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Healthcare workers' opinions on non-medical criteria for prioritisation of access to care during the pandemic

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Abstract

Introduction The COVID-19 pandemic generated overflow of healthcare systems in several countries. As the ethical debates focused on prioritisation for access to care with scarce medical resources, numerous recommendations were created. Late 2021, the emergence of the Omicron variant whose transmissibility was identified but whose vaccine sensitivity was still unknown, reactivated debates. Fears of the need to prioritise patients arose, particularly in France. Especially, a debate began about the role of vaccination status in the prioritisation strategy.

Material and methods The Ethics Committee (EC) of the University Hospital of Bordeaux (UHB), France, identified prioritisation criteria in the literature (some recommended, such as being a healthcare worker (HCW) or having consented to research, while others were discouraged, such as age with a threshold effect or vaccination status). A survey was sent within the institution in January 2022 to explore frontline physicians' adherence to these prioritisation criteria. The decision making conditions were also surveyed.

Results In 15 days, 78/165 (47.3%) frontline physicians responded, and more widely 1286/12946 (9.9%) professionals. A majority of frontline physicians were opposed to prioritising HCWs (54/75, 72%) and even more opposed to participating in research (69/76, 89.6%). Conversely, the results were very balanced for non-recommended criteria (respectively 39/77, 50.7% and 34/69 49.3% in favour for age with a threshold effect and for vaccination status). Decisions were considered to be multi-professional and multi-disciplinary for 65/76, 85.5% and 53/77, 68.8% of frontline physicians. Responders expressed opposition to extending decision-making to representatives of patients, civil society or HCWs not involved in care.

Discussion Prioritisation recommendations in case of scarce medical resources were not necessarily approved by the frontline physicians, or by the other HCWs. This questions the way ethical recommendations should be communicated and discussed at a local scale, but it also questions these recommendations themselves. The article also reports the experience of seeking HCWs opinions on a sensitive ethical debate in a period of crisis.

Keywords Prioritisation, Triage, Covid-19, Ethics committee, Vaccination status

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Introduction

During the coronavirus disease 2019 (COVID-19) pandemic, before vaccines became available, some countries faced dramatic situations where medical resources were scarce, necessitating patient prioritization [1, 2]. The scientific and bioethics literature quickly addressed the ethical aspects of prioritization [3, 4]. Patient triage is a complex process, involving a fundamental ethical dilemma: it must balance the utilitarian imperative of saving as many lives as possible with the need to respect each individual's unique circumstances, ensuring that no discrimination occurs. In France, as in many other countries, scientific societies and ethics committees provided specific recommendations based on key principles, particularly justice, equity, respect for dignity, non-discrimination, and accountability.

A predominantly medical approach was favoured, with particular emphasis on assessing the severity of patients' clinical conditions, their frailty (often using the Frailty Scale), and their prognosis (both vital and functional). Many guidelines stressed the importance of caution in using non-medical criteria [5–9]. For instance, age was not to be considered a criterion in isolation, but rather part of a broader assessment of patient frailty. Nevertheless, some non-medical criteria did emerge in these recommendations. Having consented to biomedical research or being a healthcare professional was suggested from a utilitarian perspective [3, 4].

By late 2021, a few months after the start of the French vaccination campaign, the Omicron variant of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was discovered [10]. Its high transmissibility was quickly recognized, and the effectiveness of vaccines against it was still uncertain. This led to renewed concerns about health systems being overwhelmed. As contamination rates surged, so did the number of COVID-19 patients in intensive care units (ICUs), straining healthcare systems [11, 12]. Most ICU patients at the time were unvaccinated [12, 13]. Some healthcare workers (HCWs) found it difficult not to blame unvaccinated patients, as they perceived them to be knowingly putting the health system at risk [14–16].

The University Hospital of Bordeaux (UHB), a tertiary hospital in Southwest France, was heavily involved in the pandemic response. While care units were significantly mobilized, the UHB was relatively spared from the worst effects of the pandemic and never faced large-scale triage decisions. However, the rising number of unvaccinated ICU patients raised concerns among healthcare professionals about the potential need to prioritize patients based on non-medical criteria, particularly vaccination status. Similar to their counterparts across France, some UHB professionals began discussing the possibility of prioritizing vaccinated patients and voiced their opinions on social media and in the press [17].

