Misthanasia: the story of a pandemic in the United Kingdom

Misthanasia: a história de uma pandemia no Reino Unido

Misthanasia: la historia de una pandemia en el Reino Unido

Ângelo Augusto da Silva Araújo
ORCID: https://orcid.org/0000-0002-0630-1432
University of Porto, Portugal
E-mail: angeloaugusto@hotmail.com
José Rodrigo Santos Silva
ORCID: https://orcid.org/0000-0002-1918-7122
Federal University of Sergipe, Brazil
E-mail: rodrigo.silva@academico.ufs.br
Valéria Aparecida Bari
ORCID: https://orcid.org/0000-0003-2871-5780
Federal University of Sergipe, Brazil
E-mail: valbari@gmail.com
Miguel Ricou
ORCID: https://orcid.org/0000-0002-8190-9587
University of Porto, Portugal
E-mail: mricou@med.up.pt

Abstract
A qualitative and quantitative analysis of the Sars-CoV-2 pandemic, verifying evidence of Misthanasia, even in territories with no lack of human and economic resources, due to the prioritizing of economic stabilization and the naturalization of deaths within the national public policies. As an observational territory, the United Kingdom has had its data produced and communicated in an official manner, in relation to the COVID-19 pandemic, analyzed according to analog and comparative criteria. It was possible to follow the pandemic phenomenon's evolution through time, in virtue of regular collecting and executed under relatively standardized conditions, which allowed us to create an in-panel analytical exposition, having as a comparative model the data collected in Germany, during the same period. The origin of the data sources produced come from the Institute of Health Metrics and Evaluation (IHME); Worldometer Coronavirus. Therefore, it concludes that Misthanasia characterized the course of public policies and the attitudes of the UK's government in sight of the Sars-CoV-2 contamination, exposing citizens to the risks of a disease that shows no class predilections and disrespects estates, and has a strong impact on those who are vulnerable. The naturalization of death configures itself on the primordial aspect of necropolitics and necropower, placing economy over health in different States, in the pandemic phenomenon of global scale.
Keywords: COVID-19; Right to health; Human rights; Social responsibility; Health professionals.

Resumo
Uma análise qualitativa e quantitativa da pandemia Sars-CoV-2, verificando indícios de Misthanasia, mesmo em territórios sem carência de recursos humanos e econômicos, devido à priorização da estabilização econômica e da naturalização das mortes nas políticas públicas nacionais. Como território observacional, o Reino Unido teve seus dados produzidos e comunicados de forma oficial, em relação à pandemia COVID-19, analisados segundo critérios analógicos e comparativos. Foi possível acompanhar a evolução do fenômeno pandêmico ao longo do tempo, em virtude de coletas regulares e executadas em condições relativamente padronizadas, o que nos permitiu criar uma exposição analítica in-panel, tendo como modelo comparativo os dados coletados na Alemanha, durante o mesmo período. A origem das fontes de dados produzidas provém do Institute of Health Metrics and Evaluation (IHME); Worldometer Coronavirus. Conclui, portanto, que Misthanasia caracterizou a trajetória das políticas públicas e as atitudes do governo do Reino Unido frente à contaminação do Sars-CoV-2, expondo os cidadãos aos riscos de uma doença que não apresenta predileção de classe e desrespeita propriedades, e possui um forte impacto sobre aqueles que são vulneráveis. A naturalização da morte configura-se no aspecto primordial da necropolítica e do necropoder, colocando a economia sobre a saúde nos diferentes Estados, no fenômeno pandêmico de escala global.
Palavras-chave: COVID-19; Direito à saúde; Direitos humanos; Responsabilidade social; Profissionais de saúde.

Resumen
Un análisis cualitativo y cuantitativo de la pandemia Sars-CoV-2, verificando evidencias de Misthanasia, incluso en territorios sin escasez de recursos humanos y económicos, debido a la priorización de la estabilización económica y la naturalización de las muertes dentro de las políticas públicas nacionales. Como territorio de observación, el Reino

Unido ha tenido sus datos producidos y comunicados de manera oficial, en relación con la pandemia COVID-19, analizados según criterios analógicos y comparativos. Fue posible seguir la evolución del fenómeno pandémico en el tiempo, en virtud de la recolección regular y ejecutada en condiciones relativamente estandarizadas, lo que permitió crear una exposición analítica en panel, teniendo como modelo comparativo los datos recolectados en Alemania, durante el mismo. período. El origen de las fuentes de datos producidas provienen del Instituto de Métrica y Evaluación de la Salud (IHME); Coronavirus Worldometer. Por tanto, concluye que Misthanasia caracterizó el rumbo de las políticas públicas y las actitudes del gobierno del Reino Unido ante la contaminación por Sars-CoV-2, exponiendo a los ciudadanos a los riesgos de una enfermedad que no muestra predilecciones de clase y falta de respeto a las fincas, y que tiene un fuerte impacto en aquellos que son vulnerables. La naturalización de la muerte se configura en el aspecto primordial de la necropolítica y el necropoder, anteponiendo la economía a la salud en diferentes Estados, en el fenómeno pandémico de escala global.
Palabras clave: COVID-19; Derecho a la salud; Derechos humanos; Responsabilidad social; Profesionales de la salud.

1. Introduction

The new coronavirus pandemic started in Wuhan, China, in December 2019. Since then, it has been causing health systems to collapse in many countries, especially in those that initially belittled the magnitude of Sras-CoV-2's high infectivity, as well as the relation of measures to contain viral infection. (Armocida et al., 2020; Bedford et al., 2020a; Emanuel et al., 2020) The countries that presented better pandemic control and substantial improvement of the morbidity and mortality indicators related to COVID-19 were those that paid attention and did not postpone the execution of measures for pandemic control. Such countries took advantage of the experiences from China (Li et al., 2020; Wu & McGoogan, 2020) and the recommendations of the World Health Organization (WHO), (Sohrabi et al., 2020; WHO, 2020a) fostered the spread of information about personal care, emphasized social distancing, promoted lockdowns, increased the supply of hospital structures, maintained the quota of health professionals, and stimulated the collective mindset of containing the new coronavirus. (Bedford et al., 2020b; Bremmer, 2020; Clark et al., 2020; Stafford, 2020; The Lancet, 2020) All of this has been allowing the gradual reopening of economies in a cautious manner. (Dean et al., 2020; Schumacher, 2020) In contrast, the places that took too long to consider the infectivity, speed, and virulence of the virus, (Emanuel et al., 2020) such as the United Kingdom (UK), which prioritized the belief in herd immunity, (Horton, 2020a; Iacobucci, 2020) account for a vast number of both infections and deaths. (Cohen & Kupferschmidt, 2020; Lasry et al., 2020; Pei et al., 2020)

The UK did not anticipate clear pandemic containment policies, (Cowper, 2020b) and hospitals were not prepared for the sudden growth in demand. During the pandemic's peak, the health sector and its professionals found themselves in an overwhelming scenario and directly suffered the impact of the disease, which has no class distinctions, disregards estates, and reaches all. The most serious consequences are for the most vulnerable, who absorb the aftermath of public management's bad decisions. (Horton, 2020b) We see that there no priorities were established towards collective health, the flattening of the pandemic curve, (Hunter, 2020) and human issues, and the responsibility of life and death was transferred to the whole sector through necropolitics. (Mbembé & Meintjes, 2003)

Considering the issues of necropolitics and necropower, (Misra, 2018) the latter disregards the magnitude of the pandemic and consequently disrespects the principles of human dignity; the priorities are elsewhere. From an article published by the Financial Times, (Parker et al., 2020) it can be conjectured that under economic pressure due to the recent Brexit process, the prime minister (PM) of the UK may have turned to the most advantageous economic management option concerning public funds at the outset to prioritize the economy. This was based on the idea of herd immunity and in the trust in experiences with other flu-like syndromes due to the great risk for economic recession. (Bohoslavsky, 2020) In matters related to necropower, life and human wellbeing are relegated as secondary with a disfigured perception of productivity and disregard of the need to flatten the infection curve. The lack of management has blocked the goal of decreasing demand for healthcare and avoiding its collapse.

