

National health system cuts and triage decisions during the COVID-19 pandemic in Italy and Spain: ethical implications

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ABSTRACT

In this paper, we analyse the most important documents establishing the criteria for the treatment and exclusion of COVID-19 patients, especially in regard to the giving of respiratory support, in Italy and Spain. These documents reflect a tension that stems from limited healthcare resources which are insufficient to save lives that, under normal conditions, could have been saved, or at least could have received the best possible treatment. First, we analyse the healthcare systems of these two countries before the spread of the virus, both of which have seen decreases in the number of intensive care beds and have been marked by financial cuts during the last ten years. It is a fact that a greater number of people, especially those over 70 years of age, have been left without respiratory support treatment, and therefore, there have been a greater number of deaths. It is also a fact that there has been a higher infection rate among healthcare professionals due to the delay in the management of protective measures and the inability to provide adequate care for those in nursing homes, as recognised by WHO. In the context of this health emergency, healthcare professionals have suffered a real 'moral distress' because, knowing first-hand the causes of the limitation of resources, they have had to put triage protocols into practice. Finally, we set forth a series of concrete ethical proposals with which to face the successive waves of COVID-19 infection, as well as other future pandemics.

INTRODUCTION

On 31 December 2019, China reported several cases of pneumonia causing severe illness and death in Wuhan city, the capital of Hubei.¹ A month later, the number of cases increased dramatically and spread worldwide. In Italy and Spain, the first cases were detected on 30 and 31 January, respectively. On the same day, Italy declared a national state of emergency for 6 months in order to take measures to control mobility in affected areas and preventive measures at airports. The Italian government established control measures in some northern towns, until on 8 March, it extended the quarantine to all of Lombardy and to 14 other provinces. On 11 March, the Italian government announced a mandatory quarantine for the entire country. On that same day, WHO declared COVID-19 to be a global pandemic. Throughout the month of February, more cases of infected COVID-19 patients appeared in Spain, initially as imported cases; from 26 February on, local cases began to be detected. In Spain, there was not a central focus from which the infection was spread, but Rioja, the Community

of Madrid, the Basque Country and Catalonia very soon stood out as the regions with the most cases. On 14 March, the Spanish government declared a state of alarm for the entire country, limiting its citizens' freedom of movement to certain cases and decreeing the closure of most shops and all leisure, educational and cultural facilities, with a 15-day quarantine that would subsequently be extended.

The virus would spread progressively throughout Europe, Africa and North and South America. The number of infected people continues to increase.

The disease is caused by a coronavirus, SARS-CoV-2, and is very similar to those caused by other zoonotic coronaviruses like the SARS-CoV that appeared in 2002.² The infection causes a disease with a large number of symptoms that appear around the fifth day of incubation, and has been named COVID-19.³ The period of time from the onset of COVID-19 symptoms to—in the most severe cases—the death of the patient varies in a range from 6 to 41 days.⁴ The symptoms and severity of the patient's reaction to them will depend on both the patient's age and previous illnesses. The most common symptoms of COVID-19 onset are fever, cough and fatigue. Other symptoms include sputum, headaches, haemoptysis and diarrhoea.^{5,6} In the most severe cases, analysis by CT reveals pneumonia with alterations in the amount of RNA molecules in blood serum (RNAemia), acute respiratory stress syndrome, acute cardiac injuries and increased number of ground glass opacities around the bronchioles that can cause the death of the patient. In the most severe cases, the patient must be admitted to an intensive care unit (ICU) to provide the necessary respiratory support, either through non-invasive ventilation or invasive ventilation.⁶

The spread of the virus in Italy and Spain has caused a health emergency, classified as a real health catastrophe. This catastrophic situation has been determined by the conditions of transmission of the virus, symptoms, the clinical situation which results and by its percentage of lethality.⁷ The high number of infected people who have developed acute respiratory failure has overwhelmed hospitals, especially with regard to the number of beds in ICUs. In emergency situations of this kind in which health systems have collapsed, a breakdown in patient care and attention can occur. While normal daily clinical care focuses on the individual patient's preferences and values, in a public health emergency, what is promoted is the health of the entire population in order to minimise morbidity and mortality through a prudent use of resources and specific care



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strategies. Faced with the problems of limited medical resources and disproportionate demand, several professional associations and national agencies have developed protocols for the triage of patients and the distribution of available health resources based on certain ethical and medical criteria.

