guidance might suggest that during a public health crisis such as the Covid-19 pandemic, non-priority patients should be seen in the private sector to reduce backlog and give them the opportunity to receive care more promptly.

In Practice

Ideas of justice in healthcare policy are often reflected in stakeholders' public discourses when putting forward or commenting on healthcare policy proposals. Members of the government, Members of Parliament (MPs) and members of the medical profession convey opinions and values reflecting one or more distributive justice theory when formulating healthcare policy or debating healthcare rulemaking (Germain 2019). Sometimes these discourses are even present in the final version of a law or the rule formalizing the proposal.

Discourses are social practices that shape situations and institutions (Fairclough & Ors 2011: 2). The analysis of discourses highlights these dimensions and helps unpack how stakeholders such as the medical profession pursue particular goals by advancing a rhetoric that reflects

their values when intervening in the healthcare rulemaking process (Drew & Sorjonen 2011: 2). Medical professionals engage in discussions as part of civil society and formulate formal discourses through medical professional associations that interact with various political institutions. The use they make of the rhetoric of justice in these contexts operates beyond the art of verbal persuasion. Because their words are socially embedded, their oral and written discourses also reflect the role they play in social relations (Jorgensen & Philips 2002: 61; Freeman & Maylin 2020: 158). Account should be taken of these elements and the impact they may have had on the design of allocation rules (Harrington 2017). In the words of Foucault, '[w]e must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a stumbling block, a point of resistance and a starting point for an opposing strategy' (Foucault 1980: 101).

This thus requires that we pay attention to key texts that may translate formal manifestations of ideas of justice. In non-pandemic times they take the form of White Papers and healthcare laws and, in times of a public health crisis like Covid-19, they take the form of emergency guidance documents. All of these documents speak to the process of making rules to allocate healthcare resources, but they are also an expression of the agency of the author(s) and often combine or consolidate multiple interests (Freeman & Maylin 2020: 2020: 158-160). These documents coordinate and connect stakeholders within an institution, be it the government or a professional medical association, as laws and guidelines provide governing practices to allocate resources (ibid: 159-160).

[C] THE ROLE OF MEDICAL PROFESSIONALS IN SYSTEMIC HEALTHCARE REFORMS

It is only possible to determine whether (or not) the pandemic was an opportunity for medical professionals to change the nature of their involvement. Covid-19 has certainly marked a watershed moment because of the deep and unprecedented disruption it has caused in the system. It may have also changed the original role played by medical professionals in setting rules to allocate resources. Therefore, the part they have taken in shaping these emergency rules should be contextualized and analysed in comparison to the traditional role the profession has played in healthcare law and policymaking.

To this effect, this section presents research findings shedding light on the part traditionally played by medical professionals in three major systemic reforms: the National Health Service Act 1946 establishing the

place of the medical profession in the system; the National Health Service and Community Care Act 1990 creating the internal market in healthcare; and the Health and Social Care Act 2012 proposing a drastic overhaul of the system. This analysis reveals that medical professionals have consistently used egalitarian rhetoric when engaging in the reformative process. Even though they have not proactively engaged in policymaking, their goal has remained consistent, halting or modifying governments' ambitions in order to protect their professional autonomy.

A Commitment to the Foundational Egalitarian Utopia

The foundations of the healthcare system in England were laid on a utopian misconception. After the war, Aneurin Bevan had a vision. In order to stamp down on ill-health in the country, he would reform the social security system and 'provide the people of Great Britain, no matter where they [were], the same level of service' (National Health Service Act 1946, Part I). The rationale behind the project was obviously flawed, as even the most efficient healthcare system could not eliminate all healthcare needs and productivity losses (Hunter 1997: 20).

But as Harrington argued, the NHS was conceived as an anti-market 'enclave, an exemplary zone of non-commodified human relations ... separated from the wider world' (Harrington 2017: 90). This required the support of the medical profession for its realization and survival. Harrington's image also speaks to the liberal egalitarian rhetoric that was used to unveil the project and construct the system, appealing to both the profession and the population's solidarity to provide all with equal life opportunities.

Addressing the House of Commons (HC) during the debate on the foundational Bill, Bevan mentioned his desire to make the services 'available to the whole population freely' (HC 1946a: 45-49). He based his remarks on the report of the Committee on Social Insurance and Allied Service led by William Beveridge which explicitly stated that the system had to be equal, universal and based on 'need' rather than 'means' (Beveridge 1942: 1). According to Beveridge, account had to be taken of inequalities, and financial capacity should be side-lined as 'each individual [had to] stand on the same terms; [as] none should claim to pay less because he is healthier or has more regular employment' (Beveridge 1942: 6-7).

