

Ethical aspects of admission or non-admission to the intensive care unit

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Abstract: The question of admission and non-admission to the intensive care unit (ICU) raises several ethical questions. There is a fine line between the risk of loss-of-opportunity for the patient in case of non-admission, and the risk of unreasonable therapeutic obstinacy, in case of unjustified admission. Similar difficulties arise in decisions regarding re-admission or non-re-admission, with the sole difference that the intensivists already know the patient and his/her medical history. This information can help inform the decision when re-admission is being considered. Intensive, i.e., life-sustaining care should be implemented after shared reflection involving the caregivers, the patient and the family, and the same applies for non-implementation of these same therapies. Anticipating admission or non-admission to the ICU in case of acute organ failure, or in case of potential deterioration represents a major challenge for our discipline in the coming years.

Keywords: Intensive care unit (ICU); admission; re-admission; non-admission

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In the everyday practice of intensive care unit (ICU) physicians, the admission of a patient to the ICU usually does not raise any significant ethical questions. In most situations, there are well established criteria that enable the ICU physician to make an unequivocal decision about admission, such as failure of one or more organs, age, comorbidities, therapeutic potential and available therapeutic options, prognosis, expected quality of life after discharge, patient's wishes, etc. The patient is therefore admitted to the ICU with maximum therapeutic engagement in the context of a curative healthcare project (1). However, some patients may be admitted to the

ICU in a palliative context. In these circumstances, which are relatively uncommon, it is essential that the healthcare project be clearly defined in advance with the patient and his/her family, and that the main points be noted in the patient's medical file.

The main difficulties with admission to the ICU primarily arise in acute and unforeseen situations requiring intensive care, as the event is obviously not anticipated, and thus, not discussed in advance. ICU physicians who are called on in emergency situations to make decisions that may have serious repercussions, often find themselves at a loss when faced with the patients and their families.

The emergency nature of the situation, the physical and/or psychological distress of the patient and/or their family, the stress to the healthcare team, the inappropriateness of the hospitalisation ward, the absence of the usual medical intermediaries, a lack of knowledge of the patient's healthcare pathway or medical files, a lack of information in the medical file about end-of-life wishes, not knowing about the patient's choices or the family's wishes, isolation of the decision-makers, no possibility to organise a multidisciplinary collegial meeting at urgent notice, all count among the difficulties that ICU physicians have to face in such situations (2,3). Beyond the clinical justification for admission to the ICU, there also exist a range of weighty ethical issues that contribute to the decision on whether or not to admit a patient to the ICU.

To admit or not to admit: that is the question

It is actually difficult to dissociate "admission" from "non-admission". As with a decision to admit, the decision not to admit a patient also follows a request from another physician to the intensivists for ICU management for a given patient. All such requests do not necessarily lead to the patient being admitted to the ICU. Indeed, there are clinical situations that do not justify admission to the ICU, either because the patient is too-sick-to-benefit, or because of the patient's own wishes or those of his/her entourage (4-6). Other situations, however, can be less clear-cut, and call for closer collaboration between the requesting physician and their ICU counterpart. The legitimacy of the admission can then be discussed between the requesting physician, and the ICU physician, with this latter given the opportunity to evaluate organ failure and the potential to reverse it, the vital and/or functional prognosis, and the potential repercussions for the patient arising from the disease and a potential stay in the ICU. Although there also exist established criteria for non-admission (as for admission), the decision may be clouded in uncertainty or subjectivity, because it is made in an emergency, in isolation, and without availing of appropriate intermediaries or up-to-date information that could help the intensivist make a final choice.

Admitting a patient to the ICU implies the use of human and technical resources, as well as medications and financial costs that are expended in the hope of achieving a benefit for the patient, while simultaneously taking into account the various parameters detailed above. It is important to note that according to French legislation (7), when an

intensivist does not admit a patient to the ICU, he/she is creating a situation that may limit that patient's access to care that is likely to prolong or maintain life. On the other hand, "unreasonable obstinacy" also reprehensible, i.e., therapies whose sole aim is to maintain the patient alive. Indeed, ICU physicians are usually called on in situations where the patient's vital prognosis is in danger, and often in an emergency. Failing to admit to the ICU a patient who is in danger of imminent death could be equated to a failure to engage the resources that would keep the patient alive, thereby leading to the patient's death. Of course, in situations of uncertainty, without adequate information or documentation, or in the absence of appropriate correspondents, it is always possible to admit the patient to buy some time for reflection and to seek out pertinent information that could usefully contribute to a multidisciplinary, collegial meeting, for example [see (8) in this issue]. This aspect is specifically noted in the 2016 update of the French law relating to end-of-life, which specifies that in emergency situations, the physician is not obliged to take account of any existing advance directives for the patient if they are not available at the time of the patient's management (9).

