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Abstract

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Misthanasia: the story of a pandemic in the United Kingdom with mixed methods

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Abstract: This paper, as a case study, the object of observation and analysis, through mixed methods, is the public health of the United Kingdom (UK), according to aspects of management, ethics, social responsibility and compliance with the international control offices in force during COVID-19 pandemic. It was found that the UK was late in following the WHO’s instructions due to apparent disbelief in the pandemic’s magnitude, which was strengthened by the belief in herd immunity and possibly for loosening economic policy. Using Germany as a comparative model, this study demonstrated with the articulation of qualitative and quantitative analysis, the great difference found with the pandemic’s possible consequences. This miscellaneous case study points to evidence of Misthanasia in the UK.

Descriptors/Keywords: COVID-19; Right to Health; Human Rights; Social Responsibility; Health Professionals.

Introduction
The new coronavirus pandemic started in Wuhan, China, in December 2019. Since then, it has been causing health systems to collapse in many countries, especially in those that initially belittled the magnitude of Sras-CoV-2’s high infectivity, as well as the relation of measures to contain viral infection 1–3. The countries that presented better pandemic control and substantial improvement of the morbidity and mortality indicators related to COVID-19 were those that paid attention and did not postpone the execution of measures for pandemic control. Such countries took advantage of the experiences from China 4,5 and the recommendations of the World Health Organization (WHO) 6–7, fostered the spread of information about personal care, emphasized social distancing, promoted lockdowns, increased the supply of hospital structures, maintained the quota of health professionals, and stimulated the collective mindset of containing the new coronavirus 8–12. All of this has been allowing the gradual reopening of economies in a cautious manner13,14. In contrast, the places that took too long to consider the infectivity, speed, and virulence of the virus1, such as the United Kingdom (UK), which prioritized the belief in herd immunity 15,16, account for a vast number of both infections and deaths 17–19.

The UK did not anticipate clear pandemic containment policies 20, and hospitals were not prepared for the sudden growth in demand. During the pandemic’s peak, the health sector and its professionals found themselves in an overwhelming scenario and directly suffered the impact of the disease, which has no class distinctions, disregards estates, and reaches all. The most serious consequences are for the most vulnerable, who absorb the aftermath of public management’s bad decisions 21. We see that there no priorities were established towards collective health, the flattening of the pandemic curve 22, and human issues, and the responsibility of life and death was transferred to the whole sector through necropolitics 23.

Mixed methods research offers powerful tools for investigating complex health systems and processes, a need evident in the analysis of the COVID-19 Pandemic. In addition to enhancing the indicators inferred in the analysis by mixed methods, the approach also improves the visibility of the cultural, social and geographical aspects involved in the context of the empirical field. In Brazil, mixed methods have also been consecrated in overcoming any subjective interpretations, which are subjected to the double test of quantitative and qualitative analyzes. In this article, we started to use and emphasize mixed methods, since the idiosyncrasy of medical professionals, as is the case of the main author and conductor of the study, cannot be overcome by the analytical rigor and by the epistemics of the field addressed.

As noted by the authors, at the end of the study, it was possible to establish strengths and weaknesses, challenges, and environmental threats, which are elements also present in the establishment of public policies involved in this analysis. Thus, the research of mixed methods provided this study with more evidence than the use of one of the two approaches, qualitative or quantitative, in isolation. By using mixed methods, the researchers were equipped to use and compile different data sources, all the tools available. Knowing in advance that cold data carries the cost of human lives, mixed studies still allow you to report on the theory and philosophical principles related to the problem researched: medical ethics and political ethics.

Considering the issues of necropolitics and necropower 24, the latter disregards the magnitude of the pandemic and consequently disregres the principles of human dignity; the priorities are elsewhere. From an article published by the Financial Times 25, it can be conjectured that under economic pressure due to the recent Brexit process, the prime minister (PM) of the UK may have turned to the most advantageous economic management option concerning public funds at the outset to prioritize the economy. This was based on the idea of herd immunity and in the trust in experiences with other flu-like syndromes due to the great risk for economic recession 26. In matters related to necropolitics, life and human wellbeing are relegated as secondary with a disfigured perception of productivity and disregard of the need to flatten the infection curve. The lack of management has blocked the goal of decreasing demand for healthcare and avoiding its collapse.

