

The case for legislation: explicit rather than implicit rationing (who gets into the ICU and who doesn't)

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TO THE EDITOR: Decisions at times of uncertainty are difficult, especially when there are limited resources and opportunity cost. In critical care, this translates as, "who gets into the intensive care unit and who doesn't?". The ICU is commonly full but, despite it containing patients with limited lifespans, we cry, "we need more beds!".

This mindset, unchecked, would consume all the nation's resources with ever-expanding ICUs. Hospital bed shortages, waiting lists and Pharmaceutical Benefits Scheme restrictions are forms of implicit rationing; a response to the economic problem of unlimited desires and limited resources. With limited numbers of ICU beds, the clinician is in the unenviable position of having to make rationing decisions. Is this fair or right? Shouldn't the community, by way of its representative government, have some say in who gets admitted and who doesn't?

It is proposed that the College of Intensive Care Medicine undertake discussions with government on explicit rationing and legislation that determines who gets offered an ICU bed and who does not. Innovative policy would diminish pressure on beds and gatekeeper clinicians, while directing more care to those most likely to have better long-term outcomes.

The Queensland Government implementation guidelines for end-of-life care acknowledge the relevant concept:¹ "the tension between ... government knows best; ... patient knows best; ... and ... medical officer knows best." Currently, "government" is silent on who gets into the ICU and is ambiguous about what constitutes futile care; a surprisingly tricky issue. Willmott and colleagues² and others³ encapsulate the confusion. Does futile care mean care that will not work, or will not achieve survival for x, y or z days or months, or does it simply mean care not worth implementing? Ultimately, all care is futile; eventually everyone dies. So how much survival is *not* futile?

This discussion is not about withholding futile treatment but expanding this to a broader concept. There are significant ethical hurdles, but let us imagine:

- withholding admission to the ICU when the standard mortality ratio exceeds a fixed percentage, or when the patient has achieved a fixed percentage of life expectancy

- an oncological model in which the patient has less than an x% chance of 5-year survival
- withdrawing care when a patient's progress in the ICU deviates from a partogram-like line.

These are controversial ideas. Ethicists and well meaning clinicians will protest. However, be mindful of the limited resources and the opportunity cost. We must pursue better allocative efficiency, and not allow ever-expanding ICUs to treat patients with ever-more marginal prospects.

Predicting individual outcomes is problematic, but the fact remains that when the chances of survival are stacked against a patient, it is inefficient to unnecessarily spin the wheel of chance when there are better bets lining up.

How can this be progressed? Critical care is invasive and costly, but how many ICUs can provide their 5-year survival figures? Can they provide them by age, scoring system, surgical or medical outcome, or useful combinations of all? This information should be available.

With many patients and limited facilities, decisions must be made. This is where firm clear guidelines from governments would help. If some rationing decisions could be explicitly made, this may ease some of the heartache for patients, families and clinicians.

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- 1 Ethics Team, Clinical Policy Unit, Centre for Healthcare Improvement. Implementation guidelines — end-of-life care: decision-making for withholding and withdrawing life-sustaining measures from adult patients, part 2. Brisbane: Queensland Health, 2002. <https://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-005-1-2.pdf> (accessed Jan 2016).
- 2 Willmott L, White B, Downie J. Withholding and withdrawal of "futile" life-sustaining treatment: unilateral medical-decision making in Australia and New Zealand. *J Law Med* 2003; 20: 907. http://advancecareplanning.org.au/library/uploads/documents/Willmott_White_Downie_-_Unilateral_futile_life-sustaining_treatment_decisions_in_Australia_and_New_Zealand_-_published_by_JLM.pdf (accessed Jan 2016).
- 3 Helft PR, Siegler M, Lantos J. The rise and fall of the futility movement. *N Engl J Med* 2000; 343: 293.