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THE CHOICE OF SOPHIE: AN ETHICAL AND LEGAL APPROACH IN PANDEMIC TIMES[*]

A ESCOLHA DE SOFIA: UMA ABORDAGEM ÉTICA E JURÍDICA EM TEMPOS PANDÊMICOS

LA ELECCIÓN DE SOFIA: UN ENFOQUE ÉTICO Y LEGAL EN TIEMPOS DE PANDEMIA

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Abstract: The expression "Sophie's choice" defines the imposition of making a decision under pressure and enormous sacrifice. The COVID-19 pandemic caused a worldwide crisis, characterized by the scarcity of resources, making Sophie's choice present in the reality of public and private hospitals. Given this scenario, the purpose of this article is to address and analyze ethical and legal aspects of Sophie's choice in times of Pandemic. Ethics must be based on the principle that to deny human rights is to destroy our humanity. In analysis of the applicable international human rights diplomas, there is no legal justification for adopting a priority medical care scheme in the context of a pandemic that takes into account the possibilities of post-treatment life. We conclude that the establishment of objective criteria for "Sophie's choice" in the context of the pandemic COVID-19 violates both ethical precepts and general human rights principles.

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Resumo: A expressão “escolha de Sofia” define a imposição de tomar uma decisão sob pressão e enorme sacrifício. A pandemia da COVID-19 gerou uma crise mundial, caracterizada pela escassez de recursos, tornando a escolha de Sofia presente na realidade dos hospitais públicos e privados. Diante desse cenário, o objetivo deste artigo é abordar e analisar os aspectos éticos e legais da escolha de Sofia em tempos de pandemia. A ética deve se basear no princípio de que negar os direitos humanos é destruir nossa humanidade. Na análise dos diplomas internacionais de direitos humanos aplicáveis, não há justificativa legal para a adoção de um esquema de atenção médica prioritária no contexto de uma pandemia que considere a possibilidade de vida pós-tratamento. Concluímos que o estabelecimento de critérios objetivos para a “escolha de Sofia” no contexto da pandemia COVID-19 viola os preceitos éticos e os princípios gerais dos direitos humanos.

Palavras-chave: Covid-19; Pandemia; Diretrizes; Direitos humanos; Direito à saúde.

Resumen: La expresión “La elección de Sofía” define la imposición de tomar una decisión bajo presión y enorme sacrificio. La pandemia COVID-19 generó una crisis global, caracterizada por la escasez de recursos, haciendo presente la elección de Sofía en la realidad de los hospitales públicos y privados. Ante este escenario, el propósito de este artículo es abordar y analizar los aspectos éticos y legales de elegir Sofía en tiempos de pandemia. La ética debe basarse en el principio de que negar los derechos humanos es destruir nuestra humanidad. En el análisis de los estatutos internacionales de derechos humanos aplicables, no existe justificación legal para la adopción de un esquema de atención médica prioritaria en el contexto de una pandemia que considere la posibilidad de vida después del tratamiento. Concluimos que el establecimiento de criterios objetivos para la “elección de Sofía” en el contexto de la pandemia COVID-19 viola los preceptos éticos y los principios generales de los derechos humanos.

Palabras clave: Covid-19; Pandemia; Pautas; Derechos humanos; Derecho a la salud.

Introduction

The guarantee of equality and equity between people of different origins, ethnic groups and social groups in the distribution of resources has gained prominence in the current world scenario. Bioethics is an instrument that provides a fair and appropriate distribution of these resources to society.

The expression “Sophie's choice”, originated in 1980, is associated with a dilemma or a necessary choice to be made. It invokes the imposition of making a decision under pressure and enormous sacrifice. The expression that was originated more than forty years ago is now present again.

The COVID-19 pandemic, caused by the new coronavirus, has been considered one of the greatest challenges ever faced in the contemporary world. In April 2020, just a few months

after the start of the pandemic in China, more than 2 million cases had already been identified, causing a real global crisis, given the scarcity of hospital resources and health professionals, making the choice Sophie present in the reality of public and private hospitals. According to the World Health Organization (WORLD HEALTH ORGANIZATION a, 2020), COVID-19 is a respiratory disease caused by the SARS-COV virus, characterized as a new disease, with a high potential for transmissibility, which resulted in high rates of cases, being declared as an emergency international public health, since 10 March 2020.

