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REVIEW

A moment for reflection. Ethical aspects in the pandemic SARS-CoV-2/COVID-19 in our clinical practice☆

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Abstract The entire world has suffered the devastating action of the SARS-COVID-19 pandemic. This is the ideal moment to stop and ask ourselves what happened and how we acted; to reflect on what we have learned not only for similar situations but for all of our clinical practice.

This work is an ethical reflection via the clinical experience of professionals dedicated to the care of critical patients in one of the countries most affected by the SARS-CoV-2/COVID-19 pandemic in the world. Some of the moral values and categories involved in decision-making in situations of limited resources are analysed, and the need for bioethics to be a part of daily practice is proposed, along with some strategies for doing so, thus facilitating decision-making by the health professional and fair and appropriate care for the patient in situations of particular vulnerability such as those experienced in this health and social crisis.

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PALABRAS CLAVE
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Cribado

Un momento para la reflexión. Aspectos éticos en la pandemia SARS-CoV-2/COVID-19 en nuestra práctica clínica

Resumen El mundo entero ha sufrido la acción devastadora de la pandemia SARS-CoV-2/COVID-19. Estamos en un momento de la situación donde se puede vivir con cierta calma, aunque la tormenta persiste. Es el momento perfecto para reaccionar, para preguntarnos qué ha pasado y cómo hemos actuado. Hay que reflexionar sobre qué podría pasar y cómo deberíamos actuar.

En este trabajo se realiza una reflexión ética a través de la experiencia clínica de profesionales dedicados a la atención del paciente críticamente enfermo. Se analizan los valores y categorías morales implicados en la toma de decisiones en situación de limitación de recursos y se plantea la necesidad y algunas estrategias para acercar la bioética a la práctica cotidiana, facilitando así la toma de decisiones por parte del profesional sanitario y una atención justa y adecuada al paciente en situaciones de especial vulnerabilidad como las vividas en esta crisis sanitaria y social.

Introduction

We are at the point where we know where the enemy will strike next, and although it is not over, we are now in a position to stop and think without letting our guard down.

Now is the perfect time to act, to ask ourselves what has happened and how we dealt with it, and also to reflect on the future and what we need to do.

Many articles published prior to this pandemic had analysed the guiding principles and specific measures to be taken in a potential global pandemic scenario. But they have been of little use, either because they never went beyond mere hypothetical strategies that were too far-fetched to be taken seriously, or because the figures associated with this pandemic have nothing to do with those considered in these fictitious scenarios. In 2005, the US Department of Health and Human Services developed a Pandemic Influenza Plan that anticipated the potential impact of moderate-to-severe influenza pandemics. This action plan was later updated following the appearance of H1N1. Predictions for the scale of the SARS-CoV-2/COVID-19 pandemic have doubled or tripled the predictions made in previous pandemics in terms of the number of deaths, number of patients hospitalised, and number of patients requiring admission to Critical Care Units.[1]

In Spain, the devastation caused by the SARS-CoV-2/COVID-19 pandemic began the week of March 9. Different levels of response were established, and all involved worked to the best of their ability at each level. Not all Spanish provinces were impacted equally – some were affected earlier on or with greater severity – and this has allowed us to learn from each other.

Political and managerial aspects at the national, regional and hospital levels have played a part. Management strategies within each service, determined by the aforementioned management levels, have been key due to the important role they play in the direct relationship with patients and their families. Managers at each of these levels have their duties and responsibilities, but all are vitally important due to their direct or indirect effect on people: patients, relatives or healthcare workers.

It is important to bear in mind that all these management strategies must be guided from start to finish by ethical principles that guide decision-making using a series of common principles that will ultimately benefit the care provide to each and every patient.

Logically, in this article we cannot or will not analyse political decisions or large-scale management strategies. Instead, we want to focus of the role that ethical issues have played in our actions as critical care professionals during this SARS-CoV-2/COVID-19 pandemic.

