Bioethical Guidelines of 'Extreme Triage' Under Covid: The Question of 'Possible Lives' in Latin America

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Assuming a shortage of medical resources to treat patients with Covid-19, many countries in Latin America have discussed or established bioethical guides for limited resource allocation in the case of a public health emergency or what is known as 'extreme triage'. Under a principle of social justice, these guides propose to allocate resources to save as many lives as possible. Countries such as Chile, México, Argentina, Colombia, Brazil and Uruguay have discussed the establishment of triage teams to administer scarce resources based on two main criteria: the possibility that a patient will improve and survive (that is, the presence vs the absence of co-morbidities) and the time the patient will take to recover. In many countries, the additional recommended principle is to allocate resources to those who can have more years of life saved. That is, younger patients.

An emergency resource allocation strategy certainly involves abandoning the Hippocratic Oath, the idea of equality between people and the sacredness of life. However, in a crisis like the one we are experiencing now, health professionals require direction to proceed in the event of facing limited resources in a scenario that seems inevitable. Bioethical procedures need to be discussed and agreed before impromptu and discretionary decisions are made by health professionals overwhelmed by the physical and emotional burden of the current crisis. Helen Ouyang (2020), a New York emergency department doctor, vividly describes her experience in the midst of the pandemic as hospitals get flooded by patients, dead and alive (https://www.nytimes.com/2020/04/14/magazine/coronavirus-er-doctor-diary-new-york-city.html). Her experience demonstrates the need for bioethical guidance on 'extreme triage' for those at the front of the pandemic risking their own physical and emotional lives to save the lives of others. However, there is also a need to question some of the assumptions behind these triage guidelines.

Bioethical triage guidelines have sparked a heated debate across the globe (Del Missier, 2020). Bioethicists have been accused of playing god by deciding who deserves the chance to live and who doesn't. In many countries, public opinion has forced bioethicists to rewrite and retract many of the recommendations for limited medical resource allocation. Many complaints have been directed towards the utilitarian ethics that often inform 'extreme triage' guidelines that proposes the allocation of scarce medical resources with the sole idea of saving as many lives as possible. The most prominent criticisms were focused on age discrimination. For instance, in Mexico, some went as far as comparing the bioethical triage guidelines to Nazi's atrocities against those perceived as old or ill (Miranda, 2020). In Argentina, a group of bioethicists questioned age as a factor in decision making since a young individual can suffer from more severe pathologies than an older one, and therefore be less likely to survive the virus (Woites, 2020). In contrast to the outcry over what many perceived as age discrimination, little has been said about comorbidities as a factor that would make someone less likely to survive. This is especially problematic as there is growing evidence to suggest that many chronic diseases are not simply the result of a genetic makeup or individual choices, but are instead deeply linked to poverty, systemic racism, structural violence, and lack of care (Burnett, et al, 2020). Failing to look at the pre-existing conditions of our health systems and the

struggles of those suffering from chronic diseases before Covid-19, could easily imply that critical medical resources are denied to those for whom the state has already failed to protect. As Palmer (2020) suggests when highlighting how wellness is increasingly being presented as a lifestyle choice, 'even before the pandemic, they [the chronically ill] had been used to the medical system giving up on them before they were given a chance'. Moreover, many of those that are being identified as particularly 'at risk' of Covid-19 are being denied the care they regularly receive as surgeons or hospitals find themselves overwhelmed by the Covid-19 crisis (Manderson and Wahlberg, 2020). Given the economic toll of the pandemic, it seems unlikely that health care systems around the word will be able to maintain [in many countries, already inefficient] pre-Covid-19 levels of care for patient groups.

As a society, we decide on the allocation of resources on a daily basis. Triage guidelines have merely illuminated a series of ethical shortcomings that pre-exist the crisis. Even as guidelines state that criteria such as race, gender or class will not be taken into account when deciding how to allocate limited medical resources, these categories are certainly involved in the configuration of health disparities, and therefore, on the likelihood of someone surviving the virus. Since 2015, Latin America has seen a serious increase in poverty rates and extreme poverty that has had a direct effect on health inequalities (Abramo, Cecchini and Ullmann, 2020). Covid-19 has exposed the extent of such inequalities across the Latin America region. For instance, there are disproportionate rates of infection and death among indigenous peoples. As of May 18th, there were up to 20,000 confirmed cases of Covid-19 among indigenous peoples from the Amazonia and in its 2,400 territories across eight countries (OPS, 2020). Black Brazilians are said to be 62 per cent more likely to die from the virus than whites, not only because of unequal access to health services but also because of the close correlation between race and chronic diseases such as diabetes and hypertension (Barrons, 2020). Woman constitute up to 70 per cent of health workers across the region, they are not only at the front of the pandemic but are also the target of attacks by those fearing contamination (UNFPA, 2020). In some cases, domestic violence is taking more women's lives than Covid-19, and women are disproportionately taking the burden of domestic and care work during lockdown (Regnér, 2020). Finally, migrants, refugees and displaced people are also being disproportionately affected by Covid-19, not only because of stigmatization in host countries but also because of the impact of border shutdowns that have left thousands of people trapped, without basic needs for survival (Segnana, 2020). A bioethical approach to the allocation of medical resources under Covid-19 must take into consideration. Many of the bodies marked as 'more likely to survive the virus', were previously configured by colonial histories of racism, violence and dispossession (Yates-Doerr, 2015; Gálvez, 2018; Mendenhall, 2019). As Barnes et al. (2015:11) suggest, 'care always has a past and how we respond to past injustices is one of the largest ethical questions we need to face'. Bioethics must engage with our regional past in order to address our present and future practices of care.