Ideas of liberal equality also emerge in the analysis of the transcripts of these debates. In particular, the importance of providing equal access to healthcare to enable the realization of life plans was the theme of many interventions (HC 1946a: 43-142, 147; HC 1946b: 59-313.)

However, the Government's vision did not resonate with those medical professionals who had launched an attack on the reform plans to create a unified system of care in the United Kingdom (UK). Disagreements precluded the achievement of a consensus as the BMA actively blocked the initiative (Webster 1988: 76). Members of the medical professional association found an ally in the Conservative Party, which also opposed Bevan's reform efforts. The animosity between the medical profession and the Government was striking in Parliament. The profession was eager to preserve its professional autonomy and felt threatened by the creation of a national system.

Conservative MP Richard Law was adamant. Directly addressing Bevan, he said that: 'The British Hospital Association and the British Medical Association [were] opposed to this Bill.' (HC 1946a: 64) He went even further in saying that 'the plain fact [was] that everybody of informed and expert opinion outside [the] House [was] against the Minister on one part of the Bill or another' (HC 1946a: 66).

Efforts to bring the medical profession on board were deployed beyond the enactment of the foundational Act creating the NHS. Eventually, medical professionals agreed to take part in the system. For both primary and secondary care medical professionals, a publicly financed healthcare system guaranteed absolute clinical autonomy. But the 'deal' struck with the post-war Government had also implicitly created a co-dependent relationship between the profession and Whitehall. The system needed medical professionals to deliver and organize healthcare services, and the profession needed the system to survive (Crimson 2009: 111). The victorious negotiations gave medical professionals a central role in healthcare law and policymaking. With professional autonomy came the power to spend and indirectly impact the allocation of healthcare resources in the NHS. Medical professionals were made the gatekeepers of the system. From that point on, clinical decisions, planning and management would have to involve them. Medical professionals would therefore always aim to safeguard the system's egalitarian utopia in order to protect their autonomy (Eckstein 1960: 1069).

A Continued Opposition to Governments' Utilitarian Libertarian Ambitions in Healthcare

Medical professionals' involvement (or the lack thereof) in healthcare law and policy in the 1980s and the profession's mobilization against the overhaul of the system in 2012 marked a change of tone. This contrasted

with the consensus that had been built with the Government at the creation of the system.

During the first three decades of the NHS, the medical profession had established a monopoly of legitimacy that was reinforced by the BMA and the Royal Medical Colleges' presence in healthcare law and policy (Klein 2013: 51-52; Baggott 2015: 118). However, public spending was untenable, and rationalization was considered in many sectors including the NHS. Margaret Thatcher's Conservative Government took a unilateral approach, signalling its desire to take control and to impose a more passive role in healthcare law and policymaking for medical professionals (Day & Klein 1983: 1813).

The relationship was tense. Clashes between the profession and the Government on healthcare spending, the organization of services, and GP contracts were intensified with the publication of the White Paper *Working for Patients* in 1989 (Baggott 2015: 26). The BMA was open about its opposition to the proposal and organized a campaign to derail the reform. It published an editorial in the *British Medical Journal* (Beecham 1989) to voice its outrage. One of the main critiques of the proposal was that it undermined the egalitarian core of the system as it would 'lead to a fragmented service [that would] destroy the comprehensive nature of the existing NHS' (ibid: 676). Medical professionals were also frustrated with the Government's decision to ignore them, as it had taken 'no steps to discuss the proposals with representatives of the profession' (ibid: 676).

Prior to the offensive launched by the medical professional organization, *Working for Patients* was debated five times in Parliament. Conservative and Labour MPs played out the conflict between the Government and medical professionals. The Labour Party accused the Government of having done 'some terribly foolish things in relation to health' and it had 'done nothing more foolish than slamming the door on the heads of the royal colleges' (HC 1989: 43-44). Indeed, the Government was proposing to restructure the system to create an internal market where the sale and purchase of healthcare services would be subject to competition. In a nutshell, *Working for Patients* proposed to introduce principles of libertarian justice in healthcare to leave internal market forces to achieve a more cost-efficient and competitive service (Davies & Powell 1991: 154).

