

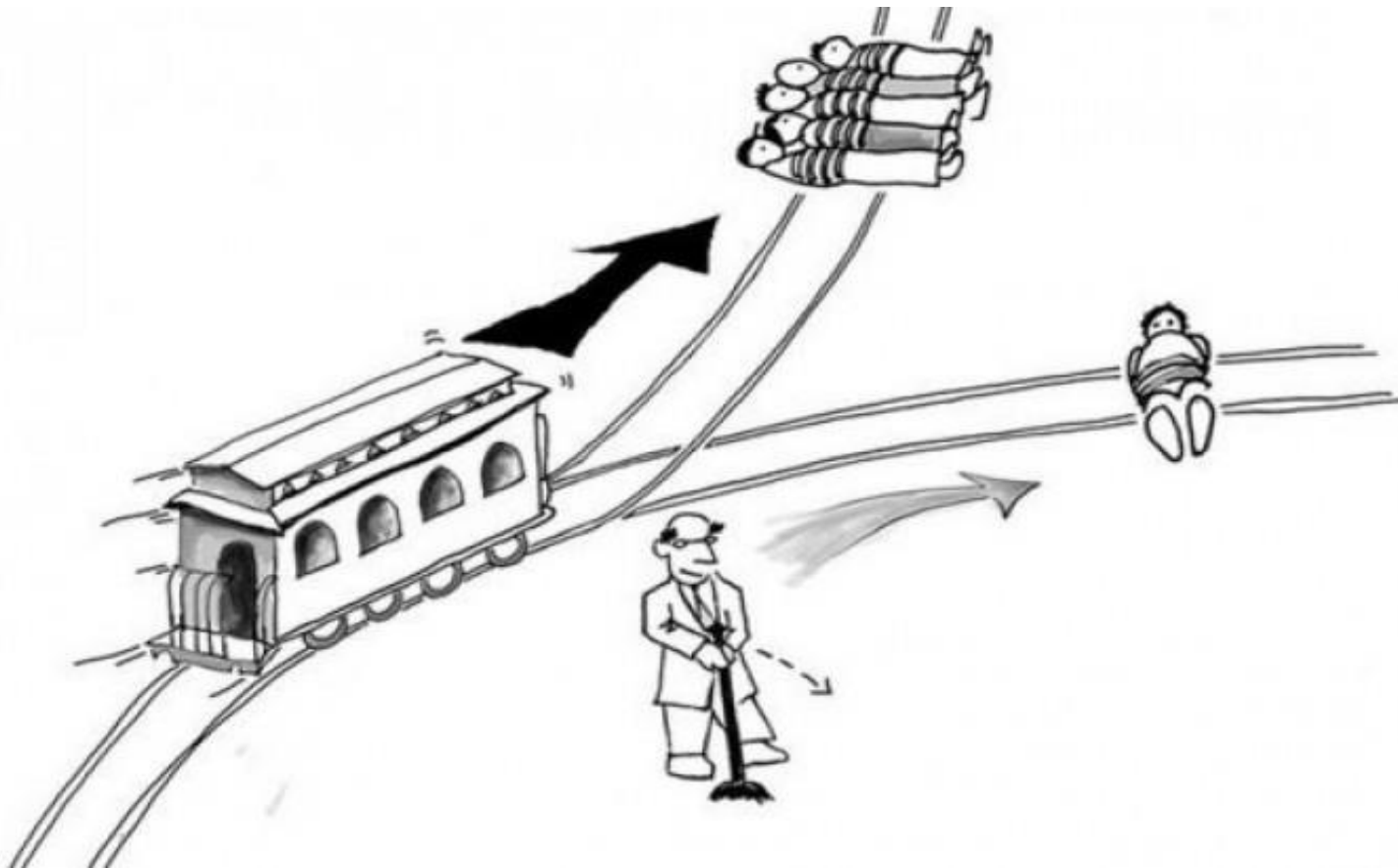
Questioni di etica in Pronto Soccorso

Fabrizio Elia– MeCAU Ospedale San Giovanni Bosco
Marco Vergano – Terapia Intensiva Ospedale San
Giovanni Bosco

Fenice

Gruppo Italiano Per la Ricerca Clinica In Medicina d'Urgenza





DO NOT RESUSCITATE

**poco tempo
e
poche informazioni**

la guerra di Piero

sta morendo ?

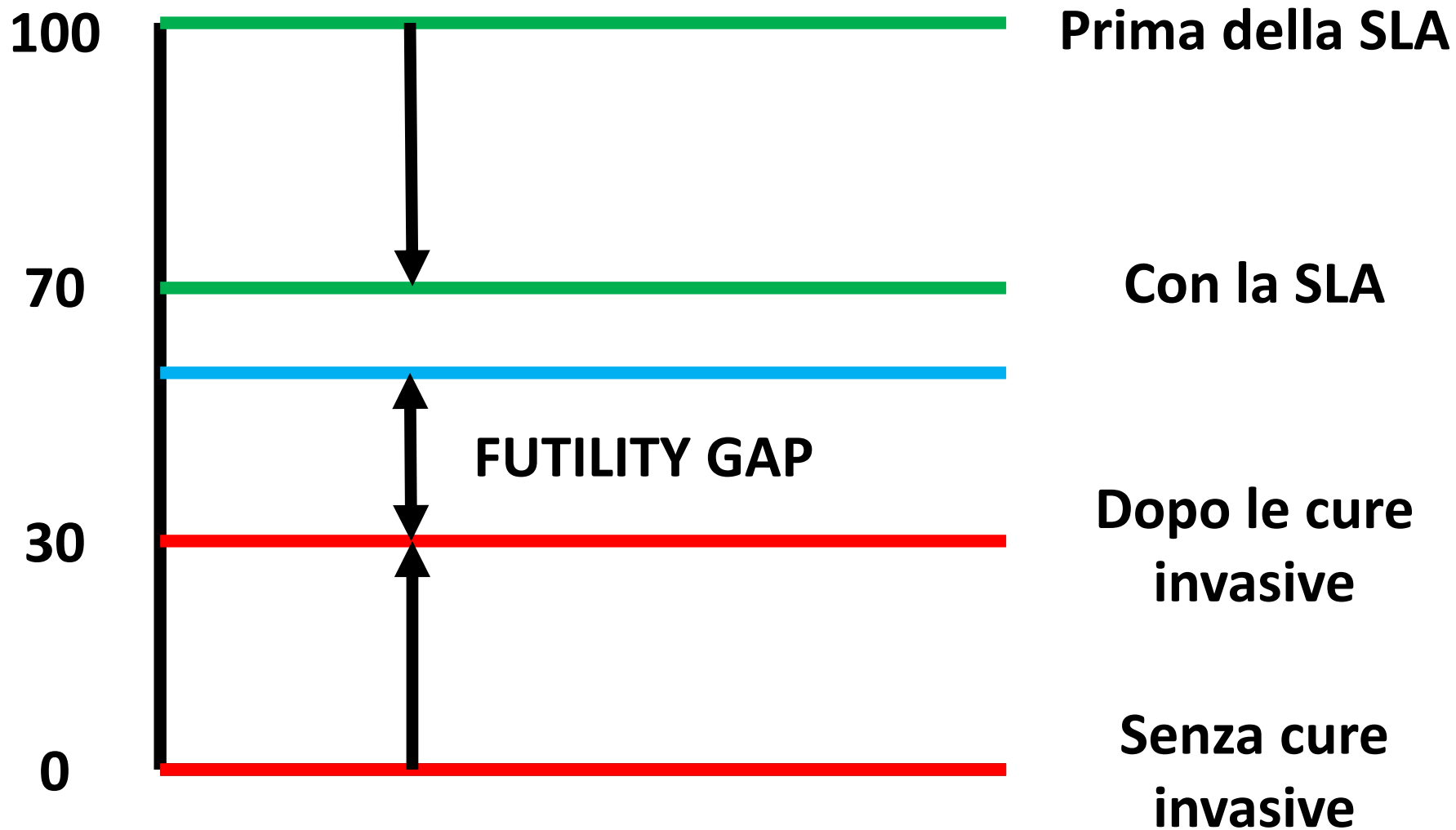
certo che si...

