



Anáhuac
México

Ethical Criteria Guideline for Health Emergencies in Mexico in the Context of COVID-19 Pandemic

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Foreword

Health emergencies pose a challenge to public health care for both people and populations. People in vulnerable situations – either due to preexisting health conditions or to their social position – are particularly affected by such emergencies. The health-care staff often face adverse situations as well, arising from the pressure generated over the National Health System¹; therefore, decisions have to be made quickly, and to such purpose they should be promptly addressed and forethought to provide for the best possible care and reduce the professional and psychological burden on the health personnel during the emergency. These decisions, being of paramount importance, must be based on the best scientific evidence available, and should be implemented by trained health workers, to carry them out promptly and avoiding any biases that could endanger the health of the patients and the population as a whole. Given the circumstances of Health Emergency, it is important to bear in mind some guidelines for well-informed health decisions, especially to care for patients that require hospitalization or that are admitted in an ICU.

¹ General Health Act. Chapter I. Article 5.

Introduction to the Problem

First, we should clear-out that the situation in Mexico at this time is a declaration of Health Emergency issued by the General Board of Health² and published in the Federation's Official Gazette last March the 30th.

Such declaration does not mean a suspension of individual guarantees, since it is not a declaration of state of alarm³.

The measures taken by the Board and published in the FOG are those corresponding to article 184 of the Tenth Chapter of the General Health Act.

Therefore, Mexico has established a democratic and rights-based road, both in the Constitution and in the Law, for the control of serious epidemics, since the state of exception and suspension of individual guarantees are not adequate measures to control epidemics, consequently they are fully respected.

The above notwithstanding, it should be pointed-out that it is the State's subsidiary responsibility **to provide the necessary means** to assist the vulnerable members of society when circumstances surpass them and they are unable to help themselves, by providing food, in addition to guaranteeing access to health care and other rights acknowledged in the Constitution.

It is also the State's obligation to provide to the **health care personnel** the essential supplies and physical, medical, surgical and technical means to **protect their health and physical well-being**, as well as to provide care and safety to the patients.

² The above according to the Constitution's Article 73, item XVI, fraction 1st and 2nd granting the Board authority to issue guidelines to be followed in case of serious or dangerous epidemics. Likewise, the above is ruled by the Tenth Chapter of the General Health Act "Extraordinary Actions in General Health Matters" in article 181.

³ For further reference on these concepts and their intrinsic differences, please see Exhibit A.

Before this situation we propose ethical and bio-ethical criteria to guide decision-making within the health crisis scenarios, aware that they **are not nor should they be the only considerations** to act in the scenarios that may arise, but with the purpose of contributing, with the highest morale and solidarity, to the difficult endeavor of safeguarding the life, dignity, integrity and autonomy of the whole population, the patients and their families, as well as of the health professionals who tirelessly care and watch over the health of all Mexicans.

I. Ethical Criteria in the Application of COVID-19 Tests

The General Secretary of the World Health Organization, Tedros Adhanom Ghebreyesus assured on March 16th that "Doing tests, tests and more tests" is the best strategy to fight against COVID-19 (OMS, 2020). However, the truth is that in many countries the economic resources, and therefore the number of tests available, are limited. Mexico invested 5.5 of its Gross Domestic Product in health in 2016 (Factbook CIA, 2020) and the emergence of a Pandemic such as COVID-19 implies an excessive expense that had not been considered. In comparison, the European Union spends 9.9 and Japan 10.9 of their GDP in health.

There are two types of tests to diagnose COVID-19⁴, and the ethical criteria for their application should be:

- Taking into consideration the shortage of tests that confirm COVID-19 cases, it is suggested to give **priority to health-care professionals**, especially those **involved** in the care, assistance and treatment of infected patients and to the scientists and physicians working to discover a cure and/or vaccine. The above, based on the fact that they are essential human resources to continue

⁴ **a) The PCR Test** (Polymerase Chain Reaction) is very accurate and consists of detecting a fragment of the genetic material of a pathogen. With PCR, a fragment of the genetic material is chosen and amplified; in the case of coronavirus, it is a molecule of Ribonucleic Acid (RNA). If, after the analysis in a microbiology lab of a respiratory sample of a person suspected to be infected, the test finds the virus RNA, the result is positive and it is confirmed that such person is infected with SARS-CoV-2. If the PCR technique does not detect the virus genetic material, the person is not infected (Corman, 2020). In Mexico, we are undergoing the last weeks of seasonal influenza, many patients with respiratory disease are not infected with coronavirus.