The current SARS-CoV-2 outbreak and the associated large number of COVID-19 cases are leading to increasing pressure on hospitals in general and intensive care units around the world. The number of ICU admissions is expected to continue to increase in many countries for some time. About a tenth of COVID-19 patients will need some form of ventilatory support in ICUs that are already full under normal circumstances.

The lack of beds for hospitalization has been regularly reported in the international media. The newspaper El País (JUCÁ, 2021) reported in a note that at least 4,132 people died before reaching an intensive care bed for the treatment of COVID-19 during the pandemic of the new coronavirus in six Brazilian states: Rio de Janeiro, Rio Grande do Norte, Minas Gerais, Espírito Santo, Bahia and Maranhão, resulting from the size of the pressure suffered by SUS. In view of this, health agencies are advancing in the elaboration of prioritization protocols in order to select the order of hospitalization or even which patients will be hospitalized and which ones will not be.

However, this leads us to much deeper conflicts than just technical ones, reaching an ethical and legal issue. Who are the people who are being sentenced to death when the protocols are carried out? Which lives are being protected by established protocols? Which lives are being risked and put at risk?

Given this scenario, the objective of this article is to address I) the applicability of Sofia's choice in times of pandemic; II) analyze ethical aspects; III) discuss the legal aspects of Sofia's choice in times of pandemic.

1. The choice of Sophie: concept, origin and applicability in pandemic times

The term “Sophie's choice” was originated in the eighties, due to the novel created by Willian Styron (STYRON, 2010). The plot based on facts tells the story of a Polish woman named Sophie, whose etymology goes back to the Greek word *sophia*, literally meaning

wisdom. The story takes place in World War II, where Sophie is arrested and a Nazi officer gives her the option of saving only one of her children from execution, or they would both be killed. The character bases her choice on objective criteria, choosing the child she believed to have the greatest chance of survival, considering the other child fragile and leading him to death.

Since then, the use of the term has symbolized a dilemma, a decision between two contrary and unsatisfactory alternatives, with a painful and difficult choice.

With the advancement of the COVID-19 pandemic, which reaches an alarming figure of 183.368.584 cases, including 3.975.503 deaths officially confirmed by the World Health Organization (data of 05 July 2021), there was an increase in political conflicts and evidence of lack of hospital structure (WORLD HEALTH ORGANIZATION b, 2021). In Brazil, in 04 July 2021, there were 18.769.808 confirmed cases, including 524.417 deaths (BRASIL, 2021).

In view of the rates close to 100% of bed occupancy in public and private hospitals in several countries around the world, the term “Sophie's choice” has been used in the medical context, where health managers issue guidelines for the creation of prioritization protocols of beds in intensive care units.

The current scenario increases the need for a choice, due to the high demand for treatment, with absolute scarcity of resources, depletion of beds, respirators, medications, wards, tests for COVID-19 and even specialized professionals.

In the United States, the scarcity of resources was initially demonstrated by the absence of high filtration N-95 masks for healthcare professionals. In Italy, crucial resources are preferably used for patients who have the greatest benefits from treatment. In South Korea, patients die in their homes waiting for a hospital bed.

During the COVID-19 pandemic, relatively scarce resources include UTI beds, ventilators and access to tests. The University of Washington at St Louis, the University of Pittsburgh and the state of New York have developed models for assigning scores to patients, based on age and comorbidities, to target the allocation of these scarce resources to individual patients.

The Brazilian Association of Intensive Care Medicine, together with other associations, developed a protocol with recommendations based on the SOFA score assessing the chances of survival of each patient, assessing the presence of comorbidities, prioritizing younger individuals.

In an interview with the French newspaper Le Parisien, health professionals reported that they were being forced to deprive intubation of elderly people who had viral pneumonia and who had other associated diseases (MARI, MÉRÉO, 2020).

In Brazil, the selection and prioritization of patients is carried out daily in view of the insufficient distribution of resources in Brazilian public health. The choices range from a simple distribution of gas packs to a single ICU bed, including medications and treatments of varying complexity (CARVALHO, 2020, p.1).

