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Two public health conflicts during the pandemic

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Abstract

The COVID-19 pandemic saw unprecedented responses to the allocation of scarce and insufficient triage resources and to the difficulties in establishing containment measures, which oscillated between suggestive, persuasive and coercive. Classical triage criteria were replaced by extreme utilitarianism based on objectively evaluated medical criteria to privilege the critically ill with a recoverable prognosis by applying extreme support and treatment measures. Mandatory containment measures and the call for vaccination failed to achieve convincing scientific support; applied irregularly and plagued by uncertainties and insecurities, they affected disadvantaged groups and caused public outcry and disrespect. Triage based on utilitarian medical criteria caused distress and serious mental strains in medical decision-makers and members of ad hoc committees. These experiences suggest renewing the individualistic and elitist bioethical discourse to privilege the common good over individual interests.

Keywords: Pandemics. Triage. Health surveillance.

Resumo

Dois conflitos na saúde pública na pandemia

A pandemia de covid-19 respondeu de forma inédita à atribuição de recursos escassos e insuficientes em situações de emergência (triagem) e às dificuldades para estabelecer medidas de confinamento que oscilavam entre medidas sugestivas, persuasivas e coercitivas. Os tradicionais critérios de triagem foram substituídos por extremo utilitarismo que se baseava em critérios médicos avaliados objetivamente para privilegiar pessoas gravemente doentes com prognóstico recuperável, aplicando medidas extremas de suporte e tratamento. As medidas de confinamento obrigatórias e o chamado à vacinação não tiveram respaldo científico convincente e foram irregularmente aplicadas e assoladas por incertezas e inseguranças, afetando os mais desfavorecidos e provocando manifestações públicas e desrespeito da população. A triagem baseada no utilitarismo causou temores e conflitos entre os tomadores de decisão médica e membros de comitês *ad hoc*. Isso mostra a necessidade de renovar o discurso bioético individualista e elitista em prol de privilegiar o bem comum sobre os interesses individuais.

Palavras-chave: Pandemias. Triagem. Vigilancia Sanitaria.

Resumen

Dos conflictos en la salud pública en pandemia

La pandemia del covid-19 ha respondido de forma inédita a la asignación de recursos escasos e insuficientes en emergencia (*triage*) y a las dificultades de establecer medidas de contención que fluctuaban entre ser sugerentes, persuasivas y coercitivas. Criterios clásicos de *triage* fueron reemplazados por un utilitarismo extremo basado en criterios médicos objetivamente evaluados para privilegiar personas gravemente enfermas con pronóstico recuperable al aplicar medidas extremas de soporte y tratamiento. Las medidas obligatorias de contención y el llamado a la vacunación no lograron respaldo científico convincente; aplicadas en forma irregular y plagada de incertidumbres e inseguridades, afectaron a los más desaventajados y causaron protestas públicas y desacatos. El *triage* basado en criterios médicos utilitaristas provocó desazones y serias tensiones mentales en los decidores médicos y miembros de comités ad hoc. Estas experiencias sugieren renovar el discurso bioético individualista y elitista en busca de privilegiar el bien común por sobre intereses individuales.

Palabras clave: Pandemia. Triaje. Vigilancia Sanitaria.

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Humanity has been chronically wounded since neoliberal globalization was installed as the sole political-economic alternative after the withering away of socialist regimes, which became authoritarian systems of government with severe transgressions to personal and social freedoms. These regimes were emaciated by an economic decadence that tarnished their doctrinaire purity, and opening them to transnational capitalism totally and its insensitiveness to inequity and to the environmental costs of its expansive activity, and deaf to the language of ethics.

Caught in the whirlpool of hyperactive behavior that feeds a recursive and autopoietic circle of production-consumption-production, what sociologist Hartmut Rosa [1] calls the survival of modernity through a "dynamic stabilization," humanity is divided between a large majority living in multifactorial poverty with unsatisfied basic needs, and a small minority isolated in its world of privilege and excess.

This contemporary situation is the backdrop to the emergence of the voracious SARS-CoV-2 virus that caused the COVID-19 pandemic, urging public health to undertake prevention and containment strategies. None of this had gone unnoticed by bioethics. Despite its little presence in these events, bioethics intends to maintain its discursive guidelines in the post-pandemic world and reflect on health policies implemented without abiding to bioethical thought or that caused public dismay and rejection, increasingly manifested in the questioning of the effectiveness of a sanitary response to new viral pandemics.

