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Good rules for ICU admission allow a fair allocation of resources, even in a pandemic

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The new coronavirus COVID-19 pandemic has reached most countries in the world. The epicentre has moved from China to Europe within a few weeks and increasingly stresses its healthcare systems. Italy has paid a particularly heavy toll in human lives, and Switzerland has seen a similar exponential increase in COVID-19 infections and hospital admissions during recent days. From the experiences in China and Italy [1, 2], great pressure for more intensive care units (ICUs) and beds, staffed with specially trained nurses and physicians, and equipped with respirators, can be felt in our country.

In such a dramatic and frightening situation, society, patients and their families, as well as healthcare workers, expect "the system" to respond to the massive demand for ICU beds. Such responses must not only lead to an expansion of the facilities needed, including technical equipment and training professionals in this field, but also, and even more importantly, define clear guidelines for admission to the ICU when beds are scarce. The rules must be based on appropriate and accepted ethical principles, be adapted to the specific medical possibilities and limits of intensive care, as well as consider the wishes and values of the patients.

Within less than 3 weeks after the first detection of COVID-19 infections in Switzerland, the Swiss Society of Intensive Care Medicine (SSIM) together with the Swiss Academy of Medical Sciences (SAMS) has elaborated detailed and coherent guidelines defining the criteria for admission to the ICU in situations of bed shortage, as are to be expected in the present pandemic [3, 4]. As well as their rapid conception and publication, these texts have the merit of establishing a uniform national framework for patient care in a time where shortages of these resources could be particularly painful, and not only for the patients concerned. Such triage decisions are a stressful burden for the ICU team, but knowing that the rules are the same for all hospitals in the country and that these apply not only to COVID-19 patients but to all potential admissions can be reassuring. Good guidelines must respect the national and cultural situation of a given region. For instance, some of the recent triage recommendations relating to the present pandemic from the US (March 23, 2020, [5, 6]) seem not really appropriate for the sensitivity and feelings in most European countries. The Swiss Society for Infectious Diseases has elaborated a list of drugs and a number of reflexions for potential antiviral therapies in COVID-19 infections [7]. Although this disease is threatening the whole population, severe forms and deaths are more frequent in elderly, frail and multimorbid persons. In situations with an unfavourable prognosis, appropriate offers for palliative care are essential. The specialist societies in palliative medicine have set up a number of principles in COVID-19 patients for this type of care [8], and specifically for the elderly [9].

The *Swiss Medical Weekly* wished to participate in the awareness campaign in the scientific community and the population in general by the publication of ethical, medical and social aspects of these triage decisions, as well as of other related problems of the COVID-19 pandemic. It is important to realise that limitations in resources can result in similar discussions in other situations. In all cases, decisions must be based on sound, transparent and understandable rules.

We all hope that the nightmare of the pandemic will be behind us in a few weeks or months. A certain number of lessons must, however, survive the acute phase of the present disaster. A few relate to intensive care specifically. For these, my principal choices are as follows. Firstly, knowing the patient's wishes and preferences for therapeutic measures and the limits not to be passed is an enormous help for the team having to make triage decisions. Second, flexibility of hospital structures is impressive during this crisis, allowing expansion of ICU facilities including personal resources. The use of operating theatres, recovery rooms and other equipped wards, the assignment of nurses and physicians trained in anaesthesia and related domains to the ICU has provided for additional capacities in our country. Thirdly, the expectations that politics will solve (all) problems are always high − and criticisms are coming fast. However, we have to realise that defining treatment in complex patients and in difficult situations such as rationing therapy must remain the responsibility of the healthcare professionals, including nurses, physicians and other personnel involved.

In this regard, the guidelines of the Swiss Academy and the Societies of Intensive Care Medicine, Infectious Diseases and Palliative Medicine are essential for managing and overcoming the consequences of the COVID-19 pan-

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demic in our country − and possibly in others − in an optimal way.

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