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Bioethical Parameters for Judicial Decision-Making in Public Health Emergencies: A Normative Framework Derived from COVID-19 Health Judicialization in Brazil

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Abstract

Background. Health judicialization intensified substantially during the COVID-19 pandemic in Brazil, placing courts at the centre of decisions involving resource allocation, therapeutic access, vaccination mandates, and intergovernmental health governance. Despite growing empirical literature on judicial conduct during this period, a normative gap persists: no structured bioethical framework has been proposed to guide judicial reasoning in public health emergencies. This study addresses that gap.

Methods. A two-stage normative methodology was employed. First, empirical findings from a prior qualitative documentary analysis of 585 judicial decisions rendered during COVID-19 in Brazil (2019–2025), organized across four thematic axes, were systematically synthesized. Second, structured normative-bioethical analysis was conducted using reflective equilibrium between those empirical findings and three complementary theoretical frameworks: principlist bioethics, Latin American social bioethics, and public health ethics benchmarks.

Results. The Bioethical Matrix for Judicial Orientation in Sanitary Emergencies (BMJOSE) is proposed, comprising four axis-specific bioethical parameter sets and five cross-cutting principles: proportionality, equity of access, evidence-based reasoning, institutional transparency, and protection of the minimum existential core. Each axis is accompanied by its central bioethical tension, normative anchors, and operational parameters for judicial deliberation.

Conclusions. BMJOSE constitutes an original normative contribution aimed at reducing arbitrariness and enhancing bioethical coherence in judicial decision-making during sanitary crises. The framework applies across Brazilian jurisdictional levels and may inform analogous contexts in countries with constitutionally guaranteed rights to health. Implementation requires institutional dialogue between courts, health regulatory bodies, and bioethics institutions.

1 Background

Public health emergencies expose a structural paradox in constitutionally guaranteed health systems: courts, whose institutional purpose is the adjudication of individual rights claims, become actors in collective health governance when administrative systems fail under crisis conditions. This paradox was dramatized during the COVID-19 pandemic in Brazil, which generated an unprecedented volume of judicial decisions involving intensive care unit (ICU) access, provision of experimental and non-incorporated medications, vaccination mandates, and intergovernmental disputes over the governance of the Unified Health System (SUS). Unlike routine health litigation, pandemic-era judicialization operated under conditions of radical temporal urgency, scientific uncertainty, and systemic resource scarcity that fundamentally altered the institutional context of judicial deliberation.

The Brazilian constitutional order, established by the 1988 Federal Constitution, formally recognizes health as a universal and immediately enforceable fundamental right, imposing affirmative obligations on public authorities at municipal, state, and federal levels [1]. This constitutional architecture creates

structurally fertile conditions for health judicialization: constitutional normativity guarantees rights whose material realization depends on fiscal capacity, administrative coordination, and institutional design, generating a persistent gap between what is legally promised and what is materially delivered [2]. The COVID-19 pandemic acutely widened this gap, exposing the structural fragilities of the SUS under conditions of acute resource scarcity and administrative fragmentation.

Comparative international experience confirms that health judicialization under constitutional rights frameworks is not uniquely Brazilian. In Colombia, India, and South Africa, constitutionally grounded rights to health have similarly produced extensive judicial involvement in health policy, with courts ordering provision of antiretroviral medications, hospital access, and essential services in ways that reshaped health governance beyond individual disputes [3,4]. In each of these contexts, scholars have identified a recurrent normative deficit: courts act without explicit bioethical parameters to guide their deliberation, producing heterogeneous and sometimes contradictory outcomes that reflect individual judicial reasoning rather than principled institutional standards [5,6]. The Brazilian pandemic context reproduces and intensifies this deficit at scale.

