ETHICAL ASPECTS OF ACCESS TO INTENSIVE CARE IN A PANDEMIC CONTEXT

ASPECTS ETHIQUES DE L'ACCES AUX SOINS INTENSIFS EN CONTEXTE PANDEMIQUE

F. MEDHIOUB KAANICHE [1,3,*]; D. DLENSI [1,3]; F. ZOUARI [1,3]; M. ZRIBI [2,3]; D. BERKHAIS [1,3]; H. BEN HASSEN [1,3]; M. SMAOUI [1,3]; R. ALLALA[1,3] ET Z. HAMMEMI[2,3]

1 : Service universitaire de réanimation, Hôpital Régional Mahres, Université de Sfax-Tunisie.
2 : Service de médecine légale, CHU Habib Bourguib; Université de Sfax- Tunisie.
3 : Faculté de Médecine de Sfax ; Université de Sfax –Tunisie.

E-mail de l'auteur correspondant : fatma_kaaniche@yahoo.fr

Abstract

Introduction: The certification of health structures is closely linked to the evolution of the ethical approach.Case of ethical questioning: In an intensive care unit, fourteen beds are occupied by patients hospitalized for serious COVID-19 pneumonia. Only one bed is kept for an absolute emergency. A first patient, aged 68, with a history of overweight, hypertension, type 2 diabetes and COPD, presented with respiratory distress requiring intubation and mechanical ventilation. The second patient is a 40-year-old man with lung neoplasm in remission before COVID-19 infection. He also presents with respiratory distress requiring intubation and mechanical ventilation. Which patient should we prioritize? Discussion: ethical reflection finds its full justification at the heart of intensive care services, particularly in a pandemic situation where practitioners find themselves over-demanded over a long period of time. Conclusion: It is useful to offer recommendations to guide practitioners in potentially difficult choices.

Key - Words: Ethics; Access; Resuscitation; Pandemic.

Résumé

Introduction : La certification des structures sanitaires est étroitement liée à l'évolution de la démarche éthique. Cas de questionnement éthique : Au sein d'un service de réanimation, quatorze lits sont occupés par des patients hospitalisés pour des pneumopathies graves à COVID-19. Un seul lit est gardé pour une urgence absolue. Un premier patient âgé de 68 ans aux antécédents de surpoids, d'HTA, de diabète type 2 et de BPCO, se présente pour détresse respiratoire nécessitant l'intubation et la ventilation mécanique. Le deuxième patient est un homme de 40 ans atteint de néo du poumon en rémission avant l'infection par le COVID-19. Il se présente de même pour détresse respiratoire nécessitant l'intubation et la ventilation mécanique. Quel patient doit-on privilégier ? Discussion : la réflexion éthique trouve pleinement sa justification au cœur des services de réanimation, notamment en situation de pandémie où les praticiens se trouvent sur-sollicités sur une longue période de temps. Conclusion : Il est utile de proposer des recommandations afin de guider les praticiens dans des choix potentiellement difficiles.

Mots - Clés : Ethique médicale ; Accès aux soins ; Réanimation ; Pandémie.

ملخص

مقدمة: أصبح التصديق على الهياكل الصحية مرطبة ارتباط وطيد بتطور المنهج الأخلاقي للمهنة الطبية
حالة تساؤل اخلاقي: في وحدة العناية المركزة، يشغل المرضى الذين يعانون من التهاب رئوي خطير مرتبط ب-كوفيد-19- أربعة عشر سريرًا. ولا يتبق سوى سريرا واحدا، يتم الاحتفاظ به لحالات الطوارئ المطلقة التي تهدد حياة المريض.
المريض الأول، البالغ من العمر 68 عامًا، يعاني من مجموعة من أمراض مزمنة (زيادة الوزن وارتفاع ضغط الدم و السكري من النوع 2 ومرض الانسداد الرئوي المزمن)، المريض يعاني من قصور حاد بوظائف التنفس تستوجب التنفس الاصطناعي
أما المريض الثاني فهو رجل يبلغ من العمر 40 عامًا يعاني من سرطان الرئة في مرحلة شفاء مبكر اصيب بفيروس -كوفيد- 19 كما انه يشكو من قصور حاد بوظائف التنفس تستوجب التنفس الاصطناعي ايضا .
أي من هذين المريضين له الاولوية ليتم ايواؤه بقسم العناية المركزة ؟
المناقشة: يجد التفكير الأخلاقي جوهره ومبرره في قلب خدمات العناية المركزة، لا سيما في حالة الوباء حيث يجد الاطباء أنفسهم مثقلين بهاجس التساؤلات الاخلاقية .الخلاصة: من المفيد تقديم توصيات لتوجيه الاطباء في الخيارات التي قد تكون صعبة