Although these views were isolated and represented the personal opinions of individual professionals, the context of widespread fear and debates surrounding the unvaccinated population prompted the UHB Ethics Committee (EC) to intervene. The EC sought to prevent any perception that these opinions reflected official UHB policy. In addition to its usual role of reinforcing ethical principles and disseminating triage recommendations, the EC took the initiative to conduct a survey among UHB HCWs regarding the use of non-medical criteria in prioritization decisions.

The primary objective of the survey was to assess the level of agreement among frontline physicians—those directly involved in potential triage decisions—regarding the use of non-medical criteria for patient prioritization. The secondary objective was to evaluate their views on specific conditions for decision-making and to compare their responses with those of other groups within the UHB, including non-frontline physicians, non-medical HCWs, and non-HCW professionals. In addition to presenting the survey results, this article also shares the UHB EC's experience in soliciting HCWs' opinions on such a sensitive issue during a time of crisis.

Methods

The UHB is the largest tertiary hospital in Southwest France, with approximately 1,500 available beds, over 1,500 physicians, and 8,300 non-medical HCWs. At the time of the study, the UHB was facing the fifth wave of the COVID-19 pandemic, driven by the emergence of the Omicron variant. ICUs were reorganized, with some being dedicated specifically to COVID-19, allowing other ICUs to remain as isolated as possible and to continue caring for patients admitted for non-COVID-19-related reasons. Two emergency departments, five ICUs, and the mobile emergency unit—comprising a total of 165 physicians—were considered first-line units potentially involved in prioritization decisions during this period. Admission decisions were made by physicians and were strictly based on medical criteria in accordance with national French recommendations.

Although the UHB managed to adapt its medical resources continuously and avoided overwhelming situations, no large-scale prioritization of patients for ICU admission was necessary. As recommended by the French National Consultative Ethics Committee (CCNE), a local ethics support team was proposed, but it proved to be of limited use for first-line physicians. No formal committee or protocol was put in place for managing a potential overflow situation.

The survey was independently developed by the Board of the UHB EC. The working group responsible for its design included five physicians from various medical and surgical specialties and two HCWs (one nurse and one occupational therapist), all of whom had completed training in medical ethics. At the time, no patient representatives were part of the UHB EC Board. Drawing on national, international, and foreign recommendations for patient prioritization, the working group identified five ethically non-consensual prioritization criteria that were not strictly medical, as well as several decision-making modalities. Some of these criteria had been recommended in at least one national or international guideline (such as being an HCW, consenting to biomedical research, or having children). Another criterion—an age threshold—was considered unethical, while vaccination status was a subject of debate in France.

The survey assessed HCWs' agreement with these prioritization criteria and decision-making conditions using a Likert scale with answer options of "totally agree", "agree somewhat", "disagree somewhat", "totally disagree", and "do not know". For age, a binary response option was provided, and for affirmative answers, thresholds ranging from 50 to 95 years in 5-year increments were suggested. HCWs were asked about the relevance of implementing these criteria and decision-making conditions during the ongoing fifth wave of the pandemic (current practices were not evaluated). A group consisting of seven physicians, five residents, and seven paramedics from the Radiation Oncology department at UHB conducted cognitive pretesting to ensure the clarity and intelligibility of the questions. The working group then validated the final version of the survey. A user-friendly and concise questionnaire was chosen to maximize response rates and avoid taking up too much of HCWs' time during this challenging period. The final version of the survey is presented in Table 1.

The primary objective of the study was to use a descriptive analysis to evaluate the agreement of frontline physicians with the different proposals. The survey also included other UHB professionals for comparison. If the participants had any questions or comments at the end of the survey, they could contact the investigators via telephone or mail. The participants were informed of the study content and objectives before responding, and the data were anonymized and protected according to the current French regulations.

Statistical analyses were performed after excluding the "do not know" responses, the number of which can be calculated as the difference between the number of subjects and the number of responses. Statistical analyses included the chi-square test and Fisher's exact test. A p-value of < 0.05 indicated statistical significance.

Results

The survey was available from 10 to 25 January, and was disseminated via a large-scale email to HCWs at the UHB. A total of 245 physicians responded, including 78 frontline physicians, equating to a response rate of 47.3% ($n = 78/165$). In total, 1,286 responses were collected from all professional categories; the population characteristics and participation rates according to profession are presented in Table 2.

