



POINT OF VIEW

An ethics crisis within the health crisis due to COVID-19[☆]

Una crisis de ética dentro de la crisis sanitaria por la COVID-19

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The SARS-CoV-2 global pandemic¹ has been testing our healthcare system and the maturity of our society when time has come to face an exceptionally dramatic crisis like this. In this sense, we are grateful for all the bioethical reflections and constructive comments that have been made on the importance of prioritizing resources. However, we also wish to discuss a series of not very objective statements made by Dr. Montalvo Jääskeläinen et al.² regarding a document signed by several scientific societies (SS) with ethical recommendations on decision-making processes in the exceptional situation of crisis due to the COVID-19 pandemic in the intensive care unit setting.^{3,4} We believe their statements do not reflect the goals and contents included in the document, and show a total lack of knowledge on the first-line healthcare provided to critically ill patients with COVID-19. The document was supposed to be a set of guidelines to be able to make inevitable and complex decisions in such an exceptional situation as the one posed by the collapse of the healthcare system. This document is based on scientific criteria, abides by the current legislation and according to its writers, distances itself from utilitarianism and tries to fill up a large and existing void from positions that are closer to humanism, personalism, and principlism. In this context, *the anticipation and participation of other agencies and institutions during the writing of recommenda-*

tions intended to guide our actions would have been much appreciated.

Triage is defined as the need to prioritize insufficient resources for patients who may need it. In our healthcare system we have a history of prioritizing limited resources like patient waiting lists for organ transplants. However, it was not until the arrival of this pandemic that the very concept of triage was put into question the way it has.

These recommendations were made in an obvious rush by expert professionals who work around the clock and are trained in bioethics, not only with theoretical but also with practical training in the healthcare system. They were the first recommendations ever published in Spain (Italy already had implemented their own), but some matters we believe deserve further discussion. However, we do not share the taste for the jugular shown by those who are yet to approach the authors for term clarification, propose a totally different writing or, most important of all, discuss the criteria that should be followed. A bioethical framework to guide the decision-making process cannot be limited to considering a proposal or an action simply good or bad. Instead, it should also come with alternatives to the issue at stake, and maybe even shed light on the possible intermediate courses of action that should be followed.⁵ In conclusion, the goal here is to be able to build something together for the good of everyone.

We agree with De Montalvo Jääskeläinen et al.² that only the state can limit the rights of its citizens. The documents proposed by the SS do not have legal value, do not limit personal rights or impose actions on anybody. That is why we question the suggestion that the Spanish Ministry of Health should keep an eye on the recommendations made by the SS, particularly knowing that there is an ongoing relation between the former and the latter.⁶ As the Spanish Bioethics Commit-

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tee (SBC) says, the SS are fundamental actors that provide the public authorities with the necessary knowledge to establish national criteria of prioritizing.⁷

Back in mid-March 2020 many regions had shortage of resources. Around 1000 patients were dying each day and tens of healthcare professionals died while taking care of them.⁸ For example, in Madrid, although the beds of intensive care units (ICU) tripled because other units were being occupied such as operating rooms and new spaces with just a few basic resources the number of ICU admissions kept going up at a rate of 100 admissions each day.⁹ Not all critically ill patients were being assisted by health professionals with the same level of experience or admitted to units with the same type of resources. Still, all of us gave everything we had at the time. As a matter of fact we do not remember any ethical debates on the type of unit patients were being admitted to, which maybe would be desirable. The *Spanish Society of Intensive and Critical Care Medicine and Coronary Units* published a series of documents with recommendations¹⁰⁻¹³ including a contingency plan for the distribution and multiplication of resources.^{14,15} A matter whose competence falls directly into the hands of the Administration. However, as far as we know, these documents have not been criticized, just the opposite.

