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TRIAGE: ENDGAME REALITIES

George P. Smith, II*

. . . . Until recently doctors were committed to trying to save all their patients. But now, with the advent of such expensive and complicated procedures as open heart surgery, transplants, and artificial organs, hospitals had to pick and choose to whom to give these life saving operations. For the time being, these techniques were limited by extraordinary costs and by the space available in the sophisticated units needed for aftercare. In general, the teaching staff tended to favor patients with multi systemic disease, who did not always do well, while private physicians such as Thomas leaned toward otherwise healthy, productive members of society. . . .

. . . . It was as if no one understood that surgery, that life-giving process, as well as the costly intensive care unit, were intended for patients who would recover, not the living dead

. . . . 'Look,' shouted [Dr.] Thomas [Kingsley], 'all I want to do is surgery on people who deserve to live, not a bunch of mental defectives or people who are going to die of other illnesses. Medicine has to understand that our resources are limited. We can't let worthy candidates wait while people with multiple sclerosis or gays with autoimmune deficiencies take valuable beds and OR time.¹

THE HISTORICAL PERSPECTIVE

The classical definition of *triage* may be acknowledged as being:

The medical screening of patients to determine their priority for treatment; the separation of a large number of casualties, in military or civilian disaster medical care, into three groups: those who cannot be expected to survive even with treatment, those who will recover without treatment, and the priority group of those who need treatment in order to survive.²

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1. R. COOK, *GODPLAYER* 75, 118, 360 (1983).

2. *STEDMAN'S MEDICAL DICTIONARY*, 4th unabridged lawyer's ed. at 1476 (W. CORSETTE, ed. 1976). See also, R. VEATCH, *A THEORY OF MEDICAL ETHICS* 259-71, 202 (1981).

Even before "*triage*" found significant application to military or civilian catastrophes, its root meaning in French—"sorting, picking, grading or selecting according to quality"—was subsequently first applied in the English language to the process of separating wool according to quality and even later, to the separation of coffee beans into three categories: "best quality," "middling" and "triage coffee", with the last consisting of beans which had been broken and were, thus, the lowest in grade.³ Over the course of time, the use of triage has been expanded to other situations where it has become, in actuality, a metaphor for social, economic and even political decisions.⁴

Both the idea and the process of sorting casualties of war were developed by Napoleon's chief medical officer, Baron Dominique Larrey.⁵ One of the baron's early goals in his efforts to organize an efficient system of medical services to the injured was to perform surgeries as soon as possible after soldiers sustained their injuries. To this end, he developed "ambulances" whose purpose was not only to transport the wounded from the battle area but also serve as mobile units for providing instantaneous medical assistance.⁶ Additionally, he put into operation a scheme for sorting casualties on the basis of their medical need. Accordingly, "Those who are dangerously wounded must be tended first, entirely without regard to rank or distinction. Those less severely injured must wait until the gravely wounded have been operated on and dressed."⁷ Medical personnel, then, were concerned centrally with finding ways to conserve scarce resources—with the first and foremost being their time and their energy.⁸

Although during the Civil War the United States did not essentially classify wounded soldiers for purposes of medical treatment, but rather provided such care without regard to physical condition, during World War I, it did in fact adopt from the French and the British, the principle of *triage*.⁹ And, to this day, the current military policy of the armed forces of the United States is recognized as a policy of *triage* which involves both the evaluation and the classification of casualties for not only purposes of treatment but of evacuation which is tied to the principle "accomplishing the greatest good for the greatest number of wounded and injured men."¹⁰ Thus, it is—then—that an explicit utilitarian rationale is embraced and extolled.

3. Childress, *Triage in Neonatal Intensive Care: The Limitations of a Metaphore*, 69 VA. L. REV. 547, 549 (1983).

4. D. RUND & T. RAUSCH, TRIAGE 3-10 (1981).

5. G. WINSLOW, TRIAGE AND JUSTICE 1 (1982).

6. *Id.* at 2.

7. *Id.*

8. *Id.* at 5.

9. *Supra* note 3, at 550.

