TRAGIC CHOICES IN THE TIME OF PANDEMICS

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**** 20 marzo 2020 ****

As the World Health Organisation declared Covid-19 a pandemic on March 11, 2020, WHO's Director-General, Dr. Ghebreyesus, stressed the importance of a ready reaction from the states, directed at the containment of the spread of the virus, while also finding a "fine balance between protecting health, minimising economic and social disruption, and respecting human rights".

At the time of writing, with the total number of positive cases well within the 5-digit territory, the Covid-19 emergency has been putting the Italian health system to a severe test. Data recovered from the first two weeks of the Covid-19 outbreak show that about 1 in 10 of infected patients require intensive treatment in the form of ventilatory support, due to interstitial pneumonia characterised by severe hypoxemia, which is potentially reversible, but can result in a long, acute phase, and has lead to abnormal exploitation of intensive care units, whose maximum capacity has been severely challenged.

It is in this context that the *Italian Society of Anesthesia, Analgesia, Resuscitation, and Intensive Care* (SIAARTI), noticing a massive imbalance between the availability of intensive resources and the actual clinical needs of the population, introduced the *Recommendations of clinical ethics for admission to intensive care treatments and their suspension, in exceptional conditions of imbalance between needs and available resources* (March 6), which have since been heavily criticised on multiple fronts.

Tracing SIAARTI's words, the extraordinary nature of the proposed measures - which deems them justifiable only after efforts to increase the availability of resources and the possibility of transfers have been assessed - must be communicated with the patients and their families, not only for a matter of transparency and to maintain trust in the public health service, but also to ensure that caregivers' juridical responsibility be subjected to careful verification of both expertise and due diligence, from a defensive medicine perspective, by clarifying the allocation criteria of healthcare resources, as well as to relieve caregivers from the responsibility for

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emotionally burdensome choices made for each case.

At the core of such recommendations, regarding all ICU patients, both Covid-19 infected and not, there are the principles of clinical appropriateness, proportionality of care, and distributive justice.

SIAARTI deems multiple factors worthy of consideration, starting from the age of the patient and the foreseeable increase in mortality due to preexisting clinical conditions, as such, unrelated to the ongoing pandemic, as well as the presence of comorbidities and the estimated length of the progression. While these circumstances are not dismissed based on a perceived lack of intrinsic value or merit, SIAARTI's recommendations seem to embrace a consequentialist approach - according to which extraordinary measures should be taken to reserve resources for patients who are presumed to have the highest chance of survival, as well as more years of life ahead of them -, as opposed to maintaining a *first-come, first-served* criterion, which would amount to choosing not to treat altogether, should the scenario of total saturation of intensive resources occur. It should be noted that the ceiling of care placed before mechanical ventilation must not preclude access to lower care intensities.

A scenario like the one depicted in SIAARTI's recommendations belongs to the field of the so-called disaster medicine, whose ethical component presents enormous similarities with the literature regarding the trolley problem, a thought experiment in ethics (Sommaggio, P., Marchiori, S. 2018. *Break the Chains: A New Way to Consider Machine's Moral Problems*, in *BioLaw Journal* 3:241-257).

In fact, what these recommendations address is a real-life scenario of a variation of the trolley problem as initially formulated by Philippa Foot in 1967. Foot's original trolley problem scenario involves a runaway trolley headed towards five workers, who are working on the tracks. The trolley cannot be stopped, but it can be diverted to another track, where only one person is working. Depending on whether one chooses to pull the lever - thereby adhering to a consequentialist approach and ensuring the greatest good for the greatest number -, or not divert the trolley and let events unfold naturally - in a deontological fashion -, the accident would result in either one or five deaths (research shows that the vast majority of people would intervene to save four lives; moralmachine.mit.edu).

