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LETTER TO THE EDITOR

COVID-19: A look from the perspective of bioethics

COVID-19: una mirada desde la perspectiva de la bioética

Dear Editor:

One of the main challenges the public health system is facing nowadays is coping with the threat posed to society by infectious/transmissible diseases,[1] which may involve putting into practice measures that include restrictions on civil liberties to serve the common good such as isolation or quarantine in the event of an epidemic/pandemic.

The beginning of the outbreak of COVID-19, both globally[2] and domestically, and the subsequent declaration of a Public Health Emergency of International Concern,[3] has meant a paradigm shift in the way we conceive of medicine and the current public health system, which has faced a process of decision-making and a course of action inconceivable just a few months ago.

March 25th the Spanish Bioethics Committee published: ''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'',[4] and April 3rd the paper ''Informe del Ministerio de Sanidad sobre los aspectos éticos en situaciones de pandemia: el SARS-CoV-19''[5] was published, the latter submitted a series of recommendations to ''aid decision-making on the implementation of therapeutic and patient care measures.'' Both reports focused mostly on aspects related to healthcare rather than those related to ethical values and issues.

The procedures to control the transmission (standard preventive measures, specific preventive measures, hand hygiene, barrier measures, isolation precautions etc.) should be well known amongst professionals and implemented in accordance with the mode of transmission of the microorganism involved. Whether standard or contact measures designed to prevent droplet spread or airborne transmission, they all should respect the time frame and other specific guidelines as described by the CDC.[6]

Both in primary health care and the hospital environment, we are moving into uncharted territory, where we are unsure of the ''utility'' of our actions or their ''benevolence,'' where the resource constraints call the ''justice'' of our decisions into question, where we are undermining the ''autonomy'' of the population and associating ''stigmatization'' to a part of it. On top of everything, our ''legitimacy'' is challenged by our lack of well-grounded scientific knowledge.

The use and optimization of resources has been overcome as we have suffered from a shortage of the most basic materials for infection control in the healthcare environment (lab coats, masks, hand-hygiene products etc.), tools for diagnosis (microbiological analysis tests etc.), materials for the treatment and care of the sick (life support equipment, respirators, hospital beds, drugs etc.), not to mention the scarcity in human resources caused by the lack of professionals as a result of sick leave caused by the infection itself, and the quality of care for patients with non-COVID-19 pathology that may be diminishing.

The word isolation, which was removed from most documents regarding infection control due to its negative or pejorative nature, is being widely used again and with varying degrees that go from the generalized confinement established by the government for a large part of the population, to the quarantine for asymptomatic individuals in contact with people at risk, to the self-isolation for those with mild symptoms who had to carry out such isolation at home, and finally to the strict isolation of those patients admitted to health centers with a diagnosis of COVID-19.

In terms of training and briefing, we were faced with a massive number of protocols, procedures and recommendations which were modified and updated almost daily. They were based on poor scientific evidence and came in gradually from our own experience as the outbreak/epidemic/pandemic evolved, often based on the opinion of ''experts.'' These sometimes contradictory messages have caused mistrust amongst society and our own colleagues, who had to implement protocols and guidelines of unspecified timelines.

As far as research is concerned, we must undoubtedly use the information available in the different countries affected, albeit in a cautious way, given the disparity of criteria when collecting this information (different epidemiological surveillance systems), in order to base future decisions and actions on reliable data and verified information. We must also share this information and facilitate the work of the different research groups, not only to publish but to generate scientific knowledge.

We consider an in-depth analysis by bioethics committees will be required in order to face similar situations in the future with the utmost ''safety'', not only from the

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perspective of clinical or therapeutic decisions, but also with a global ethical approach.

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