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

References

1. Coleman CH, Bouësseau MC, Reis A. Contribución de la ética a la salud pública. Bol Organ Mund Salud. 2008;86:578–9.
2. European Centre for Disease Prevention and Control. Rapid risk assessment: outbreak of acute respiratory syndrome associated with a novel coronavirus, Wuhan, China; first update – 22 January 2020. Stockholm: ECDC; 2020. https://www.ecdc.europa.eu/en/publications-data/risk-assessment-outbreak-acute-respiratory-syndrome-associated-novel-coronavirus [accessed 01.04.20].
3. Centro de Coordinación de Alertas y Emergencias Sanitarias. Valoración de la declaración del brote de nuevo coronavirus 2019 (n-CoV) una Emergencia de Salud Pública de Importancia Internacional (ESPII); 2020. https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov-China/documentos.htm [accessed 01.02.20].
4. 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.comitedebioetica.es/documentacion/index.php [accessed 01.04.20].
5. Romeo Casabona CM, Urruela Mora A. Informe del Ministerio de Sanidad sobre los aspectos éticos en situaciones de pandemia: el SARS-CoV-2. Ministerio de Sanidad; 2020. https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov-China/documentos.htm [accessed 06.04.20].
6. Siegel JD, Rhinehart E, Jackson M, Chiarello L, the Healthcare Infection Control Practices Advisory Committee. 2007 Guidelines for isolation precautions: preventing transmission of infectious agents in healthcare settings; 2020. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html [accessed 01.04.20].

Miguel Porras-Povedano[a,*], Virginia Santacruz-Hamer[b], Diego Jesús Lomeña-Urbano[a]

[a] *Área de Gestión Sanitaria de Osuna, Osuna, Sevilla, Spain*
[b] *Hospital Quirón Salud Córdoba, Córdoba, Spain*

[*] Corresponding author.
E-mail address: miguel.porras.sspa@juntadeandalucia.es (M. Porras-Povedano).

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Prevención e identificación temprana de casos sospechosos COVID-19 en el primer nivel de atención en Centro América

Prevention and early identification of COVID-19 suspected cases at the first level of care in Central America

Sr. Editor:

La infección por el coronavirus del síndrome respiratorio agudo severo tipo 2 (SARS-CoV-2), causante de la enfermedad por coronavirus 2019 (COVID-19), ha impactado al mundo de múltiples formas en el sistema de salud, y específicamente en la atención primaria, en muchas regiones, incluyendo América Latina[1,2]. Esta vasta región incluye más de 20 millones de kilómetros cuadrados de superficie, que corresponden aproximadamente al 13,5% de la superficie emergida del planeta, abarcando 20 países. Dentro de América Latina, la subregión Centroamericana incluye siete países independientes: Guatemala, Belice, Honduras, El Salvador, Nicaragua, Costa Rica y Panamá. Por tal razón, queremos discutir acá implicaciones más específicas de la COVID-19 en Centro América, para el COVID-19 en la atención primaria.

COVID-19 es la infección respiratoria aguda con más impacto y daño internacional en las últimas décadas[3]. La mejor estrategia de manejo, según los Centros de Control y Prevención de Enfermedades (CDC), es evitar la exposición al virus[4]. Por décadas hemos practicado las medidas de prevención en el nivel primario de atención para contener enfermedades, evitando la dispersión y el impacto de algunas de estas. Pero ¿por qué COVID-19 ha generado tanto impacto en algunas poblaciones? Para el caso de Honduras y otros países de Centro América, los primeros casos registrados fueron en las ciudades más grandes, y por ende

Tabla 1 Número de pruebas de laboratorio y pruebas positivas en los países de la región Centroamericana (2 de julio de 2020)

País	Pruebas	Positivos	Positividad (%)	Muertes	Letalidad (%)
Belice	2.281	28	1,20	2	7,1
Guatemala	31.427	19.011	60,50	817	4,3
Nicaragua	N/D	2.519	N/D	83	3,3
Honduras	49.308	20.262	41,10	542	2,7
El Salvador	167.584	7.000	4,2	191	2,7
Panamá	133.449	34.463	25,8	645	1,9
Costa Rica	38.500	3.753	9,7	17	0,5
Total Región	422.549	87.036	20,6	2.297	2,6

Fuente: Reported Cases and Deaths, Territory, or Conveyace. Disponible en: https://www.worldometers.info/coronavirus/?utm_campaign=homeAdvegas1. ND: no determinada.