Covid-19 doesn't exist in isolation and requires that we consider social and structural conditions also as pre-existing and problematic (Mendenhall, 2020). Some of these conditions are embodied by individuals (i.e. age or comorbidities) but others are found in institutional practices and policy approaches to address Covid-19. A pre-existing condition could be found in the current denigration of our health systems or the so called 'care deficit' as the effect of the international migration from Latin America. However, another pre-existing condition could be the place of bioethics in the region and the low impact that research has had in policy making (Garcia et al., 2019). We must confront the possible limits of bioethics to account for the political nature of the new place that science and medicine have in the world of politics in order to face unexpected challenges such as Covid-19 (Hernández Martínez, 2019).

Bulcock (2010) describes the general features that distinguishes Ibero-American from American bioethics. She identifies the communitarian character of the former versus the individualistic or autonomy-centred of the later. The author looks at central role of physicians and theologians in the development of an Ibero-American bioethics that identified itself as a social and political movement. In contrast, the establishment of American bioethics was institutionalized by academia and

philosophy departments. Some Latin American theoretical approaches assert to such distinction. For instance, complex, intervention and protection bioethics are all theoretical models critical of individualistic and autonomy-centred approaches and all engage with a broader view of bioethics capable of encompassing human rights, public health and social inequality (Schramm 2008; Goldim 2009; Port and Garrafa, 2009). However, confronting Covid-19 from a bioethical approach requires us to problematize the very notion of community before and after the crisis. Following Esposito, we must rethink the basis of our political and social relations to unveil how, in the name of the 'common', we have reactivated the worst forms of structural violence (Bird and Short, 2013). Mestizaje, as the foundational myth found in many of the region's national histories, is one example of how in the name of a 'common' origin, indigenous, black and Asian ancestries were to be violently and progressively erased from national identities. Mestizaje is still today the logic that works to deny the persistence of racist practices across many countries in Latin America through the idea that we have all a common past and we are all mixed (Moreno Figueroa, 2010).

In the post-pandemic world, bioethics must go beyond procedures and ethical committees to fully understand the challenges ahead. Following Esposito (2020), Covid-19 presents a particular biopolitical dynamic that manifests in three particular features: the change of focus from individuals to population segments (i.e. identification and surveillance of 'at risk' and 'a risk' groups); a process where politics becomes medicalized and medicine gets politicized, and finally, the increasing entanglement of political and biological life that allows for the transference of democratic action to states of emergency. If we aim to fully grasp the way forward, we must explore the political implications of these processes in our own contexts. For instance, in Mexico, Giovanni López, a 30 year old bricklayer was beaten to death by police officers for not wearing a face mask in public. As Giovanni's unlawful killing shows, police brutality must be seen as another pre-existing condition that complicates the forced implementation of state measures to care for the wider population under Covid-19.

When it comes to the current state of emergency, it is also crucial to think about new and old forms of power in the region and their potential impact when managing the administration of life under Covid19. We must engage with a bioethical approach to the allocation of care not only in times of emergencies, but through the everyday care responsibilities grounded in democracy. As Tronto (2015) suggests 'democracy is not simply giving people a voice. It is giving people a voice in the allocation of caring responsibilities'.

Following a theoretical tradition that attempts to go beyond an autonomy-centred approach to bioethics, we must engage with a democracy centred on care, one that could truly grasp the particular caring needs and obligations of our regional context during and after Covid-19. The series of essays on 'Bioethics and Covid19 from a Latin American perspective' aims to engage with an approach to bioethics capable of encompassing the pre-existing conditions that shape our current experiences in the context of this unprecedented crisis. The texts cover a range of issues deeply linked to the political dimensions of Covid-19, from the racialization of the virus in Chile, to the lessons of international solidarity and cooperation in Cuba. The idea of the series of connected blog posts is to offer a regional approach to a form of bioethics with the power to problematize not only the diverse experiences of managing Covid-19 but also the many common pre-existing conditions that mark some lives as less equipped for survival, as less possible than others. Covid-19 threatens not only those alive but also those whose dead bodies bear the last hope for justice and truth. Finally, as the virus has put into question our assumed superiority as a species and the social contracts that sustain us, we must resist going back to normality and instead reinvent new ways of being in the word.

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