

Getting to the Truth: *Ethics, Trust, and Triage in the United States versus Europe during the Covid-19 Pandemic*

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History tells us that it was Dominique Jean Larrey, Napoleon's chief surgeon, who came up with the system of triage on the battlefield and invented the first ambulances. Famously, Larrey would select among the wounded the ones who needed urgent care over less-urgent cases regardless of their nationality, military rank, or even whether they were allies or enemies. *Triage*, a French word used especially in wartime and during disasters, involves allocating treatment to patients amidst a lack of sufficient resources so as to save as many lives as possible.

In the early days of insulin discovery in 1922,¹ as well as at the time of the release of penicillin for civil use in 1942, life-and-death decisions about allocating such rare resources were made with little ethical guidance.² Hemodialysis was restricted in the 1960s according to criteria that would make us cringe today;³ conversely, organs are allocated routinely today and with great social acceptance. Ethical issues around triage have been at the forefront of debates during the worldwide Covid-19 pandemic.

In a time of shortage of skilled staff members, intensive care unit (ICU) beds, life-sustaining technologies, and so on, the goal of triage is to favor the most likely to survive over the least likely. This utilitarian perspective is a common feature of all triage guidelines. All also state that patients should be cared for regardless of income, ethnicity, or social status, and there is also fairly strong consensus that neither a lottery nor a first-come-first-served rule is an acceptable option.

In the Covid-19 pandemic, few countries will acknowledge that any triage has taken place for fear of being held responsible for the lack of health care resources or for the failures to provide an efficient response to the crisis. Among the first parties to confess the grim choices they had to make were distraught doctors in Italy,⁴ which was hit early by the pandemic compared to other European countries and was

little prepared. In some cases, patients sixty-five and older were no longer candidates for mechanical ventilation (while ice rinks were reportedly being used as makeshift morgues). In reality, however, doctors in many countries have faced terrible decisions about how to allocate scarce resources (including hospital beds, ventilators, dialysis, extracorporeal membrane oxygenation machines, and drugs). Triage is not only about access to scarce resources but also about how long a patient will stay on a machine in an ICU before it is withdrawn. Stories of patient triaging surface in reports here and there, but getting a clear picture of what has been going on remains difficult—and often requires day-by-day study of blogs, social media, and reports from frontline workers.

Yet understanding how different societies allocate tragically scarce resources is crucial.⁵ In this essay, I will compare discussions and guidelines around triage and the reality of triage decisions in the United States with what happened in Europe, both in anticipation of and during the pandemic. Why did the issue generate so many vivid and public ethical debates in the United States and relatively few in most European countries, even though the latter were also affected by the rationing of health care resources? Are countries with socialized health care better equipped to face the hard choices of triaging? Is there greater consensus and trust that leads to more acceptability of such choices?

Discrimination as a Central Issue in the United States

In the United States, where individualism and patient autonomy are highly valued, having to restrict or withhold care during a public health emergency seems so alien to the prevailing medical culture that, inevitably, the triage protocols that might be put in place required careful development and were met by the public with much scrutiny. In a country without universal health care coverage and with worse structural inequalities than in much of Europe, debates in medicine, ethics, and the media about the alloca-

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tion of scarce resources have largely focused on how to avoid certain forms of discrimination such as those based on race, disability, and age.

Guidance for triage during a pandemic has been published by ethical⁶ and professional associations,⁷ physicians, ethicists, and multidisciplinary teams at the state level,⁸ where much of the relevant health law is enacted in the United States. Many official and formal guidelines drafted in anticipation of a pandemic were updated and adapted for the Covid-19 pandemic.⁹ There are over sixty such guidelines in the United States, and whether issued by a state, a hospital, or a professional society, they have a strong focus on how to support a triage plan with an explicit ethical framework.¹⁰ Most state plans require an emergency order by the governor to be activated. When such an order is issued, statutory protections for health care professionals for actions taken during triage go into effect. In New York State, health care providers have been given civil and criminal immunity during the pandemic even without an emergency triage order.¹¹ Some states do not have any triage plans; in this situation, decisions may fall to institutional ethics committees. The many sets of guidelines¹² reflect a growing consensus among experts about how to prioritize saving more lives rather than more years of life. Moreover, most guidelines in the United States insist on separating triage decision-making from clinical care by the treating physician to preserve the fiduciary doctor-patient relationship.¹³ Triage committees and triage officers are supposed to take over these difficult decisions to avoid any moral distress among members of a patient's medical team.¹⁴

