



Canadian Geriatrics Society

Kenneth Rockwood
MD FRCPC, FRCP
*Division of Geriatric
Medicine, Dalhousie
University*

Linda Dykes
MBBS, FRCEM
*Director of Emergency
Medicine, Bangor, Wales,
UK*

COMMUNICATING AN ETHICAL BASIS FOR DECISION-MAKING IN RELATION TO FRAILITY AND ALLOCATION OF SCARCE RESOURCES IN THE COVID-19 PANDEMIC

Invited commentary for the article "COVID-19 and Ethical Critical Care Triage – Utilizing This Period to Further Knowledge Translation of Frailty and ICU Evidence during a Pandemic and Beyond", in the *Canadian Geriatrics Society Journal of CME*.

Conflict of Interest:

Kenneth Rockwood has asserted copyright of the Clinical Frailty Scale through Dalhousie University. Use is free for research, education or not-for-profit care. (Users are asked not to change it or charge for its use.) In addition to academic and hospital appointments, he is President and Chief Science Officer of DGI Clinical, which in the last five years has contracts with pharma and device manufacturers (Baxter, Baxalta, Biogen, Shire, Hollister, Nutricia, Roche, Otsuka) on individualized outcome measurement. In 2017 he attended an advisory board meeting with Lundbeck.

He is Associate Director of the Canadian Consortium on Neurodegeneration in Aging, which is funded by the Canadian Institutes of Health Research (CAN-137794), with additional funding from the Alzheimer Society of Canada and several other charities. He receives research support through grants from the Canadian Institutes of Health Research, the Canadian Frailty Network, the Nova Scotia Health Research Foundation, the Nova Scotia Health Authority Research Fund, the Dalhousie Medical Research Fund as the Kathryn Allen Weldon Professor of Alzheimer Research, and the Fountain Family Innovation Fund of the QEII Health Science Centre Foundation.

This commentary was published in May 2020.

We seem now to be getting through the challengingly intense phase of what for most of us will be our first public health emergency. With it have come many dislocations to not just what we do, but how we need to think. This includes ethical decision-making that emphasizes not autonomy, as has been the determining feature to now, but benefit. Understanding benefit begins with understanding the chance of survival. A World Health Organization guidance is clear, if arresting in relation to geriatric medicine in ordinary time: “scarce resources should be reserved for patients with life-threatening conditions. When all those with life-threatening conditions can no longer be treated, priority will be given to those who are expected to have the best chance of survival as a result of treatment. Conversely, treatment in this phase will, if possible, be withheld only from those who are unlikely to benefit from it. Individuals with a poor prognosis will be given palliative treatment only in this phase.”¹

In many settings, age has functioned as such a criterion. On its face, this might not seem unreasonable to many people. Everyone as they age is that much closer to death. There is an intuitive sense of what the WHO document calls the “fair innings” argument: “everyone is entitled to some “normal” span of life ... [therefore] younger persons have stronger claims to lifesaving interventions than older persons because they have had fewer opportunities to experience life.”² This is not some medieval view. In the UK as recently as 1973, a standard textbook of geriatric medicine noted that “The aged uraemic patient is usually not a case for haemodialysis because the possibility of getting access to haemodialysis is usually limited to only a small proportion of all patients with renal failure”³. Indeed, somewhat caught off guard by the rapidity and the magnitude of the need for scarce ICU beds, age was used in the Lombardy region as a rationing criterion in the COVID-19 pandemic.⁴ Geriatricians know well, however, that age is neither a sensitive nor a specific measure of the likelihood of potential benefit, and hence the proposal for age-based rationing has drawn the objections of this group and others.^{5, 6}

Against this background, it is perhaps encouraging to see – as pointed out by Varshney in this issue⁷ – that instead of using age, many jurisdictions are employing the Clinical Frailty Scale, a measure of the degree of frailty,⁸ as a rationing criterion. This is progress, but not unproblematic. As has been pointed out, the Clinical Frailty Scale has not been validated in people under the age of 65 years. Indeed, the syndromes that help to define frailty in older adults such as declines in cognition (especially delirium), function, mobility (including motor speed), balance, sense of health efficacy, and social engagement – relate to risk in the context of age-associated health deficit accumulation.⁹ At least in the case of people aging with intellectual disabilities, risk in relation to stable impairment remains stable, increasing more in relation to deficit accumulation, and worsening of cognition and function.^{10, 11}

A special challenge in the COVID-19 pandemic has been that the Clinical Frailty Scale is being used by people who have never used it before, some important fraction of whom will be unfamiliar with the complexity of frailty, and all that it entails. This is distinct from the original intent of the scale, which was to summarize the result of a geriatric assessment. Even so, it is not without precedent, as the scale is now widely used as a screening tool in emergency department setting.¹² Still, the need for more information on how to reliably screen for the degree of frailty has become pressing, so that [the paper put forward by Varshney](#)⁷ is valuable and welcome.