الكلمات المفاتيح:اخلاقيات مهنة الطب ;التمتع بالرعاية الطبية ; الإنعاش الطبي ; الوباء

INTRODUCTION

The development of the ethical approach in healthcare establishments has become an injunction in the certification of healthcare establishments [1]. Aimed at improving the quality of care, this process of ethical reflection is particularly necessary in certain specialties such as palliative and intensive care. The experience of the H1N1 pandemic in 2009 and COVID in 2019 revealed that a significant number of patients presented severe forms requiring intensive care. Health authorities have implemented measures to increase the capacity to care for patients requiring mechanical ventilation, by increasing the number of intensive care beds and canceling certain scheduled operations, but it is possible that human and material resources may become insufficient when even limited, which would imply prioritization [2]. The decision being taken urgently, by staff which potentially overworked over a long period of time. It therefore appears useful to propose recommendations in order to help practitioners in potentially difficult choices

CASE OF ETHICAL QUESTIONING IN INTENSIVE CARE

In an intensive care unit, fourteen beds are occupied by patients with serious pneumonia linked to SARS-COVID-19, twelve of whom are intubated and ventilated. Faced with the large influx of patients, eight continuing care beds were transformed into intensive care beds. To strengthen the resuscitation team, staff from other services have joined the "Covid bis Resuscitation" service, whose care activity far exceeds the capacity of almost all of the staff, already exhausted by a crisis which has been going on for several weeks. Of these eight beds, only one remains, kept for absolute vital emergencies. However, it is difficult to make choices, or even to reject some patients from treatment in the intensive care unit. Attached is the example: A first patient, aged 68, with a set of comorbidities (overweight, hypertension, type 2 diabetes and COPD), presented with respiratory distress requiring intubation and mechanical ventilation. This patient, retired for 10 years, is the father of four teenagers. His wife, particularly present, is the person of confidence. The second patient is a 40-year-old man suffering from lung cancer in early remission before infection with SARS-COVID-19, with no assurance of possible total remission. He has no children, is unemployed and has broken ties with his family. He also presents with respiratory distress requiring intubation and mechanical ventilation. He did not declare any trusted person.

- Which of these two patients should be preferred?
- Who should be allocated the remaining bed?
- Should we prioritize the father of the family, already fighting a certain number of illnesses, or the young man with no obvious ties, who is fighting a lung adenocarcinoma from which he was not completely cured?
- Who ultimately gets to decide?
- In whose interest: the patient, a healthcare team, a society?
- Should we look at the least costly for society through the prism of a utilitarian ethics, or on the contrary take into account a significant family environment, if we refer more to ethics of consideration?

It is not easy to find the most favorable outcome to this dilemma, with its heavy consequences.

DISCUSSION

1. Ethical reflection in an intensive care environment

Ethical reflection is a necessity in intensive care units. There is an ethical reflection from the moment when a moral conflict arises from a caring relationship between two values or two associations of values, which we will then call an ethical dilemma [3]. It is therefore a question of providing a consensual response to this dilemma, not always the best, but the least bad. The disciplinary field of ethics is based on four key principles: beneficence, non-maleficence, justice and autonomy [4]. The ethics linked to care is responsible for a certain caution regarding sometimes very technical acts of care at the center of a health system whose major interest is the consideration of individual vulnerabilities and respect for human dignity [5].

