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Allocation of Resources and Health Professionals' Burden During the Covid-19 Pandemic: Reflection on Advanced Directives, Informed Consent, And Social Perception in Mexico

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ABSTRACT

One of the main problems in the COVID-19 pandemic is the insufficient availability of resources. This deficiency has resulted in emotional and moral burdens of health professionals. Decisions are having to be made as to who will live and who will die. Moreover, given the global impact of this pandemic, negative impacts are heightened in low and middle-income countries such as Mexico. Authors focus on two issues related to, but not exclusive, to the Mexican healthcare system in an attempt to partially address scarce resources and health professionals' burden. First, is the empowerment of patients' autonomy through the incorporation of advanced directives (i.e. non-resuscitate order, the use of intensive care unit and/or ventilator) within informed consent. And second, the socio-cultural perception of risk as relevant for public engagement on protective behavioral patterns. We argue that addressing these issues could possibly lessen the burden of healthcare professionals and bring about greater autonomy among the public.

Introduction

The COVID-19 pandemic has proven to be one of the most extreme emergencies in modern public health. As such, it has challenged healthcare systems around the world. While we have seen some successful approaches to COVID, it is possible to find important flaws that have a direct and negative effect on morbidity and mortality even in the wealthier, more advanced and developed countries. One of the key persistent global problems within health systems is the insufficient availability of resources (hospitals, Intensive Care Units (ICU), protective equipment for health professionals, ventilators, etc.). This significant deficiency or treatment gap (i.e. between the treatment required and the treatment provided) has resulted in a significant moral burden on health professionals because of the constant medical decision-making of surrounding who gets to live. These psychological and moral demands go beyond the ordinary training skills of the majority of health professionals, and therefore make them vulnerable to mental health disorders (Jianbo Lai, et al., 2020).

Accordingly, a variety of frameworks and guidelines have been developed to improve medical and ethical decision making (i.e. distributive justice, autonomy, etc.), and to diminish emotional and moral burdens of healthcare professionals (Gostin, 2020) (Emanuel, et al., 2020). Nevertheless, despite substantial efforts, ethical needs or gaps resulting from the COVID-19 pandemic remain. There is no consensus on how to ameliorate them.

Moreover, amidst the unprecedented global impact of COVID-19, there are more vulnerable contexts. These include the reality and inequity of low and middle-income countries (LAMIC) characterized by lower economic growth, under sourced and insufficient healthcare systems, political systematic failures, apathetic and erratic governmental responses, and poor social engagement on restrictive measures. Mexico is an example of a LAMIC (Litewka and Heitman, 2020). Thus, the issues raised are whether and how to ethically address the increasing and overwhelming medical and moral demands in disadvantaged and more vulnerable populations and healthcare systems, expected during the COVID-19 pandemic. This question should not be taken to confer that in a LAMIC's such as Mexico's healthcare system, there are no ethical models or different ethical principles. Rather, we submit that the COVID-19 crisis is embedded in a complex and complicated context and those have to be taken into account when the goal is to further patients' good, improve healthcare professionals' well-being, and promote public health. Hence, reflections of the local LAMIC's ethics, society, and culture are needed in constructing a viable response.

Patients' Autonomy and Socio-Cultural Perception of Risk

More complex settings need prudent and practical reflections that align with the local ethical and socio-cultural context. These should enable plausible guidelines to facilitate medical and moral decision-making. Moreover, these reflections could be applicable in other healthcare systems - inclusive of the developed world, not only for the COVID-19 pandemic, but for future similar situations and/or pandemics.

The required reflections should be based on the current global information of COVID-19 in different domains such as the (a) global analysis of the natural history of COVID-19 and prevention, contention, and mitigation responses, (b) scientific facts, even if partial, iterative, or unknown, (c) local availability, accessibility, and quality of resources, (d) socio-cultural perception of risk as relevant to safe-protective behavioral patterns and public anxiety, (e) affected populations including communities in extreme poverty, persons with chronic diseases, children, pregnant women, senile adults, indigenous people, migrants/refugees, imprisoned convicts, persons living in domestic violence situations and mental health patients, (f) respect on human rights, and (g) rigorous bioethical principles such as human dignity.

This paper focuses on two specific issues related to, but not exclusive to, the Mexican healthcare context and system. It is believed that this focus could be relevant in partially addressing the treatment and ethical gaps during this medical and humanitarian crisis as it relates to empowerment of patients' autonomy and socio-cultural perceptions of risk.

Advanced directives within informed consent: How valid? How valuable?

