DOI: 10.1590/1413-812320232810.09272023EN

The view of Ethics and Bioethics on the health worker and health work in the context of the COVID-19 pandemic in Brazil

Swedenberger do Nascimento Barbosa (https://orcid.org/0000-0002-6231-2291) [1]

Abstract *The article is about ethics and bioethics with a focus on the health worker and health work in the context of the pandemic of COVID-19 in Brazil. It brings in an unprecedented debate on social and economic inequalities, evidenced in the world, regarding access to vaccines, medicines, tests, PPE, among others, which brought suffering and death. The dispute for these products occurred on a global scale and producing countries closed their markets and commercial dependence led to dramatic situations. During the pandemic, several ethical issues were evidenced: conflicts, dilemmas, and ethical infractions occurred in different situations, such as in health care settings, in the relationship between managers and health care workers, within health care teams, and between health care teams and society. The article also brings the polemic debate whether the deaths caused by COVID-19 in Brazil should be seen as biological or social phenomena: fatality, homicide, mysthanasia or social euthanasia. The article concludes that in public management it is imperative that the Ethics of Responsibility and Humanization of Care be applied. In this context of uncertainties and challenges for humanity, it is fundamental the participation of society around an agenda guided by ethical principles, human dignity, environment, and democracy, with inclusive public and economic policies.*

Key words *Ethics and bioethics, Worker, Health, COVID-19, Debate*

[1] Universidade de Brasília. Asa Norte. 70910-900 Brasília DF Brasil. berger. barbosa06@gmail.com

Fiocruz research on healthcare professionals during the COVID-19 pandemic revealed frightening and cruel invisibility in institutions, which led to illnesses, work-related discouragement, and hopelessness.
Maria Helena Machado

Introduction

The magnitude of the COVID-19 pandemic crisis is that of unprecedented systemic threat to human life that knows no borders. We are dealing with an economic, sanitary, and humanitarian crisis, all at once, as we experience scenarios of risk to health, safety, food conditions, and living conditions.

Its short-term, medium-term, and long-term effects on health, economy, and social interaction will have a direct impact on the health system, exposing vulnerabilities and challenges to existing social welfare in several countries[1].

Global and joint actions, such as the Covax Facility, unfortunately accounted for less than 20% of all vaccine doses contracted worldwide. Unequal access to vaccines, medication for hospitalized COVID-19 patients, tests, PPE, breathers, etc. resulted in suffering and death. The race for these products took place on a global scale, and producing countries closed their markets. Commercial dependency in this case reached dramatic levels. In Brazil, states and cities were held hostage by international middlemen who charged outrageous prices for these products; not to mention the occasions in which they sold the products but never actually delivered them[2].

Brazil faced coronavirus at a time when the Unified Health System (SUS) was frail, with sparse resources, underpaid workers under poor working conditions, outdated physical and technological structures, and a series of predatory initiatives designed to deconstitutionalize the SUS model and change it into a "new system", under the control and direction of the private sector. Nevertheless, SUS showed strength and resilience, and attempted to fulfill its constitutional role of ensuring the right to healthcare for all Brazilians.

To conduct an ethical analysis of the pandemic's impacts on the country, it is first important to understand that *anything that impacts welfare or causes suffering, not only to human beings, but to all sentient beings, is an ethical problem*. The way human health and welfare are affected by the etiological agent of a disease, such as SARS-CoV-2, is not the same for everyone[3].

The World Health Organization (WHO) acknowledges these differences and associates them with a person's living and working conditions; with other social, economic, cultural, and ethnic/racial factors; with living conditions, diet, education, and income; among others. According to Whitehead[4], all health differences between the best and the worst performance in indicators for the different socioeconomic groups represent health inequities, including unhealthy and stressful work[4].

In Brazil, these differences may be found throughout the country. In large urban centers, slums concentrate environmental characteristics conducive to the rapid spread of coronavirus.

According to the Brazilian census conducted by the Brazilian Institute of Geography and Statistics (IBGE, 2010), these areas are characterized by irregular water supply, poor garbage collection, and open sewage. These conditions reveal a scenario of extreme social vulnerability; turn slums into preferential victims of diseases, including cholera, dengue fever, Zika, and tuberculosis; and produce precarious health indicators. With COVID-19, the result could not have been more devastating[5].

According to the COVID-19 Social Impact Observatory, along with the Unifying Panel for Covid-19 in Slum Regions, and the Socioepidemiological Bulletin of COVID-19 in Slum Regions, organized by Fiocruz, information obtained by local leadership in partnership with primary healthcare (PHC) units, recorded deaths that were invisible to society, as their magnitude is not represented in official statistics[6,7].