The utility of the paper is much enhanced by inclusion of the infographic that describes useful tips for completing the scale. An infographic appears to be an efficient way of communicating a great deal of information in a usable form that is readily digested. It appears further to alert many more people to the content of a paper than would have seen it otherwise.¹³ Even so, although the manifold benefits of an infographic can extend to propelling a medical society to adopt social media innovation whether that results in more downloads of the article is not clear.¹⁴ Here, however, our concerns are less about downloads and more about successful use of the scale.

Obviously what the future holds is not clear to any of us. It seems likely, however, that, without an especially rapid development of vaccination or treatment, the probability of a second wave is non-trivially high.¹⁵ If that is so, then the lessons learned about how to manage frail older adults who become acutely ill, especially if their illness becomes severe, will be needed for some time yet.

REFERENCES:

1. World Health Organization. Ethical considerations in developing a public health response to pandemic influenza. https://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2c.pdf Accessed May 3, 2020 Page 7
2. Glossary to World Health Organization. Ethical considerations in developing a public health response to pandemic influenza. https://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2c.pdf Accessed May 3, 2020 Page V.
3. Sourander LB, Genito Urinary System, in Brocklehurst JC. Textbook of Geriatric Medicine & Gerontology. Edinburgh: Churchill Livingstone 1973, Page 295.
4. Cesari M, Montero-Odasso M. COVID-19 and Older Adults. Lessons learned from the Italian epicenter. *Canadian Geriatrics Journal* 2020;23: 152-154. <https://doi.org/10.5770/cgj.23.445>.
5. Montero-Odasso, Hogan DB, Lam R. et al. Age Alone is not adequate to determine health-care resource allocation during the COVID-19 pandemic. *Canadian Geriatrics* 2020;23:155-159. <https://doi.org/10.5770/cgj.23.452>
6. Hubbard RE, Maier AB, Hilmer SN, Naganathan V, Etherton-Beer C, Rockwood K. Frailty in the Face of COVID-19 [published online ahead of print, 2020 May 6]. *Age Ageing*. 2020;afaa095. doi:10.1093/ageing/afaa095.
7. Varshney N. COVID-19 and ethical critical care triage – utilizing this period to further knowledge translation of frailty and ICU evidence during a pandemic and beyond, *Canadian Geriatrics Society CME Journal*, 2020; 10(1). <https://canadiangeriatrics.ca/2020/05/covid-19-and-ethical-critical-care-triage-utilizing-this-period-to-further-knowledge-translation-of-frailty-and-icu-evidence-during-a-pandemic-and-beyond/>
8. Rockwood, K, Song X, MacKnight C, et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ* 2005; 173(5): 489-495.
9. Rockwood K, Howlett SE. Age-related deficit accumulation and the diseases of ageing. *Mech Ageing Dev*. 2019;180:107-116. doi:10.1016/j.mad.2019.04.005
10. Schoufour JD, Mitnitski A, Rockwood K, Hilgenkamp TI, Evenhuis HM, Echteld MA. Predicting disabilities in daily functioning in older people with intellectual disabilities using a frailty index. *Res Dev Disabil*. 2014;35(10):2267-2277. doi:10.1016/j.ridd.2014.05.022
11. Schoufour JD, Mitnitski A, Rockwood K, Evenhuis HM, Echteld MA. Predicting 3-year survival in older people with intellectual disabilities using a Frailty Index. *J Am Geriatr Soc*. 2015;63(3):531-536. doi:10.1111/jgs.13239
12. Theou O, Squires E, Mallery K, et al. What do we know about frailty in the acute care setting? A scoping review. *BMC Geriatr*. 2018;18(1):139. Published 2018 Jun 11. doi:10.1186/s12877-018-0823-2
13. DeNicola N, Good M, Newton L. Back to the future: a history of ACOG in social media's golden age. *Curr Opin Obstet Gynecol*. 2014;26(6):495-502. doi:10.1097/GCO.000000000000123
14. Thoma B, Murray H, Huang SYM, et al. The impact of social media promotion with infographics and podcasts on research dissemination and readership. *CJEM*. 2018;20(2):300-306. doi:10.1017/cem.2017.394
15. Leung K, Wu JT, Liu D, Leung GM. First-wave COVID-19 transmissibility and severity in China outside Hubei after control measures, and second-wave scenario planning: a modelling impact assessment. *Lancet*. 2020;395(10233):1382-1393. doi:10.1016/S0140-6736(20)30746-7.