Reflecting Byk, (BYK, 2015) all of this political and social contextualization allows us to go beyond to emerging Bioethical arguments that disrupt the principled rigidity of frontier Bioethics. Since the 1990s, Intervention Bioethics has arisen as a new concept in Bioethics in Latin America as a social and scientific phenomenon. (Garrafa & Porto, 2003) Intervention Bioethics seeks to perceive various issues in their social, cultural, and political context and to integrate them in a sentiment that is based on the principles of universality and equity. This concept has foundations in utilitarianism, which guides debates and offers directions of a political and social nature. (Sodeke & Wilson, 2017) In this context, Bioethics brings with it the relation of premature and mournful death of both social and political character, which are observations that ultimately lead to the concept of Misthanasia: mournful, suffering death that could have been avoided for social and political reasons. (Penteado Setti da Rocha et al., 2017)

From this perspective, many citizens in the UK may have lost their lives because of the National Health Service's (NHS's) overcrowding and overburdening of professionals. (Horton, 2020b) Furthermore, due to the greater exposure of those vulnerable to infection, (Sohrabi et al., 2020) deaths occurred that could have been avoided. The quantity of these occurrences and the levels of responsibility are impossible to determine. However, Germany, which is seen by some as the world's model for pandemic control, (Bennhold, 2020) presented a structure of sizeable hospital services in advance, and even with a well-established quota, they managed to plan efficient mitigation policies, which were held up by massive tracking through exams. This resulted in the health sector's passage through the pandemic peak demand pressure, and the fatality rate was lower than in other European countries that had opposing experiences. (Stafford, 2020)

Intervention Bioethics permeates daily matters and expresses itself with Misthanasia. This study offers a qualitative and quantitative analysis based on a miscellaneous, sequential, exploratory, and transformative project (Creswell & Clark, 2015) and a case-study approach. (Yin, 2015) The quantitative procedures involved factual and qualitative observation, as well as the verification of indexes and observed numerical indicators, which were collected and disclosed by official offices. The structure has the objective of analytical integration of data to answer the following question: is it possible that during the observed pandemic period, the proportional fatality of the UK was much higher than Germany's due to the fact that there was an initial belief in herd immunity?

Bioethics is considered as an area whose goal is to amplify the involved vision in diverse matters in this study. Thus, this article proposes data integration with the concept of Misthanasia. This concept was originally suggested for countries with great inequity and marginal socioeconomic development, (Garrafa & Porto, 2003; Penteado Setti da Rocha et al., 2017) but it has been configured with the notion of Expanded Frontiers of Death. With the purpose of answering this question while integrating Misthanasia, a comparative analysis is presented using data from the UK and Germany. This dialectic formation of qualitative and quantitative research involves social, political, epidemiological, and philosophical factors. A synthesis is established that could guide future administrators to a more complex vision in a timely manner to avoid the loss of human lives being normalized for whatever reasons. The study also provides an analytical induction for other locations.

2. Methodology

This quantitative and qualitative research is based on a miscellaneous, sequential, exploratory, and transformative project (Creswell & Clark, 2015) and a case study method. (Yin, 2015) It is grounded in philosophical, axiological, and methodological assumptions with interpretive foundations related to social constructivism and transformative structures from a Bioethical perspective. Its objectives are descriptive and explanatory based on a situational diagnostic that was implicated in a previous exploratory procedure. As a case study, the subject of the observation and analysis is the public health of the UK, which was verified and analyzed according to aspects of management, ethics, social responsibility, and obedience to international control offices that were in effect during the COVID-19 pandemic. The methodological option is dialectic since it

is about an observed social phenomenon concerning a group of antagonistic social forces, which will result in synthesis and analytic induction after a constructive-transformative, sequential, and methodological analysis.

For such a proposition, a specialized group of procedures of technical and scientific character was applied. The phenomenon's dynamic and the time of feasibility was considered as a limiting factor, with safety criteria of the systematic and dialogical collation of information, as well as immediate scientific production regarding the theme. The applied procedures were a concept search of related literature for the construction of a theoretical reference; factual, qualitative, and documented analysis of the ephemerides linked to the COVID-19 pandemic; and quantitative analysis of data obtained through official and secure sources. This data refers to the indexes and its numerical indicators that confirm infection and epidemic fatality. The data was collected using a specialized, universal methodology, underwent statistical procedures, and was verified in terms of its veracity and origin on an international level, which emanate from public power and health administrators. Immediate verification was obtained from publications in scientific periodicals that are qualified on the theme for monitoring the state of the art.

This was followed by epidemiological factors, which were described by statistical means, and then verification, analysis, and presentation of the data and graphs. It was possible to monitor the pandemic phenomenon's evolution with time due to regular collection and execution under relatively standardized conditions. This allowed us to create an in-panel exposition. A comparative model was obtained from data collected in Germany during the same period.

The reason for selecting these two nations is related to the following matters:

- Similar or equivalent socioeconomic structures according to the following:

The Gini Coefficient: (The World Bank, 2020)

•   Gini Coefficient: UK – 34.8 (2016); Germany – 31.9 (2016)

The World Factbook: (Central Intelligence Agency, 2020)

•   Population below the line of poverty: UK – 15% (2013); Germany – 16.7% (2015)

•   Average age and population above 65 years old: UK – 40.6 years (18.48% above 65); Germany – 47.8 years (22.99% above 65);

•   Longevity: UK – 81.1 years; Germany – 81.1 years;

- Geographic proximity;

- Proximity of the introduction and first case of COVID-19:

•   UK – Introduction: 23/01/2020; - First case: 26/01/2020; (Lillie et al., 2020)

•   Germany – Introduction: 19/01/2020; - First case: 27/01/2020; (Böhmer et al., 2020)

- Pandemic peaks in close periods: (Worldometer, 2020)

•   UK – 10/04/2020;

•   Germany – 27/03/2020;

- Highlights to be observed from The World Factbook: (Central Intelligence Agency, 2020)

•   Hospital bed rate per 1000 inhabitants: UK – 2.8 beds; Germany – 8.3 beds;

•   Population of Germany: slightly poorer and older than the UK's;

From a political and medical-ethics standpoint, the concept of Misthanasia originating from daily Bioethics will be examined in the analysis. The visibility of its occurrence in the UK due to the public policy deliberations regarding health by the PM and its repercussions and verifiable confirmations are examined through the inquiries chosen for the case study. We keep in mind that the UK is one of the countries ranked among the highest in terms of global numbers of deaths and infections, although economic conditions do not justify such an effect of pandemic outbreak.

The obtained data refers to estimates made by the Institute for Health Metrics and Evaluation (IHME) and is available

for consultation and download through the following web address: http://www.healthdata.org/covid/data-downloads. Its level of numerical update ranges from the register of the first cases of COVID-19 until June 6, 2020. This website also shows the ICU bed capacity in each country. Simple linear regression models were used for each interval to adjust the daily death tendencies. The graphs and the statistical analyses were made in the software R 4.0.0. The data was analyzed in an observational manner by means of indexes and indicators of public and official nature. The variables are:

- Absolute number of total of cases

- Absolute number of total of deaths

- Graph regarding social distancing

- Total of cases in logarithmic curve and bar graph

- Graph containing daily deaths and projections

- Graph that relates infection, testing, and projections

- Graph with projected hospital resources

The origin of the produced data sources and the segments of analyzed punctualities is Worldometer coronavirus. (Worldometer, 2020) The aspects and legal fulcrums described respect the international ethical guidelines and recommendations for the use of data. From the selected data, the following rivaling hypotheses are formulated as part of the quantitative research and the qualitative relation established by previous observation, in virtue of containment policies initially fostered by the UK's PM:

- The initial position of the UK's PM influenced in the demand's behavior

- The initial position of the UK's PM did not influence the demand's behavior

The hypotheses establish the descriptive-explanatory analytical perspective. The specific details of the relation among the variables is beyond the article's purpose.