b) The Rapid Tests, which are less accurate, detect in a blood sample from the patient the existence of antibodies against the virus; they do not search for the virus genetic material chains. A patient who has been in contact with coronavirus produces a series of proteins as defense against the virus. In the test, a surface is coated with proteins from the virus and, right away, the patient's antibodies will bind on these virus proteins to attack them. The Food and Drug Administration (FDA) authorized the use of rapid tests early in April 2020 (FDA, 2020) due to the health emergency. This is why the Ministry of Health in Mexico had not officially allowed the use of rapid tests before the approval by FDA.

providing care and treatment and, eventually to find the cure or vaccine for the virus and therefore reduce infections and the death rate⁵.

- By the same token, it is suggested to give priority in tests application to **vulnerable and high risk populations**⁶, which include senior citizens 65+ years old, persons with comorbidities, such as diabetes, hypertension, immunological or cardiorespiratory systems disease, as well as concomitant factors such as obesity. The above, with the double purpose of providing for quick diagnosis and early start of treatment to increase success rates and also to prevent infecting caregivers since, most of them are persons who depend on others; therefore the belief that a prompt positive diagnosis may prevent caregivers from future infection.

- Last, and as recommended by the United States Public Health Service, priority 3 implies that, as allowed by the resources, test the persons from the communities surrounding the cases at the hospital that increase fast, to reduce spread among the community and guarantee the health of the essential workers. This group includes:

- Critical infrastructure workers with symptoms
- Persons that do not meet any of the criteria above with symptoms
- Workers from health centers and first responders
- Persons that do not meet any of the criteria above with symptoms
- Individuals with mild symptoms at communities with a high number of hospitalizations due to COVID-19

⁵ According to priority 1 as established by the United States Public Health Service (cdc.gov 2020). Cfr. Adalja AA, Toner E, Inglesby TV. Priorities for the US Health Community Responding to COVID-19. JAMA. Published online on March 3, 2020. doi:10.1001/jama.2020.3413

⁶ Ibid. United States Public Health Service. Priority 2

II. Ethical Criteria in Patients Selection and Distribution of Health Resources

- Try and get, through all possible means and according to article II of the Declaration of Health Emergency issued by the General Board of Health, the largest possible number of material and human resources to face the health crisis with the obligation to request, import or purchase them in an efficient and orderly manner. This responsibility falls, at the states on the governors, and for the federation on the President of the Republic.
- If, once the above-mentioned measure has been exhausted, a resources shortage scenario is faced, priority must be given to **health care professionals** and most of all, to those involved in the care, assistance and treatment of infected patients and to those scientists and physicians involved in the discovery of a cure or vaccine. It is right to set aside ventilators for them. This, based on our comments above.
- While every patient deserves medical care as stated in Article 4th of the Constitution, not all of them should receive the same type of care, for some the treatment will be for healing purposes and for others it will be palliative care. That is why, regarding the issue of the patients to whom resources should be assigned, at all times **human dignity** should prevail as a fundamental value of medical care and ethical behavior, providing the **maximum comfort and quality of life** as possible to those patients whose underlying conditions reduce their chances to live, observing **palliative care** principles and making every therapeutic effort for those who have greater possibilities of survival.
- It is **forbidden to abandon patients or to refuse palliative treatment** to those who, due to their preexisting conditions are not candidates to receive healing treatment or a place in the intensive care units. Abandoning patients is a felony and serious lack of ethics in health care professionals.
- The ethical decisions must be based on a criterion that assesses the **greatest survival possibilities** and, therefore, to whom the resources assigned will be more beneficial as per the **benefit principle**. Extreme care should be taken to **prevent falling** into other criteria such as solely age or the number of years saved, as well as the criterion of who arrived first or who has larger economic resources to be treated.