Compared to European concerns, triage ethics in the United States have delved deeply into questions about various forms of discrimination; the greatest challenge has been drafting a triage plan that would not amplify structural inequalities based in racism, ableism, ageism, and so on. Should saving more lives be the sole criterion or not? Some parties denounced the biases that would lead to favoring individuals with no disabilities or preexisting conditions—with the result that “equity would be sacrificed in the name of efficiency.”¹⁵ Numerous debates have taken place around how to account for conditions such as cognitive disabilities or mild dementia and for the biases of quality-of-life judgments. The first federal intervention to enforce civil rights in rationing protocols required Alabama to rescind guidelines excluding people with intellectual disabilities or dementia from ventilator access.¹⁶ The questions at stake are not only ethical but also legal, as rationing protocols could violate federal civil-rights law in cases of discriminatory health care

decisions. For example, the Rehabilitation Act of 1973 explicitly forbids the exclusion of an “individual with a disability” from any service by a federally funded entity.

Another challenging issue of potential unjust discrimination, relayed by the media, has been age cutoffs. To avoid the slippery slope of undermining the principle of the equal worth of people who are elderly (as well as those who are disabled) within the general population, it has often been recommended to consider life years as a secondary criterion only, and even then with some caution. The Age Discrimination Act of 1975 prohibits “discrimination on the basis of age in programs or activities receiving Federal financial assistance.” The ban covers all activities of recipient institutions, such as hospitals. Age remains an intensely debated issue, especially since Covid-19 hits older adults harder. Despite the debates, some citizen groups, having looked at draft protocols, expressed fears that even using predicted survival to determine who would get access to resources—the most common strategy—might be unjustly discriminatory. The disturbing reality is that, in the inherently unfair U.S. system, the pandemic is having the gravest effects on the most vulnerable populations.

Yet at least the issues have been discussed. The work to develop clear ethical frameworks and the focus on avoiding unjust discrimination are laudable efforts to prevent worsening of the inequalities inherent in the social system, even though the efforts obviously did not (and could not) remedy the country's underlying vulnerabilities caused by racism, ableism, and social inequalities. The pandemic has revealed and to some extent amplified both health inequalities and the unfairness of the whole system. Still, this dramatic context has allowed an open discussion and a public engagement process to reflect on the need for more work in public health ethics, reactivating questions about how to ensure more equal access to health care. It has also shown that triage plans cannot be constructed without attention to the overall social context.

Finally, many debates around disability have been extensively reported not only in the bioethical literature¹⁷ but also in popular media.¹⁸ After the release of triage protocols in March, vivid debates followed the action of disability rights advocates,¹⁹ and the Office of Civil Rights at the Department of Health and Human Services opened an investigation into the advocates' concerns.²⁰ Scoring systems were questioned, with lengthy discussions about how to achieve equal opportunity by reasonable accommodation to avoid further discrimination. Nothing similar happened in Europe, at least to that extent.

The Untold Reality of Triage in Europe

Quite puzzlingly, many European socialized health care systems had not given much thought to any anticipatory fairness or potentially unjustly discriminatory process regarding triage. Though vague guidelines were in some cases drafted at the time of the H1N1 flu pandemic or Ebola, there has been little discussion on updates regarding Covid-19. Most European states seemed to rely on the assumption that decisions about rationing or denying life-saving care to maintain public resources are inherently part of the constraints of a public health system—and even more so in the face of scarcity during an emergency. As a consequence, these issues are not generally thought to require public discussion of ethical frameworks. In this context, physicians remain the gatekeepers of the health care system. Triage guidelines are almost always drafted by professional societies; they remain available mostly within the health care milieu and have generated little or no discussion outside of it. In fact, there has been little public awareness or scrutiny of any proposed triage plan in most European countries.

