Presidenza del Consiglio dei Ministri

COVID 19: CLINICAL DECISION-MAKING IN CONDITIONS OF RESOURCE SHORTAGE AND THE "PANDEMIC EMERGENCY TRIAGE" CRITERION

8 April 2020

Presentation

In the context of the Covid-19 pandemic, the healthcare system has been subjected to enormous pressure. In this opinion, the Committee examines the problem of patient access to treatment in conditions of limited health resources.

In accordance with the fundamental principles of the Constitution (the right to health protection, the principle of equality, the duty of solidarity) and the universalistic and egalitarian criterion on which the National Health Service is based, the Committee believes that there must be respect for the principles of justice, fairness and solidarity, in the allocation of resources. In this context, the ICB recognises the clinical criterion as the most appropriate point of reference, deeming any other selection criterion, such as age, sex, condition and social role, ethnicity, disability, responsibility for behaviours contributing to the onset of the pathology, costs, to be ethically unacceptable.

The Committee believes that *pandemic emergency triage* should be based on a premise, *preparedness* (preparation of action plans in the field of public health care, in view of exceptional conditions, with a transparent chain of responsibilities), *clinical appropriateness* (medical evaluation of the efficacy of the treatment in relation to the clinical need of each individual patient, with reference to the urgency and seriousness at the onset of the pathology and to the prognostic possibility of recovery, considering the proportionality of the treatment), *actuality* that places the individual evaluation of the patient physically present in the emergency department into the broader perspective of the "patient community", with a periodic review of waiting lists.

The Committee also points out that the allocation of health resources in conditions of their scarcity requires maximum transparency towards the public, in order to render everyone's choices truly free and informed. The ICB notes with concern the proliferation of legal disputes against health professionals in the context of the current pandemic emergency and believes that there should be consideration of the idea of limiting possible profiles of professional liability of healthcare workers in relation to the activities carried out to deal with the Covid-19 emergency.

Specific attention is dedicated to those *most vulnerable*, who may feel at risk of abandonment, in particular the elderly, in residential care facilities, for whom the Committee recommends that appropriate care, protection and attention should be ensured in order to prevent Sars-CoV-2 virus infection.

The document was coordinated by Profs: Stefano Canestrari, Carlo Casonato, Antonio Da Re, Lorenzo d’Avack, Assunta Morresi, Laura Palazzani, Luca Savarino. With the contribution and input of all the members of the Committee.

At the session of 8 April 2020 the opinion obtained, by a large majority, the favourable vote of those present, Profs.: Salvatore Amato, Luisella Battaglia, Carlo Caltagirone, Stefano Canestrari, Carlo Casonato, Francesco D'Agostino,

Bruno Dallapiccola, Antonio Da Re, Lorenzo d'Avack, Mario De Curtis, Gianpaolo Donzelli, Mariapia Garavaglia, Marianna Gensabella, Assunta Morresi, Laura Palazzani, Tamar Pitch, Lucio Romano, Luca Savarino, Lucetta Scaraffia, Monica Toraldo di Francia and Grazia Zuffa. Prof. Cinzia Caporale subsequently also endorsed the opinion.

Prof. Maurizio Mori voted against and wanted to clarify the reasons for his dissent, in a minority position, as published together with the opinion.

Prof. Carlo Petrini, delegated member of the Committee by the president of the National Institute of Health and Dr. Maurizio Benato, delegated member of the Committee by the National Federation of MDs and Dentists Colleges, although not entitled to vote, wished to express their endorsement. Paola Di Giulio, delegated member of the Committee by the president of the Superior Health Council, although not entitled to vote, abstained.

Profs. Riccardo Di Segni, Silvio Garattini, and Massimo Sargiacomo, absent from the session, also endorsed the opinion.

1. Premise

For several months, our country is having to face an unprecedented threat to the health and life of its citizens, caused by the rapid and growing spread of the Sars-CoV-2 virus. A threat that is all the more difficult to counter since the global pandemic risk warning launched by international bodies has been underestimated, resulting in delays in preparing to face health emergencies[1]. The health care system[2] has been subjected to extraordinary pressure and has had to quickly reorganise and restructure itself, in an attempt to identify and isolate contagious subjects and, in severe cases, to be able to treat Covid-19 patients in hospital in intensive and sub-intensive care units, often set up in a very short time. In the context of public health, the Covid-19 pandemic has taken on particularly dramatic aspects.

