

THE ALLOCATION OF SCARCE RESOURCES IN INTENSIVE CARE AND THE COVID-19 PANDEMIC FROM THE PERSPECTIVE OF BIOETHICS AND HUMAN RIGHTS

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RECEIVED:	MAR. 26 th , 2023
ACCEPTED:	APR. 20 th , 2023

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- **ABSTRACT:** The Covid-19 pandemic collapsed the healthcare systems and required actions that would ultimately be able to guide the allocation of scarce resources. The efforts coordinated by the federal government are linked to good governance, so the absence of these actions implies the violation of Patients' Human Rights, including the right not to be subjected to cruel, inhuman, or degrading treatment. Actions that alleviate the suffering of people under health care constitute ethical and political responsibility and legal responsibility for those with the legal duty to act to prevent bad outcomes. The relief of suffering is a humanitarian measure of a democratic state and, when not observed, should trigger responsibility for crimes against humanity. This accountability is established not only as a measure of justice for patients subjected to inhumane, degrading, and cruel treatments, such as those who have died as victims of asphyxiation.
- **KEYWORDS:** Bioethics. Human rights. Allocation of scarce resources.

A ALOCAÇÃO DE RECURSOS ESCASSOS DE CUIDADOS INTENSIVOS E A PANDEMIA DE COVID-19 SOB A ÓTICA DA BIOÉTICA E DOS DIREITOS HUMANOS

- **RESUMO:** A pandemia de Covid-19 colapsou os sistemas de saúde e exigiu ações que pudessem, em última instância, orientar a alocação de recursos escassos. Os esforços coordenados pelo governo federal estão vinculados à boa governança, de modo que a ausência dessas ações implica a violação dos Direitos Humanos dos pacientes, incluindo o direito de não ser submetido a tratamento cruel, desumano ou degradante. As ações que aliviam o sofrimento das pessoas sob cuidados de saúde constituem não só uma responsabilidade ética e política, mas também uma responsabilidade jurídica para aqueles que têm o dever legal de agir para evitar maus resultados. O alívio do sofrimento é uma medida humanitária de um Estado democrático e, quando não observada, deve desencadear a responsabilidade por crimes contra a humanidade. Esta responsabilidade é estabelecida não só como uma medida de justiça para os doentes sujeitos a tratamentos desumanos, degradantes e cruéis, como os que morreram vítimas de asfixia.
- **PALAVRAS-CHAVE:** Bioética. Direitos do Homem. Alocação de recursos escassos.



1. Introduction

Bioethics¹ is an area of study based on a multidimensional approach. This premise allows us to reflect on its theoretical dimension, including the references to Interventional Bioethics, Principled Bioethics, Personalist Bioethics, and Bioethics in the context of the Human Rights of Patients, among others. These references pursue to inform the foundations that support this branch of knowledge, that is, the assumptions and values that must be respected when dilemmas, or even false dilemmas, arise in the context of health care². In addition to its theoretical aspect, bioethics can also be investigated in its normative dimension, that is, the Declarations of Rights prepared by international organizations, which aim to protect threatened legal interests, in the face of scientific and biotechnological progress and advances.

In this context, it is common, within the scope of the philosophy of science, to verify that scientific advances bring with them, like a *Janus*³, with its double face: on the one hand, the solution to a specific demand in the scope of health care and, on the other hand, a new challenge, not only ethical but also legal, that has taken place since the advent of new technology. Finally, to complete the dimensional triad of bioethics, it is necessary to observe its institutional dimension, which allows, from a pragmatic point of view, to verify the actions effectively adopted by health institutions to implement the practice of bioethics in health care environments. These actions include developing and implementing hospital bioethics and research ethics committees, among other methods.

Given these multiple perspectives, the reflections proposed below are based on the theoretical dimension of bioethics, specifically the framework of the Patient's Human Rights (PHR), whose exponents are Cohen and Ezer (2013) and Paranhos

- 1 Defined by the Kennedy Institute of Ethics, Georgetown University, Bioethics designates "The systematic study of the moral dimensions - including moral visions, decisions, conduct and policies - of the life sciences and health care, employing a variety of ethical methodologies in an interdisciplinary setting" (REICH, 1995).
- 2 In this context, health care means a person's actions to maintain or improve a patient's health; on the other hand, "healthcare", as a closed compound word, means healthcare system.
- 3 "In Roman mythology, Janus (or Jano) is the two-faced deity who keeps one of his faces always turned forward, the future, and the other, backward, in appreciation of what has already happened. He is the god of transformation and the mediator of human prayers to other gods. He guarded the portals and paths through which Roman soldiers passed during war. His reign in Italy was a time of peace and prosperity. Saturn endowed him with rare prudence, placing the past and the future before his eyes. He is also the god of principles, the first month of the year, January, *januarius* being consecrated to him" (LEODORO, 2003, translated).

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(2018)⁴. The authors point out that these rights are already at an advanced stage of normative structuring in other countries that aim to recognize, identify, list, and guarantee patients' rights when they are under health care. In Brazil, however, these rights constitute a branch still unknown by most legal doctrine. Albuquerque (2016) warns that the patient's rights should be distinct from the human rights of patients; even though they share specific regulations, they differ essentially in terms of legal nature. While the patients' rights refer to health law and personality rights, or even consumer law, focusing on the obligations and responsibilities assumed by the players, the human rights of patients assemble the international law of human rights and have, among others, their main concerns, discrimination, exclusion, and disrespect for self-determination that patients suffer, mainly due to their increased vulnerability. In the case of this article, this is increased not only by "being patient" but also due to the catastrophic scenario that befell nations as a result of the advent of the Covid-19 pandemic.

The present research aims to identify the adoption of national parameters for the allocation of intensive care resources by the Ministry of Health during the establishment of the chaotic reality that made the public and supplementary health system collapse because of the Covid-19 pandemic. This includes the macro allocation - to inform and coordinate the health teams (federal, state, municipal) subject to the most different cultural, economic and social realities - and the micro allocation regarding the scarcity of intensive care resources. Establishing national parameters concerning disasters, public health emergencies, and pandemics strengthens the capacity for preparation and readiness in the regional responses offered to the population and can collaborate to mitigate the risks and impacts on different population groups.

It is a consensus in the scientific community that new threats involving viruses such as Sars-CoV-2 (like Covid-19, SARS, and MERS, in the past) will continue to occur and, therefore, the values capable of guiding the planning of response actions to a pandemic must be quickly and clearly stated within the scope of the macro allocation of intensive care resources, as they can guide the establishment of regional parameters,

4 "While the PHR see the patient holistically, concerned with their non-discrimination and social inclusion, patients' rights see them as subjects of a contractual relationship for providing health services, resembling them to the consumer. PHR is provided for in international treaties of a binding nature, while patients' rights are contained in patient letters or national declarations without legal force. In non-compliance with PHR, the victim can seek help from international human rights protection systems (UN or regional systems), while patients' rights are not supported internationally (ALBUQUERQUE, 2016). Still, the PHR care for patients and health professionals, as violating their rights impacts the relationship quality with patients and care environments (COHEN; EZER, 2013)" (ALBUQUERQUE; BOTTLE; PARANHOS, 2017, translated).

with the aim that decisions about the distribution of scarce resources can be political, ethical and legally justified. The pandemic emergency and the context of health scarcity do not authorize States to release themselves from due respect for human rights, notably, the duty to ensure their citizen's access to health and, to the patient in particular, the right not to be submitted to cruel, degrading and inhuman treatment, as well as to guarantee the relief of suffering as a humanitarian measure of a Democratic State⁵.