In this article, we will analyse the most important documents which establish the criteria for the treatment and exclusion of COVID-19 patients, especially in regard to the giving of respiratory support, in Italy and Spain. First, we will analyse the conditions of the healthcare systems of these two countries before the spread of the virus, which have seen a decrease in intensive care beds and which have been marked by cuts in both countries over the last 10 years. We will analyse whether economic policies focused on reducing healthcare expenditure, privatisation of healthcare and decentralisation of healthcare competencies in regional and autonomous governments have contributed to the severity of the COVID-19 pandemic in both countries. It is a fact that a greater number of people, especially those over 70 years of age, have been left without respiratory support treatment, and therefore, there have been a greater number of deaths; that there has been a higher infection rate among healthcare professionals due to the delay in the management of protective measures, and lastly, the inability to provide adequate care for those in nursing homes, as recognised by WHO. In the context of this health emergency, health professionals have suffered a real ‘moral tension’ because, knowing first hand the causes of the limitation of resources, they have had to put triage protocols into practice. Finally, we set forth for both governments a series of concrete ethical proposals with which to face the successive waves of COVID-19 infection, as well as other future pandemics.

ETHICAL SCENES FROM A CATASTROPHE

The condition we are dealing with is described in terms of catastrophe, disaster, emergency, crisis. The term ‘catastrophe’ (from the Greek *καταστροφή*, subversion) evokes the results of an event that upsets people’s lives and overwhelms environmental balances, lifestyles and productivity. The term ‘disaster’ underlines the triggering causes that can be different, but are above all related to human action. In Perry’s opinion the term ‘disaster’ indicates an event that causes serious damage, the results of which persist for a short time without the affected system collapsing irreversibly, while the term ‘catastrophe’ indicates a sudden and violent reversal that produces serious and irreversible damage in a system.⁸ The Federal Emergency Management Agency defines disaster as ‘an occurrence of a natural catastrophe, technological accident or human caused event that has resulted in severe property damage, deaths, and/or multiple injuries’.⁹ In any case, a catastrophic or disastrous event leads to emergency situations that undermine the capacity to respond to them, and therefore, causes a gap between the damage to people and things and the ability to deal with it. A pandemic is characterised by a catastrophic event due to the sudden onset. There is difficulty in tackling it in a short time, the serious damage to the population in terms of health and survival, the dramatic disproportion between the high number of requests for assistance and the resources available. The COVID-19 pandemic is a paradigmatic example of a health catastrophe, just as the ethical scenarios evoked by this dramatic emergency are paradigmatic.^{10–13}

The ethical issues following the COVID-19 pandemic are manifold: from advance planning for the management of emergency situations (preparedness) to attention to the conditions of greatest vulnerability (children, the elderly, people

with disabilities), from the duty of caring to support to health workers, from management of pandemic containment measures (social distancing; confinement or lockdown; use of apps for tracking contacts) to correctness of information.^{14 15} One of the most serious and painful ethical problems emerging in the various types of catastrophe is also determined—as already mentioned—by the wide gap between care emergencies and available healthcare resources in terms of staffing and means. In a pandemic event, the imbalance can occur from the outset or may worsen later with the increase in the number of patients and the progressive involvement of the different areas of a country.

In many European countries, and especially in Italy and Spain, which recorded a high number of victims, the COVID-19 pandemic saw the trend described, above with the initial explosion in an epicentre and the involvement of vast neighbouring regions within a short span of time. Acute respiratory failure with severe hypoxaemia from interstitial pneumonia with resistant cough and tracheobronchial secretory bulk and, above all, from rapid thrombosis of the small pulmonary vessels, required the availability of a large number of beds in ICUs, and healthcare personnel capable of managing these problems, especially in the initial phase of the pandemic.

In this first phase, the pathophysiology of COVID-19 respiratory failure, and the methods necessary to intervene in response to the causes of lung failure, at least to mitigate their severity, were not yet known. In Italy and Spain, intensive care beds and ordinary hospital beds, reduced—over time—by a policy inspired by the criteria of saving economic resources and regional fragmentation of the health system, immediately proved to be largely insufficient with respect to emerging needs. There is still no precise analysis of the extent of the phenomenon, but the inadequacy of the available healthcare personnel, forced to work wearisomely long shifts and the early filling up of intensive care and hospital stay beds have been reported by several parties, and also by the health authorities.

THE NUMBERS OF A CATASTROPHE FORETOLD

The rapid increase in the number of patients with COVID-19 who needed hospitalisation and ICU hospitalisation highlighted the close and dramatic link between the organisation of healthcare and clinical activity. An inadequate health organisation both at hospital and territorial level to respond a pandemic challenge, the scarcity of resources, not least the availability of intensive care beds and pulmonary ventilators, conditioned the possibility of intervention by doctors, who had to face an emergency situation and the difficult choice of which patients to care for.