Within the issue of resource allocation under normal and emergency situations, the sub-theme of triage or allocation of scarce and insufficient resources in decision making situations has taken center stage. This is what Foucault [2] called "making live by letting die." Such biopolitical words reflect how bioethics has been ignored in the establishment of emergency triage criteria.

The second aspect analyzed here refers to the conflict between health regulations and individual autonomy. This strife has been causing a progressively growing social unrest, the point of unleashing the paradoxical situation of public demonstrations against prevention and containment measures that are maintained even as the pandemic loses strength, thus being claimed as unjustified limitations.

The path of triage

The idea of medical triage arose during the human catastrophe of the Napoleonic wars, when the scarce resources of military medicine left untreated those who could heal without intervention and the seriously wounded who would die even if they received medical care, in order to focus efforts on treating soldiers who would only be saved with the available treatment. This model based on medical criteria became an administrative way of ordering emergency medical care, prioritizing the most severe cases and delaying care for more mild cases, until, eventually, all receive the care needed.

If the original triage is inclusive/exclusive, its administrative form is partially inclusive. The color coding that is usually displayed in the waiting rooms of emergency services confirms this: five categories, from patients requiring resuscitation and immediate care (red code), to those who do not require emergency care (blue) and will be treated after emergency (orange), urgency (yellow) and minor urgency (green) have been attended. All will receive attention in order of severity.

In catastrophic situations—earthquakes, mass accidents—people suffer multiple injuries simultaneously, raising an urgent demand for trauma care that exceeds the material and personal therapeutic availabilities. The intent to prioritize by order of severity is limited by the difficulty of determining, on a case-by-case basis, the prognosis to be expected and comparing it to that of others. While waiting for medical reinforcements, a probabilistic and uncertain medical triage is used to complement a delayed triage while waiting for renewed resources.

Triage in pandemics

More than two centuries of experience and a vast literature on the subject [3] were silenced by health authorities and emergency medical teams, who requested ethical guidelines to deal with the COVID-19 pandemic [4,5]. Unesco opted for an early declaration urging public health to provide services beyond its real possibilities: *the massive nature of this worldwide phenomenon, for a sustained* (*albeit*

extraordinary) period, calls on the health systems of each region to provide their populations with safe, effective and evidence-based care responses, despite recognizing that in these cases, and given the characteristics of the COVID-19 pandemic, transparency is the main criterion for assignment [6].

In a similar vein, public health was called upon to operate with objective, transparent and public criteria [7]. However, the chaos of urgency care, uncertainties and lack of direction do not allow for objectivity, safety and evidence; the call for transparency can be a criterion for communication, but not for allocation.

At the beginning of the pandemic, it was impossible to predict the aggressiveness, dissemination and duration of COVID-19. Research efforts to develop vaccines were frenetic, and epidemiologists were assessing herd immunity given the possibility that the virus could become endemic, despite the latent danger of the emergence of more aggressive variants. Many voices were raised to recall the bioethics efforts to develop validated and widely recognized ethical criteria and principles [8,9]. However, the unexpected virulence of SARS-CoV-2 and its erratic and unpredictable behavior went beyond bioethical discourse, and led to crude medical decisions, performed at the cost of severe stress and discomfort for decision makers and executors of actions with extreme life-threatening consequences.

The pandemic triage has unique characteristics that, due to severely affected individuals and an alarming resources shortage, mainly in nations with precarious medical care, required *ad hoc* regulations, since the pandemic is a prolonged process with several alarming spikes that take to the limit or exceed the availability of intensive care unit (ICU) beds, mechanical ventilators, professional resources and protection material for professionals in front lines. Strictly utilitarian hospital protocols surface, prioritizing the scarce resources to those requiring critical care, and to patients with the highest probability of survival for at least one year after hospital discharge [10].