In this opinion, the Committee intends to examine a specific ethical problem, that of patient access to treatment under conditions of limited health resources. A problem of great complexity, which requires considering and reconciling different principles, such as, among others, the protection of life and health, freedom, responsibility, justice, fairness, solidarity, transparency. The Committee considers this reflection a priority and necessary, also taking into account the difficult choices that doctors in healthcare facilities are called to make. At the same time, the Committee reserves the right to deal with the many other ethical issues raised by the Covid-19 emergency shortly.

In preparing this reflection, the ICB intends to underline how in our Constitutional Charter there are some fundamental principles that can provide valid orientation in the bioethical field. In particular, art. 32 - where health is referred to as a "fundamental right of the individual" and as a "collective interest" -, art. 2 - which recognises and guarantees the personalist principle and the duty of solidarity - and in art. 3 – which contemplates the principle of equality – all of

[1] See the Report published in September 2019 by the Global Preparedness Monitoring Board (GPMB) and entitled *A World at Risk, Annual Report on Global Preparedness for Health Emergencies:* https://apps.who.int/gpmb/assets/annual_report/GPMB_annualreport_2019.pdf. The GPMB is an organization promoted by the World Health Organization (WHO) and the World Bank.

[2] Once the emergency is over, there will be the opportunity to re-examine the difficult test that our health care system has undergone, in an effort to ensure prevention from disease and adequate treatment to all. As of now, however, we can highlight some critical issues, such as: inadequate funding to the National Health Service, as already highlighted by the ICB in the Opinion *A Call for Safeguarding the National Health Service*, (2017) and in the Motion *Inequalities at Birth* (2015); incorrect programming in the training and recruitment of doctors, especially specialists, also connected to the blocking of the turn-over of health personnel; insufficient funding of scholarships for attending medical schools; an organizational structure with heavy territorial in homogeneities: over time our National Health Service has been de facto transforming into a set of Regional Health Services (in addition to those of the autonomous provinces), thus leading to an unacceptable inequality between citizens, depending on the region in which they reside; the failure to update and the non-implementation, both at national and regional level, the "National Preparedness and Response Plan for Pandemic Influenza", prepared after the avian flu of 2003 by the Ministry of Health and no longer updated after 2006; the downsizing of the role of primary care and territorial medicine; the progressive separation between health and social care policies, with the consequent devaluation of the latter.

these constitute an indispensable point of reference for the care relationship, even when fostered in extremely critical conditions such as the current ones.

Together with the constitutional principles, the ICB deems necessary the addition of the reference to law 833 (1978), instituting the National Health Service which prescribes that care must be ensured according to universalistic and egalitarian criterion. It is a duty to always do everything possible to guarantee the protection of health to everyone, no one excluded; equally everything must be done to avoid being in a situation of serious shortage of resources (professionals, health care devices, beds). For this purpose, there must be an adequate and equitable allocation of health resources, directed and subsequently concretely implemented. However, the terrible emergency triggered by the Sars-CoV-2 virus brings us up against such a shortage, and the dramatic problem of how best to manage these resources to ensure the right to health referred to in the Constitution.

2. The distribution of scarce resources: the ethical criteria for access

The monitoring of public health and disaster medicine are the two areas of reference subject matter of this document. They have a particularly rich and varied sector literature. In the current dramatic situation, in some particularly hard hit areas of the country, a condition emerges in which the resources available are not in fact sufficient to cover the urgent needs for care of all the patients. Also considering that the people who need medical care are not only those infected by the ongoing epidemic, but also those affected by acute and chronic pathologies who suddenly witness a drastic drop in the personnel and means of care essential for them and until then available.

For some weeks now, we have been witnessing a massive reorganisation of healthcare, logistics and personnel, to try to meet all needs, and not leave anyone behind. But the situation remains critical and the health care system is subjected to severe stress: hence the need to identify criteria for access to resources that are appropriate to the exceptional nature of the moment. In this regard, the Committee expresses solidarity and strong support for doctors and healthcare workers and social workers who are dramatically involved in the fight against the epidemic: they are on a daily basis confronted with the tragic problem of allocating scarce resources compared to the enormous need as well as having to make quick decisions, sometimes in a very short time. A broad international discussion involving scientific societies, national and international ethics committees and experts[3] has opened up around this problem and is still ongoing.