The number of deaths from COVID-19 is comparable in Italy and Spain and, as already stated, is closely related to a 10-year history of reorganisation of health services, cuts in health and inequalities in the territory, following the regional decentralisation in Italy and in the autonomous communities in Spain. Let us analyse the ‘history’ through numbers. The parameters, taken into consideration on the basis of the availability of the data, are: allocation of resources in healthcare (economic and human resources); number of hospitals in the area; hospital beds; intensive care beds.

The situation in Italy

Even if with an important difference between the regions, thanks to the virtuous behaviour of some of them, in Italy, there has been—in the period 2010–2019—a progressive reduction of spending on healthcare. An €8.8 billion increase in healthcare resources was, in fact, lower than the inflation rate, and

produced a significant reduction in the budget. The emergence of insurance and health funds to compensate for the spending reduction in healthcare has also favoured only some parts of the population and put the universality of the Italian Health Service at risk. In 2017, the total resources for healthcare were equal to 8.8% of Gross Domestic Product (GDP) (European average=9.8%) and per capita healthcare expenditure was equal—in Italy—to €2483, where the European average stood at €2884. Seventy-four per cent of healthcare expenditure had been financed by public funds, while the remainder had been mainly borne by patients. Although the Livelli Essenziali di Assistenza covers a wide range of health services, non-refundable expenses for families are relatively high (24%) and make up the majority of the remaining health expenditure. Private health insurance plays a marginal role, covering only about 2% of total health expenditure. Regional differences in terms of hospital and territorial organisation, contributory capacity and efficiency of healthcare raise concerns about the ability of poorer or less well-performing regions to provide high-quality health services without increasing regional taxes or the existing deficit. However, through very strict spending controls, most regions have managed to keep health budgets in balance in recent years. In 2017, nationally supervised recovery plans were imposed in only seven regions out of twenty (Abruzzo, Calabria, Campania, Lazio, Molise, Puglia and Sicilia), fewer than in 2007.^{16–19}

Fifty per cent of the cut in healthcare resources concerned employees and affiliated personnel, and in particular, doctors and nurses, with the total loss of 42 800 permanent employees. If, in 2017, the total number of doctors per inhabitant in Italy was higher than the European Union average (4.0 vs 3.6 per 1000 inhabitants), nevertheless, the number of doctors who practised in public hospitals and as family doctors was falling. In addition, half of the active doctors were over 55 years of age. The national average of nurses was 5.6/1000 inhabitants, against the European average of 8.4/1000 inhabitants.

As regards healthcare facilities, the number of hospitals has decreased—in the last 10 years—from 1165 (54% public; 46% private) to 1000 (51.8% public; 48.2% private). The closure of the smaller hospital facilities led to their conversion into facilities for residential territorial assistance (2,000) and for semiresidential care (700). As a consequence, the availability of beds has decreased from 225 thousand beds (4.3/1000 inhabitants) in 2007 to 191 thousand beds (3.6/1000 inhabitants) in 2017. The distribution of this indicator is very uneven at a territorial level: from Molise (4.4/1000 inhabitants) to Calabria (3.0/1000 inhabitants), Campania (3.1/1000 inhabitants) and Puglia (3.1/1000 inhabitants). This is a greater drop than that of the European average, which decreased from 5.7 to 5 in the same period. The greatest decrease was recorded in the regions that were first subject to the return plan. The insufficiency of local health services and the reduction of beds in hospitals have led to an increase in the overcrowding of emergency services, especially in large cities, bringing with them important management problems at certain times of the year. In 2017, the percentage of emergency room visits with a duration longer than 24 hours was 2.8%, with a range of 0%–18%.

Intensive care beds underwent a slight increase—from 4840 (8.02/100 000 inhabitants) in 2012 to 5090 (8.42/100 000 inhabitants) in 2017, with a reduction in beds per coronary unit from 2724 (4.5/100 000 inhabitants) in 2012 to 2601 (4.3/100 000 inhabitants) in 2017. It is difficult to make a comparison with the European Union on ICU beds, since Eurostat reports only the number of beds intended for the treatment of acute cases (excluding rehabilitation cases, long-term hospitalisation

and live infants). Again, Italy, with 2.6 beds per 1000 inhabitants, is below the European Union average (3.7/1000 inhabitants), the fifth lowest figure in the Union.