2. Inaugural milestone of the 21st century: the Covid-19 pandemic

Historian Eric J. Hobsbawm teaches that, most of the time, words speak louder than many documents when it comes to representing social transformations that, due to their complexity, depth, and drama, imply the reorganization of history and the recognition of the advent of a new era. The word "industry" and "factory", for example, forged the historical-cultural reality of a world that, from the 18th century, began to organize itself through the capitalist mode of production and the market economy, replacing the practice of barter (HOBSBAWN, 2003, p. 15).

It was believed, at the time, that human genius, competent to invent railroads and automobiles, among other feats, would be equally capable of creating a more just and egalitarian world. However, we saw two World Wars in the first half of the 20th century. Faced with this fact, it is imperative to recognize that the 19th century only ended, from the historical point of view, in 1918, that is, eighteen years after the chronological beginning of the 20th century, with the end of the First World War, when it was verified that the evolution ethics of humanity does not necessarily accompany its technical development.

Similarly, the 20th century did not end on any other date than March 11th, 2020, which implies recognizing twenty years after its chronological beginning, when the World Health Organization declared the epidemic outbreak of Covid-19 as

5 Several scientists made the alert during the Symposium "Covid-19 Vaccines: Unfinished Business", held by Columbia University in the United States. "We cannot guess what the next threat will be, where it will emerge, or when it will happen. Nevertheless, we can be smarter and prepared for that moment, as it will be inevitable". The warning was given by virologist Dennis Carroll, who is responsible for the Global Virome Project, an international initiative that seeks to track new potentially dangerous viruses. The scientist has extensive experience with emerging diseases and is known for leading strategies to contain the Ebola outbreak in Africa (COLUMBIA, 2022) (HELENA, 2022).

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a pandemic⁶. Here, then, is the historical beginning of the 21st century (SCHWARCZ, 2020, p. 7). If the 21st century was being identified as the age of biotechnology, expressions that converged from the Human Genome Project were inserted, such as artificial intelligence, nanotechnology, robotics, and genetic engineering, capable of apprehending and relating the physical and virtual world. With the emergence of the coronavirus, the word “pandemic” will take center stage and change the human way of being, living, and relating; that is, it will resize the human condition and (re)determine this century.

Recognized as the transmitting agent of Covid-19, a disease scientifically known as SARS-CoV-2, the coronavirus originates from a family of viruses that, in most cases, causes respiratory infections that manifest through a clinical picture that varies from asymptomatic infections to severe acute respiratory episodes, in addition to other complications and damage to the human body, which can even be fatal⁷.

The responsibility for determining whether an event constitutes a Public Health Emergency of International Concern rests with the Director-General of WHO and requires convening a committee of experts called an Emergencies Committee. Thus, fulfilling its institutional mission, with the first cases of Covid-19 infection were registered on December 31st, 2019, when the World Health Organization (WHO), an agency linked to the United Nations, was alerted to several cases of pneumonia in Wuhan City, Hubei province, in the People’s Republic of China. It was a new strain of virus that had not previously been identified in humans. One week after the official notification, on January 7th, 2020, the Chinese authorities confirmed the maximum alert made by the WHO. The hypothesis was that the virus had migrated from a bat to humans, invading the immune system and seriously infecting people; this even justified the closure of a typical Chinese Market, where several species of edible exotic animals were sold.

From China to the other continents, it took just a few weeks. In Europe, Italy has become a dramatic example of the lethality of the new coronavirus in what is

6 The word “pandemic” is related to the geographical distribution of a given disease, that is, to its power to spread around the world, because, from the Greek, the expression “pan” means “of all people”. It does not refer to the severity of the disease itself, but to its potential of spreading across the planet. Nevertheless, gravity was quickly recognized in its most different features. Information sheet on Covid-19 (ORGANIZAÇÃO PAN-AMERICANA DE SAÚDE (Pan American Health Organization), 2020).

7 The coronavirus is a kind of virus classified by virologists as zoonotic; it is found when the virus passes from one animal species to another or when, from an animal, the virus migrates to humans. The fact that they “learned” how to circumvent the human immune system and cross the barrier between species is a reason for great apprehension among researchers, who warn of the risks of new pandemics with increasingly shorter intervals between them (COLUMBIA, 2022).

conventionally called the first wave of the pandemic; in America, the city of New York, in the United States, has become the epicenter of an unprecedented health crisis. In commonplace, in Asia and other continents, the realization that, in the face of an event of this magnitude, the health systems of most different countries collapsed.

With the pandemics' outbreak, the constitutive sense of current societies, markedly individualistic, had to be revised. If the dominant tonic was competitiveness, the pandemic showed that there would be no solution without awareness of community life, a collective spirit, and a spirit of cooperation. Health emergencies related to catastrophes and calamities, natural or stimulated, such as tsunamis, earthquakes, volcano eruptions, and pandemics, involve the population's health and make the issue inexorably collective, as they imply the management of public resources that are, in most cases, insufficient, and in the protection of the most vulnerable people^{8,9,10}.

These actions and decisions about allocating resources in complementary and different areas of action are fundamental if the reality imposed is the scarcity of resources for both public and supplementary health systems. It happens because the demand for services due to the pandemic is significantly greater than the supply capacity of elementary items. This goes from protection masks – proved as an effective measure to reduce virus transmission – to advanced life support equipment, such as artificial ventilation devices and intensive care unit beds.

In the micro allocation of resources, which includes decision-making in hospitals, outpatient clinics, and primary health units, clinical criteria must be adopted to determine the appropriate distribution of scarce resources, such as drugs, artificial ventilation equipment, and beds in therapy units intensive. However, for these criteria to be adopted transparently and ethically and for the measures to prove to be socially equitable, there must be some political and administrative coordination, called macro allocation, which is produced through the actions of the Ministry of Health, the highest entity of the Federal Executive Branch in the management and distribution

- 8 “In situations of catastrophe and public health emergencies, the scarcity of resources becomes a collective problem, with implications for a large part (if not all) of the health system, in several countries, as in the case of a pandemic. The response to this, therefore, must also be collective, transparent and ethical, under penalty of loss of public trust, moral damage and confusion between roles and responsibilities” (RIBEIRO; SADY, 2021, p. 267, translated).
- 9 “Faced with scarce resources, Bioethics can make a concrete contribution to discussions on the priorities for its application in its honest and more equitable distribution and control. In this sense, it is worth remembering that the more organized the population is to claim and defend its interests, the greater the possibilities for effective participation and decision-making in the entire distributive process” (GARRAFA, 2004, p. 53, translated).
- 10 Etymologically, vulnerability comes from the Latin *vulnerare*, to injure; *vulnerabilis*, which causes injury. The term was used with an ethical meaning in the Belmont Report of April 18th, 1979 (HHS, 2021).

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of health resources. This coordination is translated through the adoption of national parameters for the distribution of scarce resources. Therefore, it is considered a responsibility of the State, at the federal level, to adopt national parameters for the allocation of resources, especially those for intensive care, observing the specific needs in different geographic regions in situations of urgency and health emergency, such as the Covid-19, especially given the fact that these criteria imply temporary limitations of rights¹¹.

National parameters for the allocation of intensive care resources in the context of the Covid-19 pandemic must, in addition to involving civil society, rely on the participation of sectors of the population directly affected, such as health professionals and patients, should be aligned with the ethical principles informed by the World Health Organization, as well as with the values stated in the Universal Declaration on Bioethics and Human Rights.