Severely affected since the beginning of the pandemic in Europe, Italy has been engaged in the development of triage criteria. The Ethics Committee of the Italian Society of Anesthesia, Analgesia, Resuscitation and Intensive Care (Siaarti) mainly recommended ensuring "the highest probability of survival," applying the Sequential Organ Failure Assessment (Sofa) scale for multiorgan and multifunctional assessment—respiratory, cardiovascular, hepatic, coagulation, renal and neurological. Low scores in this scale indicate less dysfunction and a better prognosis, thus receiving priority during triage.

Early versions of the Siaarti specified strict triage criteria, excluding patients over 80 years of age who had organ dysfunctions or suffered from dementia "beyond a given degree" [11]. Shortly after, these exclusion criteria were abandoned, and physicians were to apply their own clinical judgment and justify their decisions on including patients with the highest probability of survival, as assessed by the Sofa scale, in what one committee member named "soft utilitarianism."

The Italian National Bioethics Committee (CNB) also accepted this strictly medical criterion, warning that it was adopted as an "exceptional pandemic *triage*" based on preparedness, appropriateness in terms of therapeutic efficacy, and actuality [12]. The Alfonsina Academy recognized this criterion as "the only good possible" in the emergency pandemic situation [13].

Like other Latin American nations, Argentina published an ethical guide for the triage process in pandemics, drafted according to Sofa medical criteria: *the allocation of critical resources should be based on objective, technical, neutral and verifiable criteria* [14]. The only non-medical criterion for attaching priority in extreme situations is the social value of the people who work in emergency care services, since they are more exposed to the risk of contagion and if they become ill, they further reduce the scarce and highly specialized healthcare personnel.

Age criteria are proposed occasionally and generally rejected as they introduce discriminatory ageism [15]. Although some bioethicists argue that prognosis should be evaluated in years of life saved, *there are many reasonable grounds for balancing saving more lives against saving more years of life; any balance chosen between lives and life-years must be consistently applied* [16], inevitably discriminating against older individuals.

Pandemic triage based on strictly medical criteria of severity and prognosis has been generally accepted [17]; however, it is an inclusion/exclusion

criterion that unavoidably condemns those affected by high Sofa scores to an early process of death, barely mitigated by the palliative measures they are expected to receive. The election of an inclusive/exclusive triage brings about anguish for the physicians who must make these decisions, even when they are supported and accompanied by the triage committees created *ad hoc*.

These committees apply three criteria based on medical evaluation: exclusion of the unsalvageable (irreversible shock); Sofa-based prioritization; and constant evaluations to remove ventilators from patients in a condition of "acute decompensation" [18,19] or, according to another criterion, if the patient *is in stable condition or, at least, if it is neither pointless nor significantly worsening. The scarcity of resources unveiled the need for wartime triage, fraught with ethical decisions. The hesitation to either abide by first-come, first-served criteria or "apply a horribly utilitarian calculus" to decide who would be treated or left to die sharpened the physicians' distress* [20].

The utilitarian nature of medical triage during pandemics [21] is disturbing, and particularly distressing when the decision to remove a patient from the ventilator device to "save the life" of another who will survive with a favorable prognosis if treated without delay. Recognizing that the most critically ill patients are those who have suffered from inequalities and inadequacies of medical care throughout their existence is a complex task. First come, first served is another form of discrimination in favor of those with the most efficient means of transportation and communication. However, it is unavoidable given that the pandemic is a prolonged process with unpredictable exacerbations.

Triage in pandemics will continue to be pragmatic and strictly medical wherever a severe mismatch between emergency requirements and available resources exists. This situation hits poorer societies the hardest, since the only solution or mitigation of this drama is to have more emergency medical spaces, personnel and equipment. This, however, not only requires political will, but also economic means and the expectation of awakening the solidarity dormant in theoretical reveries.

The work of ethics committees, both for research and care, has been hampered by uncertainties, lack of precedents and lack of guidance in face of difficulties regarding material and human resources [22]. Initial empirical studies confirm the willingness to rigorously apply medical evaluations in pandemic emergency situations, despite the fact that in all other situations bioethical values and the personal criteria of caregivers take precedence. This will demand reflection once the current emergency is over, since all value-based criteria tend to discriminate against disadvantaged individuals.

Medical police

Public health between the common good and individual autonomy

An initiator of public health, Johann Peter Frank [23] (1745-1821) published his monumental work *System einer vollstaendigen medicinischen Polizey* (*A complete system for a medical police*), in which he referred to the term "medical police," which had already been used by W. T. Rau [24] in a text dating back to 1764, in which he proposed a force responsible for health surveillance and education.