- The assessment of the patients that should be treated, even with respiratory therapies, and those who are not candidates must be made in a **comprehensive way**, taking into consideration medical scales such as SOFA, qSOFA or APACHE II or III and **should never substitute global medical criterion or reflection**. To such purpose, it is recommended to confirm with another colleague the assessment and to make this a constant exchange among treating doctors. Never should one sole factor, disease or condition be assessed to make decisions.
- It is suggested to start a quick and prompt process of informed consent⁷ with the patients who are admitted and assessed at the hospital, since it allows informing the patient about the diagnosis, prognosis and treatment and, in case of patients whose conditions put them within the vulnerable population, with little possibilities to survive, this information process will take special relevance since they will be told that, due to their previous conditions, **they are not candidates to receive healing treatment; however, they should always be referred to other areas, such as palliative care** to receive attention and quality of life.
- The patient should also exercise **responsibility** and respond to the common good by observing community ethics with solidarity.
- As far as possible, it is suggested to draft the **advanced healthcare directive** as part of the admission protocol when the patient arrives to the areas designated to receive them. The purpose of this document is **to allow the patient to refuse to any extraordinary measures** that could be undertaken in case their health worsens, relieving the doctor from the responsibility to decide whether to impart those measures⁸.
- In case the patient is unable to express his/her will due to his/her health conditions, the **decision about the treatment will fall on the “next of kin”** as stated by law, namely, the spouse, if absent, the children of full age, if absent and if the parents are still alive, they should make the decision and if absent a blood relative. In case **there is no family member, the doctor shall make the**

⁷ Please remember that, in cases of urgency, a verbal informed consent is permitted, for it is faster and best adapts to these scenarios. Cfr. Exhibit 4 of the National Guidelines for the Integration and Operation of the Hospital Bioethics Committees. CONBIOÉTICA. Available for download at the site: <http://www.conbioeticamexico.salud.gob.mx/descargas/pdf/registrocomites/Guia_CHB_Final_Paginada_con_forros.pdf> Date of last inquiry: April 6, 2020

⁸ This is only valid at this time of health crisis, for we should remember that the advanced healthcare directive is a most personal document, that should be written in sound mind and psychological faculties, something that, in this scenario may be not fully achieved.

decisions, which will be based solely on the comprehensive and objective assessment mentioned in paragraphs above, without sticking to one sole factor considering it prevailing.

- In this situation and given the isolation measures of the patients confirmed as positive, the family can express their decision by phone or through a remote connection with mobile devices.
- A patient cannot be extubated without the consent from the patient or a family member, just to give it to someone else, for this would be committing an act of euthanasia and therefore homicide. To this purpose, it is suggested to anticipate an advanced healthcare directive observing the due process for consent as mentioned in paragraphs above.
- Whenever assisted ventilation is considered **futile**⁹ and, given that there is no obligation to keep non-beneficial and/or extraordinary measures for the patient, extubating is suggested; however, before doing it, check again with SOFA or APACHE scales, confirm with another colleague the prognosis and course of action proposed, as well as talking to the family about the medical decisions suggested and, if possible, obtain their explicit consent.
- **Withdrawing the ventilator causing the death of the patient should not be assessed under any circumstances, as double effect principle, since death does not come upon as secondary effect of a therapeutic action, but it was expected very soon, nor as the principle of the greater good because death is not tolerated under this scenario, but only medically assessed as a triggering consequence; however, it is ethical to proceed, after observing the recommendations enumerated above since the patient's death is neither pretended nor wanted, in first instance, nor is it using such death as a benefit for another person¹⁰.**
- If the irreversibility and confirmation of medical futility criterion is not met, it is not ethical to withdraw the ventilation support, not even if it could save the life of another patient.
- If there are two persons with the same survival prognosis, the criteria will be determined by chance (draw or some other mechanism) to procure the greatest objectivity in the decision.

⁹ Futile care is understood to be a treatment that is not fulfilling the purpose initially desired or which is not beneficial for the patient, in a few words it is useless. Cfr. García, D. García G. Laurent, A. Navarrete, V. Et. al. (2011). Diccionario enciclopédico de Bioética. México, Trillas. P. 57.

¹⁰ This would mean considering the person a mean and not an end.

- In Pandemics, economic resources are not considered when assigning health resources, they cannot be bought or forced or manipulate their allocation. Whoever does so, shall be subject to the corresponding penalties stated by law.