3. Bioethics and human rights declaration and the humanitarian crisis

The humanitarian crisis that emerged in the field of health as a result of the Covid-19 pandemic placed bioethics at the center of discussions and imposed on many of those who had never dedicated themselves to its study to identify and adopt criteria capable of guiding them in inevitable choices in the face of scarce resources.

The word “choice” deserves special attention in this context, as it finds the word “discernment” as its first synonymous expression, which means “judgment” or “wisdom”, there is also the register of “choice” as “predilection”, “inclination”, “preference”, “distinction” and “triage”. “Choosing” means “highlighting”, “electing”, or “selecting” (HOUAISS, 2003, p. 285). Operated in Bioethics, the word “choice” takes on different contours. On the one hand, those who experience the common bioethical desire to see respect for the patient’s choices when deliberating about his health, the procedures that he or she wants to undergo, and the therapies they are willing or

11 “The criteria for allocation of intensive care resources, as they imply limitations of rights, notably the right to life and the right to health, must, as in other countries, be established based on national parameters set by the Ministry of Health”. Guidelines for allocating intensive care resources in Covid-19 were prepared by the Observatory for the Rights of Patients and the Brazilian Society for the Quality of Care and Patient Safety, together with the Unesco Chair of Bioethics - University of Brasília (DIRETRIZES, 2021).

not to participate. In this context, decisions consecrate respect for autonomy and the patient's self-determination principles¹². On the other hand, there is also the need for choice on the part of health professionals, a dilemma particularly experienced by the health team, which is often faced with the reality of scarce resources in the face of high demand and, in these circumstances, chooses who will receive the treatment and who will receive support for symptom relief. This is a challenge in which Bioethics^{13,14} is genuinely inserted.

However, the situation has worsened severely due to the health system crisis caused by the pandemic. The new reality suddenly took hold, increasing the need for hospital beds, revealing the precariousness and scarcity of materials, inputs, devices, tests, equipment, and staff, all essential resources for medical care and clinical follow-up, all limited, restricted, insufficient, given the absolute need imposed by the significant increase in the number of infected people and the severity of the new strains of Covid-19. In mid-2021, in Brazil and the world, there was already a rumor of a second wave of contamination, an increase in the aggressiveness of symptoms, the worsening of infections caused by new variants of the virus, and a high degree of lethality. In the face of a chaotic reality, health professionals were forced to choose which lives they would dedicate themselves to saving.

The inability to manage the care for infected patients, due to the shortage of supplies, in most different health systems, including nations considered economically rich, indicated that the States would need to be guided by international principles, informed by the World Health Organization and that, in turn, they should establish national parameters and guidelines capable of assisting medical teams in making choices,

12 "The principle of patient autonomy is super-dimensioned in Bioethics, notably in US Bioethics [...] in the sphere of human rights, autonomy has unique relevance, consisting of a constitutive element of human dignity by prescribing the right of every person to self-determination [...]" (ALBUQUERQUE, 2016).

13 According to Leocir Pessini and Christian de Paul de Barchifontaine, the first time this type of choice had to be made was on November 9th, 1962, when an article published in *Life* magazine, whose title was "They decide who lives and who dies", told the reality of a committee, installed in Seattle, formed by a small group composed of non-medical professionals who had the objective of selecting patients for the dialysis program, made possible thanks to the invention of Dr. Belding Scribner. There was a greater demand than supply for the treatment, and the committee had to establish criteria to guide the choice and to help in decision-making (PESSINI; BARCHIFONTAINE, 2010, p. 26-27).

14 The difficulty of this type of deliberation meant that the decisions made in this context were called "Sophie's Choice", an expression that gained prominence as the title of a work of fiction authored by William Styron, published in 1979 and awarded by the National Books. In the book, the American author narrates the story of Sofia Zawistowk, a Polish survivor of the Auschwitz concentration camp forced to choose between her two children, Jen and Eva, which the Nazis would exterminate in the gas chamber. If Sofia did not choose one of her children, both would be sent to their deaths.

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which are often fatal, for patients who would not be contemplated directly, but who needed palliative care. The values that underpinned the WHO recommendations were inspired by the foundations of the UNESCO Universal Declaration of Bioethics and Human Rights, among which the following stand out: human dignity and human rights, autonomy, informed consent, recognition of human vulnerability, and respect for the integrity of the person, privacy and confidentiality, equality and equity, non-discrimination and stigmatization, respect for cultural diversity and pluralism, solidarity and cooperation, social responsibility and empathy.

Many of these principles embodied the patient's human rights and were summarily disrespected during the Covid-19 pandemic. This fact led several scholars to state that bioethics could have been more successful in offering an ethical protocol that could establish guidelines that respected the values listed above.

Modern bioethics is not only a result of deep scientific transformations and achievements, but also a consequence of a fast-developing globalization process and the increasing importance of international collaboration in solving global problems.

A combination of high potential and real danger of modern biotechnologies, taking precautionary and preventive measures without prior humanitarian expertise, assigned a special socio-regulatory status to bioethics. Today, bioethics is the science of searching, evaluating, and selecting criteria for a moral attitude to the living (NEZHMETDINOVA; GURYLEVA; BLATT, 2022).

The conjuncture of the pandemic and the consequent severity of the crisis that took place in the health sector caused the scope of action of bioethics to be sharply expanded. Thus, the values that initially constituted it, such as life, health, well-being, and social justice, were joined by others, which began to claim, on the one hand, the leadership of the State and, on the other, the cooperation of society. In this sense, the Joint Center for Bioethics at the University of Toronto, since 2006, has already recognized the essential values in the planning of response actions to a pandemic:

[...]personal freedom, protection of society from possible harm, proportionality, privacy, responsibility to provide health services, interaction, equality, trust, solidarity, and good governance.

Only adherence to these moral principles and their incorporation into sanitary-epidemic, medical, economic, legal, administrative, and social technologies can ensure success and prevent unjustified risks for all population groups (NEZHMETDINOVA; GURYLEVA; BLATT, 2022).

In emergencies, such as natural catastrophes, war, or a pandemic, the notion of a collision between individual and collective interests is erroneous. Bioethics proposes overcoming this dichotomy and expanding this reductionist view of personal autonomy, self-determination, and individual freedom to remember that no one lives alone: we live in the community, in collectivity. The principle of collective interest is expressed in the Federal Constitution. Although its interpretation is challenging, it is possible to argue that “[...] rests on the pursuit of the common good and respect for the dignity of the human person, being the foundation, criterion, and limit of all public administration actions” (NORA, 2021, translated). This ethical-normative framework not only informs the bases that must be in place when emergencies arise but as they make it possible for choices to be rational and make the allocation of scarce resources ethically justifiable, but it also imposes that public administration coordinates actions and responses to society efficiently and transparently. The challenge is monumental because, in short, it is about answering to what extent it is possible to make ethical choices in the face of scarce resources.

4. Allocation of scarce resources

As of the 70s, resource allocation became a new area of study. It arose, among other factors, due to the change in society’s behavior, notably as a result of the growing urbanization of life and the incorporation of technological devices in health treatments. Reflections in this sphere start, on the one hand, from the premise that the population’s health needs are continually much greater than the capacity of the resources available for their assistance, even considering the economies of economically developed nations. On the other hand, it is necessary to consider the obligation of States to implement access to health as a universal human right.

