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Hospital Resource Distribution and the Ethical Principle of Justice

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Abstract
Introduction: COVID-19 occurrence has placed significant pressure on critical care units (ICUs) and other patients, and it is still creating problems. The problem is that many patients need respiratory assistance and have sometimes lengthy ICU stays, which leads to problems with the hospital's resources including mechanical ventilation and beds. It is not always theoretically possible to treat all patients needing intensive care, which poses crucial ethical dilemmas as to who should benefit from and not be shortened from the available services.
Objectives: This article aims to discuss the issues regarding hospital resources and the ethical principle of justice during the current outbreak of COVID-19.
Methods: The method employed in this article is qualitative based. This article will analyse the materials to study the patterns of legal issues in digital platforms and use digital data in enhancing the policy response. Analysis of content can range from simple word counting to thematic analysis or conceptual analysis via the digital platforms of websites and digital data from the Ministry of Health (Malaysia) and the World Health Organisation.
Results: Aside from that, this paper depicts the language and communication between the doctor and the patient in a way that both parties can comprehend. For instance, Bahasa Melayu and English language. This article found that there are shortages of resources to be distributed to patients during the pandemic COVID-19.
Conclusions: In conclusion, it is suggested that it is incumbent for the government to prepare a policy response to address the needs of hospital resources without neglecting the ethical theory of justice.

Keywords: *COVID-19, hospital resources, justice, language, medical law.*

1. Introduction

The COVID-19 epidemic and the huge increase in COVID-19 cases contribute to the increased pressure in hospitals, especially in ICUs, all over the world. For some time to come, the number of admissions to ICUs in many countries is projected to continue to increase. Around one-tenth of COVID-19 patients need some form of ventilator support (mechanical ventilation) and beds that are almost complete in normal conditions (invasive or non-invasive) in ICUs (Jean-Louis Vincent & Jacques Creteur, 2020). COVID-19 lesions are potentially reversible, so efforts are needed to help patients. The acute period of the disease however will last for a few days and weeks, sometimes extending the occupancy of the bed, resulting in a crucial shortage of ICU beds and ventilators available (Jean-Louis Vincent & Jacques Creteur, 2020). There are various ethical obstacles to the extremely poor use of ICU linens, equipment and staff as to how the available resources can be best allocated to achieve optimal results (Jean-Louis Vincent & Jacques Creteur, 2020). In this article, the authors will discuss on some of the tough ethical choices that will have to be made in dealing efficiently with the problem of utilizing

hospital resources, especially ICU beds, mechanical ventilation and at the same time, not forsaking the ethical principle of justice.

Decisions on right or wrong, just, or unreasonable, are not obvious responses explicitly derived from universal principles (Rosamond Rhodes, 2020). Rather, they are the conclusions we reach after the knowledge we collect, the crucial considerations are derived from tangential ones, and the specific implications of alternative options are evaluated in order to choose a plan that is ideally suited to the circumstances. In summary, addressing the context involves discernment and judgment in order to achieve good solutions. In this regard, we must start to address what is known and unknown when decisions are to be taken concerning COVID-19.

The fact that the virus causing COVID-19, identified as SARS-CoV-2, is a new coronavirus mutation that first emerged in China, in late 2019 (Rosamond Rhodes, 2020). It is increasingly spreading around the world, infecting and killing people. Doctors were asked to treat infected patients, but they were completely unaware of the disease. They were unsure as to how the disease was transmitted, what signs or complications to anticipate when it was infectious in the course of the disease, and who is rather fragile or proportional to its impact. They knew nothing of successful or counter-productive therapies, and they were left to extrapolations and guesses based on experience with very similar circumstances. The illness was especially contagious and fatal. They were aware of it. The period and the course of the disease were surprisingly unpredictable though it resembled influenza in a variety of ways.

Some countries in the world, such as the United States of America, Italy and Spain, which record high infections and death rates on a daily basis, are now facing a shortage of medical resources such as mechanical ventilation, so they have to limit the use of these devices and give them to patients who have a greater chance of recovery (Fadhlina Alias & Saryanti Hussin, 2021). The use of limited resources, which is the object of competing claims for patients who are unlikely to improve and have very low recovery rates, is considered a waste because such resources can be used to benefit patients with a better prognosis to recover (Abu El-Noor et. al, 2014).