The empirical literature on COVID-19 health judicialization in Brazil documents heterogeneous decision patterns across thematic domains, courts, and temporal phases of the pandemic [7,8]. Studies have identified an adaptive trajectory in judicial reasoning, with early decisions emphasizing individual urgency and later decisions progressively incorporating technical criteria, systemic constraints, and distributive considerations [7]. This evolution suggests institutional learning capacity, but also reveals that bioethical coherence emerged incrementally and inconsistently, rather than being grounded from the outset in structured normative principles. The costs of this incoherence, including distributively inequitable allocation of scarce resources, provision of scientifically unsupported treatments, and governance fragmentation, are well documented [9,10].

A critical normative gap therefore persists in the literature. Substantial scholarship has described how courts acted during the pandemic and evaluated the systemic effects of their interventions [7-10]. Frameworks for administrative allocation of scarce medical resources during COVID-19 have been proposed and debated extensively [11,12]. The ethics of pandemic public health measures, including vaccination mandates, therapeutic protocols, and triage criteria, have been subjected to rigorous bioethical analysis [13,14]. What remains largely absent is a structured normative framework specifically designed to guide judicial, rather than administrative or clinical, reasoning in public health emergencies. This study addresses that gap by proposing the Bioethical Matrix for Judicial Orientation in Sanitary Emergencies (BMJOSE), a normative framework derived from systematic analysis of empirical judicial patterns and grounded in three complementary bioethical theoretical traditions.

2 Methods

2.1 Study design

This study employs a normative methodology with empirical grounding, structured in two analytically distinct but interconnected stages. The design corresponds to the methodological approach of reflective equilibrium, which seeks coherence between particular empirical judgments and general normative principles through iterative bidirectional adjustment [15]. This approach is recognized in empirical bioethics as a means of grounding normative claims in the reality of institutional practice without committing the naturalistic fallacy of inferring prescriptive conclusions directly from descriptive observations [16]. Empirical findings function diagnostically, revealing the bioethical tensions and normative deficits that theoretical analysis must address, while theoretical frameworks supply the normative content that guides parameter construction.

2.2 Stage 1: Empirical basis

The empirical foundation of this study consists of findings from a prior qualitative empirical-documentary analysis of 585 judicial decisions related to COVID-19 health judicialization in Brazil, spanning 2019 to 2025 [7]. Cases were retrieved from the AASP/JUIT jurisprudence database using a Boolean search strategy combining COVID-19 epidemiological descriptors with health litigation terms. Systematic probabilistic sampling (k=18) was applied to a universe of 17,537 identified cases, followed by deduplication and eligibility screening. Decisions were organized into four thematic axes: (i) ICU access and resource scarcity; (ii) federative conflicts and SUS governance; (iii) medication provision during the pandemic; and (iv) vaccination mandates and individual autonomy. The present study treats those empirical findings as analytical inputs, synthesizing their key bioethical dimensions to inform normative parameter construction. This methodological relationship between studies is analogous to the use of systematic review findings as the empirical basis for clinical guideline development.

2.3 Stage 2: Normative-bioethical analysis

Three complementary theoretical frameworks were selected through a structured scoping process and applied through reflective equilibrium to derive the normative parameters of BMJOSE.

First, principlist bioethics, as elaborated by Beauchamp and Childress (2019), provides foundational analytical categories of respect for autonomy, non-maleficence, beneficence, and justice. In BMJOSE, these principles are applied in their extended institutional, rather than exclusively clinical, dimensions: autonomy is reinterpreted relationally, incorporating its public health boundaries; beneficence encompasses systemic rationality alongside individual benefit; non-maleficence extends to population-level consequences of judicial orders; and justice operates across distributive, procedural, and equity-of-access registers.

Second, Latin American social bioethics, developed principally by Garrafa and Porto within the tradition of bioética de intervenção [18], contributes the categories of structural vulnerability, equity, and collective social responsibility. This framework is theoretically indispensable for the Brazilian context, in which

health judicialization operates against a backdrop of profound and structurally entrenched inequality. It foregrounds the distributional consequences of judicial decisions for non-litigant populations and requires that bioethical analysis attend to the structural conditions that produce litigation-dependent health access.