The severe acute respiratory syndrome caused by SARS-CoV-2 has made this equation between supply and demand in health care even more complex. Rational, objective, transparent, and, above all, ethical criteria needed to be identified and established by international organizations to guide States politically and administratively regarding allocating scarce resources in the context of a Pandemic. Adopting these parameters by the States would translate into more efficient and responsible management by health bodies and systems, enabling more coherent choices and allowing fairer health deliberations. When it comes to establishing objective criteria to achieve an

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equitable distribution of health care, the idea of what is acceptable and what is ethical, whether in health or other equally essential areas such as, for example, safety or education, involves understanding the most elementary values that a given society elects as fundamental. The issue of resource allocation in health thus necessarily incurs an ethical dimension¹⁵.

The predominance of utilitarian ethics¹⁶ is evident in Western culture, marked by capitalist production and the market economy. When associated with the theme of resource allocation, it can lead to the understanding that allocating is reduced to rationing. It is essential to distinguish between the terms “rationalization” and “rationing”, not only due to the phonetic similarity of the words, which can lead to a misunderstanding, but also because both are present when the subject is allocation of resources in health¹⁷.

One of the questions raised from the beginning was whether decisions in the context of the pandemic should be based on adopting the classic patient risk classification parameters that determine, for example, the order of arrival or greater severity/priority. This is due to the excessive increase in cases of contamination by Covid-19, which has caused the collapse of health systems. The question is whether this reasoning would lead to allocating scarce resources, such as intensive care resources, to patients with a reasonable clinical expectation of survival. It is not possible to face this question without first remembering that “allocate” in economic terms is not limited

15 “We call ‘Ethics’ this philosophical discipline that constitutes a second-order reflection on moral problems”, that is, on the choices we make, on the decisions we make, on the value judgments we formulate, and that guides our posture, not only in everyday life but, above all, in ambivalent situations, in conflicting conditions, every day when it comes to life - *biós* - and health (CORTINA, 2005, p. 20, translated).

16 Utilitarianism is a philosophical current that has among its main precursors John Stuart Mill and Jeremy Bentham, and which advocates, in short, that actions, decisions, and choices should always take into account the maximum benefit and minimum damage they can generate (ABBAGNANO, 2003, p. 986-987).

17 Maria do Céu Patrão Neves teaches that “to allocate”, in the economic-financial sense, ultimately consists of managing resources, whether these resources are scarce or not. “Rationing” is one of the possible methods of “allocating”; however, it is not the only one. Allocating may not be exactly rationing - products - that is, reducing the number of resources given that demand exceeds supply; allocating may be related to rationalization, which is to say, to the use of a method that results from reason. Understood in this way, rationalization of allocation implies decision-making about scarce resources in health. This decision will be rational insofar as it seeks to maximize benefits, that is, to use the scarce resources available in the most efficient way possible. It is inferred that the allocation rationality impels that health resources, exceedingly scarce, should be allocated to patients with better clinical parameters and who, therefore, can respond better to treatment. The author also records that, although the use of utilitarian ethics is not safe from criticism, the allocation of resources in times of a pandemic, that is, an excessive increase in cases of contamination by Covid-19, which caused the collapse of health systems and cannot be based on the adoption of the classic patient triage parameters, which adopt, for example, the order of arrival or the highest-severity/highest-priority, because this reasoning would culminate in the allocation of scarce resources for intensive care to patients without a reasonable clinical expectation of survival (NEVES, 2020).

to mathematical calculations; “to allocate” means “to destine”; in this context, if the challenge is to adopt a good destination for scarce health resources, the parameters observed in this choice must align with the values of Bioethics and the dictates of the Patient’s Human Rights to be ethical, fair, and universally valid.

The perspective of Bioethics and the Patient’s Human Rights then assumes a central role in this task. Through these approaches, it is necessary to identify whether the government adopted national parameters and the positive or negative results that are observing them brought about for society. It is also essential to assess the resulting risks and benefits and determine whether adopting these parameters would offer subsidies so that health team professionals could base their decisions clinically, morally, and legally¹⁸.

Thus, investigating the existence or not of international ethical criteria that would guide States in setting national parameters of scarce resources for intensive care; examine whether these parameters were implemented internally by the Ministry of Health - an agency of the Federal Executive Branch responsible for the organization and elaboration of policies aimed at health and, therefore, for the macro allocation of resources -; verify to what extent the adoption or not of national allocation parameters of scarce intensive care resources may have resulted in an overload for the health teams and the disrespect for the human rights of the patients - all these are issues that must be considered not only due to the economic bias usually associated with the term “allocation” of resources, but, above all, taking into account the values of Bioethics and the Patient’s Human Rights.

It is precisely in this sense that the recommendations made by AMIB (Associação de Medicina Intensiva Brasileira - Association of Brazilian Intensive Medicine), ABRAMEDE (Associação Brasileira de Medicina de Emergência - Brazilian Association of Emergency Medicine), SBBG (Sociedade Brasileira de Geriatria e Gerontologia - Brazilian Society of Geriatrics and Gerontology), and ANCP (Academia Nacional de Cuidados Paliativos - National Academy of Palliative Care) about the allocation of depleted resources during the Covid-19 pandemic, indicating the responsibility of the

18 As Diego Gracia teaches, the need for moral justification was unthinkable until recently, when the tonic of medical practice was based on medical paternalism. Once paternalistic medicine was overcome, mainly due to the advent of free and informed consent, affirmed on the occasion of the publication of the Nuremberg Code, medical decisions, until recently unquestionable, began to be shared with patients in respect for the principle of autonomy (GRACIA, 2007, p. 39).

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public power in the macro coordination of response actions to society and recording the direct relationship between the absence of this coordination and the increase in the number of deaths, as well as identifying the existence of a parallel between the lack of establishment of guidelines used in patient triage and the increase in moral stress of healthcare teams regarding decision-making, as follows:

It is part of the responsibility of professionals and public authorities to prepare for the possibility of resource exhaustion.

According to recommendations and guidelines of international medical societies, the establishment of a protocol for the allocation of resources in depletion is a requirement that is part of the preparation for a pandemic situation where there is the possibility that even the contingency measures are not enough to deal with the increased demand of critically ill patients.

The *American College of Chest Physicians*, for example, argues that the absence of an appropriate triage system when contingency measures have been exhausted can contribute to an increase in the number of unnecessary deaths, increase the burden of moral stress on health professionals, and erode the credibility of health care as decisions will be taken in inconsistent ways and with unclear and questionable criteria. To be ethically defensible, however, depleting resource allocation processes must only occur in secret, with proper recording, and subjectively and consistently. On the contrary, they must appear based on clear, transparent, technically well-founded protocols, ethically justified, and aligned with the Brazilian legal framework.

Another objective that guides the need for this protocol is to protect professionals at the forefront of care by removing from their hands the responsibility of making emotionally exhausting decisions that may increase the already high risks of mental health problems precipitated by the pandemic of COVID-19 and, consequently, compromise the ability to work in the short and long term. In addition, the concern about potential legal challenges regarding these decisions can also increase the risks of damage to professionals' mental health. Consistent protocol use by various health institutions ensures that more patients are equally subject to the same criteria approved by the authorities responsible for scientific and ethical-legal zeal in the process (SUS, 2020, translated).

From the above, it appears that the health crisis resulting from the Covid-19 pandemic has imposed on nations to face not only the SARS-CoV-2 virus but also to meet other no less important battles, among them: the dissemination of false news related to the effectiveness of medicines; the denialist behavior of some agents that caused

significant damage in the effective fight against the disease and the false dilemma between protecting life or the economy – situations resulting from the fear experienced by society in the face of a virus with a high degree of transmissibility and lethality, totally unknown to the world scientific community; and, finally, the absence of political leadership in the implementation of measures against the pandemic outbreak.