The issue of resource scarcity is not limit to Malaysia; it affects the entire country. It is because other nations, including developed ones like the United States of America, have faced similar problems. For instance, mechanical ventilation equipment is also inadequate to accommodate a significant number of patients around the world. Therefore, it is important to have better guideline to this problem which pertaining to medical resources and its scarcity according to principle of justice.

2. Materials and Methods

This article adopted a pure legal research methodology by using qualitative analysis on COVID-19, hospital resources and the principle of justice. By using content analysis, this article analysed the research on COVID-19, hospital resources and principle of justice. Referring to Krippendorff (2004), analysis of content can range from simple word counting to thematic analysis or conceptual analysis. This article will analyse the materials as to study the patterns of legal issues in digital platform and using digital data in enhancing the policy response. Analysis of content can range from simple word counting to thematic analysis or conceptual analysis via digital platforms of websites and digital data from the Ministry of Health (Malaysia) and the World Health Organisation.

3. Principle of Justice

Intensive care units (ICU) should in practice, be reserved for patients who feel they will recover with reasonable quality of life. According to James, F. R., Power, N., and Laha, S., ICUs are specifically staffed and equipped, separate and self-contained areas of a hospital devoted to the management of patients with life-threatening situations (James, F. R., Power, N., & Laha, S., 2018). They employ the expert knowledge and abilities of medical, nursing, and other staff experienced in the care of these conditions to provide dedicated facilities for the support and monitoring of vital physiological functions (James, F. R., Power, N., & Laha, S., 2018). According to Talmor D, et al., these units are well-known for reducing critical illness mortality rates while also being cost-effective (Talmor D, et al. 2006). However, with considerably more referrals than available beds, the number of beds is a restricted resource. This issue is only anticipated to worsen over the coming years with the rise in demand for intensive care bed days estimated to likely be in the order of 4% per annum (Packham V & Hampshire P, 2015). It is also acknowledged that not all patients benefit from admission to the ICU, with evidence that certain patient factors (e.g., comorbidities like chronic obstructive pulmonary disease and end-stage liver cirrhosis, as well as

conditions like multi-organ failure) are associated to better or worse outcomes from referral to ICUs (Packham V & Hampshire P, 2015).

Admitting patients who are going to breathe their last breath, regardless of any medical effort, is not acceptable (Jean-Louis Vincent & Jacques Creteur, 2020). It shows the welfare of a person should be protected ethically. Not only that, for instance, according to Charles, procedures in the mortuary and for the postmortem of a person also emphasize ethical aspects (Charles A., 2021). Likewise, it should not be admitted to patients who are not seriously ill and do not need 'care intensive.' Unloading the ICU earlier than usual may also be encouraged, especially if any kind of breathing support outside the ICU can be continued. Thus, in the case of certain patients most likely to die, and even for others who are likely to be doing well, intensive care admission or advanced discharge can be rejected. These two ends of the continuum will rise, so that the number of available ICU beds will effectively be increased in a crisis situation as at present (Jean-Louis Vincent & Jacques Creteur, 2020).

The central ethical concept of distributive justice can be applied and can help direct the proper distribution of scarce health resources when the situation becomes very important (Jean-Louis Vincent & Jacques Creteur, 2020). The principle of distributive justice requires a fair and equal provision of health care to everyone, not individual patients, but to all those who need them. Distributive justice promotes the distribution of wealth to those that are most likely to benefit. Most significantly, this does not necessarily mean that the patients most likely to survive, since many can be treated outside the ICU.

In its text book, Principles of Biomedical Ethics, Beauchamp and Childress initially devised the four principles as the standard theoretical structure for a study of ethically applicable circumstances in medicine (Beauchamp, TL & Childress, JF., 2009). While the importance and scope of the four principles of Beauchamp and Childress is often debated, the role of authority in the area of medical ethics of the four principles is not challenged. In short, autonomy, beneficence, non-maleficence and justice are four main principles. As far as justice is concerned, it is a philosophy that stresses justice and equality among people (Beauchamp, TL & Childress, JF., 2013).