Third, the public health ethics benchmarks framework proposed by Childress and colleagues (2002) provides operationalizable evaluative criteria for public health interventions, including effectiveness, necessity, proportionality, minimal infringement, and equity. These criteria translate directly into the cross-cutting principles of BMJOSE and supply the evaluative infrastructure most directly applicable to judicial governance of health emergencies.

The reflective equilibrium process involved iterative analysis of each thematic empirical axis against all three frameworks, identifying convergent and divergent normative implications and resolving tensions through principled adjudication. Cross-cutting principles were identified through convergence analysis, isolating those with support from at least two frameworks across all four axes. The framework was assessed for internal normative consistency, contextual adequacy to the Brazilian jurisdictional context, and practical operationalizability by judicial actors without specialized bioethical training.

3 Results

3.1 Overview of the BMJOSE framework

BMJOSE is organized across two structural dimensions. The first comprises four thematic axes, each characterized by a central bioethical tension, specific normative anchors, and a set of axis-specific operational parameters derived from the empirical and theoretical analysis. The second dimension comprises five cross-cutting principles constituting the irreducible bioethical conditions for legitimate judicial intervention in any public health emergency. Table 1 presents the complete framework. Narrative elaboration of each axis and principle follows.

Table 1. Bioethical Matrix for Judicial Orientation in Sanitary Emergencies (BMJOSE)

Thematic axis	Central bioethical tension	Normative anchors	Axis-specific parameters
I. ICU access and resource scarcity	Individual urgency vs. collective equity in the allocation of life-sustaining resources under scarcity	Distributive justice; non-abandonment; proportionality; beneficence (systemic)	• Require courts to assess systemic impact of individual orders on other patients in equivalent clinical conditions • Mandate consultation with health authorities on resource availability and existing triage protocols before issuing provision orders • Prioritize evidence-based triage criteria over individualized judicial allocation • Apply non-abandonment floor: minimum dignitary care must be preserved even where full provision is impossible • Prohibit resource denial without explicit proportionality assessment articulated in the decision
II. Federative conflicts and SUS governance	Individual rights enforcement vs. institutional competence allocation within cooperative federalism	Procedural justice; institutional solidarity; shared constitutional responsibility; governance legitimacy	• Treat shared constitutional health responsibility as an ethical, not merely juridical, obligation among federative entities • Reject inter-entity jurisdictional disputes as justification for denial or delay of essential care • Identify and mandate action by the most operationally capable entity, with subsequent inter-entity financial resolution handled administratively • Require courts to address governance failures directly rather than deflecting to procedural allocations of blame • Promote institutional solidarity as a legally enforceable bioethical duty in intergovernmental health disputes

Thematic axis	Central bioethical tension	Normative anchors	Axis-specific parameters
III. Medication provision during pandemics	Individualized therapeutic claims vs. evidence-based systemic incorporation and collective rationality	Beneficence; non-maleficence; evidence-based reasoning; therapeutic rationality; regulatory legitimacy	• Require scientific evidence of therapeutic efficacy and safety as a necessary precondition for judicial provision orders • Distinguish state omission in delivering established treatments from legitimate therapeutic uncertainty requiring regulatory evaluation • Apply non-maleficence standard: courts must assess risk of harm from ordering treatments without established evidentiary basis • Align judicial reasoning with CONITEC evaluation processes; departure from regulatory determinations requires explicit justification • Reject medication orders grounded exclusively on individual prescription absent regulatory or scientific support
IV. Vaccination mandates and individual autonomy	Individual liberty and bodily integrity vs. collective protection obligations and the harm principle	Relational autonomy; beneficence (collective); proportionality; solidarity; harm prevention principle	• Recognize that autonomy in public health contexts is relationally bounded by harm prevention obligations toward third parties • Uphold evidence-based vaccination requirements as proportionate when sanctions are non-punitive and medically grounded • Subject vaccination restrictions to proportionality review: measures must not exceed what is strictly necessary for epidemiological objectives • Apply heightened scrutiny to proxy-based vaccine refusal for minors and decisionally vulnerable individuals • Ensure accessible and effective compensation