III. Sundry

3.1 Conscientious Objection on the Part of Health Care Providers

Conscientious objection consists of the refusal to comply with the mandate arising from a norm, whether juridical, moral or social, claiming that such norm is against their own ideological, moral or religious beliefs¹¹. Conscientious objection is born from the freedom and dignity of the human person¹², however, the purpose of this protection is aimed for intrinsic, objective and universal values, not for opinions arising from one's own subjectivity, where each person express their individual interpretation of the norm, and therefore:

- In situation of extreme demand of medical and emergency services the health care staff cannot resort to conscientious objection¹³ to refuse care and attention to any patient, whether sick from COVID-19 or any other disease since, by doing so, they would be infringing the individual guarantees contemplated in the Constitution, especially the right to protection of health stated in the Constitution's Article 4th.

¹¹ Tavera, L. Objeción de conciencia. Rev. peru. ginecol. obstet. [online]. 2017, vol.63, n.4 [quoted 2020-04-06], pp.581-590. Available at: <http://www.scielo.org.pe/scielo.php?script=sci_arttext&pid=S2304-51322017000400010&lng=es&nrm=iso>. ISSN 2304-5132

¹² Cfr. Exhibit 8 of the National Guidelines for the Integration and Operation of the Hospital Bioethics Committees. CONBIOÉTICA. Available for download at the site: <http://www.conbioeticamexico.salud.gob.mx/descargas/pdf/registrocomites/Guia_CHB_Final_Paginada_con_forros.pdf> Date of last inquiry: April 6, 2020.

¹³ Since conscientious objection is expressed through the refusal to observe the mandate from a Law or order, there is the juridical requirement that such objection should be previous and following all the existing protocols in each juridical ruling. Failure to meet this previous requirement could hide suspected discrimination, since the Constitution and the International Treaties ratified by Mexico forbid any action that assumes discrimination due to subjective reasons. Therefore, such action would mean the violation of a fundamental right.

- The limitation in human, medical and technical resources does not justify abandoning the ethical and legal obligation of providing care to a patient and ease their suffering, always observing the informed consent and the patient's human rights.

3.2 Psychological Assistance and Support to Health Care Professionals and Patients and Families.

- After a TRIAGE, an extubation or the decision to extubate, it is convenient to hold a **debriefing** session to balance the emotions experienced. It is convenient to find a support group to do so but, due to the difficulties in this pandemic, isolation and social distancing, the right time for this may be procured virtually or, after the health crisis is over, take the time and hold the necessary sessions with health care experts.
- Even if the pandemic may force doctors to stay several days living at the hospital, as is already happening in other countries, they should try to sleep, whenever it is feasible and take 5 minutes breaks from the ICU or the ER, at least twice per shift.
- Do breathing, relaxation, etc. exercises... to reduce stress.
- The ethical reason why health care personnel should also find moments of emotional peace is because in addition to helping to their efficiency and health, **as persons they also need to nourish these areas**, emotional and spiritual.
- Facing this pandemic, which has spread through every country, and which we had never lived before, there is **MOURNING**. The reason for this mourning is the loss of the life we led. No one will ever live the same again, after this experience, particularly those who caught the disease or took care of patients. In addition, our scale of values changes and that challenges us into a crisis.
- To reach acceptance, realism is required, living with the new normalcy that now prevails, and focus it as **normality**.

- We therefore suggest procuring the necessary psychological support to accompany the processes of both the professional health care providers as well as the patients and their families and the mental health care team should therefore be available to carry out this task in a quick and effective way.

3.2.1 The Right to the Final Farewell

- Observing the **solidarity principle** and meeting all the safety protocols, it should be allowed and procured, using all the possible means, that the isolated patients may stay in virtual contact with their families, and in case they are near death, allow them to say goodbye through a remote connection.
- **Respect, at all times, the patient's beliefs, values and individual preferences and, as much as possible, assist them spiritually and psychologically, notwithstanding the beliefs of the health care providers.** Virtual means may be procured to offer such assistance, provided the limitations of each worship allow it and always keeping the rules of safe distance and isolation in the cases confirmed as positive.

3.3 Disposal and Ethical Management of COVID-19 Confirmed Dead Bodies

- According to the Operating Guideline for the Management of Dead Bodies from COVID-19 Cases issued on March 29 by ISSSTE (Mexican Institute for Safety and Social Services to Government Workers)¹⁴, **restricted access should be allowed to the closest family of the deceased person to say farewell, without any physical contact with the dead body or the surrounding areas that could be infected.** This should be done observing the safety protocols established and with the proper protective material.
- **At all times shall a dignified and respectful treatment** be given to the dead body during preparation, transportation and final destinations.
- As far as the religious beliefs of the family allow it, incineration should be preferred over other final destinations.

