CRITICAL CARE

LETTER

Can we afford open-ended ICU care? Yes we can, but …

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See related review by Crippen *et al*., http://ccforum.com/content/14/3/222

The question whether we can afford open-ended intensive care unit (ICU) care should be answered with 'yes we can, but …' [1]. The discussion is polarized. The US system will crash because everybody is right when it comes to open-ended care, and in Europe endless care is prohibited or rationed. With polarization, we lose sight of the middle path, where truth and solutions usually are found.

The rationale that it is better to treat 10 non-survivors than not to treat one possible survivor is erroneous. We are not freeing patients destined to die but are condemning them to suffer in the ICU for an indeterminate length of time. For each survivor, many others are harmed. Nobody knows the right balance, and questionable choices are unavoidable. It is our responsibility to make those decisions together with the patient and family. We now admit many patients who have a bad prognosis. The number of patients dying in the ICU is increasing [2]. Admitting patients who have a 1-year survival of 30% causes harm to 70% [3].

We should educate the public that life and ICU care are not commodities. ICU care has limitations and, without exception, causes harm. We should teach our colleagues that there is no safe side and that we have to have the courage to make decisions. We should also improve end-of-life care. If imminent death is inevitable, we should do our utmost to give the patient a good death [4]. Open-ended care for everybody causes harm to too many and is not affordable. With courage and education, we might avoid both harm and exorbitant cost and be able to provide intensive care for the patients who need it.

Author's response

David Crippen

Educating the American public as to the 'right thing to do' in health-care management is a moot issue. They have already been educated by other, interested sources. Malpractice attorneys routinely tell patients in the American health-care system that physicians frequently err in the diagnoses they make. The tabloids issue warnings that patients predicted to die wake up later [5]. Politicians opine that feeding tubes are a basic right [6]. Health-care reform, political candidates say, will kill patients in order to save money [7]. So in this environment, educating a patient population by mere physicians is met with resistance.

In the new millennium, America endeavors to join the global medical village and ensure affordable health care for all Americans [8]. This will be impossible using the country's current open-ended expenditure system. Priorities will have to be established to avoid financial meltdown in an arena in which patients want it all, want it now, and want someone else to pay for it [9].

Citizens who have become experts in gaming resource systems will immediately disarm any subjective prioritizing that is based on 'the right thing to do'. The only way resources can be managed effectively is by setting objective limits on who will be allowed to access the most expensive of our resources. Simply having capriciously optimistic expectations is no reason to be allowed open-ended ICU care. We will have a choice between what is fair and what the public feels entitled to. If we choose the latter, the system will collapse. When that happens, the former will be forced on us and either we'll get used to it or we won't.

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Abbreviation

ICU, intensive care unit.

Competing interests

The authors declare that they have no competing interests.

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