Thematic axis	Central bioethical tension	Normative anchors	Axis-specific parameters
			mechanisms for genuine adverse events as a condition of ethical mandate legitimacy
Cross-cutting principles (applicable to all axes)			
• Proportionality and reasonableness: every judicial order calibrated to the least restrictive means necessary • Equity of access: distributional consequences of decisions must not systematically favour litigants over non-litigants in equivalent situations • Evidence-based reasoning: deliberation must incorporate best available scientific and technical evidence • Institutional transparency: bioethical basis of decisions must be explicitly articulated in reasoning • Protection of the minimum existential core: life-preserving care cannot be denied on fiscal grounds alone			

CONITEC: Comissão Nacional de Incorporação de Tecnologias no SUS (National Committee for Health Technology Incorporation). SUS: Sistema Único de Saúde (Unified Health System).

3.2 Axis I: ICU access and resource scarcity

The acute scarcity of intensive care resources during COVID-19 constituted the most ethically charged domain of health judicialization, placing courts at the intersection of individual constitutional rights and the distributive imperatives of collective health governance. Judicial orders compelling immediate ICU admission or resource provision generated allocative ripple effects extending well beyond the individual litigant, reallocating scarce resources among patients in equally urgent conditions who lacked legal representation. This dynamic exposed a foundational structural inequity: litigation-based access systematically privileges those with legal and socioeconomic resources, reproducing and amplifying pre-existing inequalities in health access [10,20].

The principlist principle of justice, in its distributive and procedural dimensions, is the governing normative category of this axis. Courts adjudicating resource scarcity claims cannot restrict their reasoning to the individual rights of the party before them; the constitution also guarantees health as a universal right to those who are not in court. A judicial decision ordering ICU provision for one patient is simultaneously a resource allocation decision affecting others, and its ethical legitimacy depends in part on its systemic consequences. This does not require courts to conduct epidemiological modelling but does require them to engage substantively with the systemic context of their decisions, including requesting information from health authorities on available capacity, existing allocation protocols, and anticipated distributional impacts [11,12].

The principle of non-abandonment, transposed from its origins in clinical ethics to this institutional context, establishes a floor for judicial deference to resource constraints. While BMJOSE does not require courts to order provision in all circumstances of scarcity, it prohibits categorical denial of care without a proportionality assessment that explicitly considers the minimum dignitary protection owed to every patient. Courts that defer unconditionally to administrative resource allocation decisions without examining their conformity with constitutional and bioethical minimum standards fail to discharge their function as guardians of fundamental rights [21].

3.3 Axis II: Federative conflicts and SUS governance

Brazil's cooperative federalism distributes SUS health governance responsibilities across municipal, state, and federal entities, each bearing constitutionally defined but often overlapping obligations. During COVID-19, coordination failures generated jurisdictional disputes over procurement, vaccination programme management, and emergency health regulation, which courts were frequently called upon to resolve. The normative character of these disputes is often misunderstood: inter-entity litigation in health governance is not merely a procedural question of competence allocation but an ethical problem of institutional solidarity and responsibility [22].

From the perspective of Latin American social bioethics, the use of federative jurisdictional disputes to delay or deny health care provision constitutes an ethical failure of institutional solidarity. Garrafa and Porto identify responsibility and solidarity as foundational categories of bioethics of intervention in structurally unequal societies [18]. Applied to intergovernmental health disputes, solidarity requires that federative entities prioritize patient welfare over administrative convenience, and that courts enforce this priority as a legally binding bioethical obligation. A federative conflict that results in the denial of essential care is not a neutral governance failure; it is a violation of the constitutional and ethical duties shared by all levels of public authority.

