Ethicists, doctors and triage decisions: who should decide? And on what basis?

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ABSTRACT
We report here an emerging dispute in Italy concerning triage criteria for critically ill covid-19 patients, and how best to support doctors having to make difficult decisions in a context of insufficient life saving resources. The dispute we present is particularly significant as it juxtaposes two opposite views of who should make triage decisions, and how doctors should best be supported. There are both empirical and normative questions at stake here. The empirical questions pertain to the available level of evidence that healthcare professionals would rather not be left alone with their ‘clinical judgments’ to make triage decisions, and to the accounts of distributive justice that doctors and healthcare professionals rely on, when making triage decisions. The normative questions pertain to how this empirical evidence should inform guidelines on how prioritisation decisions are made in a context of emergency, and who gets to have the authority to do so. This debate goes beyond the discussion of the care of critically ill patients with COVID-19 and has broader implications beyond the national context for the discussion of how to relieve moral distress in contexts of imbalances between healthcare resources and clinical needs of a population.

The first view we present here is the one put forward by the Ethics Committee of the Italian Society of Anaesthesia, Analgesia, Resuscitation and Intensive Care (hence, SIAARTI Ethics) in early March 2020, at the peak of the Italian COVID-19 outbreak. The SIAARTI recommendations adopt an approach aimed at ensuring the ‘highest probability of survival’. The recommendations rely on comorbidities and functional status of critically ill patients as criteria to rank patients for preferential access to intensive care units (ICU). While they do not point to a specific age cut-off for admission to ICUs, they note that an age limit for admission to ICU—contextual to the given hospital—may ‘ultimately need to be set’. This view was published as a response to Italian doctors working on the front lines at the peak of the outbreak in Northern Italy. Many healthcare professionals working on the front lines reported experiencing severe moral distress. Rationalising critical healthcare resources is not typically a feature of healthcare systems in high-income countries (HIC), and many doctors in Italy were confronted with life/death decisions for the first time. Rosenbaum reported how some Italian doctors working in intensive wards in Lombardy at the peak of the epidemic preferred to remain silent on the basis for making decisions on rationing life-saving resources.

The second view we present is the one put forward by the Italian National Committee for Bioethics (Comitato Nazionale per la Bioetica, hence CNB). The CNB is Italy’s governmental bioethics body and provides recommendations in the form of reports, or ‘opinions’. In early April 2020, the CNB released a report disagreeing with the SIAARTI approach and arguing that clinical judgment should remain the only appropriate criterion for triaging critically ill patients with COVID-19. According to the CNB, triaging on the basis of a ‘predetermined class’, including: age, gender, social condition and role, ethnic minorities, disability and, personal responsibility towards health, is discriminatory and ethically unacceptable.

In their 2020 opinion titled “Clinical decision-making in conditions of resource shortage”, the CNB argues that triage can be ethically justified only in light of the ‘exceptionality’ of the moment. The document refers to triage for patients with COVID-19 as ‘pandemic emergency triage’, to underline the exceptionality of the event in a context of universality of care and right to health as enshrined in the Italian Constitution. Article 32 of the Italian Constitution states, ‘The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent.’

The two key criteria for this ‘pandemic emergency triage’ as outlined by the CNB are: (A) clinical appropriateness; and (B) actuality. With the former, the Italian medical literature refers to clinical judgment relative to the efficacy of the treatment which is being considered, and to the clinical need of each single patient. With the latter, the CNB understands the revisability of the clinical judgment, made necessary by the emergency context. In other words, triage is considered ethically justifiable only in light of the emergency, and the ethicists in the Italian National Bioethics Committee refer to clinical judgment as the only criterion according to which prioritisation of patients can be ethically justified.

One of the authors of this article, MM, is a member of CNB and the only CNB member to submit a dissenting opinion, or ‘minority report’, highlighting how this approach negates the reality of the concept of triage itself, which presupposes having criteria in place. Indeed, the premise of the CNB report is that of ‘preparedness’; that is, according to the guidelines put forward by WHO in 2018, the moral duty to put in place strategies for the healthcare system to deal with pandemic emergencies and increase healthcare system capacities to
avoid having to triage patients. Hence, a tentative yes to triage, but only very narrowly conceptualised.

The SIAARTI Ethics recommendations differ in their substance from the CNB opinion, as the former explicitly state the need to have criteria in place which go beyond clinical judgment, and that are based in distributive justice concerns. It is to this end that the SIAARTI recommendations put forward age as the only non-clinical criterion to apply when confronted with two patients who, from a clinical point of view, are considered to have the same probability of survival. The SIAARTI recommendations also advise on the revisability of ICU admission decisions—they explain how any admission to the ICU needs to be understood as an 'ICU trial', to be revised on a daily basis.

