SIAARTI
Italian Society of Anesthesia Analgesia Intensive Care and Intensive Care

RECOMMENDATIONS OF CLINICAL ETHICS FOR ADMISSION A INTENSIVE TREATMENTS AND FOR THEIR SUSPENSION, IN EXCEPTIONAL CONDITIONS OF IMBALANCE BETWEEN NEEDS AND AVAILABLE RESOURCES

Working group Marco Vergano, Guido Bertolini, Alberto Giannini, Giuseppe Gristina, Sergio Livigni, Giovanni Mistraletti, Flavia Petrini

Version: Clinical ethics recommendations for admission to intensive treatments and for their suspension, in exceptional conditions of imbalance between needs and available resources - version 01
Published on 06.03.2020

UNOFFICIAL translation by Barbara Borgatta.

Original document can be found at: http://www.siaarti.it/SiteAssets/News/COVID19%20-%20documenti%20SIAARTI/SIAARTI%20-%20Covid19%20-%20Raccomandazioni%20di%20etica%20clinica.pdf

Unofficial translation

The predictions of the Coronavirus epidemic (Covid-19) currently underway in some Italian regions estimate an increase, in many centres, in cases of acute respiratory failure in the next few weeks (with the need for ICU admission) of such magnitude as to cause an enormous **imbalance** between the **real clinical needs** of the population and the **effective availability** of intensive resources.

It is a scenario where **criteria for access** to intensive care (and **discharge**) may be needed not only strictly **clinical appropriateness** and **proportionality of care**; but also inspired to a criterion, as shared as possible, of **distributive justice** and **appropriate allocation of limited resources healthcare.**
A scenario of this kind can be substantially assimilated to the field of "disaster medicine", for which ethical reflection has over time developed many concrete indications for doctors and nurses engaged in difficult choices.

As an extension of the principle of proportionality of care, **allocation** in a context of **serious shortage of healthcare resources** must aim at guaranteeing intensive treatments to patients with greater chances of therapeutic success: it is therefore a matter of **favouring the "greatest life expectancy "**.
The **need for intensive care** must therefore be integrated with other elements of "clinical suitability" to intensive care, thus including: the type and severity of the disease, the presence of comorbidities, the impairment of other organs and systems; and their reversibility.
This means not necessarily having to follow a criterion for access to intensive care like *"first come, first served"*.

It is understandable that the carers, by culture and training, are not accustomed to reasoning with criteria of maxi-emergency triage, as the current situation has **exceptional characteristics.**
The **availability of resources** does not usually enter the **decision-making process** and the choices of the individual case, until resources become so scarce as to not allow treating all patients who they could hypothetically benefit from a specific clinical treatment.

It is implicit that the application of rationing criteria is **justifiable** only after that by all the subjects involved (in particular the "Crisis Units" and the governing bodies of hospital facilities) all possible efforts have been made to **increase the availability of resources** existing (in the in particular, Intensive Care beds) and after **assessing any possibility of transfer** of the patients to centres with greater availability of resources.

It is important that a **modification in access policies** could be **shared** as much as possible among the **operators** involved.
Patients and their families interested in applying the criteria must be informed of the **extraordinary nature** of the measures in place, due to an issue of duty of candour and maintenance trust in the public health service.

The **purpose of the recommendations** is also that:
(A) to relieve clinicians from a part of **responsibility** in decisions, which can be emotionally burdensome, carried out in individual cases;
(B) to make the **allocation criteria** for healthcare resources explicit in a condition of their own extraordinary scarcity

Unofficial translation

From the information available now, a substantial part of subjects diagnosed with infection from Covid-19 requires **ventilatory support** due to **interstitial pneumonia** characterized by **severe hypoxaemia**. The interstitial disease is potentially reversible, but the acute phase can last many days.

Unlike more familiar ARDS cases, with the same hypoxemia, Covid-19 pneumonia appears to have slightly better lung compliance and respond better to recruitment, medium-high PEEP, proning cycles and inhaled nitric oxide. As for the most well known ARDS cases, these patients require protective ventilation, with low driving pressure.

All this implies that the **intensity of care** can be **high**, as well as the use of human resources. From the data for the first two weeks in Italy, about one tenth of infected patients require **intensive care treatment** with assisted ventilation, invasive or non-invasive.

Unofficial translation

RECCOMMENDATIONS

1. The **extraordinary** admission and discharge **criteria** are **flexible** and can be **adapted** locally to the availability of resources, the real **possibility of transferring patients**, the **number of accesses** in progress or expected. The criteria apply to **all intensive patients**, not only to patients infected with Covid-19 infection.