BMJOSE proposes a pragmatic, capacity-oriented approach to intergovernmental health disputes. Rather than mechanically assigning liability to the formally designated responsible entity, courts should identify the entity with the greatest operational capacity to deliver the required intervention and mandate immediate action from that entity, leaving inter-entity financial resolution to subsequent administrative processes. This approach operationalizes the principle of institutional solidarity while preserving the ultimate accountability of the constitutionally designated responsible authority. Judicial transparency in articulating this reasoning creates an accountability record that enables higher courts and health administrative bodies to progressively refine intergovernmental responsibility standards for future emergencies.

3.4 Axis III: Medication provision during pandemics

The COVID-19 pandemic generated a distinctive and ethically complex pattern of medication litigation involving treatments promoted in the absence of adequate scientific validation. Brazilian courts were repeatedly asked to order provision of hydroxychloroquine, ivermectin, nitazoxanide, and other substances as early treatment protocols despite the absence of established regulatory approval or evidentiary support for their efficacy in COVID-19. This pattern represents a paradigmatic case of non-maleficence failure in judicial reasoning: orders issued in the name of individual beneficence that exposed patients to therapeutically unsupported treatments, allocated resources away from evidence-based interventions, and judicially legitimized scientifically contested practices [23].

The principlist framework requires that judicial provision orders satisfy both beneficence and non-maleficence standards. A court that orders provision of a medication without established efficacy cannot be characterized as acting beneficently toward the claimant; it is imposing a therapeutic intervention whose risk-benefit profile has not been established. The public health ethics benchmarks of Childress and colleagues further require that any health intervention be demonstrably effective: judicial medication orders that fail this criterion lack adequate bioethical justification, regardless of their grounding in individual prescription or constitutional rights argumentation [19].

BMJOSE draws a normatively critical distinction between two categories of medication claim that pandemic judicialization conflated: genuine state omission in delivering treatments with established efficacy and regulatory approval, which warrants strong judicial intervention to enforce constitutional rights; and claims for non-incorporated or scientifically contested treatments, which require judicial restraint pending appropriate regulatory evaluation through CONITEC processes. Confusing these categories, as pandemic-era courts frequently did, produces both non-maleficence failures at the individual level and systemic rationality failures at the collective level, as resources are redirected from evidence-based interventions toward therapeutically unproven alternatives [24].

3.5 Axis IV: Vaccination mandates and individual autonomy

Vaccination litigation during COVID-19 presented an inversion of the typical health judicialization structure: rather than demanding state provision of health services, claimants contested state-imposed health obligations, asserting individual autonomy and bodily integrity against mandatory vaccination requirements. This inversion required courts to engage directly with one of the most fundamental tensions in public health ethics: the conflict between respect for individual self-determination and the collective harm prevention duties that ground public health governance [14,25].

The bioethical analysis of this axis requires a relational, rather than atomistic, conception of autonomy. Liberal theories of individual liberty treat autonomous choices as self-regarding when they affect primarily the chooser. Vaccination decisions in pandemic contexts do not satisfy this condition: individual refusal carries externalities affecting transmission dynamics, healthcare system burden, and

the protection of immunocompromised and vulnerable populations who cannot be vaccinated. The harm principle, as applied in public health ethics, justifies restriction of individual liberty when its exercise poses substantial and non-trivial risk of harm to identifiable others [13,19]. Evidence-based vaccination mandates grounded in sound epidemiological reasoning and proportionate in their coercive elements fall within this justification.

BMJOSE also identifies a dimension of vaccination litigation that received insufficient normative attention in pandemic-era judicial reasoning: the adjudication of adverse event claims and the ethical conditions for compensation. Mandatory vaccination programmes that are ethically grounded in solidarity and harm prevention carry a corresponding ethical obligation to ensure accessible compensation for those who suffer genuine adverse consequences of compliance. Courts that uphold vaccination mandates without attending to the adequacy of compensation mechanisms fail to honour the reciprocal obligations that make solidarity-based health requirements ethically legitimate [26]. The framework's parameters for this axis therefore extend beyond the adjudication of mandate validity to encompass the institutional infrastructure of therapeutic justice for vaccination-related harm.

