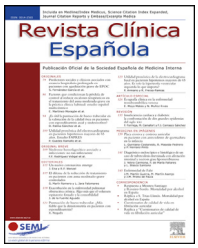
Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Revista Clínica Española 221 (2021) 184–186

Revista Clínica Española

www.elsevier.es/rce



CORRESPONDENCE

The COVID-19 era: Ethics in times of crisis☆

Tiempo de COVID-19: ética en tiempos de crisis

Dear Director,

I would like to present a brief reflection on the conflict of values that has arisen in clinical care and public health in the COVID-19 pandemic.

Spain, like other nations, has been overwhelmed by the COVID-19 pandemic. It has placed a massive burden on the health system, leading to a mismatch between the population's needs and the availability of clinical care and advanced life support. This situation has forced us to adopt common criteria for the allocation of resources so that serious inequities in care do not emerge. Any criteria or protocol adopted to ration scarce resources must never be applied mechanically or automatically: every human being has the right to personal consideration. However, this does not preclude us from trying to establish general prioritization criteria that must then be applied on an individual basis.[1]

Triage in situations of scarcity is not extraordinary in clinical practice; in fact, it is common in organ transplantation and even in routine clinical care in many institutions. To ensure that the ethical principles of fairness and the greatest good for the greatest number of patients are respected, triage criteria should be as objective as possible. These clinical criteria attempt to determine which patients have both a more favorable prognosis (greater chances of survival and benefit derived from treatment) and a shorter a priori duration of expected ICU admission.[2]

The issue of age often comes up when determining which criteria to consider. Although older adults are a higher-risk population, age cannot be the sole factor behind the adoption of a behavior, since any decision must depend on the general clinical condition of the patient.[3]

However, on the one hand, if we do not take age into account, we too often provide care that is expensive and ineffective. On the other hand, if we make age the sole criterion for making decisions, we are in effect taking a giant step toward openly valuing some lives over others, an approach that challenges the basic principles of medicine.[4]

It is true that with advanced age, there is less physiological reserve and lower expectations of complete recovery, but comorbidity, frailty, and clinical complexity better define the limits of adequate treatment than age alone.[5] Furthermore, decision-making must take into account patients' opinions about their expectations and choices.

In regard to properly assigning mechanical ventilation, the criteria should be the same as in normal medical practice. Mechanical ventilation is an intensive treatment that must be indicated according to the objectives set for the intervention and depending on the patient's medical condition, the evolution of the disease to date, the treatment options, and the prognosis.[6] Although the chances of survival may be low, treatment should continue unless deemed ineffective or at the request of a patient or their surrogate.[7] Once patients have already received mechanical ventilation, the decision to withdraw it is especially difficult.[8]

New York State guidelines reject old age as a ranking criterion because it discriminates against older people. Furthermore, age already indirectly influences any criteria that assess an individual's overall health (given that the likelihood of having chronic medical conditions increases with age) and there are many cases in which an older person might have a better clinical outlook than a younger person. Only when all available clinical factors have been examined and the probability of mortality among the patient group has been determined to be equal can age be used as a deciding factor in selecting a patient for ventilator therapy.[9]

An ethically sound framework for healthcare during public health emergencies must balance the duty of patient-centered care with the public-centered duties of promoting equality and equity for all in the distribution of risks and benefits in society. It is essential to respect the dignity of each patient. Medical treatment must be proportional to the patient's condition and basic factors (chronic diseases, risk factors, and others) that must be included as part of the analysis of each patient's possibility of recovery.[3]

The choice to set limits on access to treatment is not a discretionary decision, but a necessary response to the overwhelming effects of a pandemic. The difficulty lies in how to do it ethically and consistently, rather than basing decisions on each individual institution's approach or a physician's intuition in the heat of the moment.

Proposals for resource allocation in pandemics concur on four core values: maximizing the benefits of scarce resources, treating people equally, promoting and rewarding instrumental value, and prioritizing the most disadvantaged;

☆ Please cite this article as: F.-M. Gamboa-Antiñolo, Tiempo de COVID-19: ética en tiempos de crisis. Rev Clin Esp. 2021;221:184–185.

no single value is enough on its own. Fair allocation requires a multivalue ethical framework that can be adapted according to the resource and context. This highlights the need for fair and consistent allocation procedures which must be transparent and reflect the guidelines for prioritization that ensure that individual physicians are not faced with the terrible task of making decisions on the fly.[2,10]

Overemphasis on resource reallocation without sufficient evidence could have unintended negative consequences for vulnerable populations. In the race to save lives, many governments focused on increasing capacity in acute care hospitals, while subacute care facilities, which often house older adults and people with disabilities, were largely overlooked. As a result, vulnerable groups were not adequately protected. Nursing homes have become hotspots for transmission of and death due to COVID-19.[11]

In times of crisis, it is necessary to develop a code of ethics that is capable of encompassing the values of people and the society they live in as well as the uncertainty that disease always entails. A review of the ethics of proper care is needed.