The care related to consultation and responsibility of data dissemination that uphold the argumentation developed here refer to the verification of authority and source legitimacy, its official character, or association structure (with shared responsibility among several authorities). All the data was previously collated from a plurality of sources and subjected to prior statistical analysis so that the obtained conclusions would not present tendencies derived from indexed interpretations.

3. Results and Discussion

Misthanasia: the expanded frontiers of death

In 1989, the Brazilian Márcio Fabri dos Anjos (Anjos, 1989) suggested a new definition for premature, avoidable death of political and social nature: Misthanasia. The word Misthanasia has an etymology of Greek origin and is composed of mis (unfortunate, mournful) + thanos (death) – "unfortunate death." Conceptually, the word can be employed as a noun or adjective depending on the objective of its usage. Misthanasia is death related to mitigating social and political factors that lead to the removal of peoples' lives in a precocious way. (Penteado Setti da Rocha et al., 2017) It represents painful death, troubled acceptance by family members and friends, and death conditioned to an adverbial subordinate the "if" clause; for example: "If there were more hospital beds, not that many people would have died;" "If the mitigation policies had been timely and straightforward, not many people would not have been infected."

Misthanasia refers to issues related to premature social death. It defines the loss of possible survival years and people's longevity lost because of social matters associated with actions or lack of attitudes of public powers. Six years after the debates that generated Misthanasia as a new concept of death, there were several debates concerning utilitarian ethics based on principles of universality and equity, which are benefits that extend to all and for a longer amount of time. From these debates, a new expansion of Bioethics emerged in 1995: This new way of thinking in Bioethics has a Latin-American origin

and wins the world with a politicized and active view, which steps out of the principiological comfort of frontier Bioethics to discuss daily social matters. (Garrafa & Porto, 2003) Within this concept, the concept of Misthanasia is integrated, (Anjos, 1989) which differs from the concepts of social Euthanasia and Cacotanasia.

Social Euthanasia is death caused by problems of social-political order, which undergoes a neological transfiguration to an etymologically more well-adapted word, Misthanasia. Euthanasia's is from the Greek for "good death". (Ricou & Wainwright, 2019) In Social Euthanasia, death by social-political factors is not a good death; it is a painful, unfortunate, and premature death of the individual. Cacotanasia is death amidst pain and anguish that is not necessarily connected to social-political matters. It is rushed death without the information and consent of the patient.

The UK was late in following the WHO's instructions due to apparent disbelief in the pandemic's magnitude, which was strengthened by the belief in herd immunity and possibly for loosening economic policy. The criticism based on the PM's early attitudes can be found in many articles from specialized magazines. On June 19, 2020, the UK garnered an absolute number of 300,469 infection cases and 42,288 deaths from the new coronavirus. (Worldometer, 2020) To verify this fact, aside from the disclosed references, an analysis of the social distancing peak that occurred is presented (Figure 1).

Figure 1: Graph of the peak of social distancing in the UK on April 1, 2020.
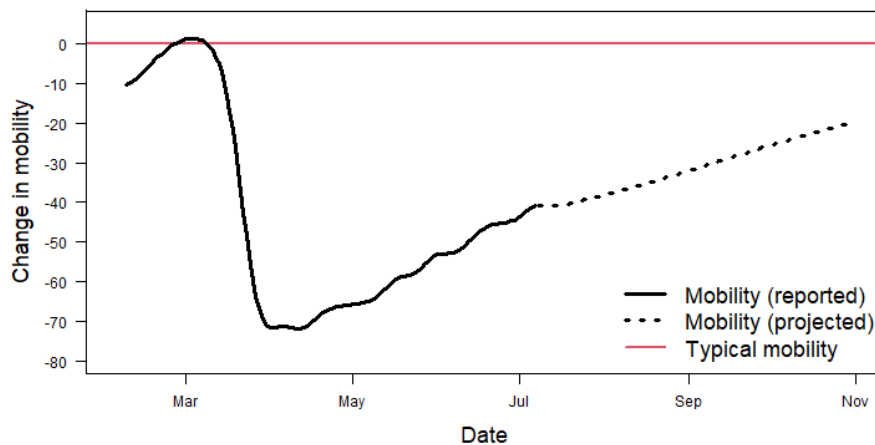
Source: http://www.healthdata.org/covid/data-downloads, accessed on August 15, 2020.

Epidemiology of the United Kingdom (UK) in comparison to the phenomenon in Germany

The graph demonstrates that distancing indeed happened after the government announced social distancing measures, and the peak occurred on April 1, 2020. The measures reached 72% of the population, considering zero mobility. (Worldometer, 2020) The social distancing measures remained with high adherence until the last observed date, May 5, 2020. The graphs that are to be analyzed below are related to the Sars-CoV-2 infections and the number of infected people. They are presented in Figures 2A and 2B.

Figure 2A demonstrates a plateau formation that suggests the flattening of the pandemic curve, which can be confirmed by the graph of daily new case registers with a low observational statistical tendency in Figure 2B. The UK (Worldometer, 2020) reached its daily infection peak of 8,681 cases at 9 days after the social distancing peak, after which there was a decreasing tendency. The graph of the average number of daily deaths in Figure 2D demonstrates an apex on April 13, 2020, with 966.59 deaths at 3 days after reaching the infection apex. (Worldometer, 2020) After this date, there was a strong propensity of decline that remained until the last observed date, June 3, 2020.

Figure 2: (A) Graph of total of cases in the UK, logarithmic curve. (B) Bar graph of the total of daily cases in the UK, (C) Graph of the total of deaths in the UK, logarithmic curve. (D) Graph of the daily total death average in the UK.
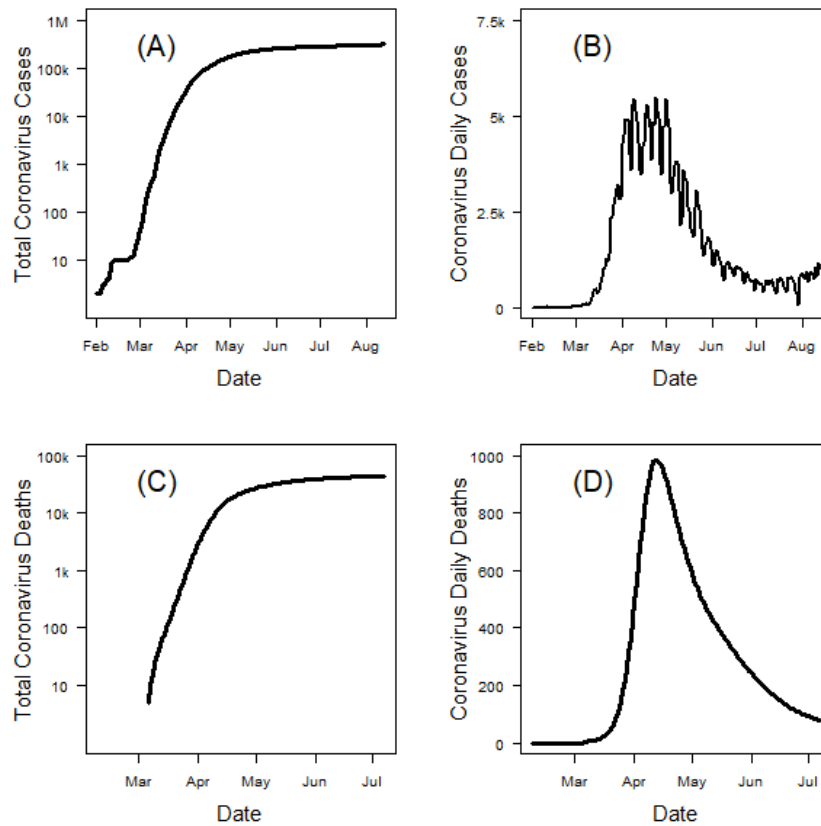
Source: http://www.healthdata.org/covid/data-downloads, accessed on August 15, 2020.