Although there were no portable ventilators or anesthesia equipment available, there were tens of patients who still needed both medical resources. This kept happening because the public institutions had given no specific instructions on how to face this situation. Therefore, each health professional inexorably had to face and solve these problems individually at the ICU setting. The SBC report did not approach this important and unavoidable matter in their first session of March 2020 because they thought that the issue at stake still did not pose specific problems of bioethical relevance. *We would have welcome specific prioritizing instructions issued by the public authorities with specific criteria provided by the SBC, but such thing never happened. When there are more patients than resources available, the decision on who should benefit from these resources is unavoidable.*

Three aspects have been criticized: first, the limitation of resources associated with age. However, *in the recommendations, age alone is not considered as a sole criterion for the allocation of resources whatsoever.* On the contrary, there are numerous criteria so that decisions can be made on an individual basis, also in compliance with the Madrid Official Medical General Council of March 23.¹⁶ According to this institution it is acceptable—even unavoidable—to establish life expectations in the short-term. Both experience and the medical literature available confirm that not only age, but also diseases defined by a low level of conscience, and many other factors can reduce the possibilities of exceeding prolonged courses on mechanical ventilation.^{17,18} Just as an example, age and comorbidities are two factors that are taken into consideration during the selection of candidates eligible to receive trasplants.^{19,20} Actually this criterion is not considered utilitarian and is widely accepted by all. *We suggest changing the criterion of cognitive impairment for one with a wider scope that includes conditions or disorders that have a worse prognosis regarding mechanical ventilation or in which weaning the patients from mechanical ventilation becomes more difficult (obviously in this context of lack of resources only) while explicitly saying that age alone is not be a single criterion.*

It is our understanding that the criteria listed aim for applying scarce resources to those who will probably bene-

fit the most from them by eliminating exclusive categories, something the authors share by quoting the work of Wakam et al.²¹ De Montalvo Jääskeläinen et al., however, criticize the document with the recommendations made for that they consider the worst possible interpretation of it. But, at the same time, they admit that not even age above 80 would be an explicit or absolute exclusion criterion according to the text they criticize. They throw the entire medical profession under the bus when they reproduce a quote by Samuel R. Bagenstos: “there is ample evidence of widespread bias against people with disabilities among medical professionals”. They seem to suggest that there is an apparent discrimination towards people with disabilities. *The only time the term “disability” appears on the recommendations made has nothing to do with the selection or discrimination of people with or without disabilities, but with survival per se, more precisely, serious adverse event-free survival.* We understand that it is difficult to write one criterion using simple terms that, from the clinician point of view, is easy to understand but that, at the same time, can give rise to erroneous interpretations among the general population. Any arguments used to defend the rights of disabled populations by the different organizations are relevant, necessary, and totally shared by us. That is why we do not think criticizing the recommendations made by the SBC is the right thing to do since they were never intended to generate such discrimination in the first place.

To this point, the term “social value” has been the most controversial of all. We understand that this term *per se*, without further explanation, is opened to interpretation. However, after talking to them we do not think the authors had any utilitarian intentions in mind. *Every person is worthy just for the sake being a person.*²² We share the criticism for the inaccuracy it shows, but the controversy has certainly been blown out of proportion to the point that *the very SBC suggests criteria or social values that should be taken into consideration regarding prioritizing:* “it can be ethical to prioritize people who are essential to keep an outbreak under control”, or “other professionals particularly important for the management of the pandemic”, and “the principle of the greater protection of the minor requires prioritizing care to children and adolescents”. So it seems somehow inappropriate to say that it is utilitarian when only its inaccuracy is on the line. As a matter of fact, the consideration that, when needed, health professionals (globally) deserve priority treatment regarding access to therapies from the healthcare system does not seem to be consistent with the previous reflections made by the authors. Certainly, it can be a prioritizing criterion, but not the only one, as it happens with age.

Finally, we simply cannot understand the criticism made to the recommendation of promoting evidence-based procedures to facilitate weaning from mechanical ventilation avoiding therapeutic obstinacy. Mechanical ventilation has complications that may result in morbidity and mortality. As a matter of fact, it is under constant investigation to reduce the time patients remain on this therapy, which is something that is observed every day in every ICU on a routine basis. Therefore, it is wrong to conclude from this sentence that weaning a patient from mechanical ventilation to benefit others is advised.

In conclusion, the aforementioned recommendations were published in an exceptional situation of lack of resources and instructions from the public authorities or orientations from

the SBC. This led to the inevitable selection of patients without uniform criteria. These recommendations were published to guide the decision-making process of allocating insufficient resources to patients based on their chances of benefiting from such resources to maximize the number of lives saved without discrimination based on age, disability or any other factors. We have given suggestions to avoid inappropriate and inaccurate interpretations and wish to encourage open debates to achieve the necessary tools to prioritize resources in future pandemics.

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