The problem of healthcare is resource constrained (Munthe C, Fumagalli D & Malmqvist E, 2021). As far as we want to treat everybody, there are sometimes insufficient beds, physicians, nurses, or drugs. Justice is now the concept that allows us to decide who is given priority in these cases. However, Beauchamp and Childress pointed out the many different philosophical theories of justice in circulation, not suggesting their own understanding. They noted how resources allocations rely on the philosophy of justice that an organization subscribes to. For example, a coherent approach to justice distributes resources to achieve the best or happiest outcomes. This could lead to the death of an elderly patient with no dependents to save a young parent. In comparison, they propose that someone like John Rawl's wishes that any person should agree to access health services in accordance with principles. This could mean that we assign resources based on who needs care the most, as emergency responders and paramedics consider when triage takes place. This means that a significant number of patients or victims are urgent for accidents or diseases to assess the treatment order (The Ethics Centre, 2017).

Whenever a resource is distributed, we should strive to achieve fairness. Justice demands that similarly situated citizens are handled similarly or "equally" (Rosamond Rhodes, 2020). An ICU bed could be blocked and not accessible to another patient who benefits from ICU treatment due to continued inadequate therapy. (Vincent, JL., 2005). Moreover, the costs of futile treatment may otherwise be better used (Vincent, JL., 2005). The challenge in pursuing fairness is that the administration of allocations has several conflicting concepts. In order to identify the appropriate principle(s) for a specific allocation, discernment is required and dedication is needed to set aside other (i.e., irrelevant) considerations in a pointed manner. Equality then requires that the same principle(s) be used for that situation in making each distribution decision (Rosamond Rhodes, 2020). Plus, all individuals have rights to health care and medical treatment, according to Zahir et al. (2019a: 2019b) (Zahir et al., 2019a; Zahir et al., 2019b). Individuals have a voice to express their freedom in relation to their medical treatment (Zahir et al., 2017a; Zahir et al., 2017b; Zahir, 2017c; Zahir et al., 2019a). It is vital to ensure that the autonomy of an individual when making his decision regarding to medical treatment must be respected (Zahir et al., 2021; Zainudin et al., 2021). Over the years, the Ministry of Health (MoH) of Malaysia has initiated several health programmes to improve patients' safety and population welfare (this is being done in coordination with the private health system) (Health Care in Malaysia, 2010).

It is important to ensure that the principle of justice is followed. It is because, when this principle is followed all the problem in maintaining and distributing of medical resources or medical equipment can be handled in effective manner. So, there is no problem of scarcity of medical resources or medical equipment to be used in the hospital for now and future.

4. Overview of Resources and Scarcity

The most prevalent cause for denying ICU admission, according to Sinuff et al., is a low predicted benefit of treatment, which also corresponds to patient mortality (Sinuff et al., 2004). Triage was based on factors such as bed availability, severity of illness, medical diagnosis, and age (Halvorsen, 2010). In ICUs, withholding and/or withdrawing intensive care are considered priority determinants, and the discrepancies in how they are emphasised pose a threat to fair priorities (Hurst S, et al., 2005; Tallgren M, K, et al., 2005). From this perspective, research on what influences end-of-life decisions is important for this topic. According to research, futility is an ethical challenge in critical care, and clinicians provide futile care in some circumstances. Futility is also a resource concern, because a large portion of the resources allocated to ICU treatment is spent in the final few days of the patient's life (Moselli NM, et al., 2006).

It is also a problem for health-care delivery when attempting to prevent death prevents the proper transfer of care from occurring at the right moment (Hov R, et al., 2007). Because this entails ethically challenging acts for doctors, research has focused on how treatment is sustained when actual judgments are made. This appears to be linked to the removal of mechanical ventilation in particular, a scenario that may be described as necessitating a more active withdrawal of treatment and hence being more difficult to complete (Rydvall A, et al., 2007).