Even with the projections indicating the pandemic peak on June 23, 2020, only after the sixth day after the daily death peak, the curve shows a noticeable change suggesting testing and tracking intensification in the UK (Figure 3A). (Worldometer, 2020) This next graph indicates how prepared the UK was regarding its supply structure to respond to the pandemic's demands. The graphs are based on projections of the available hospital beds, ICUs, and infirmaries according to the saturation by demand (Figure 3B).

Figure 3: (A) Graph of the estimated infection projection, confirmed cases, testing, and projected tests for the UK. (B) Graph of the projections of infirmary bed needs, ICUs, and ventilators for the UK.
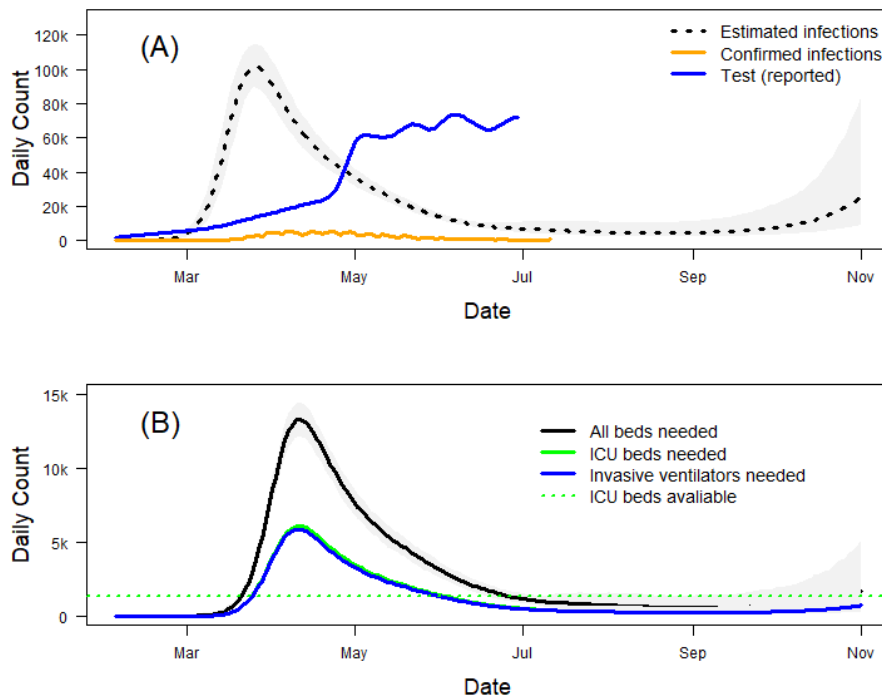
Source: http://www.healthdata.org/covid/data-downloads, accessed on August 15, 2020.

On April 12, 2020, according to the projections, the need for hospital beds had reached its apex, surpassing availability, especially that of ICUs and ventilators. In this projection, the demand's apex occurs 2 days after the contagion peak and 1 day before the death peak. (Worldometer, 2020)

Epidemiology of Germany, a successful model of epidemiological control

The story of Germany's attitudes in facing the pandemic is perceived differently by the world. (Bennhold, 2020) Prior to the pandemic, Germany had a hospital structure that stood out. (Central Intelligence Agency, 2020) Indeed, Germany assumed mitigation policies in advance that were aligned to massive tracking with exams, and as a result they did not suffer greatly in relation to pressure from patients' demands due to COVID-19. (Bennhold, 2020) There were 190,126 registered infection cases and 8,946 deaths, (Worldometer, 2020) which are much lower than those of the UK. Germany hit their social distancing peak on March 25, 2020, which was 7 days prior to the UK, but their average social distancing was lower than that of the UK at 60% (Figure 4).

Figure 5A demonstrates the logarithmic curve of registered total cases, which shows a plateau formation of similar shape to the UK's indicating pandemic control. Nevertheless, there was a lower amount of cases, and the plateau forms before the UK's. The curve of the apex of new daily cases (Figure 5B) shows that Germany reached its peak on March 27, 2020, which is 2 days after the social distancing peak. Compared to the UK, Germany hit its infection apex with fewer cases and 14 days earlier. (Worldometer, 2020)
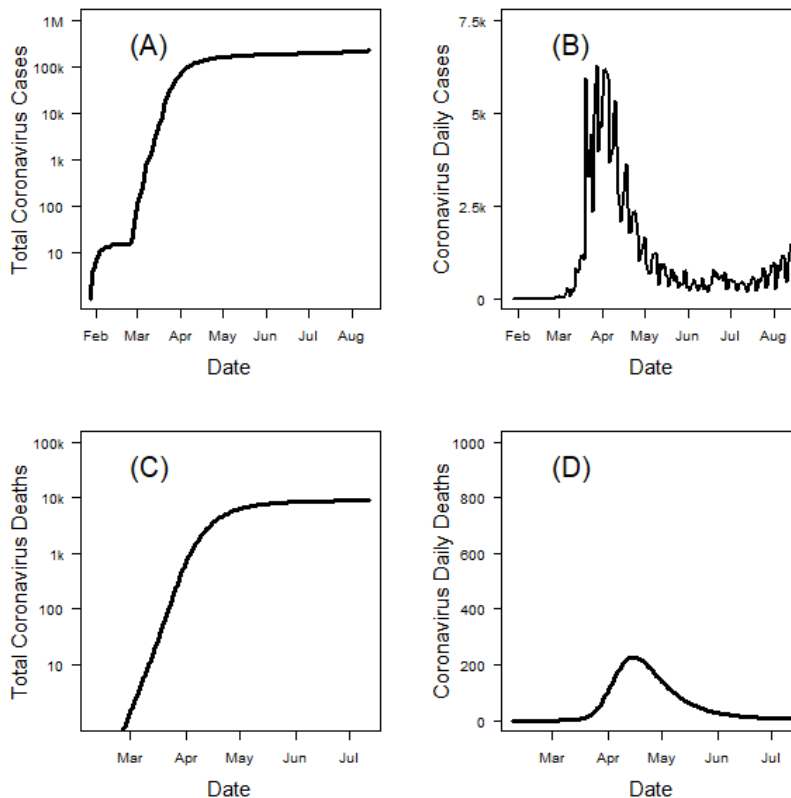
Figure 4: Graph of Germany's social distancing peak on March 25, 2020.
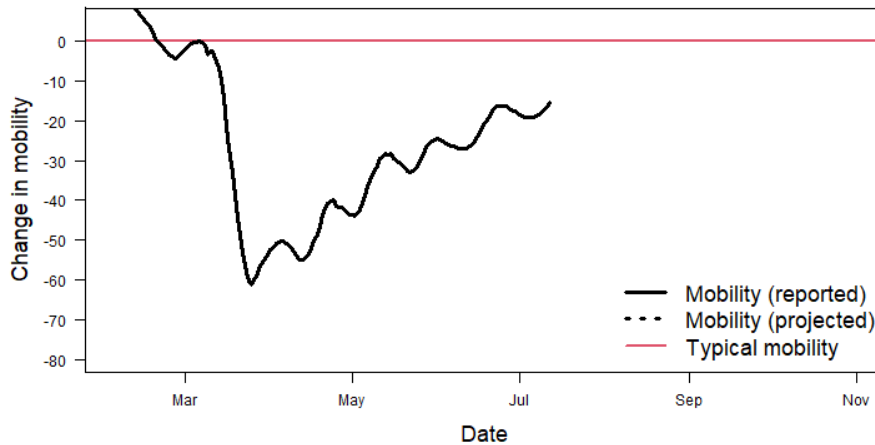
Source: http://www.healthdata.org/covid/data-downloads, accessed on August 15, 2020.