The National Institute of Excellence in Health and Care in Great Britain has developed guidelines to facilitate the assessment of intensive care clinicians on the patient in need of intensive care. The recommendations suggest that physicians consider the benefit of treatment, assessing the likelihood that the patient will recover to an acceptable outcome (GERMAIN, 2020, p.359).

The Italian Society of Anesthesia recommends that the age, comorbidities and functional status of any critical patient should be assessed. A longer and more resource-consuming clinical course can be anticipated for elderly patients with comorbidities, compared to younger patients who have lower costs. Society says that the principle is based on saving limited resources, prioritizing patients who are more likely to survive. The authors also report that in the worst scenario of complete saturation of UTI resources, the criterion “first come, first served” is not recommended, as, ultimately, it would result in the denial of access to ICU care for many patients potentially curable (VERGANO, 2020, p.165).

The National Institute of Excellence in Health and Care (NICE), that provides national guidance and advice to improve health and social care in the United Kindom (UK), recently published the COVID-19 rapid guidelines for intensive care in adults and recommends the use of the Clinical Fragility Scale in patients aged 65 and over and states that decisions on admission to intensive care units (UTIs) should be made based on the potential for medical benefit.

The definition of the priority groups that should receive vaccination against COVID-19 is also controverse. The World Health Organization (WHO) Strategic Advisory Group of Experts on Immunization (SAGE) published a roadmap for prioritizing uses of COVID-19 vaccines in the context of limited supply (WORLD HEALTH ORGANIZATION c, 2020, p. 14-15). It is a technical recommendation for vaccine prioritization. According to SAGE, when there is very limited vaccine availability, only for 1–10% of the population (stage I), the priority groups should be:

- Health workers at high to very high risk of acquiring and transmitting infection should be the first group to receive immunization (stage Ia).
- Older adults defined by age-based risk specific to country/region; specific age cut-off to be decided at the country level (stage Ib).

When there is vaccine availability for 11-20% of the population, the following groups should be considered (stage II):

- Older adults not covered in Stage I.
- Groups with comorbidities or health states determined to be at significantly higher risk of severe disease or death.
- Sociodemographic groups at significantly higher risk of severe disease or death (depending on country context, examples may include: disadvantaged or persecuted ethnic, racial, gender, and religious groups and sexual minorities; people living with disabilities; people living in extreme poverty, homeless and those living in informal settlements or urban slums; low-income migrant workers; refugees, internally displaced persons, asylum seekers, populations in conflict settings or those affected by humanitarian emergencies, vulnerable migrants in irregular situations; nomadic populations; and hard-to-reach population groups such as those in rural and remote areas).
- Health workers engaged in immunization delivery (routine programme-specific and COVID-19).
- High-priority teachers and school staff (depending on country context, examples may include: preschool and primary school teachers because of the critical developmental stage of the children they teach, teachers of children where distance learning is very difficult or impossible).

Stage III was defined for moderate vaccine availability, for 21–50% of the population:

- Remaining teachers and school staff.
- Other essential workers outside health and education sectors (examples: police officers, municipal services, child-care providers, agriculture and food workers, transportation workers, government workers essential to critical functioning of the state not covered by other categories.
- Health workers at low to moderate risk of acquiring and transmitting infection.
- Personnel needed for vaccine production and other high-risk laboratory staff.
- Social/employment groups at elevated risk of acquiring and transmitting infection because they are unable to effectively physically distance (depending on country context, examples may include: people living or working in detention facilities, incarcerated people, dormitories, informal settlements or urban slums; low-income people in dense urban neighbourhoods; homeless people; military personnel living in tight quarters; and people working in certain occupations such as mining and meat processing).

Nevertheless, each country has autonomy to define its priorities. As an example, the government of Indonesia (a Southeast Asian country severely hit by COVID-19) prioritized

early-stage vaccination for health workers, civil servants, and citizens aged 18-59 years old. This is inconsistent with the SAGE WHO recommendation (THE CONVERSATION, 2021).

And, in some countries, as Brazil, the federal government defines the vaccine prioritization, but local governments, as States, have autonomy to decide the prioritization in the general category of, for example, health workers (SAÚDE PEDE…2021).