5. Health crisis and political crisis

In global terms, the WHO took over the coordination of actions to guide nations in adopting guidelines for coping with the pandemic. However, what kind of guideline could be initially adopted and disseminated by the WHO in the face of complete ignorance about the behavior of the new virus?

This question refers to the reflections of Yuval Noah Harari, who points out that from the black plague, which broke out in the 14th century and killed 1/3 of the European population, to infection caused by the smallpox virus, which infected 15 million people in 1967, some valuable lessons on measures to combat pandemics were bequeathed, among them the fact that the adequate protection of the population comes from the exchange of reliable scientific information, solidarity, and global cooperation. The author records that the black plague spread rapidly across Europe even before globalization, which proves that it is not just a matter of protecting geographic borders; in 1979, ten years after smallpox left a balance of 2 million deaths in the world, WHO declared the complete eradication of the disease due to the successful global vaccination campaign.

However, it is essential to emphasize that it would be enough for a single country to stop vaccinating its population for the whole world to remain vulnerable to the smallpox virus; another pertinent lesson concerns isolation measures such as quarantines, for example, as they prove to be quite important at a particular stage in the fight against the virus. However, when countries fail to establish a cooperation relationship, they are left with the impression that they are alone in fighting the virus, which makes governments resist adopting isolation measures, as they fear economic collapse with the closure of cities. In this sense, the author teaches:

When a particular epidemic hits a country, it must be willing to honestly share information about the outbreak without fear of economic catastrophe, while other countries must be able

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to trust that information and be willing to extend a helping hand. Instead of ostracizing the victim. [...] The most important thing people need to learn about the nature of epidemics is that their spread in any country endangers the entire human species (HARARI, 2020, p. 18-19, translated).

Regarding the economy, trust is the most valuable currency in the market: the crisis generated in the health sector was aggravated and had repercussions on the economy and other sectors of social life, mainly due to the lack of trust between people. Harari warns:

To defeat an epidemic, people need to trust experts, citizens need to trust public authorities, and countries need to trust each other. In recent years, irresponsible politicians have deliberately undermined trust in science, institutions, and international cooperation. As a result, we need leaders who can inspire, organize and fund a coordinated global response (HARARI, 2020, p. 23, translated).

The author records that, during the Ebola epidemic in 2014, the United States assumed world leadership, having done the same in the financial crisis in 2008, when it led a consortium of countries, took responsibility for itself, and avoided the global economic collapse. In the Covid-19 pandemic, however, the US resigned from this leadership, cut support for international organizations such as the WHO, and publicly revealed, in the figure of its ruler, disapproval of the scientific community, minimizing the severity of the disease and refusing to adopt elementary measures, as the use of a protective mask to combat the spread of the virus. As a result of this strategy, in the second half of 2020, the United States led, in absolute numbers, the total number of deaths from Covid-19 in the world; in second place was Brazil (SANTOS, 2012, p. 165).

6. The brazilian experience

In Brazil, the first case occurred in early February 2020, with the so-called “patient zero”, as it became known, it was a 61-year-old man returning to São Paulo after a tourist trip to Italy. So, the health systems of most different countries would collapse: there were not and still are not hospitals, health professionals, protective equipment, tests capable of diagnosing contamination in sufficient numbers to meet the demand,



there are no vacancies for hospitalizations, there are no beds in intensive care units, neither are there enough respirators to meet everyone who needs care due to contamination. In addition, to the difficulty of health professionals in general and of the medical team in particular, facing a severe and unknown illness, there is another challenge, such as the scarcity of resources, that compels them to make choices that consist of determining which patient will receive the bed, treatment, therapy, medication, mechanical ventilation and which patient will remain unattended¹⁹.

Coordinating a triage like this one, which ultimately can mean the death of the patient who is not chosen to receive adequate assistance, must be carried out by making every possible effort so that the risk classification that determines these choices are ethical, fair, humanitarian, and rational. In an urgent emergency, whether resulting from a natural catastrophe or a virus, guidelines for allocating scarce resources, especially those offered in intensive care units, must be established and shared clearly and honestly. This service policy must be verified in the light of national parameters so that the human rights of patients remain assured by the State; notably, the right not to be discriminated against due to their origin, belief, social class, or age, among other factors. Deliberating on these parameters is, in addition to a political requirement, a legal and ethical obligation that must consider both the values of Bioethics, especially concerning the principles of the Patient's Human Rights. The adoption of national parameters for the allocation of scarce resources, deemed essential to an efficient macro allocation of resources, must be carried out by the Ministry of Health, an agency of the Federal Executive Branch responsible for the organization and preparation of policies aimed at the health of the population. Based on the establishment of complete and transparently shared national parameters, choices within the scope of the macro allocation of scarce resources can be rationalized and guide the establishment of critical regional parameters for the micro allocation of resources so that decisions can be equitable.

The pandemic emergency and the context of health scarcity do not authorize States to release themselves from the due respect for human rights, notably, the duty to guarantee their citizens the right not to be discriminated, as well as the relief of suffering as humanitarian measures. Coordinating a national policy to combat

19 In the same sense, ALBUQUERQUE, CARVALHO and TANURE (2021, p. 196, translated) point out: "The Covid-19 pandemic harms the rights of infected patients and those suspected of being infected, as well as generating fear and uncertainty in health professionals, patients, and their families".

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the pandemic is relevant, especially in a country of continental dimensions like Brazil, where there is abysmal inequality in the living conditions of different population strata.

Thus, it is pertinent to ask what the emergency actions shared by the federal government with the other states of the federation and what risks classification were indicated; what strategies were adopted and encouraged by the federal government, through the Ministry of Health, given the scarcity of resources and the need to triage patients infected with Covid-19; to what extent the adoption of national parameters, informed by the federal government through the action of the Ministry of Health, during the pandemic, impacted the human rights of patients and health professionals who had to be responsible not only for the care of seriously ill patients infected by Covid-19 but also faced moral dilemmas related to the allocation of scarce resources and had to choose, amidst the collapse of the health system, who would receive assistance.

Any reflection on these questions must admit the similarity between the North American and Brazilian federal governments in managing the pandemic²⁰. Brazil, like the United States, assumed a position of denial of the disease, discredit concerning scientific discourse, and hostility in observing basic measures to contain the spread of the virus. While the Brazilian health system collapsed due to the exponential increase in cases of contamination by Covid-19, essential resources became scarce, such as masks, protective equipment for the clinical team, beds, and respirators, among others, and a political crisis took hold.

