For the readmission of patients from the high-dependency unit, other wards or the A&E department, the same criteria apply as for primary ICU admission. The fact that a patient has already been treated in the ICU does not provide an automatic entitlement to readmission.

In cases where it can be assumed that a patient transferred from the ICU to a general ward will not benefit from renewed ICU treatment (e.g. patients with severe COPD, severe irreversible organ failure, severe multimorbidity, severe neurological impairment, advanced dementia, etc.), it is advisable to rule out readmission to the ICU at the time of the transfer. If essentially new aspects emerge, this decision should be reviewed and readmission discussed.

9.3. Resource scarcity and triage

If available resources are no longer sufficient to optimize the chances of all individuals concerned, decisions on rationing become unavoidable. These must be based on ethical principles, and the criteria applied must be justified and made transparent. In cases of absolute resource scarcity, such as may arise during a pandemic, highest priority is to be accorded to patients whose prognosis is good with, but poor without, ICU treatment.

Complications and mortality in an ICU decrease as the number of patients treated (number of cases) increases and average bed occupancy decreases. If average bed occupancy exceeds 80% of maximum capacity, it is no longer possible to guarantee emergency ICU admissions or safe transfer of patients from the ICU, which leads in turn to higher readmission rates and higher mortality. Given that occupancy rates in many ICUs are usually relatively high, it is therefore necessary in the event of resource scarcity to consider all options (postponement of elective procedures, transfer to another ICU or early transfer to another ward). Early transfer may involve complications for the patient if the necessary support (staff and equipment) cannot be adequately provided outside the ICU. To avoid these risks for patients, efforts should primarily be made to obtain additional staff, so that at least all available beds can be used. In addition, beds should be sought in other/external ICUs. In such cases, primarily patients with good chances of a favourable outcome should be transferred, and at the same time an offer should be made to readmit them in the event of a protracted course. If these measures prove unsuccessful and the resource scarcity becomes more acute, rationing of life-sustaining treatments becomes unavoidable. Initially, efforts should be made to reduce levels of staffing and material resources to the minimum acceptable quality standard for all patients. Only when these measures also prove inadequate does it become necessary to ration intensive care as such. This calls for an equitable triage procedure.

If in a large-scale emergency, such as a pandemic, it is no longer possible to provide intensive care for all patients, it must be ensured that triage is conducted according to ethical principles. The criteria applied must be objectively justified and transparent. They are to be applied without discrimination (e.g. on grounds of age, sex, canton of residence, nationality, religious affiliation, social and insurance status or existing chronic disability) in an equitable procedure. This is to be managed by trustworthy and experienced persons, who are legally accountable and who adapt the triage procedure to changing requirements.

In a large-scale emergency, highest priority is to be accorded to those patients whose prognosis is good with, but poor without, ICU treatment. In the event of rationing, patients who would normally be monitored in the ICU but can also be cared for in another ward without their prognosis being seriously compromised are not to be admitted. Patients with a poor prognosis for whom ICU treatment of limited duration would be indicated under normal circumstances are to be cared for outside the ICU in a large-scale emergency. The decisive factors for prognostic assessment in this context are the probability of short-term survival of ICU treatment as such and the presence of any comorbidity with a poor short-term prognosis, but not medium- or longer-term life expectancy.

29 Cf. Bagust et al. (1999), Lapinaho et al. (2000).

30 In the context of modern emergency medicine, "triage" primarily refers to the assignment of new patients to those treatment pathways which offer the best possible treatment chances for individuals and at the same time permit optimum utilization of all available resources. If these resources are no longer sufficient to optimize the chances of all the individuals concerned, triage is used to manage rationing. Triage decisions can then directly affect life and death, as in the original battlefield medicine sense.