3.6 Cross-cutting bioethical principles

Five principles apply across all thematic axes and constitute the irreducible bioethical conditions for legitimate judicial intervention in sanitary emergencies. Their cross-cutting character reflects their derivation from convergent support across all three theoretical frameworks and their applicability to the structural features of health emergency litigation regardless of thematic domain.

Proportionality and reasonableness require every judicial order to be calibrated to the least restrictive means capable of achieving its constitutional objective. In public health emergencies, proportionality analysis is contextually sensitive: the severity and urgency of the health threat legitimately expands the range of measures that may be considered proportionate. However, this expansion does not eliminate the requirement; it recalibrates it. Courts must assess whether the remedy ordered is proportionate to the right at stake and the harm threatened, and must articulate this assessment explicitly in their reasoning. Over-inclusive orders that impose excessive systemic costs and under-inclusive orders that fail to provide meaningful relief both fail the proportionality standard.

Equity of access establishes that the distributional consequences of judicial decisions must not systematically favour litigants over non-litigants in equivalent clinical situations. This principle operationalizes the justice category of principlist bioethics in its distributive dimension and responds directly to the critique advanced by Ferraz and others that health judicialization in Brazil has structurally privileged higher socioeconomic strata who possess greater legal resources [5,20]. The equity principle does not prohibit individual judicial orders but requires courts to consider their systemic distributional effects as a necessary component of the deliberation process, not an optional policy consideration.

Evidence-based reasoning mandates that judicial deliberation incorporate the best available scientific and technical evidence pertaining to the health claim at issue. Courts are not required to resolve scientific uncertainty, but they must demonstrate substantive engagement with the evidentiary basis of the claims before them rather than relying exclusively on individual medical prescriptions or expert opinions that are unmoored from regulatory and scientific consensus. In rapidly evolving emergency contexts, this principle requires courts to develop procedural mechanisms, including expedited consultation with health authorities and regulatory agencies, for accessing relevant technical expertise within the temporal constraints of emergency adjudication.

Institutional transparency requires courts to articulate explicitly the bioethical basis of their decisions, specifying the principles invoked, the interests balanced, and the systemic consequences assessed. Transparent reasoning serves multiple functions: it enables institutional learning across decisions and over time; it supports external accountability and appellate review; and it contributes to the broader societal deliberation on the values governing resource allocation and rights enforcement under crisis conditions. Opaque judicial decisions in health emergencies, however well-intentioned, foreclose the institutional learning pathways through which jurisprudential standards can progressively improve.

Protection of the minimum existential core establishes that no patient may be denied life-preserving care solely on fiscal or administrative grounds. This principle is grounded in Brazilian constitutional doctrine [27,28] and in international human rights instruments governing the minimum core content of the right to health, including the UNESCO Universal Declaration on Bioethics and Human Rights [29]. It sets a threshold of protection below which judicial deference to state resource constraints cannot legitimately descend, regardless of the fiscal constraints invoked. While the minimum existential core does not render all health claims judicially enforceable, it establishes the irreducible constitutional floor against which administrative denial of care must always be assessed.

4 Discussion

4.1 Contribution and positioning in the literature

BMJOSE addresses a normative gap that existing literature has identified but not filled. Scholars working in the bioethics of public health have produced extensive frameworks for administrative and clinical decision-making under crisis conditions [11-13], and legal scholars have extensively analysed the constitutional dimensions of health judicialization in Brazil and comparatively [3-5]. However, the intersection of these two domains, the bioethical governance of judicial decision-making in health emergencies, has received insufficient systematic attention. BMJOSE occupies this intersection, translating the prescriptive resources of bioethical theory into the institutional language of judicial deliberation.