According to Halvorsen, in terms of how end-of-life issues are managed, documented, and conveyed, research sheds insight on differences in the basis for decision-making (Halvorsen, 2010). Variations that could cause the patient's death to be prolonged as well (Halvorsen, 2010). Professional differences, as well as differences between and between countries, as well as differences between and within hospitals, were discovered. Decision-making processes and end-of-life decisions are influenced by cultural, religious, professional, and personal values (Moselli NM, et al., 2006). Several studies show that there are discrepancies in whether and how patients' choices and autonomy are taken into account while making treatment decisions near the end of life. In Europe, patient autonomy receives less attention, whereas in the United States, patient autonomy and advanced directives are more important topics (Sprung C, et al., 2008). Recent European research have emphasised the need of enhancing the patients' perspective and autonomy in decision-making (Sprung C, et al., 2008). While in Malaysia, it has been noted that in Malaysia, patient autonomy is only recognised through legal means (Che Ngah, A., et al., 2019). In various legal instances involving questions of permission, guidance, and information disclosure, the courts have ruled in favour of patient autonomy (Che Ngah, A., et al., 2019). However, non-legal options of recognising patient autonomy are limited (Che Ngah, A., et al., 2019). With relation to patient preferences, attention is also brought to the significance of effective treatment, conversation, and information with the patient's next of kin as guardians, as well as to differing perspectives on the role and decision-making capacity of families (Browning A., 2009).

End-of-life decision-making, according to research, should be a multi-professional process involving all viewpoints (Halvorsen, 2010). Several studies have found that physicians and nurses in intensive care units had differing opinions on end-of-life issues and when treatment ought to be assessed as futile. Sometimes there is a conflict of care within the treatment team, as well as between the staff and the patients' families. Involvement or non-involvement of nurses in decision-making is also a problem. Conflicts can lead to moral ambiguity and distress for all parties involved. Inadequate communication between physicians and nurses about these concerns also obstructs effective patient care (Palda V, et al., 2005). The perspectives and challenges of treating more patients in older age groups have been examined, the outcomes have become increasingly apparent (Somme D, et al., 2003). Ageism is a problem in other sections of the health-care system, and it necessitates collaboration among professionals (Dodds S., 2005). Age, gender, race, and educational position, among other factors, contribute to unjustified judgments about patients or groups of patients in Europe and the United States for instance, according to research (Halvorsen, 2010). It has not been established that actual medical and nursing treatment has a worse effect (Dodds S., 2005). Furthermore, according to Doolen J & York N, awareness of the various cultures present

in multicultural society should be improved in order to offer effective medical treatment and nursing care at the end of life (Doolen J & York N, 2007).

Nurses and physicians are somewhat obligated to bear responsibility for distributing health care resources properly, according to their ethical and societal responsibilities (Halvorsen, 2010). Professionals in the medical field are likewise responsible for their actual patients. They have a legal obligation to provide each of their patients with reasonable and personalised nursing and medical care (Vetlesen AJ & Nortvedt P., 2000). The difference between these two viewpoints can be characterised as a conflict between a proximity ethics and a consequentialist or utilitarian approach to ethics. On the one hand, nurses and physicians have a moral responsibility to the patient. On the other hand, they are morally responsible for allocating nursing and medical resources in a way that maximises the societal value of health care commodities while also considering other current and future patients. An ethical angle known as ethics of proximity attempts to highlight the significance of personal interactions and relationships with specific people as unique sources of differential and equal treatment (Vetlesen AJ & Nortvedt P., 2000).

There will always be uneven power dynamics in health care, as the patient is dependent on the doctor and nurse in a tight relationship (Halvorsen, 2010). For appropriate treatment, trust between the patient and the health care practitioner is required, in which the patient's vulnerability is recognised and taken seriously. Patients and families, who are often key sources of communication and information in intensive care, will be unable to share and be honest if there is a lack of confidence (Browning A., 2009). The patient's confidence in receiving the greatest treatment, being in good hands, and being cared for in a professional competent manner is vital. Patients have the right to know that their best interests are being attended after and that they are being treated fairly in comparison to other patients (Halvorsen, 2010). An interpersonal relationship with the patient is essential in order to acquire someone's trust and to be able to provide suitable help in accordance with the patient's needs and professional standards. One of the fundamental difficulties in modern health care is the increasing fragility of such personal interactions. Some patients do not feel seen or heard, and they do not always believe they are receiving adequate care for their illnesses. Health care workers, on the other hand, have had the experience of not being able to provide enough assistance due to a lack of resources or a number of other causes (Halvorsen, 2010).