... ma anche no

biologia
vs
biografia

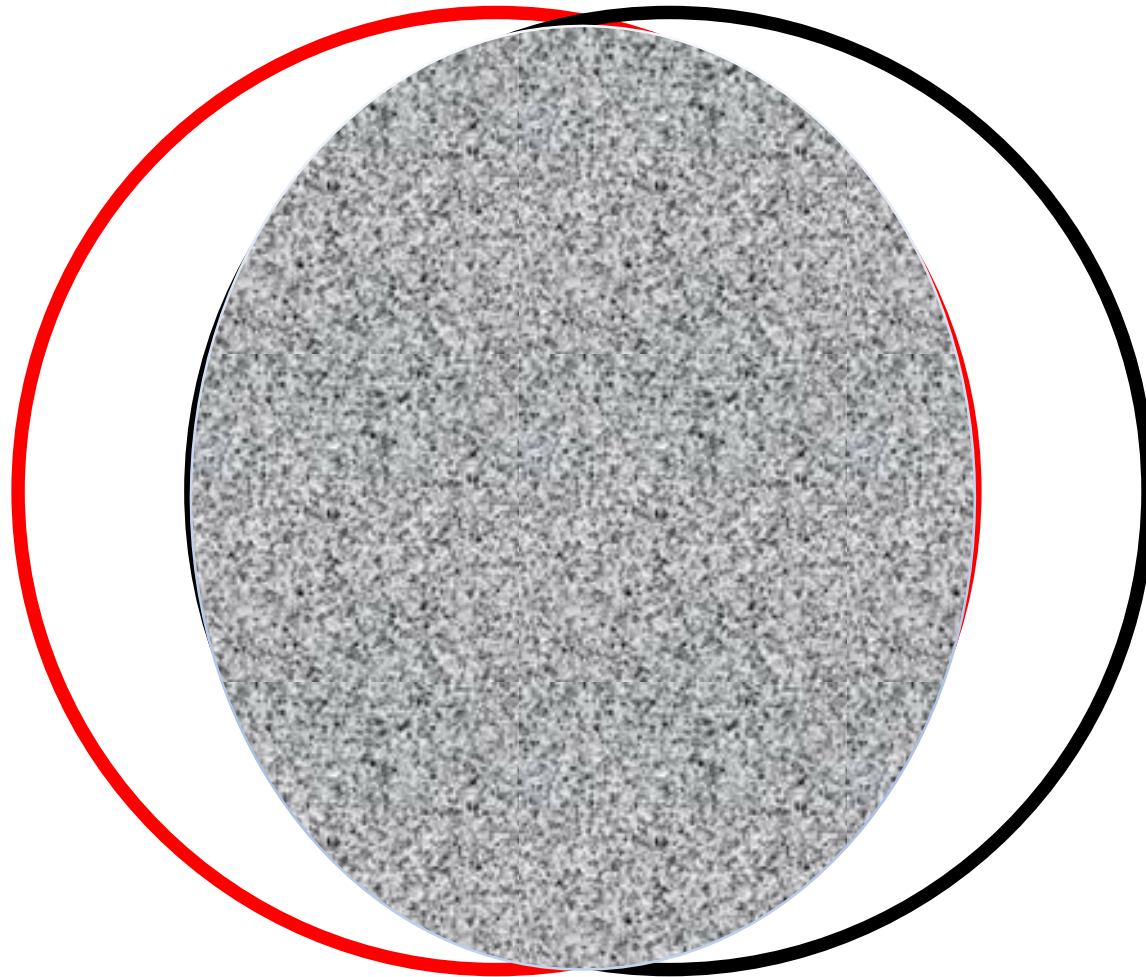
disease
vs
illness

**cure appropriate
e
proporzionate**



PAZIENTE

MEDICO



**CURE
PROPORZIONATE**

**CURE
APPROPRIATE**

Il campo di gioco

Vergano Minerva Anestesiol 2017



**La medicina del III
millenio**



Il paziente del III millennio

A photograph of a patient lying in a hospital bed, surrounded by medical equipment. The patient is wearing a nasal cannula and has several IV lines connected to their chest. A large blue tube is also connected to the patient's chest. To the left of the patient, there is a medical monitor displaying vital signs, including a heart rate of 100 and a blood pressure of 97. Below the monitor, there is a blue medical device, possibly a ventilator or a pump. The patient's face is partially obscured by a black rectangular box. The background shows a window with a view of the outdoors.

Chronic critical patient

PANCREATITE ACUTA – 96° DIE DI RICOVERO

Hospital dependent patient



BPCO – 13° RICOVERO IN 1 ANNO

Biologia

e

Biografia



CrossMark
click for updates



ANALYSIS

BMJ 2015;350:h705 doi: 10.1136/bmj.h705 (Published 13 February 2015)

Too much technology

Our abilities to produce and use technologies appear to outrun our abilities to reflect on their application. To avoid becoming technological titans and ethical Lilliputians **Bjørn Morten Hofmann** argues we need a more reflective and responsible implementation of health technology



a Mathieu Kassovitz film

LA HAINE

how far you fall doesn't matter, it's how you land...

« Questa è la storia di un uomo che cade da un palazzo di 50 piani. Mano a mano che cadendo passa da un piano all'altro, il tizio per farsi coraggio si ripete: **“Fino a qui, tutto bene. Fino a qui, tutto bene. Fino a qui, tutto bene.”** Il problema non

