


Article

# The Triage of “Blameworthy” Patients

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**Abstract:** One question that has sometimes cropped up in the debate on triage and the management of scarce healthcare resources concerns patients’ merits, demerits, and responsibility with regard to their own medical condition. During the current pandemic, some have wondered, when it comes to accessing healthcare, whether patients who have refused vaccination—despite the availability of vaccines and pressure to get vaccinated from the health authorities—should be given the same priority as patients who have diligently undergone vaccination in accordance with the authorities’ recommendations. The issue of patients’ merits and demerits is not new, and it did not emerge with the pandemic for the first time. In the past, the question was often posed whether terrorists have the right to receive the same treatment as their victims, with the same degree of priority, all clinical conditions being equal. Another issue that has been raised concerns patients suffering from diseases caused by unhealthy lifestyles that they have freely adopted: drinking, smoking, eating fatty foods, practising extreme sports, etc. The conclusion reached in the present article is that it is indeed possible to identify certain general rules for cases of this sort, as is shown by the literature on the topic. However, slavishly following these rules, even in exceptional cases for which it is impossible to make detailed provisions, can lead to disastrous consequences. Therefore, following Aristotle, the article seeks to take account both of the rule of justice and of equity, which is a form of “situational justice” capable of filling the gaps of general norms in the light of concrete cases.

**Keywords:** triage; undeserving sick; responsibility; forfeiture of rights; justice; equity (epieikeia); phronesis



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## 1. Peter Singer: The Vaccinated First

In a recent article, Peter Singer reflects on the issue of the collateral victims of people not vaccinated against COVID-19 [1]. Singer presents the case of Dale Weeks, who died of sepsis at the age of 78 in a small rural hospital in Iowa. Weeks could have been saved, had he been transferred to a larger hospital and undergone surgery. Regrettably, however, in this bigger hospital all beds were occupied by COVID-19 patients, most of them unvaccinated. When it finally became possible to organise Weeks’ transfer, it was already too late for him.

In situations such as this one, according to Singer, “a different solution is available, one that respects the decision of those who choose not to be vaccinated but requires them to bear the consequences of their choice” [1].

The solution identified by Singer is this:

Hospitals that are at or near capacity should warn the populations they serve that, after a certain date—far enough in the future to allow ample time for people to get fully vaccinated—they will give vaccinated patients priority over unvaccinated patients with COVID-19.

After the announced date, when both a vaccinated and an unvaccinated patient with COVID-19 need the last available bed in the intensive care unit, the vaccinated patient should get it. If the last ICU bed is given to an unvaccinated patient because at the time there was no one else who needed it, and a vaccinated patient with a greater or equal need for the facility then arrives, the bed should be reallocated to the vaccinated patient [1].

Obviously, Singer notes, unvaccinated people must still be treated, should any places be available:

Hospitals with sufficient capacity should, of course, continue to treat unvaccinated patients with COVID-19 as best they can. Despite the extra strain this puts on hospital staff, everyone should have sufficient compassion to try to save lives, even when those whose lives need saving have made foolish, selfish choices [1].

According to Singer, exceptions might be made for patients for whom vaccination is clearly contra-indicated:

Exceptions should be made for those few patients for whom vaccination is contra-indicated on medical grounds, but not for those who claim to have religious grounds for exemption. No major religion rejects vaccination, and if some people choose to interpret their religious beliefs as requiring them to avoid vaccination, then they, and not others, should bear the consequences [1].

This position of Singer's is a very delicate one and deserves in-depth scrutiny. The crucial point here is to establish whether triage is in all cases a medical matter, or whether it also entails extra-clinical (or even ideological) elements and considerations.

Those who believe that triage should exclusively be performed on the basis of strictly clinical criteria <sup>1</sup>, are usually motivated by the praiseworthy intention of avoiding any kind of discrimination based on personal characteristics. On the contrary, Singer's criterion would go beyond the purely clinical assessment of the various cases, by making the moral and social disapproval of a patient's health or lifestyle choices weigh upon the triage process. Exclusion from healthcare, or the assignment of a lower place on the list of patients awaiting treatment, would therefore amount to a way of punishing a given behaviour adopted by the patient. By virtue of ideological rather than medical considerations, this patient could even be treated after someone else who is deemed less in need from a clinical perspective.