The policy proposal was eventually formalized, and a Bill was introduced in Parliament. A libertarian but also utilitarian rhetoric gathered momentum (House of Lords (HL) 1990: 1289, 1304, 1382). The reform aimed to maximize utility in healthcare by optimizing available resources. The Government had a 'duty to make sure that money [was]

used to bring the maximum benefit' (HL 1990: 1382). In the House of Lords, Conservative Lord McColl of Dulwich made a similar case and countered the medical professionals' grievances arguing that:

the solution lies in the introduction of competition. We believe that it will help to solve that problem. It is fair to say that the Royal Colleges are fearful that competition will result in some hospitals going to the wall. Competition is much more subtle than that. It will provide the missing incentive for people to make sure that they give the kind of service that customers will appreciate. It will keep them just that little bit more on their toes (HL 1990: 1255-1387).

On the other hand, numerous members of the Lords put forward arguments in favour of universality, comprehensiveness and equality in healthcare, in supporting medical professionals (HL 1990: 1276, 1292, 1322-1323, 1332, 1354). Former Vice-President of the Royal College of Nursing and cross-bench member Baroness Cox spoke of the NHS as 'a popular and generally equitable health service' and suggested that her professional colleagues '[could] not and [would] not support proposals which appear[ed] to risk damaging this precious institution and thereby possibly harming those whom it serves' (HL 1990:1322).

The reform that resulted from these exchanges and negotiations provided a mixed result. It established the internal market in healthcare but also preserved the egalitarian foundations of the NHS (Bevan & Robinson 2005: 55). The most drastic change for medical professionals was not their redefined clinical roles, but the place they were now given in healthcare law and policy. They had preserved their autonomy, but the Government had proven that it had the ability to change the system without their policy input. Although vehement, medical professionals were confined to a reactionary role. However, they had also made no concerted effort to put forward a proposal for a new allocation of healthcare resources.

A few years on, the culture change that involved libertarian and utilitarian strategies in healthcare initiated during the Thatcher era was taken forward by New Labour in the 1990s and climaxed under the Coalition Government in 2012 (Newman & Vilder 2006: 199). This was by far the most extensive overhaul of the NHS since its creation, and the Government faced significant push-back from medical professionals. Consumerist rhetoric focusing on patients' choice, as well as the introduction of formal partnership with private and independent providers in healthcare, had infiltrated the policy discourse (Glennerster 2015: 297).

Medical professionals most adamantly vested themselves with the role of guardian of the NHS, and this transpired during the debate on the Second Reading of the Health and Social Care Bill. During these

exchanges, two groups formed and used distinct discourses of justice. On one side, members in support of the reforms adopted libertarian and consumerist rhetoric aiming to empower patients offering more choice and a more efficient healthcare system with the introduction of greater competition among providers (HL 2011: 1469-1720). Conversely, members acting as ‘spokespersons’ of the medical profession returned to the traditional egalitarian rhetoric, focusing on equality in access to care in order to provide all with services meeting their needs, particularly the most vulnerable (HL 2011: 1479, 1481, 1482, 1497, 1499, 1500, 1502, 1506, 1507, 1508, 1509, 1511, 1675, 1680, 1689, 1702, 1703, 1708).

Here again, medical professionals had tried to make a substantial entrance in the healthcare law and policy arena, but their contribution to change was limited to critique. They had secured the egalitarian core, but the consumerist approach had gained significant traction. This also meant that, in the systemic allocation of healthcare resources, they would continue to be limited to their clinical role.

[D] THE ROLE OF MEDICAL PROFESSIONALS IN SHAPING HEALTHCARE LAW DURING THE COVID-19 CRISIS

Within its structure and in order to run the system the NHS has established a specific relationship between medical professionals and the state. Medical professionals’ lack of proactivity in healthcare policy over the past 70 years is also a result of this organization and power dynamics. However, the pandemic has brought about game-changing circumstances that marked a turning point in healthcare law and policy. The absence of systemic rules to allocate resources during the first weeks of the crisis bestowed upon the medical profession an opportunity to play a central role in drafting new rules.

Medical professionals first reacted by openly expressing their disappointment with the Government’s handling of the Covid-19 crisis and in particular the lack of national guidance (Glover-Thomas 2020: 362-363). The militaristic language and rhetoric portraying frontline workers as heroes fighting a war against the virus was acting as a distraction from the Government’s duty to outline rules to allocate resources fairly (Cox 2020: 511-512).