The Italian dispute speaks to a wider debate in clinical ethics about triage decision-making, and how best to support doctors who are being confronted with the necessity of triage decisions. The starting point for both sets of recommendation is the same: a context of disequilibrium between life-saving healthcare resources and number of critically ill patients, at the peak of the COVID-19 outbreak in Italy, and the emergence of moral distress experienced by doctors and healthcare professionals on the front lines. This was not only an Italian situation by any means. Moral distress was also experienced by doctors in the UK and USA, as reported, and elsewhere in the world. In HICs, doctors may be confronting life/death decisions for the first time during the pandemic. Less privileged healthcare systems in the Global South may encounter these decisions daily, outside the emergency crisis caused by COVID-19.

What is the most appropriate solution to the moral distress experienced by doctors and healthcare professionals in a context of imbalance between life-saving resources, and clinical needs of the population?

There is more than one possible response to this question, as the Italian dispute shows.

On the one hand, SIAARTI Ethics responded by providing criteria for triaging, which could be applied by doctors facing an ethical dilemma. So did the British Medical Association in the UK, the National Institute for Health and Care Excellence, and so did many professional ethicists around the world. At the peak of the pandemic, there seemed to be an emerging consensus that healthcare professionals on the front lines should be supported by interdisciplinary triage committees or triage teams who could make decisions independently from clinical staff.

According to this first view, by making criteria explicit, and supporting doctors with a triage committee, doctors are relieved of having to make such difficult decisions alone, and can focus on the care and well-being of that particular patient in front of them, even in the case in which the care that is being offered is not intensive care, but palliative care. Similarly, according to this view, patients and their families will benefit from having clear, transparent criteria published for how decisions are being made. According to the second view, closer to CNB in spirit, ethicists are not being helpful by publishing their opinions on which criteria doctors should follow. On the contrary, as there is no moral consensus on what triage criteria are most appropriate (a classic problem for philosophers, and ethicists), the proliferation of opinions and recommendations only increases the confusion and moral distress experienced by healthcare professionals on the front lines. As argued by Jongepier and Jongsma (2020), a better way of supporting clinicians during the emergency would be to ‘stand firmly behind the clinicians, who are now making impossible decisions, and to tell them: You’re doing okay, your choices are ethically justifiable’. Along similar lines, the ethicists of the Italian National Bioethics Committee recommended that doctors make triage decisions alone, on the basis of their clinical judgments only.

What sort of evidence supports each view?

The separation of clinical care from triage decision-making based on a clear set of criteria has been recommended on the basis of the evidence that healthcare professionals would rather not be left alone with their ‘clinical judgments’ to make triage decisions. However, how much evidence there actually is about how doctors and healthcare professionals would want to be supported when faced with triage decisions in a context of emergency remains a contested matter. Would they rather rely on an independent triage committee, on a clear set of guidelines and criteria, or on clinical judgment only? Are there cultural differences, or other factors, impacting these preferences? Are there other ways, beyond these two options, in which they would like to be supported? What is the role of ethicists in the pandemic?

Who gets to have authority and produce this guidance is also disputed. In Italy, the UK and the USA, different deliberative bodies have come forward with different sets of recommendations. In the UK, Richard Huxtable has called for more clarity on national ethics guidance regarding COVID-19. In a recent editorial, he raised both substantive and procedural questions: ‘Which account of distributive justice should inform decisions, and thus determine which patients should receive—or not receive—even life-saving treatment?’, and: ‘Who should be involved in making or contributing to such decisions, especially during a fast-moving pandemic?’

There are both empirical and normative questions at stake here. The empirical questions pertain to the level of evidence available that healthcare professionals would rather not be left alone with their ‘clinical judgments’ to make triage decisions, and to the accounts of distributive justice that doctors and healthcare professionals rely on, when making triage decisions. The normative questions pertain to how this empirical evidence should inform guidelines on how prioritisation decisions are made in a context of emergency, and who gets to have the authority to do so. These are complex questions that go well beyond the pandemic. David Jones, historian, and Bernard Ackerman, Professor of the Culture of Medicine, Harvard University, has criticised - among others - bioethicists for being ‘infatuated’ with the perennial question of ‘who gets the ventilator’. He has a point. These are not new questions for bioethics; on the contrary, bioethicists have been discussing them for at least 50 years, when they were tasked with criteria on how to allocate dialysis machines in the 1960s in the USA. However, we seem to have forgotten these questions as we rode the wave of optimism in technoscience and medicine we have thought we could conquer infectious diseases through immunisation programmes and antibiotics.

The pandemic confronts us with the actuality of these questions. Antibiotics resistance, vaccination hesitancy, and animal-to-human viral spillovers ring clear alarm bells that we will see more pandemics in the 21st century. We need to have these conversations about triaging outside of a pandemic, in order to best support our healthcare professionals, our patients, and their families. With this we would like to open a conversation, and a call for research.

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REFERENCES


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