Development

The reports issued by the Ministry of Health and by the Spanish Bioethics Committee on the COVID-19 pandemic make an in-depth assessment of all the ethical aspects involved. These are the reference documents in this regard. In this article, we will discuss some of the issues that have received the least attention in the documents most widely disseminated in society and in the field of healthcare.

The role of bioethics in this context

Successive ethical recommendations in Spain and in other countries

Early this year, we received news from Wuhan, a Chinese city over 9000 km away from Spain (later defined as the epicentre

Ethical aspects that merit an in-depth analysis

1. The role of bioethics
   - Successive ethical recommendations in this regard in Spain
   - The need to introduce bioethics into clinical practice
2. Resource allocation
   - Triage
   - Teamwork
   - Impact on healthcare workers
   - What are the guiding principles for allocating scarce resources?
     State of normality
     Utility
     Equity. Protection of vulnerable groups
   - Protocols
   - Prioritization of certain groups
3. Family- and accompaniment-related factors

of the SARS-CoV-2/COVID-19 pandemic) that they had problems with a virus. This interested some more than others, but was of no concern to us in terms of our daily lives, our plans, or our families. The virus eventually reached Europe; however, it was still far away — we may have had to change our travel plans, but we were still oblivious to the danger. Finally, it broke out in Spain. Our lives, our interests, our hopes and concerns changed overnight.

We had reports from Italy, where the first case of acute respiratory failure due to COVID-19 was documented on February 21, and where over the following days, despite the measures taken, the number of patients requiring hospitalisation and intensive care increased exponentially. Fifteen days after diagnosing the first case, Italy had the second highest incidence of patients infected by COVID-19 in the world.

On 10 March, various hospitals nationwide, following the advice of their ethics committees, began to publish documents addressing ethical considerations in the management of patients who may require admission to intensive care units.

On 20 March, the Spanish Society of Anaesthesiology and Pain Therapy (SEDAR) released its ''Ethical framework for the COVID-19 pandemic'', in which it analysed ethical principles and gave certain recommendations regarding the basic elements in a triage protocol and other specific recommendations.[2]

At around the same time, the Spanish Society of Intensive, Critical and Coronary Unit Medical Care (SEMICYUC) released its ''Ethical recommendations for difficult decision-making in intensive care units due to the exceptional crisis caused by the COVID-19 pandemic''. In this article, they put forward triage and treatment recommendations, and specific recommendations for ethical decision-making.[3]

On 25 March, the Spanish Bioethics Committee published its ''Report on the bioethical aspects of prioritizing health resources in the context of the coronavirus crisis'', a long, well-founded article that discusses various ethical factors of vital importance in this pandemic.[4]

On 2 April, the Spanish Ministry of Health published its ''Report on ethical issues in pandemic situations: SARS-CoV-2'', an extensive, well-founded and well-advised document that puts forward recommendations to help decision-making in treatment and care measures for COVID-19 patients in the context of a pandemic marked by limited resources. It calls for optimal planning and management of these resources at the local, regional and national level, making reference to organisational decisions across the entire healthcare system.[5]

On 15 April, the Spanish Bioethics Committee released a new document, ''Declaration on the right and duty to facilitate accompaniment and spiritual assistance to patients with COVID-19 at the end of their lives and in situations of special vulnerability: in which it focusses exclusively on the issue of accompaniment.[6]