Reflecting Byk 27, all of this political and social contextualization allows us to go beyond to emerging Bioethical arguments that disrupt the principled rigidity of frontier Bioethics. Since the 1990s, Intervention Bioethics has arisen as a new concept in Bioethics in Latin America as a social and scientific phenomenon 28. Intervention Bioethics seeks to perceive various issues in their social, cultural, and political context and to integrate them in a sentiment that is based on the principles of universality and equity. This concept has
foundations in utilitarianism, which guides debates and offers directions of a political and social nature. In this context, Bioethics brings with it the relation of premature and mournful death of both social and political character, which are observations that ultimately lead to the concept of Misthanasia: mournful, suffering death that could have been avoided for social and political reasons.

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

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

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

**Methodology**

This research, made possible through the application of mixed methods, can be described by the following procedures:

a) In response to the questions and hypotheses, both quantitative and qualitative data were collected and analyzed, with verification and reliability from different sources: national, international public and collective health agencies and specialized press groups;

b) Rigorous procedures were used to conduct quantitative and qualitative research, with verification and monitoring of curves and levels in the data panels, during the observation of the empirical field;

c) There was integration or combination of the findings from the quantitative and qualitative results, and the applied philosophical aspects obeyed universal principles of professional ethics involved in the researched problem;

e) Reported to the theory and philosophical principles related to the procedures and phenomena that generate the qualitative and quantitative indicators studied, to overcome the subjective aspects of observation, in favor of a universalizing analysis.

Therefore, the analysis practiced, using the mixed methods used here, was based on philosophical, axiological and methodological assumptions with interpretative foundations related to social constructivism and transformative structures from a Bioethics perspective. Its objectives were descriptive and explanatory, based on
a situational diagnosis. As a case study, the object of observation and analysis is the public health of the United Kingdom, which has been verified and analyzed according to aspects of management, ethics, social responsibility and compliance with the international control offices in force during COVID-19 pandemic. The methodological option is dialectical, since it is a social phenomenon observed in relation to a set of antagonistic social forces, which will result in synthesis and analytical induction after a constructive-transformative, sequential and methodological analysis.

For this proposition, a specialized set of technical and scientific procedures was applied. The dynamics of the phenomenon and the time of viability were considered as a limiting factor, with safety criteria for the systematic and dialogical survey of information, as well as the immediate scientific production on the subject. The applied procedures were the search for concepts in the pertinent literature for the construction of a theoretical framework; factual, qualitative and documented analysis of the events linked to the COVID-19 pandemic; and quantitative analysis of data obtained from official and secure sources. These data refer to the indexes and their numerical indicators that confirm the infection and epidemic lethality. The data were collected through specialized and universal methodology, submitted to statistical procedures and verified for their veracity and origin at the international level, from the public authorities and health managers. The immediate verification was obtained from publications in scientific journals qualified in the theme to monitor the state of the art.

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

The reason for selecting these two nations is related to the following matters:
- Similar or equivalent socioeconomic structures according to the following:
  - The Gini Coefficient 34:
    Gini Coefficient: UK – 34.8 (2016); Germany – 31.9 (2016)
  - The World Factbook 35:
    Population below the line of poverty: UK – 15% (2013); Germany – 16.7% (2015)
    Average age and population above 65 years old: UK – 40.6 years (18.48% above 65); Germany – 47.8 years (22.99% above 65);
    Longevity: UK – 81.1 years; Germany – 81.1 years;
  - Geographic proximity;
  - Proximity of the introduction and first case of COVID-19:
    UK – Introduction: 23/01/2020; - First case: 26/01/202036;
    Germany – Introduction: 19/01/2020; - First case: 27/01/202037;
  - Pandemic peaks in close periods 38:
    UK – 10/04/2020;
    Germany – 27/03/2020;
  - Highlights to be observed from The World Factbook35:
    Hospital bed rate per 1000 inhabitants: UK – 2.8 beds;
Germany – 8.3 beds;

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

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

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

- Absolute number of total of cases
- Absolute number of total of deaths
- Graph regarding social distancing
- Total of cases in logarithmic curve and bar graph
- Graph containing daily deaths and projections
- Graph that relates infection, testing, and projections
- Graph with projected hospital resources