Regarding prioritization criteria, frontline physicians exhibited a balanced view on prioritizing patients based on vaccination status. Similarly, responses were divided regarding the use an age threshold as a criterion for prioritization. For frontline physicians (as well as for the other populations considered), the three most frequent age thresholds considered are 75, 80 and 70. However, there was clear disapproval of other proposed

Table 1 Final version of the REPR survey (Reflexion Ethique à la PRiorisation)

In case of scarcity of medical resources during the pandemic, decisions should be based on the following criteria:
- Being vaccinated
- Being a health professional
- Having children
- Having consented to biomedical research
- Patient age as a binary threshold (if yes, state the precise age in 5-year increments from 50 to > 95 years)
Prioritisation decisions should:
- Be multiprofessional (including health professionals other than physicians)
- Be multidisciplinary (including health professionals outside intensive care or emergency units)
- Include patient representatives (through patient associations)
- Include representatives of the society (i.e. individuals other than patient representatives)
- Be made by non-implicated health professionals
- Be subject to national regulations

Table 2 Population characteristics

		n (% of the population of responders)	Participation rate (1/N (%)
Total		1286 (100%)	1286/12946 (9.9%)
Profession	Frontline Physicians	78 (6.1%)	78/185 (42.2%)
	Non-Frontline Physicians	167 (13%)	167/1351 (12.4%)
	Other Healthcare Workers	744 (57.9%)	744/8385 (8.9%)
	Non-Healthcare Workers	298 (23.2%)	298/3025 (9.6%)

prioritization criteria, particularly regarding the prioritization of patients who had consented to biomedical research, which received equivocal responses (Table 3).

Regarding decision-making conditions, frontline physicians expressed strong approval for multiprofessional and multidisciplinary decision-making processes. Conversely, there was clear opposition to involving external professionals or representatives of patients or civil society in these decisions (Table 4). Compared to other HCWs, frontline physicians generally shared similar opinions, but were more opposed to the proposed prioritization criteria and decision-making processes than non-HCW respondents at the UHB.

Discussion

Prioritization according to non-medical criteria

To our knowledge, this was the first study to explore the perspectives of physicians, and more broadly of HCWs, on ICU prioritization criteria through a survey conducted during a pandemic crisis. This added to the originality of the study. French national scientific societies and the CCNE issued recommendations early in the COVID-19 pandemic, with scientific societies releasing guidance in spring 2020 and the CCNE following with recommendations in late 2020 and again in late 2021 [5–9]. These guidelines emphasized principles such as fair and equal access to care, distributive justice, respect for patient autonomy and dignity, transparency, and collegial decision-making. They also urged caution against using binary or non-medical criteria, such as age or social value, to avoid discrimination. However, national French recommendations did not address vaccination status, with scientific societies discussing it only in press releases [18].

French recommendations also highlighted the moral burden placed on HCWs and explicitly prohibited prioritization strategies based on "first come, first served" or the use of lotteries. Furthermore, the use of ethical support teams was suggested, though no detailed descriptions of their roles or functions were provided. While French recommendations were largely consistent with those of other countries, France's absence from international comparisons in the bioethics literature raises questions [19–22].

Our study revealed that frontline physicians did not support certain recommended prioritization criteria, such as prioritizing HCWs or patients who had consented to biomedical research. Conversely, they expressed support for criteria that were either not recommended (e.g. age with a threshold effect) or not discussed in the recommendations (e.g. vaccination status) [23]. The prioritization of HCWs, and of individuals who had consented to biomedical research, has been largely supported in other recommendations, with the ethical justification rooted in the principle of reciprocity: it would be unethical not to prioritize individuals who have taken risks or made contributions to society [3, 24]. For HCWs, their instrumental value, in terms of the indirect benefits to society, was also a key consideration [5, 24–27]. French guidelines, however, did not endorse HCW prioritization, as it could be seen as a form of social hierarchy based on solity [6–9].