Although Frank understood medical police as a strategy to manage the *polis* and not as a police order, he could not deny that, as a loyal adept of cameralism, his goal was to boost the production of a healthy people to fill the coffers of the absolutist king. Therefore, compliance with hygiene and sanitation measures was in the interest of the imperial coffers, acquiring, from the beginning, an authoritarian and paternalistic tone that hygiene and public health could never get rid of.

Public health has been emptied of content as neoliberal democracies hand over to individuals the responsibility to prevent diseases and promote health, according to epidemiological research that explore population risks that the caring physician associates with the singular profile of their patient to indicate how to live a "healthy life," in a shift from the public to the private known as the "new public health" [25].

The opposite position confirms the public responsibility of providing high-quality healthcare in an equitable manner, the need to provide the State with sufficient resources through specific taxes or a mandatory health insurance system. Not even the countries that adopt comprehensive social medicine have managed to achieve or sustain it in a State shrunk by capitalist globalization.

The individualism of modernity marks the deterioration of State protection in guaranteeing access to basic needs for goods and services, and the unresolved (unsolvable?) disagreements between public health mandates and the resistance of individual autonomies, an issue that became more acute during the COVID-19 pandemic. While authorities try to limit containment measures, citizens protest every proposal to tighten mobility limitations in the incidence of new cases. This mismatch has been especially painful in the conflict between anti-vaccine movements and the authoritative tendency of government-sponsored prevention programs.

The International Covenant on Civil and Political Rights (1966), which complements the Universal Declaration of Human Rights, recognizes that in "times of public emergency," States may derogate *from their obligations under the Covenant* [26]. In the wake of the COVID-19 pandemic, many nations have resorted to the institution of the State of Emergency in the form of a State of Catastrophe (Law 18.415/1985, of Chile) [27]. This status is decreed in face of a public calamity that puts the population at risk, adopting restrictive administrative measures that limit freedom of movement or travel (curfew), freedom of assembly (quarantine), altering the right to property and hindering commercial, labor and recreational activities.

Legal language is inevitably subject to generalizations, inaccuracies and interpretation requirements. This explains why declarations and laws that restrict personal freedoms in exceptional situations cause social unrest and unease, manifested in disrespect and mobilizations that are not exempt from aggressiveness.

Since the end of the last century, public health has become aware that it lacks a code of ethics to validate and legitimize public health policies [28], fostering louder academic activities that become effective when they are anchored in the four Georgetown principles of individualism [29].

(Bio)ethics in public health

Once we know we have the power to prevent significant harms, we acquire the responsibility to do so [30]. The ethical legitimacy of a public health action rests on the belief that benefits far outweigh the undesirable side effects for both the individual and the population. Despite the uncertainties of a pandemic, the so-called precautionary principle is invoked, despite its flaws that subject it to criticism and rejection. From the point of view of the ethics of protection, it is proposed to reinforce the legitimacy of imposing mandatory health measures that meet at least four conditions in order to be compelling and enforceable [31]:

1. Recognition of a problem that actually causes or threatens to cause harm of unacceptable proportions to the community.
2. Ability to prevent or solve a large part of the problem (effectiveness) with demonstrably efficient actions—benefits outweigh the acceptable/accepted negative effects—which should be proportional to the magnitude of the task undertaken.
3. Certainty of the randomness of undesired effects. All participants in public health actions should have the same probability of suffering undesired negative effects.
4. Acceptability of disciplinary provisions necessary to obtain the most effective outcomes, including restrictions on autonomy, essential to deter dissenters and "treadmill travelers."

The current pandemic poses a situation of extreme uncertainty and insecurity, complicated by the unpredictable mutations of SARS-CoV-2, which modify its virulence and speed of dissemination to the point of calling into question the various containment measures, as well as the degree and duration of the vaccines' protection [32]. These confusions have caused contradictory and variable sanitary measures in some authoritatively focused nations, whereas others see regionally disaggregated plans, with severe consequences for national, corporate and individual economies.