In 2020, the Ministry of Health was headed by three ministers. In March, under Minister Luiz Henrique Mandetta, Brazil was closely following the situation of the health crisis experienced by European countries and, in compliance with WHO guidelines, it was taking the first measures to face the pandemic. Initially, quarantine aimed to contain the spread of the disease and flatten the epidemiological curve, avoiding overloading the health system. As previously mentioned, the quarantine has the potential to generate damage to the economy: to use a typical expression in the health area, the economic crisis can arise as a side effect, which can only be minimized when there is an understanding that the situation is global and that the duty of cooperation is

20 “The proximity between North American and Brazilian governance in managing the pandemic is quite clear – compared to what happened to European and Asian countries. As we have seen, Brazil and the United States refused to recognize the legitimacy of scientific discourse and fully assumed the strategy of negationism” (BIRMAN, 2020, p. 79, translated).

imperative among nations, as the spread of the virus in any country puts all of humanity at risk. Thus, although cities like São Paulo and Rio de Janeiro had complied with the social isolation guidelines to avoid the collapse of hospital medical care, the federal government rejected the measure. Emphasizing the economic situation and minimizing the severity of the disease, the head of the nation adopted an opposite position to the guidelines of his health minister. In an escalation against the basic guidelines that were being shared by the WHO, implemented by other countries, and corroborated by the Ministry of Health, the federal government started to bring up crowds, harass health authorities, criticize the press for the coverage and dissemination of contamination numbers and deaths, disrespecting the pain and suffering of fatal victims and their families, ignoring the need to use protective masks in closed places, endorsing the use of hydroxychloroquine, even after conclusive studies were published informing not only the ineffectiveness of the drug for the treatment of the disease, as well as the risks related to misuse and, finally, when the scientific community, in record time, for the solace of society, announced the arrival of the vaccine, the president began to deny the importance of vaccination, personally refusing to be vaccinated.

Scholars of the subject emphasize that one of the most harmful situations for the population in the face of the pandemic was the double message and the lack of consensus among the head of the governments in the three spheres of action: federal, state, and municipal. While most governors and mayors were committed to adopting and sharing simple but effective measures to combat the virus, such as using masks and social distancing, the federal government was moving in the opposite direction of good governance.

7. Good governance: the context of the pandemic

The expression “good governance” is present in the materials released by the Courts of Accounts, mainly Brazil’s Tribunal de Contas da União (TCU - Federal Court of Accounts). There was an attempt to posit it in the *caput* of art. 37 of the Federal Constitution with the use of the expression “good public governance” through the presentation of the Project of Constitutional Amendment n° 32, which dealt with the Administrative Reform, originating from the Ministry of Economy and which, among other measures, proposed to expand the list of principles governing public administration.

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In general, good governance is spoken of under this bias, from a perspective that seeks to optimize the management of public resources. However, it should be noted that “governance” is not synonymous with “management”. While “governance” is the directing function, “management” is the realizing function²¹. Thus, good governance presupposes practices of leadership, strategy, and control. A good observation of these practices by the representative who manages public resources allows better targeting of services and public policies offered to citizens. It is, above all, in a crisis scenario like the one that was established with Covid-19 that good governance proves to be essential, and it is not on a whim that leadership emerges as the first skill for good governance. That is the fundamental competence in times of crisis. Among the guidelines pointed out by the TCU as instruments for good governance, the leader’s leadership is paramount in efficiently managing scarce public resources. The ability to promptly establish an action plan and communicate it clearly and transparently to the other entities of the federation, to formally define the roles and responsibilities of the internal instances that support the government, increases the opportunity for an effective and equitable response to the population. In this sense, the report prepared by the TCU entitled “Ten steps to good governance” lists the principles and guidelines aimed at this end, namely:

These are general governance guidelines: 1. formally define and communicate the roles and responsibilities of internal organisms and those that support governance and ensure that they are performed effectively; 2. establish transparent, evidence-based, and risk-oriented decision-making processes motivated by equity and a commitment to serving the public interest; 3. promote values of integrity and implement high standards of behavior, starting with demonstrating exemplary conduct by the organization’s leadership and support for the integrity policies and program; [...] 10. consider the interests, rights, and expectations of interested parties in decision-making processes; [...] 15. edit and revise normative acts, guided by good regulatory practices and the legal system’s legitimacy, stability, and coherence, and conduct public consultations whenever convenient (TRIBUNAL DE CONTAS DA UNIÃO, 2021, translated).

21 Organizational governance is the application of leadership, strategy, and control practices, which allow the representatives of an organization (which manages public resources) and the stakeholders interested in it to assess their situation and demands, direct their actions and monitor their performance. Functioning increases the chances of delivering exemplary results to citizens regarding services and public policies (TRIBUNAL DE CONTAS DA UNIÃO, 2021).

As can be seen, the decision-making process of the representative must be transparent, evidence-based, motivated by equity, committed to the common good, and consider stakeholders' rights and expectations in the decision-making process. There is no possibility of good governance without leadership, and, in turn, there is no good leader, "good" in the Aristotelian sense of the term, that is, ethical and fair, without empathy. Empathy, however, is a moral virtue in the Greek sense of the time and an essential tool for establishing a culture of respect for the Patients' Human Rights.

8. Empathy and patients' human rights

Aline Albuquerque recalls that empathy is an essential disposition for life in society. According to the author, this ability consists of the following:

[...] in altruistic behavior and favor of the well-being of the other [...] we are gregarious beings, whose social connections have a direct impact on our lives, others affect us, and we affect them, and in this lies the richness of species and its fragility [...] empathy [...] allows a connection with mental states, including emotions, thoughts and the situation in which the other is found, it is a capacity to be cultivated [...] it allows a response based on otherness, insofar as it provides an openness to the other, which expands the ability to create a meaningful connection and weaken oneself - which strengthens our shared humanity (ALBUQUERQUE, 2022, p. 24, translated).

From empathy as an ethical imperative of life in society to clinical empathy, studied in the health field, an essential change in positioning has occurred. Little by little, attempts have been made to debunk the myth of the need for distance between the health professional and the patient. Based on this new relational pattern, clinical empathy comes to be understood, in a tight synthesis, as overcoming a biomedical model centered on the disease, for the recognition and validation of the desires and emotions of people who are under health care, presenting itself, since then, as a structuring value of patient-centered care.

The effort made in recent decades by Bioethics and the Human Rights of the Patient to instill in the clinical team the practice of empathy and to break with the cycle of power asymmetry, characteristic of the relationships established between health teams and patients, has intensified with the arrival of the pandemic. The federal government informed no basic directions, parameters, guidelines, or essential criteria to help triage

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infected patients. Establishing a macro allocation policy for scarce resources could mitigate the responsibility and weight borne by health teams in decision-making. The partnership with research centers could have been carried out, as happened in several countries. Universities, with their researchers, in helping the population, could have acted much more effectively if they had been called upon to cooperate with the federal government. What was seen, however, was the opposite of this. A series of obstacles and difficulties were imposed on the standard and excellent effort that Brazilian scientists constantly carried out. During the Covid-19 pandemic, the federal government proved being incapable of establishing a respectful relationship with the scientific community, which ended up making the situation worse with the desperation of family members who were unsuccessfully looking for an ICU bed for patients who needed artificial respirators or even exhausted clinical teams without adequate protective equipment, or the pain of the bereaved families or because of the joy that came with the arrival of the vaccine. In all these situations and many others, the federal government's response was derision and hostility.

Aline Albuquerque teaches that “empathy is a central component of human morality” and morality, as well as efficiency, are constitutional commandments, founding principles of public administration that, when not observed, give rise to the responsibility of those who under these precepts should act.

9. Accountability for results in the management of the Covid-19 pandemic

Responsibility is linked to one action or omission, which is not only connected to the freedom everyone has to act but, in some cases, to the duty that certain people have to act because of other people.