Figure 5: (A) Graph of Germany's case total, logarithmic curve. (B) Bar graph of Germany's total daily cases. (C) Graph of Germany's total deaths, logarithmic curve. (D) Graph of Germany's average daily death total.


Source: http://www.healthdata.org/covid/data-downloads, accessed on August 15, 2020.

Germany hits its daily death peak on April 15, 2020 (Figure 5D), with an average total of 224.11 deaths. This occurred 19 days after the apex of daily cases. After this date, there is a strong decreasing propensity. (Worldometer, 2020) Compared with the UK's data, the average total daily deaths is much lower, and the peak happens 2 days after the UK's. Germany's testing even prior to the WHO declaring the pandemic was realized in a constant matter (Blanco & Bellack, 2020).

The curve of exam intensification becomes clearer on March 8, 2020, which is 3 days before the declaration of a pandemic state and 19 days prior to reaching the pandemic apex (Figure 6A). (Worldometer, 2020) The testing escalation remained constant until the April 5, 2020. Contrasting with the UK, the testing curve showed a greater testing proportion given the number of infections.

Figure 6 B presents the projection curves related to hospital bed demands. According to the projections, on April 14, 2020, Germany had reached the apex of hospital resource demand, equal to the UK, which was 1 day prior to reaching the peak number of deaths. (Worldometer, 2020) The projections graph demonstrates that the demand did not surpass the number of available hospital beds, and there was excess supply in relation to the amount demanded. This information presents the distortion related to the UK's data, where demand exceeded supply to a great extent.

Figure 6: (A) Graph of the projection of estimated infection, confirmed cases, testing, and projected testing for Germany. (B) Graph of the projections of infirmary beds needed, ICUs, and ventilators for Germany.
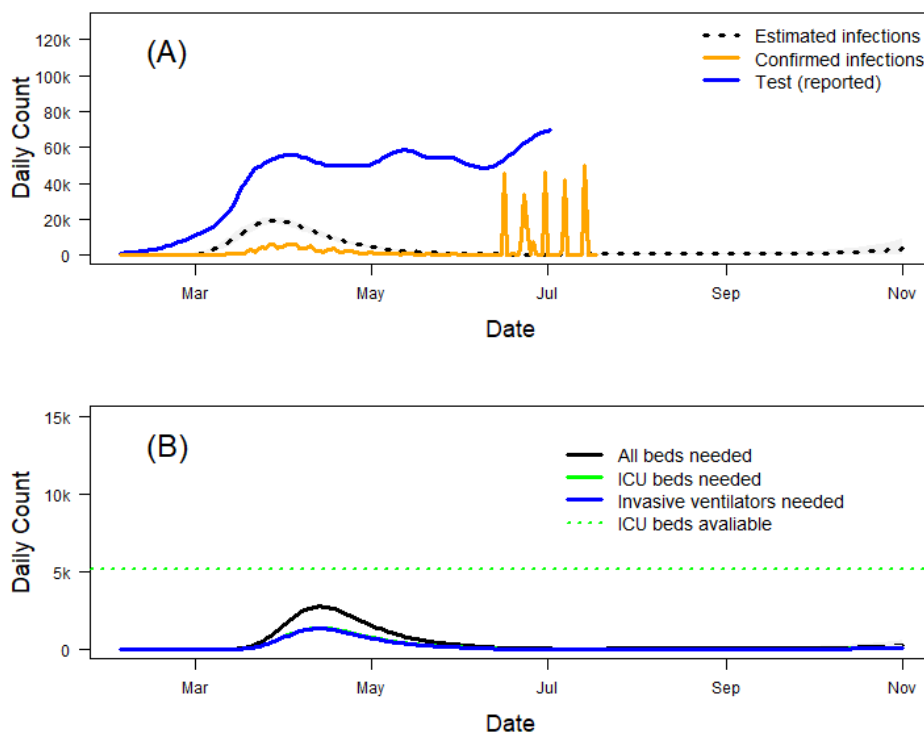

Source: http://www.healthdata.org/covid/data-downloads, accessed on August 15, 2020.

General panorama of mortality and provided structures

Regarding the UK, a maximum capacity of 1,247 ICU beds was observed (around 1.87 beds per 100 thousand inhabitants). The number of people who needed the ICU surpassed that value on March 23. The black line in Figure 7A shows the growth prior to that date, where the death count rises at a rate of 4 additional deaths per day. The red line in Figure 7B shows the growth following that date with a rate of 56 additional deaths per day. In Germany, a maximum capacity of 5,383 ICU beds was observed (approximately 4.48 beds per 100 thousand inhabitants). The number of people who needed beds never exceeded the health system's capacity. During the same period observed in the UK (Figure 7B), an average growth of 1 additional death per day was observed before March 23, and there was an increase of 11 extra deaths per day after this date.

Figure 7: Graph of the correlation between daily deaths and the hospital supply saturation in the UK (A) and Germany (B).
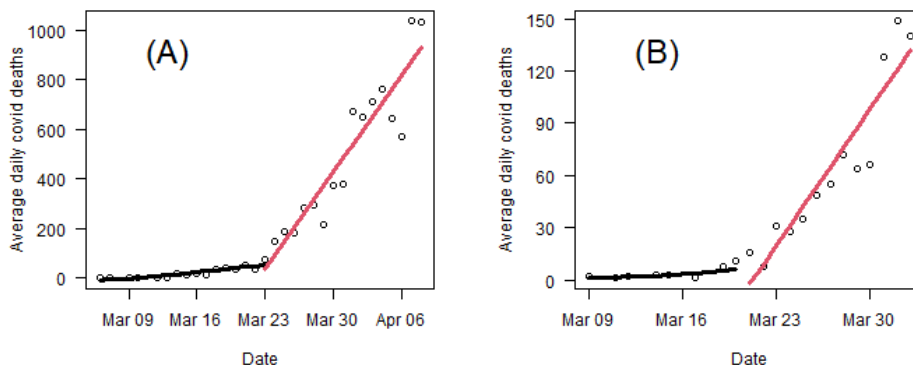
Source: http://www.healthdata.org/covid/data-downloads, accessed on August 15, 2020.

Discussions on the integrations of values

As of June 21, 2020, there were 8,936,552 infections and 467,068 deaths due to Sars-CoV-2 around the world, with a viral lethality of 5.23%. In the UK, the lethality rate was 14.05%, and in Germany, it was 4.69%. In March 2020, the WHO estimated the global lethality rate at 3.4% (WHO, 2020b). In light of the difference in proportional lethality between both countries, a few factors stood out, such as the introduction and diagnostic of the first cases in both countries, which had very similar data. (Böhmer et al., 2020; Lillie et al., 2020) Germany has an older and poorer population, (The World Bank, 2020; Central Intelligence Agency, 2020) along with a larger proportional number of beds and smaller pressure on the supply due to demand, (Anderson et al., 2020; Wyper et al., 2020) along with a larger proportional number of beds and smaller pressure on the supply due to demand. (Pandit, 2020; Walker et al., 2020)

The first considerations of the pandemic control policies in both countries and the UK's belief in herd immunity analyzed by a qualitative perspective were possible to follow in epidemiological observations from a quantitative perspective. Through the development of the concepts of Misthanasia, (Penteado Setti da Rocha et al., 2017) the difference between the lethality proportion of both observed countries could be tied to this concept, which inspired the study's exploratory purpose from a Bioethics standpoint. From this perspective, the goal of this article was to analyze the collected data with the concept of Misthanasia.