Furthermore, doctors had to contend with a lack of resources, which forced them to overlook critical medical and nursing treatment (Halvorsen, 2010). Furthermore, both hidden and conscious values influenced bedside priorities with regard to limiting intensive care treatment, and these values appeared to override each other in diverse ways, influencing medical and nursing assessments of the intensive care patient (Halvorsen, 2010). These values also appear to influence how and to what extent priority criteria served as a foundation for limiting intensive care treatment priorities. All patients who meet the usual medical criteria for ICU beds and ventilators are eligible, and they are given a priority score on a scale of 1 to 8 (lower scores indicate a greater likelihood of benefiting from critical care), based on (1) their likelihood of surviving to hospital discharge, as determined by an objective measure of acute illness severity; and (2) Patients' chances of long-term survival based on the presence or absence of comorbid conditions that affect survival (White DB, 2020). Individuals who perform duties that are essential to the public health response are also given more priority by having points deducted from their priority score (White DB & Lo B., 2020). In the event of a tie in priority rankings between patients, life-cycle considerations are utilised as a tiebreaker, with younger patients receiving priority because they have had less time to experience life's stages (White DB & Lo B., 2020). To address the imminent prospect of a ventilator shortage, hospitals and states must develop and implement policies that more fairly distribute scarce resources and better support dying patients and their families.

5. Preparedness and Strengthening the Capacity of Hospitals in Malaysia

According to the digital data from the Ministry of Health, Malaysia, has announced that, with effect from 6 October 2020, COVID-19 patients had a total of 6,795 beds, 2,820 of them in MoH hospital and 3,975 in Quarantine and Low-risk centres (Noor Hisham Abdullah, 2020). The occupancy rates are currently 36 percent and 29 per cent for these two types of installations across the country. As regards the number of beds in the ICU (intensive care unit), COVID-19 has a total of 437 beds with a 6% occupancy rate. In MoH hospitals, there are a

total of 1,505 ventilators available at 37% utilization rate across the region. For non-COVID-19 patients, this is included (Noor Hisham Abdullah, 2020).

There are 710 beds and 1,886 beds, respectively, for six MoH hospitals and for 10 COVID-19 Low Risk Quarantine and Treatment Centres. The bed occupancy rate in MoH hospitals is 75% and in PKRC is 35% by 6 October 2020. Sabah (one of the states in Malaysia) has 72 beds for vital COVID-19 patients with a vacancy rate of 38% as regards its Intensive Care Facilities. MoH has and continues to establish support teams of physicians, medical officers, medical assistant officers and health care staff in the management of these additional wards under the State Department of Health of Sabah. For example, MoH sent additional medical devices for use in Sabah hospitals (Noor Hisham Abdullah, 2020).

COVID-19 is an infectious illness for which there is no recognised vaccination at the very early stage. The World Health Organization (WHO) based on digital data reported on 11 March 2020 that a COVID-19 outbreak that began in Wuhan at the end of 2019 has progressed to the status of a worldwide pandemic. The WHO reported that as of 1st April 2020, there have been more than 900,000 positive cases worldwide, with approximately 50,000 deaths. The WHO has asked on nations to take immediate and aggressive action to halt the virus's spread, citing "the alarming levels of spread and severity" (Human Rights Watch, 2020). Understanding health as a human right imposes a legal obligation on states to provide timely, affordable, and quality healthcare, as well as the underlying determinants of health, such as safe potable water and sanitation, food, housing, education, and equality (World Health Organization (WHO), 2020).

In anticipation of an international estimate of five thousand new COVID-19 cases, the MoH expanded its bed capacities by the end of February 2021 (Code Blue, 2020). Malaysia's population of total 25,456 beds for COVID-19 patients in hospitals and low-risk quarantine and treatment centers throughout the country is 43% as of 23 December 2020, says Health Minister Adham Baba (Code Blue, 2020). Of the 871 beds available in ICU, 159 are currently in use in patients with COVID-19 (18%). Of the 1,581 fans available, a total of 591 are reserved for COVID-19 patients with 79 ventilators (5%) (Code Blue, 2020). The situation is still under control in Malaysia at the moment. MoH has improved and introduced numerous public health and hospital preparedness initiatives to expect an increase in cases, as foreseen by the Institute for Health Metrics and Evaluation (IHME) (Code Blue, 2020).