It is important to remember that when a patient is not admitted to the ICU, it is essential to ensure that appropriate care, commensurate with the patient's state of health, is administered, and this does not necessarily (or exclusively) mean comfort or palliative care. Not admitting to the ICU should not be equivalent to abandoning the patient. On the contrary, it is the intensivist's duty to take this eventuality into account and work with colleagues in other wards to ensure that the patient receives appropriate care, as underlined in the 2005 French legislation regarding patients' rights at the end-of-life (7).

Nevertheless, as mentioned above, the difficulty resides in evaluating, in an urgent context, the unacceptable risk of loss-of-opportunity on the one hand, and the more reprehensible risk of unreasonable therapeutic obstinacy, on the other hand. The intensivist finds him/herself in a similar situation to that of decisions relating to the level of therapeutic engagement that are taken when the patient is in the ICU. The major difference is that the decisional context is not the same for the intensivist deciding on potential admission, since physicians deciding on therapeutic engagement have the advantage of knowing the patient's file and healthcare history, and having the patient's family at hand to consult if necessary, thus enabling thoughtful decision-making without haste.

In this regard, it should be underlined that over the last few years, ICU physicians have built up a wealth of experience in judging the level of therapeutic engagement. It is likely that within most ICUs, the risk of engaging in disproportionate healthcare measures (termed “unreasonable obstinacy” in French legislation) by admitting the patient to the ICU is now lower than the risk of creating a loss-of-opportunity by failing to admit the patient. Collegial decision-making has now become the norm in ICUs, and this process undoubtedly protects both the patient and the healthcare team. It should be possible for the collegial decision-making process to be instituted as soon as a request for admission to the ICU is made. Indeed, in our view, the collegial decision-making process can protect the patient from inappropriate decisions, especially when that decision is NOT to admit the patient to the ICU.

In view of these considerations, it seems more appropriate to speak of a “lack of indication for admission to the ICU” rather than “refusal to admit”, insofar as ICU management would likely not yield any benefit for the patient in terms of diagnosis, therapeutics or prognosis, taking into account the mobilization of resources and the constraints inherent to a stay in the ICU.

When evaluating the legitimacy of a request for admission to the ICU, it seems preferable to indicate that the patient does not present an indication for intensive care at that time (too-sick-to-benefit, or not sick enough to benefit), rather than refusing admission. The term “refusal” carries negative connotations, and may sound definitive, whereas in fact, the clinical situation is constantly evolving and may therefore be re-evaluated at any time. A clinical situation may present no indication for ICU admission at one specific timepoint, but may perfectly well change, and present clear criteria for ICU admission at a subsequent evaluation.

To readmit or not to readmit: that is also the question

What of the patient who has recently been discharged from the ICU, and who now presents again with an indication for ICU admission: is it justified, or even reasonable, to re-admit such a patient? Can re-admission be considered as unreasonable obstinacy? Is there a need to define a level of therapeutic engagement for patients being re-admitted to the ICU?

As for the question of the initial admission, here again it is impossible to dissociate “re-admission” from “non-

readmission”. This situation arises frequently when the prior pathway of care has been difficult or chaotic, or when severe or debilitating illness has been diagnosed, or a disease with limited therapeutic options, or when the ICU stay has led to serious physical, functional, nutritional or psychological repercussions for the patient and/or their family, and finally, when re-admission could be considered as unreasonable obstinacy. It is fundamental to try to answer this question, which will necessarily arise during the ICU stay of a significant proportion of patients.