10. *Id.*

A DISTRIBUTIONAL STANDARD

Distributing scarce medical resources involves obvious problems of distributive justice. Although acknowledged as existing, they are quite difficult to resolve in a pragmatic manner. Consequently, owing to this often insurmountable difficulty, the question of how the distribution will be made is reduced to the issue of who will make the first order decision.¹¹ Yet, unless *triage* decisions are to be but recognized as but arbitrary and capricious, some criteria must be in place for scrutiny and examination. The Hemodialysis Program of Seattle Washington's Artificial Kidney Center studied eighty-seven such centers around the country in order to develop a set of criteria for allowing patients to be admitted to their programs.¹² The dialysis candidate profile that emerged found the following criteria to be used always in the selection and admissions process: medical suitability (good prognosis with dialysis); absence of other disabling disease; intelligence (as related to understanding treatment); likelihood of vocational rehabilitation; age; primacy of application for available vacancy in the hemodialysis program; and a positive psychiatric evaluation (re acceptance of disease and goals of the actual treatment).¹³ The following conditions were judged as excluding selection of a patient for participation in the program: mental deficiency; poor family environment; criminal record; indigency; poor employment record; lack of transportation and lack of state residency.¹⁴

Fault may be found with one or more of these factors used in selection. But, absent a unifying philosophy of medicine which defines with precision its goals for achievement, acknowledges whether such achievement is possible, and determines whether it reflects a desirable goal of contemporary human culture¹⁵ and develops rational guidelines for making necessary critical choices,¹⁶ medicine will not be successful.¹⁷ Medicine has existed in the twentieth century without a vital philosophy is due to the simple fact that its

11. Kass, *The New Biology: What Price Relieving Man's Estate?* SCI. 782 (Nov. 19, 1971).

12. R. FOX & J. SWAZEY, *THE COURAGE TO FAIL*, chs. 7, 8 (1974).

13. *Id.*

14. *Id.*

Additional factors of consideration in utilitarian decision making in broad issues of *triage* may be listed as: the past services rendered of a candidate; potential future contributions; life expectancy; role in the family; prospect for success of the use of the scarce medical resource in question; and the progress of science factor. Rescher, *The Allocation of Exotic Medical Life-saving Therapy* in *MORAL PROBLEMS IN MEDICINE* at 526, 529 (S. Gorowitz, et. al. eds. 1976).

15. Rescher, *supra* note 14, at 523.

16. E. PELLEGRINO & D. THOMASMA, *A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE*, viii (1981).

17. *Id.*

successes "in curing" has been of enormous and overpowering.¹⁸ Indeed, "this success is due to knowledge and technique based on experience, not theories and philosophical speculation."¹⁹

Today, there is a recognition that an admirable goal of a national health policy is quality health care at an affordable cost.²⁰ Cost containment thus has become a major force of wide significance and application in all levels of health care decision making.²¹ There is little disputation of the fact that resources are scarce relative to wants and that they have alternative uses; and furthermore that differences in individual wants mean an assignment of different values to these wants.²² The basic dilemma, then, is where to determine a line of compromise between competing interest groups.²³

PRINCIPLES OF ALLOCATION: UTILITARIAN V. EGALITARIAN

Since the law provides at present no uniformly agreed upon principles which may be applied in order to regulate the allocation of scarce medical resources, current medical practice draws upon a structure for decision making evolved as such from a number of philosophical and ethical constructs.²⁴ There are five utilitarian principles of application which are operative in the hierarchy of *triage*: the principles of medical success; immediate usefulness; conservation; parental role and general social value.²⁵ Translated as such into decisional operatives, what emerges is a recognition that priority of selection for use of a scarce medical resource should be accorded to those for whom treatment has the highest probability of medical success, would be most useful under the immediate circumstances, to those candidates for use who require proportionally smaller amounts of the particular resource, those having the largest responsibilities to dependents or those believed to have the greatest actual or potential general social worth.²⁶ The utilitarian goal is—simply stated—to achieve the highest possible amount of some good or resource.²⁷ Thus, utilitarian principles are also commonly referred to as

18. *Id.*

19. *Id.*

20. *Id.* at 267.

21. *Id.* at ch. 12.

22. *Supra* note 19.

23. *Id.* at 268.

24. Note, *Scarce Medical Resources*, 69 COLUM. L. REV. 620 (1969). See VEATCH, *supra* note 2, at 259-71; Spicker & Raye, *The Beating of Prognosis on The Ethics of Medicine: Congenital Anomalies, the Social Context and The Law* in THE LAW-MEDICINE RELATION: A PHILOSOPHICAL EXPLORATION at 189, 195-203 (S. Spiker, J. Healer, Jr. eds. 1981).

25. *Supra* note 5, at 106.

26. *Id.* at 63-86.

27. *Id.* at 87.