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[3] E.g. between scientific societies and institutes: SIAARTI, *Clinical Ethics Recommendations for the Allocation of Intensive Care Treatments, in Exceptional, Resource-Limited Circumstances,* 6 March 2020*;* Belgian Society of Intensive Care Medicine*, Ethical Principles Concerning Proportionality of Critical Care During the 2020 COVID-19 Pandemic in Belgium,* 2020; The Hastings Center*, Ethical Framework for Health Care Institutions Responding to Novel Coronavirus Sars-CoV-2 (COVID-19); Guidelines for Institutional Ethics Services Responding to COVID-19*, 16.3.2020. Among the national ethics committees and departments of ministries of health, on the specific issue of the distribution of resources: *Informe del Comité de Bioètica de*

The acute emergency situation that has affected our system of public health care has highlighted how fundamental it is to ensure requirements and conditions that allow us to respect human dignity and the fundamental ethical principles adopted by the Charters of International Rights - starting from the Universal Declaration of Human Rights - and nationally - our own Constitution. The Committee therefore believes that in the allocation of resources, the principles of justice, equity and solidarity must be respected, in order to provide all persons equal opportunities to achieve their maximum health potential. It also deems necessary the implementation of all possible strategies, including those of an economic-organisational nature, in order to ensure the universality of care.

3. The criterion of "pandemic emergency triage"

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 for example age, sex, condition and social role, ethnicity, disability[4], 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. In this regard, one could speak of pandemic emergency triage, the fundamental lines of which are based on a premise, preparedness,[5] and on two key concepts: clinical appropriateness and actuality

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Espana Sobre los Aspectos Bioéticos de la Priorizacion de Recursos Sanitarios en el Contexto de la Crisis del Coronavirus, 25.3.2020; Nuffield Council on Bioethics, *Ethical Considerations in Responding to the COVID-19 Pandemic*, 17.03.2020; Department for Health, Ireland, *Ethical Framework for Decision-Making in a Pandemic*, 2020. Other National Bioethics Committees have generally spoken on Covid-19 (France, Germany, Austria) and International Committees (International Bioethics Committee and World Commission of the Ethics of Scientific Knowledge and Technology by UNESCO, European Group on Ethics in Science and New Technologies, Bioethics Committee of the Council of Europe). Among the experts a special mention goes to: E.J. Emanuel et al. *Fair Allocation of Scarce Medical Resources in the Time of Covid-19*, in "New England Journal of Medicine", 23 March 2020.

[4] In the United States, some associations of the rights of people with disabilities have reported the adoption, by some States, of rationing protocols for life-saving treatments that are discriminatory for people with disabilities. Following these reports, the Director of the Civil Rights Office of the Department of Health and Human Services, Roger Severino, opened an investigation, to ensure that no state, even during the pandemic emergency, was allowed to discriminate patients on the basis of disability, age, ethnicity. See Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services, *BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19),* 28.3.2020.

[5] The term indicates a long-term operational emergency preparedness program. In this regard, see the definition proposed by the World Health Organization in https://www.who.int/environmental_health_emergencies/preparedness/en/: "Emergency preparedness is a program of long-term development activities whose goals are to strengthen the overall capacity and capability of a country to manage efficiently all types of emergency and to bring about an orderly transition from relief through recovery and back to sustainable development".

= ***Preparedness***

This involves the preparing of action strategies in the field of public health, in view of the exceptional conditions relative to emergencies caused by pandemics. In other words, we must evaluate how to manage the inevitable conflict between collective public health objectives (to ensure maximum benefit for the largest number of patients) and the ethical principle of ensuring maximum protection for the individual patient in exceptional situations: a dilemma difficult to solve in the concreteness of choices, as shown in the extensive literature on the subject.

In this regard, the ICB particularly highlights two aspects:

- the need to provide a transparent chain of responsibilities and tasks, with clearly defined times and methods (e.g. identifying the competent authorities at national and local level to whom to entrust ultimate responsibility for the finding and allocating of resources); the complexity of the necessary operations requires adequate operational tools, first of all without any excess of bureaucracy to procure the necessary resources, in the timescale dictated by the current emergency;
- it should however be kept in mind that the adoption of priority criteria in making resources available can trigger dynamics which might not be easily reversible.

= **Clinical appropriateness and actuality**

Clinical appropriateness. Clinical appropriateness means the medical evaluation of the effectiveness of the treatment in relation to the clinical need of each individual patient, with reference to the severity of the onset of the pathology and the prognostic possibility of recovery. This treatment must always be proportionate, that is, take into account the balance of benefits and risks with respect to the patient, considered from the point of view of both the objective and subjective clinical dimension (perception of pain and suffering, perception of the invasiveness of treatments, etc.).