In May 2021, Veena Babulal reported that because of the high volume of patients, patients cannot expect full ICU care, but doctors can intubate and monitor them there (Veena Babulal, 2021). We have ran out of ventilators and must wait for more to arrive from other hospitals. We pass one unit (of ventilator) to the next patient when one becomes available. We still have ample oxygen supplies for the time being. The male and female wards were previously separated, but we had no choice but to ask mothers and children to share a bed on multiple occasions. This is due to the fact that the wards can only accommodate a maximum of 35 beds (Veena Babulal, 2021).

A nearby facility had been transformed into a ward for individuals suffering with Stage 3 COVID-19 symptoms, and that the facility would soon be expanded to include those suffering from Stage 4 symptoms, as well as those who require oxygen. COVID-19 patients in Malaysia are classified into the following categories (Ministry of Health, 2021). The patient's clinical management is based on these categories, which are as follows:

Clinical stage 1: Asymptomatic (refers to a condition or a person who has no symptoms).
Clinical stage 2: Symptomatic, No Pneumonia
Clinical stage 3: Symptomatic, Pneumonia
Clinical stage 4: Symptomatic, Pneumonia, Requiring supplemental oxygen
Clinical stage 5: Critically ill with multi-organ involvement

Symptomatic treatments such as antipyretics, optimal nutritional support, and the maintenance of fluid and electrolyte balance should be given to patients with COVID-19 illness (Ministry of Health, 2021). Patients with COVID-19 illness should have their vital signs closely checked and their disease progression monitored according to the clinical staging of the illness. There should be a clear mechanism for close follow-up and a referral channel in place in the event that medical care needs to be escalated (Ministry of Health, 2021). All doctors and specialists in the hospital who had been allocated to treat COVID-19 patients had been moved to the "COVID-19 pool" and were ready to treat COVID-19 patients at any time. On average, one to three doctors are on duty per shift on the

wards (Veena Babulal, 2021). Veena Babulal reported that now the focus is on those with greater odds of survival, such as the young, rather than the very elderly or patients with comorbidities, due to a lack of resources, but we have yet to reach a point in our ICU where we are forced to choose who gets treatment and who does not (Veena Babulal, 2021).

It can be seen that medical equipment is so important. From now on and for the future plan, it is important to have a strategy with regard to our medical equipment. It is because, based on the principle of justice, the medical equipment should be enough and can cope high demand of patients in the hospital. When we are discussing the hospital, it is not just for government hospitals, but, it includes private hospitals. Therefore, government and health care providers need to deal with problems justifying resource distribution among the patients effectively.

6. Language and Communication

Aside from that, this paper depicts the language and communication between the doctor and the patient in a way that both parties can comprehend. The use of language can encumber access to medicines both for the treatment of pain. Referring to a person as a "substance abuser" instead of "a person with substance use disorder" evokes stigma and there is evidence that it reduces patients' access to suitable treatment (The BMJ, 2017). Furthermore, vague terminology may result in misunderstanding of the nature of pain treatment and the management of substance use disorder. Clear, unambiguous, non-stigmatising terminology is recommended by the World Health Organization (WHO) as one way in the medical environment including access to medicines (The BMJ, 2017).

Everybody should use appropriate terminology, including patients, governments, and international bodies. Hitherto journals read by healthcare professionals have a particular responsibility to communicate clearly in ways that benefit patients. Certainly, humans believe that using proper terminology in scientific publications is critical to increasing the quality and clarity of scientific communication, as well as patient access to medications used to treat dependence and pain (The BMJ, 2017).

In a July survey of nearly 100 doctors, it was discovered that 80% of those surveyed had been in a conversation where they had no idea what was being said because of the language used (Tasnim Lokman, 2018). Dr. Lee Boon Chye, Deputy Health Minister, said that because English and Bahasa Malaysia are used for medical records, they should also be used for communication among medical personnel in the wards (Tasnim Lokman, 2018). He did note, however, that it was not the same with doctor-to-patient communication or direct communication between doctors. Communication between patients and doctors is commonly done using a patient's language, or in a language, the patient can understand. Verbal communication between a doctor and another is a private matter, even if it is work-related (Tasnim Lokman, 2018). For instance, Bahasa Melayu and English language. As a result, the government must prepare a policy response to address the needs of hospital resources without ignoring the ethical theory of justice by using language that the public, including doctors and patients, can understand. It is vital that the language used is easily understandable so that it can be implemented and monitored.