Hans Jonas (2006, p. 19) builds his responsibility theory by structuring it into three categories: the good, the duty, and the being. Of these categories, the first two directly discuss the present article, as they especially relate to the domain of ethics, the good, and the legal scope, the duty. The responsibility of parents towards their children, for example, is not only an ethical responsibility to care for the good of the children but also a legal one, since there is an express lawful provision, with legal consequences, in case of omission. It is also worth remembering that according to the law, those with a legal duty to act when omitting themselves are responsible for the deletion and the



result of the omission: parents have a duty to act for their minor children; doctors, similarly, have a legal duty to act concerning their patients, and if there is an omission, these people will answer for the result of the omission that is, if the omission results in the death of the minor or the patient, they will answer for homicide in terms of the law. Thus, the conduct typified as a crime in our criminal law provides for “actions” (commissive conduct) and “omissions” (omissive conduct), and in the latter case, there is what is called a “generic duty of protection” (GRECO, 2007, p. 151). Alongside these two types of conduct, there is still the “criminally relevant omission”, provided for in art. 13, paragraph 2, of the Penal Code:

Art. 13 Relevance of the omission

§ 2º - The omission is criminally relevant when the omission should and could act to avoid the result. The duty to act is incumbent on anyone who:

- a) has an obligation of care, protection, or surveillance by law;
- b) otherwise assumed responsibility for preventing the outcome;
- c) with its previous behavior, it created the risk of the occurrence of the result (BRASIL, 1940).

The penal norm specifies an action, but the individual remains inert, even though he can and should act to avoid the result. In this situation, there is a “special duty of protection” (GRECO, 2007, p. 151), and the agent occupies the so-called position of “guarantor” since he has a legal obligation of care, protection, or surveillance, having assumed responsibility for preventing the outcome; or have created a risk of the outcome occurring. If, from a legal perspective, the rule is clear, it would be possible to question the responsibility of the representative under the ethical view, that is, what kind of ethical responsibility could there be concerning the political function, that is, in the light of ethics, which order of responsibility a representative assumes when he is willing to govern. Hans Jonas answers this question assertively as follows:

However, to mention the final and most fundamental aspect of all, there is a relationship of affection, akin to love, on the part of the political individual towards the collectivity whose fate he intends to guide, for that collectivity is “his” in a sense. Much more profound than that of a community of interests: he emerged from this collectivity (as a rule) and became what he is thanks to it and, therefore, he is not his father, but the “son” of his people and his land (his social group and so on), thus “brotherly” with all those who share these ties - the living, those to

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come and those who have died [...] an emotional identification with the collective, a feeling of “solidarity” (JONAS, 2006, p. 183, translated).

Max Weber, in turn, questioning himself about what would be the qualities that the ruler should present in the exercise of the mandate, proposes the reflection in the following terms:

What inner joys can it offer, and what personal preconditions does it presuppose in those who turn to it?

[...] With this we enter the field of ethical questions; for that is where the question belongs: what kind of person does one have to be in order to be allowed to put one's hand in the spokes of the wheel of history (WEBER, 1926, p. 50-51, translated).

The author highlights passion, responsibility, and a sense of proportion as essential qualities to the public man. He teaches that the governor's passion consists of the “purpose to achieve”. However, he recalls that “it does not make you a politician if, as service in a ‘cause’, it does not also make responsibility for this very cause the decisive guiding star of action” (WEBER, 1926, p. 51, translated). He emphasizes that a sense of responsibility must accompany passion and devotion to a cause. He says that are ultimately only two types of deadly sins in politics: irresponsibility and, often, but not always, lack of objectivity (WEBER, 1926, p. 52, translated). The federal government's absence of responsible legal, ethical, and political behavior in managing the Covid-19 pandemic in Brazil has led to the dramatic result of what scientists call “avoidable deaths”.

The balance of the lack of responsibility in managing the pandemic was the death of more than 600,000 Brazilians and the contamination of tens of millions of citizens. Actions and omissions can be subsumed under different criminal types, acts of administrative impropriety, and crimes of responsibility. Violations deserve to be brought to an end before the Judiciary so that the pain and suffering of patients and their families do not go unanswered.

It is necessary to remember that the maxim that law enforcement has a pedagogical character goes back to Plato, considering, thus, the scientific community's alert that other pandemic events are coming shortly. It is unacceptable that, given the real possibility of facing new pandemics, the attitude of the country's representative in the face of a pandemic outbreak should not be assimilated; it is unacceptable that the head

of the nation mocks science, the press, the population, patients and bereaved families and that he adopts a denialist posture that results in a mortality rate four to five times higher than the world average and that there are no consequences due to their actions and omissions. In this sense, although there have been all sorts of violations by the federal government²², for the present research, the offenses that constitute injuries to the Human Rights of Patients are directly related to the object of the work and deserve to be highlighted. It is reiterated that the pandemic emergency and the context of health scarcity do not authorize the States to release themselves from due respect for the Human Rights of the Patient, notably, the relief of suffering as a humanitarian measure of a Democratic State.

The Human Right of the Patient not to be subjected to cruel, inhuman, or degrading treatment was flagrantly violated due to the political inability to establish guidelines related to the macro allocation of resources. The federal government's omission is not only due to the lack of technical capacity to manage the pandemic but also, as highlighted above, to the lack of empathy, solidarity, and leadership, essential qualities of the representative of a nation. The most outstanding example of the lack of commitment concerning the management of the pandemic by the federal government was verified by the drama faced by the population of Manaus due to the shortage of medicinal oxygen; the episode demonstrates, as if completed, the total disrespect of the federal government towards patient's human rights. The deaths in Manaus were not only the result of contamination by Covid-19; the deaths of those patients were due to asphyxiation; that is, the contaminated patients were not guaranteed the minimum resource, that is, medical oxygen, so that they could fight against the disease. It should be noted that the federal government had been notified; despite the notification, it did not adopt any measure, plan, or initiative that promptly showed concern for oxygen replenishment and patient care (SENADO FEDERAL, 2021, p. 266-303). It was flagrantly omitted.

22 At the end of the instructional phase carried out by the CPI, it was possible to identify the occurrence of the following crimes provided for in the Penal Code: i) attempted murder (art. 121 c/c art. 14); ii) danger to the life or health of others (art. 132); iii) epidemic (art. 267); iv) infraction of preventive sanitary measure (art. 268); v) omission of disease notification (art. 269); vi) quackery (art. 283); vii) incitement to crime (art. 286); viii) forgery of a private document (art. 298); ix) ideological falsehood (art. 299); x) use of a false document (art. 304); xi) irregular use of public funds or income (art. 315); xii) passive corruption (art. 317); xiii) prevarication (art. 319); xiv) administrative advocacy (art. 321); xv) usurpation of the public function (art. 328); xvi) influence peddling (art. 332); xvii) active corruption (art. 333); xviii) fraud in bidding or contract (art. 337-L); xix) procedural fraud (art. 347). In the same way, the crime against humanity was identified (Decree n° 4.388, of 2002 - Rome Statute of the International Criminal Court, art. 7° , 1, k), as well as the crime of criminal organization, foreseen in Law n° 12.850, of 2013 (SUS, 2020).

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The population of Manaus experienced moments of despair due to the chaos that settled in the health system of Amazonas. There were deaths from suffocation due to lack of medical oxygen. As we will seek to clarify, the federal government already knew the inability of the authorities responsible for the health system to solve the difficulties related to the pandemic.

In fact, in April 2020, the federal authorities were informed about the vulnerability of the state of Amazonas through Recommendation No. 6/2020 of Ministério Público Federal (Public Prosecutor's Federal Office), with Ministério Público do Trabalho (Public Prosecutor's Labor Office), and the Ministério Público do Estado do Amazonas (Public Prosecutor's of the state of Amazonas Office). On that occasion, it was recommended that the Ministry of Health promote follow-up, audit, and control actions, to improve access to health in that State.