The situation in Spain

As regards healthcare expenditure, between 2012 and 2016, the Spanish central administration paid €412 million out of the total, while most of the expenditure (€66.45 billion) was financed by the regional administrations. The contribution of the central administration decreased by 4.63% between 2012 and 2016, and that of the regional administrations increased by 4.78%. If we analyse per-capita healthcare expenditure, we can see an increase from €2046/inhabitant in 2012 to €2190/inhabitant in 2016, with an average annual increase of 1.7% over 5 years. The national figure does not, however, highlight the significant differences in contributions from the autonomous communities, both in financing and in the impact of cuts in healthcare spending. The per capita per year contribution can, in fact, vary by more than €500 between the autonomous community that invests more and the autonomous community that invests less for healthcare. For 2018, this contribution varied from a minimum of €1166.4 (Andalusia) to a maximum of €1693.49 (Basque Country) with an average of €1403.53. As regards the impact of the cuts, between 2008 and 2013, eight autonomous communities had a percentage decrease in spending above the average (–20.3%). The autonomous community with the highest cuts was Castilla-La Mancha (–28.5%); the autonomous community with the lowest cuts was Cantabria (–7.9%).^{20–23}

Between 2012 and 2016, the number of medical specialists per 1000 inhabitants increased by 4.97%, with important differences between the various autonomous communities. The number of primary care medical personnel per 1000 patients assigned remained unchanged between 2014 and 2016, with a reduction of 1.30% between 2012 and 2016. Nursing staff in specialist care per 1000 inhabitants increased—on average—by 4.14% in Spain between 2014 and 2016 and by 6.17% between 2012 and 2016. Nursing staff in primary care per 1000 patients assigned decreased on average by 1.54% in Spain between 2014 and 2016, while the percentage remained unchanged between 2012 and 2016. Overall, taking into account local variability, there was a reduction between 2010 and 2014 of 9400 jobs in public hospitals. In the period 2012–2016, the percentage of places in day-hospital per 1000 inhabitants increased on average by 7.32%. The percentage of hospital beds per 1000 inhabitants remained stable between 2014 and 2016, with a reduction of 1.98% in the 2012–2016 period. In the period 2010–2014, there was a total loss of 5600 beds across Spain.

According to data reported by Eurostat, the availability of beds intended for the treatment of acute cases is 3.0 beds per 1000 inhabitants, which puts the country below the average of the European Union (3.7/1000 inhabitants). Also in this case, the considerable numerical variability among the autonomous communities must be kept in mind. For example, the Autonomous Community of Madrid had before the pandemic only 600 intensive care beds for a population of 6 661 949 persons (0.09/1000 inhabitants). The same situation occurred in Catalonia, with 600 intensive care beds per 7 565 099 inhabitants (0.073/1000 inhabitants).

MAKING DECISIONS IN A TIME OF PANDEMIC

While mobilising aid and directing all available resources to patients with COVID-19, setting up suitable *ex novo* structures and finding the necessary medical-surgical devices on the

market, the medical societies and ethics committees of the countries concerned have issued documents which to indicate criteria and guidelines to help doctors to make difficult decisions about individual patients. The objective impossibility of giving all patients the necessary treatments led to the exclusion of certain types of patients from the ICUs or ordinary assistance, or to the suspension of treatments already begun that would otherwise lead to their discharge.

In Italy and Spain, two documents have been published by scientific societies which have become the subject of intense debate. In Italy the Società Italiana di Anestesia, Analgesia, Rianimazione e Terapia Intensiva (SIAARTI) has published a series of documents on the subject of COVID-19, including one about the allocation of intensive care treatments.²⁴ The document was prepared by a working group that sought to offer concrete indications for doctors and nurses engaged in difficult choices,²⁴ bearing in mind the sudden moments of an unexpected influx of seriously ill patients to the emergency room, the very short time to make decisions, the burden of responsibility, and the emotional tension of the healthcare personnel involved. A similar document was produced by the Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias (SEMICYUC).²⁵

Both documents see the need to move from decision criteria valid in normal times to decision criteria for a pandemic emergency. In particular, while in normal conditions the criteria for access to and discharge from intensive treatments are clinical appropriateness and their proportionality, for situations of serious and prolonged emergency, the principle of distributive justice has been proposed in order to evaluate the appropriateness in terms of the microallocation of resources.²⁶ The term 'appropriateness' refers to a purely clinical evaluation, while the term 'proportionality' indicates the ethical dimension of the choice, and takes into account the relationship between means (therapies, resources, professional commitment) and results in terms of health and quality of life.

Clinical appropriateness therefore assesses the relationship between the patient's condition and the treatments that are carried out; the measure of appropriateness is the individual subject. The appropriateness in the microallocation of resources, on the other hand, verifies the reasonableness of the distribution of the resources actually available. Thus, it may happen that a treatment that is clinically appropriate and ethically proportionate under normal conditions of availability of therapeutic resources, is considered disproportionate for the same patient in the under the conditions of a time of pandemic. The scarcity of available resources highlights the relativity of the category of proportionality: a clinically appropriate means can be assessed proportionate or disproportionate according to the context in which the evaluation is carried out.

