

Be careful what you wish for: ICU is no panacea

Posted on [April 24, 2020](#) by [Mike King](#)

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In current debates about allocation of scarce ICU resources, we suggest there is undue optimism about the ‘good’ of intensive care unit (ICU) access. Most critical COVID-19 patients who receive access to a ventilator will still die. The minority who survive will likely leave with significant morbidity and a long and uncertain road to recovery. This reality is obscured in the current bioethics literature on ICU triage in which scarcity and value are conflated.

ICU triage debate

The COVID-19 pandemic has generated extraordinary demand for critical care and required hard choices about who will receive potentially life-saving interventions. The ethical debate about ICU triage is largely focused on whether utilitarian approaches aimed at maximizing efficiency and number of lives (or life years) saved should be supplemented by equity considerations that attempt to protect the rights and interests of members of marginalized groups. Utilitarian approaches base criteria for access to ICU on [capacity to benefit](#), understood as survival. Supplementary [equity considerations](#) would [modify these criteria](#) to give a more diverse group of people a chance of entering ICU.

But the debate is more complex than it first appears. Both utility and equity approaches to ICU triage assume ICU is a valuable good – the dispute is about how best to allocate it. Psychologist and marketers know that [scarcity sells](#). People [value a commodity](#) more when it is difficult or impossible to obtain. Global publicity and panic regarding ICU capacity risks distorting patients’ and families’ (and possibly clinicians’) assessment of best interests and decision-making about admittance to ICU with severe COVID-19.

[Emerging data](#) show death rates of 50% – 88% for ventilated COVID-19 patients. In [China](#) and Italy about half of those with COVID-19 who receive [ventilator support will die](#). [Analysis](#) of 5,700 patients in New York City showed mortality for those receiving mechanical ventilation was 88%. The high proportions of people who die despite ICU admission make it particularly important to consider what might constitute better or worse experiences of dying with COVID-19, and how ICU admission affects the likelihood of a “good” death.

We propose that the focus on equity concerns during the pandemic should broaden to include providing all people who need it with access to the highest possible standard of end of life care. This requires attention to [culturally safe](#) care in the following interlinked areas:

1. Advanced care planning

Talking to patients and their loved ones about clinical prognosis, ceilings of treatment and potential end of life care is challenging even in normal times. During COVID-19 the challenges are exacerbated by uncertainty and urgency, the absence of family support, and the [barriers of personal protective equipment \(PPE\)](#). Where possible, proactive advanced care planning (ACP) should occur with high-risk patients, the frail, those in residential care and those with significant underlying morbidities. If ACP conversations happen prior to COVID infection they may involve known health providers and carers, and not be hampered by PPE.

2. Palliative care

Scaling up palliative and hospice care is an essential component of the COVID-19 pandemic response. [Avoiding non-beneficial or unwanted high-intensity care](#) is critical when health systems capacity is stressed. [Rapid palliative care policy changes were implemented in Italy](#); including more support in community

settings, changes in admission criteria, and daily telephone support for families. Attention must also be paid to [threatened supply lines](#) for essential medications for sedation and pain management.

3. Communication

The pandemic response needs to include COVID-19 communication teams. Less than half of ICU physicians—([40.6 % in high income countries and 46.3 % in low-middle income countries](#)) feel comfortable holding end-of-life discussions with patients' families. With ICUs at capacity and health providers under extraordinary pressure their capacity to effectively support end of life decisions and to ease dying will be reduced.

Communication teams must include people with skills to care for diverse populations – particularly those most vulnerable to the inequitable impact of a pandemic. These include: interpreters, social workers, disability advocates and cultural support officers for ethnic and religious minorities.

Conclusion

The equity implications of ICU allocation policies are important, but so too is recognition that ICU admission may exacerbate and prolong suffering rather than ameliorate it. The capacity for harm as well as benefit, should be emphasized in triage tools and debates.

Paper title: Be careful what you wish for: ICU is no panacea [*Under preparation for the Journal of Medical Ethics*]

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Acknowledgements: We would like to thank Owen Schaefer for helpful comments.

Competing interests: None declared