Interestingly, the majority of frontline physicians, and HCWs in general at UHB, expressed clear disapproval of these criteria, particularly regarding the prioritization of patients who had consented to biomedical research. This finding contrasted with recommendations that consider such prioritization as ethically justified. Additionally, prioritizing individuals based on family status (i.e. having children) appeared in only one national guideline [19]. While this criterion was included in our survey due to its emotional resonance, it was highly controversial and ethically questionable. Although it sought to prevent children from becoming orphans, it introduced potential unfairness, as there are numerous reasons—often not by choice—why individuals may not have children.

The two other criteria—vaccination status and age—were frequently addressed in both French and international recommendations, as well as in social debates [5–9, 14–17, 20, 28]. In our study, the responses regarding these criteria were notably balanced. Approximately half of the frontline physicians, who were most exposed to the effects of the pandemic and directly involved in triage decisions, were open to considering prioritization

Table 3 Prioritisation criteria

	Factors considered for prioritisation to ICU access in times in a pandemic (*N* = answers other than "I don't know)																
	Age-related (1053)		Being Vaccinated (1224)				Being a Health Professional (1206)				Having children (1196)				Having consented to biomedical research (1212)			
	Yes (n-%)	No (n-%)	Disagree (n-%)		Agree (n-%)		Disagree (n-%)		Agree (n-%)		Disagree (n-%)		Agree (n-%)		Disagree (n-%)		Agree (n-%)	
			TD (n-%)	RD (n-%)	RA (n-%)	TA (n-%)	TD (n-%)	RD (n-%)	RA (n-%)	TA (n-%)	TD (n-%)	RD (n-%)	RA (n-%)	TA (n-%)	TD (n-%)	RD (n-%)	RA (n-%)	TA (n-%)
Profession			NS				***				**				***			
Frontline physicians	35 50,7%	34 49,3%	38 49,3%		39 50,7%		54 72,0%		21 28,0%		49 66,2%		25 33,8%		69 89,6%		8 10,4%	
			23 29,9%	15 19,5%	21 27,3%	18 23,4%	33 44,0%	21 28,0%	17 22,7%	4 5,3%	30 40,5%	19 25,7%	21 28,4%	4 5,4%	51 66,2%	18 23,4%	8 10,4%	0 0,0%
Other physicians	116 48,7%	122 51,3%	85 53,1%		75 46,9%		118 73,8%		42 26,2%		97 60,3%		64 39,8%		129 77,7%		37 22,3%	
			59 36,9%	26 16,3%	47 29,4%	28 17,5%	72 45,0%	46 28,8%	29 18,1%	13 8,1%	53 32,9%	44 27,3%	56 34,8%	8 5,0%	80 48,2%	49 29,5%	23 13,9%	14 8,4%
Other HCWs	73 49,3%	75 50,7%	346 49.1%		359 50.9%		468 68.1%		219 31.9%		446 64.8%		242 35.2%		440 63.9%		249 36.1%	
			234 33.2%	112 15.9%	196 27.8%	163 23.1%	282 41.1%	186 27.1%	119 17.3%	100 14.6%	267 38.8%	179 26.0%	183 26.6%	59 8.6%	294 42.7%	146 21.2%	169 24.5%	80 11.6%
Non HCWs	272 45,5%	326 54,5%	117 41.5%		165 58.5%		163 57.4%		121 42.6%		142 52.0%		131 48.0%		161 57.5%		119 42.5%	
			80 28.4%	37 13.1%	84 29.8%	81 28.7%	90 31.7%	73 25.7%	71 25.0%	50 17.6%	79 28.9%	63 23.1%	97 35.5%	34 12.5%	107 38.2%	54 19.3%	71 25.4%	48 17.1%
Total	496 47,1%	557 52,9%	586 47.9%		638 52.1%		803 66.6%		403 33.4%		734 61.4		462 38.6%		799 65.9%		413 34.1%	
			396 32.4%	190 15.5	348 28.4%	290 23.7%	477 39.6%	326 27.0%	236 19.6%	167 13.8%	429 35.9%	305 25.5%	357 29.8%	105 8.8%	532 43.9%	267 22.0%	271 22.4%	142 11.7%

(*P*- values: *NS* non significant; * = $p < 0.05$; ** = $p < 0.01$; *** = $p < 0.001$)

