Is Fair Triage Possible?: Navigating the Complexities of Triage in Healthcare Crises

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Videodermal hospitals packed with COVID-positive patients gasping for breath lent the public a sobering look at the human cost of the pandemic. For the healthcare workers behind the camera, the patients relegated to the hallway represented excruciating decisions to prioritize others’ access to scarce Intensive Care Units (ICU) beds. For the first time in modern memory, the medical resources available in even the most developed areas on Earth had run dry, and when deciding who would benefit from precious life support resources, protocols fell apart, ethical standards were strained, and lives fell in the balance. From the French word “trier,” meaning “to sort,” triage refers to deciding which patients receive what medical care. With origins in the 18th-century French military, many core principles of triage are pragmatic and coarse, designed to quickly restore a fighting force by prioritizing those most likely to recover. A notable American anaesthesiologist, bioethicist, and World War II medic, Dr. Henry Beecher, remarked on the distribution of scarce penicillin: “By all that is just, it would go to the heroes who had risked their lives … they did not receive it, nor should they have; it was given to those infected in brothels.” Such practices, where the circumstances and magnitude of need are disregarded and the likelihood of recovery is prioritized, are known as “utilitarian triage.”

Also looking to maximize the total impact of medical intervention – often measured in quality-adjusted life years (QALY) – are agencies like the NIH that historically advocate a predominantly utilitarian approach, urging the prioritization of ICU beds based on the likelihood of improvement. But in non-military mass casualty events, what is good for the collective – and what the public deems acceptable – may look entirely different. In addition to utilitarian methods, bioethics scholars propose a second ethical framework: egalitarian triage, where those most in need of medical attention take priority. While egalitarian approaches may result in worse total outcomes in metrics like QALY, they are often more palatable to the general public and medical providers. When push comes to shove, doctors making executive decisions are often reluctant to deny treatment to those suffering the most. Analyses find that when rationing ICU beds, those who are less ill but who may benefit quickly are often denied in favor of those who face steeper odds. This pattern may arise from intrinsic moral sensibilities, but cogent ethical arguments can also support it. Groups faced with medical discrimination and lack of access to healthcare are often in worse health across several indicators, and consequent decisions to deny care can stem from and compound existing inequities. The Civil Rights Act prevents the inclusion of protected classes in triage decision-making, and scholars propose amendments to guidelines to further account for disparities – such as, removing diseases found predominantly in specific demographics from the criteria and adjusting health scores for income.

At the height of the COVID-19 pandemic in 2020, triage practices were no longer a theoretical exercise but a daily reality under a deluge of patients. State health authorities issued flow charts including conditions such as heart disease, cognitive disabilities, and – in one iteration of Alabama’s guidance – AIDS. Problematically, many conditions used as deciding factors may serve as proxy indicators for other protected classes. For example, almost all Alzheimer’s patients are elderly, and age is a protected class and a strong predictor of COVID-19 outcomes. Disability and civil rights groups sued several health agencies, leading the Health Department’s civil rights office to issue a bulletin affirming the rights of protected groups in triage cases. “Our civil rights laws protect the equal dignity of every human life from ruthless utilitarianism,” said the office’s director, Roger Severino.

While this is a noble goal, there is little dignity in dying from a viral infection in a crowded hospital. Fundamentally, triage decisions are an unpleasant trolley problem, offending our moral and ethical sensibilities no matter how we delineate between those who receive care and those who do not. Responding with indignation and criticizing such decisions as “ruthless” is easy. Proposing better alternatives is hard. No healthcare workers are responsible for a shortage of resources, but instead, they are responsible for administering certain ones in the first place. Some advocate lottery-based or first-come-first-serve approaches, but inaction is a choice – that may result in more overall deaths and fewer added years of life. Where we draw red lines regarding triage guidelines reflects not evidence-based consensus but rather the point where our intolerance for difficult ethical decisions begins to constrain our goal of saving as many lives as possible. On aggregate, maximally utilitarian triage brings a greater number of healthier individuals home to their families. But on a human level, egalitarian triage feels better – to the officials legislating it, the healthcare workers enacting it, and the general public. In some senses, the ideal system is utilitarian at its core, but egalitarian in appearance and enactment. There are many ways this dichotomy may be curtailed. Current flowcharts often use an exclusion-first approach, systematically eliminating those ineligible for treatment. Not only does this create more susceptibility to public and legislative scrutiny, but it also frames the actions of healthcare decisions as an unpleasant trolley problem, offending our moral and ethical sensibilities no matter how we delineate between those who receive care and those who do not.

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professionals as acts of deprivation. Humans are loss-averse, meaning we avoid making decisions framed in terms of potential negatives. Health agencies should rewrite guidelines to attenuate the psychological biases of those enacting them, reframing triage processes as targeted assistance to those in need.

Additionally, healthcare providers use computerized systems to score patient viability based on a number of metrics. Suppose this process is further automated based on biometrics, which no individual clinician is responsible for recording or inputting. In that case, the difficult task of evaluating a patient's eligibility for care can be distributed across multiple individuals and obfuscated in the process.

These changes will lift a portion of the ethical burden of triage. Providers will adhere more closely to guidelines, make difficult, time-sensitive decisions faster, and suffer from reduced emotional trauma. While this change may also mitigate some public backlash, triage decisions will always challenge our social norms – particularly in America and other wealthy countries, where acclimation to abundance has left us incapable of grappling with zero-sum problems. Even during the invasion of Iraq, thanks to an unprecedented airlift and field hospital program, death rates among American troops were far lower than in most modern conflicts but inspired proportionally greater backlash. When we face the next natural disaster, terrorist attack, or epidemic, we will again be challenged with these difficult decisions. Still, we should not misdirect our anger at the healthcare providers making them. We must understand that our discomfort with triage as a concept does not necessarily indicate its unethical nature but reveals our alienation from loss. • • •