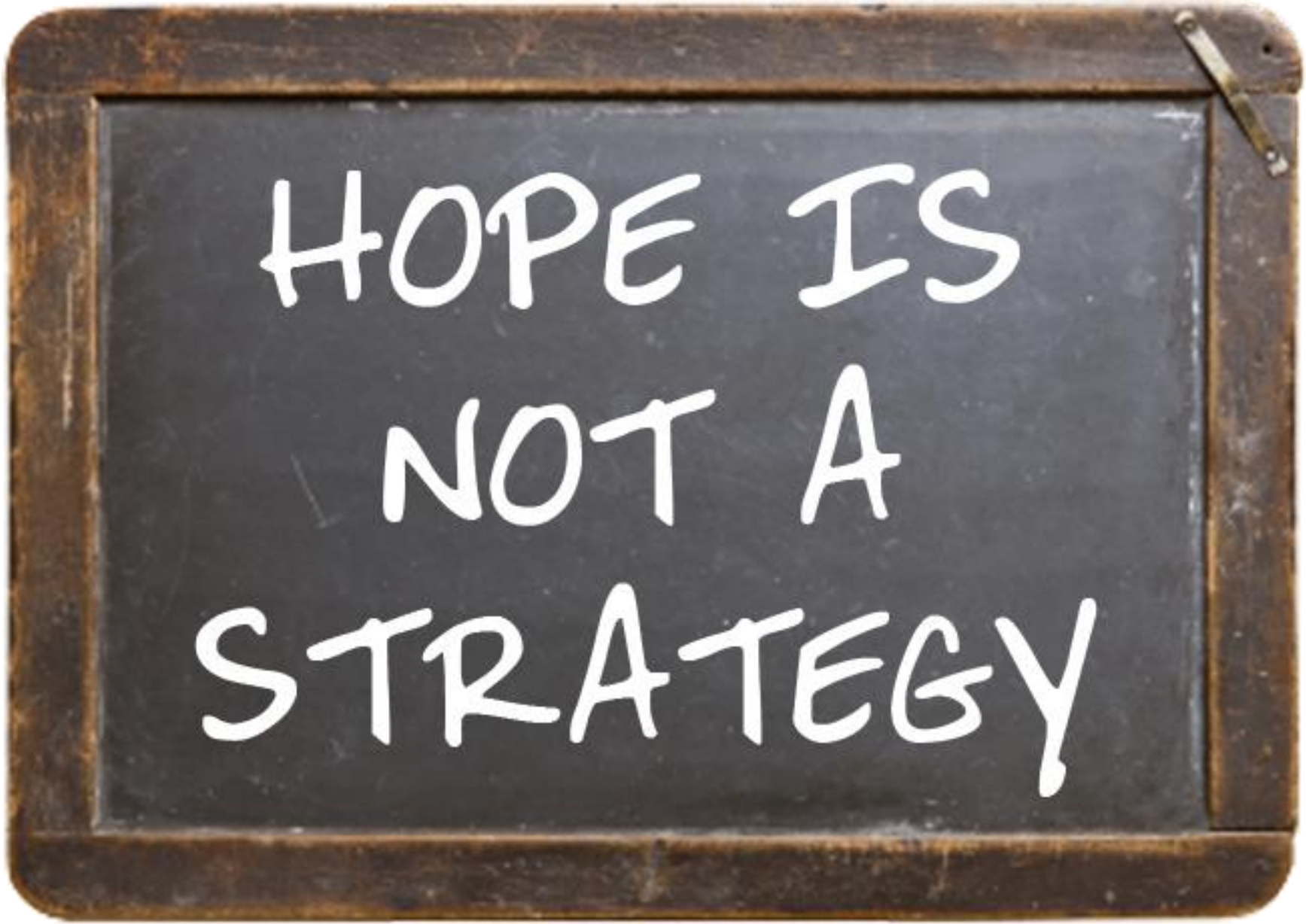
The patient who fell off a skyscraper



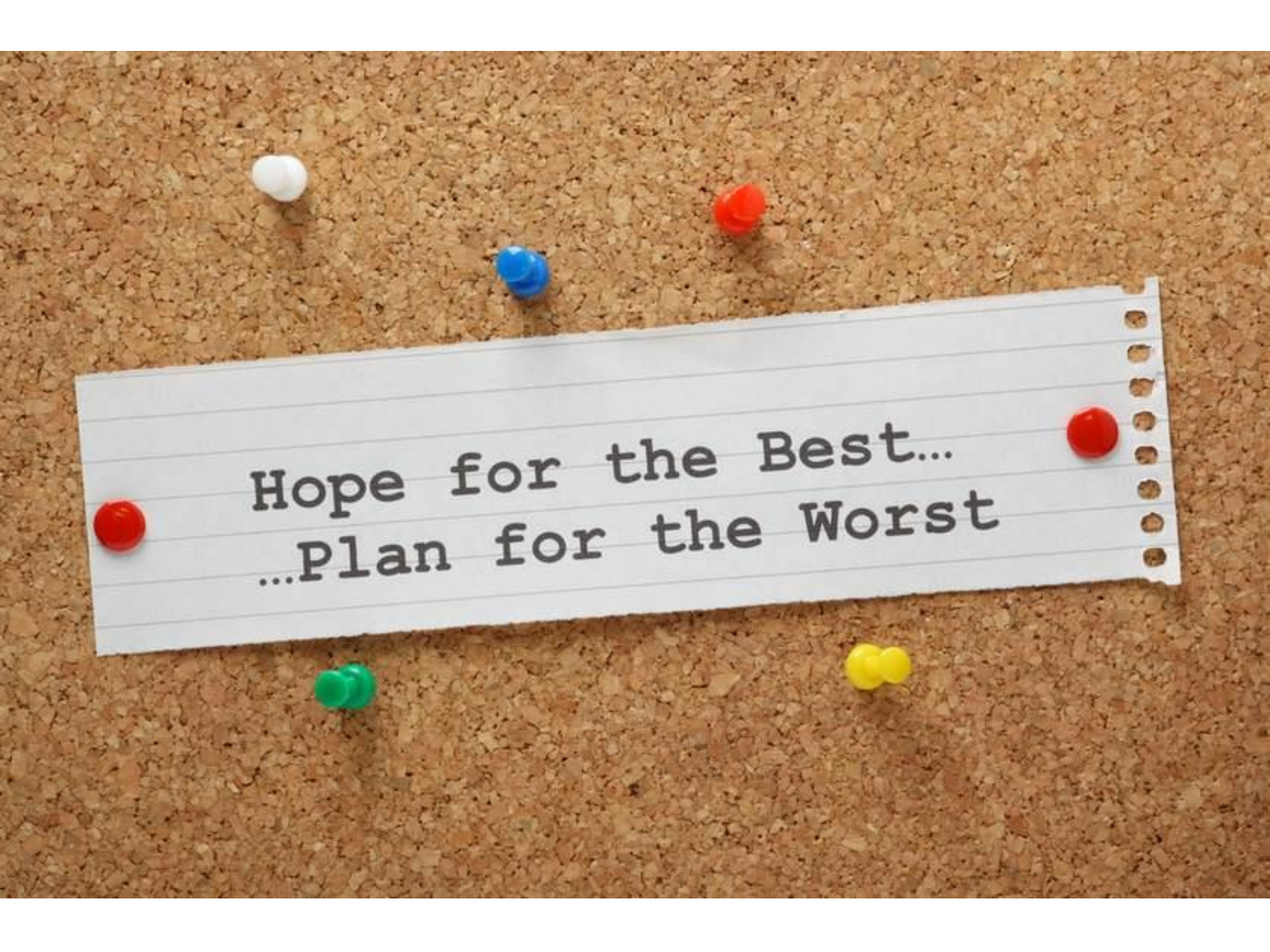
The patient who fell off a skyscraper

Our job is not confined to slowing the rate of
descent.

It is also our concern to ... equip people for a
landing as smooth as possible



HOPE IS
NOT A
STRATEGY



Hope for the Best...
...Plan for the Worst

Legge 219/2017 - ARTICOLO 5 – PIANIFICAZIONE CONDIVISA

- rispetto all'evolversi di una patologia cronica e invalidante o caratterizzata da inarrestabile evoluzione con prognosi infausta, può essere realizzata una **pianificazione delle cure condivisa tra il paziente e il medico ...**
- **il paziente e, con il suo consenso, i suoi familiari** o la parte dell'unione civile o il convivente o una persona di sua fiducia **sono adeguatamente informati** sul possibile evolversi della patologia in atto, su quanto il paziente può realisticamente attendersi in termini di qualità della vita, sulle possibilità cliniche di intervenire sulle cure palliative
- il consenso del paziente e l'eventuale indicazione di un fiduciario sono **espressi in forma scritta ...** e sono inseriti **nella cartella clinica** e nel fascicolo sanitario elettronico

Consenso informato
situazione attuale

Disposizioni anticipate
situazione posta in un
futuro imprevedibile

Pianificazione condivisa
situazione posta in un
futuro prevedibile



SIAARTI
PRO VITA CONTRA DOLOREM SEMPER

SOCIETÀ ITALIANA DI ANESTESIA ANALGESIA
RIANIMAZIONE E TERAPIA INTENSIVA

**GRANDI INSUFFICIENZE D'ORGANO "END STAGE":
CURE INTENSIVE O CURE PALLIATIVE?
"DOCUMENTO CONDIVISO"
PER UNA PIANIFICAZIONE DELLE SCELTE DI CURA**

Documento approvato e condiviso da:

- SOCIETÀ ITALIANA ANESTESIA ANALGESIA RIANIMAZIONE TERAPIA INTENSIVA (SIAARTI)
- ITALIAN RESUSCITATION COUNCIL (IRC)
- ASSOCIAZIONE NAZIONALE MEDICI CARDIOLOGI OSPEDALIERI (ANMCO)
- SOCIETÀ ITALIANA MEDICINA EMERGENZA URGENZA (SIMEU)
- SOCIETÀ ITALIANA CURE PALLIATIVE (SICP)
- SOCIETÀ ITALIANA NEFROLOGIA (SIN)
- ASSOCIAZIONE NAZIONALE INFERMIERI DI AREA CRITICA (ANIARTI)
- SOCIETÀ ITALIANA MEDICINA GENERALE (SIMG)
- ASSOCIAZIONE ITALIANA PNEUMOLOGI OSPEDALIERI (AIPO)

F

uncertainty





The NEW ENGLAND
JOURNAL of MEDICINE



A Day in the Life of Oscar the Cat

David M. Dosa, M.D., M.P.H.

Traiettorie ...



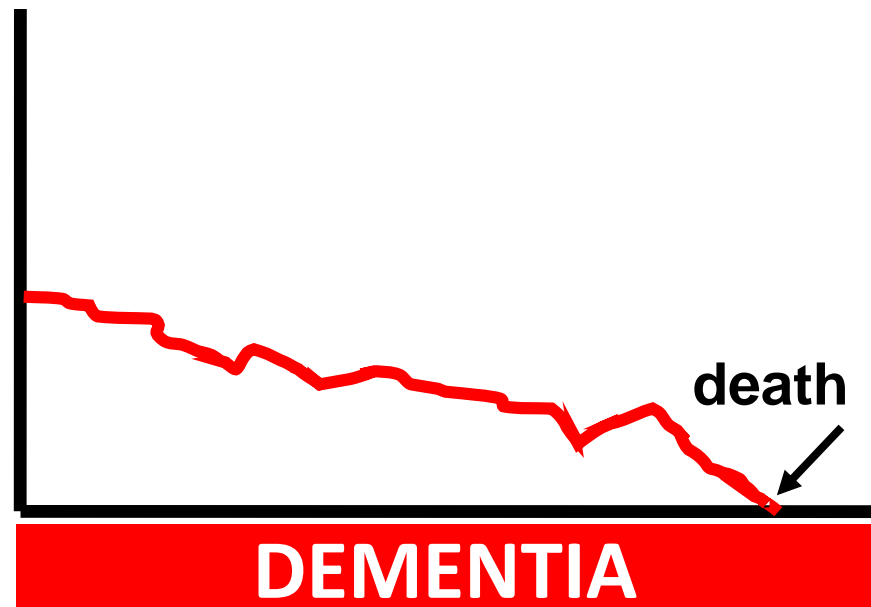
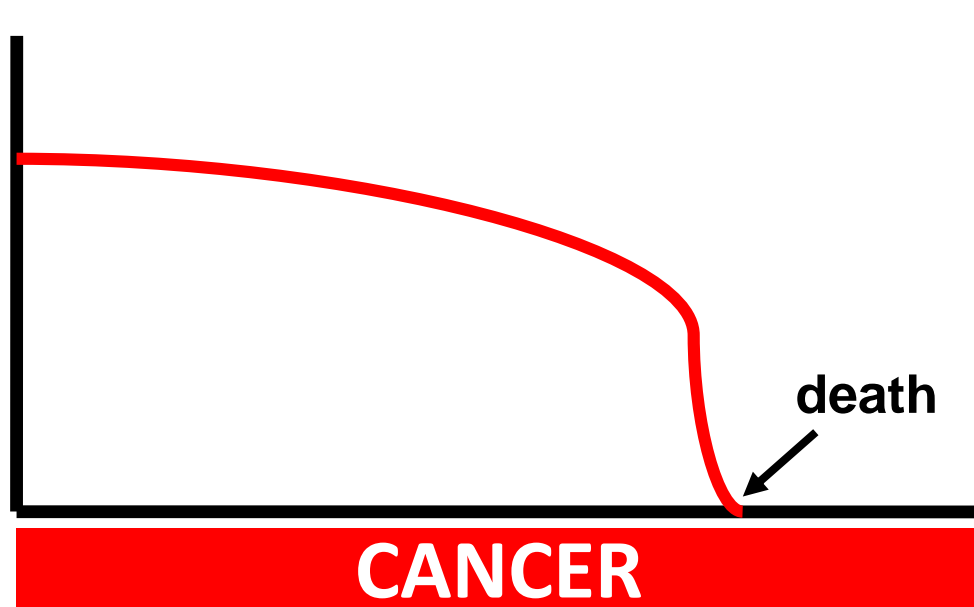
CANCER



