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Clinical Cases

Disaster Triage

Triage duties in the event of a medical disaster have different ethical rules than normal situations.

Commentary by James F. Childress, PhD

Several simultaneous explosions have occurred at an indoor stadium packed with eager fans during the third quarter of a championship basketball game. Initial reports from eyewitnesses indicate that the detonated devices released a gas throughout the stadium, which quickly overwhelmed the crowd and sparked panic. An unknown number of people were severely injured or killed in the stampede to exit the stadium. Paramedics at the scene report that, to varying degrees, the individuals affected by the gas have respiratory distress, muscle fasiculations, vomiting, and convulsions. Several have been noted to have pinpoint pupils. No one is yet sure, but all signs indicate that a anticholinesterase nerve agent was released inside the stadium.

Rebecca, a senior emergency medicine resident at the hospital closest to the stadium, is working intensely to see the first few patients coming into her emergency room from the game. She is working with the staff to control patients' convulsions, administer atropine, and intubate and ventilate patients when necessary. She becomes nervous as the crowd of patients grows larger and several people become critically ill over the course of several minutes. She recognizes that the capacity of the emergency department will soon be overwhelmed. Patients need to be diverted elsewhere. Rebecca recently completed a terrorism response course at her hospital and is horrified that the need for that training arose so quickly.

Rebecca has just finished intubating a young woman and is running to check on another patient when the head physician, Dr. Harrison, announces to the staff that it is time to implement the "capacity triage plan." Rebecca remembers that this means the staff is only to attend to those patients who are potentially salvageable and must triage patients by their likelihood of recovery. The patient load, in both numbers and acuity, is beyond the staff's capacity to care for all of them.

Dr. Harrison says to Rebecca and 2 nurses, "We need to work in such a way that we can save the lives of the greatest number of patients."

Rebecca looks at the groups of people around the emergency room. She knows that this is the predesignated plan, but now the patients who are dying and their desperate family members are right in front of her. She wonders if this triage plan is the right thing to do, especially when she has always been trained to prioritize the care of the most ill patients. How can she now pass over those patients who seem likely to die? Doesn't this go against everything it means to be a doctor—just abandoning them like this? What if the dying patients had been her own family members?

Commentary

Rules of triage, the allocating of scarce medical resources in an emergency such as a bioterrorist attack, can engender moral distress for health care professionals who have to implement them. Yet we need rules such as a "capacity triage plan," established in advance of emergencies, so that everyone will know how to respond. Otherwise, confusion and even chaos will reign. Although rules of triage must be formulated with the best medical information available, they are not merely medical in nature. They also reflect important moral values.

Triage is one way to ration health care when caregivers cannot meet everyone's needs at the same time and to the same degree. Systems of triage, whether informal or formal, all have an implicit or explicit utilitarian rationale—they are designed to produce the greatest good for the greatest number by meeting human needs most effectively and efficiently under conditions of scarcity. They are structured to satisfy the formal criterion of justice (to treat similar cases similarly and equal cases equally), and their minimal material criteria for distribution of treatment is some combination of patients' needs and the probability of successful treatment.

Allocation decisions based on medical utility do not necessarily compromise equal regard for individual persons and their lives. Each patient counts as 1 and only 1; hence, computing the *number* of lives that can be saved is compatible with regarding each human life equally. All patients are treated *as equals*, even if they receive *unequal treatments*, if—but only if—those treatments proceed according to medically acceptable and ethically defensible rules justified to the public in advance of the emergency.

The perception that health care professionals are abandoning some patients creates a major problem for those patients and their families, as well as for the professionals involved in triage. In turning away from critically ill patients to care for others who are less ill, Rebecca feels that she is abandoning both the dying patients and "their desperate family members." Preparation for a disaster such as a bioterrorist attack means developing medically acceptable and publicly defensible rules of triage, creating other forms of care for patients, and anticipating the possibility of health care professionals' moral distress before an emergency occurs. For Rebecca, it is now too late to raise concerns.

Traditional codes of medical ethics did not adequately address situations of triage because of their focus on physicians' responsibilities for individual patients. In most situations, it is appropriate for physicians to attend first to the worst-off in the confidence that others can wait their turn without undue burden or risk. It is not surprising, then, that Rebecca experiences moral distress because of the dramatic conflict between the values that have pervaded her medical training, on the one hand, and the rules of triage, on the other. It is difficult to shift from assigning priority to patients who are the sickest to assigning priority to patients who are most likely to survive.

The process of setting the rules of triage should be transparent and open, and all the relevant stakeholders, such as health care professionals and the public, should offer input in identifying, specifying, and ranking all the relevant values. Only then will it be possible to ensure public confidence in the fairness of the critical medical decisions that will have to be made quickly, with little or no time for explanation and justification. Furthermore, in the crisis itself, professionals must make consistent judgments and decisions based on these rules. Otherwise distrust will erupt and cooperation will vanish.

Rules of triage need to be fair and to be perceived as fair. Engendering and maintaining the public's trust will be more likely if the public participates in creating those rules: for instance, determining what to emphasize in medical utility, deciding which functions and roles are essential if it is necessary to make judgments of narrow social utility (ie, to give priority to some sick or injured persons because they are needed for important social roles in the crisis), and establishing whether to have a weighted lottery. Such determinations are not clear-cut, as various simulation exercises around the country have indicated (eg, Operation Top-off and Dark Winter), and the public should participate in making them. Furthermore, the issues will become even more difficult if, in order to contain infectious diseases, quarantine and isolation become necessary. "The public will not take the pill," some have noted, "if it does not trust the doctor."

When societies confront tragic choices—where fundamental social-cultural values are at stake—they must, as Guido Calabresi and Philip Bobbit stress in their book, *Tragic Choices* [1], "attempt to make allocations in ways that preserve the moral foundations of social collaboration," or, in my language, to create and maintain public trust.

Reference

1. Calabresi G, Bobbit P. *Tragic Choices*. New York, NY: WW Norton & Company; 1978.
   Google Scholar

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