The principle of distributive justice excludes the egalitarian principle which provides for the equal distribution of the means available independently from the comparison between patients, but based only on the criteria of therapeutic proportionality. The rule of 'first come, first served', apart from patients for whom intensive care would be clinically inappropriate, admits new patients only on the basis of their order of arrival. This rule is explicitly rejected by the SEMICYUC document: 'In the case of disproportion between demand and availability, it is legal to establish an admission triage between patients, based on the principle of distributive justice, without following the usual criteria that the first to arrive is the first to receive assistance'.²⁵ Egalitarianism has the advantage of being absolutely impartial, and is more effective in guaranteeing everyone's right to healthcare, but it is mechanical and impersonal and, in the

end, irresponsible, because it entrusts the distribution of available resources to chance, which takes the place of choice and responsibility.

According to the SIAARTI document, the fundamental criterion should be that of 'guaranteeing intensive treatments to patients with greater chances of therapeutic success: it is therefore a matter of privileging the 'greatest life expectancy' [...] The need for intensive care should therefore be integrated with other elements of 'clinical suitability' for intensive care, which include: the type and severity of the disease, the presence of comorbidity, the compromise of other organs and systems, and the reversibility thereof'.²⁴ In practice, it is a question of admitting to intensive care those who can benefit most from it in order to make the most of its therapeutic potential, avoiding waste that, in a situation of scarcity of resources, would be a crime against the common good. According to SEMICYUC, it is a question of 'maximising the benefit of the common good'.²⁵

Recommendation no.3 of SIAARTI, which introduces an age limit for entry into intensive care, was the cause of a great deal of debate. Within the contingency of limited resources, it would be considered lawful to give an opportunity for treatment to those who have more life in front of them and, therefore, to a young person rather than to an elderly person. The interpretation of this criterion is utilitarian in that it is justified by the maximisation of collective well-being, measured as the amount of years of life saved.

In this sense, the Spanish's document, with reference to the principle of maximum performance of therapies in terms of costs/efficacy, underlines that 'in dealing with two similar patients, priority must be given to the person with more years of life, adjusted for quality or quality-adjusted life year. It is an indicator of health that combines quantity and quality of life. Give priority to life expectancy with quality'.²⁵ Sensing the risk of falling into a discriminatory and utilitarian logic, SIAARTI specifies, however, that by setting age as a criterion for exclusion, we do not want to attribute different value to human existences, but rather, to 'save the resources that could be very scarce, first for those who have the greatest chance of survival, and second, for those who can have more years of life saved, with a view to maximising the benefits for the greatest number of people'.²⁴

Coming to the concrete details of clinical reality, the SEMICYUC document classifies patients into four categories, and indicates two that, in a situation of scarcity of resources, will not enter the ICUs: 'Priority 3 patients: These are unstable and critically ill patients who have low chances of recovering from their underlying or acute diseases. Priority 4 Patients: Patients whose admittance is not generally indicated, due to minimal or improbable benefit due to a low-risk disease. Patients whose terminal and irreversible disease makes their death imminent'.²⁵ Therefore, no explicit reference is made to age as a criterion, but rather to the patient's clinical situation, prognosis and the possibility of receiving effective advantage from intensive treatments. It is then indicated what to do with older patients, and decision criteria are proposed that do not exclude anyone a priori for the sole reason of age. Specific recommendations can be summarised as follows: (1) all patients with respiratory failure are entitled to assistance, the intensity of which is determined on the basis of objective criteria of therapeutic proportionality; (2) patients over the age of 80 with comorbidity receive non-invasive respiratory aid (high concentration oxygen mask, high flow oxygen therapy, non-invasive mechanical ventilation); (3) patients between 70 and 80 years of age without significant comorbidity can undergo invasive mechanical ventilation.²⁵

In this regard, the SIAARTI document explains that ‘the presence of comorbidities and functional status must be carefully assessed, in addition to the age of the patient. It is conceivable that a relatively short course of treatment in healthy people will potentially become longer, and therefore more ‘resource consuming’ of healthcare services in the case of elderly, frail or severely comorbid patients’.²⁴ Consistently pursuing the utilitarian perspective, the SEMICYUC document introduces some indications which are *prima facie* disturbing. Also in the specific recommendations, the Spanish Scientific Society suggests, in fact, that ‘any patient with cognitive impairment, from dementia or other degenerative diseases, would not be on invasive mechanical ventilation’.²⁵ The impression is that the use of the scarce resources available to keep patients with intellectual disabilities alive is considered wasteful. The selection of patients by strictly utilitarian criteria leads to the penalisation of those with particularly intellectual disabilities, reversing western societies’ declared attitude of favourability to disabilities and frailties. The protection and guardianship of the most vulnerable is lost when the life of the strongest is at stake, as if the care of patients with disabilities was a mere concession for ordinary times and, like the autonomy of the patients, fails under crisis conditions.