DEMENTIA

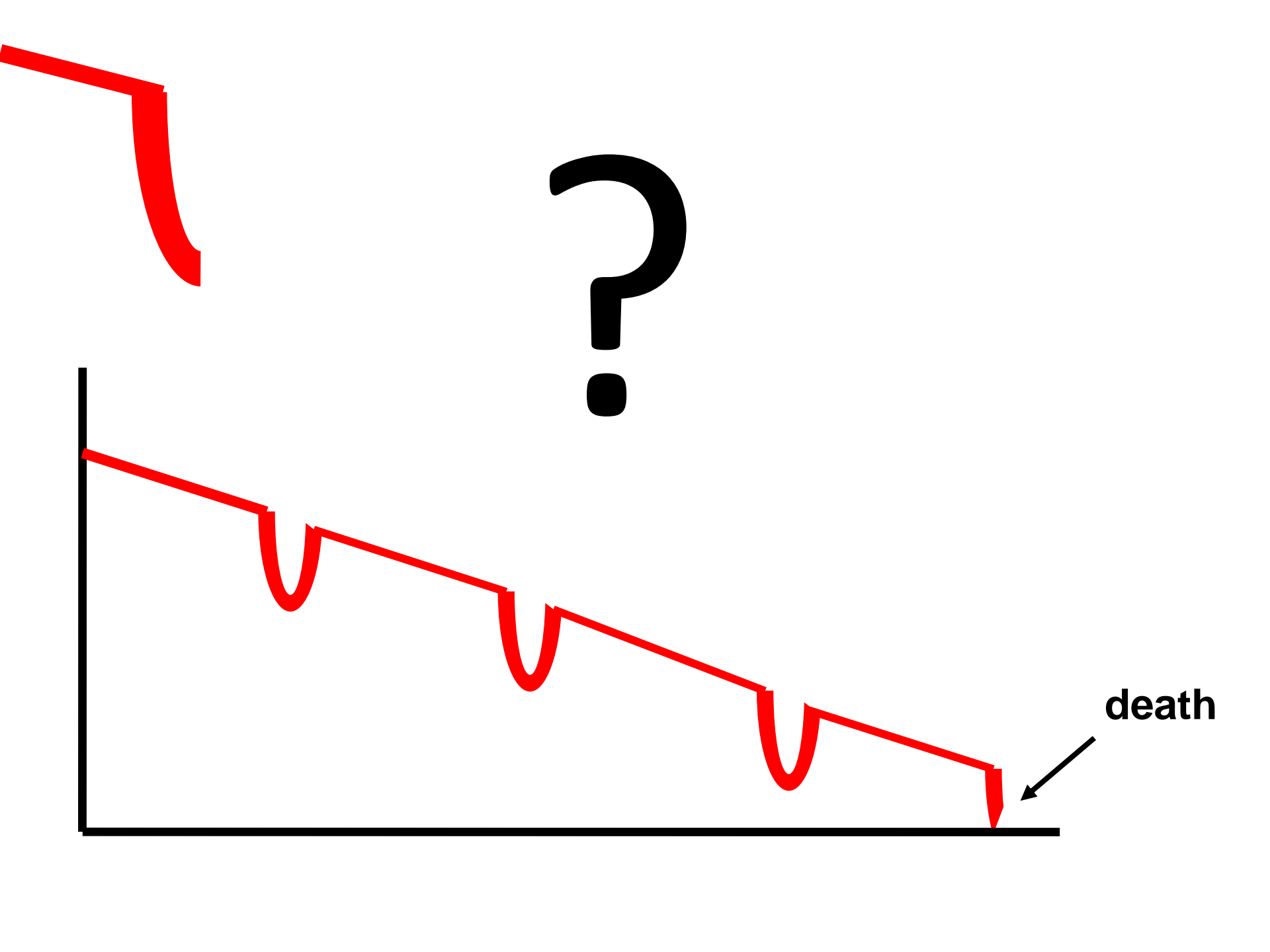


ORGAN SYSTEM FAILURE



... e segmenti





My patient suffering from chronic respiratory failure must have undergone tracheal intubation or tracheostomy?

My patient suffering from chronic renal failure must have undergone hemodialysis?

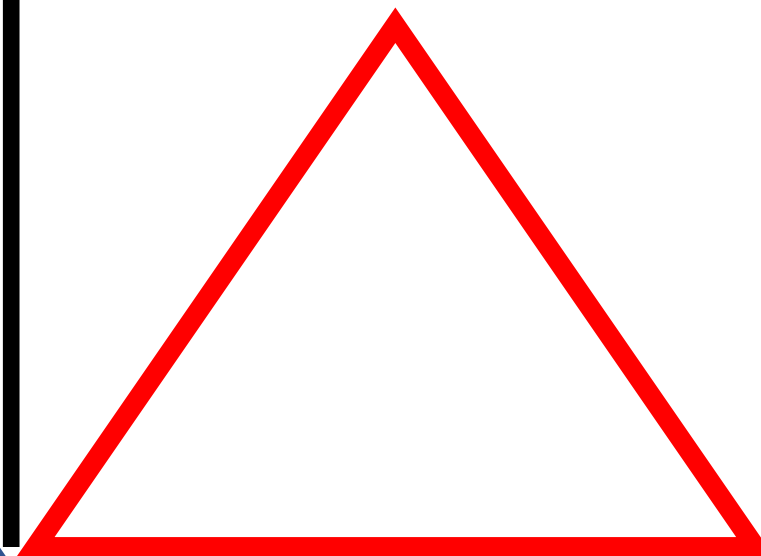
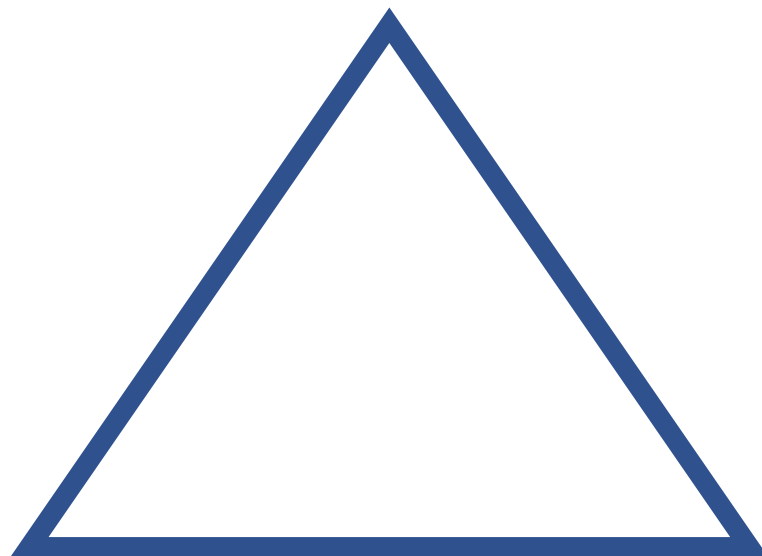
My chronically ill elderly patient must have undergone surgical procedure?

...

or not ?

