Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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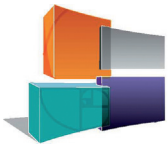
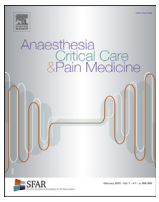


SFAR
Société Française d'Anesthésie et de Réanimation



Letter to the Editor

COVID-19 and ethical considerations: Valuable decision-making tools from the leading medical societies in France

The current COVID-19 pandemic has resulted in a significant increase in the number of hospitalised patients requiring mechanical ventilation for severe acute respiratory distress [1]. In France, public health measures were implemented rapidly to limit the spread of SARS-CoV-2 and to permit hospitals to increase the number of intensive care beds. However, these actions and the overall response to this crisis have raised serious ethical concerns, particularly with respect to triage and prioritisation of access to intensive care units (ICUs) if the demand ultimately exceeds the supply of care [2].

Ethical reflection has been carried out at the national level by the National Consultative Ethics Committee ("Comité Consultatif National d'Ethique"), which provides advice toward guiding society and developing policies in the face of the ethical challenges such as those posed by the COVID-19 pandemic [3]. Additional operational recommendations have been put forward by the leading medical societies in France (FLMS) to assist practitioners with ongoing decision-making [4–7]. These recommendations serve to remind everyone of the need to respect the critical and fundamental ethical principles that could be easily overlooked in a pandemic situation; these principles include respect for the dignity of all, non-maleficence, collegiality in all decisions and respect for the wishes and autonomy of each patient. All agree that the principle of distributive justice takes on an important role in this context, just as it is taken into account in everyday life apart from the stresses introduced by the pandemic. Decisions need to focus not only on the individual needs of a given patient, but also the good of society as a whole; this would include a focus on maximising the number of lives saved. If one is taking into account the number of years of life to be saved, as suggested by the American recommendations, patient age will of necessity become a major criterion with respect to decision-making. Indeed, the Italian Society for Intensive Care Medicine has put forward age thresholds for prioritising access to critical care [8].

The recommendations made and criteria chosen by the FLMS were introduced with all necessary transparency so as to facilitate their acceptance amongst physicians and the general public. The criteria emphasise the need to protect the most vulnerable patients from the risk of discrimination and arbitrary decisions. Criteria commonly used for decisions related to ICU admission include frailty, presence of co-morbidities, prior level of personal autonomy, nutritional status and cognition; patient age is included amongst these factors as well as the severity of the disease assessed by the Sequential Organ Failure Assessment score. It is critical to recognise that no specific criteria were defined. This was a deliberate decision; ICU admissions ultimately depend on the ability to adapt to circumstances within given situations and contexts; amongst the latter issues, much depends on the availability of critical care beds, resuscitation equipment and the requisite scientific and medical knowledge required for appropriate care and treatment of this disease. Likewise, no age threshold been defined beyond which access to ICU care would be denied, save for statements included in the joint recommendation of the French Society of Anaesthesia and Intensive Care (Société française d'anesthésie et de réanimation) and the French Military Health Service (Service de santé des armées; SSA) [4]. However, consideration of patient age as a sole criterion does not seem to be acceptable; the consideration of any single criterion considered in isolation would not be appropriate in these circumstances. It would appear that a discussion of all relevant criteria should be carried out without reference to any specific hierarchy; several helpful decision-making tools have been proposed by the SFAR [4,5].

The authors propose several levels of prioritisation with respect to ICU treatment when faced with limited capacity for critically ill patients; these are colour-coded as indicated, with each priority level corresponding to a specific course of action. As shown, there are four levels of priority; amongst the criteria to consider are the definitive need for resuscitation and the probability that an individual will derive significant benefit from this level of care [4]. This categorisation strategy is similar to that recommended for surgical triage in war and in response to a disaster; for example, the P4 category here is analogous to surgical "expectants" who are those individuals who are too badly injured, whose chances of survival are very limited, and whose appropriate management would require the implementation of too great or even too uncertain levels of resources to the detriment of others who are less seriously affected [9]. This text also proposes a cognitive aid in the form of decision-support algorithms that consider the proposed criteria and suggest a course of action based on the level of priority established.