"good maximizing strategies."²⁸

Egalitarian alternatives—contrariwise—seek either a basic maintenance or a restoration of equality for persons in need of a particular scarce resource.²⁹ There are five basic principles utilized here: 1.) the principle of saving no one—thus priority is given no one because, simply, none should be saved if not all can be saved; 2.) the principle of medical neediness under which priority is accorded to those determined to be the medically neediest; 3.) the principle of general neediness which allows priority to be given to the most helpless or generally neediest; 4.) the principle of queuing where priority is given to those individuals who arrive first and—lastly— 5.) the principles of random selection where priority of selection is given to those selected by pure chance.³⁰

To the utilitarian, maximizing utility, and hence what is diffusely referred to as the "general welfare," are both the primary Ground and Subject of all judgments.³¹ That which is required in order to maximize utility overall may, thus, infringe upon an individual's own entitlements or rights to particular goods.³² Accordingly, moral rights are either rejected generally or recognized as certainly not absolute.³³

Philosophy and religion may well provide us all with the necessary balance and direction for life and allow us to develop an ethic for daily living and a faith as to the future, but in cases of neonatology where law, science, medicine and religion interact great care must be exercised in order to prevent inexplicable fears and emotions—oftentimes fanned by journalistic prophets of the "what if" shock culture—taking hold of and thereby blocking powers of rationality and humanness.³⁴ The basic challenge of modern medicine should be, simply, to seek, promote and maintain a level of real—and when the case may indicate, potential—achievement for its user-patients which allows for full and purposeful living.³⁵ Indeed, man himself should seek to pursue decision-making responsibilities and exercise autonomy in a rational manner and guided by a spirit of humanism. He should seek—fur-

28. *Id.*

29. *Id.*

30. *Id.*

31. Gewirth, *Can Utilitarianism Justify Any Moral Rights?* in *ETHICS, ECONOMICS AND THE LAW* 167 (J. Pennak & J. Chapman eds. 1982).

32. *Id.* at 167-68.

33. *Id.* at 168.

Bentham, in effect, rejected moral rights generally. Hart, *Bentham on Legal Rights* in *OXFORD ESSAYS IN JURISPRUDENCE*, at 171-201 (A. Simpson 2d ed. 1973).

34. See generally, Smith, *Intrusions of a Parvenu: Science, Religion and The New Biology*, 3 *PACE L. REV.* 63 (1982); Smith, *Uncertainties on The Spiral Staircase: Metaethics and The New Biology*, 41 *THE PHAROS* 10 (1978).

35. G. SMITH, *GENETICS, ETHICS AND THE LAW* 2, 8 (1981).

ther—to minimize human suffering and maximize the social good. Defining the extent and application of the social good will vary with the situation of each case, obviously.³⁶

RULES OF EXCLUSION AND FINAL SELECTION

Perhaps utilization of a Rule of Exclusion might go far to eliminate what may be viewed as the harshness of *triage*. Under such a rule, some individuals would be simply eliminated from “competition” for the particular scarce modality of treatment or care facilities even if the resource(s) were in unlimited supply.³⁷ Thus, applying this rule, the scarcity of the resource(s) in question would never even be considered.³⁸

Rules of Exclusion are preferable—in certain definite ways—to Rules of Final Selection when implementing the principles of *triage*. With Rules of Exclusion it is generally unnecessary to make comparisons between specific individuals; for either the patient meets the minimum medical criteria or he does not. When operable, these rules have the appearance of greater objectivity and less arbitrariness than a Final Selection Rule that states simply: “First come, first served.”³⁹ If the standard of exclusion is structured in such a manner and at a level high enough to achieve the purpose of initially reducing the applicant group to that specific treatment number, the very selection process will turn on the decision of exclusion and obviate the need to even be forced to apply additional rules of ultimate or final selection.⁴⁰

There are, essentially, two approaches to structuring and applying Rules of Final Selection: utilize a comparative analysis of the social utility of curing various patients in a selection pool or undertake no comparison but rather apply an arbitrary—yet egalitarian—formula, normally first come, first served (regardless of whether the first served might be a socially irresponsible derelict).⁴¹

As observed, medical providers failed—themselves—in the past to articulate precise rules to guide them in determining patient social utility *vis-à-vis* use of a scarce resource or for that matter to structure a list of exceptions to the first come rule of final selection. These rules of final selection based—it is seen—on value judgments and value judgments alone, are not arguably within a special area of competence for a physician to make. Contrariwise,

36. *Id.* See D. CRANE, THE SANCTITY OF SOCIAL LIFE: PHYSICIANS TREATMENT OF CRITICALLY ILL PATIENTS (1978).

37. *Supra* note 27, at 654.

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.* at 657.

rules of exclusion are based on and, indeed, formulated from professional evaluations and considerations and are regarded as less subjective and arbitrary and more acceptable to both patients and doctors alike than the rules of final selection.⁴²

No principle of preference is clearly correct, humane or totally just. Other suggestions include selection of a patient user by chance or randomization and queuing⁴³, the establishment of separate waiting lists for patients in different age groups and for those with or without families⁴⁴ and—perhaps most ideally—widespread support and development of a program calling for the total utilization of artificial organs which would alleviate the scarcity of natural organs.⁴⁵ To one degree or other, all of these suggestions are attractive. Obviously no definite solutions can be submitted here. If, however, health care providers seek to pursue their decision making responsibilities in a rational manner and guided by a spirit of humanism which minimizes human suffering and maximizes the social good of each situation, a humane standard of justice will be achieved and *triage* will operate as a complement to its attainment.

