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CORRESPONDENCE

# A crisis of ethics in the ethics of crisis

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*Dear Editor-in-Chief*,

The exceptional context of the COVID 19 health crisis, responsible for sudden overwhelming of the healthcare system, has generated silent and unprecedented ethical tensions about which we would like to discuss and debate.

Medical ethics is aimed at matching ''just action'' with a situation imposed by pathology, in the interest of the patient and society, by respecting the universal principles of beneficence, non-maleficence, autonomy, and justice [1]. Schematically, several ethical types may be distinguished: philosophical (theoretical) ethics, pragmatic (concrete) ethics, individual ethics and public health ethics.

Ethical questionings in surgery are interpreted through the prism of the irreversibility of and transgression (agreed-upon mutilation) and are structured around two main thematic axes: the genesis of Knowledge (innovation, level of evidence) [2,3] and ''moral'' integrity (the locked-up nature of the operating theater, information, obstinacy) [4]. In his daily activity, the surgeon uses principles of ethics in accordance with principles of surgical practice; when confronted with a medical issue, he provides simple, effective, tailored and rapid responses. Surgical ethics is consequently pragmatic, individual and—above all—operational.

At the outset of the current crisis, surgeons were able to immediately adapt to the emergency, their sole objectives being not to harm and to successfully address unprecedented challenges [5]: postponed if not cancelled surgical interventions, conversion of their units into COVID+ wards and redeployment, paramedical staff reorientation, regulation of bed assignment or transfers from the SAMU emergency services, etc.

However, at times the exceptional circumstances collided with seemingly simple and reflexive surgical ethics. The saturation of intensive care units, many of which were largely given over to COVID+ treatment, led to frequent debates on the prioritizing of COVID+ patients over other patients, whose survival was in some cases just as much at risk. Other surgeons were compelled to insist more than usual on the relevance of certain indications for surgery (''urgent'' cancers, peritonitis, etc.), as though these COVID- patients, our everyday caseload prior to the crisis, had somehow become less high-priority in a momentary state of sanitary emergency. Protocolized, evidence-based practices (laparoscopic approach, anastomosis without protective stoma) were advocated in view of limiting operating time, risks of complication and length of hospital stay or of reducing hypothetical contamination. Our usual clinical reasonings seemed to have been upended.

Under such extraordinary circumstances, even though each operator clearly perceives an inescapable need to adapt to a population-wide demand for care, some choices remain difficult, especially for a surgeon with his instinctive ethics. While individual ethics are firmly anchored in our practices, the contexts presented by ''saturating'' sanitary crises are conducive to the triumph of public health ethics (the greatest good for the greatest number) over individual ethics (what is most beneficial for a given individual), a triumph leading to situations of *de facto* opposition between the two concepts. In the perspective of other crises, the resultant tension warrants serious consideration on the sanctuarization of notions such as the singularity of the patient and equity in access to healthcare, our objectives being that the two ethical stances be viewed as complementary rather than contradictory, and that they combine to constitute a single notion of individual and collective good.

## Disclosure of interest

The authors declare that they have no competing interest.

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