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Reply to ''Considerations on ICU triage ethics during the COVID-19 pandemic''☆

Respuesta a «Algunas consideraciones sobre la ética del triaje en UCI durante la pandemia COVID-19»

To the Editor:

We read the comments made to the article: «Considerations on ICU triage ethics during the COVID-19 pandemic».[1]

We should mention the historic framework within which these recommendations were made, of great difficulty and without any similar historic precedents.

There are 2 basic premises surrounding emergency care or care provided during a crisis situation: in the first place, health authorities have a moral duty to reduce the morbidity and mortality of an emerging disaster and, secondly, ethical principles based on distributive justice and a criterion of proportionality should prevail.

Therefore, in case of mismatch between the clinical needs and the effective availability of resources, a triage system should be implemented for the sake of common good. Since triage is implemented by other specialists before ICU admission, we thought this was the proper triage system due to its practicality. Afterwards, other triage algorithms have come up like the one from Sprung et al. including aspects associated with the patients, the severity of the clinical process, and the prediction of survival.[2]

Our recommendations are not trying to cause any discriminations away from the intensivists' best clinical judgement, the patient's clinical situation or the expectations of survival as the Spanish Ministry of Health recommends.[3] Instead, we wish to encourage thinking among the healthcare workers by offering them objective criteria agreed by our scientific medical society. As a matter of fact, this is no different from what is normally done in our intensive care units where, upon admission, decisions are made on what supports are indicated, which will eventually be useless, and why their use is justified.[4]

Regarding age, it is well known that it is a factor associated with mortality in patients with ARDS due to COVID-19[5] and, although it is true that age should not be considered as the only factor, it has a high specific weight in the main prognostic indices. As a matter of fact, we should remember that an ICU admission is not synonymous of survival, an expectation that may have been triggered by the availability of more ventilators or their indiscriminate use without a reflection on the benefits, indications, and risks involved, which may lead to situations of therapeutic obstinacy.

Finally, we should state clear that these recommendations are flexible, adapted to the current pandemic situations, and should be reassessed on a dynamic basis and based on the epidemiological situation and availability of resources. Above all, the clinical criterion should always prevail as well as the patients' will and preferences to always observe attitudes of respect and dignity.

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