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Ethical Deliberation in the Allocation of Respirators and Beds during the Covid-19 Pandemic in Brazil

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Abstract

This chapter proposes a theoretical reflection on the ethical deliberation process in the allocation of beds and respirators, in the light of the Theory of Health Justice, the Accountability for Reasonableness approach and the principle of health equity of the Brazilian Unified Health System (SUS, as per its Portuguese acronym), before the COVID-19 pandemic in Brazil. The pandemic has become a serious threat to health systems, as installed capacity has been exceeded whether in terms of material resources, equipment, technology and human resources. Thus, according to the theory of Accountability for Reasonableness, a fair and deliberative process aims to ensure resource allocation through limits and constraints (reasonableness), but government responsibility derived from human rights must be considered, allowing for health programming (accountability). Faced with this scenario, where the situation will often require us to make choices, this chapter intends to discuss the assumptions for ethical deliberation, taking into account the context of the act and its foreseeable consequences.

Keywords: Equity in Access to Health Services, Resource Allocation, Social Justice, Coronavirus Infections, Pandemic

1. Introduction

Throughout December 2019, in Wuhan city, Hubei province, Chinese health authorities identified pneumonia cases of unknown aetiology, which were subsequently attributed to the emergence of a new coronavirus (SARS-Cov-2) [1]. The World Health Organisation (WHO) has declared a state of public health emergency of international concern. Originally called 2019 - n - CoV, the infection caused by the new coronavirus was officially named COVID-19 on 11th March 2020, when it was declared a pandemic [2].

According to the Ministry of Health, in Brazil, until 28th April 2021, 14,521,289 confirmed cases of infection by COVID-19 had been notified, with 79,726 deaths [3]. This advance has led government agencies to adopt strategies to control the

spread of the virus, such as closing schools and shops, banning meetings, instituting teleworking, isolating people in their homes, and also banning international and even national travels [2].

The Brazilian Unified Health System (SUS, as per its Portuguese acronym) has always been at the front line of public health emergencies in Brazil and it has not been different in the context of facing the COVID-19 pandemic. It is one of the largest health systems in the world and the fight against the pandemic has integrated all levels of healthcare, based on its guidelines and principles described in the organic laws of health n° 8080 and n° 8142, dated 1990 [4, 5]. SUS must respond in a planned, systematised and equitable way to this new challenge imposed.

In an analysis of SUS, in its 30 years of existence, the system's lack of priority and underfunding, associated with the country's economic crisis and especially, the Constitutional Amendment 95 (EC-95/2016), which freezes the public budget for twenty years, were highlighted as factors detrimental to the system [6]. Thus, the system is overloaded and, faced with the new pandemic context, needs investment in material resources and equipment, as well as physical and human resources [7].

In the context of the pandemic in China, substantial regional disparities in the availability and accessibility of health resources were observed that could partially explain the low mortality rates (despite the large number of cases) in the more developed provinces, such as Zhejiang (zero deaths among 1,171 confirmed cases) and Guangdong (four deaths among 1,322 cases). Following analysis of this data, the Chinese government moved to rapidly build new local medical facilities in the less developed provinces, a key measure that helped control the epidemic, protect front-line health professionals and mitigate the severity of the disease in patients [8].

A reflection was introduced by health professionals from the United States on the need for resources to care for a large number of patients with COVID-19 after the declaration of the pandemic in the country, questioning how prepared the US hospitals were in relation to material and human resources in the face of uncontrolled transmission of the virus and consequent challenges in clinical decision making. In moments of crisis, health resources must be allocated in an ethical, rational and structured way, so as to benefit a greater number of patients. It is pointed out that the main conflict in decision making is the definition of ethical criteria for the allocation of mechanical ventilation equipment and beds in Intensive Care Units (ICU) [1].

We need to think about what ethical duties should be observed in this scenario, when the health system is being demanded beyond its capacity. How to allocate resources equitably, ensuring resources to all levels of care and regions? [2].

In pandemic contexts, there is a direct concern with equity in the use of resources as a moral and legal imperative to respect, protect and fulfil human rights in relation to health service delivery, based on international norms and standards. Nevertheless, in relation to the human rights-based approach, "even if attention is paid to the philosophical foundations linked to relevant rights recognised in international law, this does not provide guidance on how these relevant rights help determine priorities among claimants" [9].