The need to introduce bioethics into clinical practice

It is especially interesting to observe the sequence of these documents. Medical societies specialising in the care of critical patients published their proposals on the ethical issues emerging in this pandemic before experts at the national level. Each hospital began to establish its own protocols based on first-hand experience and reports on the pandemic in the media, on social networks, or from other hospitals. On 23 March, the Ministry asked its advisory body, the Spanish Bioethics Committee, to draw up a report on the ethical implications that the recommendations published by these medical societies could have on the most vulnerable social groups. The formal request was made following a suggestion by the Committee itself, which was concerned that each hospital or scientific society was establishing its own triage and care prioritization criteria and protocols with no regard for common criteria, and in many cases without sufficient advice from experts in bioethics. Coincidentally, or perhaps prior to the request made by the health authorities, public opinion began to question the criteria used to distribute resources. In the days leading up to the request – 21 and 22 March – the following headlines appeared in Spanish newspapers: ''ICUs collapse'' (*El Mundo*, 21 March 2020), ''Spain enters the worst phase with UCIs at breaking point'' (*El Periódico*, 21March 2020), ''Doctors prioritize patients based on their life expectancy'' (*El Correo*, 21 March 2020), ''these are the criteria used to decide who gets an ICU bed'' (*El Español*, 20 March 2020), ''over-stretched hospitals to give priority to patients with the longest life expectancy'' (*El Mundo*, 20 March 2020), ''Spain reports over 1000 deaths with Madrid ICUs inundated'' (*El País*, 21 March 2020), among others.

The foregoing is a good sample. Medical societies and the hospitals themselves made provisions for what was to come, or what had already happened, and established their criteria, with varying degrees of success, on the basis of advice, to a greater of lesser extent, from bioethicists. Either way, these decisions were made with the best intentions and a desire to improve the situation. However, the criteria used were localised and differed among hospitals, revealing a lack of minimal uniformity of bioethical criteria, and giving rise to unacceptable differences in decision-making among centres. Bioethicists, obviously, neither treat patients nor are able to judge the fine print of established protocols. But we need their help: we need a series of guidelines on which to base our particular role within the hospital or within the medical society itself.

This, perhaps, is the best opportunity for bioethicists to show the fundamental role they play in our society in response to public demand. The work of bioethicists does not produce money, they do not generate tangible resources, they do not solve the materiality of working hours, but they are necessary. They are necessary not only to respond to public opinion, but because they can guide our steps along the path that each medical services or each healthcare worker must travel. Let us not lose sight of the fact that it is society that has demanded the presence of bioethicists. All bioethics advisory bodies, large and small, are important at the level at which they act. Hence the importance of the Spanish Bioethics Committee at the national level in helping both healthcare workers and the healthcare authorities to take the right decisions. The advisory council of a national body has called on healthcare workers and other national organisations to adapt their measures to the proposed ethical principles. The moral authority underlying the strength and degree of commitment required by their recommendations make them practically mandatory. It is vitally important to define, as far as possible, these principles, since it is imperative to plan the allocation of scarce resources before a situation evolves into a crisis. If this is not done, decisions will be made on the basis of local necessities. We must strive to unify and implement ethical principles at every level, despite the effort required. To ignore this need is to ignore the evidence.[7,8] In the words of the Spanish Ministry of Health's report on ethical issues in pandemic situations: ''Our starting point is that ethics cannot be set aside during a public health catastrophe such as the SARS-CoV-2 pandemic. On the contrary, in a crisis it is more important than ever to articulate ethical guidelines for extraordinary circumstances and to prevent decision-makers from failing to consider professional standards when under pressure''.[5]

Prioritising the allocation of resources

Screening

This has taken centre stage in this pandemic. All the documents and recommendations, and public opinion itself, have focussed on this as the most important or, at least, as the most controversial issue. During the onset of the pandemic, it became evident that demand for healthcare outstripped the resources available — mainly specialized staff, access to diagnostic tests, beds in critical units, and ventilators. Not only are these resources insufficient to meet demand, but they are unevenly distributed across the country, making it even harder to allocate them without undermining the rights and dignity of individuals.[1,9]

In this situation, it has become imperative to manage the available of resources by applying certain restrictions that can only be part of a raft of extreme measures. These measures are only justified when efforts have been made at all levels to increase the availability of and equal access to resources in all regions by studying the feasibility and safety of transferring patients to other hospitals.[10]

Health workers cannot assume responsibility for allocating the resources available to them if such resources have not previously been allocated at the national level according to certain criteria, once the authorities have ensured that all available resources have been obtained and can be accessed equally by all.

