

# Coronavirus may put ICU beds in short supply—but that doesn't mean the elderly shouldn't get them

April 6 2020, by Paul Komesaroff, George Skowronski and Ian Kerridge

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Credit: AI-generated image ([disclaimer](#))

Although recent encouraging news suggests [the rate of new coronavirus cases](#) in Australia is slowing, our medical facilities could still be overwhelmed at some point.

[One modeling study](#) has suggested that, if [public health measures](#) are not observed or do not work, demand for the existing 2,200 intensive care unit (ICU) beds in Australia will be exceeded within a few weeks. More [optimistic views](#) of our achievable ICU capacity would merely delay this event for a few weeks.

Critical [shortages of ICU beds](#) and other medical resources overseas have resulted in [large numbers of deaths](#). In these countries there have been vigorous debates about which of many eligible patients should be given access to care facilities in short supply.

This discussion is [now underway](#) in Australia.

For many clinicians, the question of who has access to limited ICU beds presents disturbing challenges, especially in view of a [widely disseminated proposal](#) that has gained [particular support in Italy](#). This bases decisions about who is granted access to ICU beds on calculations of the future years of life that could potentially be achieved through treatment (or, in some proposals, "quality adjusted" years of life).

This would deny access to people above a certain age as well as to people with disabilities and certain [medical conditions](#).

## **What is a person worth?**

This approach is deeply problematic.

It has taken many years for us to move away from judging the value or worth of a person by their age, race, sexual preference, physical ability, religion or other personal characteristics.

The [worst outrages of the 20th century](#) resulted directly from such approaches, which were [often claimed at the time](#) to be supported by

"ethical" justifications.

There has also never been a public discussion, and certainly there is no agreement, about whether the "ethical value" of a person can be calculated mathematically on the basis of the total number of years he or she might live.

The alternative, which has [been developed](#) and [routinely employed](#) in hospitals around Australia for years, applies a process of rigorous discussion about the potential benefits and burdens of treatments proposed for every individual patient, taking into account all relevant clinical features and whether acute problems can be overcome.

It entails a detailed analysis of technical issues and results. It involves open discussion with the patient, medical carers, family members, and expert ICU staff, about medical, social, emotional and ethical issues.

It embraces flexibility and a readiness to adapt and change protocols with changing circumstances. It takes into account the specific circumstances of individual patients' lives, including their personal preferences and religious and cultural beliefs.

It leaves aside personal characteristics not relevant to the medical decision at hand, such as race, gender, sexual preference and ethnicity.

## **Age can be relevant**

This is not to say that age can never be a relevant consideration. Indeed, in some conditions, advanced age is [closely linked](#) with the likelihood of a poorer response to a treatment.

Sometimes this is because increasing age is directly linked to age-related diseases that reduce the likelihood of a successful outcome from

treatment, such as [certain types of cancer](#).

At other times, for reasons that are much less clear, age itself [appears to predict poor outcomes](#) of treatment, leading to its inclusion in many scoring systems for predicting outcomes of treatment, including in intensive care and cancer care.

In both cases it is valid that age be taken into account in decision-making. It is also possible that age may be relevant to more philosophical considerations, for example, whether older people consider themselves to have already lived a "fair innings" or whether young people should be given the opportunity to live a life and gain their potential.

While these may also be relevant considerations, and be accepted by many, including sometimes by older people themselves, they are [much less clear and much more contested](#), and require ongoing debate.

The key point is that, even in these cases, age is never taken as a defining quality or characteristic of a person but rather as a potential signifier of other relevant characteristics or risk factors. Its relevance is linked to what it implies for the particular person, not to an assumption that old people have diminished value and are less worthy of treatment.

In extreme settings, time and resource constraints may add greatly to pressures on the decision-making process but the same principles still apply. In fact, it is exactly in these contexts that it is most important to resist resorting to criteria that are not founded on evidence or valid ethical arguments.

## **How do we respond?**

The ethical strength of a society is revealed in how it responds to serious challenges. If we have values worth defending, this is the time to fight

for them.

Most of us do not want to move to a society based on the arbitrary imposition of measures that discriminate against people on the basis of ethically or medically irrelevant [personal characteristics](#).

Future generations will judge us on how we respond to this crisis and whether we have been able to defend our core values. This is the time, perhaps more than any other, when we have to [keep our ethical nerve](#).

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