According to WHO data, as of 10 March 2021, a total of 300.002.228 vaccine doses have been administered in the whole world (WORLD HEALTH ORGANIZATION b, 2021).

The pandemic thus exposes social inequalities cruelly and openly to the most vulnerable groups. These facts generated the emergence of international ethical and legal controversies, bringing up discussions related to the feasibility of applying objective criteria in the choice of patients to be treated.

2. Ethical aspects

With the implementation of specific regulatory rules on the (non) care of patients with COVID-19, the act based on the power to make live or let die is exercised. This choice is supported by an alleged moral that, in practice, assesses which lives are most worth living. This results in discussions that are not only medical and scientific, but also cover ethical and legal aspects.

The use of instruments that prioritize hospitalization due to the vulnerability of each patient indirectly represents a choice to let die people with disabilities, elderly and poor.

Citizenship shapes and is shaped by our most deeply rooted values of justice and equity, determining that they are the good in society (MORRIS, 2001, p.15).

Mello reports that one of the forms of materialization of social construction that a standard body is called normal is in the underestimation of people who do not correspond to the standard established by society. Thus, the idea is that an individual is capable or incapable, taking into account only his/her body (MELLO, 2016, p. 3267).

Germain, in analyzing the distribution of health resources in Britain in times of a pandemic, warns that the egalitarian conception of justice and distribution that underlies the functioning of the health system is in danger of being replaced by a classification based only on objective criteria that are adopted in the choice of those that will be hospitalized (GERMAIN, 2020, p.359).

Sophie's choice in times of pandemic directly confronts the ethics of care defined as a branch of deontology that takes into account moral feelings and the human being's ability to care responsibly for others (KITTAY, 1999). It is important to remember that, as a body, we are all exposed to vulnerabilities. Precariousness is a condition imposed on all human lives, which are exposed to social and political forces. Urquizia and Azul (2021, p.2) complement that the harmful effects of the pandemic are felt by the population that in the normal state are vulnerable and that with the epidemiological crisis they begin to suffer hypervulnerabilization.

A document prepared by the Brazilian Association of Collective Health and more than 40 entities from social movements reports the need to provide other resources to guarantee the universality of the social right to health, with respect for other rights, such as the right to life, equality, dignity of the human person and in compliance with the principle of equity in the health system.

The Brazilian Society of Bioethics, in response to these recommendations for prioritizing care, prepared an official document emphasizing that the guidelines should be based on respect for human dignity, with decisions and conduct that do not devalue and discriminate people, communities, minorities and vulnerable groups. It also highlights the right of access to the best treatment on an equal basis.

Osoegawa, Lisboa and Nogueira (2021, p.3) understand that the lack of access, the omission and the inadequacy of public policies in facing the pandemic create a panorama of deepening the situation of vulnerability.

The UK disability organization expressed its opinion in a letter released to the public:

> The fact that we need significant levels of support and social care to live our lives, or that we may need in the future as a result of the pandemic, should not lead health professionals to think that we should not benefit from treatment. We have the right to participate fully in decisions about our lives, including decisions about life and death. Decisions and protocols on access, provision and evaluation of treatment and care provided to individuals during the Covid-19 pandemic should be developed in collaboration with disabled people's organizations and representatives of human rights organizations (DISABILITY RIGHTS, 2020).

Medical ethics is conceptualized as the normative consideration of ethical issues in medical practice, seeking to establish what is right or wrong in an action within a structure of values, this presents the principle of justice that establishes equity as a fundamental condition, where ethics consists in treating the individual correctly and appropriately, giving each one what is due, so that the professional acts impartially, not allowing the interference of social, cultural, religious, financial aspects in the doctor-patient relationship and in the treatment

performed. Resources should be evenly distributed, with the aim of reaching, with greater efficiency, the largest number of people assisted (BRASSINGTON, 2018, p.227).

The Brazilian Medical Association states that, for protocols to be ethically defensible, it is necessary that they:

> Do not occur in secret, without proper registration and in a subjective and inconsistent manner. On the contrary, it is essential that they occur on the basis of clear, transparent, technically well-founded, ethically justified protocols and aligned with the legal framework (DISABILITY RIGHTS, 2020).