The principlist perspective reasons that the UK NHS (Grosios et al., 2010) mainly focused on predictive and preventive matters. In opposition to this, the attitudes of the UK's PM, Boris Johnson, in facing the pandemic were initially skepticism due to a belief in herd immunity and, (Boseley, 2020; Krishna, 2020) supposedly, protecting the economy, (Parker et al., 2020) which are implicated in the delay of mitigation measures and exam tracking. (Agosto et al., 2021) The experiences seen in China were disregarded, (Li et al., 2020; Wu & McGoogan, 2020) and so were the WHO's recommendations (Keaten et al., 2020) related to the contagion containment measures. (Cowper, 2020a; Horton, 2020b; Hunter, 2020)

This attitude, which reflects Sibony (2020) and Betsch, (2020) could have been implicated in the early behavior of British people, who took a little longer to adhere to the social distancing (Figure 1). This resulted in an infection peak with a high number of cases on April 10 (Figure 2B). Germany had a contrasting attitude (Figure 4). (Blanco & Bellack, 2020; Gibadło, 2020) Despite having lower adherence than the UK, it reached its isolation apex 7 days prior to the UK, and they had a lower case count (Figure 5B).

Despite the first cases having similar dates, (Blanco & Bellack, 2020; Lillie et al., 2020) the beginning of viral tracking with exams was of the utmost importance for the recognition and isolation of the infected. (Blanco & Bellack, 2020; Gibadło, 2020) Differently from the UK, Germany intensified infection tracking 3 days prior to the WHO declaring a

pandemic (Figure 6A), which happened in the UK nearly a month and a half later (Figure 3A). Logically, after the population was exposed to the virus, in places that were strongly engaged with infection control, there would be a smaller amount of infected people contaminated, and consequently, fewer deaths (Figures 2 and 5). (Ebrahim et al., 2020; Lasry et al., 2020; Pei et al., 2020)

The UK took longer to express the plateau in the curve (suggesting pandemic control) than Germany (Figures 2 and 5). This resulted in a possible obstruction of health services along with a large number of infected presenting to hospitals in the UK. The projections of demand were greater than the resources available. (Hunter, 2020) On account of the lack of capacity, this could be related to factors that explain the higher death count. (Giordano et al., 2020; Horton, 2020b; Walker et al., 2020)

The quantitative analysis suggests that the influences of the early conducts of pandemic control (Krishna, 2020) are related to the demand behavior and could consequently be connected to the possible overload of the UK's hospitals. This may have impacted the mortality and proportional mortality. It is inferred that the answer to the quantitative question, in part, is given as concluded, observing the need for a specific analysis of the correlation between the variables; therefore, the perspectives of the analytical, descriptive, observational and inferential statistics support and augment the paths of the qualitative analysis.

The relation of the attitudes of the UK's early public policy in facing the pandemic was massively questioned. (Boseley, 2020; Clark et al., 2020; Horton, 2020b; Iacobucci, 2020) The political direction shown by the government's attitudes allegedly demonstrates the prioritization of economic issues. (Hunter, 2020; Kickbusch et al., 2020) Using Germany as a comparative model, this study demonstrated the great difference found with the pandemic's possible consequences. (Gibadło, 2020; Mahase, 2020) This miscellaneous case study points to evidence of Misthanasia in the UK.

Misthanasia is unfortunate death that could have been avoided and would not happen if there were social and public actions that prioritized human life. Misthanasia characterizes a public policy that does not result in priority towards matters related to human dignity and its main principles and the right to protection and life as an independent effect of intentionality. Even if this concept is not evidently clear, death could be related to Misthanasia when it is based on questionable beliefs, consequences of actions, or a lack of attitudes that lead to a larger death count that is otherwise avoidable. The behavior of the UK's demand that was distinctly observed from the model possibly led to greater lethality (Figure 7). The proportional lethality augmented by social or political issues does not cease to characterize Misthanasia.

The political actions of a government that induce or lead to Misthanasia focus on matters other than life. In this case, it is noted that the initially adopted belief by the UK's PM brought about tragic outcomes for the population. Even with the correction of the initially adopted trajectory, the measures were insufficient to mitigate the consequences and tragic aftermath, and hence, the perceptions of Misthanasia persist.

4. Final Considerations

The experiences and dissemination of information from China (Wu & McGoogan, 2020) and the WHO's analyses (Keaten et al., 2020) provided alerts about the pandemic's risks. The biggest concern was not only the virus' lethality rate but the high infectiousness rate. (Sohrabi et al., 2020) According to the WHO (Keaten et al., 2020) and the modeling of studies that evaluated various pandemic scenarios, (Giordano et al., 2020; Pandit, 2020; Walker et al., 2020) the high infectiousness rate could result in congestion of the whole health system, which would lead to deaths due to a lack of capacity to address the demand and risks of inefficiency and inaccuracy in the health system's actions. (Anandaciva, 2020; Patterson & Clark, 2020) Embracing herd immunity (Hunter, 2020; Krishna, 2020; Sibony, 2020) disrespected the WHO's recommendations for emergencies in public health, in addition to the individualistic response of human beings when exposed to the risks of bad luck. This study did not emphasize the absolute disregard, but the delay in perception of the state of emergency and the way of

dealing with the pandemic challenges with mitigation policies, (Cowper, 2020b; Iacobucci, 2020) which suggested a possible collapse of hospital networks. (Horton, 2020b) The result of all this relates to the death count, for which statistics are being gathered, as well as the mourning of surviving family members.

The popular dissatisfaction with the UK government's actions are headlining tabloids and is seen through the thousands of deaths and the perception of xenophobic attitudes. (Tara, 2020) This is accompanied by the impacts caused by the pandemic on the NHS related to the care for other pathologies, which could be associated with other mortality etiologies because of bad assistance. (Charlesworth, 2020; NHS, 2020) Therefore, it is concluded that Misthanasia characterized the public policies of the UK's government. The naturalization of death is configured in the primordial aspect of necropower. When the economy is prioritized based on the belief that many more people will die of hunger, there may be a disregard of the experiences of other countries and the WHO's alerts.

References

Agosto, A., Campmas, A., Giudici, P., & Renda, A. (2021). Monitoring COVID-19 contagion growth. *Statistics in Medicine*, 40(18), 4150–4160. https://doi.org/10.1002/sim.9020

Anandaciva, S. (2020). *Critical care services in the English NHS*. The King's Fund. https://www.kingsfund.org.uk/publications/critical-care-services-nhs?gclid=Cj0KCQjwv7L6BRDxARIsAGj-34qC6QgV9sbebMOlfadpTcieLF_AvtEZ7VbXG2wfJj3osVpUfAmb224aAkopEALw_wcB

Anderson, G., Frank, J. W., Naylor, C. D., Wodchis, W., & Feng, P. (2020). Using socioeconomics to counter health disparities arising from the covid-19 pandemic. *BMJ*, 369(June), m2149. https://doi.org/10.1136/bmj.m2149

Anjos, M. F. (1989). Eutanásia em chave de libertação. *Boletim Do Instituto Camiliano de Pastoral Da Saúde*, 57, 6.