Each patient should be seen in the totality of his clinical situation, taking into account all necessary assessment factors. Notwithstanding the priority of treatment according to the degree of urgency, other factors are routinely subject to evaluation: the severity of the ongoing clinical condition, comorbidity, short–term terminal illness, etc. Age, in turn, is a parameter that is taken into consideration in view of the correlation with the current and prognostic clinical evaluation but it is not the only parameter nor even the main one. The priority should be established by evaluating, on the basis of the indicators mentioned, the patients for whom the treatment can be reasonably more effective, in the sense of ensuring the greatest chance of survival. That is, a criterion must not be adopted, according to which the sick person would be excluded because they belong to a category established a priori.

It is also important that the therapeutic decision concerning the different patients to be treated, according to the severity of their pathology, is as far as possible the result of consultation between several doctors, to ensure comparison between different points of view and the most correct choice possible, and, just as importantly, to allow the sharing of the responsibility and burden of a decision that will always be agonizing.

However, it will always be necessary for those who do not access the health facility or for the patient who has renounced invasive life-saving treatments, to be treated with less invasive systems and to resort to pain therapy and palliative care where necessary. The continuity of care with respect to the individual patient must therefore always be guaranteed.

Actuality. This is the criterion that most characterises pandemic emergency triage, compared with the procedures usually adopted in hospital emergency departments. Compared to the usual triage[6], in pandemic emergency triage, patients are considered differently: this totality includes, in addition to those who are "physically present", those who have been evaluated and observed from a clinical point of view, mindful of their critical conditions. In fact, in an emergency situation such as the pandemic that has hit our territory, not only patients physically present in the emergency room but also those hospitalized and not yet subjected to the vital support of assisted ventilation are in need of life-saving health treatments. - from less invasive support to transfer into intensive care – likewise the patients, already clinically evaluated at home, whose conditions have suddenly worsened. Compared to triage in normal times, pandemic emergency triage places the individual assessment of the patient in the broader perspective of the "patient community".[7]

In pandemic emergency triage, the periodicity of reviewing waiting lists follows, as far as possible, the timing of the pathology. In fact, it is reasonable to think of some doctors who, communally, review the priorities within a waiting list of patients, for whom it would be appropriate to receive required treatments for which there is unfortunately limited availability and their taking home care into account. These priorities are decided and/or reviewed on the basis of the clinical criterion and according to contingent situations, without excluding anyone a priori, and at the same time using all available resources.

Furthermore, emergency conditions go beyond the care of the single individual: in exceptional situations many facilities of the healthcare system, not only hospitals, are reorganised, both in the coordination of the various departments within a health care complex, and in the distribution of patients and the specialties of care between different hospitals. This reorganisation concerns

[6] Under normal conditions, with triage, operators in an emergency department aim to establish priorities for access to therapies; they therefore compose waiting lists that concern only patients who are physically present.

[7] Something similar occurs for organ transplants, where a list of those in need of a transplant is compiled, considering both the order of arrival, and primarily criteria of clinical appropriateness; the priorities are then periodically reviewed on this list, always following the same criteria.

the facilities already available, as well as any that may be set up on a provisional basis to deal with the emergency. Consequently, the staff is redistributed and recruited according to the new, impending needs.

Using triage in a pandemic emergency also at this logistical level means planning on a large scale, always keeping in mind the objective of avoiding the formation of categories of persons who are then disadvantaged and discriminated against. It is an ethical duty, both in the management of various pathologies and in that of patients suffering from the same disease, to exclude automatic action and a priori choices in the access to different treatment paths.

In fact, it should be remembered that it is not only Covid-19 patients who require intensive care or sub-intensive therapy. Sick people with other very serious pathologies also need it. Just as we cannot forget those chronically ill patients who in these days are in a sort of double, heavy isolation: on the one hand they must pay great attention to ensure compliance with the restrictive rules laid down, because they are more exposed to the virus; and on the other they cannot undergo routine and periodic medical checks, considering that contacts with doctors have been decreased, when not actually suspended.

4. Further reflections

Finally, the ICB considers it appropriate to highlight the following.