Table 4 Decision-making conditions

	"Prioritisation decisions should …" (*N* = answers other than "I don't Know)																							
	… be multi-professional (*n* = 1253)				… be multidisciplinary (*n* = 1202)				… include representatives of patients (*n* = 1168)				… include representatives of civil society (*n* = 1150)				… be done by nonimplicated professionals (*n* = 1187)				… be subject to national regulations (*n* = 1175)			
	Disagree (n-%)		Agree (n-%)		Disagree (n-%)		Agree (n-%)		Disagree (n-%)		Agree (n-%)		Disagree (n-%)		Agree (n-%)		Disagree (n-%)		Agree (n-%)		Disagree (n-%)		Agree (n-%)	
	TD (n-%)	RD (n-%)	RA (n-%)	TD (n-%)	TD (n-%)	RD (n-%)	TD (n-%)	RD (n-%)	TD (n-%)	RD (n-%)	RA (n-%)	TA (n-%)	TD (n-%)	RD (n-%)	RA (n-%)	TA (n-%)	TD (n-%)	RD (n-%)	RA (n-%)	TA (n-%)	TD (n-%)	RD (n-%)	RA (n-%)	TA (n-%)
Profession	NS				***				***				***				***				***			
Front-line physicians	11 14,5%		65 85,5%		24 31,2%		53 68,8%		49 67,1%		24 32,9%		55 75,3%		18 24,7%		56 74,7%		19 25,3%		33 45,8%		39 54,2%	
	3 4,0%	8 10,5%	26 34,2%	39 51,3%	4 5,2%	20 26,0%	26 33,8%	27 35,1%	24 32,9%	25 34,3%	16 21,9%	8 11,0%	36 49,3%	19 26,0%	15 20,6%	3 4,1%	20 26,7%	36 48,0%	18 24,0%	1 1,3%	13 18,1%	20 27,8%	28 38,9%	11 15,3%
Other physicians	19 11,6%		145 88,4%		29 17,7%		135 82,3%		99 63,5%		57 36,5%		120 76,0%		38 24,0%		115 71,9%		45 28,1%		81 51,9%		75 48,1%	
	6 3,7%	13 7,9%	60 36,6%	85 51,8%	10 6,1%	19 11,6%	60 36,6%	75 45,7%	44 28,2%	55 35,3%	38 24,4%	19 12,2%	61 38,6%	59 37,3%	21 13,3%	17 10,8%	42 26,3%	73 45,6%	36 22,5%	9 5,6%	39 25,0%	42 26,9%	45 28,9%	30 19,2%
Other HCWs	54 7.4%		675 92.6%		237 34.5%		450 65.5%		395 58.3%		282 41.7%		479 73.2%		175 26.8%		446 64.8%		242 35.2%		216 31.8%		463 68.2%	
	21 2.9%	33 4.5%	188 25.8%	487 66.8%	98 14.3%	139 20.2%	214 31.1%	236 34.4%	198 29.2%	197 29.1%	181 26.7%	101 14.9%	250 38.2%	229 35.0%	99 15.1%	76 11.6%	181 26.3%	265 38.5%	176 25.6%	66 9.6%	96 14.1%	120 17.7%	272 40.1%	191 28.1%
Non HCWs	27 9.5%		257 90.5%		56 20.5%		218 79.5%		123 46.9%		139 53.1%		159 60.0%		106 40.0%		131 49.6%		133 50.4%		59 22.0%		209 78.0%	
	10 3.5%	17 6.0%	113 39.8%	144 50.7%	18 6.6%	38 13.9%	120 43.8%	98 35.8%	58 22.1%	65 24.8%	91 34.7%	48 18.3%	76 28.7%	83 31.3%	58 21.9%	48 18.1%	47 17.8%	84 31.8%	83 31.4%	50 19.8%	21 7.8%	38 14.2%	116 43.3%	93 34.7%
Total	111 8.9%		1142 91.1%		346 28.8%		856 71.2%		666 57.0%		502 43.0%		813 70.7%		337 29.3%		748 63.0%		439 37.0%		389 33.1%		786 66.9%	
	40	71	387	755	130	216	420	436	324	342	326	176	423	390	193	144	290	458	313	126	169	220	461	325

(*P*- values: *NS* = non significant; * = $p < 0.05$; ** = $p < 0.01$; *** = $p < 0.001$)

based on vaccination status, a sentiment shared by other UHB professionals. This principle aligned with the responsibility of citizens to preserve the healthcare system, a concept enshrined in French law [16, 18, 29].