The framework's most significant methodological contribution is its application of reflective equilibrium to the derivation of normative parameters from empirical judicial data. This approach differs from both

purely deductive bioethics, which applies pre-existing principles without empirical grounding, and from purely descriptive socio-legal scholarship, which documents practice without normative prescription. By treating empirical patterns as diagnostic inputs that reveal bioethical deficits requiring theoretical remedy, BMJOSE exemplifies the integrated empirical ethics methodology advocated by Molewijk and colleagues (2004), producing normative guidance that is simultaneously theoretically grounded and empirically informed.

4.2 Relationship to existing normative frameworks

BMJOSE builds on but extends the principlist tradition in several respects. Beauchamp and Childress developed their four-principle framework for the clinical encounter between individual practitioners and patients [17]; its application to institutional and judicial contexts requires theoretical translation that BMJOSE systematically undertakes. Autonomy becomes relational autonomy, acknowledging its constitutive embeddedness in social relationships and its legitimate limitation by collective harm prevention obligations. Beneficence encompasses systemic rationality, recognizing that individual-level therapeutic provision may be collectively harmful when it reallocates resources from evidence-based to unvalidated interventions. Justice is pluralized across distributive, procedural, and equity-of-access registers appropriate to the institutional context of judicial health governance.

The incorporation of Latin American social bioethics is theoretically essential for the Brazilian context and represents a significant departure from frameworks that apply exclusively Anglo-American principlist or utilitarian traditions. Garrafa and Porto's bioética de intervenção prioritizes structural vulnerability and distributional responsibility as central ethical categories in societies marked by profound inequality [18]. This emphasis prevents BMJOSE from collapsing into an individualistic rights-reasoning framework that ignores the structural conditions producing litigation-dependent health access. Sen's, Nussbaum's, and Powers and Faden's substantive frameworks of social justice similarly ground the equity-of-access principle in a theory of what human beings are owed independent of their capacity to assert rights through litigation [30-32].

4.3 International comparisons and transferability

The comparative international literature on judicial governance of health rights identifies consistent patterns across diverse constitutional systems: courts in Colombia, India, and South Africa have all been called upon to enforce constitutional health rights under conditions of resource scarcity, generating analogous debates about the distributional consequences, institutional competences, and normative bases of judicial intervention [3-6]. In Colombia, the Constitutional Court's T-760 decision issued structural orders addressing systemic failures in health system coverage, demonstrating that courts can move beyond individualized remedy to engage with collective governance imperatives. South African health rights jurisprudence, particularly in the Grootboom and Treatment Action Campaign cases,

established proportionality and reasonableness review as the standard for adjudicating socioeconomic rights claims, directly anticipating principles embedded in BMJOSE.

These comparative experiences strengthen the framework's transferability while also revealing the limits of decontextualized application. The specific federal structure of the Brazilian SUS, the constitutional immediacy of the right to health in the 1988 Constitution, and the volume and diversity of Brazilian health litigation create a particular institutional context that BMJOSE is calibrated to address. Adaptation to other national contexts would require recalibration of the axis-specific parameters to reflect different health governance architectures while preserving the cross-cutting principles, which are grounded in theoretical frameworks of recognized international applicability [29,32,34].

4.4 Implementation pathways

Practical implementation of BMJOSE requires engagement at multiple institutional levels. Within the judiciary, the National Council of Justice (Conselho Nacional de Justiça, CNJ) has authority to issue resolutions and technical recommendations on health judicialization; future iterations of such instruments could formally incorporate BMJOSE parameters, providing a hierarchically authoritative reference for judges across all jurisdictional levels [33]. At the regulatory level, health authorities including the Ministry of Health and ANVISA could develop expedited technical guidance protocols for responding to judicial consultations during health emergencies, providing the evidentiary infrastructure that the evidence-based reasoning principle requires within the temporal constraints of emergency adjudication. Within bioethics institutions, the national network of Research Ethics Committees and bioethics advisory bodies could play consultative roles in the development of emergency health litigation protocols, ensuring that specialized bioethical expertise informs judicial governance of health crises.