Although these decision-making aids can be a valuable resource for practitioners who are required to make difficult decisions in emergency situations, their use does not preclude thorough individualised assessments using a thoughtful, rational and collegial approach that take into consideration patients' wishes regarding invasive ICU care. These criteria are by necessity evolving and will depend largely on the context and the availability of appropriate hospital resources. Likewise, regular reassessment of these criteria should be undertaken on an individual basis during the hospital stay; no decisions should be considered as fixed or immutable.

In the event of a new epidemic peak of COVID-19 or a future health crisis, these recommendations, if used properly, will remain valuable tools for frontline health care workers.

Funding

No financial support.

https://doi.org/10.1016/j.accpm.2020.05.001

Disclosure of interest

The authors declare that they have no competing interest.

References

[1] Yang X, Yu Y, Xu J, Shu H, Xia J, Liu H, et al. Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study. Lancet Respir Med 2020. http://dx.doi.org/10.1016/S2213-2600(20)30079-5.

[2] Emanuel EJ, Persad G, Upshur R, Thome B, Parker M, Glickman A, et al. Fair Allocation of Scarce Medical Resources in the Time of Covid-19. N Engl J Med 2020. http://dx.doi.org/10.1056/NEJMsb2005114 [Epub ahead of print].

[3] Covid-19 - Contribution du comité consultatif national d'éthique: enjeux éthiques face à une pandémie. Comité Consultatif National d'Ethique; 2020, https://www.ccne-ethique.fr/sites/default/files/reponse_ccne_-_covid-19_def.pdf (accessed april 21, 2020).

[4] Leclerc T, Donat N, Donat A, Pasquier P, Libert N, Schaeffer E, et al. Prioritisation of ICU treatments for critically ill patients in a COVID-19 pandemic with scarce resources. Anaesth Crit Care Pain Med 2020. http://dx.doi.org/10.1016/j.accpm.2020.05.008 [Epub ahead of print].

[5] A propos des décisions médicales d'admission des patients en unité de soins critique en contexte pandémique 2020. Comité d'éthique de la SFAR. https://sfar.org/download/comiteethique-a-propos-des-decisions-medicales-dadmission-des-patients-en-unite-de-soins-critiques-en-context-pandemique-quelques-reperes-ethiques/.(Accessed april 20, 2020).

[6] de Montgolfier S, Lamblin A, Leport C. Recommandation professionnelle multidisciplinaire opérationnelle: Aspects éthiques et stratégiques de l'accès aux soins de réanimation et autres soins critiques en contexte de pandémie COVID-19; 2020, https://www.coreb.infectiologie.com/UserFiles/File/procedures/rpmo-ethique-rea-covid-19-vf-24-corr26-mar20-2.pdf (Accessed April 20, 2020).

[7] Critères d'admission et modalités de prise en charge en réanimation en contexte pandémique. Comité d'éthique de la SRLF; 2020, https://www.srlf.org/wp-content/uploads/2020/04/20200410-Reco-Ethique-SRLF.pdf. (Accessed April 21, 2020).

[8] Clinical ethics recommendations for the allocation of intensive care treatments, in exceptional, resource-limited circumstances. Rome: SIAARTI. http://www.siaarti.it/SiteAssets/News/COVID19%20%20documenti%20SIAARTI/SIAAR%20-%20Covid-19%20-%20Clinical%20Ethics%20Reccomendations.pdf.(Accessed April 19, 2020).

[9] Rigal S, Pons F. Triage of mass casualties in war conditions: realities and lessons learned. Int Orthop 2013;37:1433–8. http://dx.doi.org/10.1007/s00264-013-1961-y.

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Available online 7 May 2020