The communication from the trusts to doctors was also uncoordinated because of the confusion around the course of treatment and illness management (BMA News 2020c). Frontline workers were approaching

Royal Medical Colleges and the BMA with pressing questions on how to deliver ethical care to their patients, manage staff and allocate scarce PPE under unprecedented circumstances (Huxtable 2020a: 1). These professional organizations then took on the responsibility of filling the regulatory void.

On 1 April 2020, the BMA published its guidance document ‘COVID-19 – Ethical Issues. A Guidance Note’ (BMA 2020a: 1). The Association saw great responsibility in providing its members with ethical advice and to help them avoid future litigation. The BMA’s strategic position as the largest registered trade union also meant that it might get some attention from the Government on pressing issues around scarce resources specifically relating to the use of PPE (Huxtable 2020b: 2). A few days after the BMA had issued its note (BMA 2020a), the RCP published its guidance on the ‘Ethical Dimensions of COVID-19 for Frontline Staff’ (RCP 2020). This was supported by the medical profession’s regulator and 16 Royal Medical Colleges and Faculties.¹

The two pieces of guidance followed a similar structure and addressed similar themes. Perhaps the guidance drafters expected that if these documents echoed one another, it would be clearer for clinicians to provide ethical care and help preserve some form of equal access to services wherever possible. Regardless, both documents remain deeply utilitarian in the principles they outline, marking a notable departure from the traditional egalitarian rhetoric the medical profession had thus far consistently and exclusively adopted in its commentary and input on major healthcare reforms.

BMA Ethical Guidance

The BMA’s 10-page note is structured around three themes: the importance of an ethical framework for guidance; appropriate guidelines for the allocation of resources; and solutions for potential triage issues. The guidelines were drafted with the overarching goal of providing frontline medical professionals with clarity and principles on how to ethically ration healthcare resources as the pandemic was unfolding. Throughout,

¹ Supporting the guidance document from the Royal College of Physicians were: the Faculty of Occupational Medicine of the Royal College of Physicians; the Faculty of Pharmaceutical Medicine; the Faculty of Sexual and Reproductive Healthcare; the Royal College of Surgeons of Edinburgh; the Faculty of Intensive Care Medicine; the Royal College of Anaesthetists; the Royal College of Psychiatrists; the Royal College of Emergency Medicine; the Royal College of Ophthalmologists; the Royal College of General Practitioners; the Royal College of Nursing; the Faculty of Sport and Exercise Medicine UK; the Royal College of Physicians of Edinburgh; the Royal College of Radiologists; the Royal College of Physicians and Surgeons of Glasgow; and the Faculty of Health.

emphasis is placed on the importance of openness and transparency in the process (BMA 2020a: 3, 4, 8, 9). The document thereby speaks directly to issues of both distributive and procedural justice in times of crisis.

The opening summary relates the difficult climate that led to the publication of the document and acknowledges the difficult decisions that are confronting medical staff. It mentions resources 'becoming increasingly restricted and choices of available care [being] limited' (BMA 2020a: 1). It implicitly acknowledges the Government's strategy or absence thereof by stating that 'the allocation of potentially life-saving treatment to individual patients [would] fall [on] health care providers and individual health professionals' (BMA 2020a: 2).

It is noted, however, that the intention should remain to meet 'all patients' clinical needs but, if they become necessary, prioritization and triage decisions will be professionally challenging' (BMA 2020a: 1). This particular statement strikes at the heart of the dilemma confronting medical professionals in their clinical roles and the BMA experts in their guidance-drafting role. As early as the first weeks of lockdown in England, sustaining the equal access to services approach in healthcare was becoming increasingly challenging because of unusual working conditions and lack of resources. In fact, the guidance bluntly refers to '[the] little or no surge capacity in the NHS' (BMA 2020a: 2).

The BMA chose to rely on the existing UK Government framework developed during the 2009 flu pandemic to elaborate its Covid-19 ethical guidelines (Department of Health and Social Care 2017). This decision speaks to the urgency of developing guidance to provide answers and solutions to medical professionals acting 'blind' on the frontlines, and to how they were forced to multi-task and double their role as clinicians with guidance drafting. The medical profession also did not depart from its traditionally more passive role in healthcare policymaking, relying on the Government's established position to frame the allocation process and offering more of a commentary than a different stance.