General theories of justice alone do not provide adequate guidance for the problem of priority setting. This is because these theories are too broad to provide precise answers to the key distributional questions necessary for priority setting. However, the Accountability for Reasonableness approach, suggested by Daniels, guides prioritisation and is consistent with human rights due to its concern with justice and the social determinants in its process, which enables it to be applied to health systems [9].

Accordingly, this chapter proposes a theoretical reflection on the process of ethical deliberation in the allocation of ICU beds and respirators, in the light of the Theory of Health Justice [10] and Accountability for Reasonableness approach [9], both proposed by the American philosopher and politician Norman Daniels; and the principle of SUS equity, before the COVID-19 pandemic in Brazil.

2. Ethical models of justice and allocation of scarce resources in pandemic situations

In this theoretical reflection, the relationship between the allocation of health resources in the context of the pandemic in an equitable way was constructed based on the work *Just health: meeting health needs fairly* [10], proposed by Norman Daniels, which discusses his theory of health justice, and on the work *Justice and Human Rights: Priority Setting and Fair Deliberative Process* [9], produced by the author in partnership with the academic lawyer Sofia Gruskin, which introduce the Accountability for Reasonableness approach.

Norman Daniels is a philosopher who works at Harvard University in the United States of America (USA) and is specialist in Bioethics. In his first work that addressed the topic of justice for health, Daniels described a deliberative process based on human rights and the principle of justice, through which health priorities would be set up to guide political decisions [11].

Daniels [10] resumes this work through other constructions in which the ideas are reformulated responding to several criticisms from various authors, at which point he explains that certain theories of justice do not contemplate the premise of equity. The author explains that a fair health process should ensure the legitimacy and fairness of decisions involving the definition of limits in the distribution of resources. In the field of health sciences, his books and articles have been widely cited in scientific publications that discuss the allocation of health resources from the principle of justice. In one of his articles, he emphasises the need to gather scientific evidence on the results of applying the “accountability for reasonableness” model to improve the legitimacy of decision-making health processes [12].

As a human rights-based approach, we suggest the following ones as key elements of Accountability for Reasonableness: 1. Direct concern for equity in the use of resources; 2. Examination of factors that may constrain or support planned interventions, including the legal, political, economic, social, and cultural context; 3. Participation and negotiation among all stakeholders, even if the primary responsibility lies with government officials to facilitate these processes and determine which interventions can have the greatest and best health impacts; and 4. Government responsibility and accountability for the way decisions are made, resources are allocated, and programmes implemented and evaluated, including the impact of these decisions on health and well-being [9].

A fair and deliberative process developed as a form of procedural justice to set limits under resource constraints must be complemented with measures to ensure appropriate stakeholder involvement and governmental responsibility derived from human rights. This description of fair process provides a coherent rationale for emphasising the key components of a human rights-based approach. At the same time, the emphasis on government responsibility operationalises the outcome of calling for a fair process. The combined approach makes the content and justification for the progressive improvement or realisation of a human right to health clearer. It is believed that “the result is generally politically feasible and can provide appropriate guidance to policy planners and implementers concerned with improving the health of the population in a fair way” [9].

The main idea behind Accountability for Reasonableness is that people are able to agree and justify, even when resources are limited, the reasons for the priorities they determine are necessary to meet health needs fairly. The following four conditions make the notion of Accountability for Reasonableness [9] more precise: 1. Publicity condition: decisions that set priorities for meeting health needs and their justifications must be accessible to the public; 2. Relevance condition: decisions on priorities should be supported by a reasonable explanation of why they were selected and determined; thus, a justification is reasonable if it appeals to accepted evidence, reasons and principles, including a wide range of stakeholders in decision making; 3. Review and appeal condition: there should be mechanisms for contestation and dispute and, more broadly, opportunities for review and improvement of policies in the light of new evidence or arguments; and 4. Regulatory condition: there should be public oversight of the process to ensure that conditions 1, 2 and 3 are met [9].

Thus, by forming a public record of decisions and the reasons behind them, the reasoning applied to priority setting can be improved over time. The involvement of various stakeholders in the process is not only useful to ensure that a range of relevant arguments and interests are considered, but also enables adherence and enhances legitimacy, even when the difficulties inherent in ensuring the presence and hearing of vulnerable groups are recognised. All these conditions fit well with the main elements of a human rights approach [9].

