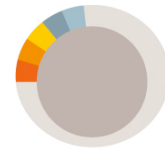


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Ethical Challenges for Critical Care

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The questions we are raising have no simple answer. In 2005, I read a NHS emergency planning guidance project raising a prediction of a potential 50 000 pandemic-related deaths, with no mention of critical care issues. We had to work on a document dealing with such issues. At the end of a tricky process, after many months of work, we managed to release a dedicated document in 2006.

The perspective of a lack of critical care capacity can not be ruled out. The main problem we may face – apart from equipment and facilities shortage – basically involves staff. The key uncertainty lies in the proportion of healthcare workers who would not come to work in a pandemic situation. We have no means to predict exactly how people would react. The morale of staff is a parameter which importance should never be underestimated. Trust could be the only reliable asset in pandemic time. It is somewhat hard to explain to planning committees. It is quite uneasy to expose why individuals will comply with their own professional duties and why they will ignore them. In other words, why should you put your own family at risk?

A very interesting study was conducted in New York, to assess the willingness of a sample of 6,428 healthcare workers to report to work in various circumstances. It was established that 48 % of them would be willing to report to work during a SARS outbreak. No equivalent survey was conducted in the UK. But it is certain that one of the lessons we must keep from the SARS epidemic is the crucial importance of staff confidence.

Critical care triage: which cardinal principles to retain?

If you want something done, you have to produce a draft document. At least, you come with a ready starting point for discussion. And when we produced critical care pathways of action to face a pandemic flu, we made a starting point explicit: *“Nevertheless, and however controversial, in escalation towards ‘worst case’ scenarios increasing age, chronic disease and comorbidities may have to be accepted as appropriate triage criteria in addition to the more conventional ones of severity of illness or injury, inevitability of severe disability, or irrecoverability.”*

The discussion about the ethical principles that must remain safe in a pandemic time was not a soothe one. Indeed much tension was raised when we had to link the impact of a pandemic state with a plan to tackle it. Clearly, people disagreed and we had to dissipate some kind of trouble. I made a mistake when I said in a meeting of the clinical advisory group for pandemic influenza: *“if there is only one ICU bed and the choice is between a 9 year old and a 90 year old I don’t think any of us would have any difficulty making this decision”*. Of course, this way of reasoning is unacceptable. We retained a principle to shed ethical light in our discussion process. It was: *“the greatest good for the greatest number”*. It is derived from emergency planning cases. It must be noticed that this sentence is not consistent with an ethical framework needs as it does not take fairness into account. Thus it should not appear in any guidance.

As an alternative, we set this guiding rule: *“the priority is to reduce the impact on public health, i.e. to reduce illness and save most lives in a way that is fair and in accordance with the ethical framework”*. Maybe we did not change much but the *Ethical framework for policy and planning responding to pandemic influenza* was approved by the Department of health of the Cabinet Office.

Preparedness on papers is easy

Reading this document, nothing looks questionable. Everyone matters. Moreover, everyone matters equally, which does not mean that everyone is treated the same. The interests of each person are the concern of us all, and of society. And the harm that might be suffered by every person matters, so minimising the harm that a pandemic might cause is a central concern. A large set of individual principles were mentioned. Nevertheless, they do not differ from those that must be applied in the usual medical practice. Maybe what has to be published in the ideal political world does not leave any room for polemics.

Nevertheless, considering disaster scenarios (take the London bombing for an example) we cannot miss the huge gap between what is proclaimed and reality. It is not easy to put the stress on such a painful point.

The real dilemmas we risk to encounter

A few months ago, a draft was released, called: *Pandemic influenza, surge capacity and prioritisation in health services*. It refers to the SOFA score, devised to assess patients’ need for critical care in an influenza pandemic. Triage criteria are proposed to distinguish those who will benefit from critical care units resources from others who won’t. Such a score brings some progress in the discussion aimed at providing guidelines to ICUs. Nevertheless, it should be perceived as a starting point. Imagine that about 550 patients require ventilation and that roughly 50 beds are available. A SOFA scale processing would only reduce the group of potential beneficiaries by a third... In other words, we would have 7 “appropriate” patients queuing for a single bed. Then how will we decide? How will we match the ethical criteria we ideally want to preserve? Lottery could be the only way to allocate scarce resources if we are inconsistent and failing in our preparedness. But neither lottery nor ICU closure are acceptable from an ethical point of view.

We all call for the compliance with principles such as openness, transparency, inclusiveness, accountability, reasonableness. At this point, doctors’ responsibility has to be questioned. What will they do, facing impossible choices? If they had to give priority to someone, someone would always accuse them for that. Thus doctors, whatever they do, will be guilty. This is somewhat paradoxical as they would be at the leading edge of the “fight” against a pandemic. In order to illustrate how the stark circumstances could challenge us, we should look at what happened to Dr. Pou in New Orleans. She had to abandon patients in the town hospital due to the hurricane. Disasters can change all care

parameters and let us in the front of impossible situations. We would be damned if we do and damned if we don't. Now, we must properly consider the nature of professional risks on ethical and legal grounds. We need assurance that clinical staff will not face professional criticism or litigation for providing the best care they can under very difficult circumstances. Eluding these issues, many staff members may finally have to vote with their feet.