It turns out that, having overcome the first wave of the new coronavirus and even knowing the difficulties of the State of Amazonas, the federal government has not put into practice any contingency plan to prevent a future spread of contamination by the virus. The second wave began in September 2020, and by December, contamination and deaths were already rising at an accelerated pace. With the year-end festivities approaching, a sharp increase in cases was already expected, which would result in a probable collapse of the healthcare network in January 2021, which in fact, occurred.

The lack of coordinated and planned actions by the federal, state, and municipal governments to overcome the crisis, amid the abrupt and consistent increase in hospitalizations, led the health system to collapse. Without proper monitoring of the amount of medicinal oxygen that hospitalized patients were already consuming and without a reliable estimate of the volume that would be needed to meet the increased demand caused by the growing cases of Covid-19, the local health system found itself out of supply, even though he was warned about escalating oxygen consumption. This inaction and lack of planning resulted in dozens of deaths due to the suffocation of people hospitalized due to Covid-19 (SENADO FEDERAL, 2021, p. 26-27).

Among the many violations perpetrated by the federal government to the Human Rights of Patients in managing the Covid-19 pandemic, this article considers the situation experienced by patients in Manaus as the most emblematic. The tragic scenes experienced by patients and their families on that occasion were followed in real-time, thanks to press coverage, which shocked the country as much as the declarations of the head of the nation regarding that situation.

If there were no technical-administrative competence in managing the Covid-19 pandemic, there would already be a severe violation of the principles of public

administration, such as the principle of efficiency, but that was not all. In addition to the inefficiency that cost lives, there was a lack of ethical responsibility, which translated into a lack of political will to undertake efforts to mitigate the suffering of patients as a humanitarian measure of a solidary, democratic, and the rule of Law State. This finding necessarily implies the legal responsibility of the head of the nation for crimes against humanity, specifically under the mode of extermination, provided for in art. 7, paragraph 1, b and paragraph 2, b, of the Rome Statute, enacted in Brazilian Law through Decree No. 4.388/2002, which establishes that “extermination” comprises the intentional subjection to conditions of life, such as deprivation of access to food or medicine, intending to destroy a part of a population.

Although it is not possible to impute to the President of the Republic that the free and conscious will achieve the result, that is, death by suffocation, it is undeniable that he consciously assumed the risk of acquiring it when, being able and having to act, he chose not to. Failure to hold accountable those who ethically, legally, and politically had the duty to protect the population and who deliberately failed to do so is, after all, promoting a new violation of the patient’s human rights since many bereaved families claim justice.

10. Conclusion

The patient is always at the end of medical activity. It is not the disease, nor its cure, that should be at the center of health teams’ concerns. The theoretical framework of Bioethics and the Human Rights of the Patient proposes that more than the possibility of healing, what should inspire the clinical team is caring. Health care implies the willingness of the clinical team to share information with the patient, to respect their decisions, to guarantee access to information, intimacy, and privacy, and to avoid their discrimination while promoting their inclusion as an agent capable of self-determination even with increased vulnerability due to their clinical condition. Many of these rights were violated during the Covid-19 pandemic, and possibly the justification was precisely the chaotic situation that suddenly befell the public and supplementary health systems. One of these rights, however, when disrespected, violated in a more dramatic way the core notion of humanity that was hard constituted throughout the last century, that is, the right not to be subjected to cruel, degrading, or inhuman treatment, which is, in ultimately, the corollary of Bioethics and the Patient’s Human

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Rights. It must be admitted that the Covid-19 pandemic quickly installed itself as a severe and urgent phenomenon in Asian countries and on the European continent and that this unexpected supervenience imposed on many countries the drama of not having enough time to carry out the adequate management of the resources of health.

In this sense, the lack of efficient management due to this surprising scenario resulted in deaths that could have been avoided, according to local authorities. Thus, a philosophical inference that can be drawn is that it is not possible to escape the tragedy of life. Living contains risks, and perhaps the biggest in recent years has been the possibility of being infected by the coronavirus, a highly lethal, transmissible virus responsible for the collapse of countless health systems worldwide. Among the most common symptoms presented by infected patients was shortness of breath. The death of infected patients often resulted from asphyxiation. However, if the patient was assisted, the resources made available, and even so, the supervenience of death occurred, death could be understood as inevitable. However, what to say about patients who died due to asphyxiation without being offered medicinal oxygen, for example.

In Brazil, this reality imposed itself, making the pandemic outbreak even more tragic. The resources in the health field are generally scarce because demand is more significant than supply, and in times of a pandemic, they inevitably become scarcer. This is an elementary conclusion that points to the need to adopt coordinated actions, called macro allocation of scarce resources. In urgent and emergency situations, such as natural disasters or pandemic outbreaks, these actions are part of the powers of the Chief of the Executive Branch. When the acute crisis reaches the entire Brazilian society, that is, it affects the various federative entities, as occurred in the pandemic, the responsibility falls on the nation's representative, the head of the federal government, who must be able to coordinate, through the Ministry of Health, efficient response to society, capable of guiding the other federative entities, based on scientific evidence, based on guidelines adopted by the World Health Organization, in the establishment of policies for the macro allocation of resources and in the implementation of measures to minimize the damage and, above all, to mitigate the suffering of the population.

In this sense, it must be remembered that Brazil had an advantage over Asia and Europe, as the virus reached the people of those continents first. There was an interval of time until the collapse experienced in Italy, for example, took hold in Brazil. This interregnum could have served for the Brazilian government to monitor the evolution



of the virus in those countries and map the weaknesses of the Brazilian health system, recognizing the vulnerabilities of the sector. This interval could have served for the federal government to strategically call for the participation of Brazilian scientists and researchers, for them to ally themselves with the scientific community and research centers, recognized internally and internationally for the level of excellence of the work they carry out, so that it would help with the establishment of measures that were capable of mitigating the damage caused by the virus.

It should be noted that the effective reduction of suffering is not required since it would be unreasonable to demand it since the notion of suffering is fundamentally subjective. However, what is being complained of is that the federal government, based on the concept of good governance, leadership, and efficiency, should adopt macro-allocation measures of scarce intensive care resources, capable of guiding States and Municipalities in the micro-allocation of scarce resources, such measures as, for example, risk classification criteria for the care of critically ill patients. This was not the attitude of the federal government.

Despite being previously notified by the Federal Public Ministry of the tragedy that was announced in Manaus with the lack of medical oxygen supply, the federal government maintained its hostile, disrespectful, and abusive behavior not only with the scientific community and the press but, above all, with the patients and their family members. A denialist, he publicly rejected the adoption of one of the most elementary, modest, and effective measures to combat the spread of the virus, that is, the use of protective masks; deliberately brought up crowds; compared Covid-19 to a “little flu”; declared that although he called himself the Messiah, he did not perform miracles “if he [the patient] dies, patience”; simulated, during a YouTube live, what would be death by asphyxiation without any sign of solidarity, empathy or regret; publicly defended the ineffectiveness of the vaccine by personally rejecting immunization.

It is inevitably concluded that the government refrained from acting when it had an ethical, political, and legal obligation to do so to avoid the result. Its omission implied a direct violation of the patient’s human right not to be subjected to cruel, degrading, or inhuman treatment, thus giving rise to accountability for a crime against humanity before the International Criminal Court as a measure not only of justice for patients and victims of death by asphyxia, as well as respect for Bioethics and the Patient’s Human Rights.

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