1. The criteria for allocating healthcare resources under conditions of their scarcity require maximum transparency. The criteria adopted in the healthcare system must be clearly known to the public, so that everyone's choices in this regard are truly free and informed. In emergency conditions, marked by the isolation of patients, the difficulties that, in terms of lack of resources, time constraints and emotional overload burden the care relationship, there must be particularly careful attention paid to respect for the personalist criterion in relation to individual choices and in particular, on the possibility of resorting to using the tools of advance treatment directives and shared care planning.

2. With this document, the Committee also intends to address doctors and healthcare workers and social workers reiterating its gratitude for their work and strong support in consideration of the difficulties they face in their daily choices: the Committee realises that they should not be left alone. It underlines how limited available health resources were during the emergency, in both structural and organisational terms, including an often undersized staff, both in hospitals and in the territorial area. Health professionals have often found themselves having to work for long consecutive hours, at a gruelling pace, sometimes even with a lack of personal protective equipment at high risk of becoming infected and even dying: there are in fact a great number of deaths among healthcare workers. The scientific uncertainty that characterises the novelty of the current pandemic emergency must also be taken into account: in combating the contagion from

Covid-19, one operates in the absence of consolidated guidelines, good clinical-care practices recognised as such by the scientific community, without therapeutic evidence. In view of this, the ICB reports with concern the proliferation of legal disputes against health professionals in the context of the current pandemic emergency. In this regard, the Committee believes that there should be consideration of the idea of limiting possible profiles of professional liability of health professionals in relation to the activities carried out to deal with the Covid-19.

3. To this, a reflection is added dedicated to those who are most vulnerable, compared to the rest of the population, who may feel particularly at risk of abandonment. It should be emphasised that the contagiousness of an epidemic inevitably brings with it the risk of loneliness, for health requirements: the fragile - the elderly, the disabled, the sick – in order to avoid the danger of contagion may be removed from their loved ones and familiar environments and, in the event of hospitalization, transferred to wards obviously intended for isolation, where access is limited only to specialised personnel: conditions in which even receiving a simple phone call can become a problem. Among the many vulnerable people, special attention must be paid to the elderly. Their equal right to receive adequate care and, when admitted to specialised facilities (e.g. old people's homes), to obtain appropriate protective equipment for Covid-19, timely and numerous tests to isolate patients suffering from the virus, from other patients. The suffering that accompanies death caused by respiratory insufficiency must be avoided through the adoption of appropriate protocols, which obviously include pain therapy and palliative care, when necessary.

Nor can we forget the terrible ordeal to which the terminally ill are subjected, without the possibility of being able to say goodbye to their loved ones for the last time. In addition to denying the patient accompaniment at the end of life the epidemic makes it impossible for those who are left behind to be able to share their grief, through the funeral rites. These painful wounds, in addition to many others, will also leave their mark on the lives of people and communities.

It is to be hoped that support will also be provided to ensure closeness and accompaniment to particularly vulnerable persons, not only in clinical but also in social and human terms.

The minority position of Prof. Maurizio Mori: the Siaarti Recommendations point in the right direction

The ICB Opinion on Covid-19 is inadequate because in words it claims to address the problem of triaging or the selecting of patients to undergo intensive treatments, but in reality it is unable to even identify the terms of the problem regarding the choice and ends up leaving the last word to individual clinical judgment without giving precise indications. Moved more by the intent to give reassurance, it is as if the Opinion denies the exceptional reality that took place regarding the need to make choices or triage. I will attempt to explain why and how the SIAARTI Recommendations (Italian Society of Anaesthesia, Analgesia, Resuscitation and Intensive Care) point in the right direction.

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Italy was the first western country to suffer the sudden, powerful and deadly shock wave of the Covid-19 pandemic. On February 21, 2020 the first official diagnosis of Covid-19 was made and the next day there were outbreaks in Codogno and Vò Euganeo, which at the time seemed o be isolated incidences that were likely to remain so. A large part of public opinion considered the alarmism excessive and rumours were circulating that Covid-19 was nothing more than "a slightly more serious influenza". Apart from the few "red zones", life in the country continued almost normally until and including Sunday 8 March.

In Lombardy, however, the health situation precipitated immediately and from the beginning of March the requests for hospitalization grew exponentially: on March 6 a group of resuscitators immediately published the Siaarti Recommendations "for the admission to intensive treatments and for their suspension, in *exceptional* conditions ". There are no official data yet, but in the Lodi-Bergamo-Brescia-Cremona quadrilateral, an estimate made by the field operators states that from 5 to 25 March, the most critical period, for each single bed in the intensive care units available there were at least 10 patients in need of that bed, a figure that is confirmed by the fact that in a few weeks there were approximately 20,000 deaths, roughly double the official figure.