At the root of both Foot's thought experiment and the imbalance between patients' needs and resources, lies the need to make an intrinsically tragic decision, as none of the alternatives is undoubtedly right or wrong. In this sense, the deontological approach of deciding not to decide,

is almost a decision, no less full of consequences than a consequentialist one. In fact, choosing not to compile a list of patients most deserving of treatment - ascertained that the lack of intensive care support does not preclude treatment in the lower degrees of care - would mean adhering to a strict *first-come, first-served* approach, which would by itself be strictly regulatory.

In addition to the criteria for access to intensive care, SIAARTI proposes that all ICU patients be labelled "ICU trial", and be subjected to daily reassessment, based on criteria of appropriateness as well as proportionality of care. Similarly, caregivers should discuss and define in advance the patients which deserve intensive care treatment, including the instruction "do not intubate" in case of patients with a low chance of survival, in order for medical staff to be able to intervene promptly in case of abrupt clinical deterioration. The decision to limit intensive care should be thoroughly discussed and shared by the medical team as well as, potentially, by the patients and their families. In this sense, SIAARTI's recommendations suggest that the possible existence of advanced treatment provisions (DAT, regulated by the Italian law no. 219/2017, *Rules on informed consent and advanced medical directives*) should also be considered, although it should be noted that such provisions are a source of significant disagreement even after being confirmed by a ruling of the Constitutional Court (judgment no. 242/2019, which declared Article 580 of the Criminal Code unconstitutional).

In this regard, one could argue about the advisability of there being a further distinction between *not intubating* and *extubating* patients in need of intensive care, as well as about the precise meaning that the expression "medical-clinical adequacy" should acquire in this context.

As mentioned, SIAARTI's recommendations were criticised on several fronts.

In particular, such recommendations were followed on March 7 by a note from Dr. Anelli, President of the *Italian National Federation of Physicians Surgeons and Odontologists* (FNOMCeO), as well as by observations from the *Rosario Livatino Study Centre* (RLSC), together with the *Italian Catholic Medical Association* (AMCI) (March 10).

Let us start with the latter. In their observations, RLSC and AMCI noted that medical doctors are inevitably more prone to error when they have to quickly make dilemmatic choices under extraordinary situations of emergency, and should not be held liable without rigorous verifications of their diligence and expertise. In this sense, they seem to adhere to SIAARTI's purpose to partially lift caregivers' responsibility deriving from such emotionally burdensome choices. At the same time, they do not offer a strong enough argument to suggest that reacting

to potential errors should be preferred to preventing such errors from occurring in the first place. Furthermore, while RLSC and AMCI dismiss the role of SIAARTI's recommendations, as they aim to provide guidelines in a situation of abnormality that should by itself be logically impossible to control, it seems reasonable to assume that different caregivers, especially put under considerable pressure from the severity of the surrounding health crisis as well as the urgency of the decision they have to make, could react differently to the same scenario. We ask ourselves to what extent it is preferable to leave decisions of this magnitude to caregivers - knowing that this will increase their stress levels and, consequently, their propensity to make avoidable errors - than to regulate them, albeit partially and in a fallible way, and guarantee more uniform homogeneous criteria.

Moreover, RLCS and AMCI state that clinical appropriateness in view of reasonable hope of recovery should be the only criterion employed in this respect, and reject any other criteria, including that of temporal priority, which would open the door to discretion, which would lead to medical arbitrariness. To this, we respond by asking: is a *first-come, first-served* approach not just based on temporal priority as well as the SIAARTI's one? Furthermore, solid access criteria are already in place: should we also discard any criteria which would change the order in which patients are admitted to cure, depending on the severity of their illness and urgency of care? In this sense, how should we interpret Article 3.2 of the Italian Constitution? Should it be possible to take it to mean that guaranteeing access according to ordinary criteria during an extraordinary situation would violate the principle of substantive equality, due to the different life expectancy of the patients, or should this emergency be all the more reason to reiterate such a conception? Similarly, could we not see how one would consider it painful, but overall sensible, to use the limited resources available at one time to try to save the greatest number of lives, rather than trying to save everyone, almost inevitably ending up treating patients less likely to survive, and therefore being able to save fewer lives?