SEARCHING FOR THE BEST POSSIBLE CRITERION

In both Spain and Italy, there has been some criticism, from official positions, of some of the aspects of the previously reviewed Recommendations.

In Italy, the Order of Physicians intervened with a note dated 7 March 2020, in which it distanced itself from SIAARTI and stated that ‘our guide, before any document that subordinates ethics to rationing principles and that should in any case be discussed collegially by the profession, remains the Code of Medical Ethics. And the Code is clear: for us, all patients are equal and should be treated without discrimination’.²⁷ In a context of dialogue and confrontation, after this position, in October 2020, a joint document of SIAARTI and Federazione Nazionale dell’Ordine dei Medici Chirurghi e Odontoiatri (FNOMCeO) has been produced.²⁸ The main novelty of the joint document lies in the attempt to combine the egalitarian principle with the need for a rational distribution of resources.

A month after the document of SIAARTI, the Italian Bioethics Committee (ICB) also intervened with an opinion on clinical decision making in pandemic emergencies.²⁹ The ICB does not accept the criterion of distributive justice, as formulated by SIAARTI, stating that: ‘when faced with a situation, such as the current one, the serious shortage of resources, the ICB evaluates the clinical criterion to be the most appropriate reference point for the allocation of the same resources: any other selection criterion, such as age, sex, condition and social role, ethnicity, disability, responsibility for behaviours contributing to the pathology, costs, is deemed ethically unacceptable by the Committee. In particular, the ICB continues to consider the triage method valid, however, it must be rethought on the basis of the exceptional nature of the moment’.²⁹ The document of the Spanish Bioethics Committee (SBC) also focuses on the bioethical aspects of priority allocation of care in the context of the COVID-19 crisis.³⁰ It rejects a resource allocation criterion based on patient arrival priority because it is based on the false assumption that ‘the community is made up of subjects in a perfectly equal situation’ (of conditions) and opens on a criterion that takes into account the patient’s ability to recover, but warns against a utilitarian drift based on the social utility of a patient and openly criticises some SEMICYUC recommendations that

put ‘disability-free survival’ before mere survival and that end up discriminating against the disabled and in particular the mentally disabled.³⁰

In choosing between the egalitarian criterion, which privileges the order of arrival of patients in need of intensive care, and the criterion of distributive justice, which makes resources available to those who draw the greatest benefit from them, it is not easy to find a solution. Our proposal refers to the principle of distributive justice, reinterpreted in a personalist perspective, with the goal of avoiding the possible utilitarian drifts of this principle and the risk of legitimising discrimination between people.

Every person—young or old, able or disabled—has the right to access clinically appropriate treatments. The scarcity of therapeutic resources does not nullify the law, but makes it difficult or impossible to satisfy the needs of all those who would avail themselves of them. In practice, before depriving someone of an intensive treatment, physicians will try to resort to all available resources, also turning to other accessible healthcare structures that can still offer treatment, whether within the national territory or abroad. The most sophisticated means will be assigned to those who draw some advantage from them, without, however, absorbing resources beyond measure to the detriment of others, and also taking into account the patient’s condition for triage in hospital and the state of health before COVID-19 (presence of any comorbidities that negatively affect the prognosis). The joint document SIAARTI-FNOMCeO is expressed in this sense by stating that ‘in the case that the imbalance between needs and available resources persists, priority for access to intensive treatment is given to those who can get thanks to them a concrete, acceptable and lasting benefit’.²⁸ For example, if the conditions are desperate and the prognosis is most likely poor in the short term, it would be futile to put the patient, whether young or old, in intensive care. It will also be necessary to consider whether to discontinue intensive treatment in a patient whose condition, despite all possible efforts, does not improve and on the contrary slides towards the *exitus*. In this case, it would not be a question of freeing an intensive care bed, but rather of accepting the inevitability of the patient’s death. Finally, we cannot forget that when the scarcity of means, and not considerations of the presumed unequal value of people, prevents everyone from being given what is clinically most appropriate, everyone’s right to a ‘decent minimum’ always remains: the right to be intentionally abandoned, to receive ventilator and cardiocirculatory supports even if they are not invasive, to be accompanied with palliative care in a suitable environment or, if this is not possible, at home.