Nevertheless, Singer's position can hardly be dismissed as "ideological". At times, the incentive to include extra-clinical considerations in triage can be very strong, to the point of making an exclusively clinical perspective appear counter-intuitive.

To better clarify this aspect, I would like to consider a more dramatic case than that of unvaccinated patients. This is the case of a doctor who throughout his career always subscribed to the clinical criteria, professing a willingness to treat everyone on the basis of their needs, even terrorists.

## 2. Gino Strada: Children and Women First

Gino Strada was a war surgeon and the founder of Emergency, an independent and neutral association that offers free medical care to war victims, promoting peace, solidarity, and respect for human rights. Emergency has always treated all patients, making no discrimination. Precisely for this reason, it has sometimes been criticised—for instance, for treating the Taliban in Afghanistan, thereby allowing them to resume their military activities after recovery <sup>2</sup>. However, not even Gino Strada always succeeded in keeping true to the principle that everyone must be treated, with no discrimination whatsoever. In his book *Green Parrots: A War Surgeon's Diary* he recounts [5]:

Years ago, Margaret, our Australian head nurse in Kabul, took me by the arm. "Come, there are already a hundred or so wounded people in the courtyard, you must do the triage."

Among them were many fighters, an unusual situation, and those fighters looked somewhat familiar to us. They had been keeping us and our hospital under fire for days, with no respect for the wounded or for those who, like us, were only there to provide aid. I felt a mix of fear and rage, I felt the weight of having worked for days in the midst of machine-gun and mortar fire.

Not even when I came face to face with a mujahedin with a bullet in his stomach, did I manage to overcome my rage. My mind was swarming with emotions and feelings, but there was no room for pity, which instead always ought to be there in a doctor's head.

It was tough to admit it, but I cared nothing at all about those wounded guerrilla fighters who had been terrorising us for days.

"The triage is over, Margaret—I told her a few minutes after we had started moving through that crowd of people lying on the ground—children and women first!"

"Whaaat?"

"That's right: children and women first. If you don't like it, then ask someone else to do the triage." I went back to the operating theatre without even waiting for an answer.

Over the following days, I often found myself thinking about this choice, which had not been based on medical ethics or on any rational approach to the problem.

It is true that children and women there were the only blameless people—they had been on the receiving end of the violence. Those who wage war, I had told myself, those who shoot to kill, must certainly take account of the possibility of getting a bullet in the stomach.

And why should I have given precedence to those who only half an hour earlier had been shooting at me?

It took me some time to find the strength to tell myself that, ultimately, that had only been a kind of revenge, the transformation of a doctor into a ruthless and immovable judge.

And it frightened me.

That choice had nothing to do with my profession. I have searched for excuses, but in the end the verdict has remained the same: what would we call this, being an accessory to mass murder and failing to assist? [3] (pp. 57–58).

This public confession made by Gino Strada strikes me as extremely interesting because it encapsulates all the elements and contradictions that make the exclusively clinical criteria seem necessary yet, at the same time, highly problematic.

Strada's initial choice not to treat the terrorists who had opened fire on the hospital and wounded some of the children and women who were now awaiting triage with them, is based on an immediate moral intuition, on a basic sense of justice that leads us to immediately distinguish between victim and perpetrator. It is not an entirely unjustified and arbitrary choice. However open to criticism this choice may be, it still has some truth value, which cannot be easily dismissed. The sense of justice that drove Strada to make his initial choice is related to the indignation that Singer feels when talking about the victims of the unvaccinated.

In order to better highlight the kind of difficulties which emerge when we seek to remain faithful to exclusively clinical criteria no matter what, I will consider a further case: an imaginary but, alas, not wholly implausible one. Let us imagine a terrorist breaking into a kindergarten and opening fire on the children there. The police rush to the place and shoot the terrorist, who is taken to the nearest hospital in a very serious condition, along with his young victims. There are not enough places for everyone in the intensive care unit and there is no time to move the patients to another hospital. This raises the issue of choosing whether to place one of the wounded children or the terrorist in intensive care. Let us further imagine that clinical criteria suggest a slight preference for the terrorist<sup>3</sup>. Should the doctors strictly abide by clinical criteria, the child would be destined to die. It is likely that the choice of saving the terrorist rather than the child would lead to public

turmoil, so much so that the doctors would have to be escorted by the police to avoid a possible lynching. What is to be done in such a case?