The philosopher also addresses global justice and its implications for health inequalities and human rights, emphasising that it can be applied in the reform of health systems and in the definition of health priorities. He also reflects that we cannot speak of a theory of justice for health without understanding the importance of global justice and social determinants, and that these can be protected when the appropriate health policy is adopted. When reflecting on professional obligations related to justice, he questions whether they should follow the population's point of view, which addresses the issue of social justice, or whether they should meet health needs depending on severity criteria, not taking into account other facts about the individual. It also points out that medical professionals are not in a position to judge and should not consider their judgements to indicate their recommendations [13].

2.1 Ethical and fair deliberation in the allocation of scarce resources in the COVID-19 pandemic

A scenario devastated by COVID-19 is in place and we are living a great dilemma: how to allocate scarce health resources in the face of this situation? Although SUS has its foundations based on principles, it has been facing significant annual losses in budgetary resources. It is known that pandemics caused by viruses are serious threats to health systems by imposing excessive demands that exceed the installed capacity both in terms of material resources and human resources [13].

According to a reflective study, several healthcare services in Brazil suffer from a lack of essential materials and equipment for care in this pandemic. This risky situation, without advance planning, can lead to waste of resources, damaging the confidence of health service users and professionals, in addition to causing loss of life. In light of the above, the system and service providers must be prepared to make the most of limited resources in order to reduce the damage to the system, people and society [13].

Those faced with pressing practical decisions about priorities in health resource allocation need an approach that provides guidance and enhances perceptions of legitimacy and justice; however, neither human rights nor general principles of distributive justice alone are sufficient to solve disagreements when setting priorities.

Any legitimate solution must make its prioritisation path sufficiently clear, so that everyone involved perceive it as fair and justified [9].

The Pan American Health Organisation (PAHO) [14] analysed a database of patients with COVID-19 and found that 19.4% of cases will present a mild condition; 40% a moderate condition; 15% a severe condition, requiring hospital admission; and 5% a critical condition, requiring mechanical ventilation. Thus, the need for expansion of care capacity can be divided into: patients with a mild or moderate condition, requiring home isolation and monitoring of symptoms; patients with a moderate or severe condition, requiring pharmacological treatment and clinical admission; and critically ill patients, requiring admission with mechanical ventilation and specialised intensive care capacity.

According to Cabral *et al.* [7], most health institutions do not have the capacity to meet an excessively high demand, as happens in pandemics, causing a lack of equipment and beds. What can we do before this dilemma of scarcity of resources?

Some strategies are being held, such as social distancing, which promotes the flattening of the epidemic curve and reduces demand on the health system. There are other important strategies to be used to solve resource allocation issues, such as, for example, the exercise of authority by the managers of the various spheres, in the mobilisation of industries for the rapid supply of resources; displacement of inputs and human resources from more affected areas to those of higher incidence; postponement of elective and non-emergency examinations and procedures [2].

In Brazil, Law n° 13979 was published on 6th February 2020, providing for measures to address the public health emergency of international importance resulting from the new coronavirus. The law sets out some strategies such as isolation, quarantine, medical examinations, laboratory tests, vaccination and cancellation of elective surgeries and examinations. It also waives bidding for the acquisition of goods and services to address the public health emergency. Furthermore, it determines exceptional and temporary authorisation for the importation and distribution of any materials, medicines, equipment and inputs in the area of health subject to sanitary surveillance, without registration with the Brazilian National Health Surveillance Agency (ANVISA, as per its Portuguese acronym), considered essential to assist in combating the COVID-19 pandemic, provided that justified by the competent authority. Another measure adopted is the exceptional and temporary restriction of highways, ports or airports, as long as recommended by ANVISA [15].

Protecting public health can mean protecting people of greater social vulnerability and those who are institutionalised, considering that the spread of the virus occurs rapidly in these places. In addition, resources need to be rapidly allocated to places where outbreaks occur, thus reducing the transmission of the infection and the hospitalisation rate. Priority groups also deserve attention, especially people with comorbidities, since they are more likely to fall ill and pass away. Finally, we must not forget the demands of social justice, ensuring the poorest and most marginalised a fair distribution of resources [2].