Age cannot be a factor of discrimination in the sense of a priori exclusion: it can be assumed, in fact, that the health conditions of an elderly person have deteriorated compared with those of a younger one, but, like all presumptions, the situation can be reversed in concrete cases. With the same clinical conditions of triage and in the absence of other options, there are those who propose to consider—in a perspective of solidarity—whether to favour those who have yet to live their lives, rather than those who have already travelled a long stretch. Such a solidarity imposed ‘*ex officio*’ may, however, seem to do violence to the freedom of the person. It is difficult to imagine that an elderly person with severe respiratory difficulties will agree with the choice of the doctor who wants to exclude him from intensive care in order to leave the few places available to younger patients who could soon arrive in the emergency room. This, in fact, is the logic of distributive justice—however it is defined—which does not guarantee everyone the same access to resources (in this case to healthcare resources), and whose choices in regard to implementation are made according to the perspectives, ethical

hierarchies and legal systems of a certain part of society and do not arise from the choice of the potential recipient of the therapeutic act. The personalist conception of civil society is not that of a sum of individuals, but of a network of relationships, and solidarity is nothing other than the ethical dimension of the relationship.³¹ However, the principle of distributive justice tends to attenuate the patient's autonomy and deny him a treatment that is not patently disproportionate, going against the principle of beneficence. In times of catastrophe, medical paternalism is overpowering, disturbing and, perhaps, inevitable because, in the end, it is the doctors involved in triage who decide in the name of collective beneficence or the common good. Even more questionable would be the choices of inclusion or exclusion from therapeutic treatments based on current or future social utility. Discrimination against people with disabilities happens precisely in this perspective.

In this context, the therapeutic alliance between doctor and patient is put into crisis because the doctor must simultaneously take into account the good of all potential patients. To avoid making arbitrary assessments, clear and practicable criteria are needed that make it possible to make the decision for the priority access of some, based on the principle of distributive justice, with the right to care for each regulated by the objective criteria of clinical proportionality. The risk of developing unfair and discriminatory decision-making structures is not hypothetical. The IBC opportunely underlined this risk: 'The adoption of priority criteria in making resources available can trigger dynamics that risk not being easily reversible. Important decisions of significant impact must not set precedents to be applied in a future that has returned to normal'.²⁹ In an even more complex way, the SBC underlined the risk of strengthening an efficiency-based and discriminatory mentality towards weaker subjects: 'Although the adoption of an allocation criterion based on the patient's ability to recover can be justified in a context of scarce resources, in any case the spread of a utilitarian mentality, or, worse still, negative prejudices towards elderly or disabled people, should be prevented'.³⁰ For those who do not accept the logic of utilitarianism, the expression 'social utility' certainly cannot be considered interchangeable with the expression 'common good'.³²

In this regard, again we read in the document of the SBC: 'The term 'social utility' that appears in some of the recently published recommendations seems to us extremely ambiguous and ethically debatable, because every human being by the mere fact of being so is socially useful, in view of the ontological value of human dignity'.³⁰ Depriving someone of proportionate care is always bad and, when it is not possible to do differently, one is forced to choose what appears to be a '*minus malum*', a lesser evil. It is an evil that we are forced to accept in a situation of scarce resources because to choose otherwise would lead to not exploiting the full therapeutic potential of available resources and this would be contrary to the common good. We need to be very careful, thinking back to Hanna Arendt's reflections on the concept of 'lesser evil'.³³ This means that the conscience of doctors and public opinion do not become habituated to choices that are not characterised by full egalitarianism and that what was initially accepted as simply right is now considered as absolutely right: the selection of patients according to criteria that are not centred on their actual needs, but are heavily conditioned by the scarcity of resources and healthcare personnel. This is particularly true for older people, those with intellectual disabilities, and those who suffer from chronic and degenerative diseases.

Nor should the scarcity of resources and healthcare personnel, which put health systems in Italy and Spain in extreme difficulty,

be accepted as inevitable. It is true that a catastrophic event that overwhelms concrete resources and that requires painful choices can always happen. In Italy and Spain, however, doctors would not have faced the pandemic attack unarmed if over the years the choices of national and local health policy had taken into account the common good, of which health is not a secondary element, and if the alarms launched at the time by science had found a farsighted and effective reception. In real democracies, biopolitical choices are not immutable, but are in the hands of citizens.

CONCLUSION

The healthcare systems: between duty and foresight

As we have seen in the analysis of the situation caused by the COVID-19 pandemic, a health emergency can mean limiting individual rights and preferences. The ethical documents that we have analysed reflect a tension that stems from limited health resources that are insufficient to save lives that, under normal conditions, could have been saved, or at least could have received the best possible treatment. We find, therefore, a moral tension between patient-centred care, the egalitarian ethical model, which is the clinical ethical model in normal situations, and the distributive justice ethical model, which is the ethical decision model in health emergency situations. Doctors are trained in caring for patients, but emergency health situations require that they change their usual practice, and on some occasions must make decisions by which they prioritise the community when it comes to the fair distribution of limited resources. This move from a clinical practice centred on the patient and supported by clinical ethics, to patient care guided by the ethics of public health, creates great anguish and moral tension for physicians.