How HCWs interpret vaccination refusal is central to decision-making, as it influences their choices. While refusal may be viewed as a risky personal behaviour, it raises ethical concerns about whether it is appropriate to discriminate on this basis. Historically, risky behaviours (such as smoking) or perceived immoral behaviours have not served as obstacles to care. However, in times of limited health resources, the concepts of solidarity and responsibility may prompt HCWs to deprioritize patients who, based on questionable reasons, deliberately endanger the healthcare system [22]. Furthermore, since COVID-19 vaccination was not mandatory in France (except for HCWs), prioritizing patients based on a voluntary choice was problematic. This criterion was a focal point of media debates, and several scientific societies and institutions emphasized the ethical implications [30, 31].

Age should not be considered a binary factor for prioritization, even though some countries, including Italy, suggested the possibility of introducing an age threshold in extreme cases. Instead, the concept of frailty—where age is only one among several factors—was preferred [4–9, 20, 21, 28]. Nonetheless, several prioritization guides stressed the importance of maximizing life-years, which led to the prioritization of younger patients [21]. While an age threshold may lead to discrimination, opinions on this criterion in our study were evenly divided, including among frontline physicians.

Except for the criterion regarding prioritization based on research consent, the responses reflected the unequivocal reality of ethical debate among frontline physicians, and more broadly across all professional categories. Although there were significant differences between professions, these differences were largely quantitative rather than qualitative, indicating a shift in response proportions rather than a fundamental disagreement. The occurrence of these debates aligned with ongoing social media discussions at the time of the survey. Hospitals are not isolated from broader societal discourse; deontological codes, published recommendations, and ethical guidelines do not necessarily lead to uniform interpretations of critical prioritization criteria within the hospital community.

This internal debate raises questions about how the professional community at the UHB perceives and interprets the decisions made by frontline physicians. Triage decisions are binding not only for the frontline physicians, but also for the broader team of HCWs who are responsible for providing subsequent care to admitted patients. The high degree of variability in the assessment of certain prioritization criteria may result in uncertainty regarding the perceived relevance or consistency of decisions made at the frontline.

Our findings also highlighted concerns about the dissemination and application of ethical guidelines within our institution. Beyond questions about the morality of individual stakeholders or the methods used to communicate ethical recommendations, one could question the intrinsic value and practical relevance of these guidelines. A significant gap between ethical recommendations and the opinions and practices of HCWs places both parties in a difficult position: HCWs may be perceived as acting unethically, while the guidelines themselves may be viewed as ineffective if not accepted by those they are meant to guide. Such a disconnect is particularly counterproductive during times of crisis.

Moving forward, authentic efforts in education and communication are essential, as is a thorough examination of the value and professional or social acceptability of these recommendations. Anticipation and preparedness are imperative for future pandemics. In this context, a public health approach could prove valuable, as it provides a wealth of ethical benchmarks to guide decision-making [32].

Decision-making conditions

Several recommendations have emphasized the importance of triage committees or, at the very least, the need for collegial, multidisciplinary decision-making, with the involvement of patient associations in the spirit of health democracy [7–9]. In our study, the relevance of multiprofessional triage decisions was acknowledged across all professions. However, there was less of a consensus regarding the inclusion of professionals from outside the frontline (i.e. multidisciplinary decisions), particularly among frontline physicians. Interestingly, both frontline physicians and other HCWs expressed opposition to the involvement of representatives from patient associations or society, as well as non-involved HCWs, in decision-making.

Our findings suggested that the closer one is to the decision-making process, the less appropriate it seems to share decision-making authority. This may stem from the inherent association between decision-making and the subsequent care process, where HCWs bear a moral commitment and responsibility. While prioritization decisions are ethically fraught, exposing HCWs to emotional burden and potential regrets, they also provide an opportunity to imbue care with meaning, particularly when ethical considerations are involved. Reducing frontline physicians to their technical role alone could lead to moral distress just as intense as that if they were the sole

decision-makers. Moreover, frontline physicians make prioritization decisions on a daily basis; thus, overlooking their expertise, particularly in emergency situations where efficiency is paramount, would be imprudent.