Ethics then diversified, highlighting the notion of consideration [5] and responsibility [6] in the face of the vulnerability of others. State of vulnerability particularly pronounced in patients in vital distress, for whom care choices sometimes pose real dilemmas and require multidisciplinary deliberations. Thus, the medical and paramedical team in charge of the patient whose care is being discussed, meets to obtain a consensus and, failing that, the best compromise. This approach in the intensive care unit is considered as a method or tool for group work for common decision-making processes. It appears appropriate, responsible and humanly effective, to invite the person of trust, or failing that, the patient's loved ones, to these meetings and deliberative moments. This allows not only to bear witness to the patient's wishes, but also out of respect for them and to take into consideration wishes and choices that could have been made at the end of their life [7].

2. Ethical reflection in crisis situations

The H1N1 pandemic in 2009 and in particular that of COVID in 2019 highlighted, both on a medical and social level, which many countries were not ready to. The health system and the professionals who make it strong have tried to offer the best they have in order to save as many patients as possible. The situation we have described is just one ethical difficulty upon entry into intensive care among others, experienced harshly by the healthcare team, who felt a feeling of incomprehension, ineffectiveness, even helplessness, faced with a succession of waves which mistreated them. The choice to be made in certain situations, which ethicist philosophy calls the “ethical dilemma”, is essential. Various situations which remind us how no therapeutic or ethical decision is forever immutable, firm and definitive. But also, that the dilemma only finds a force of life and a reflective utility if it allows us to reflect for a moment and collectively on the care process which seems to have the most meaning, opportunity for the patient, and bring the most hope for all those concerned [2]. The need to adapt choices to such situations in intensive care leads to temporarily favoring the ethical principle of distributive justice. This consists of preserving rare resources (such as intensive care beds) for the benefit of as many people as possible and to care for patients for whom admission to critical care would be beneficial, in order to avoid deaths due to lack of space [8]. In the name of the ethical principle of non-maleficence, this implies decisions of non-admission or re-evaluation for immediately serious cases whose prognosis would be unfavorable, in order to avoid initiating, or continuing, invasive treatment, without real benefit, taking into account the prognosis. It is therefore necessary to carry out an assessment of the benefits and risks while respecting the fundamental requirement of dignified and respectful care of all patients, whatever their vulnerabilities and to ensure end-of-life support, in the best possible conditions. Taking into account the patient's opinion on the nature and intensity of care, expressed by the patient himself, if not by the trusted person or even his family, is essential to respect the principle of autonomy [2].

3. Intensive care admission process in a crisis situation

In a context of pandemic, where human, therapeutic and material resources could be or become limited, it is possible that over-demanded practitioners over time will be forced to make difficult choices and urgent prioritizations regarding access to resuscitation. The ethical principles of respect for the dignity of all patients whatever their vulnerabilities, non-maleficence of decisions, autonomy, confidentiality of medical data, as well as, exceptionally, that of distributive justice, are guides for the management of serious patients.
Here are some ideas in a crisis situation:

3.1. Decisions informed by potentially evolving objective elements concerning the state of severity, the previous state of health and autonomy, taken in the best possible conditions; taking into account the opinion of the patient (or failing that of the trusted person or relatives in the absence of an identified trusted person), throughout the course [9].

Decision support unit including paramedical staff and a practitioner with skills appropriate to the situation (geriatrician, attending physician, palliative care doctor, or other practitioner) with a view to a collegial strategy. These cells would also allow a discussion on the "eligibility" thresholds for resuscitation, depending on the evolution of the admission request.