### 3. Ronald Dworkin and the Distinction between “Option Luck” and “Brute Luck”

The present special issue features an article by Stefano Semplici [6] that most aptly draws upon Ronald Dworkin’s well-known distinction between “option luck” and “brute luck”, i.e., between what happens to us without any responsibility on our part and what instead happens to us because of certain choices that we knew (albeit with no definite certainty) could have possible negative consequences. Ronald Dworkin writes:

Option luck is a matter of how deliberate and calculated gambles turn out—whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined. Brute luck is a matter of how risks fall out that are not in that sense deliberate gambles [ . . . ]. If someone develops cancer in the course of a normal life, and there is no particular decision to which we can point as a gamble risking the disease, then we will say that he has suffered brute bad luck. But if he smoked cigarettes heavily then we may prefer to say that he took an unsuccessful gamble [7] (p. 293).

Ultimately, Gino Strada applies this distinction when he writes:

children and women there were the only blameless people—they had been on the receiving end of the violence. Those who wage war, I had told myself, those who shoot to kill, must certainly take account of the possibility of getting a bullet in the stomach [5] (p. 58).

The same kind of reasoning could probably be applied to the terrorist in our imaginary example, or to Singer’s unvaccinated people, or indeed to alcoholics who become sick because of their bad habits.

In his article Stefano Semplici also refers to Gerald Cohen, according to whom people who make different choices from others (for example, the choice to avoid vaccination) must not necessarily be assigned a condition of equality, if it is their very own choices that have placed them in a condition of inequality. Cohen asks himself: “Why should one person pay for another’s truly optional choices?” [8] (p. 444).

### 4. Arguments in Support of Clinical Criteria

Let us leave the questions raised in the previous two sections aside for the moment and take a step back, to illustrate all the sound arguments that, in principle (yet not in the specific case under consideration), support clinical criteria.

Some of these arguments are provided by Gino Strada himself, in his account of why he came to regret the choice he had made. Strada states that he had turned “into a ruthless and immovable judge” [5] (p. 58) and that “it frightened” him [5] (p. 58). He also states that this choice had nothing to do with his profession [5] (p. 58). Herein lies one of the first problems we face: we must first of all ask ourselves whether a doctor is fit to play the part of the judge and to establish who should be treated and who not, on the basis of some crime that has been committed. Can a doctor punish a patient for his criminal conduct or, worse still, take revenge? Strada himself admits that, “ultimately, that had only been a kind of revenge” [5] (p. 58).

The point that Strada makes seems a crucial one to me. Richard Ashcroft offers similar remarks in an article devoted to the issue of providing medical treatment for terrorists:

Deciding that an individual under our care or control is a terrorist without the restraint of legal due process, and under the impression that someone is *essentially* a terrorist, our enemy as it were metaphysically, justifies undermining both medical ethics and the rule of law, and corrodes the decency and legitimacy of our society in a fundamental way [9] (p. 52).

In formulating these remarks about people who are judged to be terrorists by doctors, with no due process or presumption of innocence, Ashcroft quite appropriately evokes Giorgio Agamben's and Carl Schmitt's reflections on the "state of exception" [10,11].

A position close to Ashcroft's can be found in an article by Michael Davis, who states:

Of course, there are theories of *punishment* that rely on forfeiture of rights, but physicians are not supposed to be agents of punishment. Forfeiture of rights is not part of medical ethics [12] (p. 57).

Davis adds a further remark:

Even if we accept the claim that, in effect, terrorists are simply criminals who have committed very serious crimes, they would nonetheless be entitled to the same medical treatment as others who commit serious crimes [12] (p. 57).

Why—Davis asks—should terrorists be treated differently from other people?

