

Essay/Personal Reflection

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# Is shortening the response-to-treatment waiting time appropriate during the Covid-19 pandemic?

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Covid-19 is causing a catastrophic sanitary problem worldwide. Many countries find themselves in the midst of this sanitary problem, while others will soon be facing the same fate.

The Covid-19 pandemic public health goal should not only be to protect the life of a few patients, but also to save the lives of as many patients as possible (Berlinger et al., 2020). If it were possible to save everyone, the duty would be straightforward and simply that — to save everyone. However, as we reach the peak of the pandemic, this may not be possible. That is why, utilizing all the means available (SEMICYUC, 2020), the duty is to save the life of as many patients as possible (Emanuel et al., 2020).

There are many ethical dilemmas that have come out of the Covid-19 pandemic. The discussion about what the ethical parameters for medical decision-making should be is still open for consideration. Specifically, a few clinical strategies that consider the intrinsic dignity of the human person requires further elucidation.

The aim of this paper, during Covid-19 pandemic's peak, is to consider whether it is appropriate to limit therapeutic efforts, knowing that the staying time in intense care units (ICUs) for patients with Covid-19 is significantly longer and that mortality rates are higher especially for those who do not demonstrate signs of improvement.

## Challenges in modern ICUs

Owing to great technological development, it is possible to carry out treatments within modern ICUs that end up in a therapeutic obstinacy. Patients who are seriously ill opt for negative extreme measures such as euthanasia, while other people choose from the opposite end of the spectrum: artificial prolongation of life. In the latter, by using every therapeutic means available, the death of the agonizing patient results inconsequential.

Except when the prognosis is clear, establishing a precise limit without falling into therapeutic obstinacy is not easily achievable with some patients who are seriously ill and treated in ICUs. Among the many challenges of the Covid-19 pandemic, the scarcity of resources for adequately caring for all patients is the most pressing one (Berlinger et al., 2020; Emanuel et al., 2020; SIAARTI, 2020). It is a human limitation that is difficult for the medical community and society in general to process. Furthermore, not being able to offer the appropriate therapeutic means brings forth pain and anguish (Berlinger et al., 2020; Emanuel et al., 2020).

But there is also another challenge yet to be solved in modern ICUs: the difficulty of accepting the limits of a treatment that has not produced any benefits. There is a tendency to avoid the suspension of treatment, which does not allow the patient to die. This is understandable because physicians find easier withholding additional interventions than withdrawing those already in place, particularly when mechanical ventilation is involved.

Of important ethical note, in cases where the treatment is futile, its suspension would lead to the patient's death, but would not be an intentional cause.

The decision to continue the treatment may not be so dramatic as many times we end up thinking it is a new possibility for recovery, perhaps the last one. A justification is always possible as modern medicine could always affirm, except in extreme cases, that there is always some form of recovery. This justification can also be expressed as a question: Is there any way to demonstrate that there are no chances of recovery?

If making the decision to limit treatment in simple cases is challenging, how do we proceed when the case is "catastrophic", such as in Covid-19 pandemic? (SIAARTI, 2020). This current situation provides us with a context in which to study the limits of modern therapeutics.

The challenge that Covid-19 poses to the medical team is how to prudentially make decisions concerning limiting treatment. This includes not starting a treatment, not progressing with a new therapy, or stopping one already begun. Approaching this pandemic as a valuable

opportunity is crucial, perhaps the pandemic may help us to increase our practical knowledge on dealing with exceptional circumstances (SEMICYUC, 2020; SIAARTI, 2020).

Thus, the appropriate waiting time before withdrawing the treatment that was initiated is a critical decision. During normal circumstances, when dealing with severely ill patients in the ICUs, the waiting time for a response to treatment is provided by the available time until the patient prognosis is clear. This is determined by utilizing clinical parameters in which medical improvement is evident or, on the contrary, an unfavorable prognosis carries him or her to death (Truog et al., 2020).

Covid-19 has taken the health community by surprise, especially in learning how long the waiting time for treatment should be. We do not yet have sufficient scientific evidence and medical experience to establish what the response of severely ill patients is, although we already know that it does have a prolonged acute phase (SIAARTI, 2020). In other circumstances, even more during circumstances of uncertainty, it is appropriate to have “more possibilities of response” (Silberberg et al., 2020). But in times of pandemics, as long as there are many other patients expecting immediate life-sustaining treatment, it seems reasonable that the waiting time should be shorter. This does not mean an act of abandonment (Schneiderman et al., 1990; Gedge et al., 2007) nor an act of depriving anyone who has still a reasonable chance of survival with the opportunity to live (Emanuel et al., 2020). It is important to know as best as possible, given the limitations of our circumstances, what the patient response to treatment is before making a final decision.

If the waiting time in a pandemic seems to be shorter, then continued patient evaluation is especially important. When patients have begun their negative response to treatment, it may be necessary to offer treatment to others who have not had the chance to be treated (SEMICYUC, 2020; SIAARTI, 2020; Truog et al., 2020). But when the patient has not yet provided his response, the treatment that was initiated should be continued.

More than ever, especially during a pandemic, therapeutic obstinacy is not admissible. Not presenting sufficient possibilities of treatments to patients is a danger. On the other hand, ethics would dictate that if a therapeutic test is negative for a patient, then it is prudent to give that opportunity to others who otherwise could benefit from the treatment. The regret of not having done one more extreme attempt may later remain. Perhaps the medical community should come up with a collaborative decision: we have to work with and perform what is reasonably available and conduct it with transparency (Nuffield Council on Bioethics, 2020; SEMICYUC, 2020; SIAARTI, 2020; ).

Creating treatment guidelines and specific professional teams may be a good strategy for tackling such complex decisions,

especially by distributing the psychological burden of health professionals. This approach would also allow us to combine the common good and the individual good of the patient (Emanuel et al., 2020; Truog et al., 2020).

This supportive team is a valuable contribution for the physicians in charge of caring for patients in ICUs: they can help with the decision-making of withdrawing treatment, promote the communication with the family, facilitate in the ethical discussion of life-sustaining treatment, support the patient and families emotionally, and pave the way for palliative care (Truog et al., 2020).

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