¹⁴ Document available at: https://s7cdn.joomag.com/pdf/1/1389/1389663/2020_04_04__0967444001586039539.pdf?md5=OHQ9gUKTAzZ_xVO2Z5O_DQ&expires=1586122899&name=Mi+primera+publicacion&1586039586
Date of last inquiry: April 5, 2020.

3.4 Other Measures to Prevent and Mitigate COVID-19 Spread

- A suggestion is made to release from prison inmates that pose a low-risk or were charged with misdemeanor, always under strict domiciliary watch, in order to prevent spreading the disease at prisons and other confinement centers.
- Likewise, and under the consideration and criteria of migration authorities, it is suggested to lift the circulation restriction in migrants detention centers in order to allow them to return to their places of origin and apply the healthy distance measures recommended by the Ministry of Health.

3.5 Ethical Considerations for the Research Processes During Emergencies:

- Conducting research at times of health emergencies is ethical and desirable, provided the **general principles** of the research protocols as well as the **central purpose** of finding the disease's behavior patterns for its eventual cure and/or vaccine are taken into consideration.
- The **risk-benefit balance** should always be weighed, especially in procedures with human persons and having a contingency plan that **covers the possible health risks** that those involved could face.
- With no exception whatsoever, the patients' or next-of-kin **informed consent** should always be prepared and obtained to proceed with the corresponding research. The state of emergency does not authorize any researcher to bypass this step.
- The results of the research should be of **public domain with the obligation to share them** with all the countries that are undergoing the same health emergency. **Global solidarity** should be the guiding principle.
- In case **cures or vaccines** are found to counteract the effects of the sickness caused during the health emergency, priority for their administration should be given first to health care professionals and second to the vulnerable populations. After that distribution they may be administered to the general population.

IV. Information Management

4.1 Privacy and confidentiality: Disclosing the identity of the infected people

- The identity of the people who have tested positive for COVID-19 should be protected and it should not be disclosed in the media. However, the closest contacts, such as family and friends with whom they maintain day-to-day contact may be informed about the diagnosis and should in turn receive the relevant information about risks and preventive measures.
- In turn, the family and close friends must keep in strict reserve the identity of the infected persons, refraining from disclosing the information on the media. This is based on the responsibility, respect and prudence principles.

4.2 Relation with persons in contact while infected

- The patients who show COVID-19 initial symptoms (suspicion) or with a positive diagnosis must provide to the health care staff the name and location of the persons with whom they have been recently in touch, to follow-up the potentially infected people and proceed as per the corresponding observation, diagnosis and, if applicable, quarantine protocols.

4.3 Truthful Information

- At times of contingency due to pandemics, such as COVID-19, it is everybody's duty to:
 - a. Stay informed from reliable sources (try to be critical and reflexive when choosing the best possible sources) about the health risks and the possibility to get infected and infect other people.
 - b. Refrain from sending messages, through any means, that are alarming, based on misinformation, with little or no scientific support and which purpose is generating fear, doubt and confusion about the pandemic.

Exhibit A: Conceptual differences between State of Alarm, State of Siege and State of Exception

Even if some media use these three concepts as synonyms, from a juridical point of view there are big differences among them¹⁵. Therefore, and even though they are not acknowledged in every country's constitution, we will briefly go over the implications each one has based on their construal in the Spaniard Constitution, specifically article 116.

1. State of alarm

The State of Alarm is declared by the Government through a decree. It may be declared in a portion of or throughout the national land and its maximum duration is 15 days extendable to other 15 days. The decree will determine the scope of the territory, the duration and the effects of the State of Alarm; however, this declaration does not imply the suspension of constitutional guarantees¹⁶.

It is declared under any of the following circumstances:



¹⁵ Balle, J. M. L. (1989). The states of alarm, exception and siege (I). *Revista de Derecho Político*, (30). Barcelona, Universidad Autonoma de Barcelona. Pps. 23-54.

¹⁶ Cfr. Catoira, A. A. (2011). El Estado De Alarma en España. *Teoría y Realidad Constitucional*, 28. Madrid, UNED. Pgs. 313–341. <https://doi.org/10.5944/trc.28.2011.6961>

2. State of Exception or State of Emergency

The State of Exception or State of Emergency is declared by the Government prior authorization from the House of Representatives. In this case, before creating the Decree, it will be necessary to include the effects that its approval will have on the population.