Logically, criteria for admission and discharge from critical care units are required in these circumstances. These should not only be based on clinical and pro rata considerations, but also on the basis of fair distribution and the location of scarce healthcare resources. Therefore, allocation plans must contain ethical guidelines to align all actions taken in these circumstances with standards of good practice, thereby alleviating the burden on doctors and guaranteeing equality for all.[1]

These planning criteria must be flexible. They cannot become so strict as to prevent healthcare workers from making their own clinical judgement with regard to each patient. Moreover, clinical judgement must always be present when implementing planning criteria in order to avoid automatic or routine decision-making.

Teamwork in the distribution of resources

One aspect of resource allocation that has been addressed by many authors and is of paramount importance in a pandemic is the role of teamwork in the distribution of available resources.

Clinicians caring for critical patients use resources that are not their own. They manage these resources, but they cannot have *de facto* ownership of them. They are professionals who, in respect of the resources available to them, are at the service not only of patients, but also of other professionals. Therefore, the selection of patients to be admitted to critical care units cannot depend exclusively on the assessment of the professionals in charge of managing these resources.

The SEDAR recommends that: ''critical care admission criteria should be discussed and defined for each patient as soon as possible; ideally, staff should draw up a list of patients considered candidates for intensive care if their clinical status deteriorates, provided there are beds available''.

The best strategy for this complex and delicate task of resource allocation is to set up clinician working groups. A mere protocol will not suffice; instead, we believe that allocation criteria, being flexible, should be adapted to the availability of resources at the local level, the potential transfer of patients, and the current or planned number of hospital admissions and potential admissions to critics care units. These working groups will have to evaluate the flow of patients both in and out of the different units (emergency room, wards, and critical care units). This will allow resources to be allocated more fairly and transparently, since decisions made at one point in the pandemic will not necessarily be the same as those made at another time, and obtaining a complete picture of the situation with prevent the unjustified discrimination of patients. These measures will avoid the danger of enforcing closed protocols that curtail clinical action, and will at the same time increase staff satisfaction by improving their situational awareness and encouraging consensus decision-making.[10,11]

Impact on healthcare workers

The moral weight of allocating the resources available to front-line health workers can only be delegated after optimal planning of care resources at the local, regional and state levels. We need bioethicists to help us establish lines of action that alleviate the stress of decision-making among hospital staff, but that do not undermine their own capacity to take ethical decisions in specific cases. Rosenbaum, in a perspective article published in the *New England Journal of Medicine*, reveals that when doctors in hospitals in northern Italy at the height of the pandemic were asked how they select patients, many declined to answer or changed the subject. ''We have to decide who must die and whom we shall keep alive'', ''This is not a nice thing to say'' or ''You will just scare a lot of people'' are some of the comments reported in the article.[8]

Mental health specialists at London's *King's College* believe that the current unprecedented situation compels doctors to make dramatic decisions, such as how to allocate resources to patients in similar clinical situations, and to work under such pressure that it causes moral injury and can lead to mental health problems. ''Moral injury'' is a term traditionally used in the military medical literature, and is defined as psychological distress that results from actions, or the lack of, that violate a person's morals or ethics. It is not in itself a pathological condition, but those who develop moral injury are at risk of experiencing negative thoughts and feelings about themselves or about others. These symptoms can contribute to the development of mental health disorders, including post-traumatic depression, stress disorder, and even suicidal ideation.[12]

The emotional impact on healthcare workers is further compounded by two other factors. Fear of infection during their shift and fear of transmitting to virus to their closest relatives makes them hypervigilant both at work and at home. Added to this continuous state of alert, their high workload, long working hours, and irregular rest periods, is the fact that the outcomes of their work are often frustrating. The initial lack of understanding and experience in the disease and its aggressiveness in certain population groups means that the outcome achieved are not proportional to the therapeutic effort made.

These psychological issues will not disappear as soon as the pandemic is under control, but will persist either latently or overtly in our healthcare workers, and they must be acknowledged so that we can help those who have helped others.

What are the guiding principles for allocating scarce resources?