TRATTARE

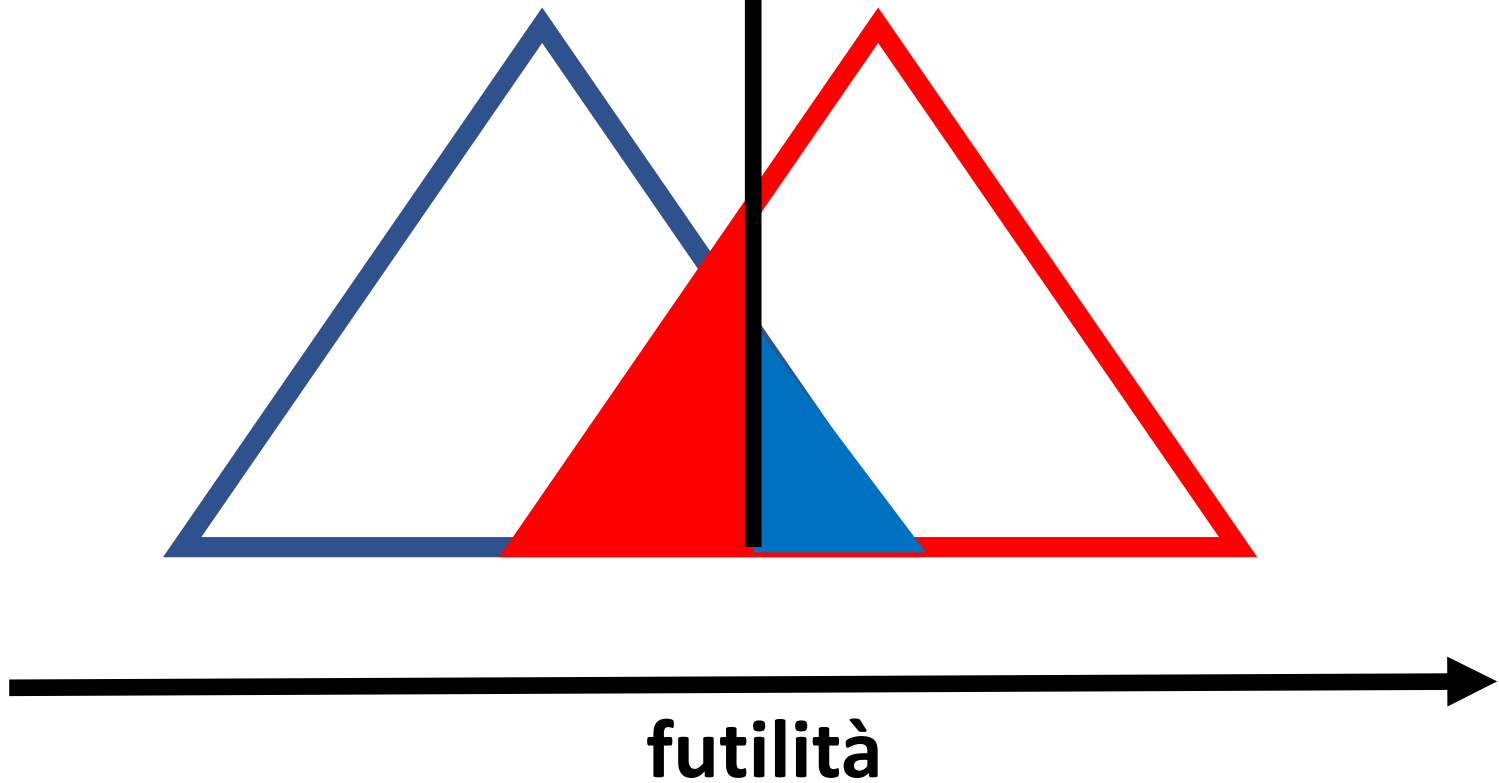
NON TRATTARE



futilità

TRATTARE

NON TRATTARE



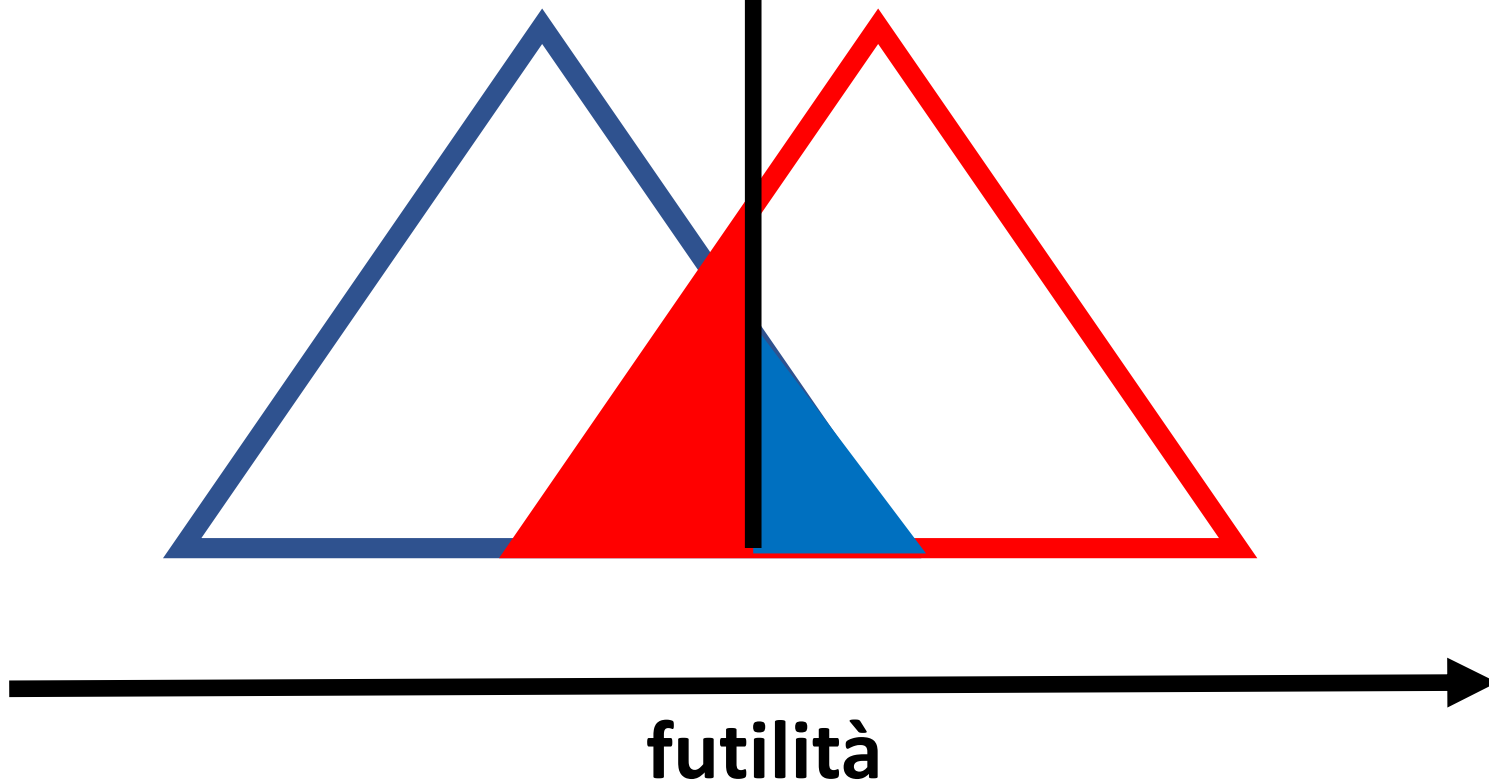
Prognostic paralysis

**“There is a problem – I have to fix
it”**

“Do everything we can”

