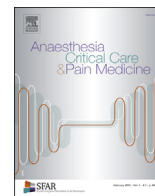




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## Editorial

## COVID-19 and ethics: We learn as we go. But where are we going?



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For several months now, the novel SARS-CoV-2 pandemic has plunged us into an ongoing, day-to-day crisis, challenging and disrupting our lives, especially as anaesthesiologists and intensivists.

Last spring, we were stunned by the sudden and massive arrival of COVID-19 patients. We feared shortages of both human and material resources, and worried about our own risk of contamination. We focused our efforts on the reorganisation necessary for the care of “COVID-19” patients. At the time, de facto priority was given to these patients, to the detriment of other pathologies that had nonetheless not gone away. Facing a tense situation that could quickly devolve into one of saturation, strategies for allocating scarce critical care resources had to be conceived in a hurry [1,2]. Some of us were reticent about these strategies, born under the restraints of action and emergency. How can we (or do we) approach the idea that one patient could be privileged over another?

The challenges of last spring were overcome largely thanks to hospital reorganisation, to decision-making processes that have been established as closely as possible to realities on the ground, to the lifting of financial restrictions, and to the involvement and creativity of caregivers. During the summer, we began to better understand COVID-19 pathophysiology and identify the risk factors for severe cases or death [3]. We have all seen, and often regretted, the restrictions placed on relatives of hospitalised patients, both in accompanying care and in funeral rites [4]. We have also started to assess the serious impacts of lockdown, as well as the level of disorganisation in the health care system as a whole. Thousands of cancers have not been diagnosed, thousands of kidneys have not been transplanted, and even benign conditions have deteriorated into more serious pathologies [5,6]. There is a high probability that opportunities were lost during the immediate crisis, and its current prolongation with high plateau. We can fear long-term consequences and future epidemiological studies will no doubt answer many questions, advancing our ethical approach to crisis management.

The autumn resurgence of the epidemic raised last spring's issues once again. We had learned from the first wave, but in some cases, our concerns were stronger the second time around. Our earlier experiences informed our approach to the allocation of scarce resources—an issue that was now faced by all levels of the health care system: from allocation between two critical COVID-19 patients, to allocation between critical COVID-19 and non-COVID-19 care, as well as between critical care and urgent scheduled care.

The ethical issue that has preoccupied us for many months now is the following: how can we ensure fair allocation of scarce resources while giving everyone a chance? Indeed, re-thinking approaches to triage is necessary, if not absolutely essential [7].

One conceptual approach to addressing this challenging issue is to insist that any decision on prioritisation combine the main principles of ethics with a respect for the patient's dignity. A major conflict arises between the principles of autonomy, beneficence, and non-maleficence on the one hand, and justice on the other hand. On one hand, in order to comply with ethical principles, the usual decision-making processes and criteria must be applied within the logic of “usual” ethics: respect of the patient's wishes and values; consideration of the patient's previous condition and current clinical severity; consultation and collegiality. No single criteria alone can provide all the relevant values to decide a patient's level of priority [1]. Usually, physicians tend to focus primarily on the interest of the individual in his or her singularity. Priority is given to autonomy and beneficence prior to justice. However, in the current situation, in order to best comply with the principle of justice, resources must be allocated fairly by giving priority to those patients who are most likely to benefit from them, whether in terms of survival and/or quality of life. Some have summarised this decision process by referring to logic of “exceptional” ethics. These are not exceptional ethics but rather ethics in exceptional times. In this scenario, it is, ethically, a way to consider and understand the major impact of the situation, which might lead to see the interest of the individual supplanted by the interest of the community [8]. Finally, how can individual and collective interests best be brought together? The implementation of triage algorithms that apply a “utilitarian” logic aimed at maximising the number of lives saved or years of life saved is a way of addressing this delicate issue [9]. Some countries have proposed prioritisation committees composed of non-physicians and physicians not directly involved in the care of the patients concerned [10]. These practical approaches may disturb the care relationship and disempower decision-makers, restricting the essential individual approach. However, if each individual life is of equal value, how can we reconcile theoretical ethics, based on

ethical principles, with pragmatic ethics having to respond to acute and individual field situations? How can we, in a crisis, adapt our “usual” ethics so that they do not become exceptional, with the risk of being arbitrary?

In practice, these decisions inevitably contain an element of dissatisfaction and pose moral dilemmas. For intensivists, prioritising patients is an ethical and emotional challenge. Deciding which patient will be given a chance, and who will not, is a heavy burden. Balancing the interests of the individual with those of the community poses numerous questions. Who, among caregivers, patients, relatives, experts, or citizens, has the legitimacy to make decisions? Moreover, on which criteria must a decision be based, particularly when medical criteria (*i.e.*, established prognostic factors) are no longer sufficient (if they ever were)? Who will assume responsibility for lost opportunities? One thing is certain: the way in which allocation strategies are established, and the transparent manner in which they are communicated, are just as crucial as their contents. These strategies must be accessible to all, thus remaining open to criticism and possible amendments [11].

Today, we know the extent of the risks we are likely to face. No longer in permanent crisis mode, less focused on our actions and strengthened by our experiences, we have a duty to ask ourselves questions that are not easily resolved. What have we learned from these months of pandemic? Are we better prepared to face such challenges? Are we open to feedback and collective brainstorming? Today, an ethical and political debate is needed beyond the restricted circle of medical and institutional experts, in order to collectively consider the risk, and to be better prepared for it. The question of resource allocation concerns not only caregivers, but also patients and, more widely, citizens. Everyone must understand the complexity of this issue and the difficulty of the decisions that have to be made. Sharing our reflections on the principles that guide our actions, sharing our experience of previous crises, will allow more transparent strategies to be developed with the full responsibility of all concerned actors. To this end, several approaches have been proposed, such as deliberative democracy sessions, as well as the involvement of patients in the writing and revision of prioritisation reports [12]. The question of democracy in health care also involves territorial issues: how can we avoid the fact that quality of care depends on a facility's geographical location? An efficient balance must be found between centralised and decentralised strategies. In any case, the lack of democracy in health care can only make us more vulnerable in times of crisis. The involvement of the wider community will allow us to make choices that are as moral as they are medical, and will help people understand decisions that they may have felt were questionable.

In even the most difficult circumstances, the care given to others has remained the most important priority. An extraordinary collective ingenuity has arisen, inspired by the responsiveness, the creativity, and the synergy of caregivers. Wherever we go from here, let's not forget that.

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The authors have no competing interest to declare.

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