Dr. Anelli's criticism about SIAARTI's recommendations reminds readers of the centrality of the medical code of professional ethics, which states that all patients are equal and treated without discrimination. However fully competent to judge the appropriateness of care, medical doctors are not, nor should they be, required to make such tragic choices. To do so, we should employ all public, private, and military resources at our disposal to avoid the conditions of disaster medicine hypothesised by SIAARTI.

The application of rationing criteria is and should be the *extrema ratio* and should require a

collegial bioethical discussion within both the medical profession and society at large.

Before concluding our discussion, let us turn our attention to disaster medicine once again, and to the *Italian Disaster Medicine Association* (AIMC) in particular. As we mentioned, such discipline regards the large-scale application of medical care following an event that is going to exhaust all available resources. Given the numerous references to disaster medicine and the firm willingness to prevent the need to resort to such measures, it may be interesting to find out what the worst-case scenario would be. To do so, we carry out the analysis of two intra-hospital emergency plans available on the AIMC website, regarding *S. Camillo Hospital* in Rome and the hospitals of Castelfranco and Montebelluna, respectively (for a legal framework of health emergencies regulations in Italy and Europe, see Decision No. 1082/2013/EU, State-Regions Agreement Act of 1992, DPR March 27, 1992). What emerges from these documents is that, should they be used to deal with the Covid-19 emergency, they could not provide clear enough indications to caregivers in case of a severe lack of capacity and resources.

In particular, according to *S. Camillo*'s emergency plan, the Medical Doctor Disaster Manager should identify and monitor the structure's accommodating capacity by checking the equipment for the need of critically ill patients - to whom it would be safe to assume ICU patients belong. Were they to detect any critical issues, they would be expected to "solve them", plain and simple.

Conversely, Castelfranco and Montebelluna's emergency plan comprehends a sequence of steps for structuring emergency procedures, namely: establishing standard procedures, training, application, review and criticism, correction.

To sum up, the Covid-19 pandemic is severely testing the Italian health system, as more patients need intensive treatment than there are resources to guarantee such care. This has led to the need to make tragic decisions in situations of healthcare resources' saturation, which closely resembles Foot's trolley problem and resulted in SIAARTI's recommendations on the one hand, but also in several criticisms on the other hand.

In short, one can either choose to prioritise certain characters and circumstances, like SIAARTI does, thereby adhering to a consequentialist approach, or (apparently) decide not to choose, like FNOMCeO, RLCS, and AMCI, thus conforming to a deontological perspective.

Although Castelfranco and Montebelluna's emergency plan's directions seem more in line with the concept recalled by Dr. Anelli, one wonders whether SIAARTI's recommendations deserve to be so vigorously rejected or it is more important to have generally shared but imperfect

guidelines, than none whatsoever.

It could be argued that those who criticise SIAARTI's recommendations are not criticising the choice not to provide intensive care to all patients itself, as much as they are disapproving SIAARTI's proposal to regulate in a general and abstract form (albeit through mere recommendations, as such without any claim of coercibility) a situation that would be better kept anomalous.

Concerning this criticism, by all means shareable, one could counter-argue that the soundness of SIAARTI's recommendations does not lie in them being generally implemented, but rather in them providing a compelling defensive argument, should a healthcare choice be contested or become in issue as the subject-matter of a legal proceeding. If that was the case, the line of defense could be the following: "I acted as I did – in accordance with discretion and appropriateness criteria – to face a peculiar situation of that patient in such a context. I had to make a tragic choice, which my peers share."

In the hope that hospitals will be able to cope with the Covid-19 emergency through the purchase and construction of all means necessary to provide adequate treatment to every patient in need, and that the dramatic scenario predicted by SIAARTI will not occur, we believe that SIAARTI's recommendations may serve to reassure caregivers, whatever decisions they may have to take under such tragic circumstances.