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

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

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

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

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

Misthanasia: the expanded frontiers of death

In 1989, the Brazilian Márcio Fabri dos Anjos suggested a new definition for premature, avoidable death of political and social nature: Misthanasia. The word Misthanasia has an etymology of Greek origin and is composed of mis (unfortunate, mournful) + thanos (death) – “unfortunate death.” Conceptually, the word can be employed as a noun or adjective depending on the objective of its usage. Misthanasia is death related to mitigating social and political factors that lead to the removal of peoples’ lives in a precocious way. It represents painful death, troubled acceptance by family members and friends, and death conditioned to an adverbial subordinate the “if” clause; for example: “If there were more hospital beds, not that many people would have died;” “If the mitigation policies had been timely and straightforward, not many people would not have been infected.”
Misthanasia refers to issues related to premature social death. It defines the loss of possible survival years and people’s longevity lost because of social matters associated with actions or lack of attitudes of public powers. Six years after the debates that generated Misthanasia as a new concept of death, there were several debates concerning utilitarian ethics based on principles of universality and equity, which are benefits that extend to all and for a longer amount of time. From these debates, a new expansion of Bioethics emerged in 1995: This new way of thinking in Bioethics has a Latin-American origin and wins the world with a politicized and active view, which steps out of the principiological comfort of frontier Bioethics to discuss daily social matters. Within this concept, the concept of Misthanasia is integrated, which differs from the concepts of social Euthanasia and Cacotanasia.

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

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

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

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

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

Figure 2 (A) demonstrates a plateau formation that suggests the flattening of the pandemic curve, which can be confirmed by the graph of daily new case registers with a low observational statistical tendency in Figure 2B. The UK reached its daily infection peak of 8,681 cases at 9 days after the social distancing peak, after which there was a decreasing tendency. The graph of the average number of daily deaths in Figure 2 (D)
demonstrates an apex on April 13, 2020, with 966.59 deaths at 3 days after reaching the infection apex\textsuperscript{38}. After this date, there was a strong propensity of decline that remained until the last observed date, June 3, 2020.

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

Even with the projections indicating the pandemic peak on June 23, 2020, only after the sixth day after the daily death peak, the curve shows a noticeable change suggesting testing and tracking intensification in the UK\textsuperscript{38} (Figure 3 (A)). This next graph indicates how prepared the UK was regarding its supply structure to respond to the pandemic’s demands. The graphs are based on projections of the available hospital beds, ICUs, and infirmaries according to the saturation by demand (Figure 3 (B)).
Figure 3: (A) Graph of the estimated infection projection, confirmed cases, testing, and projected tests for the UK. (B) Graph of the projections of infirmary bed needs, ICUs, and ventilators for the UK. Source: http://www.healthdata.org/covid/data-downloads, accessed on August 15, 2020.

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

Epidemiology of Germany, a successful model of epidemiological control

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

Figure 5 (A) demonstrates the logarithmic curve of registered total cases, which shows a plateau formation of similar shape to the UK’s indicating pandemic control. Nevertheless, there was a lower amount of cases, and the plateau forms before the UK’s. The curve of the apex of new daily cases (Figure 5 (B)) shows that Germany reached its peak on March 27, 2020, which is 2 days after the social distancing peak. Compared to the UK, Germany hit its infection apex with fewer cases and 14 days earlier.
Germany hits its daily death peak on April 15, 2020 (Figure 5 (D)), with an average total of 224.11 deaths. This occurred 19 days after the apex of daily cases. After this date, there is a strong decreasing propensity\(^{38}\). Compared with the UK’s data, the average total daily deaths is much lower, and the peak happens 2 days after the UK’s. Germany’s testing even prior to the WHO declaring the pandemic was realized in a constant matter\(^{41}\). The curve of exam intensification becomes clearer on March 8, 2020, which is 3 days before the declaration of a pandemic state and 19 days prior to reaching the pandemic apex\(^{38}\) (Figure 6 (A)). The testing escalation remained constant until the April 5, 2020. Contrasting with the UK, the testing curve showed a greater testing proportion given the number of infections.

Figure 6 (B) presents the projection curves related to hospital bed demands. According to the projections, on April 14, 2020, Germany had reached the apex of hospital resource demand, equal to the UK, which was 1 day prior to reaching the peak number of deaths\(^{38}\). The projections graph demonstrates that the demand did not surpass the number of available hospital beds, and there was excess supply in relation to the amount demanded. This information presents the distortion related to the UK’s data, where demand exceeded supply to a great extent.