The State of Exception is declared whenever serious consequences are expected on the citizens' exercise of their rights and freedom, the normal operation of the democratic institutions, the essential public services or any other aspect that affects public order.

In the State of Exception certain rights may be suspended or deprived from, such as: the right to freedom, the inviolability of the home, extend the maximum term of arrest, secret in communications, freedom of expression, among others¹⁷.

3. State of Siege

The State of Siege is declared by the absolute majority of the Congress at the proposal of the Government, whenever a serious situation is produced or threatened (insurrection or act of force against the sovereignty) and it cannot be solved through other means.

In the State of Siege the population may be deprived from their fundamental rights and the power will not lay on the hands of the President of the Country but on the army's and the *Ius in Bello* or Right of War under the Geneva Convention shall be applied, specially the third article referring to the civil population at the homeland¹⁸.

¹⁷ Cfr. Fix-Zamudio, H. (2004). Los estados de excepción y la defensa de la Constitución. Boletín mexicano de derecho comparado. No. 111. México. Pps. 801-860. <http://dx.doi.org/10.22201/ijj.24484873e.2004.111.3805> For further reference about this state see: Dorantes Díaz, F. J. (2012). Estado de excepción y derechos humanos. Antecedentes y nueva regulación jurídica. Alegatos - Revista Jurídica de La Universidad Autónoma Metropolitana, 81. México, UAM. Pgs. 393-410.

¹⁸ Bru Peral, E. M. (1999). Estados de alarma, excepción y sitio. Madrid, Universidad Carlos, Instituto Fray Bartolomé de las Casas.

In Mexico, these three concepts are regulated differently:

The Federal Constitution of the United Mexican States only acknowledges, in article 29, the State of Exception in the following cases:

- a) Invasion (war, i.e, a State of Siege would be declared)
- b) Serious disturbance of public peace or any other that puts the society in serious danger or conflict.

Only the President of the United Mexican States, with approval from the Congress or the Permanent Commission, may restrict or suspend throughout the country or at a given place the exercise of the rights and guarantees that were an obstacle to quickly and easily face the situation.

Let us take a look at the process Mexico has developed before this pandemic and the reason for the Declaration of Health Emergency which, as mentioned at the beginning of this document, does not imply the suspension of individual guarantees, respecting the rule of law and with full respect of human rights:

We refer to article 73, where the Government's faculties are stated, specifically number XVI which grants faculties to the Government to dictate laws about general health; in the first item it states:

Art. 73. XVII 1st "The General Board of Health shall report directly to the President of the Republic, without intervention of any Ministry; its orders and provisions shall be compulsory for the whole country.

2nd In the event of serious epidemic or risk of invasion of exotic diseases, the Ministry of Public Health shall issue immediately the appropriate preventive measures, which may be approved by the President of the Republic".

This means that the Constitution acknowledges the existence of a body named General Board of Health, which reports directly to the President and which is the highest institution to legislate

about health for the whole State. However, in case of serious epidemic, such as COVID, the Ministry of Health shall have the obligation to issue the necessary measures to face the epidemic, over the initial authority of the President, whose only task will be to later approve them. This is, in emergency situations due to epidemics, the power is undertaken by the Ministry of Health and its Secretary will have the highest responsibility to lead the contingency and choose who will work with him, as is the case of the Vice-minister of Health.

The General Health Act, under the Tenth Chapter: Extraordinary Action on General Health, article 181 states:

"In the event of serious epidemic or risk of invasion of transmissible diseases, emergency or catastrophic situation that affect the country, the Ministry of Health shall issue immediately the essential measures to prevent and fight any damage on health, which may be later approved by the President of the Republic".

The measures issued by the Ministry of Health are those disclosed last Monday the 13th, when the Stage Two of the contingency was decreed. These measures do not restrict the citizens' rights and guarantees, quite the opposite, the participation of the civil society is requested to control the epidemic.

