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The morality of allocating resources to the elderly care in intensive care unit

A moralidade da alocação de recursos no cuidado de idosos no centro de tratamento intensivo

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Received from Fundação Oswaldo Cruz, Escola Nacional de Saúde Pública Sérgio Arouca. Rio de Janeiro (RJ), Brazil.

Course Conclusion Paper for the Post-Graduation Course in Ageing and Elderly Health.

Submitted on November 1st, 2009
Accepted on November 15, 2009

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ABSTRACT

The world is ageing. In Brazil and several other countries worldwide, the changes in the population age mix came along with increased demand for expensive health care. Currently, some moral conflicts arise from allocating public resources for health, as the magnitude of social health inequalities and limited resources require the public management priorities to be based on knowledge of the health situation and the impact of policies, programs, projects and actions on health. In this context, the intensive medicine both managers and physicians involved in intensive care, are subject to moral conflicts, especially concerning fair resources micro-allocation for the elderly in the intensive care unit setting. This paper aims to review these conflicts under the bioethics tools light.

Keywords: Bioethics; Medical ethics; Aged; Resource allocation; Intensive care units

INTRODUCTION

World population ageing is a new issue. It is estimated that in 2050 about 2 billion people will be aged sixty years or older.[1] The growing elderly people share in the total population is a response to the change signaled by some health indicators, specially decreased fertility and mortality, and increased longevity. The "older" population portion is also increasing, and the population deemed elderly is growing older.[2] In Brazil, and several other countries worldwide, the age population mix changes came along with increased health care demand.

The actors involved in resource allocation, particularly the managers and physicians, are expected to make effective decisions based on real resources scarcity, and the premise that it is morally legitimate to proceed some rationalization on resource allocation in such situations.[3] This kind of decision is an important field for Bioethics research, and its tools provide significant contribution for approaching these issues.[4]

Indeed, Bioethics aims not only to describe and analyze moral conflicts, the descriptive facts dimension needed to understand the conflicts nature and magnitude, but also to propose solutions, part of the normative or prescriptive dimensions.[5,6] Thus, bioethics is a tool for approaching the conflict resulting from increased demand versus limited health care offer, implying – in this discussed case – moral conflicts when electing the intensive care vacancies beneficiaries. Particularly in Brazil,

this discussion is still not very much visible, except for some academic papers.[3,7-9]

Resource allocation

The assistance universality is one of the Brazilian Governmental health system (SUS) driving principles, and is represented in our Constitution which holds health care as a right of all and the State's obligation. Other SUS's principles are integrality and equity, the first one assuring that the person's health care needs are considered even when they are not the same as for the majority, and the second, meaning that all should have equal opportunity to use the health care system.

However, the social and regional inequalities in Brazil causes the health needs different. For health policies managers, the administration of scarce health care resources becomes a source of conflict, as they should, simultaneously, adhere to the SUS's principles and deploy some kind available resources rationalization.[10] This implies an apparently unsolvable conflict. Indeed, such an universal health system may not incorporate indefinitely costs without incurring a bankruptcy risk, as well as it cannot ignore its universal vocation, under the risk of loosing identity and legitimacy.[11]

Traditionally, two dimensions are considered for health resource allocation: "macro-allocation" – respecting the public health policy allocation and distribution – and "micro-allocation" – respecting the individualized election of those who should benefit from the available services. The micro-allocation problem involves, e.g., electing patients for the scarce vacancies in intensive care services.[12]

In practical life, if choices have to be made for the resources scarcity, this means that physicians and managers should have criteria for resource allocation and patient selection, which are not only pragmatically effective but also morally right.[13,14]

Managers and intensive care physicians resource allocation morality on elderly care

Beauchamp and Childress[15] understand that in micro-allocation situations, it is valid using admission criteria based on scientific objectivity, such as severity, emergency, treatment time and prognosis. The objective-scientific criterion is very used for intensive care unit patients' admission, mostly due to the often admission emergencies.

The perspective of success for a procedure is considered a morally valid criterion, as well as using such scarce resources without reasonable chance of benefit would be an unfair waste. However, when managers and intensive care physicians use this kind of criterion, they should avoid discriminatory attitudes, as would be the trend to prioritize less severe cases, aiming to get better results; i.e, more patients' cure success with higher survival chance, as being not in critical conditions. Thus, are left unassisted patients who, although severely ill, would benefit from specialized technological attention in the intensive care unit (ICU) setting, also having chance to be cured.[16] In this specific case, as the scarce resources, expensive measures are provided to patients with better life expectancy, and elderly patients are in risk to have their ICU admission denied.[17]

The denial of an ICU bed, exclusively based on age, is controversial. For instance, Rivlin[18] argues that using age as a rationing criterion should be considered just as illegal as racism. Although, on Daniel Callahan's pondering – who is favorable to age-based allocation – the author proposes in his book "Setting Limits"[19] that prudence should be used on medicine targeting: to help people having longevity with a reasonable quality of life – which would be between the end seventies and early eighties – and relieving pain. In summary, it should be avoided the deliberate prolongation of life at all costs, in addition to avoidance of starting measures – as prolonged mechanic ventilation or artificial resuscitation – when these measures have, in fact, no chance to improve the patient's quality of life.

It is thus reasonable to say that rationing elderly patients in intensive care units should be based on objective information and the patient's best interest.[20] In the SUPPORT study,[21] 85% of the interviewed patients expressed specific wishes regarding either reanimation or non-reanimation. Only 23% had discussed their wishes with their doctor, and in half of the discussed cases, the patient didn't want to be resuscitated; 58% did not want discussing their wishes with the doctor, and among them, 25% did not want to be resuscitated. In 50% of the cases, the non-reanimation recommendations were prescribed by the doctors or requested by the families without the patients' consent.