7. Results and Discussion

Crises like the current pandemic are thankfully relatively rare, but this ensures that there is little room to grow (Jean-Louis Vincent & Jacques Creteur, 2020). In any hospital, the number of ICU beds are usually relatively small and well-occupied. Due to the expensive and limited services and facilities required to provide sustainable treatment, economic considerations play an essential role in providing end-of-life care (Fadhlina Alias & Puteri Nemie Jahn Kassim, 2019). Therefore, health care providers need to deal with problems justifying resource distribution among patients (Fadhlina Alias & Puteri Nemie Jahn Kassim, 2019). The obvious solution to the shortage of facilities like beds is to raise the number of beds for critically ill patients in some way (Jean-Louis Vincent & Jacques Creteur, 2020). The less advanced units such as rehabilitating rooms, coronary care units or stroke units can be upgraded to ICUs. This presents potential problems with recruiting a sufficient number of trained personnel for the additional beds. A second choice is that such procedures are generally reserved for the ICU on general premises. There are three forms of ICU care which cannot be given in any other area: acute respiratory failure mechanical ventilation, acute renal failure renal alternatives and acute circulatory failure cardiovascular support (shock). For COVID-19, certain types of respiratory aid may be taken into account outside

the ICU such as high-flow, positive continuous pressure from the airway or noninvasive respiratory aid, considering the fact that workers are inexperienced or qualified to use the equipment. Every individual is entitled to the right to health and medical treatment (Zahir, 2020). Every individual is entitled to treatment including treatment if he or she suffers from COVID-19 (Zahir, 2020).

In this case, the whole notion of triage is to optimise the value obtained from ICU admission. According to Sharon E. Mace and Thom A. Mayer, triage is a priority for treatment or disaster victims based on disease or injury, seriousness, prognosis and availability of resources (Sharon E. Mace & Thom A. Mayer, 2008). The drive to triage is to assess patients who need to be urgently revitalized. To designate patients into a pre-designated field of patient care, prioritising their care (Sharon E. Mace & Thom A. Mayer, 2008). The term "triage" originated from the French verb trier which means to sort (Sharon E. Mace & Thom A. Mayer, 2008). The French military used triage as, for example, a clearing-up hospital for wounded soldiers at the time of Napoleon (Sharon E. Mace & Thom A. Mayer, 2008).

According to Emanuel et. al, it is justifiable that the patient be removed from the ventilator or released by the ICU to compensate for those other individuals who would benefit better (Emanuel et. al, 2020) this opportunity should be made clear to patients and their families at the time of admission (Jean-Louis Vincent & Jacques Creteur, 2020). The withdrawal of a patient's ventilator support in order to use the system to try to save patients with a stronger prognosis can be incredibly hard for patient care workers and their families (Jean-Louis Vincent & Jacques Creteur, 2020). However according to Biddison et. al, it should not be considered an act of killing in such cases and does not require the consent of the patient; decisions like these are ethically allowable (Biddison et. al, 2014). Taking carefully into account the need to optimize the benefits for all could minimize subsequent withdrawal requirements at the beginning of such an epidemic (Jean-Louis Vincent & Jacques Creteur, 2020). Patients more likely to recover do not have to be admitted to the CUI and can be handled efficiently in general wards. The conditions for ICU admission include the severity of the acute condition, co-morbidity, chronic degree of organ failure or the possibility that a normal quality of life will be restored (Smith, G. & Nielsen, M., 1999).

Networking between healthcare workers is critical during or after a pandemic such as this in order to share information and skills. Daily team debriefing should be given priority in terms of both time and resources. It may also assist healthcare staff in identifying burnout signs or emotional illness early on. Strong post-crisis debris and psychological support are necessary. Economic factors are important in providing care because the resources and facilities needed to provide sustainable treatment are costly and limited. At certain point, it might be justifiable that the patient be removed from the ventilator or released by the ICU to compensate for those other individuals who would benefit better if the principle of justice has been failed to follow or the medical resources remain limited in the future.