Armocida, B., Formenti, B., Ussai, S., Palestra, F., & Missoni, E. (2020). The Italian health system and the COVID-19 challenge. *The Lancet Public Health*, 5(5), e253. https://doi.org/10.1016/S2468-2667(20)30074-8

Bedford, J., Enria, D., Giesecke, J., Heymann, D. L., Ihekweazu, C., Kobinger, G., Lane, H. C., Memish, Z., Oh, M., Sall, A. A., Schuchat, A., Ungchusak, K., & Wieler, L. H. (2020a). COVID-19: towards controlling of a pandemic. *The Lancet*, 395(10229), 1015–1018. https://doi.org/10.1016/S0140-6736(20)30673-5

Bedford, J., Enria, D., Giesecke, J., Heymann, D. L., Ihekweazu, C., Kobinger, G., Lane, H. C., Memish, Z., Oh, M., Sall, A. A., Schuchat, A., Ungchusak, K., & Wieler, L. H. (2020b). COVID-19: towards controlling of a pandemic. *The Lancet*, 395(10229), 1015–1018. https://doi.org/10.1016/S0140-6736(20)30673-5

Bennhold, B. K. (2020). A German Exception? Why the Country's Coronavirus Death Rate Is Low. *The New York Times*, 2–7.

Betsch, C. (2020). How behavioural science data helps mitigate the COVID-19 crisis. *Nature Human Behaviour*, 4(5), 438–438. https://doi.org/10.1038/s41562-020-0866-1

Blanco, A., & Bellack, M. (2020). *Coronavirus testing, social isolation, lockdown: How countries try to contain covid-19*. The Washington Post. https://www.washingtonpost.com/world/2020/03/13/how-countries-around-world-have-tried-contain-coronavirus/?arc404=true

Böhmer, M. M., Buchholz, U., Corman, V. M., Hoch, M., Katz, K., Marosevic, D. V., Böhm, S., Woudenberg, T., Ackermann, N., Konrad, R., Eberle, U., Treis, B., Dangel, A., Bengs, K., Fingerle, V., Berger, A., Hörmansdorfer, S., Ippisch, S., Wicklein, B., … Zapf, A. (2020). Investigation of a COVID-19 outbreak in Germany resulting from a single travel-associated primary case: a case series. *The Lancet Infectious Diseases*, 20(8), 920–928. https://doi.org/10.1016/S1473-3099(20)30314-5

Bohoslavsky, J. P. (2020). *COVID-19: Urgent appeal for a human rights response to the economic recession United Nations Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, parti*. United Nations Human Rights. https://www.ohchr.org/Documents/Issues/Development/IEDebt/20200414_IEDebt_urgent_appeal_COVID19_EN.pdf

Boseley, S. (2020). *Herd immunity: will the UK's coronavirus strategy work?* The Guardian. https://www.theguardian.com/world/2020/mar/13/herd-immunity-will-the-uks-coronavirus-strategy-work

Bremmer, I. (2020). *The Best Global Responses to COVID-19 Pandemic*. Time. https://time.com/5851633/best-global-responses-covid-19/

Byk, C. (2015). *Tratado de Bioética: em prol de uma nova utopia civilizadora*. Paulus.

Central Intelligence Agency. (2020). *The World Factbook*. https://www.cia.gov/the-world-factbook/references/guide-to-country-comparisons/

Charlesworth, A. (2020). *Shock to the system: COVID-19's long-term impact on the NHS*. The Health Foundation. https://www.health.org.uk/news-and-comment/blogs/shock-to-the-system-covid-19s-long-term-impact-on-the-nhs

Clark, H., Coll-Seck, A. M., Banerjee, A., Peterson, S., Dalglish, S. L., Ameratunga, S., Balabanova, D., Bhan, M. K., Bhutta, Z. A., Borrazzo, J., Claeson, M., Doherty, T., El-Jardali, F., George, A. S., Gichaga, A., Gram, L., Hipgrave, D. B., Kwamie, A., Meng, Q., … Costello, A. (2020). A future for the world's children? A WHO–UNICEF–Lancet Commission. *The Lancet*, 395(10224), 605–658. https://doi.org/10.1016/S0140-6736(19)32540-1

Cohen, J., & Kupferschmidt, K. (2020). Countries test tactics in 'war' against COVID-19. *Science*, 367(6484), 1287–1288. https://doi.org/10.1126/science.367.6484.1287

Cowper, A. (2020a). Covid-19: are we getting the communications right? *BMJ*, 368, m919. https://doi.org/10.1136/bmj.m919

Cowper, A. (2020b). Budgeting for covid-19: changing the narrative and narrating the change. *BMJ*, 368, m1053. https://doi.org/10.1136/bmj.m1053

Creswell, J. W., & Clark, V. L. P. (2015). *Pesquisa de Métodos Mistos-: Série Métodos de Pesquisa*. Penso Editora.

Dean, S., Pleitgen, F., & Schmidt, N. (2020). *Merkel warns Germany is on the "thinnest ice" as Europe realizes social distancing is here to stay*. CNN. https://edition.cnn.com/2020/04/23/europe/merkel-coronavirus-social-distancing-europe-intl/index.html

Ebrahim, S. H., Ahmed, Q. A., Gozzer, E., Schlagenhauf, P., & Memish, Z. A. (2020). Covid-19 and community mitigation strategies in a pandemic. *BMJ*, 368, m1066. https://doi.org/10.1136/bmj.m1066

Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., Zhang, C., Boyle, C., Smith, M., & Phillips, J. P. (2020). Fair Allocation of Scarce Medical Resources in the Time of Covid-19. *New England Journal of Medicine*, 382(21), 2049–2055. https://doi.org/10.1056/NEJMsb2005114

Garrafa, V., & Porto, D. (2003). Intervention Bioethics: A Proposal For Peripheral Countries in A Context of Power and Injustice. *Bioethics*, 17(5–6), 399–416. https://doi.org/10.1111/1467-8519.00356

Gibadło, L. (2020). *The Government Gains: The German Political Scene during the COVID-19 Pandemic*. PISM Polski Instytut Spraw Międzynarodowych. https://pism.pl/publications/The_Government_Gains__The_German_Political_Scene_during_the_COVID19_Pandemic

Giordano, G., Blanchini, F., Bruno, R., Colaneri, P., Di Filippo, A., Di Matteo, A., & Colaneri, M. (2020). Modelling the COVID-19 epidemic and implementation of population-wide interventions in Italy. *Nature Medicine*, 26(6), 855–860. https://doi.org/10.1038/s41591-020-0883-7

Grosios, K., Gahan, P. B., & Burbidge, J. (2010). Overview of healthcare in the UK. *EPMA Journal*, 1(4), 529–534. https://doi.org/10.1007/s13167-010-0050-1

Horton, R. (2020a). Offline: COVID-19—a reckoning. *The Lancet*, 395(10228), 935. https://doi.org/10.1016/S0140-6736(20)30669-3

Horton, R. (2020b). Offline: COVID-19 and the NHS—"a national scandal." *The Lancet*, 395(10229), 1022. https://doi.org/10.1016/S0140-6736(20)30727-3

Hunter, D. J. (2020). Covid-19 and the Stiff Upper Lip — The Pandemic Response in the United Kingdom. *New England Journal of Medicine*, 382(16), e31. https://doi.org/10.1056/NEJMp2005755

Iacobucci, G. (2020). Covid-19: UK lockdown is "crucial" to saving lives, say doctors and scientists. *BMJ*, 368, m1204. https://doi.org/10.1136/bmj.m1204

Keaten, J., Cheng, M., & Leicester, J. (2020). *WHO declares coronavirus a pandemic, urges aggressive action*. AP NEWS. https://apnews.com/52e12ca90c55b6e0c398d134a2cc286e