Thus, Gruskin and Daniels [9] warn that it is necessary to implement a fair deliberative process, developed as a form of procedural justice to set limits under resource constraints. In addition, they argue that this process should be complemented with human rights measures to ensure exclusion of discrimination, requiring the participation of affected populations in relevant decision making.

In the context of the pandemic in Italy, in the period of the greatest contagion of the virus, although the health system was highly efficient, it was impossible to meet the needs of the high number of critically ill patients simultaneously, during the peak of the pandemic, because they required more complex and expensive technologies [16]. Due to examples of nations that have already experienced this situation of overloaded health services, the rulers of many countries are concerned

about their population, considering that, if there is a high number of severe cases, many people may die because there will not be sufficient mechanical ventilators and ICU beds. In this type of public health emergency, the ethical obligation of health professionals to prioritise the well-being of individual patients may be overridden by public health policies that prioritise the greatest good for the greatest number of patients. These circumstances raise a critical question: when demand for ventilators and other intensive care far exceed supply, what criteria should guide these rationing decisions? [17].

Faced with this scenario, where the situation will often require us to make choices, we ask: what are the assumptions for deliberation at this juncture, taking into account the context of the act and its foreseeable consequences?

A fair and deliberative process aims to ensure resource allocation through limits and restrictions (reasonableness), but it must consider governmental responsibility by allowing for health programming (accountability) [10]. This ensures a fair correlation for the operationalisation of health resources. For PAHO, the implementation of public policies should consider aspects such as universality, equality and non-discrimination, access to ensure mechanisms and social participation [18].

Thus, in the light of the theoretical frameworks of this reflection, we propose practical guidelines for health decision making, considering the context of scarcity of intensive care beds and equipment during the pandemic period of COVID-19 in Brazil, highlighting that some recommendations are suggested by authors and organisations from various countries. In order to demonstrate this information in a clearer way, we designed the following flowchart (**Figure 1**).

In order to hold the allocation and use of resources in a more just and ethical way during the pandemic, some factors must be considered, such as: assessing life expectancy in the short and long term, taking into account the current illness and comorbidities, using validated instruments; estimating life expectancy, prioritising patients with the probability of surviving longer after treatment; considering the right to live the complete life cycle; and identifying irreversible cases that should be referred for Palliative Care [13].

Thus, moral deliberation can be seen as a systematised and contextualised means for the critical and public analysis of life events, considering the values and duties involved in a concrete fact and seeking to understand them by listening and exchanging opinions and arguments between the parties, in order to guide a situation along a reasonable, prudent and feasible path, but without claiming to find the ideal or right decision. For a solution, ethical problems need constant and continuous assessment. The use of the deliberative procedure proposed by Diego Gracia for clinical bioethics in 1992 and 2020 proposes three distinct moments of human intelligence: the cognitive moment (facts), the valuation, estimation or preferences (values) and the realisation (duty, voluntary act) [19].

Even though resource constraints may not allow for a fully deliberate and equitable process in all cases, accountability for reasonableness helps reduce much of this imprecision by providing an explicit record of how alternatives are chosen. Over time, this record can reveal the true commitments to change that a government is able and willing to make [10].

One of the necessary conditions of the Accountability for Reasonableness approach proposed by Norman Daniels is that decisions on priority setting should provide a reasonable explanation of why the selected priorities were determined to be the best approach. It is also important to consider that, specifically, a justification is reasonable if it appeals to evidence, reasons and principles accepted as relevant by fair-minded people. The inclusion of a wide range of stakeholders in decision making is closely linked to this condition [9].

Figure 1.
Practical guidance for health decision making during the period of scarcity.

According to Gruskin and Daniels [9], a fair process, involving human rights, calls for negotiations among all stakeholders, even if the primary responsibility lies with government officials to facilitate these processes and determine which interventions may have the greatest health impacts. Thus, the involvement of various stakeholders in the process is not only useful to ensure that a range of relevant arguments and interests are considered, but also enables adherence and

enhances legitimacy, even when the difficulties inherent in ensuring the presence and hearing of vulnerable groups are recognised. In addition, another condition pointed out by Norman Daniels in his approach is the condition of review and appeal where there should be mechanisms for contestation and dispute and, more broadly, opportunities for review and improvement of policies in the light of new evidence or arguments [12].