Regarding the implications of the neoliberal model on healthcare professionals' work conditions, even prior to the onset of the COVID-19 pandemic, researchers indicated problems with regard to the health-disease process for the workers involved, which are followed by weakened rights, reduced social protection, and precarious work positions[8]. Vizzaccaro-Amaral[9] points out that the socioeconomic problems during the pandemic, with tragic implications for the workers' environment and health, reflect the escalation of a pre-existing problem, which, in his analysis, is the structural crisis of contemporary capitalism[9].

Fiocruz decided to investigate this universe of workers who constitute the healthcare workforce in the context of the pandemic. The studies "Healthcare professionals' work conditions in the scenario of Covid-19 in Brazil" (main research)[10] and "Invisible healthcare workers: work conditions and mental health in the scenario of

Covid-19 in Brazil" (subproject)[11] unveiled these workers' realities. Many of them, while working in the frontline to combat the COVID-19 pandemic, are rarely viewed as such by society. These are nursing, oral care, X-ray, laboratory and clinical analysis technicians and aids, community healthcare agents, and endemic disease control agents. This workforce also includes stretcher bearers, ambulance drivers, maintenance and operational support teams, cleaning and kitchen teams, and administrative and management teams, who do not even have a "healthcare professional citizenship".

As the research coordinator explains, "consequences of the pandemic for this group of workers are much more unfortunate. These are people who work mostly by silently following orders and are completely invisible to management, to their direct supervisors, to the healthcare system as a whole, and even to the users who seek assistance and care. Therefore, they are devoid of social, technical, and labor citizenship".

These studies included the participation of 15,132 healthcare professionals and 21,480 invisible healthcare workers from over 2,300 cities in all regions of the country. Results were only achieved with strong support from the National Health Council (*Conselho Nacional de Saúde* - CNS) and the National Health Secretary Council (*Conselho Nacional de Secretários de Saúde* - CONASS) and with the engagement of unions and agencies that work in defense of workers' rights.

Fiocruz research results indicate that 53% of "invisible" healthcare workers feel unprotected from COVID-19 at work. (Chart 1). This number is slightly lower for workers with college degrees (43%). The generalized fear of contamination affects 23.1% of the invisible workers, as compared to 18% of all healthcare professionals. The lack, scarcity, and inappropriate use of personal protective equipment (PPE) affects invisible workers (22.4%) and healthcare professionals (23%) in a similar manner. Other items researched, such as the absence of the required structures to conduct the work, were mentioned as the main reasons for feeling unprotected (12.7% and 14.9%, respectively). Very similar data were found regarding gender distribution: 72.5% female vs. 22.6% male, among the invisible workers; and 77.6% and 22.1%, respectively, among healthcare professionals; with the predominant age group (36 to 50 years of age) showing results at 50.3% and 44%. A strong disparity that should promote an important debate about the healthcare workforce is that related to color/race and socioeconomic conditions. For the first criterion, among invisible workers, 59.1% are black or mixed race, and 36% are white. Among healthcare professionals, 57.7% classify themselves as white, while 39.9% are black/brown race.

On November 12, 2020, during the 73rd World Health Assembly, which took place remotely in Geneva, the WHO recognized the "sacrifice and dedication of millions of workers in the industry" in the frontline of the fight against the pandemic, and designated 2021 as the International Year of Health and Care Workers: "Healthcare workers play a key role in ensuring the population's health and welfare". In unison with the WHO, the two UNESCO Ethics Commissions (IBC and COMEST), in 2020 and 2021, approved declarations that recognized, among other aspects, the role of healthcare workers in combating the pandemic, and the bioethical and ethical perspectives of science and technology, rooted in human rights, as a fundamental ethical framework to combat the COVID-19 pandemic[12,13].

The adjustment to Brazilian parameters of UN/WHO/UNESCO guidelines regarding the ethics applied during the pandemic in Brazil was conducted by the Brazilian Bioethics Society (*Sociedade Brasileira de Bioética* - SBB), with two recommendations to public administrators[14,15].