The criteria used for allocating resources should be clearly defined and feasible.[5]

In this critical situation, it is difficult to establish a single criterion for the distribution of resources. Instead, we need several ethical values that can be tailored to individual needs in order to determine which patients warrant allocation of these scarce resources, since there is no all-encompassing value that can be used for this purpose. The Spanish Bioethics Committee's proposal to establish a mixed model that includes the criteria of utility, fairness, and protection against vulnerability has been echoed by many authors.[1,4]

In some cases, an even distribution of benefits and burdens can be considered fair. But in others, it may be fairer to give preference to the worst off. It is not always possible to fully achieve both utility and fairness, and there is no single right way to resolve potential tensions. What is important is that decisions are made using an inclusive and transparent process that takes local circumstances into account.

State of normality

Following the recommendations of the Spanish Bioethics Committee, before applying these mixed models we must ask ourselves what we would do in a non-crisis situation. In a state of normality, certain decisions are taken in accordance with the basic principles of bioethics and proportionality; however, in a crisis situation these decision may mistakenly be considered inappropriate.

A fundamental criterion for evaluating admission to a critical care unit, even when sufficient resources are available, is the probability that the treatment will be effective and the risks do not outweigh the expected benefits. Futile interventions are never ethical. This decision must be based not only on the patient's current status, but also on their history of concomitant diseases (comorbidity), prior functional status, and their likelihood of recovery. Age is obviously a consideration in this prognosis or study of therapeutic proportionality, and is one of the factors used to define the patient's condition and prognosis.

Likewise, we believe that the appropriateness or disproportion of a treatment may vary according to the evolution of the pandemic: what at one point is an ordinary measure may later become extraordinary and, therefore, not mandatory. But this can only be determined as a whole, taking into account all the resources and patient flows estimated in the hospital in question.

At this point, in the interests of determining what is best for each patient, avoiding abandonment or any form of discrimination for any reason, we must discuss advance care planning and palliative care:

- Advance care planning must be carefully evaluated, particularly in patients with serious chronic diseases. The plan should be shared as far as possible between the patient, their family members and all the healthcare personnel involved in their care. The consensus decision to restrict certain treatments does not rule out the start of others on a smaller scale or in other areas of the hospital. In particularly complicated cases a second opinion can be obtained, for example, from the Healthcare Ethics Committee or the panel of experts created for the pandemic. In any event, with reference to the aforementioned teamwork, most decisions can be taken by the team in charge.
- When the decision, based on the aforementioned arguments, has been taken to withhold new therapy or withdraw existing treatment, patients must always receive proper palliative care. Palliative care, according to the regulations of each country, is a matter of good clinical practice.[10]

Some principles governing the allocation of resources by all sectors have been invalidated. The criterion of timing, ''first come, first served'', can be unfair, insofar as patients with less urgent requirements or patients with a poor prognosis are given priority over other cases. Patients who have adhered strictly to national health guidelines or who live further away from the hospital, who have difficulty getting to the hospital, or who have a good prognosis can find themselves marginalised due to their order of arrival.[1,5,10]

Utility criterion

The principle of utility states that actions are correct to the extent that they promote the well-being of individuals or communities. This definition by the World Health Organization (WHO) is intended to maximize benefits and minimize burdens by focusing on providing care to the greatest number of patients. Efforts to maximize utility require consideration of proportionality (balancing the potential benefits of an activity against any risk of harm) and efficiency (achieving the greatest benefits at the lowest possible cost). There must be a balance between saving lives and saving life-years.

How can these two benefits be balanced? The balance changes as our knowledge of the disease increases, and may vary depending on the stage of the pandemic and our understanding of the course of the disease. We may go from saving lives in the early phases of the pandemic, in which time is limited and we have little understanding of the evolution of the disease, to prioritising life years later on. Whatever the number of lives/number of life years balance chosen, it must be applied consistently.