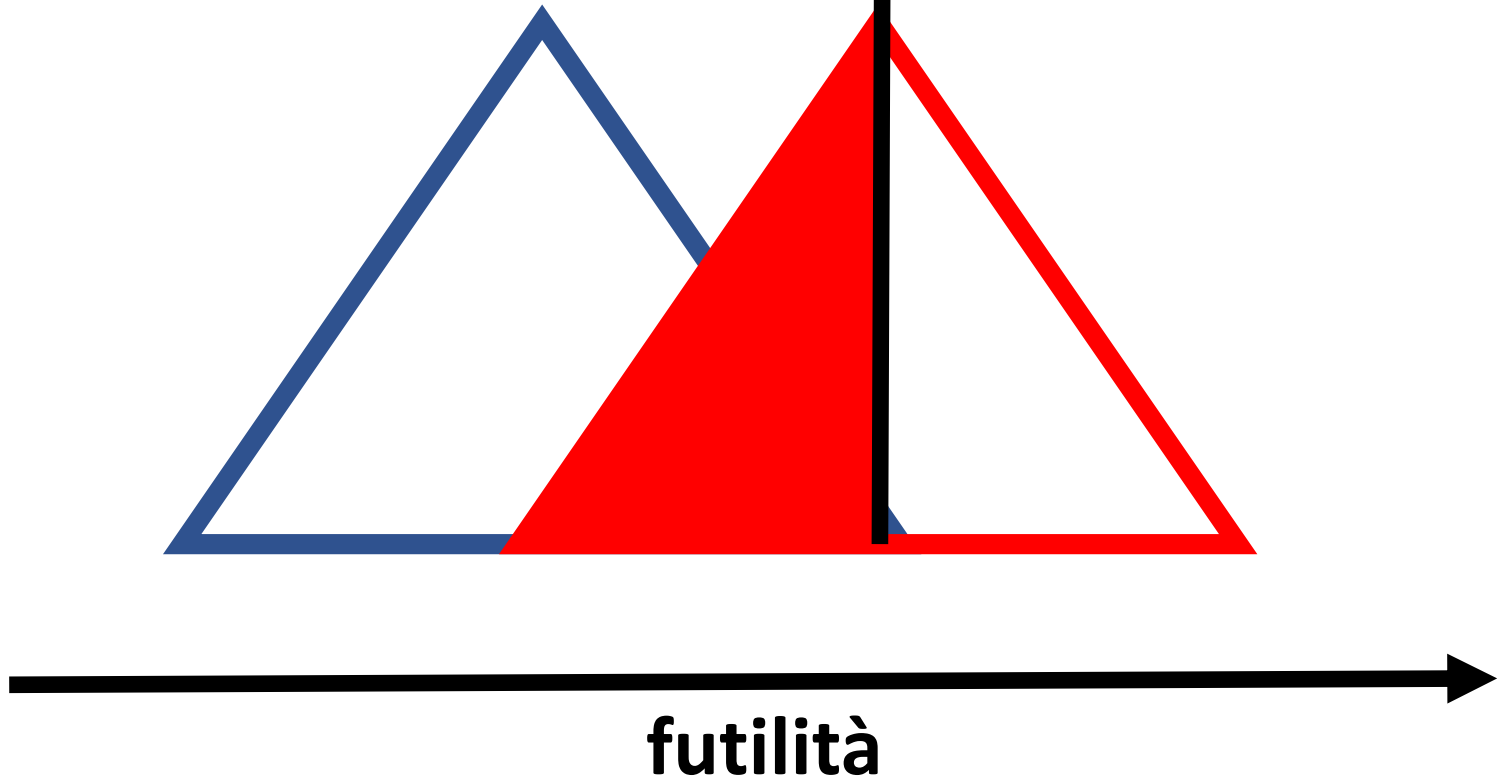
TRATTARE

NON TRATTARE



TRATTARE

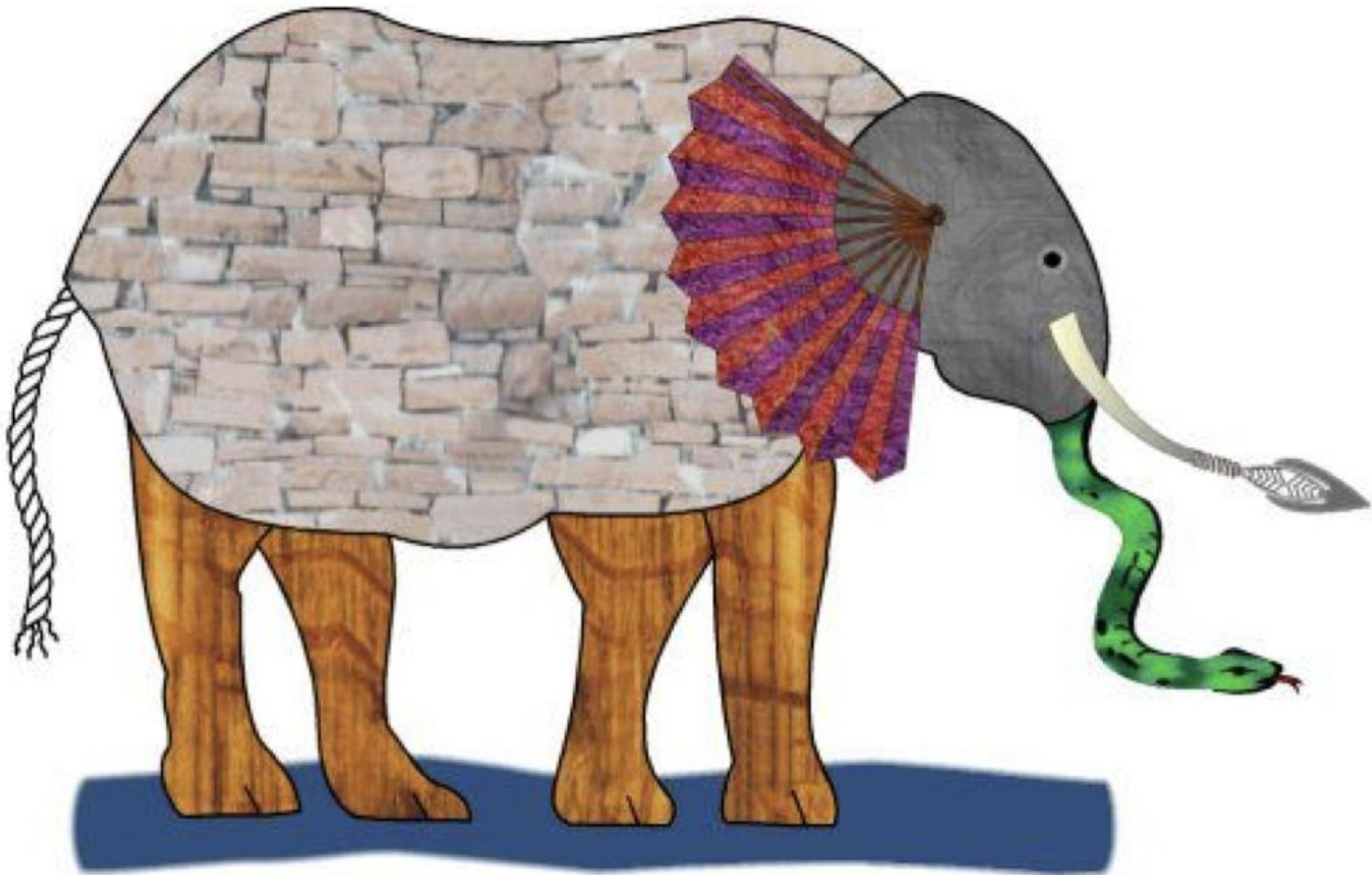
NON TRATTARE



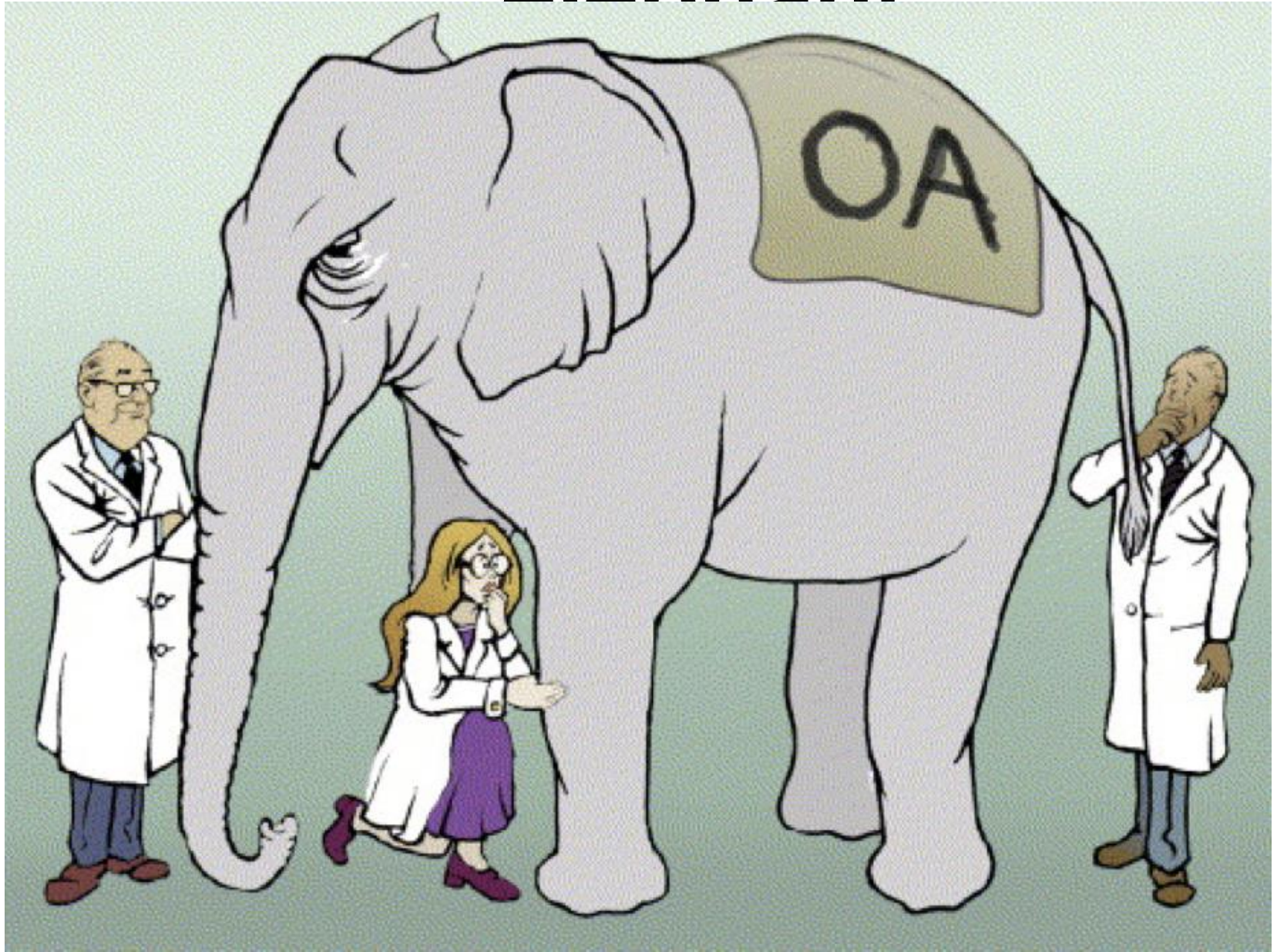
Nastri trasportatori



6 blind men and the elephant



6 blind doctors and the elephant





Who is the
captain of the
ship ?