Moral dilemmas and ethical conflicts

In discussing the "Moral dilemmas of Brazilian public management in facing the new coronavirus pandemic", Santos[16] identified six topic areas as dilemmas: 1) social distancing; 2) use of big data to manage the pandemic; 3) actions of healthcare professionals; 4) federal emergency assistance and bureaucracy; 5) suspension of classes and on-site educational activities; and 6) release of prisoners as a preventive measure. Santos[16] discussed the ethical perspective of each of the areas and explained that, in crisis scenarios, citizens and public administrators are demoted from their statuses, which leads to the development of new forms of moral reasoning: "These issues require continued reflection and debate on the ethical aspect of the pandemic, especially regarding the social and moral obligations of governments and the limits of this interference on citizens' individual rights during a crisis period". She concludes: "acknowledging and understanding moral dilemmas may produce opportune tips for developing best management practices for public organizations"[16].

Chart 1. Lack of protection in the work environment against COVID-19, Brazil.

Health Professionals		
Feeling of protection at work against COVID-19	No	43.2%
Reasons	Lack, scarcity, and inappropriate use of PPE	23.0%
	Widespread fear of being infected: at work through contact with patients and colleagues with suspected COVID-19	18.0%
	Inadequate structures and infrastructure for work	14.9%
	Inefficient hospitalization flow, creating chaos in care	12.3%
	Technical unpreparedness of professionals to act in the pandemic	11.8%
	Management insensitive to the needs of health workers	10.4%
Invisible Heathcare Workers		
Feeling of protection at work against COVID-19	No	52.9%
Reasons	Widespread fear of being infected: at work through contact with patients and colleagues with suspected of COVID-19	23.1%
	Lack, scarcity and inappropriate use of PPE	22.4%
	Inadequate structures and infrastructure for work	12.7%
	Technical unpreparedness of professionals to act in the pandemic	10.0%
	Management insensitive to the needs of health workers	8.0%
	Inefficient hospitalization flow, creating chaos in care	7.2%

Source: Research "Conditions of the Work of Health Professionals in the Context of COVID-19 in Brazil" - ENSP-CEE/FIOCRUZ, 2020/2021, and Research "Invisible healthcare workers: working conditions and mental health in the context of COVID-19 in Brazil" - ENSP-CEE/FIOCRUZ, 2021/2022.

By categorizing bioethics as an essential area of knowledge to be considered in the public health scenario, the author states that individual and collective welfare is one of the public health activities to which bioethics can significantly contribute. The challenge is not that of imposing restrictions on individual freedoms, but that of focusing on collective interests and formulating public policies, carefully based on an ethical perspective. Bioethics, much like applied ethics, is concerned with analyzing moral arguments for and against certain practices that impact the quality of life and well-being of humans and other living beings and the quality of their environments, as well as with decision-making based on these analyses[17].

German Jewish philosopher Hans Jonas[18], in studies on human behavior in the face of access to new technologies, defended the need and urgency of formulating a Theory of Responsibility as a new ethical principle that guides contemporary men (at his time) toward preserving the human integrity and essence of future generations. In this construction, he distinguished and classified the *Ethics of Responsibility* in the individual, public, or planetary dimensions. The first dimension – individual ethics – addressed behaviors that individuals should adopt for themselves and towards others. The second dimension emphasizes *Public, State, and Government responsibility towards their citizens*. The third dimension is a call to all to defend the planet and mankind, identifying this as the ethics of planetary responsibility[18].

For Jonas, the concept of *Responsibility* concerns the care of other beings, which, given the threat to their vulnerability, becomes a concern associated with the human condition of being able to care. According to Jonas, *responsibility is the value that should guide practical actions*. Therefore, the idea of *care as an obligation* must be an essential aspect of action (such as a moral action), considering the permanence of future generations on the planet when confronted with the challenges faced by the technical-scientific society.

In this sense, the debate must include the Public and Political Responsibility perspective, as defended by Jonas. In a crisis, all political decisions have a great impact, and the potential to modify the course of history. In the case of the coronavirus pandemic public health crisis, action, whether responsible or not, is literally a decision made concerning life and death.

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As Chauí[19] reminds us, an ethical action is that which binds subjects to their praxis and consequences. This refers to the notion of moral conscience, that is, ethical subjects are those who know what they do and what motivated them, and who are responsible for their desire and action[19].

Ethical awareness is a form of being characterized by a series of factors, including: being sensitive to ethical conflicts; recognizing their meaning and importance; identifying the ethical issue discussed; reflecting and capturing the different points of view and the limitations of the moment; and having the courage to deal with beliefs and the potential for criticism. This awareness allows the transposition of concepts learned in theory to proper application in practice, constituting self-reflection[20].

During the COVID-19 pandemic, several ethical issues were identified. Conflicts, dilemmas, and ethical violations occurred in different situations, such as healthcare environments (SUS and private sector), in the relationship between managers and healthcare professionals, within healthcare teams, and between these and society. The ethical responsibility of public power, particularly executive power in this scenario, was identified and discussed by some authors.