Different orientations are possible [10] :

- Admission to intensive care, with or without restriction
- Waiting resuscitation with early reassessment if uncertainty or missing data

- If no expected profit :

➢ Extreme severity and/or fragility - palliative care proposal, to ensure a dignified and peaceful end of life, in the presence of a loved one whenever possible
➢ Moderate severity - other medical services or structures, anticipating a possible decision to admit to intensive care if worsening.

3.2. If limitation of care is considered, appropriate and compassionate end-of-life care is essential in hospital or at home. Provision of dedicated palliative care beds managed by a multi-professional and multi-disciplinary support team made up of volunteers (person from the health reserve, doctors and nurses available including psychiatrists, psychologists, psychomotor therapists and nurses (e)s responsible for transversal activities…) supporting existing palliative care teams [11].

3.3. In the event of end of life in hospital, the presence of a close relative of the patient must be possible, subject to strict compliance with protective measures. Also make possible the use of all means of communication between patients and relatives [2].

3.4. Promote taking into account the opinion of the patient or, where applicable, the trusted person (availability and updating of advance directives if they exist and identification of the trusted person) [2].

3.5. Specific local procedures for patient support, reception, communication, family support [12].

3.6. In the absence of established specific treatment and when compassionate treatment is attempted: surveillance, traceability and standardized monitoring for retrospective analysis [13].

3.7. Measures to prevent burnout among healthcare professionals: compliance with legal limitations on working hours by providing break periods, logistical and psychological support for caregivers [14].

CONCLUSION

Ethical reflection finds its essence and its justification at the heart of intensive care services, particularly in a pandemic situation where practitioners find themselves over-demanded over a long period of time. It is useful to offer recommendations to guide them through potentially difficult choices.

REFRENCES

[1] Haute Autorité de santé. Guide méthodologique. L'évaluation des aspects éthiques à la HAS. Avril 2013. https://www.has-sante.fr/upload/docs/application/pdf/2013-05/levaluation_des_aspects_ethiques_a_la_has.pdf.
[2] Sandrine M, Antoine L, Catherine L. Recommandation professionnelle multi-disciplinaire opérationnelle (RPMO). Pistes d'orientation provisoires, 24 mars 2020. https://www.google.com/search?client=firefox-b
[3] Le Coz P. L'éthique médicale. Approches philosophies. Aix-en-Provence: PUP; 2018. p. 158.
[4] Beauchamp T, Childress J, Moullié JM. (dir.). Les principes de l'éthique biomédicale. Paris: LesBelles Lettres; 2008. p. 641.
[5] Pelluchon C. L'éthique de la considération. Paris: Seuil; 2018. p. 288.
[6] Jonas H. Le principe responsabilité. Paris: Flammarion; 2013. p. 480
[7] Bernardin G. Enjeux éthiques en réanimation de l'adulte. EMC Anesthésie-Réanimation 2019;16(4):1-13.
[8] Comité Consultatif National d'Ethique. Covid-19- Contribution du comité consultatif national d'éthique : enjeux éthiques face à une pandémie 13 mars 2020
[9] Le Coz P. Petit traité de la décision médicale. Paris: Seuil; 2007. p. 199.
[10] Guidet B, Dylan W, Ariane B, Susannah L, Ximena W , Carol B et al. The contribution of frailty, cognition, activity of daily life and comorbidities on outcome in

acutely admitted patients over 80 years in European ICUs: the VIP2 study. Intensive Care Med 46, 57–69 (2020).
[11] Sebag-Lanoë R, Trivalle C. Du curatif au palliatif. Les 10 questions pour prendre une décision. Gériatries n°28 – Janv/Fév. 2002, pp 15-18
[12] De Koninck T. De la dignité humaine. Paris: PUF; 2002. p. 258.
[13] Ethics in epidemics, emergencies and disasters: Research, surveillance and patient care. Geneva: World Health Organization; 2015 (who.int/ethics/publications/epidemicsemergencies-research/en/, accessed 23 July 2016).
[14] Dawson A, Jennings B. The place of solidarity in public health ethics. Public Health Reviews. 2012;34(1):65–79