In France, a few media outlets reported at the beginning of the outbreak on a possible need for triage, with basically no consequence. The probable need for triage (*tri*) was acknowledged in a publication by the French National Consultative Ethics Committee (CCNE),²¹ but overall, the triage issue remained exclusively discussed within the medical community. In Spain, as the hospitals in Madrid became overwhelmed, the media warned of potential triage.²² Although Spain has a history of successful triage in contexts of scarcity, such as organ transplant programs, it was so ill prepared for the Covid-19 outbreak that hospitals had to draft their own protocols with little ethical guidance or public coordination.²³

In England, physicians at hospitals were confronting an excruciating debate on intensive care rationing.²⁴ In early April, officials from the Department of Health and Social Care in the United Kingdom commissioned a small committee of physicians and other experts to draft a triage protocol for ventilator access, based on a numerical ranking of chances of survival. For fear of a public uproar, however, the officials balked at publicly disclosing the plan. This attitude might be linked to the history of unofficial age rationing associated with the NHS, which has been vividly debated for years by prominent members of the House of Lords (such as Sally Greengross, the head of the International Longevity Centre UK). As reported by the media, when asked about the decisions first to draft and then to pull back the triage criteria, representatives of the Department of Health and Social Care issued a public statement that read, “As the public would expect, we do lots of work to prepare for a number of different scenarios so we are as prepared as possible.”²⁵ Finally, the National Institute for Health and Care Excellence advised prioritizing patients for ventilators using a numerical score on the Clinical Frailty Scale. The scale, deemed inappropriate for certain disabled populations, was

later amended.²⁶ The British Medical Association also published some anticipatory guidance in policy-making and cautioned against potential discrimination regarding age and disability without discussing ways to prevent it.²⁷

When, in Northern Italy, unprepared and distraught physicians reported openly withholding life-extending support from patients in order to devote scarce ventilators to those with better odds, triage guidelines were drawn hastily to assist them in choosing who would live or die. The Italian Society of Anesthesiology, Analgesia, Resuscitation and Intensive Care (SIAARTI) published their guidelines in March, several weeks after the beginning of the pandemic. In Spain, as reported on March 20, the Spanish Society of Intensive and Critical Care Medicine and Coronary Units (SEMICYUC) presented their own guidelines.²⁸ The guidelines from the French Society of Anesthesia and Resuscitation (SFAR)²⁹ were drafted on April 3. Most experts involved in the drafting of triage guidelines were ICU physicians and representatives of professional societies, and generally speaking, their stated goal was first to minimize the death toll and secondarily to maximize life years saved. Unlike for most American guidelines, there are no separate triage committees or triage officers; in most European countries, decisions are to be made by treating physicians in a collegial way, with the support of peers. In Spain, the ethics committee could be involved, and in France, the CCNE suggested that wards or hospitals create some ethical support (*cellules éthiques de soutien*) to assist clinicians. The guidelines from these countries have a lot of common features, with comparable scoring systems and the background of a similar medical culture of maintaining clinicians’ decision-making even in a triage situation with little external oversight (this is less true of guidelines in Great Britain).

There are, however, strong differences between European experiences. The most obvious one is that the Italian guidelines were published and widely debated (and even criticized) in the media, while the French guidelines were sent to hospitals with little or no publicity. The Spanish guidelines were available online; but they were vague, extremely technical, and carefully evaded the triage issue. In Great Britain, after many calls in the media and in medical and ethics journals to promote a more rule-based system for allocating scarce resources fairly and transparently instead of leaving clinicians alone in deciding, a document distinct from the former NICE guidelines,³⁰ “The Covid-19 Decision Support Tool,”³¹ reported by the media, was drafted by clinicians (not by the NHS). Circulated to clinicians, it was codifying the process for the life-and-death choices that doctors would have to make during the peak of the pandemic. Physicians would score patients on three metrics—their age, frailty, and underlying conditions. According to the document, patients with a combined score of more than eight points across the three categories should probably not be admitted to intensive care, although clinical discretion could override that decision. The scoring system reveals that any patient over seventy years would be a borderline candidate

for intensive care treatment. A patient aged seventy-one to seventy-five would automatically score four points for their age. Similarly, the Italian guidelines explicitly state that “an age limit for an ICU admission might ultimately need to be set.” The wording of the French guidelines, on the contrary, tends to avoid any explicit age- or disability-related exclusion criterion (although these categories are taken into account in the prognosis). The Spanish guidelines, accessible online, insist on life expectancy “with quality of life,” yet without defining the latter. They consider chronological age as a nondeterminant criterion and “survival without further impairment” as a crucial component of the medical evaluation and prognosis of the Covid-19 patient. Finally, the British, French, and Spanish guidelines all give explicit and absolute priority for ICU beds and ventilators to their health care providers, whatever their condition and whatever the rationing situation.