In this situation of exceptional emergency, Siaarti Recommendations have performed a valuable service by providing concrete indications to the resuscitators who found themselves having to carry out triage with very little time to decide. The Recommendations have sparked a lively public debate, because for example n. 3 has been accused of being discriminatory, as it mentions the possibility that in certain circumstances it may become "necessary to set **an age limit** for admission to Intensive Care Units". Others have instead rejected the very idea that we should go so far as to perform triage as this practice is not foreseen by medical ethics and the Constitution; still others have reiterated that any choice is entirely up to the best "knowledge and conscience" of the individual doctor.

What the Siaarti Recommendations have aroused is, however, the most important bioethical debate, whose grassroots emerge after the Welby and

Englaro cases, a debate which is extending to international level due to the leading role played by our country in the world in the fight against Covid-19. In this situation, the ICB's Opinion should have been part of the ongoing reflection and should have taken up a position on the Siaarti Recommendations, either criticising them, correcting them or accepting them. Instead, the Opinion mentioned them in a note and within a text drawn up from scratch that does not even take into consideration the main theoretical point underlying the Recommendations themselves, the one which states that in exceptional conditions "**Criteria for access** to intensive care (**and discharge**) may be needed, not only in strictly **clinical appropriateness** and **proportionality of care**, but also inspired by a criterion that is as shared as possible of **distributive justice** and **appropriate allocation of limited health care resources**".

By denying this fundamental point, the ICB's Opinion states that the only adequate criterion for the allocation of resources is "the clinical criterion" and that "any other selection criterion [...] is [...] ethically unacceptable". To clarify the nature of the problem under consideration and the type of disagreement, a concrete example should be examined. Let's imagine that Tom (70 years) and Dick (60 years) need to access the Intensive Care Unit and that, in a normal situation with two beds available, both are judged to be clinically suitable for treatment, both having reasonable opportunities to regain health. Now suppose that suddenly the situation changes and that there is only one bed available, so that it is necessary to choose whether to admit Tom or Dick. Since both had already been deemed suitable from the clinical point of view, it must be recognised that the choice is made on the basis of an extra-clinical criterion, as the clinical evaluation does not change with the change in opportunities for treatment. This is why in the new exceptional situation that has arisen, the choice of whether to admit Tom or Dick depends on an "ethical-social" criterion, which the Siaarti resuscitators identify in distributive justice concerning the allocation of scarce resources: in conditions of scarcity, there is a more stringent duty to avoid waste of any kind, therefore, for the same clinical judgment, distributive justice implies aiming at " **favouring**” the "**greatest life expectancy**".

The considerations made show that the theoretical analysis underlying the Siaarti Recommendations is correct, and that age is an extra-clinical factor. Instead of acknowledging this, the ICB's Opinion simply ignores the point and does not even take it into consideration, perhaps out of fear that the recognition of extra-clinical criteria may pave the way for possible discrimination. The need to dispel this possibility is so strong that the ICB's Opinion comes to include age in the "clinical criterion" by virtue of its frequent association with various diseases. In this sense, it states that age is "a parameter that is taken into consideration because of the correlation with the current and prognostic clinical evaluation, but it is not the only one and not even the main one". With similar considerations and some beating around the bush, not always easy to understand, the ICB’s Opinion in practice enormously widens the clinical criteria to include also other factors deemed to be relevant, concluding that "the priority [of care] should be

established by evaluating, on the basis of the indicators mentioned, the patients for whom the treatment can reasonably be more effective, in the sense of ensuring the greatest chance of survival".

The notion of "chance of survival" is rather vague and generic, but in a broad sense it can be equated with Siaarti's more precise "greatest life expectancy": if so, the ultimate aim of the choice (or triage) would be the same, and the divergence between the ICB's Opinion and the Siaarti recommendation would seem limited to the different perspective of analysis and the recognition or non-recognition of the extra-clinical criterion in the choice.