Limitations

This study had several limitations. Its monocentric nature and the specific context make the results difficult to generalize. Additionally, the representativeness of the findings is questionable due to the low participation rate, except for frontline physicians. The perception of the initiative taken by the EC may have influenced both participation and responses. The timing of the study, coinciding with the vaccination campaign, the onset of the fifth wave, the emergence of the Omicron variant, and ongoing social debates concerning the healthcare system, likely affected the perspectives within the UHB community. Burnout and professional tensions within the French healthcare system were also notable at the time of the survey and continue to be so. Furthermore, the use of a survey methodology presented limitations. Employing a simple questionnaire to address such complex issues may have affected both participation and the quality of responses. While other methodologies, such as qualitative approaches, could have provided a more nuanced understanding of these issues, they would not have enabled us to reach a large enough population, which is necessary given the importance of these debates during the period in question.

What we learnt as an EC about seeking HCWs' views on ethical debates in times of crisis

To conclude this article, we wish to reflect on our experience as an EC in seeking HCWs' views on ethical debates during times of crisis. Numerous ethical support teams were created in France during the pandemic to address prioritization issues [8, 9]. However, French recommendations allowed significant flexibility in designing and organizing prioritization processes at the local level. In response, our EC developed documents outlining ethical recommendations on various topics, with contributions from patient representatives, philosophers, and other HCWs. These topics included triage, prioritization for surgery, breaking bad news, and supporting patients, families, and health professionals, along with ethical benchmarks for prioritization decisions.

We also established a 24/7 response team, comprising a physician and a non-physician trained in ethics who could provide on-site support if needed. However, there was little demand for these services. Several factors likely contributed to this, including the efforts made by the UHB to adapt and maintain healthcare services, the need to prevent an overflow situation, and the recent establishment of the ethical support team. These factors led us to reconsider how such issues should be addressed and, more broadly, to rethink the role of the EC during a crisis.

Some French ethicists have emphasized that, during crises, the priority should be to trust HCWs, with ethical analysis taking place retrospectively [33]. However, this approach may lead to subjective and ethically problematic interpretations, resulting in highly heterogeneous practices in the allocation of medical resources across France. As noted in the literature, the goal is not merely to trust professionals, but to support them when making the "right" decision is difficult [34]. The emergence of the Omicron variant of SARS-CoV-2 in late 2021 reignited the debate over prioritization criteria. In response, our EC initiated this survey to both gather data and engage UHB professionals in direct ethical dialogue.

We adopted a novel approach by involving the stakeholders directly, rather than urging HCWs to adopt a cautious stance. After obtaining approval from the Ethical Affairs Directorate and the UHB Medical Board, the survey was widely distributed within the institution. Remarkably, within the first hour of the survey's release, some professionals contacted us to express their opinions on the survey.

After receiving 10 telephone calls, we began to systematically document the concerns and topics raised by HCWs. In total, 40 HCWs reached out to the investigators (15 via email and 25 via telephone). The most frequently raised concerns were: "shock at the content of the survey," "questioning the role of the EC," and "criticism of discrimination based on vaccination status" (Table 5).

In response to these concerns, we had to consistently reassure HCWs about the genuine aim of the survey, which was solely to gather HCWs' opinions rather than to determine forthcoming prioritization criteria. We also emphasized the EC's complete independence from hospital management. Additionally, the Director of Judiciary and Ethical Affairs received numerous calls from HCWs and unions expressing apprehension about the survey. A few days later, we learnt that networks opposing COVID-19 vaccination had accessed our survey and were using it to suggest that a broad prioritization policy was being implemented at the UHB.

Given the controversy and debates within our institution, we decided to close the survey earlier than originally planned—after only 15 days instead of the intended 6 weeks. Once the data had been collected and analysed, a careful and thorough interpretation was necessary. It became clear that certain results were challenging to convey. For instance, it was difficult to present findings showing that recommended prioritization criteria were not accepted by HCWs, while other criteria that were

Table 5 Topics raised by the HCWs in response to the REPR survey

Topics addressed by health professionals ($n=30$)	Population (n)
Declared being shocked by the content of the survey	19
Considered this is not the role of an EC to do such a survey	10
Criticised discrimination according to vaccination status	10
Declared it created debates within care team	8
Expressed a fear of extension to other criteria (tobacco, alcohol)	6
Criticised the methodological limits of the study	3
Questioned other causes of prioritisation (structural problem)	2
Declared being surprised	2
Discussed medical criteria of prioritisation	2
Interpreted the survey as a sign of a forthcoming decision	2
Other (technical problem, against regulation, moral burden)	3

not recommended or discussed were instead endorsed. Numerous meetings were held with stakeholders to interpret and make sense of these at times troubling results. Some ideas presented in the discussion section of this article stem from those meetings.