The allocation of scarce resources in the pandemic consists of four core values that have been applied in various ways such as: 1) benefit maximisation, offering priority to patients who are likely to survive longer after treatment; 2) treating people equally, implying random or first-come, first-served selection of people in similar conditions; 3) promoting instrumental value, prioritising those who can save others or rewarding those who have saved others in the past; and 4) prioritising those who are sickest or the youngest who will have a shorter life if they die without treatment [20].

Nevertheless, if resources are scarce, six recommendations are proposed that should be used to develop guidelines that can be applied fairly and consistently, these are: maximising benefits; prioritising health professionals; avoiding to allocate on a first-come, first-served basis; being responsive to evidence; recognising participation in research; and applying the same principles to all patients with or without COVID-19. It should also be noted that none of these recommendations alone will be sufficient to determine which patients will be prioritised [20].

In addition, the difficult decision on allocation of scarce resources should not fall on front-line professionals, since they are already overloaded with stress, which could cause failures. It is also necessary to prioritise health professionals in the allocation of treatments, aiming at their rapid recovery, due to the fact that they are the labour force in facing the pandemic [13]. It is recommended that two administrative references of the hospital hold the decision-making process, always informing the family of the situation and recording it in the patient's medical chart. The attributions of public health managers are also important in carrying out continuous monitoring of the resources used, enabling alignment of the protocol with the bed regulation system and timely referral of patients to other hospital units, when necessary [14].

We propose the use of protocols for decision making regarding the allocation of resources such as mechanical ventilators, considering situations where demand is greater than availability, and it is suggested that this policy be maintained while the pandemic lasts, always being decided together with the Superintendence/Board of Directors of each hospital. The process must be followed not only for cases of infection by COVID-19, but also for all critical cases [13]. Corroborating the previous statement, the fair allocation of resources must always be transparent, based on evidence and protocols and related to epidemiological data on morbidity and mortality. The population must always be included in the decision-making process [2]. The construction of an allocation protocol for depleting resources in situations of mass disasters and pandemics is not a merely technical task, but, on the contrary, must be grounded in ethical and legal principles commonly adopted at the international level [21].

Some values are fundamental in the development of protocols for resource allocation, the first value being that of justice in the distribution of resources, observing the duty to provide adequate care in any situation, managing resources, balancing equality and equity in their distribution. The second fundamental value is to ensure the maximisation of benefits, prioritising the good to the greatest number of people possible, recognising that resources should be directed to those who can really benefit, according to clinical evidence [13].

The US and UK advocate that resources should be allocated in a way that maximises the number of patients who survive treatment with reasonable life expectancy. Thus, experts state that removing a patient from a ventilator to provide it to other patients believed to be able to benefit rapidly, in order to maximise benefits, may be justifiable. Nevertheless, the potential for this decision disproportionately affects vulnerable populations, including older adults, people from minority communities or people with disabilities, and this decision is a major responsibility. Another concern is that pre-existing health disparities, fueled by inequitable social conditions, further harm certain vulnerable populations [22]. In April 2020, the first broad consensus of ethical recommendations for decision making in intensive care in pandemic situations was published by European scientific societies and institutes in the field of ethics. In general, the document proposes the application of the principle of distributive justice prioritising the best cost/opportunity and the principle of proportionality, eliminating conditions in which a minimal benefit is expected [23].

Managers and competent authorities are committed to increasing the supply of resources, making the need to use screening protocols as remote as possible, but we know that, with the progressive increase of severe cases, we must be prepared to use them [14]. The situation that several countries, including Brazil, have experienced due to the scarcity imposed by the COVID-19 pandemic highlights the need to develop a screening protocol based on ethical-legal principles. In addition, screening decisions must be made by independent teams that include medical specialists, legal counsel and health system administrators. These teams are responsible for repeatedly assessing the priority of patients. This practice is recommended in protocols widely adopted in the USA [22]. This team should be properly trained to perform its role, from protocol management to conflict resolution and communication with patients and families [21].