Thus, uncertainty and manipulation of statistical data have reduced the already fragile trust of citizens in their rulers [33]. Public health has lost all guidance on its scope and limits of action and the authority to establish both routine and exceptional health policies. The idea of public health has become polysemic and a victim of political swings between being a responsibly public discipline and the insistent tendency of the *individual mode of risk management that complies with being ethical and assuming responsibilities and obligations as "good citizens"*

committed to leading a healthy life, with personal initiatives for prevention and healthcare [34].

Electing the concept of collective health can ensure that health policies have a scope of action in which they must protect the population rather than individuals with deleterious consequences, especially in regions where inequities in healthcare cannot be assumed by the dispossessed who depend on a robust and effective State. The more underprivileged a population is, the more necessary it is to develop a strong protective State.

According to Amartya Sen[35], a democratic system that defends political, civil and social rights is crucial to prevent economic and social disasters. Collective health that is not insistently and permanently democratic is doomed to fail due to ineffectiveness, since the imposition of compulsory policies lacking legitimacy leads to conflict and disrespect.

Several countries have tightened their containment measures after the spike in cases due to the omicron variant, which has unleashed large social protest movements. The decree of authoritative sanitary measures requires giving the dispossessed the material possibility of complying with what is demanded—basic income to suspend informal jobs, facilitated access to isolation residences, support for necessary commuting to avoiding traffic and shorter distances to basic public services, guarantee of access to vaccines for those living in remote areas and to people with disabilities and the elderly. Coercive health measures will only have the ethical validation to advance if these needs are met [36].

These conditions were not met after two years of an uncontrolled pandemic. Although the protective benefit of the vaccine is indisputable, uncertainties about its immunization efficacy, duration and possible, albeit very infrequent, complications remain. This strengthens the anti-vaccine movements, especially because of the precariousness in which large dispossessed and impoverished social groups live and their chronic inequity of access to health; living conditions that prevent them from having housing space for isolation, in addition to the precariousness of labor, mostly informal, which makes it impossible to comply with quarantines.

In the event of future viral pandemics, it would be desirable to improve preparedness to better cope with the effects, as proposed at the end of the SARS pandemic in 2002, although without much effect. The unresolved uncertainties and insecurities in the current pandemic make it difficult to envisage the characteristics of the next viral invasion. The experience of COVID-19, however, confirms that the legitimacy of mandatory coercive measures depends on convincing cognitive levels, as well as on the concern and capacity of the State to palliate and compensate for the hardships that these measures cause in the population lacking resources and reserves.

Final considerations

Bioethics played no decisive role during the course of the current pandemic. Gilbert Meilaender, acknowledging once again that bioethics is not an expertise, reports on a paper signed by nearly 1,400 "bioethicists" and published by The Hastings Center, in which they emphasize that there is *a large bioethics literature on how to approach triage decisions* [37].

However, the urgency of the pandemic forced the implementation of classic triage based on strictly medical criteria to prioritize those severely affected but likely to favorably respond to intensive treatment with mechanical ventilation, which postponed any bioethical consideration until after the emergency subsided. Between SARS (2002) and COVID-19 (2019) it was said that *bioethics cannot serve as a basis to think over the balances required to advocate for public health. As we begin the process of sculpting an ethics for public health, it becomes clear that bioethics is the wrong place to start* [38].

Several authors recognize that fighting the virus with measures based on epidemiological statistics is necessary and presumably sufficient to end this pandemic or transform it into a controllable endemic. However, the pandemic intensified the effects of an exacerbated modernity that produces extensive environmental deterioration and enormous social damage that is difficult to reverse. The way for winning the current battle anchors us once again in an acceleratingly entropic world that will be hit by new microorganisms and exacerbate the virulence of those that are already known.

In the meantime, we must continue to seek vaccines, increasing our critical care capabilities in terms of intensive care units and increased

availability of hospital beds. Rather than acquiring a greater number of ventilators, it is essential to create a health emergency fund to acquire what future pandemics require according to the pathogenic peculiarities of the viral attacks to come.

Therefore, it is advisable to renew the discourse as suggested, among others, by A. Honneth [39], recognizing that in emergency situations the individualistic criterion cannot prevail, and to engage in a more imaginative ethical reflection to make health policies a field of effective, efficient and ethically legitimized action that proposes decisions that privilege the common good over individual interests. This is what bioethics is.

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