In responding to future waves of COVID-19 or other future pandemics, the ethical framework of healthcare institutions should recognise the tension that occurs between these sources of moral authority in care and public health, because these tensions arise more frequently in clinical practice during health emergencies. The duties of the competent health authorities with regard to health professionals and society in general during a public health emergency can be summarised in three main duties: plan, safeguard and guide.²⁶

The duty to plan: the control of uncertainty

Competent health authorities have a duty to plan for foreseeable ethical challenges during a health emergency. Ethical challenges arise when there is uncertainty about how to 'do the right thing' in a clinical decision when duties or values conflict. This planning of foreseeable ethical challenges includes the identification of potential triage decisions, the instruments to be used and the processes to be followed. In a public emergency situation with severe respiratory failure, such as the COVID-19, triage and level of care decisions certainly have to be made (eg, whether the patient is to be admitted to the ICU or kept in a room on the floor); decisions must also be made to start and/or withdraw life support treatments (including CPR manoeuvres and ventilatory support); referral must be made to palliative care (more focused on patient comfort) if life support treatments are not started or are withdrawn. Triage decisions may also need to be made regarding shortages of staff, space and supply. Therefore, one of the first things we have to learn, in the face of the next pandemic, is that in a public emergency situation, healthcare professionals have to have clear and fair rules to follow. Triage protocols have to help front-line professionals prioritise patients

according to their levels of care based on their needs and their ability to respond to treatment with limited resources in mind.

As we have seen, in the protocols analysed, some criteria appeared that were unfair and, in some cases, discriminatory. If the standards that are set seem or are unfair, or cause great suffering and stress to patients, then healthcare professionals will end up 'burnt out'. Moral stress frequently appears in those professionals who, following these triage protocols, cannot initiate treatment or have to suspend it, especially when it comes to life-support treatments, despite the contrary opinion of the patient or their family members. In the specific case of Italy and Spain, these situations of moral stress have been greater among those professionals who have had to refuse even the hospitalisation of patients, such as those from nursing homes.

The duty to safeguard: supporting workers and protecting vulnerable populations

Both the Italian and Spanish governments, at the public health level, are the largest employers in each country. In this sense, responding to a health emergency includes the protection of health workers. In the COVID-19 pandemic, we have seen in both countries how a large number of health workers have been infected (20% in Spain and 10% in Italy, although in the Italian region of Lombardy this reached 20%). The infection of such workers has had important consequences for the management of the hospitals and the care of the patients. Delays in the supply of protective materials (suits, masks, gloves, disinfectants) have led to such a high infection rate among health workers.³⁴ On the other hand, during a health emergency such as that of COVID-19, the most vulnerable population should have been protected, in this case, that which due to age or previous illnesses could be more susceptible to the most serious symptoms of the disease. Nursing homes were clearly vulnerable places in need of protection. However, both in Spain³⁵ and in Italy,³⁶ in general, prevention and protection measures were not taken, and nursing homes have been the most affected by the first wave of infection, reaching figures of around 66% of official deaths in both countries. The neglect of both governments in managing nursing homes has been such that WHO declared that the situation was truly dramatic.³⁷ Therefore, in the face of future waves of COVID-19, one necessary measure will be the implementation of systems to improve the care of elderly residents and the caregivers who serve them. The medicalisation of nursing homes or the referral of elderly patients to hospitals built ad hoc would help to reduce the number of infections in nursing homes, to improve the care of elderly patients, and allow them access to ICUs (especially supportive ventilatory treatments) that will surely increase in both countries after the crisis.

The duty to guide: levels of care and crisis standards of care

The tension between the public health ethical orientation towards equity, and the patient-centred ethical orientation of clinical ethics falls apart when life-support treatments are not available to all patients who could benefit from them, and that they would probably choose. Beds in ICUs and staffing are both scarce resources, and a wave of critically ill patients can quickly fill available beds. We have already seen how the option that 'the first to arrive is the first to enter' in an ICU is an unsatisfactory option for the distribution of critical resources: a critically ill patient who is waiting for a bed to be admitted to the ICU can benefit more from this resource than a patient who is actually in the ICU and whose condition does not improve. It is the principle of distributive justice with a personalist perspective that should guide medical decisions in a health emergency. If clinical

ethics services such as hospital ethics committees and professional deontological committees function as resources for health experts in normal situations of uncertainty and stress, then public organisms at the national level, such as national committees on ethics, are the ones that will have to prepare the protocols for care and treatment that would help physicians and healthcare workers to manage the predictable uncertainty and distress in healthcare emergencies such as the next waves of COVID-19 or future pandemics. In our paper, we have seen how the criteria of the triage protocols of the Scientific Societies with respect to the National Bioethics Committees varied. Health authorities must be aware that every decision in clinical practice, also in emergency situations, not only has medical implications, but also ethical implications.

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