This difference, however, is not insignificant because it has further practical consequences. Based on the correct analysis perspective of choice, Siaarti has managed to formulate fifteen quite precise and punctual Recommendations that provide practical indications for the action to be implemented within a few minutes or even less, and thanks to these guidelines it is possible to check the compliance of corresponding conduct. Instead, on the basis of the only clinical criterion always applied to the individual sick person in the current circumstances, the ICB's Opinion fails to give any general directive, but says that "one must not [...] adopt a criterion, according to which the sick person would be excluded because they belong to a category established a priori", and that it "is an ethical duty, both in the management of various pathologies and in that of patients suffering from the same disease, to exclude automatic action and a priori choices in the access to different treatment paths". This means in practice that the choices regarding access to intensive care in exceptional situations are not that different from the choices involved in the proportionality of care that take place in normal conditions. The Opinion of the ICB promises, in words, to give a criterion for triage in a pandemic emergency situation, but in reality it does not give any specific indication except that when it is not possible to guarantee the universality of treatments, it is the doctor who must choose according to his best knowledge and conscience by mixing clinical indicators at his discretion.

The Siaarti Recommendations can be improved but they point in the right direction. Recognising the presence of extra-clinical factors in the choice, opens up on one side new horizons that will have to be examined in detail and further specified. We all know that the triage or choice of who to admit for treatment is a terrible, repugnant reality that we would all like to avoid. But the task of ethics and bioethics is also to tackle these difficult problems and identify possible rationally justified solutions, at the cost of disturbing inveterate opinions. Perhaps it is out of fear that the recognition of extra-clinical factors in the choice could open the door to possible discrimination, that the ICB's Opinion came to deny preferring to reassure those observing that as always, even in exceptional situations, only the clinical criterion is of value and that everything remains much the same as before.

A discussion on the articulation of the ICB's Opinion allows us to better grasp this point. At the outset the Opinion merely notes that "for several months our country has had to face an unprecedented threat to the health and life of its citizens", as if it were a now familiar and normal reality. It immediately reiterates

that the principles contained in articles 2, 3 and 32 of the Constitution "constitute an indispensable point of reference for the care relationship, even when fostered in extremely critical conditions such as the current ones”, and that Law 833/78 instituting the National Health Service requires that "care must be ensured according to a universalistic and egalitarian criterion". In short, at the beginning it is asserted that no choice (triage) is ever allowed for any reason.

In spite of this ideal and abstract declaration, the Opinion also recognises that "the terrible emergency triggered by the Sars-CoV-2 virus brings us up against" the need to make choices, i.e. triage. This, however, is ethically licit only if done on the basis of the "clinical criterion" in compliance with the "principles of justice, equity and solidarity" which provide "all persons equal opportunities to achieve their maximum health potential" and after having done everything possible "in order to ensure the universality of care". Albeit reluctantly, the ICB's Opinion accepts triage, but in particular and special conditions. This aspect becomes clearer if we consider that, after accepting it, it immediately underlines that triage "however must be rethought on the basis of the exceptional nature of the moment" so "one could speak of *pandemic emergency triage*" characterised by particular conditions, such as preparedness, the reference to the clinical criterion and actuality open to the wider community of patients. In short: it says yes to triage, but, as we have seen, if qualified by special characteristics.

In closing the Opinion, under the auspices of the ICB regarding transparency in the criteria adopted, closeness due to doctors, the uncertainties of scientific knowledge, as well as the protection of those most vulnerable, further observations lead us to think that triage is involved, but not in a proper sense but in a special sense that is not clearly identified.

I cited the three passages in which the ICB Opinion is articulated because they correspond roughly to the analysis made by Alessandro Manzoni, at the end of chapter 31 of *I promessi sposi*, on the attitude of the Milanese to the plague of 1630 "At the beginning then, no plague. Absolutely not. On no account. It was forbidden to even breathe the word. Then, pestilential fevers: the idea admitted circuitously by adjective. Then, not true plague, that is to say, yes it is a plague, but only in a certain sense, not true plague, but something similar that does not have its own name”. If we replace the term "plague" with "triage" or (tragic) "choice" in the text, we would find a similar attitude today: ”At the beginning then, no choice, no triage. Absolutely not. On no account: it was forbidden to even breathe the word (the Italian Constitution forbids it). Then, pandemic emergency triage: the idea admitted circuitously by adjective or by qualification. Then, not true choice, that is to say, yes it is a tragic choice, but in a certain sense; not true choice or triage, but something similar that does not have its own name”.

The Siaarti Recommendations with realism, timeliness and transparency, have managed to offer quite precise indications to face the tragic problems of choice in exceptional situations: perhaps they are less reassuring, but it is from these that we must start.