

To admit or not to admit? That is the question

An octogenarian presents with abdominal pain and sepsis. The patient has significant cardiovascular comorbidity, was recently refused surgery because of frailty and requires help with activities of daily living. The patient is severely acidotic and hypotensive despite multiple fluid boluses and you have been asked to consider admitting the patient to intensive care. This article discusses some of the arguments for and against such an admission.

This case against admission to intensive care

'Too sick for intensive care' is a valid and justifiable assessment of some patients' clinical state and results from the summation of a number of patient-, disease- and care-related factors (Courtwright, 2012; Hoffman et al, 2016).

First, an intensive care admission exposes patients to potentially harmful invasive procedures and infections (Courtwright, 2012). In patients with compromised immunity it is important to consider the balance of the risks of treatment *vs* any conceivable benefit.

Second, age and pre-morbid independence are factored in because it is known that older patients and those with a poorer functional status have poorer outcomes (Hoffman et al, 2016; Andersen et al, 2017; Muessig et al, 2017). They are therefore less likely to benefit from intensive care therapies.

Third, the mortality rates of a number of disease processes are not affected by the

level of care provided. Thus, these patients are unlikely to benefit from intensive care as they are not expected to survive their illness regardless of the intensity of care provided (Courtwright, 2012). The above arguments echo the ethical principle of non-maleficence: that patient care should not cause harm, which is the premise of making decisions in the patient's best interests.

Finally, it should be understood that intensive care is a finite resource, limited by numbers of beds and staff. As such, its provision to a patient must also consider the ethical principle of justice: the fair distribution of a scarce resource (Hoffman et al, 2016; Muessig et al, 2017). The greatest good should be done for the greatest number of patients within the allotted budget. No individual patient has a right to maximal care.

The case for admission to intensive care

The description 'too sick for intensive care' is vague at best. Although there are early warning scores which can indicate when a patient is severely ill, there is no reliable test or assessment tool that can distinguish those who will benefit from intensive care from those who will not (Andersen et al, 2017). Some patients may benefit from, but are denied, a single intervention such as vasopressor support which is only available in intensive care (Courtwright, 2012). Others may be guaranteed intensive care based on their mode of presentation alone, for example emergency surgery, no matter what their pre-morbid status.

Furthermore, improvements in the management of some disease processes and their complications mean that patients with diseases that were previously considered 'lethal' do in fact survive (Courtwright, 2012). As such, a 'trial of intensive care therapies' may be life-prolonging or even life saving and should be considered for everyone (Courtwright, 2012). A significant proportion of patients considered too sick for intensive care survive to leave hospital

(Hoffman et al, 2016) which begs the question of how many times the decision to refuse intensive care is correct. Moreover, survival alone should not be considered the sole benefit of intensive care but survival with a level of disability should be valued as an outcome (Peace, 2012).

The provision of intensive care should consider first and foremost the ethical pillar of beneficence: care should be provided with the intent of benefitting the patient. In addition, all decision making should consider the concept of autonomy: what would the patient choose for him-/herself as quality of life is dependent on an individual's perception of what gives him/her pleasure.

Conclusions

With few tools to assist, admission decisions are a science and an art that comes only with experience (Andersen et al, 2017). Although it seems natural to offer maximal care to all patients, this paternalism may solely expose a patient to risk with little benefit. Time spent with loved ones with minimal intervention should not be dismissed when the alternative would be far more intrusive. **BJHM**

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Anaesthetic and critical care dilemmas are coordinated by **Dr Rob Anker**, Anaesthetic Registrar (ST6), Royal Marsden Hospital, London and **Dr Prashanth Nandhabalan**, Specialist Registrar in Anaesthesia and Intensive Care, King's College Hospital NHS Foundation Trust, London

Dr Tamsin Lane, Acute Care Common Stem Anaesthesia Trainee, Department of Anaesthesia and Critical Care, Torbay and South Devon NHS Foundation Trust, Torquay TQ2 7AA

Dr Maree Wright, Associate Specialist, Department of Anaesthesia and Critical Care, Torbay and South Devon NHS Foundation Trust, Torquay

Correspondence to: Dr T Lane
(tamsin.lane@nhs.net)