This framework provided essential core principles for the elaboration of guidelines. It lists and defines values of: 'equal respect'; 'respect'; 'minimising the harm of the pandemic'; 'fairness'; 'working together'; 'reciprocity'; 'keeping things in proportion'; 'flexibility'; and 'open and transparent decision-making' (BMA 2020a: 2). Interestingly, three out of nine principles convey elements of an egalitarian rhetoric speaking to equality ('everyone matters equally'), equality of opportunity ('an equal chance of benefiting from a resource') and proportionality ('increased burdens should be supported'). The framework also points to procedural

justice by prescribing ‘inclusive, transparent and reasonable’ decisions. (BMA 2020a: 2).

The subsequent section of the guidance addresses resource allocation and healthcare rationing issues in the event that the system becomes overwhelmed. Of all guidance documents published by medical professional organizations at the time,² the BMA’s is the most explicit about this topic. In this portion of the document, the guidance is framed in utilitarian terms as resource allocation becomes synonymous with priority-setting. The worst-case scenario is described as having all facilities and equipment used at capacity leading to ‘inescapable’ decisions and ‘strictly utilitarian considerations to be applied, and decisions about how to meet individual need giv[ing] way to decisions about how to maximize overall benefit’ (BMA 2020a: 3). This marks a notable departure from the traditional egalitarian rhetoric used by the medical profession in advocating equal access to resources for all in major healthcare reforms.

Interestingly, within the same section, the BMA suggests a conflicting and contradictory approach, explaining that ‘the ethical balance of all doctors and health care workers must shift towards the utilitarian objective of equitable concern for all’ (BMA 2020a: 2). It is difficult to reconcile utilitarian objectives with equal concerns for all, since utilitarianism mandates prioritizing only preferences achieving the greatest level of utility (Bentham 1879). As resources get scarcer it is unlikely that providing equal concern/access to medical services for all would maximize health outcomes. On the contrary, greater ‘demand on health services may outstrip the ability of the NHS to deliver services to pre-pandemic standards’, putting some patients at a higher risk of death (BMA 2020a: 3). However, pre-pandemic levels of access to care certainly did not provide a ‘utopian’ equality. Vulnerable groups have faced and continue to face significant barriers to accessing healthcare services (Germain & Yong 2020).

Directly addressing admissions to intensive care and withdrawal of treatment, the guidance reiterates a utilitarian approach for the rationing of emergency healthcare resources. It suggests ‘maximising the overall reduction of mortality and morbidity’ and

implement[ing] decision-making policies which mean some patients may be denied intensive forms of treatment that they would have received outside a pandemic. Health professionals may be obliged to

² Other than the BMA and RCP’s ethical guidance, the General Medical Council updated its guidance to the medical profession, NICE introduced critical care guidance (as mentioned above) and the Royal College of Surgeons published its ‘Good Practice for Surgeons and Surgical Teams’, offering specialized guidance for the allocation of healthcare resources for surgeon clinicians.

withdraw treatment from some patients to enable treatment of other patients with a higher survival probability (BMA 2020a: 3).

This forms the basis of the utility calculation that may be stripping clinicians of their professional autonomy, something they have so vigorously defended over the past 70 years of healthcare reforms. Medical professionals' assessment shall no longer be based on treatment plans designed for the best interests of their patients but will be constrained by the limited resources available. Emphasis is put on the potential consequences of providing treatment in a utilitarian fashion, looking at survival outcomes rather than equal access to care.

In its final section the guidance document fleshes out guidelines for triage. It addresses the process separately from the more systemic allocation of resources, triage being 'a form of rationing or allocation of scarce resources under critical or emergency circumstances where decisions about who should receive treatment must be made immediately because more individuals have life-threatening conditions than can be treated at once' (BMA 2020a: 4). Here, urgency would be the central element dictating the decision-making process. Nonetheless, it is expected that 'the principles underlying the decisions [should be] systematically applied' (ibid) and that 'decisions at all levels [should be] made openly, accountably, transparently' (ibid: 9), perhaps to guarantee consistency and procedural justice.

Rationing scarce healthcare resources through triage involves 'sort[ing] or grad[ing] persons according to their needs and the probable outcomes of intervention. It can also involve identifying those who are so ill or badly injured that even with aggressive treatment they are unlikely to survive and should therefore receive a lower priority for acute emergency interventions while nonetheless receiving the best available symptomatic relief (ibid: 4).