Now, if the patients' wishes are unknown, they cannot be correctly estimated before ICU admission. Additionally, even when the patient has declared wishing "all be done", there is no intensivist's legal or moral obligation to start treatments not expected to provide

patient's benefits.

The intense care physicians daily make tough decisions regarding who to admit and who exclude from ICU admission, in a process known as screening,[22,23] which is based on weighting the disease leading to the hospitalization, the available treatments, and the expected impact on patient's benefit.[24] In addition, the different culture and beliefs – either religious or not – can differently influence screening decisions. For instance, European intensivists give more weight to their personal beliefs on patient's age and quality of life, than their North-American colleagues.[25]

Trying to make North-American physicians more objective in their screening decisions, the Society of Critical Care Medicine[26] developed detailed recommendations based on decreasing link power priorities:

- Priority 1: those who will better benefit from ICU, as e.g., post-operative heart surgery patients.
- Priority 2: those requiring intensive care, who may need immediate intervention, as patients with chronic comorbid conditions who need emergency surgery
- Priority 3: unstable critically ill patients, who however have reduced possibility of recovering due to the underlying disease or their acute disease nature, as are the cases of malignancies or metastatic diseases with underlying infection.
- Priority 4: those who will not benefit from ICU admission, as non-donors cerebral dead patients.

However, poor compliance to these four recommendations was documented.[27]

In the very aged population, age is an important mortality predictor; however the illness acute severity is more linked to mortality. Consequently, age itself may be an improper criterion for intensive care resource allocation. However, older patients have increased risk of fragile functional results, a consequence not only of recovering daily life activities lost before the admission, but also due to the additional disabilities development during the ICU stay. Additionally, results of survival measures do not provide a reliable picture of the results in long-lived, as they do not measure the survivors functional disability. Finally, age above 80 years is an independent predictor of discharge to long-term stay services or home care.[28]

Bioethics point of view

Traditionally, moral conflicts in clinical practice are faced with the principialist model, a four- prima facie valid principles model: beneficence, non-maleficence, autonomy and justice.[15] Applying to the elderly: beneficence assumes that all doctors do good and care for the elderly patients best interest; non-maleficence establishes that any intervention should avoid or minimize risks or harms, as, e.g., unnecessary poor quality life-prolongation; autonomy requests that all patients are properly informed and consent to a biomedical act, the therapeutic project or investigation to be conducted; and, according to justice, all resources, rights, and obligations should be fairly distributed for respecting the lawful rights of all and each.

But this model should be considered insufficient to deal with public health moral conflicts, mostly taking into consideration the health systems' users conditions in developing countries.[4] Additionally, some elderly subjects or populations may no longer enjoy cognitive competence for exercising their autonomy, thus needing protection and search conditions that allow them leaving this status and acting as active agents, reducing restricted-freedom conditions due to privations, lack of empowerment and suffering caused for their increased vulnerability.

Integrated to Bioethics tools as one of its driving principles for public health policies, protection is defined by Schramm and Kottow as "the attitude of protecting or covering essential needs, (…) those which should be provided for the affected individual being able to attend other needs and interests."[13] In other words, the protection principle intends to be a minimum moral principle, as well as sufficiently comprehensive, for basic survival conditions being assured, in order to provide other judged important for each individual expressing his capabilities goods achievement.[10]

For this, both authors suggest that it would be more appropriate to start from a public health problems applied "protection ethics", as this would allow directing actions aimed to meet population's health care demands, by means of result-effective and morally correct policies. For this, health actions would be directed starting from health demands prioritization, from effective decision-making population participation.[29] Indeed, Bioethics aims to protect vulnerable "moral patients" against preventable irreversible harmful effects that could result from "moral agents". In this context, it becomes the State obligation to adopt fair resource allocation measures, so that the elderly may get the best profit from ICU technological advances, their ventilators, dialysis machines, multiparameter monitors, etc.

COMMENTS

The intensive care manager obligation is to put into the practice the State determinations, and the intensivist doctor's to aggregate them; however, it is also to carefully evaluate each patient's situation and prognosis, in the context of the available therapeutic options, considering the respect to the values and self-determination of the ill elder.

The elderly patients' life-and-death-related medical decision making process remits to the thorny resource-allocation issue. The moral discussion by the health care professionals, however, is endangered of becoming restricted to the Medicine technical field. Thus, remains open the proposal of widening the moral debate field to a larger portion of the society. And, founded on protection Bioethics, bring to the surface the reflection on the need of making a health care policy which is efficacious, efficient and effective, based on reliable data and morally justified. This would be the case, e.g., of a policy not prolonging at all costs a poor quality ICU patients' survival, only adding preventable suffering and incrementing hospital costs.

RESUMO

O mundo está envelhecendo. No Brasil e em vários outros países do mundo, mudanças na composição etária da população vêm acompanhadas por um aumento da demanda por tipos de assistência à saúde cujo custo é elevado. Atualmente, alguns conflitos morais são decorrentes da alocação dos recursos públicos em saúde, pois a magnitude das desigualdades sociais e os recursos escassos impõem que as prioridades da gestão pública se fundamentem no conhecimento da situação de saúde e do impacto de políticas, programas, projetos e ações sobre a saúde. Nesse contexto, a medicina intensiva, os gestores e os médicos em terapia intensiva estão sujeitos a conflitos morais, principalmente quanto à justa microalocação de recursos para os idosos no centro de tratamento intensivo. Este trabalho procura rever a situação destes conflitos à luz das ferramentas da bioética.

Descritores: Bioética; Ética médica; Idoso; Alocação de recursos; Unidades de terapia intensiva

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