Ostinazione irragionevole





LA RISPOSTA

L'INSULTO



LA RISPOSTA

L'INSULTO



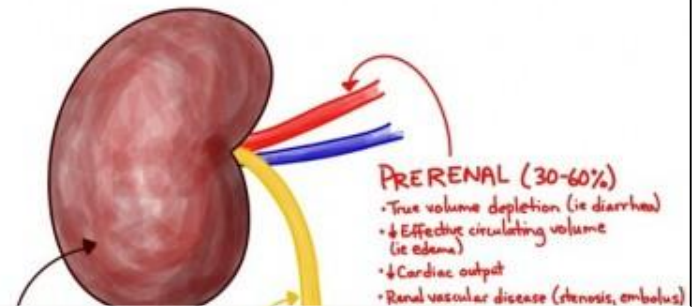
L'INSULTO LA RISPOSTA



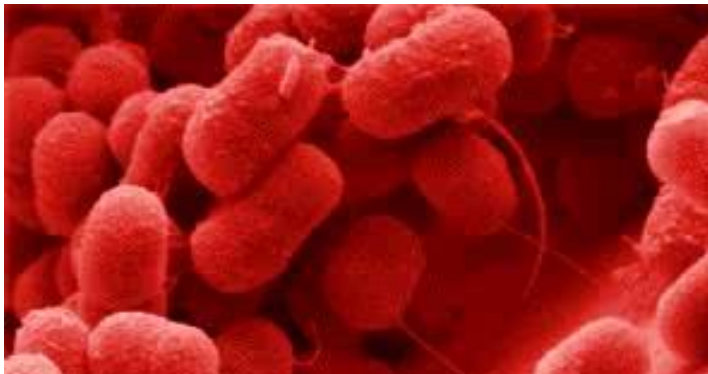


(VOLO – BARO) TRAUMA

ACUTE KIDNEY INJURY



ACUTE KIDNEY INJURY



SUPER INFECTIONS



ICU WEAKNESS - DELIRIUM



PROCEDURAL COMPLICATIONS

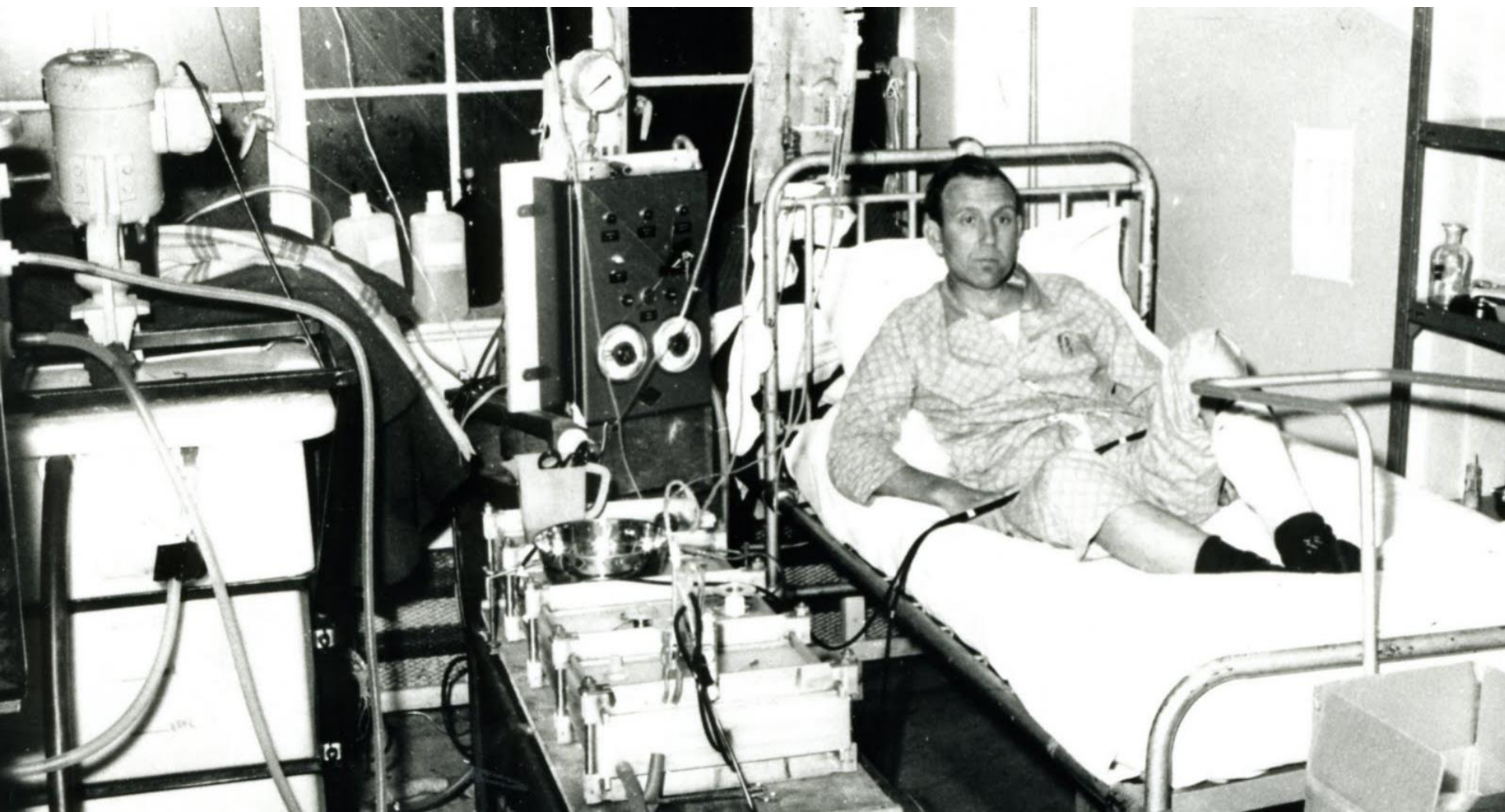


ETC, ETC...

Beneficialità
Non maleficenza
Autonomia



Beneficialità
Non maleficenza
Autonomia
Giustizia distributiva

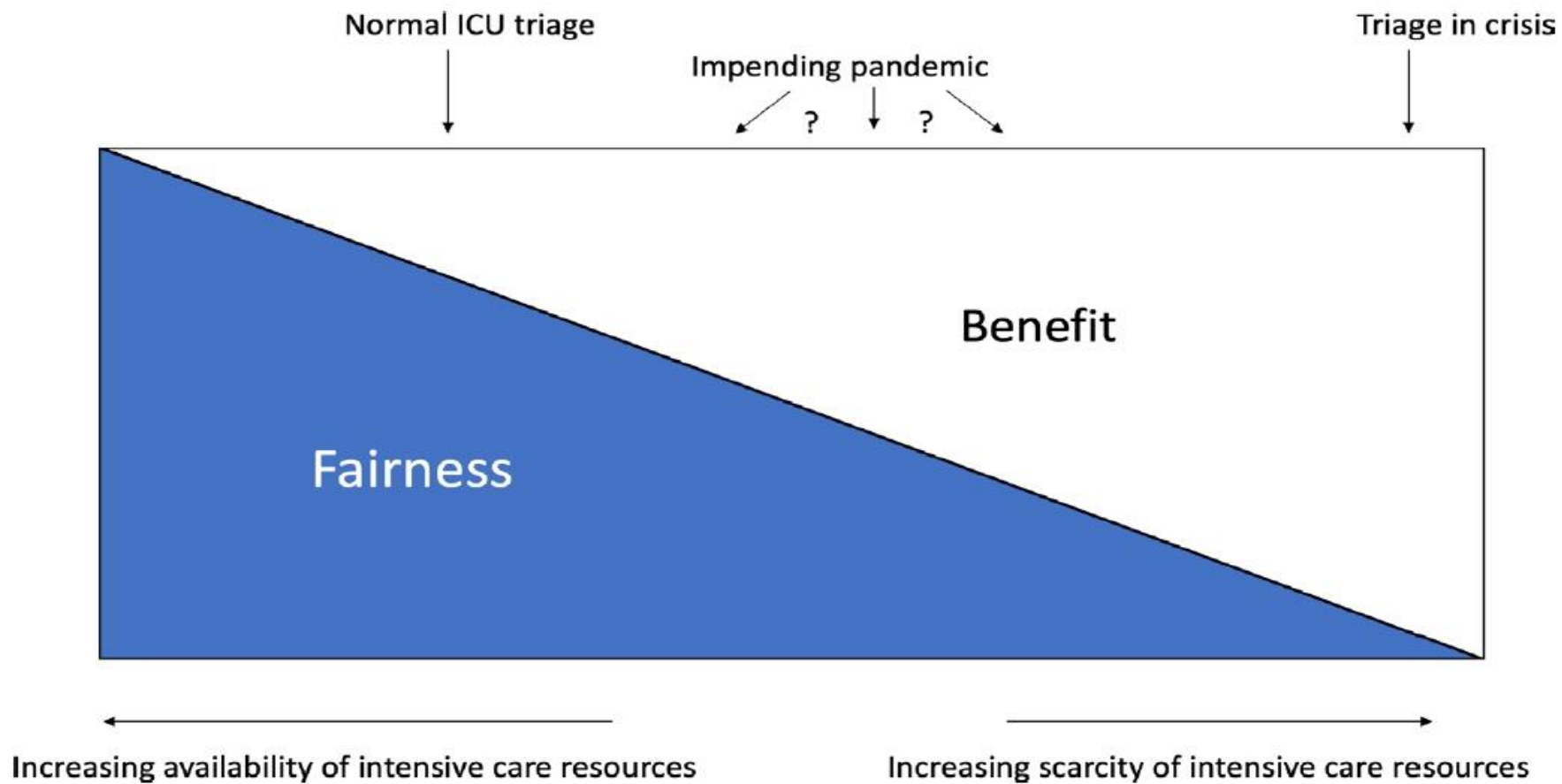


PERSPECTIVE

All in a Day's Work — Equity vs. Equality at a Public ICU in Brazil

Flávia R. Machado, Ph.D.