**General panorama of mortality and provided structures**

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

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

**Final Considerations**

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

Through the findings resulting from this research, which dispenses with the application of mixed methods, given the complexity of the problem analyzed, we verified that there were viable alternatives for managing this burning public and collective health issue. Outweighing economic issues, the preservation of human life requires an ethical, philosophical and evaluative view of the individual and his community. The analysis of the quantitative data, generated and compiled in the articulation of several suitable organizations, could be observed and reinforce the content of the findings that identify the present element of Misthanasia.

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

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

The principles perspective reasons that the UK NHS mainly focused on predictive and preventive matters.
In opposition to this, the attitudes of the UK’s PM, Boris Johnson, in facing the pandemic were initially skepticism due to a belief in herd immunity\(^{48,49}\) and, supposedly, protecting the economy\(^{25}\), which are implicated in the delay of mitigation measures and exam tracking\(^{50}\). The experiences seen in China were disregarded\(^{4,5}\), and so were the WHO’s recommendations\(^{51}\) related to the contagion containment measures\(^{21,22,52}\).

This attitude, which reflects Sibony\(^{53}\) and Betsch\(^{54}\), could have been implicated in the early behavior of British people, who took a little longer to adhere to the social distancing (Figure 1). This resulted in an infection peak with a high number of cases on April 10 (Figure 2B). Germany had a contrasting attitude\(^{41,55}\) (Figure 4). Despite having lower adherence than the UK, it reached its isolation apex 7 days prior to the UK, and they had a lower case count (Figure 5B).

Despite the first cases having similar dates\(^{36,41}\), the beginning of viral tracking with exams was of the utmost importance for the recognition and isolation of the infected\(^{41,55}\). Differently from the UK, Germany intensified infection tracking 3 days prior to the WHO declaring a pandemic (Figure 6A), which happened in the UK nearly a month and a half later (Figure 3A). Logically, after the population was exposed to the virus, in places that were strongly engaged with infection control, there would be a smaller amount of infected people contaminated, and consequently, fewer deaths (Figures 2 and 5)\(^{18,19,56}\).

The UK took longer to express the plateau in the curve (suggesting pandemic control) than Germany (Figures 2 and 5). This resulted in a possible obstruction of health services along with a large number of infected presenting to hospitals in the UK. The projections of demand were greater than the resources available\(^{22}\). On account of the lack of capacity, this could be related to factors that explain the higher death count\(^{21,46,57}\).

The quantitative analysis suggests that the influences of the early conducts of pandemic control\(^ {48}\) are related to the demand behavior and could consequently be connected to the possible overload of the UK’s hospitals. This may have impacted the mortality and proportional mortality. It is inferred that the answer to the quantitative question, in part, is given as concluded, observing the need for a specific analysis of the correlation between the variables; therefore, the perspectives of the analytical, descriptive, observational and inferential statistics support and augment the paths of the qualitative analysis.

The relation of the attitudes of the UK’s early public policy in facing the pandemic was massively questioned\(^{8,16,21,49}\). The political direction shown by the government’s attitudes allegedly demonstrates the prioritization of economic issues\(^ {22,58}\). Using Germany as a comparative model, this study demonstrated the great difference found with the pandemic’s possible consequences\(^ {55,59}\). This miscellaneous case study points to evidence of Misthanasia in the UK.

The experiences and dissemination of information from China\(^ {5}\) and the WHO’s analyses\(^ {51}\) provided alerts about the pandemic’s risks. The biggest concern was not only the virus’ lethality rate but the high infectiousness rate\(^ {7}\). According to the WHO\(^ {51}\) and the modeling of studies that evaluated various pandemic scenarios\(^ {45,46,57}\), the high infectiousness rate could result in congestion of the whole health system, which would lead to deaths due to a lack of capacity to address the demand and risks of inefficiency and inaccuracy in the health system’s actions\(^ {60,61}\). Embracing herd immunity\(^ {22,48,53}\) disrespected the WHO’s recommendations for emergencies in public health, in addition to the individualistic response of human beings when exposed to the risks of bad luck. This study did not emphasize the absolute disregard, but the delay in perception of the state of emergency and the way of dealing with the pandemic challenges with mitigation policies\(^ {16,20}\), which suggested a possible collapse of hospital networks\(^ {21}\). The result of all this relates to the death count, for which statistics are being gathered, as well as the mourning of surviving family members.

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

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

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