Funding sources

This research did not receive any funding from agencies in the public, commercial, or not-for-profit sectors.

References

1. Comité de Bioética de España. Informe del Comité de Bioética de España sobre los aspectos bioéticos de la priorización de recursos sanitarios en el contexto de la crisis del coronavirus. 2020, https://www.ibima.eu/wp-content/uploads/2020/03/Informe-coronavirus-CBE.pdf [Accessed 1 October 2020].
2. Herreros B, Gella P, Real de Asua D. Triage duringthe COVID-19 epidemic in Spain: better and worse ethical arguments. J Med Ethics. 2020;46:455–8, doi:10.1136/medethics-2020-106352.
3. Cesari M, Proietti M. COVID-19 in Italy: ageism and decision making in a pandemic. J Am Med Dir Assoc. 2020;21:576–7, doi:10.1016/j.jamda.2020.03.025.
4. Aronson L. Age, complexity and crisis: a recipe for progress in a pandemic. N Engl J Med. 2020;383:4–6, doi:10.1056/NEJMp2006115.
5. Gamboa-Antiñolo F. Comorbidity, clinical complexity and palliative care. Intern Emerg Med. 2020;15:557–8, doi:10.1007/s11739-020-02317-z.
6. Zeeh J, Memm K, Heper H, Kwetkat A. Covid-19 pandemic. Mechanical ventilation in geriatric patients — an ethical dilemma? MMW Fortschr Med. 2020;162:40–5, doi:10.1007/s15006-020-0475-v.
7. Truog RD, Mitchell C, Daley GQ. The toughest triage — allocating ventilators in a pandemic. N Engl J Med. 2020;382:1973–5, doi:10.1056/NEJMp2005689.
8. Gamboa Antiñolo F. Limitación de esfuerzo terapéutico. ¿Es lo mismo retirar un tratamiento de soporte vital que no iniciarlo? Med Clin (Barc). 2010;135:410–6, doi:10.1016/j.medcli.2009.02.046.
9. New York State Task Force on Life and the Law. New York State Department of Health. Ventilator Allocation Guidelines. 2015, https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf [Cited 31 May 2020].
10. 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;382:2049–55, doi:10.1056/NEJMsb2005114.
11. Peterson A, Largent EA, Karlawish J. Ethics of reallocating ventilators in the covid-19 pandemic. BMJ. 2020;369:m1828, doi:10.1136/bmj.m1828.

F.-M. Gamboa-Antiñolo

Servicio de Medicina Interna, Hospital Universitario Virgen de Valme, Universidad de Sevilla, Sevilla, Spain
E-mail address: minfga@us.es.

Cardiovascular events in patients with HIV infection. Preventive measures are urgent☆

Eventos cardiovasculares en pacientes con infección VIH. Urgen medidas preventivas

Dear Director,

We read the article by Estrada et al.[1] on cardiovascular disease risk in patients with HIV infection on antiretroviral treatment with great interest. The authors reported a high prevalence of cardiovascular risk factors in a population of 15,559 patients and the consequent moderate-high risk of cardiovascular disease. These data are in line with the study we recently published on acute coronary syndromes in patients with HIV infection,[2] in which we found a high prevalence of cardiovascular risk factors. In addition, we found that patients with HIV infection more frequently had hyperlipidemia and multivessel coronary disease than patients without HIV infection in the control group matched according to age, sex, and type of acute coronary syndrome.

Concern about cardiovascular diseases in patients with HIV infection is growing.[3] Although combined antiretroviral therapy has substantially improved the prognosis of HIV infection, mortality continues to be high when compared to the general population. This is in part due to a greater prevalence of cardiovascular diseases that, in large part, are due to a greater prevalence of cardiovascular risk factors in patients with HIV infection compared to the general population.[4]

☆ Please cite this article as: Martínez-Sellés M. Eventos cardiovasculares en pacientes con infección VIH. Urgen medidas preventivas. Rev Clin Esp. 2021;221:185–186.