2. Allocation is a complex and very delicate choice, also due to the fact that an excessive increase in extraordinary intensive care beds would not ensure adequate care for individual patients and would divert resources, attention and energy to the remaining patients admitted to Intensive Care. It is to be considered also the foreseeable increase in mortality due to clinical conditions not linked to the on-going epidemic, due to the reduction of surgical and outpatient elective activity and the scarcity of intensive resources.

3. It may be necessary to place an **age limit** on entry into ICU. It is not a question of making choices merely of value, but to reserve resources that could be very scarce for those who are in the first place **more likely to survive** and secondarily to those who can have **more years of life saved**, with a view to **maximizing benefits for most people**.
In a scenario of **total saturation** of intensive resources, to decide to keep a criterion of *"first come, first served"* would equate to choose not to treat any possible subsequent patients that would be excluded from Intensive Care.

4. The **presence of comorbidities and functional status** must be carefully evaluated, in addition to chronological age. It is conceivable that a relatively short illness **course** in healthy people will potentially be prolonged and therefore more resource consuming of health services in the case of **elderly, frail or patients with severe comorbidity**.
It can be particularly useful for this purpose the **specific and general clinical criteria** presented in the 2013 multi-society SIAARTI Document on **major end-stage organ failure** (Https://bit.ly/2Ifkphd).
It is also appropriate to refer also to the SIAARTI document relating to the admission criteria in Intensive care (Minerva Anestesiol 2003; 69 (3): 101–118).

5. Distinctive consideration must be taken into the possible presence of **advanced directives** for refusal of treatments (previously expressed by the patients through anticipated treatment provisions) and, in particular, as defined (together with the carers) by people who are already going through **shared care planning** of chronic diseases.

6. For patients for whom access to an intensive course is deemed "inappropriate", the decision of establishing **ceilings of care** should be in any case **justified, communicated and documented**. **The ceiling of care placed before mechanical ventilation must not preclude intensity of inferior care.**

7. Any **judgment of inappropriateness** in accessing intensive care based **solely** on criteria of distributive justice (**extreme imbalance** between demand and availability) finds justification in the **extraordinary situation**.

Unofficial translation

8. In the decision-making process, if situations of particular difficulty and uncertainty arise, it can be useful to have a **second opinion** (possibly even only by phone) from spokespersons of particular experience (for example, through the Regional Coordination Centre).

9. The **criteria for access to Intensive Care** should be discussed and defined for each patient in the most **anticipated** possible way, ideally creating in time a list of patients who will be deemed worthy of Intensive Care at the moment in which the clinical deterioration occurred, provided that the availability at that moment allow it.
Any **do not intubate order** should be present in the medical record, ready to be used as guidance if clinical deterioration occurs precipitously and in the presence of caregivers who have not participated in the **planning** and who do not know the patient.

10. Palliative sedation in hypoxic patients with disease progression is considered necessary as an expression of good clinical practice, and must follow existing recommendations. In the case of an expected non-short agonic period, **transfer to a non-intensive environment** must be provided.

11. All accesses to intensive care must however be considered and communicated as an **"ICU trial"** and therefore undergo **daily reassessment of appropriateness,** of the goals of care and proportionality of care. If it is considered that a patient, perhaps admitted with borderline criteria, does not respond to prolonged initial treatment or develops a severe complication, a decision of **"withdrawal of care"** and adjustment of **care from intensive to palliative** - in a scenario of exceptionally high influx of patients - should not be postponed.

12. The **decision to limit intensive care** should be discussed and **shared,** as **collegially** as possible, amongst the treating team and - as far as possible - in dialogue with the patient (and relatives), but must be able to be **prompt**. It is foreseeable that the need to make such decisions repeatedly in each ICU will make the **decision-making process** more robust and with enhanced adaptability to the available resources.

13. ECMO support, as it is resource consuming compared to an ordinary ICU admission, in conditions of extraordinary influx, should be reserved for extremely selected cases and with relatively rapid weaning forecast. It should ideally be reserved for **hub centres with high volume** of patients, for which the patient in ECMO absorbs proportionately fewer resources than they would absorb in a centre with less expertise.

14. It is important to **"network"** through the aggregation and exchange of information between centres and individual professionals. When the working conditions allow it, at the end of the emergency, it will be important to dedicate time and resources to **debriefing** and monitoring for professional **burnout** and **moral distress** of operators.

15. Considerations should be made regarding the **effects on relatives** secondary to patient's admission to the Covid-19 ICUs, especially in cases in which the patient dies at the end of a total visit restriction period.

Unofficial translation

-- END OF DOCUMENT --