This criterion of utility in the allocation of resources must be taken into account after distinguishing between patients who will not survive, even with aggressive treatment, and those who will survive even without any treatment. Therefore, those who are ill and can benefit from treatment will be prioritised over those who cannot benefit or who can recover without treatment. Age is one of several factors included in these criteria.[1,5] For example, patient characteristics such as comorbidities, functional status, and age must be carefully evaluated without needing to set an exact age limit for eligibility for allocation of scarce resources.

The results of the study in which people were asked which patients should be treated during a pandemic are interesting, even though this was a fictitious situation at the time it was conducted. Participants valued saving people with the greatest chance of short-term survival, followed by saving those who, thanks to a relative lack of coexisting conditions, have the greatest chance of long-term survival. All argued that age cannot define the criteria of treating or rejecting treatment, but that in certain situations it can be a factor to take into account.[8]

Equity criterion

The principle of equity refers to fairness in the distribution of resources, opportunities and outcomes. It can be defined as the ''fair distribution of benefits and burdens'', in other words, providing resources to those who need them most.

Treating people equally could be achieved by random selection or first-come, first-served, but this is not the principle of equity. Key elements of equity include equal treatment, avoiding discrimination and exploitation, and being sensitive to people who are especially vulnerable to harm or injustice.[6,13]

The criterion of equity requires several ethical values that can be tailored to individual needs.

In this regard, particular care must be taken to protect individuals against vulnerability, especially in crisis situations or mass disasters where lack of time and the need to allocate resources, as we have seen during this pandemic, can often lead to bias. The document issued by the Spanish Ministry of Health states that ''there are no grounds for discrimination other than the clinical status of the patient and their objective likelihood of survival''.

We identified three different vulnerable population groups: patients with disabilities, elderly patients, and patients with no financial resources:

- To discriminate against a patient based on their disabilities prior to their present condition is not compatible with the principles described in various national and international legal documents on human rights, since, as the bioethicists of the Spanish committee remind us, ''Rights cannot depend on the possession or not of a certain level of knowledge, skills and competence, but on the human condition, since all people, by the mere fact of being human, are equally entitled to full recognition and enjoyment of their human rights''.[4]
- In the specific case of the current pandemic, older patients are considered the most vulnerable, and ''should

be treated under the same conditions as the rest of the population, that is, taking into account the clinical criteria of each case in particular, since the age criterion can only be used to prioritize but not to deny or limit health care and access to certain life support measures''.[4,5] Age obviously has an impact on clinical prognosis, and must be evaluated accordingly, but never to the exclusion of other criteria. All the circumstances of each patient must be assessed, without excluding anyone *a priori*. The only potentially positive age-based discrimination occurs in children, but this age group has not so far been affected by this pandemic.

- Although it is not a particularly important consideration in Spain, due to our public health system, in certain countries access to healthcare depends on the patient's financial resources. In a pandemic, personal resources cannot be a limitation for treatment.[1]

Protocols

At the local or hospital level, it is best to establish specific protocols that contain basic common principles and that are drawn up considering these governing principles — protocols containing general, consensual objective criteria that facilitate the work of hospital staff and apply measures at all levels.

Although these principles help establish protocols, each patient must be considered individually, assessing their uniqueness and also considering the particular circumstances of each hospital.

As mentioned previously, these protocols facilitate consensus and ensure that individual clinicians are not faced with the daunting task of improvising or deciding who to treat.

When drawing up and implementing these protocols it is essential to guarantee their transparency or lack of arbitrary or biased decisions. Transparency leads to general acceptance followed by general understanding, thereby maintaining the trust of both patients and healthcare workers.

Some authors have expressed concerns regarding disclosure of the criteria used to allocate resources, claiming that this type of rationing is better accepted when performed in silence. These concerns came in the early stages of the pandemic in Europe, when Italy was practically the only European country affected and second only to China in the number of cases. They were voiced following widespread criticism of the ethical guidelines proposed in Italy, which were accused of age discrimination, with some even claiming that the severity of the pandemic had been exaggerated.[8] We believe these statements were the product of a feeling of utter despair in respect of the magnitude and speed of the pandemic. In the current circumstances, we can say that transparency and good communication for full understanding is vital, since successful allocation of resources requires public trust and cooperation.