Despite the challenges, we believe that our survey achieved its intended effect—creating the necessary conditions to address the significant issue of patient prioritization during times of scarce healthcare resources. Furthermore, the survey has since become a valuable pedagogical resource for teaching medical ethics at both the regional and national level.

In hindsight, we realize that we underestimated the impact this survey would have within our institution and did not fully anticipate the substantial work it would require. We conclude this article with a summary of our EC's experience with the survey. Table 6 outlines how such initiatives may be considered by each type of stakeholder.

Conclusions

Engaging HCWs in discussions about prioritization criteria and decision-making during times of crisis is an innovative and valuable initiative for an EC. However,

Table 6 Advantages and implications/risks of seeking HCWs opinions about the ethical debate of prioritisation in times of crisis

Stakeholders	Advantages and Goals	Direct implications/Difficulties/Risks
Ethics Committee	Simple and quick method to set up Reaches a larger population Creates the conditions for collective debates Helps to adapt the EC discourse to the reality of ethical opinions	Unexpected and Non-consensual procedure for an EC Contrast with the classical representations or expectations from an EC Caution, Availability, Diplomacy in the disclose and interpretation of results Challenge to maintain an institutional ethical coherence in an ethical pluralism
Bioethicists	Evaluation of the reception of and the agreement with ethical guidance Material for researchers aiming the optimization of ethical recommendations	Limitations in generalization of results (contextual specificities) No in-depth analysis (compared to qualitative studies) Minor impact on recommendations
HCWs	No time consuming and efficient way for an ethical interpellation Helps to: - Raise awareness about the ethical nature of prioritization decisions - Question decisional reflexes or discriminatory decisions - Highlight the plurality of opinions regarding decisions involving an entire community	Hard questions to answer and hard results to discover Exposition to problematic or unnecessary questions Shock effect (from individuals to direction) Possible questioning the trust in EC and more broadly in the hospital management
Community / Society	Reinforcement of Transparency and Accountability	May activate an already delicate debate with questionable results May feed mistrust (according to the interoperation of procedure and results)

such efforts require careful preparation and foresight to address the potential consequences of how the survey is perceived and how its results are interpreted. Through this survey, our EC significantly altered its approach by directly engaging stakeholders during a period marked by crisis and ethical debate. Our objective was to provoke a discussion that had previously been passively endured or left unspoken. We believe this method fostered the necessary collective reflection, and it has proven to be—both at the time and continuing into the future—an important tool for refining the role and interventions of the EC.

Abbreviations

COVID 19	Coronavirus disease 2019
UHB	University Hospital of Bordeaux
SARS-CoV-2	severe acute respiratory syndrome coronavirus-2
HCWs	Healthcare workers
Non HCWs	Non Healthcare workers
EC	Ethics Committee

Supplementary Information

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Supplementary Material 1.

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Ethics approval statement
No ethics approval needed for such study according to French regulation.

Authors' contributions
Conceptualization: TH, SM. Methodology: TH, SM, PJM. Questionnaire conception: TH, SM, SD, OM, FP, PS, VA. Data collection and analysis: PJM, TH. First draft: TH, PJM. Review and editing: TH, PJM, SM, SD, OM, FP, VA; All authors have read and agreed to the published version of the manuscript.

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Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
Participants were informed through an introductive paragraph before the questionnaire. Completion of the questionnaires was considered as a acceptance of participation (inversely, the absence of response was considered as an opposition). According French Regulation, this study is not considered as a biomedical research implying human person. This study in bioethics belongs to the field of Medical Humanities, so that it does not need the approval of an ethics committee (Articles L. 1121–1 et R. 1121–1 du Code de la Santé Publique). Likewise, informed consent is not required according to French regulations. Data were anonymised and protected according the current recommendations in France. This study was performed according to the Declaration of Helsinki.

Consent for publication
Non Applicable.

Competing interests
The authors declare no competing interests.

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