Abstract Submission Form – Panels

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Additional panelists, if any (up to three):

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Name: _____
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Institution: _____
Country: _____

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Title/Degree: _____
Institution: _____
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Proposed Session Title: Resource Allocation in the Intensive Care Unit: Bioethics Gone Bad, Bad Bioethics or Just Reality?

Describe topic or case to be discussed up to 300 words:
An informed 51-year-old gentleman with end stage terminal cancer was a “full code,” despite his terminal prognosis. Since cardiac arrest was immanent the attending physician hoped to pre-empt the event by intubating the patient. The policy in this hospital requires that intubated patients be

transferred to the Intensive Care Unit (ICU). Therefore, the physician notified the ICU of the impending intubation and wanted to make arrangements for the transfer.

The Intensive Care Unit physician refused to accept the patient stating that intubating a patient with terminal cancer would not change the outcome and that the ICU was full. The patient's physician explained that it was only a matter of time before the patient had a cardiac arrest and, since he was a full-code, resuscitated, which would require intubation and a transfer to the ICU. The Ethics Consult concluded that a planned orderly transfer was better than reacting to a crisis.

The ICU physician subsequently triaged the ICU patients and transferred a 50-year-old woman out of the unit. After being transferred the 50-year-old woman's condition deteriorated and intubation was indicated. However, she received bi-pap because intubation would require transferring her to the ICU which was full.

Describe briefly each proposed panelist's position to be offered (up to 300 words):
One way to avoid this problem would be to argue that it is inappropriate to intubate and/or resuscitate a patient with a terminal cancer diagnosis. One could simply argue that intubation in this case will not change the outcome and therefore it is medically futile. However, a determination that intubation is futile can be made only in relation to a specific goal. For example, if the goal is to restore respiratory function or to prolong life (even by only a few days) then intubation is not futile. On the other hand, if the goal is to cure the cancer or prevent the patient's eventual demise, then intubation would be futile. We think it is more likely that the term "medically futile," is being used as a means of camouflaging resource allocation decisions.

The real question is whether resource limitations should be discussed with patients? Should we have told the cancer patient that he would be putting someone else at risk by his demands for these limited resources? If there were space available in the ICU, we would have accepted the patient. However, since resources were limited and the patient had a terminal diagnosis we thought the marginal benefit this patient would receive from intubation and being transferred to the ICU was not worth the cost. Since resources were motivating our decisions, the tenets of informed consent require that this information be disclosed.

Of course, within the Canadian health care context it is uncommon to explicitly discuss costs with patients or to admit that resources influence our treatment recommendations. In fact, it could be argued that discussing resources with this patient would be coercive and disrespectful. However, we maintain that since resources had a major influence on our treatment recommendations that they needed to be discussed with the patient.

Are you planning to or will you be willing to submit a poster along with your panel?
☒Yes ☐No