Germain reports that, in Great Britain, the health system presents equality as an ethical principle, being a source of pride for society to access health services without distinction. However, the reality of the pandemic caused the system to revert automatically (GERMAIN, 2020, p.359).

Three fundamental values can be seen in the allocation of resources in times of a pandemic, these are: Maximizing the benefits produced by scarce resources; equal treatment and the prioritization of patients with worse conditions, so that no vulnerability, wealth, race can determine who lives and who dies (EMANUEL, 2020, p.251).

Nevertheless, the French Association of Coronavictmes filled a complaint against the Government due to the lack of respect for equality, denouncing arbitrary discrimination against the elderly, in the choice of patients who should or should not be hospitalized, calling the action "silent massacre".

These facts contradict the basis of ethics of care, which is based on valuing human beings, and not allowing inhumanity to become common sense or to be considered acceptable behind a concept of objectivity.

The ethics of care involves the conflict between availability and unavailability to include people or groups in the generative capacity. This is manifested through the force of sympathy that is the virtue of care, however it presents an inclination of dislike, a tendency towards rejection. Because care is selective, some type of rejection is always inevitable. Ethics, law and judgment must define the permissible extent of this inherent rejection of any group. In order to reduce it, religion and ideologies must continue to defend the universalization of care.

Such criteria are in line with the Geneva Declaration, an international document on medical oaths adopted by the World Medical Association. According to the mentioned Declaration, doctors should not allow considerations of age, illness or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social position or any

other factor to come between the doctor's duty and his/her patient (WORLD MEDICAL ASSOCIATION, 1948).

The same organization drew up an International Medical Code of Ethics, stating that it is the duty of the physician to remember his/her obligation to respect human life (WORLD MEDICAL ASSOCIATION, 2013).

For an ethical coexistence between people of different degrees of vulnerability, a sensitivity of society is needed, valuing the differences between the many forms of human being.

> More than an ethics that removes subjectivity, it is necessary an ethics that supports the situated perspective, the one that is located, in the context of the hospital, based on time in the encounter of bodies and the experiences of the subjects. It is there that embodied knowledge is found, which cannot be generalized. The objectivity that emerges from there is the type that reveals itself from specific and particular embodiments. Vision from a body that is complex, contradictory, structuring and structured life (WORLD MEDICAL ASSOCIATION, 2013).

It is necessary to apply the principle of justice in a uniform manner to all people, and not selectively to people with a geriatric profile or chronic health problems, so it is necessary to try to maximize both the number of people benefited and disability-free survival in hospital discharge and the number of years of life saved, unlinking the allocation decision based on the person's chronological age as the only strategy, opening the door to the need to evaluate other variables (RUBIO, 2020, p.443).

The application of age or social role criteria is a social obstacle and does not represent the principle that all human life has the same value and should not be exchanged for others.

Ethics must be based on the principle that to deny human rights is to destroy our humanity. It is therefore necessary to recognize that anyone is able to express preferences, regardless of his/her vulnerability. It must then be assumed that we all have the same human rights, and that some need additional resources to access those rights.

It is worth noting that it is difficult to know which patients fall into groups of better or worse prognosis, this can be particularly difficult in the preparation stage before the 'outbreak', when 'preventive selection can deny some patients intensive care that could have been saved. The Universal Declaration on Bioethics and Human Rights (UDBHR), unanimously approved, by acclamation, at the UNESCO’s General Assembly on October 19th 2005, states: Article 10 – Equality, justice and equity.

The fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably.

> Article 18 – Decision-making and addressing bioethical issues
> 1. Professionalism, honesty, integrity and transparency in decision-making should be promoted, in particular declarations of all conflicts of interest and appropriate sharing of knowledge. Every endeavour should be made to use the best available scientific knowledge and methodology in addressing and periodically reviewing bioethical issues.
> 2. Persons and professionals concerned and society as a whole should be engaged in dialogue on a regular basis.
> 3. Opportunities for informed pluralistic public debate, seeking the expression of all relevant opinions, should be promoted.

Globalization, aggravated by the pandemic, has posed perhaps the greatest ethical challenge today, considering that it is much more difficult to be at peace morally when it is known that there are human beings in harsh conditions of life or livelihood (URQUIZIA; AZUL, 2021, p.7).

Equality, justice and equity must be taken into account when choices concerning which patients will "have right to best treatment" are taken. Decision-making, concerning COVID-19 patients, is not an easy or simple task. However, reflection and dialogue on this issue should be constantly exercised, in the pursuit of more ethical and humane solutions.

3. Legal aspects

In addition to the clear ethical aspects surrounding the topic, it is certain that the choice of the patient to be treated in case of insufficient medical resources also comes up against legal issues. Despite the existence of different internal rules in each country, we cannot ignore that international rules exist and are binding on the countries that have ratified them.

Thus, despite the difference between the laws of each nation, international human rights treaties are vectors that should serve as a guide and foundation for resolving issues that may, in some way, violate such rights, especially when we are facing minority and vulnerable groups, such as the elderly and the disabled.

However, international human rights treaties reflect essential values for the international community as a whole and, therefore, have real normative superiority when in conflict with domestic laws. Thus, with an apparent conflict between an internal rule and an international human rights treaty, the latter must prevail (WORLD MEDICAL ASSOCIATION, 2013).

Based on this assumption, it is necessary to analyze what this set of international standards says about the theme.

The International Covenant on Civil and Political Rights (ICCPR) brings in its text, as the first individual human right, the right to life. According to the aforementioned international treaty, the right to life is inherent to the condition of being a human person, being deprived of life arbitrarily prohibited (UNITED NATIONS, 1966). In the same vein, the International Covenant on Economic, Social and Cultural Rights, in its article 12, provides that it is the responsibility of States Parties to recognize the right of everyone to enjoy the highest possible level of physical and mental health (UNITED NATIONS b, 1966). Both normative diplomas clearly demonstrate that the deprivation of a given patient's life by previous objective criteria, which take into account only the chances of subsequent survival, violates internationally recognized human rights principles.

There is no way to say that the refusal to care for an elderly or disabled person, or even with a certain comorbidity, so that resources are made available to younger and healthier people, guarantees the right to life or the right to the highest possible level of cheers. If it is the duty of the State to guarantee these rights without discrimination, how does Sophie's choice fit these rules?

At the regional level, it is not different. The American Convention on Human Rights, known as the San Jose Pact of Costa Rica, also protects the right to life by providing that no one can be deprived of it arbitrarily (AMERICAN CONVENTION ON HUMAN RIGHTS, 1969). The Protocol of San Salvador (Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights) guarantees, under the terms of the ICESCR, that everyone has the right to enjoy the highest level of physical well-being, mental and social (RUIZ-CHIRIBOGA, 2013).

The right to life is also protected by the European Convention on Human Rights (Article 2) and by the African Charter on Human and Peoples' Rights (Article 4) (AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS, 1981).

Thus, it is not too much to say that the right to life has almost global recognition as a fundamental human right that guarantees all other rights inherent to the human condition itself. It is strange, therefore, that the directives from a State itself can establish how to restrict this right to a certain group of people.

Nevertheless, it can be understood that such provisions are generic enough, so they are not applicable to the case of the COVID-19 pandemic, allowing States to violate such provisions in exceptional situations.

However, this conclusion is not adequate for two main reasons. First, the international treaties themselves provide for the possibility of suspending certain rights. Such hypotheses, in addition to always proving to be extremely exceptional situations, cannot infringe other obligations arising from the rules of international law, especially non-discrimination. As an example, Article 4 of the ICCPR provides:

> When exceptional situations threaten the existence of the nation and are officially proclaimed, the States Parties to the present Covenant may adopt, to the strict extent required by the situation, measures that suspend the obligations arising from this Covenant, provided that such measures are not incompatible with other obligations imposed by international law and do not entail any discrimination solely on the grounds of race, color, sex, language, religion or social origin (UNITED NATIONS, 1966).

Therefore, even if the conclusion is reached that the pandemic caused an exceptional situation that threatens the existence of a certain nation, restrictive measures of rights provided in the treaties cannot be adopted if such measures prove to be discriminatory. Second, all treaties provide for rights that can be suspended in exceptional times and none of them allows the suspension of the right to life. This demonstrates that such a right is logically and naturally above others, insofar as it is not possible for a signatory State of such international human rights treaties to restrict or suspend it, even if there is a serious fact that even threatens the very existence of its own population.

This is because the State can no longer be justified as an arbiter and sovereign over its citizens. On the contrary, in democratic regimes, the State has the sole purpose of guaranteeing the maximum social welfare for each of its people, guaranteeing the enjoyment of basic rights and, above all, human rights.

As if general protection standards were not enough, other international treaties provide specific guarantees to vulnerable groups that would be affected by the established criteria for the “Sophie choice” in the context of the COVID-19 pandemic.

The International Convention on the Rights of Persons with Disabilities, known as the New York Convention, brings several devices that can be applied in a specific way to the case studied in the present work. The general principles of the aforementioned standard list non-discrimination and equal opportunities as rights. Further, the Convention, in its Article 5,

ratifies equality as a principle by recognizing that persons with disabilities are equal before the law, without discrimination, and by obliging the signatory States to prohibit any discrimination based on disability and guarantee to vulnerable group equal and effective legal protection. It also guarantees the right to life by providing, in Article 10, that the State must ensure that persons with disabilities effectively exercise this right on an equal basis with others (HENDRIKS, 2007, p.283).

Thus, it cannot be said that the choice of a person "with greater chances of survival", over a person with disabilities, guarantees equal opportunities in medical treatment.

However, we are aware of the specific provision of the same pact that deals precisely with risk situations and humanitarian emergencies. In its article 11, the New York Convention expressly guarantees persons with disabilities protection and security.

> In accordance with their obligations under international law, including international humanitarian law and international human rights law, States Parties shall take all necessary measures to ensure the protection and safety of persons with disabilities who are at risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters (HENDRIKS, 2007, p.283).

In other words, even in situations of risk, including in humanitarian emergencies or natural disasters, there is a legal duty for the State party to guarantee the protection of these people, not justifying their disregard for medical treatment, regardless of the scarcity of resources.

As for the elderly, in addition to the non-discrimination provisions in the international treaties already mentioned - including discrimination based on age - there is little specific content for the protection of the elderly at the international level. However, at the regional level, we have made important progress in recognizing the rights of this population with the San Jose Charter on the Rights of Older Persons in Latin America and the Caribbean. It is important to note that, although this document is not binding, unlike the other international treaties already mentioned, the letter is a true guide to be followed in the treatment and recognition of the rights of the elderly. According to this soft law document, States must join efforts to promote the universalization of the right to health for the elderly and facilitate preferential access to medicines and medical equipment. In another chapter, the letter draws attention to the vulnerability of these people in emergency situations or natural disasters, urging States to include priority and preferential assistance for the elderly in relief plans (AMERICAN CONVENTION ON HUMAN RIGHTS, 196).

Thus, in the analysis of international human rights diplomas applicable to the case under study, there is no legal justification for adopting a priority medical care scheme in the context of a pandemic that takes into account the possibilities of post-treatment life, whether because such objective criteria disregard the right to life as an internationally recognized human right, either because it ends up discriminating vulnerable groups affected by the medical "Sophie choice", approaching true eugenics in a situation of serious health crisis faced worldwide.

Final Considerations

The establishment of objective criteria for the choice of Sophie in the context of the COVID-19 pandemic violates both medical ethical precepts and general human rights principles in that they end up violating the right to life inherent of any human being. Guidelines that exclude the elderly or people with disabilities from medical care end up establishing clearly discriminatory criteria in relation to these vulnerable groups.

The new coronavirus pandemic of 2020 presents an unprecedented challenge for doctors and emergency responders, as well as emergency room patients and their families. Given the significant fear, anxiety and uncertainty that accompanied the spread of the virus worldwide, there is no more important time to focus on best practices around communication, empathy and compassion.

> It is not the death of people from illness that leads us to the risk of exterminism, but of making elderly killers, people with chronic illnesses and people with disabilities: aiming at them, considering them as things, as metrics in health protocols, and not as someone. Close enough to become a number that makes the charts fat and runs the news in the newspapers, but not enough to worry about their deaths to the point of forcing another response from the state and public policies (VON DER WEID, 2020, p.18).

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