Re-admission without further discussion is often evoked for patients recently discharged from the ICU, arguing that the clinical situation at the time of discharge may have been insufficiently stabilized, that the discharge may have been premature, that the burden of care was too much for the ward receiving the patient, or even on the pretext that a sudden deterioration of the patient’s health after discharge did not give a “positive image” of the ICU. Every physician is aware that a patient’s clinical course is uncertain, particularly after a stay in the ICU. In this context, it is therefore logical to anticipate the possible need for re-admission.

It has been reported that re-admission to the ICU during a single hospital stay generates higher human, organisational and financial costs (10-12). In addition, re-admitted patients reportedly have a more severe profile (10,13), with less favourable prognosis (11,12). An interesting point that deserves to be emphasized is that re-admissions often occur at night, when all the wrong conditions for re-admission are present (reduced number of staff, information not available, emergency situation...) (10).

Conversely, while it has previously been asserted that a high early re-admission rate is suggestive of poor ICU discharge decision-making (14), a more tempered position is likely appropriate, since re-admission may depend on a number of factors unrelated to the ICU, such as insufficient availability of ICU beds necessitating early discharge, or the lack of intermediate structures or procedures to allow safe discharge from the ICU (15).

The question of non-re-admission went unexplored for many years until a recent survey among French ICUs that showed the difficulties that this issue raises, which are remarkably similar to those raised by the question of initial non-admission. While the decision not to re-admit is often made in the ICU (40% of physicians reported making 5 to 10 decisions not to re-admit every month), the opinion of the patient, family and/or surrogates is rarely taken into account, and an external opinion is rarely consulted.

The decision-making procedure is therefore not collegial in such cases, little information is given to the patient after the decision has been made, and palliative care is not systematically initiated when a decision not to re-admit is made (16).

When the question of re-admission (and thus, of potential non-re-admission) is raised, the intensivist is opening the door to the possibility of limiting the patient's access to life-sustaining therapies. This resembles decisions regarding the potential limitation or withdrawal of life-sustaining therapies. When considering the issues involved in a decision to re-admit a patient or not, it is crucial to focus on the situation where the patient and their family are already well known to the ICU team. In this context, the patient's medical history, as well as their wishes and those of their family, are already known to the ICU team, and this is a fundamental contributing element to the decision, leading to better quality decision-making.

Holding formal meetings prior to discharge of a patient from the ICU is an excellent opportunity to bring together the ICU staff, and to obtain the patient's opinion, and that of the patient's family, correspondents or other medical intermediaries. If necessary, advance directives, where present, could also be consulted. If the outcome of this meeting is to decide that the patient will not be re-admitted to the ICU in the future, then suitable measures should be put in place to plan palliative care. This procedure is similar to that reflecting on the level of therapeutic engagement, and is in line with recommendations for collegial decision-making, providing a solid and documented basis to support the decision vis-à-vis the patient, their family, the caregiving team, and the receiving ward. In theory, to ensure equal access to resources, such formal meetings should be held for all patients, but clearly, the question of potential re-admission will not arise for all patients.

While laudable, this procedure also presents some non-negligible disadvantages. A decision not to re-admit the patient to the ICU in case of future deterioration may come across as harsh at this stage of the patient's care, not only for the patient, but also for the family and even the caregivers, because the patient's clinical course after the ICU is clearly not taken into account. Yet, all physicians are acutely aware of the potentially transient nature of clinical situations that seem stable at the time of discharge. There is thus a major problem of timing regarding the decision not to re-admit.

An alternative is to decide about re-admission when the actual indication for re-admission is imminent. In this way, no definitive decisions are made without taking into account

the patient's clinical course after initial discharge from the ICU, as well as the information pertaining to the previous ICU stay. Similarly, in this approach, the initial ICU stay and the patient's course thereafter are integrated as parts of the medical history. This approach resembles the reflection that is undertaken regarding the level of therapeutic engagement, which is often decided for patients requiring life-sustaining therapies in the ICU, and is a decision-making process that is very familiar to intensivists. The conditions in which the decision regarding re-admission is made remain similar to those of the initial decision (as regards subjectivity, isolation, absence of family members etc.), but at least the physician knows the patient and his/her clinical course thus far.

