

## Intensive care resource allocation: when difficult choices have to be made

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Resource allocation in medicine applies to two complementary levels of care. One pertains to the organisation of public health and the provision of general rules informing the management of the system (macro-allocation). On the other hand, there is the need to specify decision criteria for the daily practice of health care providers who have to decide on the utilisation of their allocated resources, while dealing with a demand that often exceeds supply (micro-allocation).<sup>1</sup>

Beneficence, i.e. acting for the good of the patient, is one of the founding values of traditional ethics in medicine. However, the picture has changed when the core value of medicine shifted toward the centrality of the human person and the ideal of self-determination. The patient is now a 'health care user' who consults a professional whose knowledge and expertise is used in order to arrive at options. Good medical practice seems the result of a 'contract bargaining', which must take into account different criteria: clinical indication, patient preferences and subjective values, and appropriateness within the social context. Controlling how these three elements interact with each other requires a constant commitment and synchronised interventions.<sup>2</sup>

For cultural reasons, physicians consider, quite rightly, the costs of their interventions to be incommensurable with the life and the restoration to health of the diseased person. The most difficult problem in the distribution of resources remains the finding of convincing criteria to provide guidance, when often painful choices have to be made in the face of inadequacies in the availability of resources.<sup>3</sup>

Intensive care is one of the most expensive specialities of medicine and intensive care beds nowadays represent a limited resource.<sup>4, 5</sup> The lack of beds is a daily problem in many ICUs<sup>6, 7</sup> and bed allocation has been considered one of the thorniest and stressful aspects of the intensivist's job.<sup>8</sup> Studies have shown that resource use is often inefficient in European ICUs. One of the main reasons for this inefficiency has been identified as nursing force "waste".<sup>9</sup>

Monitoring and support of deficient vital functions are the main aims of intensive care. Usually, intensivists carry out the adequate diagnostic procedures and necessary medical and

surgical treatments required to improve patient outcomes. There has been a considerable international effort to define the ethical, clinical and economical criteria for admission to ICU and to draft the relevant guidelines. The fundamental point is that resources should be utilised appropriately, i.e. that the patient be of the right category, in the right place and at the right time. Furthermore, ethics dictates that resources be allocated where they are more likely to make an impact.<sup>10-13</sup>

ICU admission and discharge can be ruled by means of a priority scale which classifies patients based on the expected benefit to result from intensive treatment.<sup>14</sup> However, while it may be relatively easy to create "on-paper" scenarios affirming that patients who are too critical or not critical enough to benefit should not be admitted to intensive care, identifying these patients in everyday practice is far from simple.

As far as a reasonable doubt may be considered regarding the irreversibility of the clinical status, it is appropriate to initiate or continue intensive treatment. On the contrary, if the irreversibility of the clinical setting is deemed to be reasonably certain, it is appropriate not to initiate or to withdraw intensive measures to spare the patient the undue prolongation of the dying process. Excessive treatment is ethically unfair and should be strongly condemned, because it determines an inappropriate use of the means of treatment; it is likely to cause harm and pain to the patient and fails to respect the patient's dignity in death. Excessive treatment also increases the suffering of family members, is frustrating for care providers and generates an inequitable distribution of resources by curtailing them for other patients. The withdrawal of an intensive treatment, which was previously initiated because deemed to be indicated and accepted, or because the patient's clinical status and relevant prognosis were not clear enough at the time, should be considered whenever the clinical picture counter-indicates treatment continuation, the patient withdraws consent, or a previously defined therapeutic limit is reached.<sup>15</sup>

Immortality has always been an ambition for human beings. Today's medicine appears to be instrumental in dealing with this type of issues by making promises that will be hard not to break. The most urgent form of action to be undertaken regards these unwarranted expectations that society holds about the

efficacy of medicine. The message to put across ought to be that death is inescapable and that the most severe diseases are incurable.

Once the inevitability of resorting to often dramatic measures in today's health care system is postulated, we are confronted with the problem of finding an ethical justification to subsequent decisions. On the basis of the choices made necessary by the paucity of available resources, medical treatment would be "apportioned", i.e., distributed according to commitments and rules, with the inevitable exclusion of some from the utilization of the services themselves.

Rationalisation, intended as best utilisation and fair limitation, is an economic necessity, juridically and ethically legitimate. The ultimate objective must remain that of equitable apportionment.

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#### Competing Interests

None declared

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