However, even well-designed protocols can occasionally present difficult decision-making and implementation problems. To relieve front-line clinical staff of this burden, some authors recommend creating a group of physicians who are not directly involved in patient care, or committees of experienced physicians familiar with ethical principles who can be consulted on resource-allocation decisions. Others recommend separating triage staff from those who work directly with patients. We believe that creating a team made up of experienced professionals, leaders in different areas of care (emergency care, wards, critical care and epidemiologists) will ensure that the protocols can be adapted to each specific or controversial case.

Algorithms or protocols must be periodically updated for two reasons: to adapt the criteria to the state of the knowledge of both the disease and its distribution; and to ensure changes in the disease in each patient by evaluating suitability, treatment targets, and proportionality.

Prioritization of some groups to receive tests and resources

Another widely discussed issues in the initial stages of the pandemic has been the defence of the ethical principle of reciprocity, which means that society must support people who take on a disproportionate burden or risk in order to protect the public good.[13]

Many argue that priority must be given to those engaged in research into to the virus and administering treatment. According to the Spanish Ethics Committee: ''By prioritising the protection of healthcare workers, particularly those most directly involved in patient care, we directly protect society as a whole''.[4,5]

The Committee prioritises treatment for people who are difficult to replace on the basis of their instrumental value, since they are essential to ensure adequate response to the pandemic. According to other authors, these individuals form an essential workforce, and prioritising their care is a way of acknowledging their dedication to their patients despite the risk of infection, and may also discourage absenteeism.[1]

Allocating resources to healthcare workers in preference to other patients raises certain questions, and must be considered in the context of all the foregoing criteria. This dilemma is unlikely to arise, because the working population (such as healthcare personnel, special services or security forces) have a level of health prior to infection that would give them, *per se*, priority over other patients without resorting to their professional status.

Prioritising screening for healthcare personnel or personnel involved in managing the pandemic is beneficial to society as a whole, since healthcare workers themselves, due to the characteristics of their work and their contact with patients, can spread the disease to this particularly vulnerable group. Members of the security forces and special services should also have preferential access to these tests, not in acknowledgement of their service, but as a way of preventing them from spreading infection.

Family- and accompaniment-related factors

After the outbreak of the pandemic in Spain and the exponential increase in the number of cases, new concerns were voiced about isolating patients both during the course of the disease and in the last moments of life. This is considered inhumane, and has negative effects on patients, their families, healthcare workers, and society as a whole.

The compulsory isolation of COVID-19 patients due to the extremely high rate of infection further aggravates the patient's suffering by depriving them of the support of their family — a situation we have not hitherto encountered. The pain associated with the illness of a relative is intensified by separation and an inability to comfort them. This situation is particularly distressing in the case of patients who must endure their final days or hours without the support of their family.

The Spanish Bioethics Committee of Spain addressed this issue in a brief report, and suggested studying the best way to provide patients with accompaniment and spiritual or religious support according to their beliefs and the characteristics of the hospital, facilitating accompaniment without endangering the safety of healthcare workers and society as a whole.

This has prompted clinicians to introduce innovative strategies to provide patients and relatives with a ''more compassionate'' environment.[14] The Committee concludes by saying: ''this is a clearly justified, eminently humane endeavour''.[6]

Conclusions

Bioethics is a science that facilitates our clinical practice by providing us with a foundation on which to base our scientific knowledge and our own clinical experience. The SARS-CoV-2/COVID-19 pandemic has again confirmed our need for experts in this field. The guiding principles of bioethics that permeate our clinical practice must also enlighten organizational structures across all levels, ensuring respect for all manifestations of human dignity found in each individual. Bioethics and bioethicists are needed in clinical practice, not only to judge events *a posteriori*, but to ensure that they are always more humane by safeguarding the dignity of each and every person.

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