Outside of the acute context, when the situation is stable and calm, a post-ICU consultation is useful to discuss with the patient and/or the family, to anticipate what to do if the need for re-admission arises. It also provides an opportunity for the patient to report their experience of the ICU stay, as well as the feelings of the family in this regard. Such follow-up consultations post-ICU discharge can be a good time to raise the question of future hospitalisations requiring intensive care, to inform the patient about the level of care that can be offered in case of re-admission, and to discuss what treatment options might reasonably be considered, or not. The patient's clinical, physical and psychological status can be assessed, and this is helpful in evaluating eligibility for potential re-admission to the ICU if the need should arise. Sharing of information with other healthcare professionals involved in the patient's care can also contribute to this process of reflection. Finally, the post-ICU consultation can represent an ideal time to bring up the issue of advance directives with the patient. Admittedly, despite the many advantages of post-discharge consultations for interaction with patients and families who have lived through the ICU experience, and for involving them in the reflection regarding their future care, they are not applicable to decisions regarding possible re-admission to the ICU during a same hospital stay.

Overall, we propose that consultation and reflection are advisable regarding whether or not to re-admit a patient to the ICU, and these should be initiated at the end of the initial ICU stay, and be accompanied, where necessary by relevant caveats that depend on the patient's clinical course after initial discharge. The reflection process can be incremented in real time with information coming from any specific care or follow-up that the patient receives after discharge. The totality of the information will then

be integrated and taken into account if the question of re-admission arises at a later date.

Informing the patient and his/her family is a key action in this process. In this regard, a number of questions arise. Firstly, is it reasonable to impose re-admission on the patient, when he/she is unable to decide on the question, whatever the reason? Is it really likely that a patient would agree not to be re-admitted, i.e., that they would agree to forego resuscitation? Should a patient be re-admitted without question simply on the basis that they had previously been hospitalised in the ICU? Does non-re-admission systematically equal loss-of-opportunity, in the minds of the patient and their family? Naturally, there are many possible answers to all these questions, and they will depend on each individual situation, specific to each single patient. Nonetheless, these are among the issues that should be thought over when anticipating the possibility of re-admission, which is a situation that is likely to arise for any patient who is discharged from the ICU alive. Anticipating the situation also makes it possible to evaluate the information that can be imparted to the patient and their loved ones. While it is essential to keep the patient informed, it is surely also equally as necessary to spare them full disclosure, when they are in a situation of fragility or vulnerability, of information that they may find difficult, abrupt or even violent. The principle of beneficence towards the patient and their family must take precedence, and it is therefore likely more appropriate to address the more difficult questions during the hospital stay, after discharge from the ICU, as has been proposed in certain other contexts (17). Initiating reflection at ICU discharge regarding the healthcare project, including possible re-admission, should be the cornerstone on which future decision-makers may base their decisions. The post-ICU consultation could enrich this reflection, as it provides an update of the patient's status with longer follow-up.

In addition to anticipating situations that may lead to a need for re-admission to the ICU, with a view to reducing readmission rates (10,12,13,15), it is also important for the intensivists to participate—even before any potential organ failure that would require intensive care—in the development of advance care planning, whose utility has been widely documented (18-20). Ideally, intensivists should be invited to participate, in the same way as any other physician responsible for the patient, in the development of the therapeutic project (3). It certainly seems more coherent for the intensivist to be solicited “transversally”, along with the other physicians involved in the patient's care, rather

than “vertically”, after the other intermediaries, when the acute event necessitating ICU care has already happened.

Conclusions

The question of admission and non-admission to the ICU raises several ethical questions. There is a fine line between the risk of loss-of-opportunity for the patient in case of non-admission, and the risk of unreasonable therapeutic obstinacy, in case of unjustified admission. Similar difficulties arise in decisions regarding re-admission or non-re-admission, with the sole difference that the intensivists already know the patient and his/her medical history. This information can help inform the decision when re-admission is being considered. Intensive, i.e., life-sustaining care should be implemented after shared reflection involving the caregivers, the patient and the family, and the same applies for non-implementation of these same therapies. Anticipating admission or non-admission to the ICU in case of acute organ failure, or in case of potential deterioration represents a major challenge for our discipline in the coming years.

The advance development of a healthcare project, involving the intensive care physicians, should be facilitated by the definition of fields of activity for intensive and critical care medicine. However, information obtained from patients and their families after the fact (i.e., post-ICU discharge consultations, encouraging patients to prepare advance directives) and frank discussions of the patient's desires and life project should not be neglected.

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Footnote

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