LOVE AS A FRAMEWORK FOR DECISION MAKING

From a Judeo-Christian theological perspective, the meaning, the substance, and—indeed—the consummation of life is tied to inextricable expressions of Love: love of God and love of neighbor. It is through the love of others that God is recognized and loved.⁴⁶ The meaning of life under this interpretation, then, is to be found in human relationship and the qualities of respect, concern, compassion, and justice that support such relationships.⁴⁷

Social justice demands that each individual be given an opportunity to maximize his individual potential. Yet, a point is often reached where maintenance of an individual is in defiance of all concepts of basic humanitarianism and social justice. When an individual's condition is such that it represents a negation of any "truly human" qualities or "relational-poten-

42. *Id.* at 656, 665, 666.

43. *Supra* note 3, at 557-59. See generally THE ETHICS OF RESOURCE ALLOCATION IN HEALTH CARE (K. Boyd ed. 1979).

44. *Supra* note 27, at 665.

45. Freud, *Organ Transplants: Ethical and Legal Problems* in MORAL PROBLEMS IN MEDICINE at 44 (S. Gorowitz, et.al. 1976).

46. MCCORMICK, *To Save or Let Die and The Dilemma of Modern Medicine*, in HOW BRAVE A NEW WORLD 339, at 346 (R. McCormick ed. 1981).

47. *Id.*

See Morrison, *Implications of Prenatal Diagnosis for the Quality of, and Right to Human Life*, in BIOMEDICAL ETHICS AND THE LAW 329 (J. Humber & R. Almeder eds. 1976). See generally, Marcin, *Justice and Love*, 33 CATH. U.L. REV. 363 (1984).

tial,"⁴⁸ then the best form of treatment should be arguably no treatment at all.

Life should not be viewed as an end in and of itself, but rather as something that should be preserved so that other values can be fulfilled. Life should be preserved when it holds a potentiality for human relationships. Although this standard does not admit of mathematical precision and must be applied with great humility and caution, it is nonetheless a beginning from which particular medical formulations may be developed.⁴⁹

The concepts of ordinary versus extraordinary life-sustaining processes are highly relative, not only in time and locale, but also in their application to individual cases.⁵⁰ These concepts in essence serve as value judgments which determine whether a given modality of treatment poses an undue hardship on the patient or provides hope for a direct benefit.⁵¹ If a particular mode of medical or surgical intervention either imposes too great a hardship on the patient, or could offer no reasonable hope of benefit, the treatment could be correctly viewed as extraordinary and, thus, non-obligatory.⁵²

Concern must be expressed regarding the patient's comfort in the remaining days of his life, if such an extraordinary act is undertaken or withheld. This determination of whether the contemplated treatment is ordinary or extraordinary is essentially a quality of life statement.⁵³ In coming to this statement, we knowingly or unknowingly use a substituted judgment to conclude that, if we were in a similar situation, we would (or would not, as the case may be) wish to survive in such a state of impairment. Decisions of this nature are made within a vortex of deep emotionalism. They can be aided—but certainly never validated totally—by using or accepting the doctrine of *triage* as a construct for decision making.

Since the binding force of life is love, it can be argued that man should endeavor to maximize a response to love in whatever life situations he finds himself.⁵⁴ If an act renders more harm than good to the individual in-crisis, and to those around him, the act would properly be viewed as unloving. The crucial point of understanding is that a basic cost/benefit analysis is almost

48. *Supra* note 46, at 349.

49. See generally, Smith, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis?*, 63 NEB. L. REV. 707 (1984).

50. R. McCORMICK, NOTES ON MORAL THEOLOGY, 1965 THROUGH 1980, at 565 (1981).

51. *Id.*

52. *Id.*

53. *Id.* See *supra* note 49.

54. See Fletcher, *Love is The Only Measure*, 83 COMMONWEALTH 427 (1966).

always undertaken—consciously or unconsciously.⁵⁵ Of course, the methodology utilized in this assessment will be situational and incapable of absolute determination.⁵⁶ Yet of necessity, the basic norm to be used will be that of love.

55. I. KENNEDY, *THE UNMASKING OF MEDICINE* 145 (1980).

But see, O'Boyle, *On Attitudes Toward Death and The Cost of Dying*, 49 *LINACRE Q.* 48, 54, *passim* (Feb. 1982).

56. *See* McCORMICK, *supra* note 49, at 77.

