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EDITORIAL

# Deciding on ICU admission

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During the COVID-19 pandemic, which has affected hundreds of millions of people worldwide, the number of patients in need of intensive care was enormous and much higher than the routinely available capacity of ICUs in most countries. Despite increasing the number of ICU beds and despite an almost complete standstill of normal planned healthcare, a feared but realistic scenario was that patients in need of intensive care would have to be denied admission, even if they were dependent on mechanical ventilation to survive. Therefore, many countries have developed procedures and guidelines for situations when the demand for ICU beds is more than the maximum capacity. This is a very difficult process involving medical, ethical and political choices.

In this issue of the Netherlands Journal of Critical Care, Abma and co-authors present an important study comparing nine guidelines on triage decisions from ten different countries.[1] While guidelines from all the countries were based on the principle of maximising benefits from the available capacity, there were important differences. According to the authors, the guideline from the Netherlands was one of the most clearly operationalised documents, providing clear criteria to decide on which patients would or would not be allowed treatment in the ICU. This is very important. In situations where triage is necessary, doctors will be faced with impossible decisions to make, such as when only one bed is available for two patients, both with realistic chances of survival if treated with mechanical ventilation. In such circumstances you need a document with clear and unequivocal criteria to base your decision on. While the Dutch guideline was judged as being one step ahead of many other countries, the true value of a triage guideline can only be known if it is really used in actual care. In the Netherlands, we never reached the situation in which triage was necessary. Consequently, it is not fully known whether the Dutch guideline was indeed well operationalised and if healthcare workers would follow it when necessary or use other criteria to base their decisions on.

Remarkably, age itself was not a ground to choose between patients in circumstances of triage in any of the guidelines. This is also true for the Dutch guideline, although some priority is given according to generation, i.e. a categorisation of age. Examples of generations are age 40-60 years and 60-80 years. It is hard to understand why it is not allowed to choose a 61-year-old patient over an otherwise comparable patient aged 79 years. The life expectancy of older patients is less than for younger patients and consequently, from the perspective of maximising benefits, it would be better to give younger patients priority. However, in the Dutch guideline, the likelihood of surviving the illness is used as a criterion, not the expected numbers of life-years gained. Indirectly, it is possible to prioritise younger patients within the guideline, for example by the assessment of frailty. As the triage guideline has never been used in practice, we do not know how age would affect triage decisions in practice.

Interestingly, Abma and co-authors did not refer to COVID-19 in the title of their paper. We can only speculate why they choose not to refer to the Corona-virus pandemic. An explanation could be that in situations when triage is necessary, the reason for ICU admission should not influence the triage decision. In other words, patients with respiratory failure due to COVID-19 should have neither more nor less priority for ICU admission than a patient with sepsis or a ruptured aneurysm. While this is a fair way of deciding on ICU admissions, this could be hard to do in practice. During a pandemic, ICUs are divided into units with isolation precautions and units without isolation. In a period when triage is activated, what should be done if an ICU has only one available ICU bed in the non-isolation unit and two patients, one with COVID-19 and one other patient?

In those circumstances, it is inevitable to use separate triage criteria for COVID and non-COVID patients.

Despite the uncertainty about how the guideline would be used in actual practice, the Dutch guideline on triage decisions is a very valuable document. It provides guidance and very practical rules to doctors and nurses on how, during pandemics, to deal in a fair way with situations when we have to deny ICU admission to patients with death as the likely result.

However, a lack of capacity on ICUs due to overwhelming demand during a pandemic is not the only situation where healthcare workers need guidance on this topic. There are other situations when we have to make decisions on ICU admission, even if capacity is sufficient. Even in situations when patients are critically ill and when the risk of death is real, ICU admission is not always the best option for all patients. Sometimes it is better to withhold ICU treatment. Some patients prefer palliative care aiming at comfort and quality of life over intensive treatments aiming at prolonging survival. We can do more on counselling patients and their relatives and involving them in shared decision-making.[2] But it is not only a decision to be made by patients or their relatives. Sometimes, doctors and nurses should decide on withholding ICU care, even if patients do want it. Too often, ICU treatment is considered the default option in all patients who are vitally endangered. But how much do we add to the happiness of our society if we spend very large amounts of money on only prolonging life for a very limited duration? Doctors should not only consider the likelihood of survival, the number of life-years saved and the chances of good or reasonable functional status after ICU, but also the economic costs of that treatment in relation with the expected benefits. Money spent on intensive care is always at the cost of other important activities. These could be either medical, or non-medical such as education, climate and poverty. These choices are difficult to make. Maybe we need a document like the triage guidelines, made with medical, ethical and political input, on what the ICU is meant for.

## Disclosures

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## Reference

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