



PANDÉMIES, ÉTHIQUE, SOCIÉTÉ



Priority setting for access to intensive care: a German perspective

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Putting figures on a potential exceptional demand for care

Bogen is a German town of 10,111 inhabitants. There are 4 hospitals and 2 emergency centres for a total 426 hospital beds in our district (Straubing-Bogen). We own therefore 4.4 hospital beds for 1,000 residents.

On the regional (Regensburg's region) level, we count 7 beds for 1,000 inhabitants. About 5 % of hospital beds are ICU beds. In critical care units, 72 % of beds are coupled with ventilation capacities.

Germany has established a national preparedness plan.

Following a quite moderate scenario, about 30 % of the population could be infected by a variant flu virus. Even by resorting to antiviral therapies to reduce hospitalisation by a half, roughly 3 % of the 13 million seriously ill people would need hospital care.

Following our national pandemic preparedness plan, we will have to adapt our hospital to increase our capacities. An estimate ranging from 185 000 to 215 000 extra admissions has been put forward.

To our national plan, for an amount of population of 100,000 residents, coping with a pandemic exceptional demand would mean adding:

-75 conventional extra beds;

-22 ICU beds;

-11 ventilator beds.

Hospitals would have to care for 12 % more patients than usual. Our national plan stated that hospitals would provide special support for pandemic patients. Thus, they will have to be identified. Then some healthcare workers will have to specialize in flu pandemic care...

An ICU unit would have to accommodate some 60 % more patients than they usually do. But it would have 30 % less collaborators. Of course doctors and nurse are not immunized against flu. And many healthcare workers would be tempted to stay home. Thus ICU units would probably have to work with only half their staffs

Critical care has a cost

In case a major flu pandemic happened, ICU ventilation capacities would be rationed. Disaster medicine knows well what rationing is. And one can doubt rationing would be the key difficulty during a pandemic situation.

In hospitals today, we are increasingly required to take the cost of care into account. This command has caused a sort of chronic conflict of interests. Doctors are expected to provide to their patients with the best chances of recovery or survival. Some specific therapies are very expensive. Their costs significantly exceed the average amount of money spent on “usual” diseases. An ICU unit is able to provide care as long as it has not run out of money. It is our duty as doctors to maintain access to care for the largest number of patients possible. And we won't be able to do so if one or two very specific cases have led the unit to bankruptcy because of exceptionally expensive therapies. We have economic grounds to be concerned with regarding ethics and we should not take for granted that money issues would not be relevant. That's why regulation authorities should raise money to support healthcare to deal with a pandemic state.

Will a rule of justice save us?

How will we cope with pandemic from an ethical point of view? Will we solve dilemmas with checklists? It is certain that we won't. It does not make sense to establish lists of criteria to deal with situations and prioritization. We should better highlight the crucial role of the doctor who will have to take the decision to give care to someone and to deny it to someone else.

Of course, to help us, we can resort to principles (utilitarianism, rules of justice, quality of life assessment grids etc.). But if hospitals are full and many people need care facilities outside their walls doctors will face the question: what is ethically acceptable? Doctors will have to decide. They won't pass the responsibility for their own decisions taken at patients' bedsides to others. In other words, in a pandemic situation I will be the one to decide who gets the best possible medicine and care in Bogen, namely:

- who gets help and be cured of severe disease;
- who may get help in avoiding pain and suffering;
- who is allowed to get the best possible recovery;
- who will get a humane (intensive) care.

Many arguments will have to be considered. Cost effectiveness is one of them. Quality of life is potentially another. Following egalitarianism, everybody should have the same chances of survival. Libertarianism's perspective is opposed to the previous one. Will doctors have to “choose a philosophy”? And once they have, should it directly be applied at a patient's bedside?

Referring to “cost effectiveness” is a way to avoid endless debates on principles. Efficiency in resources allocation should be the rule. Given that, do ethics matter? Cost effectiveness procedures are just aimed at comparing calculation process results. Depending on cases, relative expenditures are compared to reach a same outcome: saving a life. All involved scores put a value on human life.

A cynical way to establish priorities lie in the recognition that in fact, all individuals do not have the same chances. Circumstances and individual histories tend to concretely privilege some people over others. At this point, we should notice that in a pandemic situation even privileged countries would have to learn that underprivileged patients exist.

All we can recognize is that treating only the most promising patient is unacceptable. We cannot toss a coin to select who has got to die. The prospect of gain and profit must not determine the effects of supply and demand in healthcare. It does not tell us how we will be able to act ethically in extreme situations.

Regulators should confess than the ethics of local decisions makers will matter far more than national guidelines

A pandemic occurs in a social and a cultural context. Healthcare procedures and related expenditures are set by the whole society. Thus, when rationing cannot be avoided it has to determine what is acceptable and what is not, especially when economic grounds are involved¹. It is a community’s duty to clarify the grounds of an ethics of rationing, considering the fact that doctors will be committed to concretely answer to the question “who is to live and who is not to live?”

The most difficult decisions are not abstractions: they are embodied in the people who take them. That’s why regulatory bodies should focus their reflexion on the support of those who will concretely decide in such a sensitive matter. To tackle a pandemic flu, we need social confidence and an effective ethical background embodied in physicians. These two key elements matter far more than writing national guidelines.

Doctors will talk to patients’ relatives to explain the reasons of a treatment denial. They won’t recite a list of items extracted from a checklist. Obviously, doctors must act on scientific grounds. What they do must be evidence-based. Nevertheless, they have to be responsible for what they do in each particular case. There is no point in denying this face to face responsibility.

What is at stake with the appliance of checklists? Does it mean that we will have to tell patients we refuse them because they match only 5 criteria out of 6? A doctor has no escape when he faces extreme situations. He should never hide himself behind checklist items. In a pandemic situation, we will need responsible doctors who must be helped to think ethically. To cope with the concrete dilemmas a pandemic flu would cause, ethics must be taught. To some extent, a pandemic flu would socialize medicine. Such an event would require from us to explicit the grounds of our economic and ethical conceptions. In a pandemic, not only scientists and economists will be in the frontline but mainly doctors.

1 Meyer HJ. Expensive new therapy and finite resources: An ethical dilemma for doctors and scientists. Radiotherapy and Oncology , 81: 3 (2006) 227-230