Patient-centered care
Community-centered care



Beneficialità

vs

giustizia distributiva

Clinical ethics (duty to care)
**Organizational ethics (duty to
plan)**

The Atlantic

HEALTH

WHAT THE CHAOS IN HOSPITALS IS DOING TO DOCTORS

Politicians' refusal to admit when hospitals are overwhelmed puts a terrible burden on health-care providers.

By Jordan Kisner





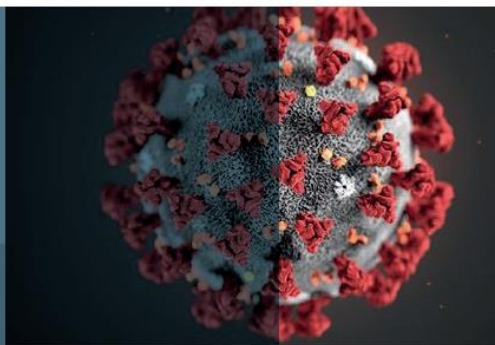
CLINICAL ETHICS RECOMMENDATIONS FOR THE ALLOCATION OF INTENSIVE CARE TREATMENTS, IN EXCEPTIONAL, RESOURCE-LIMITED CIRCUMSTANCES

Authors

Marco Vergano, Guido Bertolini, Alberto Giannini, Giuseppe Gristina, Sergio Livigni, Giovanni Mistraretti, Flavia Petrini



SIAARTI
PRO VITA CONTRA DOLOREM SEMPER



EDITORIAL

Open Access



Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances: the Italian perspective during the COVID-19 epidemic

Marco Vergano^{1*}, Guido Bertolini², Alberto Giannini¹, Giuseppe R. Gristina¹, Sergio Livigni¹, Giovanni Mistraretti¹, Luigi Riccioni¹ and Flavia Petrini¹

Background

On February 21, 2020, the first person-to-person transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV2), the virus causing coronavirus disease 2019 (COVID-19), was identified in Italy. In the following days, despite the restrictive public health measures applied to avoid the spread of the infection [1], the number of cases sharply increased. As of March 8, 2020, Italy was the 2nd most affected country in the world.

In one of the largest reports from China, 5% of COVID-19 patients required admission to the intensive care unit (ICU) [2]. Since the beginning of the COVID-19 outbreak, the availability of ICU beds has been recognized as one of the major public health concerns in Italy, where a total of 5090 ICU beds (8.42/100,000 inhabitants) were reported in 2017 [3]. Despite further efforts have been done to contain the number of cases and extraordinary measures have been put in place, the dramatic increase of ICU admission abruptly overwhelmed the ICU capacity, mostly in Lombardy and in the nearby regions of Northern Italy.

From the evidence available so far, a considerable proportion of subjects diagnosed with COVID-19 infection requires ventilatory support due to severe hypoxemia in the context of interstitial pneumonia. The interstitial lung disease is potentially reversible, but the acute course of

the disease can last several days, and ventilatory support may be needed for weeks [4]. These clinical considerations imply that caring for patients with severe pneumonia from COVID-19 can be very demanding in terms of the number of devices and staff required.

As of March 6, 2020, the Italian Society of Anesthesia, Analgesia, Resuscitation and Intensive Care (SIAARTI) issued a series of recommendations [5] and relevant ethical considerations to better inform the clinicians involved in the care of critically-ill COVID-19 patients, in a setting where a disproportionate number of patients requiring life-sustaining treatments was rapidly saturating both the existing and the newly set-up ICU beds. The most relevant recommendations are summarized in Table 1.

General principles

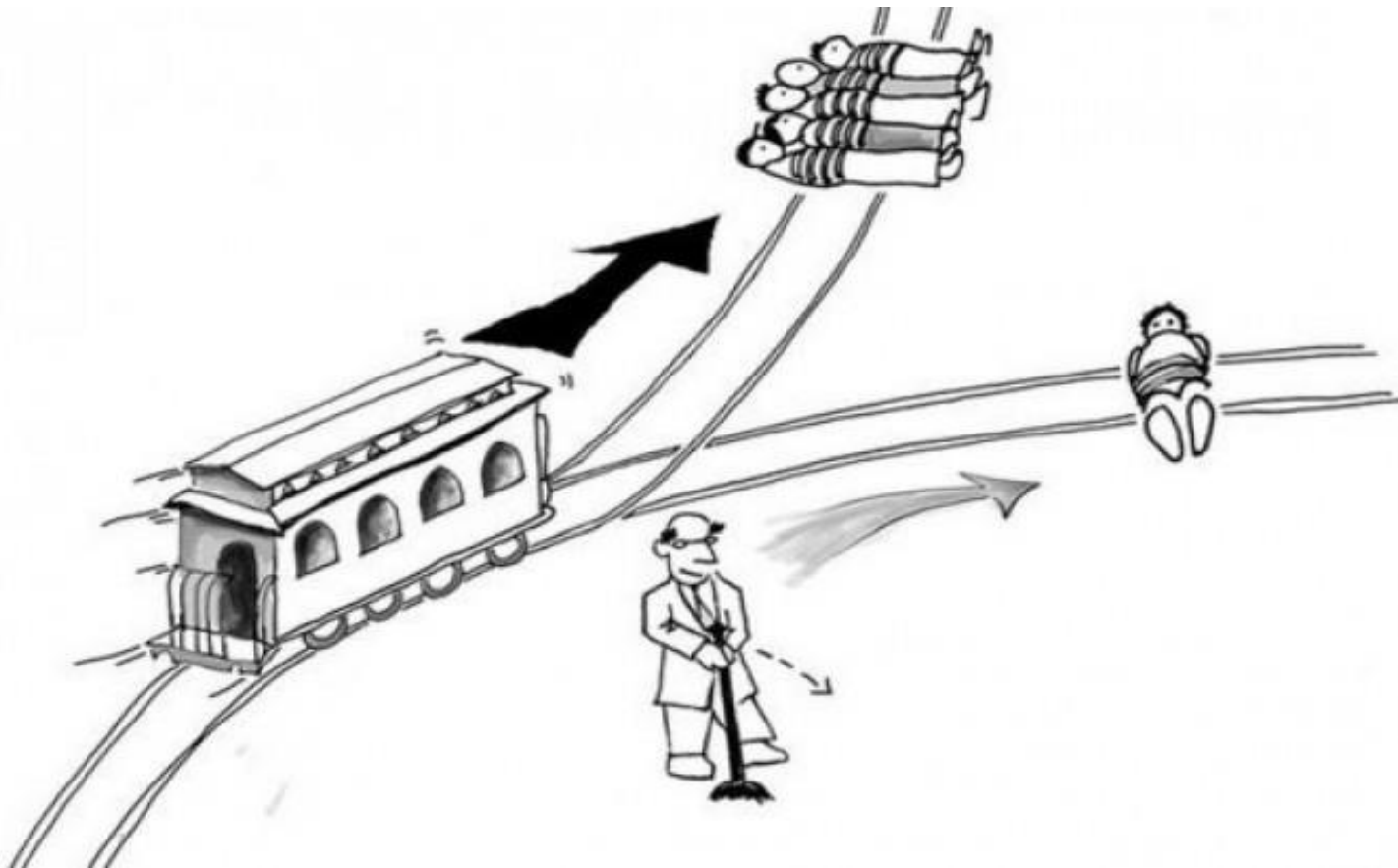
The emerging epidemic is leading to a substantial increase in the number of patients requiring prolonged ventilatory support for acute respiratory failure, potentially resulting in severe imbalances between the population clinical needs and the overall availability of ICU resources. In this scenario, criteria for ICU admission (and discharge) may need to be driven not only by the principles of clinical appropriateness and proportionality of care, but also by criteria of distributive justice and appropriate allocation of the healthcare resources, that may be more limited than usual.

The primary aim of these recommendations is therefore to supply a common framework for the admission of

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Who gets the last bed? Ethics criteria for scarce resource allocation in the era of Covid-19

1) Caregivers	8) Medical need/rule of rescue
2) Conservation of resources	9) Medical success/survivability (or prognosis criterion)
3) Fair innings or life-cycle principle	10) Population-based mortality risk
4) First come, first served	
5) General need	11) Random selection
6) Heroism	12) Social/moral worth
7) Immediate usefulness or multiplier effect	13) Workplace exposure

**«The technical and moral aspects of
patient care are inseparable»**

Albert R.

