

Who is too sick for the ICU?



In this issue a paper by Joynt and Gomersall discusses the ethical issues in deciding which patients should receive life support in the form of mechanical ventilation. This is a particularly relevant topic in South African state hospitals, where intensive care beds are extremely limited yet the demand is potentially greater than in First-World countries because of our high incidence of severe trauma and infectious disease.

Hospital administrators call for written admission policies, but developing these is a daunting task as few finite clinical criteria reliably predict death. The APACHE II score, for example, only predicts outcome in cohorts of patients.¹ On the other hand, intensivists regard these decisions as being a largely clinical matter. Intensivists want to be in control of admissions, and indeed patient selection may be one of the mechanisms whereby critical care specialist and 'closed' intensive care units (ICUs) consistently reduce ICU mortality and improve cost effectiveness.^{2,3}

Unfortunately things are no longer that simple. Recent concepts in bioethics now require end-of-life decisions to be based on clear guidelines, justified by evidence, and open to scrutiny with some degree of public participation and an element of appeal and accountability to ensure that the decision making process is being applied fairly and consistently.^{4,5}

In this regard, the paper in this issue by Van der Merwe *et al.* on the outcome prediction of the APACHE II score in a South African tertiary public ICU is particularly welcome as it provides us with the some local data on ICU outcome. The paper demonstrates that internationally acceptable mortality figures can be achieved. However, the mortality in some patient categories is surprisingly high. This may indicate a tendency to

admit too many patients who cannot be salvaged by the ICU. Another reason for the high mortality could be that tertiary hospitals in the Western Cape receive a high proportion of patients as transfers from secondary level hospitals and ICUs. A recent report has demonstrated that this category of patient has a higher than predicted mortality.⁶

The Van der Merwe paper unfortunately does not provide data on length of stay. It is the patient who dies after a prolonged ICU stay that unnecessarily consumes a disproportionate amount of scarce resources.⁷ Another shortcoming of the paper is that ICU mortality and not hospital mortality is reported. We need to know if patients are not just surviving the ICU but going home and indeed enjoying a fulfilling life – six months or a year later. To gather this kind of data is currently beyond the resources of most state ICUs.

We need to make a start at developing written, accessible and evidence-based guidelines for ICU admission in South Africa. All units should be recording illness severity scores and outcome data and using these to refine and justify their admission policies.

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