Cruz *et al.*[21] provides an overview of the emergence of ethical conflicts in managing the COVID-19 pandemic, viewing these conflicts at different levels of reach: a) in defining the main guidelines for containing the spread of SARS-CoV-2; b) in allocating resources to face the pandemic and its effects, taking into account the need to acquire and provide a significant volume of materials and equipment, primarily intended for the treatment of people; c) in communicating, institutionally or in the media, actions with lower or higher effectiveness in infection control; d) in reallocating healthcare professionals, based on urgency or regional interests; and e) in providing funding for the acquisition or production of vaccines, and prioritizing the care to specific populations and patients[21].

Garrafa and Amorim[22] discuss whether deaths caused directly or indirectly by COVID-19 in Brazil must be viewed as biological or social phenomena. Fatality? Homicide? Misthanasia? Social euthanasia? In the authors' opinions, the Brazilian government took no action to protect or strengthen SUS in the fight against the pandemic, or the care for the lives and health of professionals who are in the frontline, exposed to greater mental health, infection, and/or death risks. In addition, it is argued that the Brazilian government was omissive regarding the protection of vulnerable social groups and the at-risk population. Therefore, they mostly attribute to the federal government the practice of misthanasia, referring to the deaths of people who are socially excluded and die due to a lack of appropriate health care or an omission by the State[22].

The authors deal with the situation of health professionals in this light:

The effects of COVID-19 on the healthcare workforce, especially those who are in the frontline, in addition to the evidence described, are accentuated by the deprivation of social interaction among co-workers, the deprivation of the freedom to come and go and social life, and the deprivation of family life[22].

With no adequate responses to their demands, healthcare professionals were victims of actions and duress. Ethical violations are evidenced in some discoveries that came to public light during the Senate's Parliamentary Committee of Inquiry (CPI). The testimony of Prevent Senior's ER doctor, Walter Correa de Souza Neto, was a striking example at the CPI. He confirmed attorney Bruna Mendes Morato's statement (representing 12 Prevent Senior doctors) to the CPI that doctors had no autonomy and that patients were given a "covid kit", with a "pre-made prescription" for treating COVID-19. Doctors were forced to prescribe the "covid kit" starting in March 2020, thus enforcing the company policy of a model focusing on costs rather than the well-being required by the patient[23].

Bioethics and collective health entities repudiated these and other acts practiced with no compliance with science and ethics in medical prescriptions, research conducted with no approval by ethical committees, disposal of medication without the patient's knowledge, altering of data in death certificates, and breaching the confidentiality of patient data[24].

Unfortunately, the final report of the Senate CPI on the pandemic, despite containing serious accusations of accountability to public and private agents, found no echo in actions being taken by the government. As an aggravating factor, in recent decisions (July 2022), the Office of the Attorney General understood that government authorities must not be considered as liable for the problems and accusations presented.

The Front for Life, a movement that has brought together the National Health Council (CNS), several scientific organizations, and worker unions, among others, since the begin-

ning of the pandemic, has been demanding the Senate CPI results. They have also reinforced the need for public agents, through action to combat COVID-19, to give priority to the physical and psychosocial protection of healthcare workers and those who work in other essential areas[25]. It is important to note that several bills on this subject have been submitted to the National Congress for special attention to COVID-19 victims.

During this pandemic period, whenever the Brazilian Supreme Court (STF) was asked to stand its ground, it has, to date made important decisions instructing the maintenance of constitutional rights regarding the universal right to healthcare, the organization of SUS, and the balance of federal relations[26].

In public administration, it is equally important to affirm that the adoption of the CONASEMS Ethics Code[27], by which municipal health administrators made the public commitment around some principles, such as Integrity, Respect for people, Transparency and clarity in positions, Efficiency, and Professionalism, constitutes a breath of fresh air for best practices in public service, especially in SUS[27].

In the management of public policies, and especially of the SUS, it becomes imperative that the Ethics of Responsibility and Humanized Care be applied. Therefore, in this detailed scenario of concerns, uncertainties, and challenges to humanity, the involvement of civil society in an agenda of ethical principles, respect for human dignity, preservation of the environment, and stronger democracy, with inclusive public and economic policies, becomes critical. Answers such as these, validated by science, and universal health systems, such as SUS, based on Ethics of Public Responsibility practiced by public agents that deal with human life and its environment, with the protection of society and the workers, can make the difference toward the formation of a better world.

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Article submitted 20/10/2022
Approved 01/06/2023
Final version submitted 14/06/2023

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva