

Hospital governance, mental health, and bioethics in the COVID-19 syndemic

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Abstract

This article analyzed the institutional responses of public mental health governance adopted by a public university hospital during the COVID-19 syndemic, with an emphasis on the bioethical models underpinning organizational decisions in response to workers' psychological distress. This was an observational, descriptive-exploratory study with a mixed-methods, longitudinal, and retrospective approach, conducted between 2017 and 2021 in Alagoas, Brazil. A total of 765 records of sick leave due to mental disorders were analyzed, and interviews were conducted with managers. Data were subjected to statistical and thematic analyses. There was no significant increase in sick leave, with a higher incidence among workers with intermediate levels of contact. The analysis revealed ethical dilemmas, such as the suspension of elective surgeries. Governance responses were predominantly guided by bioethical principlism, balancing autonomy, justice, beneficence, and non-maleficence. The adoption of a bioethical model integrated with institutional strategies emerged as a protective factor for mental health and contributed to an ethical and humanized response to the health crisis.

Keywords: Bioethics. Governance. Mental health. Covid-19. Syndemics.

Resumo

Governança hospitalar, saúde mental e bioética na sindemia de covid-19

Este artigo analisou as respostas institucionais da governança pública em saúde mental adotadas por um hospital universitário público durante a sindemia de covid-19, com ênfase nos modelos bioéticos que fundamentaram as decisões organizacionais diante do sofrimento psíquico dos trabalhadores. Trata-se de estudo observacional, descritivo-exploratório, com abordagem mista, longitudinal e retrospectiva, realizado entre 2017 e 2021, em Alagoas. Foram analisados 765 registros de afastamento por transtornos mentais e foram conduzidas entrevistas com gestores. Os dados foram submetidos a análise estatística e temática. Não houve aumento significativo nos afastamentos, com maior incidência entre trabalhadores de contato intermediário. A análise evidenciou dilemas éticos, como a suspensão de cirurgias eletivas. As respostas da governança foram predominantemente orientadas pelo principlismo bioético, equilibrando autonomia, justiça, beneficência e não maleficência. A adoção de um modelo bioético articulado a estratégias institucionais configurou-se como elemento protetivo à saúde mental e favoreceu uma resposta ética e humanizada à crise sanitária.

Palavras-chave: Bioética. Governança em saúde. Saúde mental. Covid-19. Sindemia.

Resumen

Gobernanza hospitalaria, salud mental y bioética en la sindemia de Covid-19

Este artículo analizó las respuestas institucionales de la gobernanza pública en salud mental adoptadas por un hospital universitario público durante la sindemia de Covid-19, con énfasis en los modelos bioéticos que fundamentaron las decisiones organizacionales frente al sufrimiento psíquico de los trabajadores. Se trata de un estudio observacional, descriptivo-exploratorio, con enfoque mixto, longitudinal y retrospectivo, realizado entre 2017 y 2021, en Alagoas, Brasil. Se analizaron 765 registros de ausencias laborales por trastornos mentales y se realizaron entrevistas con gestores. Los datos fueron sometidos a análisis estadístico y temático. No se observó un aumento significativo de las ausencias laborales, con mayor incidencia entre los trabajadores con nivel intermedio de contacto. El análisis evidenció dilemas éticos, como la suspensión de cirugías electivas. Las respuestas de la gobernanza estuvieron predominantemente orientadas por el principlismo bioético, equilibrando autonomía, justicia, beneficencia y no maleficencia. La adopción de un modelo bioético articulado con estrategias institucionales se configuró como un elemento protector de la salud mental y favoreció una respuesta ética y humanizada a la crisis sanitaria.

Palabras clave: Bioética. Gobernanza. Salud mental. Covid-19. Sindemia.

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The 2019 health emergency caused by the new coronavirus (SARS-CoV-2) surpassed the traditional characteristics of a pandemic, constituting a global syndemic, a concept that expresses the synergistic interaction between infectious diseases, chronic conditions, and structural social inequalities, proposed by Horton¹ and grounded in the critical perspective of Singer and Clair². Therefore, the effects of COVID-19 were amplified by pre-existing social and economic factors, disproportionately impacting health systems and, above all, frontline workers³.

In Brazil, healthcare professionals were not only overwhelmed by the volume of healthcare service; they were also subjected to long hours, therapeutic uncertainties, resource scarcity, and a context of extreme decisions with profound ethical implications⁴. This conjuncture of permanent tension proved especially critical in public hospitals, where governance structures had to respond in record time to multiple dilemmas, such as allocating intensive care unit (ICU) beds, suspending elective procedures, and defining criteria for testing and protecting teams.

Faced with these challenges, public health governance was forced to reorganize flows, redefine protocols, and, above all, build ethical responses to moral dilemmas. Governance, understood as the set of coordination, deliberation, and accountability mechanisms within the institutional sphere, began to operate under the imperative of preserving the physical and psychological integrity of workers, without disregarding resource limitations and collective interests⁵.

In this context, bioethical frameworks such as utilitarianism—which prioritizes collective well-being, even to the detriment of individual rights—and principlism—based on the principles of autonomy, beneficence, non-maleficence, and justice—were problematized in the daily practice of management^{6,7} and became fundamental decision-making tools.

Although the mental illness of healthcare professionals during the syndemic has been addressed by several studies⁸, it is still necessary to understand the influence of the ethical principles adopted by governance structures. It is not only a matter of evaluating the number of sick leaves, but of understanding the foundations that supported institutional decisions.

Considering this gap, this study seeks to analyze the response of hospital public governance to the COVID-19 syndemic and, to this end, addresses the bioethical frameworks that guided institutional decisions and their relation with the mental health of the workers. The hypothesis is that resorting to a clear and institutionalized bioethics model can protect managers and their teams from moral distress and psychological overload.

Understanding the effects of the COVID-19 syndemic on healthcare workers requires frameworks that go beyond the traditional biomedical approach. Three theoretical axes are particularly relevant for the analysis: the concept of syndemic, the foundations of public governance in healthcare, and bioethical decision-making models. A syndemic is characterized by the simultaneous interaction between biological epidemics and adverse social factors, such as poverty and exclusion. In the field of public management, healthcare governance is defined as the capacity of institutions to coordinate diverse actors, negotiate priorities, and make collective decisions guided by equity and public interest⁵.

Bioethical models acquire a central role in emergencies, when governance must be able to operate under high uncertainty and maintain ethical coherence and decisional transparency. Utilitarianism, with a strong Anglo-Saxon tradition, guides decisions based on the maximization of aggregate well-being, even if it implies detriment to minorities or specific individuals^{9,10}.

Principlism, formulated by Beauchamp and Childress¹¹, proposes a matrix of four principles—autonomy, beneficence, non-maleficence, and justice—as a basis for healthcare decision-making, which provides the casuistic weighing of conflicting values, promoting institutionalized ethical deliberation. Thus, studying hospital governance from the perspective of bioethics provides an analytical key for understanding institutional resilience and the care for those who also provide care.

Method

This is an observational, descriptive-exploratory, and retrospective study, structured with a longitudinal mixed-methods design. The study was conducted at the Professor Alberto

Antunes University Hospital (HUPAA), in Maceió/AL, which is part of the network of the Brazilian Company of Hospital Services (EBSERH/Rede HU Brasil) and is a regional reference for medium and high complexity care in the Unified Health System (SUS). The study was approved by the research ethics committee (REC), and all participants signed an informed consent form.

Data collection was carried out between September 2021 and September 2022. Through the Integrated Public Servant Healthcare Subsystem (SIASS), 765 mental and behavioral disorder (ICD-10 Group F) sick leaves were granted to workers under the single legal regime (RJU). For comparative purposes, the records were divided between the pre-syndemic period (2017-2019) and the syndemic period (2020-2021). The workers were categorized according to exposure risk: 1) direct contact (continuous patient care, such as physicians and nurses); 2) intermediate contact (intermittent interaction, such as social workers and pharmacists); and 3) indirect contact (administrative and operational departments).

The qualitative stage comprised documentary analysis of HUPAA's contingency plan for COVID-19 and primary data collection with managers. After two participants were excluded from the pilot test, the final sample consisted of 16 corporate governance members, who were submitted to structured interviews, and 16 REC members, who answered an electronic questionnaire based on Thurstone's value measurement method. They were included due to their strategic advisory role in the health crisis: in the absence of a hospital bioethics committee, the committee

was responsible for guiding decisions on ethical dilemmas in healthcare service protocols.

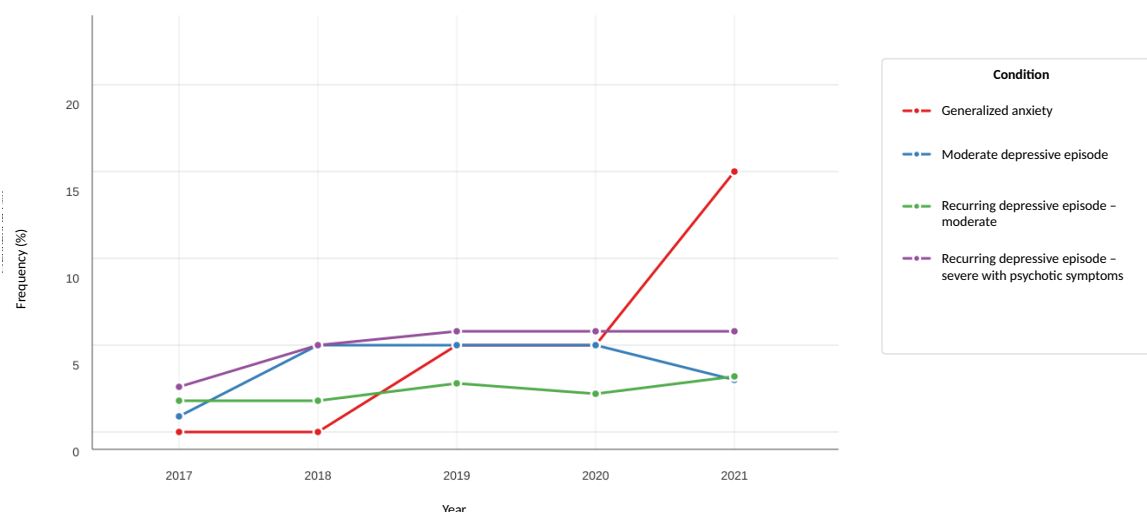
The statistical analysis, processed in SigmaPlot software (version 12.0), used descriptive statistics, Pearson's chi-square test, and analysis of variance (Two-way ANOVA) for hypothesis testing, with a significance level of $p < 0.05$. Qualitative data were processed by thematic content analysis, based on bioethical principles.

Results and discussion

Mental disorder sick leave period

The statistical analysis investigated the impact of the syndemic from two perspectives: frequency and duration of mental disorder sick leaves between 2017 and 2021. Initially, a chi-squared test showed no significant change in the proportion of leaves between the pre-pandemic period (2017-2019) and the COVID-19 period (2020-2021) ($\chi^2(1)=1.55$; $p=0.213$). Additionally, analysis of variance (ANOVA) confirmed that the average days of absence due to leave also did not undergo statistically relevant variation between the periods ($F(4.55)=0.81$; $p=0.458$). Considered in conjunction, the data indicate notable stability in illness patterns, a result that contradicts the expectation of a significant increase indicated by international studies¹².

Despite the stability, there was a punctual increase in leaves for anxiety disorders (ICD-10 F41.1) in 2021, while depressive disorders (ICD-10 F32.1) were more prevalent before the syndemic, according to Figure 1. These data indicate interpretive complexity, suggesting that mental illness is associated with the accumulation of pre-existing structural stressors.

Figure 1. Distribution of selected mental disorders (HUPAA, 2017-2021)

Source: SIASS data, analyzed by the authors (2021).

Illness by professional group: structural invisibilities

The frequency of mental health sick leaves showed distinct patterns between professional categories: the intermediate contact category showed the highest rates, peaking at 47% in 2020, while the indirect contact category had the lowest rates, of only 10% in the same year. The direct contact category maintained a stable frequency, around 35%, throughout the studied period. When comparing the periods before and during the COVID-19 syndemic, the chi-squared test showed no statistically significant change in the differences between the groups after the arrival of the syndemic ($p=0.199$) (Figure 2).

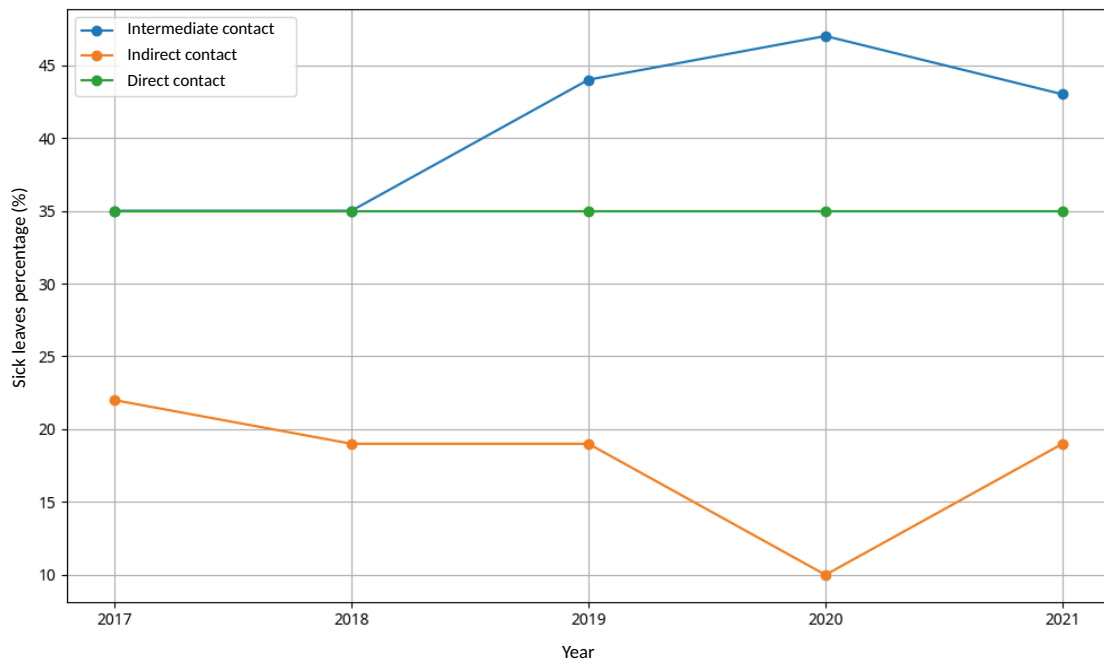
ANOVA was used in the study to perform multiple comparisons, both in relation to the periods (pre-syndemic vs. syndemic) and between the different professional groups. The main finding of the test was the statistically significant difference in the frequency of sick leaves among the three contact groups (direct, intermediate, and indirect) ($p=0.002$). The same analysis did not find significant differences when comparing the leaves of the professional groups between the pre-syndemic and syndemic phases ($p=0.237$), nor in the average duration of the leaves in the two periods ($p=0.458$).

Although the quantitative data indicate stability or even a reduction in formal sick leaves during the crisis, this finding should be interpreted with a cautious and critical approach. The specialized literature indicates

that extreme health emergency situations frequently trigger presenteeism, a phenomenon in which professionals, even when physically or psychologically ill, remain at their work post. This occurs due to a strong sense of moral duty, peer pressure, or fear of overloading already short-staffed frontline teams³.

Furthermore, the possibility of institutional underreporting is a considerable limiting factor. The operational barriers imposed by the chaos of the period, added to the exclusive focus on combating the virus, may have hindered the formal registration and acceptance of psychiatric sick leaves. Thus, the stability in the SIASS records does not necessarily reflect the absence of psychological distress, but rather the possible invisibility and reconfiguration of how this illness was experienced, endured, and, at times, neglected at the peak of the syndemic.

This finding converges with the analysis of Teixeira and collaborators¹⁹, who note the institutional invisibility of certain categories that suffer with precariousness, lack of recognition, and scarce inclusion in decision-making spaces. Therefore, mental health vulnerability encompasses psychosocial dimensions of work. This view is substantially corroborated by Miranda, Araújo, and Oliveira¹⁴, who note that the psychic vulnerability of workers, especially those on peripheral areas, is not just a clinical phenomenon but reflects chronic structural precariousness, demanding collective efforts to go beyond mere crisis management and guarantee rights and well-being.

Figure 2. Distribution of sick leaves by professional group (HUPAA, 2017–2021)

Source: SIASS data, analyzed by the authors (2021).

Ethical dilemmas and bioethics applied to management

The qualitative analysis found that managers faced substantial ethical dilemmas. Three situations were recurrent: suspension of elective procedures, causing conflicts between beneficence and justice; allocation of resources to other states, problematizing national beneficence and local non-maleficence; and difficulty in acquiring individual protective equipment (IPE), showing the clash between rapid response and bureaucratic hurdles. Among the dilemmas surveyed, the radical restructuring of the hospital service flow emerged as a critical point of ethical tension, as shown below:

“It was decided to temporarily suspend outpatient services, as well as some types of exams and elective surgeries (...). Thus, the focus was redirected to actions related to COVID-19. There was a prioritization of acute and more severe cases, ensuring that critical treatments were not interrupted” (Manager 01/Report 001).

These moral clashes align strongly with the recent findings of Glad et al.¹⁵ When investigating the qualitative descriptions of healthcare workers, the authors found that ethically challenging

situations during the crisis—especially those that imposed forced restrictions on ideal care—generated a profound disconnect between professional values and practical reality, acting as the main trigger for moral distress.

This context showed a profound conceptual tension between the utilitarian and principlist approaches. The utilitarian approach, widely present in global triage algorithms during the crisis, operates under the logic of numerical maximization, advocating for the allocation of scarce resources to save the greatest number of lives, often to the detriment of more vulnerable groups. In contrast, the data indicate that hospital governance was guided primarily by bioethical principlism (autonomy, beneficence, non-maleficence, and justice), thus rejecting the coldness of purely pragmatic calculations and being grounded in the inalienable respect for human dignity¹¹.

The adoption of the principlist model showed a direct and positive relation with the outcomes in corporate mental health. By implementing this framework through the creation of structures such as the Emergency Operations Center (COE) and the Worker Health Support Front, the institution consolidated a strategy that justifies the low prevalence of moral distress reported among managers (18.75%).

This situation is consistent with the propositions of Beauchamp and Childress¹¹, who emphasize that efficient governance must be based on clear normative values. The contemporary literature also corroborates this perspective, as it argues that the coordination between ethical clarity, deliberative spaces, and organizational support acts as a protective shield^{16,17}, strengthening public governance and directly mitigating the moral distress of workers in health emergencies.

It is necessary to carry out a deep critical problematization regarding the 81.25% of governance representatives who stated they had not experienced moral and/or psychological distress. As it refers to the institution's high-level decision-making echelon, it is imperative to consider the manifestation of social desirability and institutional defense biases in the responses. In leadership positions in healthcare, there is an unspoken expectation that the manager projects invulnerability, resilience, and absolute control before operational teams.

Consequently, institutional biases may have led to the suppression, denial, or naturalization of the severe stress experienced, which masked the true emotional impact. The refusal to report illness can act as a structural coping mechanism to maintain the stability of the organizational pyramid in times of crisis, underreporting the real burden that continuous moral deliberations represented for these professionals.

Study limitations

Despite the methodological robustness, the unique institutional scope restricts the generalization of the findings, and the reliance on secondary administrative data may have resulted in underreporting. The qualitative sample did not include residents, interns, or outsourced workers, and the focus on RJU public servants may have

limited the heterogeneity of the studied universe. Similarly, the conclusion that governance was guided by principlism and that manager moral distress was low may be biased, as they, when interviewed about their own actions, may have presented their acts in an idealized manner, under the bias of social desirability.

Recommendations for future research

It is suggested that future investigations compare different institutions and broaden the professional categories analyzed. It is also proposed the development of longitudinal studies and investigations that comparatively explore the application of different bioethical models to healthcare management, deepening the understanding of the potential of ethics applied in times of crisis.

Final considerations

This study analyzed the response of public hospital governance to the ethical and psychosocial demands of the COVID-19 syndemic. The findings showed that, although there was no significant increase in the number of sick leaves, intermediate contact categories presented greater vulnerability, indicating an invisible dimension of the crisis. The analysis demonstrated that most ethical dilemmas were resolved with a principlism-based approach, which contributed to mitigating moral distress. The implementation of support structures such as the COE and the Worker Health Support Front was decisive in sustaining organizational resilience.

This study reinforces the role of bioethics as a structuring instrument for public health governance. By demonstrating that normative models sensitive to the moral complexity of management are viable and desirable, the results broaden the theoretical scope of bioethics applied to hospital administration.

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Contribution of the authors

Simone Barros: conceptualization; data curation; writing –original draft. Diego Freitas Rodrigues: formal analysis; writing – review & editing; methodology.

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