Kickbusch, I., Leung, G. M., Bhutta, Z. A., Matsoso, M. P., Ihekweazu, C., & Abbasi, K. (2020). Covid-19: how a virus is turning the world upside down. *BMJ*, 369, m1336. https://doi.org/10.1136/bmj.m1336

Krishna, R. (2020). *Here is the transcript of what Boris Johnson said on This Morning about the new coronavirus*. Full Fact. https://fullfact.org/health/boris-johnson-coronavirus-this-morning/

Lasry, A., Kidder, D., Hast, M., Poovey, J., Sunshine, G., Winglee, K., Zviedrite, N., Ahmed, F., Ethier, K. A., Clodfelter, C., Howard-Williams, M., Hulkower, R., Jeong, G., Landsman, L., McCord, R., Moreland, A., Shelburne, J., Billioux, A., Hand, J., … Willis, M. (2020). Timing of Community Mitigation and Changes in Reported COVID-19 and Community Mobility — Four U.S. Metropolitan Areas, February 26–April 1, 2020. *MMWR. Morbidity and Mortality Weekly Report*, 69(15), 451–457. https://doi.org/10.15585/mmwr.mm6915e2

Li, Q., Guan, X., Wu, P., Wang, X., Zhou, L., Tong, Y., Ren, R., Leung, K. S. M., Lau, E. H. Y., Wong, J. Y., Xing, X., Xiang, N., Wu, Y., Li, C., Chen, Q., Li, D., Liu, T., Zhao, J., Liu, M., … Feng, Z. (2020). Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus–Infected Pneumonia. *New England Journal of Medicine*, 382(13), 1199–1207. https://doi.org/10.1056/NEJMoa2001316

Lillie, P. J., Samson, A., Li, A., Adams, K., Capstick, R., Barlow, G. D., Easom, N., Hamilton, E., Moss, P. J., Evans, A., Ivan, M., PHE Incident Team, Taha, Y., Duncan, C. J. A., Schmid, M. L., & the Airborne HCID Network. (2020). Novel coronavirus disease (Covid-19): The first two patients in the UK with person to person transmission. *Journal of Infection*, 80(5), 578–606. https://doi.org/10.1016/j.jinf.2020.02.020

Mahase, E. (2020). Covid-19: What is the R number? *BMJ*, 369, m1891. https://doi.org/10.1136/bmj.m1891

Mbembé, J.-A., & Meintjes, L. (2003). Necropolitics. *Public Culture*, 15(1), 11–40.

Misra, A. (2018). Necropower. In A. Misra (Ed.), *Towards a Philosophy of Narco Violence in Mexico* (pp. 13–46). https://doi.org/10.1057/978-1-137-52654-0_2

NHS. (2020). *Appointments in General Practice - April 2020*. NHS. https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/april-2020

Pandit, J. J. (2020). Demand–capacity modelling and COVID-19 disease: identifying themes for future NHS planning. *Anaesthesia*, 75(10), 1278–1283. https://doi.org/10.1111/anae.15144

Parker, G., Cookson, C., & Payne, S. (2020). *Defiant Johnson tries to keep Britain open for business*. Financial Times. https://www.ft.com/content/0475f450-654f-11ea-a6cd-df28cc3c6a68

Patterson, A., & Clark, M. A. (2020). COVID-19 and Power in Global Health. *International Journal of Health Policy and Management*, 2020, 1–3. https://doi.org/10.34172/ijhpm.2020.72

Pei, S., Kandula, S., & Shaman, J. (2020). Differential effects of intervention timing on COVID-19 spread in the United States. *Science Advances*, 6(49), eabd6370. https://doi.org/10.1126/sciadv.abd6370

Penteado Setti da Rocha, A. S., Rocha da Cunha, T., Souza, W., & D'Espindula, T. (2017). Human Dignity, Misthanasia, Public Health and Bioethics in Brazil. *Revista Iberoamericana de Bioética*, 5, 1. https://doi.org/10.14422/rib.i05.y2017.006

Ricou, M., & Wainwright, T. (2019). The Psychology of Euthanasia. *European Psychologist*, 24(3), 243–256. https://doi.org/10.1027/1016-9040/a000331

Schumacher, E. (2020). *Merkel cautiously optimistic as she announces lockdown rollback*. DW. https://www.vosa.tv/merkel-cautiously-optimistic-and-announces-lockdown-rollback/

Sibony, A.-L. (2020). The UK COVID-19 Response: A Behavioural Irony? *European Journal of Risk Regulation*, 11(2), 350–357. https://doi.org/10.1017/err.2020.22

Sodeke, S. O., & Wilson, W. D. (2017). Integrative Bioethics is a Bridge-Builder Worth Considering to Get Desired Results. *The American Journal of Bioethics*, 17(9), 30–32. https://doi.org/10.1080/15265161.2017.1353174

Sohrabi, C., Alsafi, Z., O'Neill, N., Khan, M., Kerwan, A., Al-Jabir, A., Iosifidis, C., & Agha, R. (2020). World Health Organization declares global emergency: A review of the 2019 novel coronavirus (COVID-19). *International Journal of Surgery*, 76, 71–76. https://doi.org/10.1016/j.ijsu.2020.02.034

Stafford, N. (2020). Covid-19: Why Germany's case fatality rate seems so low. *BMJ*, 369, m1395. https://doi.org/10.1136/bmj.m1395

Tara, J. (2020). *UK coronavirus: Tens of thousands of Britons have died. But Boris Johnson is stoking a culture war*. CNN. https://edition.cnn.com/2020/06/20/uk/boris-johnson-coronavirus-culture-wars-gbr-intl/index.html

The Lancet. (2020). COVID-19: learning from experience. *The Lancet*, 395(10229), 1011. https://doi.org/10.1016/S0140-6736(20)30686-3

The World Bank. (2020). *GINI index (World Bank estimate)*. The World Bank. https://data.worldbank.org/indicator/SI.POV.GINI

Walker, P. G. T., Whittaker, C., Watson, O. J., Baguelin, M., Winskill, P., Hamlet, A., Djafaara, B. A., Cucunubá, Z., Olivera Mesa, D., Green, W., Thompson, H., Nayagam, S., Ainslie, K. E. C., Bhatia, S., Bhatt, S., Boonyasiri, A., Boyd, O., Brazeau, N. F., Cattarino, L., … Ghani, A. C. (2020). The impact of COVID-19 and strategies for mitigation and suppression in low- and middle-income countries. *Science*, 369(6502), 413–422. https://doi.org/10.1126/science.abc0035

WHO. (2020a). *Preparing for large-scale community transmission of COVID-19*. World Health Organization. https://www.who.int/publications/i/item/preparing-for-large-scale-community-transmission-of-covid-19

WHO. (2020b). *WHO Director-General's opening remarks at the media briefing on COVID-19*. World Health Organization. https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---29-june-2020

Worldometer. (2020). *Coronavirus Cases*. Worldometer. https://www.worldometers.info/coronavirus/

Wu, Z., & McGoogan, J. M. (2020). Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China. *JAMA*, 323(13), 1239. https://doi.org/10.1001/jama.2020.2648

Wyper, G. M. A., Assunção, R., Cuschieri, S., Devleesschauwer, B., Fletcher, E., Haagsma, J. A., Hilderink, H. B. M., Idavain, J., Lesnik, T., Von der Lippe, E., Majdan, M., Milicevic, M. S., Pallari, E., Peñalvo, J. L., Pires, S. M., Plaß, D., Santos, J. V., Stockton, D. L., Thomsen, S. T., & Grant, I. (2020). Population vulnerability to COVID-19 in Europe: a burden of disease analysis. *Archives of Public Health*, 78(1), 47. https://doi.org/10.1186/s13690-020-00433-y

Yin, R. K. (2015). *Estudo de Caso: planejamento e método*. Bookman.