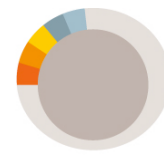


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PANDÉMIES, ÉTHIQUE, SOCIÉTÉ



Who should get care?

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A growing concern about ethical issues related to critical care in France

When we try to figure what a pandemic flu could mean, we are led to look at predictions that put forward millions of deaths. One of our main concerns is potential denial of care in ICU units. We have no experience of a massive pandemic and all we can do is drawing a parallel with what happened in 1919. Can we really accept a perspective of intensive care restriction? Rationing could be intensive care's fate¹. In ethics, triage criteria are a highly debated matter.

France set a pandemic preparedness plan a few years ago². Its content inherited from previous reflexions on SARS and bioterrorism and it contains an ICU section.

On the basis on the conclusions drawn following various models, doubling the French ICU capacities was suggested as a mean to tackle a flu pandemic.

A dedicated task force was entitled to establish recommendations. The French society of intensive care medicine was part of it, in collaboration with other professional associations. Recommendations were written in 2006, but only briefly addressing ethical issues. Many hospitals are expected to be transformed in order to face pandemic. One of the main goals of hospital plans consists in separating flows of infected patients from non infected patients. Specific ("red") areas will be dedicated to flu patients' care. Of course, we have no idea about the relevance of our plans to deal with extreme circumstances.

¹ R. Truong. Rationing in the intensive care unit. Crit Care Med 2006; 34:958-93).

² Organisation des soins en situation de pandémie grippale, fiches de recommandation. 1^{ère} édition, avril 2006.

Ethical issues were raised at governmental level. An advisory board was appointed in March of 2006. Various ethical considerations were listed and addressed, which are quite similar as those exposed in the published WHO document. The first French national conference “Ethique et pandémie grippale” took place on September 15th of 2006. One of its topics was triage procedures. Stockpiles of vaccines and antiviral drugs matter. But triage in ICU deals merely with survival and death.

Do we have a rationale to avoid lotteries in critical care units?

Triage is very common in ICU. Nevertheless, it is usually based upon beneficence. Mass disaster triage is limited both in the space and duration, and generally occurs “on the field”. Over and above, lack of ICU beds occurs only occasionally and affects elderly or debilitated patients...

When triage is put forward, it raises a conflict between utilitarianism and equity. We have to maximize a sort of global outcome but we must not put aside all ethical norms of fairness. In other words, some fundamental principles should remain safe. Several papers have been written to shed some light on such dilemmas³.

How can we rationally deal with them? We own assessment grids of the physiological state of a patient. The SOFA score has been shaped to infer rules of action from physiological parameters. Following this score and some threshold values patients will benefit from critical care units facilities or won't⁴. Moreover, depending on the evolution of the score of ventilated patients, it will be decided to pursue or to give up ventilation. Progress in SOFA score is thus translated into an increase in survival chances.

However, is there some direct link between individual scores and predictability of patients' outcomes? It would be unwise to say so. And we should quote Norman Daniels to put the right stress on what is at stake with the SOFA score: “since we are not able to construct principles that yield fair decisions ahead of time, we need a process that allows us to develop those reasons over time as we face real cases. The social learning that this approach facilitates provides our best prospect of achieving agreement over sharing medical resources fairly.”⁵.

Before setting a national “framework” or a national “strategy”, we must have a debate on the acceptability of the measures which could be involved. A deep discussion must take place among healthcare workers. We should keep in mind that in Toronto, 40% of infected people were healthcare workers, many of them working in critical care units. An individual beneficence culture prevails and appropriation of utilitarianism would require much education and debate. Moreover, healthcare workers' motivation should not be overestimated.

If preparedness local implantation requires a national framework, an effective international coordination would make things easier for all. Only education and debate will lead people to integrate preparedness plans. Lastly, pandemic flu should be prevented because it is the only way to spare us awful situations and their related ethical dilemmas.

³ For example: Melnychuk RM, Kenny NP. Pandemic triage: the ethical challenge. CMAJ. 2006;175(11):1393. Michael D. Christian.

⁴ Development of a triage protocol for critical care during an influenza pandemic. CMAJ 2006;175(II):1377-81.

⁵ Norman Daniels. Accountability for reasonableness, 25th of November 2000.