The presence of comorbidities that are known to be associated with lower survival rates 'may exclude individuals from eligibility'. (Ibid: 4) This may lead to potential instances of discrimination. On this point the guidelines specifically mention that 'decisions must not be solely based on age or disability. Ethically, triage requires identification of clinically relevant facts about individual patients and their likelihood of benefiting from available resources. Younger patients will not be automatically prioritised over older ones.' (ibid) Nonetheless, the outlined principle remains sharply focused on treatment outcomes rather than equal access to treatment for all.

Generally, the guidance is most explicit in referring to the utilitarian rhetoric to frame the triage process. Medical utility is key as medical professionals are urged to focus on ‘delivering the greatest medical benefit to the greatest number of people’ (BMA 2020a: 5). The process for ranking patients for admission into intensive care is explicitly spelled out, and the guidance suggests applying benchmarks and ‘thresholds’ in order ‘[t]o maximise benefit from admission to intensive care’ (ibid).

But when presenting its approach, the BMA suggests that it should be reconciled with ‘an egalitarian approach that ensures a fair distribution of resources’ (BMA 2020a: 5). In the event that patients with a similar chance of survival and anticipated lengths of treatment need to be admitted to the Intensive Care Unit (ICU), the BMA recommends a ‘modified queuing’ system embracing a ‘first come first served’ approach (ibid). Admittedly this approach would not guarantee equality in access to healthcare as it is ‘likely to give priority to those who are mobile, who have access to transport, or who live close to hospitals and other sites of health provision’ (ibid).

In parallel to the guidance document, the BMA also issued a series of communications on its Covid-19 emergency ethical framework and the professional association’s position on issues relating to resource allocation. A call to prioritize NHS staff for the allocation of PPE dominated the BMA’s blog posts and press releases (BMA 2020b; BMA News 2020a, 2020b). The guidance document was the BMA’s first step into arguing for the prioritization of treatment and access to PPE for the medical profession (BMA 2020a: 8), ‘both for [their] own sake and as part of maintaining effective clinical services’ (ibid: 4). Interestingly, the BMA nonetheless voiced a certain discomfort in advocating for this utilitarian approach that would prioritize individuals with the greatest social utility. It acknowledged that ‘[g]iving priority to those working in essential services in this way would move beyond [the] usual system of resource allocation and decision-makers could face criticism for discriminating between individuals on the basis of social, rather than solely medical, factors’ (ibid: 7).

The Royal College of Physicians’ Covid-19 Guidance

Similar to its BMA companion, the RCP’s guidance first spells out the ethical framework that has supported its development. Distributive justice is explicitly mentioned because it ‘is the most often cited ethical principle during a pandemic’ (RCP 2020: 3). The Royal College emphasizes that its approach must be based on fairness. This is described as more suitable

for the clinical workforce and the best way to understand and approach the ethical issues the workforce would be facing (ibid).

These framing principles mostly speak to the importance of procedural justice in looking at the decision-making process in time of crisis. All five principles ('accountability', 'inclusivity', 'transparency', 'reasonableness' and 'responsiveness') are presented as the 'principal values that inform [the] guidance' (RCP 2020: 3). Noticeably absent, however, is the idea of consistency. The guidance is clear that the fast-paced nature of the situation does not allow for permanent guidelines to inform clinical decisions. In fact, '*flexibility*' is encouraged for greater '*responsiveness*' to better meet the needs of the population (ibid: emphasis added).

The remainder of the document provides 'specific recommendations for ethical practice and decision-making' (RCP 2020: 4) addressing various ethical dimensions of the resource allocation process. The first set of recommendations focuses on the clinical decision-making process and the management of patients. Under the heading 'Ensuring fair and equitable care', it is stated that, irrespective of the system's potentially varying capacity, no group shall be disproportionately disadvantaged and that 'treatment should be provided, irrespective of the individual's background (eg disability)' (ibid). Equality in treatment is explicitly spelled out in that like patients should be treated alike and without discrimination. It is further clarified that 'decision-making should not be disease specific', but only a brief explanation without greater details is given along with a direct reference to national guidance (ibid).