Europe has been hit hard by the pandemic and has faced many shortages. As of August 21, 2020, Italy accounted for 35,400 deaths from Covid-19, Great-Britain 41,400, France 30,500, and Spain 28,800. Cautious as one must be about what newspaper articles and social media postings say about the pandemic (since some information might be anecdotal and poorly represent the global picture), concerns frequently conveyed in such sources have reflected an uneasy truth about the death toll disproportionately affecting the older population and about unresolved ethical issues. Moreover, while the topic of triaging seems surprisingly taboo in the media, we do know that Spain, Italy (particularly Lombardy), and France did, to some degree, face triaging issues, which they handled differently.

Italy was the first country hit in the West. Several reports, both national and international,³² detailed the tragic choices facing Italian doctors³³ and the criteria used before any written rules were published. The system did not initially provide any means to alleviate the enormous emotional, spiritual, and existential burdens to which the health care providers were exposed. Tragic cases of elderly patients denied ICU beds made the headlines. When the SIAARTI guidelines³⁴ were finally published, they were met by fierce criticism. Physicians, journalists, theologians, and members of the public expressed outrage at the proposed guidelines,³⁵ which apparently departed from medicine’s usual deontological principle that all lives should be valued and all sick people should be assisted. As a result, the usual secrecy surrounding end-of-life decisions could no longer hold. Frontline doctors, feeling that they were harming their patients, no longer wanted the discretionary power of life-and-death decision-making that was usually theirs. Authority, trust, and medical legitimacy were eroded by the lack of preparedness; the cost of the triage, with the number of deaths reaching more than twice the usual mortality rate for people over seventy by mid-March, shocked many. The fundamental principles of the traditional Italian system, largely based on medical paternalism, exploded—precisely because the emotional and

ethical burden that fell directly on the frontline health care providers was too heavy to be borne by them.

In France, unlike in Italy, there has not been transparency about triage issues. While a few French media outlets reported that some guidelines had been issued, none discussed the details. “It’s an issue that is difficult to expose publicly,” observed a journalist.³⁶

To ease the overflow of patients and avoid the tragic situation of Lombardy, many patients were transferred all over the country at the end of March and early April at a much larger scale than in Italy, where the lack of coordination among local governments hampered such policy. Yet triage has taken place in France. Age was, in principle, not to be used as a discriminatory criterion for accessing an ICU bed. Yet the guidelines explicitly state that “*age has to be taken into account particularly for Covid patients.*”³⁷ Triage de facto took place in the overstretched health care systems of some regions (the East and Ile de France), as reported within the medical community—but not outside it. Apparently, bedside triage was less prevalent than an upstream, informal triage, notably at the level of first responders (the Service d’Aide Médicale d’Urgence),³⁸ whereby older patients were simply not transferred to an ICU (or sometimes even to a hospital). A similar informal policy existed regarding disabled people—particularly those in institutions—who would often not be transferred to hospitals. Indeed, the French SAMU has also been criticized for using a specific scoring system (Autonomie G rontologie Groupes Iso-Ressources, or AGGIR) to evaluate different levels of frailty and dependency before allowing a transfer to a hospital. Many physicians pointed out that getting residents from nursing homes into the hospital, even when they met the right criteria, was practically impossible, although others contended that there was no general rule to deny nursing home residents such access.³⁹ Several associations in France, representing nursing homes or the disabled community, appealed to the highest court in the nation (the Conseil d’Etat) for the lack of clear protocols to ensure equal access to health care resources.⁴⁰ The Conseil d’Etat responded by quoting the different guidelines, arguing that there were protocols in place and that no age- or disability-related discrimination had been proven.⁴¹

The French situation was by no means exceptional in this respect. In Sweden, many voiced criticism over the senicide taking place,⁴² and a physician in geriatrics, Yngve Gustafsson⁴³ from Umea, reported that elders in nursing homes were given morphine instead of being taken into hospitals.⁴⁴ Such news created an uproar in Sweden among health care providers in nursing homes—although the degree of its accuracy is difficult to verify. In Spain, reports from the regional health authorities of Madrid explicitly stated that patients from nursing homes should not be sent to any hospital.⁴⁵ Similar complaints in Great Britain led the deputy chief executive of NHS Providers to call for a public inquiry to establish why mortality in care homes had been so high.⁴⁶ Policies designed to prevent hospitals from being overwhelmed pushed a greater burden onto care homes.

While the British NHS firmly maintains that there is no national guidance at all that picks and chooses who can receive treatment in a hospital, many reports provided, as in France, anecdotal evidence of nonadmission of Covid-19 patients from nursing homes.