In order to protect vulnerable populations from injustice, health systems are encouraged to adopt transparent and evidence-based screening protocols that classify patients according to priority levels [22]. Nevertheless, such protocols use physiological variables to assess which patients will benefit most, allowing for a supposedly objective prognosis. In order make these protocols work effectively, health systems and physicians need to know which allocation decisions actually save the most lives. Furthermore, poorly designed screening protocols that treat the fact of having a disability as a contraindication to receiving scarce resources, or that prioritise categories of people for withdrawal, could leave health systems subject to ethical and legal claims of unfair discrimination [22]. In Italy, at the start of the pandemic, age, number of comorbidities, severity of respiratory failure and the likelihood of surviving prolonged intubation were being considered, with the purpose of offering limited resources to those who would benefit most and have the greatest chance of survival [16].

Health systems can mitigate discriminatory screening policies by ensuring that each patient is assessed individually and that the results are used to create a transparent, evidence-based prognosis. Pre-existing disabilities may be relevant to ventilator withdrawal and reallocation, but only if they arise from an individualised assessment [22]. It is recommended that the screening method should not use social factors but rather an initial screening based on survival criteria such as the Clinical Frailty Scale, which can be applied for all ages or disease type [13]. The scale is a physical, cognitive and functional assessment tool. In order to perform the allocation of resources, the scale score can be taken into account, generating a degree of priority. The Brazilian Intensive Care Medicine Association (AMIB, as per its Portuguese acronym) recommends the use of assessment instruments of severity scores such as Sequential Organ Failure Assessment (SOFA) and Acute Physiology

and Chronic Health Evaluation (APACHE) by the screening teams. These instruments stratify the degree of severity of organ dysfunctions manifested by a patient. Screening protocols should include frequent and constant reassessment of ICU patients, avoiding dysthanasia [21].

The consensus of ethical recommendations related to intensive care, mentioned above, demonstrates the application of the principle of justice in a uniform way to all people suggesting to unlink the chronological age criterion as the only strategy, incorporating other variables such as the degree of frailty, biological age, as well as the patient's values and preferences, so that decision making occurs in a shared way among the team members and, whenever possible, with the patient and family through a respectful, transparent and trusting communication. For patients presenting acute respiratory failure, the consensus brings a screening model for ICU admission based on four prioritisation categories according to the patient's characteristics and current condition and for scarce allocation of respirators. Regarding mechanical ventilation of these patients, we propose an adaptation of the screening process based on the person's characteristics, encompassing the presence of several pathological processes different from the current ones and measurable by Charlson Severity Scale [23].

In its guiding document, AMIB considers that there are limitations to prepare screening protocols. First, preparing an ethically perfect protocol is impossible, considering that we live in a plural society. Another limitation is the absence of validated instruments to be used in screening. Nonetheless, in view of the pandemic situation of COVID-19 and the imminent depletion of equipment, especially mechanical ventilators, we must consider that there is not enough time for validation processes and, therefore, the use of instruments should always be monitored and followed-up through other assessment strategies. In light of the above, public debate and reviews of screening protocols are necessary to contribute to an ethical legitimacy of the process [21]. The Ethics Committees also work as deliberative advisors in moral conflicts of the clinic, in addition to helping health professionals and users in the learning of possibilities of alternatives of prudent solutions to be applied for each case [19].

3. Conclusion

This study has introduced theoretical reflections on the process of ethical deliberation in the allocation of beds and intensive care equipment, in the light of the Theory of Health Justice, the Accountability for Reasonableness approach and the principle of SUS equity, before the COVID-19 pandemic.

From the publications found, we observed that government, administrators and service providers have been mobilised to protect public health, making the most of limited resources and protecting the most vulnerable people and those who are institutionalised, in order to reduce damage to health systems, individuals and society. Even so, it is clear that it is impossible to meet the needs of the contingent of critically ill patients simultaneously.

As the crisis has evolved, generally speaking, nations have favoured public health policies that prioritise the greatest good for the greatest number of patients in allocating resources through reasonableness, adopting limits and constraints and government responsibility, thus enabling human rights-based health programming.

Regardless of the ethical support, if there is a scarcity of resources, there are many scenarios that will seem morally unsustainable, especially in the face of greater prognostic uncertainty. We should keep in mind the recognition that no screening protocol available will be perfect and that there may be a much better

chance of approaching reasonable deliberations when adopting a proposal that seeks a good ethical and technical basis and that are open to public scrutiny and individualised reviews involving legal counsel and health system administrators and where decision making occurs in a shared way among the team and, whenever possible, with the patient. Responsibility, cooperation and preparedness are necessary attitudes at this critical time of COVID-19 pandemic.

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