8. Policy Recommendation

Institutions and researchers across the countries have struggled to establish policies to guide public health interventions and to guide challenging clinical decisions to decide which patients will have access to a restricted supply of ventilators and which ventilator assistance would not be available (Rosamond Rhodes, 2020). Health care often maneuvers with limited resources (Munthe C, Fumagalli D & Malmqvist E, 2021). Meanwhile, Director-General (DG) of Health Tan Sri Dr Noor Hisham Abdullah on 6 October 2020 said the Ministry of Health, Malaysia has beds in the quarantine and low risk treatment centers, for COVID-19 patients (Idris A.N., 2020). However, all equipment should enough for current and for targeted or future patients. It is vital for the government to supply enough facilities such as beds and ventilators to hospitals.

Government and other related authorities' measures in response to COVID-19 is noteworthy to solving the dilemma relating to hospital resources and the scarcity of them. The treatment of COVID-19 patients is expensive and involves limited resources, for the most part in the case of critically ill patients who require mechanical ventilation (Fadhlina Alias & Saryanti Hussin, 2021). Consequently, medical practitioners are faced with complex issues in justifying the distribution of health care resources to deserving patients (Fadhlina Alias & Saryanti Hussin, 2021). Besides that, it is unavoidable for the government to prepare a policy response to address the needs of hospital resources without neglecting the ethical theory of justice by the language that understandable by public

including doctors and patients. It is so crucial that when the language used is understandable, it is easy to implement and monitor it.

Furthermore, in order to optimise public benefit, that is, "to save the most lives" during this pandemic, it is important that the authority recognises the need for physical distance (Rosamond Rhodes, 2020). At the same time, hospital leaders around the country agreed that all requirements and the need for triage policies to avoid the worst result in this case the most preventable deaths were not sufficient for human and material resources (Rosamond Rhodes, 2020). The government and health care provider must work hard to solve the issue pertaining to the virus spreading in the country. The government and other institution proactive measures in response to COVID-19 is important to eradicate the problem relating to hospital resources. In order to promote the use of hospital assets as well as to protect the concept of fairness, the COVID-19 economic implications call for urgent policy answers.

9. Conclusion

In conclusion, it can be seen that the concept of justice from an ethical point of view in the limited distribution of medical resources is very important. Here we consider some approaches that are applicable to the problem of hospital resources during this epidemic, including guidelines on triaging ICU admissions and treatments. Especially in order to avoid the worst outcome (triage), the government and the hospital, it is crucial that the government focus on saving lives during the pandemic and the three principles of justice are concentrated. While crisis such as the current pandemic are lucky enough to remain relatively uncommon, the decision-making of scarce resources is much more difficult than it is for many an unknown territory. The situation in this region is not unknown. Despite the current rare situation, it remains vital that triage rules are developed as a matter of urgency but with great caution so that ICU beds and living equipment are reserved for those most likely to survive and benefit from good living quality. The hospital, along with their patients and their families, needs to be open with these decisions. In addition, it is also crucial to ensure that the autonomy of an individual when making his decision regarding his medical treatment is also respected.

Networking between healthcare workers is critical during or after a pandemic such as this in order to share information and skills. Daily team debriefing should be dedicated to devoted time and money. This may also help healthcare workers to early identify burnout symptoms or mental distress. It is important to have strong post-crisis debris and psychological support. To sum up, it is important to ensure that we have to plan and make sure that the resources in the hospital are enough at all times. Therefore, it is important for the government to supply enough facilities such as beds and mechanical ventilation to hospitals. Government and other related authorities measure in response to COVID-19 are significant to solving the dilemma relating to hospital resources and scarcity of. The economic implications of the COVID-19 pandemic call for immediate policy responses to encourage the use of hospital resources in the direction of the theory of justice. In addition, the language used for immediate policy responses must be comprehensible and can be communicated. The purpose of this is to effectively implement and monitor it. It is necessary to ensure that the distribution of justice in this context, which offers sufficient, equal and adequate facilities for the society including to the consumers, is carried out by making a proper and just policy.

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