Additional References

Bioethics toolkit resources for COVID-19

<http://www.bioethics.net/2020/03/bioethics-toolkit-resources-for-covid-19/>

Responding to COVID 19: how to navigate a public health emergency legally and ethically

<https://www.thehastingscenter.org/responding-to-covid-19-how-to-navigate-a-public-health-emergency-legally-and-ethically/>

The toughest Triage- Allocating ventilators in a pandemic. The New England Journal of Medicine

https://www.nejm.org/doi/full/10.1056/NEJMp2005689?fbclid=IwAR19nceKEjYgMenQLnd4cO_2zWYi2tpHhSLhvnJbrajcxk9jckWDWa6h_g

Fair allocation of scarce medical resources in the time of Covid-19

<https://www.nejm.org/doi/full/10.1056/NEJMs2005114>

What if Two COVID-19 Victims Need Ventilators and Just One Is Available?. Scientific American

<https://blogs.scientificamerican.com/observations/what-if-two-covid-19-victims-need-ventilators-and-just-one-is-available/>

Who should be saved? The hard decisions in a pandemic

<https://www.susanmathews.com/2020/03/20/who-should-be-saved-the-hard-decisions-in-a-pandemic>

New York`s bioethics experts prepare for a wave of difficult decisions. The Washington Post

<https://www.washingtonpost.com/.../4501f522-7045-11ea-a3ec-70...>

Hospitals consider universal do not resuscitate orders for coronavirus patient. The Washington Post

<https://www.washingtonpost.com/health/2020/03/25/coronavirus-patients-do-not-resuscitate/>

How the Coronavirus May Force Doctors to Decide Who Can Live and Who Dies. NY Times

<https://www.nytimes.com/2020/03/12/opinion/coronavirus-hospital-shortage.html>

Who gets a ventilator when there's a crush of coronavirus patients? Maryland is coming up with a plan. Baltimore Sun

<https://www.baltimoresun.com/coronavirus/bs-hs-ventilator-surge-plan-20200327-dnguwrff7vcrfj3sg45negc3na-story.html>

Coronavirus: should frontline doctors and nurses get preferential treatment?

<https://www.susanmathews.com/2020/03/09/coronavirus-should-frontline-doctors-and-nurses-get-preferential-treatment/>

Thank you for your sacrifice: De facto rationing based on snake oil pitches. Bioethics.net

<http://www.bioethics.net/2020/03/thank-you-for-your-sacrifice-de-facto-rationing-based-on-snake-oil-pitches/>

Allocation of extremely scarce resources in Covid-19 pandemic

<https://www.susanmathews.com/2020/03/14/allocation-of-extremely-scarce-resources-in-covid-19-pandemic>

Ethics resources on the coronavirus

<https://www.thehastingscenter.org/ethics-resources-on-the-coronavirus/>

World Health Organization: Managing Ethical Issues in Infectious Disease Outbreaks

<https://www.who.int/ethics/publications/infectious-disease-outbreaks/en/>

The U.S. Centers for Disease Control: Ethical guidelines in Pandemic Influenza

https://www.cdc.gov/od/science/integrity/phethics/docs/panflu_ethic_guidelines.pdf

Johns Hopkins University COVID-19 resource center

<https://coronavirus.jhu.edu/>

National Academy of Medicine: Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2

<https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/>

AMA Journal of Ethics COVID-19 Ethics Resource Center

<https://journalofethics.ama-assn.org/covid-19-ethics-resource-center>

University of Washington Medicine COVID-19 resources

<https://covid-19.uwmedicine.org/Pages/default.aspx>

Organización Mundial de la Salud, 2020. Alocución General de apertura del Director de la OMS con motivo de la Pandemia Covid 19

<https://www.who.int/es/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---16-march-2020>

CIA Factbook GDP in Healt

<https://www.cia.gov/library/publications/resources/the-world-factbook/fields/409.html>

Corman, Víctor M et al. "Detection of 2019 novel coronavirus (2019-nCoV) by real-time RT-PCR." Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin vol. 25,3 (2020): 2000045. doi:10.2807/1560-7917.ES.2020.25.3.2000045

<https://www.fda.gov/media/136622/download>

Adalja AA, Toner E, Inglesby TV. **Priorities for the US Health Community Responding to COVID-19.** JAMA. Published online March 03, 2020. doi:10.1001/jama.2020.3413

Criteria to Guide Evaluation and Laboratory Testing for COVID-19

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>

United Kingdom Nuffield Council on Bioethics, titled Research in global health emergencies: ethical issues available in English at:

<https://www.nuffieldbioethics.org/publications/research-in-global-health-emergencies>.

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