Review of 1st wave in Italy concludes using age alone to determine if someone gets COVID-19 IC treatment is not fair

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Italy was one the countries first hit hard by the COVID-19 pandemic. In a new review presented at this weekend's Euroanaesthesia (the annual

meeting of the European Society of Anaesthesiology and Intensive Care [ESAIC]) an Italian doctor on the front line of the pandemic concludes that it is not fair to use age alone as the deciding factor on whether or not someone receives intensive care treatment.

The presentation, given by Professor Ornella Piazza, University of Salerno and Salerno University Hospital, Italy, will discuss the desperate situation many Italian hospitals found themselves in when patient demand was far in excess of availability of intensive care (ICU) beds early in the pandemic.

She will also discuss the document published by The Italian Society of Anesthesia (SIAARTI), on 6 March 2020, entitled "Clinical ethics recommendations for the breakdown of intensive care treatments, in exceptional circumstances limited to resources". In this document, the principle of: "saving limited resources, which can become extremely scarce, for those who have a much greater chance of survival and life expectancy, in order to maximise the benefits for the greatest number of people" is stated.

COVID-19 outcomes in elderly patients are usually much worse than in healthy young subjects. SIAARTI, therefore, suggested that: "together with the age, comorbidity and functional status of each patient in critical condition must be carefully evaluated in these exceptional circumstances".

While praising SIAARTI for acting so quickly in creating recommendations for treating COVID, Prof Piazza says that using age alone as the deciding factor on whether or not someone receives potentially life-saving ICU care is not the right choice. She explains: "Put simply, if there is an equal need between two patients, age can be the decisive element in defining the priority of treatment according to this guidance. Lifesaving procedures, such as intubating and ventilating,

would be carried out only in younger patients, reserving only less invasive or palliative treatments for the elderly."

She adds: "Following this principle, the elderly, lesser valued citizens (in these criteria), would give young people the right to play their game of life, as defined by the principle of a fair life expectancy. So, I question, is the age of the patient the right thing to determine whether they enter ICU?"

She explains: "Defining a rigid cut-off—a precise threshold of age—is, in my opinion, more a 'defensive' tool for young and inexperienced doctors, left in distress in the emergency room devastated by the epidemic. However, it is essential that these decisions, extremely distressing for both those affected and those forced to make them, are based on clinical factors related to therapeutic outcomes and not on the basis of discriminatory judgments about the value of individual lives."

And in cases where there are two patients but only one bed, Prof Piazza explains that doctors will never just 'give up' on the patient who does not get the bed. "For that patient, we evaluate alternative treatments," she explains. "Abandoning them is never an option, and we should explore any other possible ways we can help them."

Provided by The European Society of Anaesthesiology and Intensive Care (ESAIC)

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