Advanced directives (AD) and Informed Consent (IC) are processes for patients to exercise their right of autonomy. Both processes should be used, and if necessary, adapted during the pandemic. In Mexico, usually the IC is signed by the patient (or surrogate) during the immediate stages of hospitalization. The inclusion of AD within the IC process (for COVID and non-COVID patients) would not only anticipate patients' end of life wishes when relevant, it would also reduce the emotional and moral burden on health professionals and patients' families by releasing them from the difficult task of making end of life decisions. To illustrate, it has been argued that addressing a non-resuscitate order (NRO) during the COVID-19 pandemic is important in order to be diligent with patients' values and goals of care (Curtis, et al., 2020). Nevertheless, there are additional issues that require patients' involvement through AD and that would promote resource maximization and allocation during triage, such as patients' desire to reject the use of ICU and/or ventilators. The preference of palliative care at home could also be included. Since 2008, AD has been legally regulated in Mexico. However, only 14 states (out of 32) have adopted it, and scarcely around 10,000 persons have used this document since then (López, 2019). This poor social engagement[1] calls for a more precise, prudent and proactive inclusion of patients' values and preferences when discussing directives regarding NRO, ICU and/or ventilator at least during this pandemic. This could be a valid and valuable ethically sound approach to maximize resources through patients' autonomy and thereby diminish health professionals' emotional burden.

Socio-cultural perception of risk as relevant to health professionals' burden

Socio-cultural context shapes social perception of many health-related concepts, including risk (Glimcher and Fehr, 2014), which is key during a pandemic. For instance, recent studies indicate that indifferent or contradictory behaviors or attitudes from leading governmental authorities are instrumental for developing a sense of insecurity, misperception of risk, and social mistrust (Jang, et al., 2020). This is consistent with recent reports in Mexico regarding the implementation of quarantine specific restrictions by the Mexican government as compared to the President's discrepant and contrasting attitudes, statements and/or behaviors such as opposing physical proximity behaviors (Grillo, 2020), among others. Accordingly, national polls reveal a significant decrease in public acceptance of the President and his government, as a result of their erratic public communication and deficient approach to the pandemic (El Economista, 2020).

Another significant factor in social perception of risk is the infodemic[2] phenomena in social media, which can generate anxiety and behavioral ambivalent patterns (Cinelli, et al., 2020). In Mexico, the infodemic problem since the pandemic outbreak alert, has been pervasive across society and as a result, it has become one of the countries with more "fake news" after Turkey (UNAM, 2020). Moreover, misinformation under conditions of social stress, have nested unexpected violence against health professionals and hospitals (Miranda, 2020)[a] (Miranda, 2020)[b], requiring deployment of federal law-enforcement officers (Gobierno de México, 2020). Thus, the context of misperception of risk in Mexico during the COVID-19 pandemic, is not only increasing health professionals' emotional burden and compromising their medical performance and decision-making (Grupe, 2017), but is amplifying previous social distress and instability. In light of this, addressing governmental assertive responses (or at least non-contradictory), and collaborative alliances with the World Health Organization efforts to combat misinformation related to COVID-19 (Zarocostas, 2020), could lead to a more realistic risk perception and thus improve social protective behavioral patterns.

1 Engagement as the correct understanding and positive interaction of society. In this case, with AD.

2 Intensive widespread of mixed and contradictory information hindering decision-making analysis

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Discussion

Although different countries and cultures face diverse challenges when approaching COVID-19 treatment and ethical gaps, united efforts should strive to be compatible with human rights such as respect of human dignity and should balance between the ontological principles of medicine and public health. In essence, patients *and* the community should experience safety.

Also, it is important to be mindful that resource allocation should never replace the medical criteria based on who are most likely to benefit medically. This benefit can be partially directed by patients' values and goals of care, as well as by their desires on end of life. Fostering ethical tools such as specific directives on NRO, ICU and/or ventilators through AD within the IC, could improve ethical allocation of resources and alleviate health professionals' burden through the proactive empowerment of patients' autonomy.

On the other hand, authors posit that although developing countries are economically disadvantaged and unprepared for disease pandemics, their utilization of social risk perception could also be a valuable and viable tool. For instance, social perception of risk proved to be an important positive factor in Mexico during the 2009's H1N1 influenza pandemic. At the time, the Mexican population trusted the president Felipe Calderón and political leaders. This trust resulted in strong public engagement and support thereby resulting in collaborative national efforts to effectively address the pandemic (Litewka and Heitman, 2020). Although the COVID-19 pandemic is different in many ways, it is believed that vulnerable countries such as Mexico -and other LAMICs would be benefited by strong political leadership that addresses risk perception and reduces infodemics.

In sum, we believe that a more proactive inclusion of ethical tools and social engagement during this global health emergency will promote the patients' good, healthcare professionals' well-being, and public health. Also, we believe that the inclusion of ethical and social reflections from other countries and cultures could grant complementary information to improve global public health efforts.

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