These issues—including the practice of not transferring some Covid-19 patients for age- or disability-related reasons—did not come up as a public debate and were hardly reported in the media during the first Covid-19 wave. There seems to be an implicit consensus that these issues are better discussed within the medical community⁴⁷ and that the definition of the relevant criteria should be left to medical experts,⁴⁸ who, in turn, will advise the government regarding any ethical problems.

Lessons in Transparency and Trust

Comparing how triaging issues have been framed in the United States and Europe, and the institutional and social contexts in which they were framed, reveals two contrasting approaches leading to different outcomes. The U.S. model, grounded in a multidisciplinary and explicitly transparent approach, relies on extensive and largely public discussions at all levels; it has led to more community engagement, more efforts to avoid biases, and more scrutiny (as demonstrated by different amendments added in several state plans). Despite the dramatic situation in several parts of the country, increased preparedness has resulted at all levels. In fact, fears of the anticipated tragedy that would have resulted from triage might have averted triaging, at least to a certain degree (an interesting example being the pre-Covid trials using one ventilator for two patients).

The European approach, on the contrary, was almost exclusively medical, promoting technical expertise as the sole qualification for deciding in triaging situations. This resulted in a total lack of public involvement in identifying and discussing the values that could guide the allocation of scarce resources. When, in several countries, triaging could not be avoided, two different types of outcomes could be observed. In Italy, the traditional approach, based on old medical paternalism, basically collapsed, leading to a stark rejection from society as a whole (starting with frontline physicians themselves). In Spain, France, and the United Kingdom, while the medical paternalistic model has more or less survived, it has led to huge frustrations, with a misinformed and increasingly distrustful public demanding accountability. Granting almost exclusive legitimacy about triage decision-making to professional societies of intensivists and other medical experts, at the cost of explicitly precluding any participatory approach and any open ethical debate, has generated a perception of a lack of transparency that has undermined public trust. In a survey in April, members of the public in France rated the management of the pandemic crisis in their country as worse than in other countries and rated highest the probability that the government was hiding information on the pandemic. Members

of the public also showed the highest skepticism regarding getting all the needed treatments if they were infected.⁴⁹

As many tragic underreported aspects of the Covid-19 outbreak are emerging, some lessons can be drawn. Societies should reflect on a process for identifying and communicating values and principles that should guide any resource allocation in a situation of scarcity. Policy-makers should make the whole process more transparent, efficient, and accountable in the eyes of the public. Multiple perspectives should be integrated in such a process to build up trust and achieve legitimacy. A critical element for the sustained acceptance of any difficult triage decision relies on trust. The weakness of public debate and the absence of ethical input regarding triage protocols in Europe, compared to the extensive debates in the United States—in which there has been an unprecedented role for ethicists across the whole country in developing tools and frameworks to help health care providers⁵⁰—is particularly significant. The ethics of triage cannot be reduced to strictly medical protocols.

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Can Clinical Empathy Survive? *Distress, Burnout, and Malignant Duty in the Age of Covid-19*

by ADRIAN ANZALDUA and JODI HALPERN

In an article for the *New York Times Magazine*, Helen Ouyang, an emergency room doctor in New York City, illustrated her experience caring for an elderly man dying from Covid-19 when the city’s case count was skyrocketing:

I want to spend time with him, but more patients, much younger patients, keep arriving, struggling to breathe. I have to tend to them instead. The disease has won against him; the new patients have a chance. I don’t want to think that way, but it is the dismal truth of our new situation. I hope the morphine is enough to blur the reality that he’s all alone. I move on, forcing myself not to think about him again. Too concerned about the new patients, I never take the time to check on him again. Too exhausted at the end of my shift, I don’t say goodbye to him either. He dies later that night.¹

Distancing herself from the harsh realities of treating Covid-19 patients, and emotionally and physically exhausted, Ouyang appears to be in a state of sympathetic distress and showing signs of burnout, a serious psychological syndrome brought on by bad workplace conditions.

Ouyang’s account appeared on April 14, 2020, just as health care workers in New York and surrounding areas were shouldering their way through the peak of the deadliest coronavirus surge the country had faced. Mental health data collected on New York City health care workers during that surge proves that Ouyang’s experience was far from isolated. One study of 657 of the workers showed that 57 percent manifested symptoms of acute stress (which could lead to post-traumatic stress disorder), 48 percent experienced depression, and 33 percent showed signs of generalized anxiety.²

While these data represent mental health impacts during one of the most devastating regional outbreaks on record, such outbreaks are recurring now, during January 2021. The national Covid landscape has turned into a mosaic of

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