Regarding the allocation of resources among patients, the guidance is deferential to clinicians and provides advice solely on how to validate difficult decisions through a collaborative process. It suggested that more than one medical professional shall consider the impact of these difficult decisions. The Royal College recognizes that it may not be possible to guarantee equal access to treatment for all as '[r]esources will be inevitably stretched, with doctors having to make decisions about whether patients can or cannot receive treatment' (RCP 2020: 4). Addressing the issue of ICU beds and resources, the Royal College provides a link to the National Institute for Health and Care Excellence (NICE) guidance without detailing any other specific guiding principles (ibid: 5). Here again, the medical profession was explicit about its desire to rely on the Government's position. This is perhaps due to its natural inclination to remain more of a commentator on healthcare policy rather than an active policymaker, but also because of the controversial nature of the intensive care admissions guidance.

However, an important and interesting feature is the specific mention given to '[m]edical ethicists (sometimes referred to as bioethicists)' (RCP 2020: 5). They are designated as those that 'can help frontline staff with difficult decisions, particularly where there is significant disagreement or a stakeholder might wish some form of external appeal other than a second opinion' (ibid). Perhaps the Royal College wanted to highlight the importance of making sound and ethical decisions. It underscores the difficulty some clinicians could have in appreciating and applying the given criteria, particularly if it meant deviating from the traditional line of providing equal access to all patients.

On the topic of human resources and staff management, the guidance only invokes principles of solidarity and equity for medical professionals working outside of their specialty (RCP 2020: 5). But with regard to an issue that was highly sensitive at the time of writing because of a lack of resources, the document refers to the guidance of Public Health England on the use and allocation of PPE. However, it does make clear the need for medical staff to be properly shielded from harm in order to fulfil their clinical duties (ibid: 6). The lack of detail and precise guidelines on the topic speaks to the issue of the availability and allocation of PPE at the time and the anger that was building in the ranks of the medical profession towards the Government.

On the whole, both guidance documents expose the tension between public health ethics focusing on the health of the population and clinical ethics that focus on patient autonomy and best interests (Paton 2020). This translated into a mixed rhetoric in the guidance which promoted a utilitarian approach focusing on health outcomes to ration critically scarce resources, which was in direct tension with an egalitarian undertone that highlights the difficult decisions frontline workers will face making when the equal access approach is untenable.

Most certainly, the role of medical professionals in guidance drafting deviated from the traditional egalitarian rhetoric the medical profession has adopted when commenting on healthcare reforms. When holding the pen to draft the allocation rules for their colleagues, guidance drafters had to account for the crisis. In so doing, they reluctantly deferred to utilitarian principles since an egalitarian approach to access to care as well as their professional autonomy could not be preserved.

[E] CONCLUSION

For the past 70 years, medical professionals have mostly reacted and commented on the design and content of major reforms rather than being directly invested in healthcare rationing at a systemic level (Ham 2009; Klein 2013). In virtually all major reforms they have used the rhetoric of liberal equality to sway the debate and to protect an approach promoting equal access to universal healthcare services as well as to safeguard their professional autonomy. Although at a clinical level medical professionals have had the freedom to allocate treatment to their patients, during reformative periods they have never made concrete policy proposals for the distribution of resources in the NHS. However, for the first time, in the context of the Covid-19 public health crisis, the medical profession has had to exercise dual agency, both as clinicians on the frontlines and as healthcare rulemakers drafting emergency ethical guidance.

The nature and scale of the pandemic is incomparable to any other event affecting the NHS throughout its existence. It has brought into sharper focus ethical dilemmas that have gone beyond the firefighting of the allocation of intensive care beds during the first weeks of the crisis in England.³ It has called attention to the strain on the system present even prior to the outbreak (Antova 2020: 1) and made healthcare rationing even more of a focal point. However, the public health crisis has not substantially changed the role of medical professionals in healthcare policymaking.

The absence of national guidance during the first peak of infections presented a unique opportunity to make a bold policy proposition and for medical professionals to shape the allocation process. But circumstances that caused medical professionals to step in promptly to provide guidance led them to fall back on pre-existing frameworks. However, the distributive justice rhetoric that emerged in the drafting of the BMA and RCP's guidance documents differed from the traditional egalitarian approach in that it engaged more substantially with utilitarianism.

The suspension in the equal access to healthcare services approach, in favour of an allocation of healthcare resources focusing on outcomes and social utility, might also signal a more profound shift in the system. The pandemic, with no conscious intent on the part of the medical profession, may have shaped a distribution of healthcare resources that will have an impact on healthcare law and policymaking for many years to come.

³ NICE published its Covid-19 rapid guidelines in March 2020 to help clinicians in their assessment of patients in need of admission into critical care.

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