Investment in judicial bioethical literacy constitutes the most consequential long-term implementation pathway. Health judicialization is a structural and ongoing feature of the Brazilian legal landscape, not a crisis-specific anomaly. Incorporating bioethical reasoning into judicial education for health-related cases across all contexts would develop the institutional capacity required to apply BMJOSE parameters effectively when emergencies arise, transforming the framework from an external normative prescription into an internalized dimension of judicial professional practice [33].

4.5 Limitations

Several limitations must be acknowledged. First, the framework was derived from a specific national and pandemic context; its operational parameters may require adaptation for future emergencies with distinct epidemiological profiles, clinical technologies, or governance configurations. Second, the reflective equilibrium methodology, while methodologically established in normative ethics, involves principled value judgments in framework selection and parameter weighting that cannot be fully eliminated from the analysis. Third, the framework has not yet been empirically tested in deliberative

processes with judicial actors, limiting assessment of its practical applicability and the degree to which its parameters are actionable within judicial institutional constraints. Fourth, BMJOSE does not specify implementation mechanisms in detail, leaving open questions about formal incorporation into judicial procedural rules, continuing legal education curricula, or emergency health litigation protocols. Future research should address these limitations through structured deliberation with judges, health administrators, and bioethics experts, and through testing of the framework against both historical cases and prospective emergency scenarios.

5 Conclusions

The COVID-19 pandemic demonstrated that judicial decision-making in public health emergencies cannot achieve bioethical coherence without explicit normative orientation. Courts positioned at the intersection of constitutional health rights, resource scarcity, scientific uncertainty, and governance fragmentation require structured bioethical guidance that extends beyond formal legal doctrine. BMJOSE responds to this need by providing an integrated, principle-based, and empirically grounded normative framework for judicial reasoning in sanitary emergencies.

The framework's four axis-specific parameter sets and five cross-cutting principles constitute a normative architecture that is sufficiently flexible to accommodate the heterogeneity of emergency health litigation across different jurisdictional levels and thematic domains, while sufficiently specific to provide operational guidance for judicial deliberation. Its adoption would contribute to greater consistency, transparency, and bioethical coherence in judicial reasoning, reducing the risk of distributively inequitable, scientifically unsupported, or disproportionate judicial interventions during future health crises.

BMJOSE does not propose that bioethical frameworks alone are sufficient to address the structural determinants of health judicialization in Brazil. Sustained investment in primary care infrastructure, pharmaceutical assistance, and intergovernmental coordination within the SUS is necessary to reduce litigation-dependent health access and its attendant inequities. Nevertheless, as long as courts are called upon to adjudicate health rights claims under emergency conditions, the quality of their bioethical reasoning has direct consequences for individual welfare, collective equity, and systemic sustainability. Improving that quality through structured normative guidance is an institutional imperative whose urgency the COVID-19 pandemic has made unmistakable.

Future research should evaluate BMJOSE's practical applicability through deliberative processes with judicial actors, test its parameters against hypothetical emergency scenarios, and refine its operational dimensions through engagement with affected communities, health administrators, and bioethics specialists. The framework is offered as a contribution to this collaborative normative enterprise, grounded in the conviction that bioethically coherent judicial governance of public health emergencies is both achievable and essential for a health system committed to universal rights protection and collective solidarity.

Declarations

Ethics approval and consent to participate. Not applicable. This study is based exclusively on published literature and secondary analysis of previously collected judicial decision data. No primary data collection involving human participants was conducted.

Clinical trial number. Not applicable.

Consent for publication. Not applicable.

Availability of data and materials. Data sharing is not applicable to this article, as no datasets were generated or analysed during the current study. The normative framework developed herein is fully presented within the manuscript.

Competing interests. The authors declare no competing interests.

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Authors' contributions. F.G.B.O. conceptualised the study, developed the normative framework, conducted the bioethical analysis, and wrote the main manuscript text. S.L.F.O. and A.L.F. contributed to the theoretical analysis, reviewed the literature, and critically revised the manuscript. D.B.G. supervised the research, provided methodological guidance, and reviewed and approved the final version. All authors read and approved the submitted version.

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