Is it the unstated assumption that terrorists do not deserve good medical treatment because they are neither soldiers nor civilians but a sort of vermin or a crazed beast? I hope not. Dehumanizing one's enemy is, of course, a long first step toward committing atrocities. (. . . ) Terrorists are not in a class by themselves [12] (p. 57).

Iain Brassington adds an interesting remark on the right to conscientious objection, that is to say the right granted to some doctors not to take part in certain medical procedures on account of some strong moral convictions they hold. Brassington wonders whether conscientious objection might not also apply to the treatment of terrorists. This question makes sense, particularly in relation to doctors who have been personally affected by terrorism, or who have friends or relatives among the terrorists' victims that are awaiting treatment. In this regard, Brassington notes that conscientious objection applies to certain procedures (e.g., abortion) and not to certain patients (e.g., one particular woman wishing to terminate her pregnancy rather than another):

The opt-out rule applies to *procedures*, not to the person on whom those procedures are performed. For as long as there is no moral objection to be had to treating burns, bullet wounds or whatever—and no one in their right mind would think that there is—then the identity of the person burned or shot is neither here nor there. There is no right not to perform permissible procedures on people of whom we disapprove [13] (p. 60).

The reason why Gino Strada initially chose not to treat the terrorists is that "those who shoot to kill, must certainly take account of the possibility of getting a bullet in the stomach" [5] (p. 58). In other words, at least at first, Strada believed that the terrorists who found themselves in that situation had brought it upon themselves and, in a way, deserved it. Certainly, as we have seen, Strada later came to regret his decision, realising that a doctor cannot act as a ruthless judge by attributing blame or merit, using medical care as a form of retribution or punishment. However, this issue of merit and blame also comes into play in the case of other situations that are less exceptional and dramatic than terrorism. Henry K. Beecher mentions the case of some medical officers who, during the war, had very few resources available and were thus forced to choose whether to employ penicillin to treat heroic fighters wounded in battle or other soldiers who were suffering from sexually transmitted diseases contracted from prostitutes [14] (pp. 279–280). Were purely and strictly clinical criteria acceptable in such cases?

## 5. Illness and Blame

Leaving the context of war and terrorism aside, we still find ourselves facing the same dilemma in the case of ordinary medical treatment in hospitals: patients sometimes seem responsible for their health conditions. A chain smoker might be seen as responsible for his heart problems; consequently, his right to receive a transplant could be called into

question [15]. An alcoholic might be blamed for his cirrhosis and thus be deemed ineligible for a liver transplant [16]. The list could go on and on and include countless pathologies that are treated in our hospitals. For each of these self-inflicted pathologies, it would be possible to envisage some form of penalty in terms of access to treatment [17].

As is widely known, the issue of the relationship between illness and blame extends far back in time. A certain religious approach in the past sought to exercise control over the faithful through a pastoral of fear and guilt, which found one of its lynchpins in bodily disease. According to this perspective, illness springs from guilt, from which one must redeem oneself. An accurate description of this kind of fear-based Christianity may be found, for instance, in some works by the historian Jean Delumeau, such as *La peur en Occident* [18] and *Le péché et la peur. La culpabilisation en Occident* [19].

Religion today, at least in the West, no longer has the kind of hold over individuals that it had in the past, yet other guilt-inducing structures have taken its place. Psychosomatic theories and, to some extent, psychoanalysis have offered psychological explanations for various illnesses, particularly cancer. If people get cancer, this is because they have brought it upon themselves—for instance, by repressing their emotions. These forms of psychologistic blaming are the target of Susan Sontag's famous text *Illness as Metaphor* [20].

People have even been held responsible for autism, which has sometimes been associated with so-called “refrigerator mothers” incapable of conveying enough human warmth to their children [21,22]. More recently, certain food habits have been identified as a cause of illness, which in some cases has led patients to be blamed for their poor eating habits. The widespread availability of prevention tools, such as screenings, check-ups, and early diagnoses, might even suggest that patients are to blame—that they have brought the illness upon themselves—if they have failed to undergo all the preventive measures available.

The ways of blame are infinite. As Sandro Spinsanti suggests [23], the dystopia envisaged by Samuel Butler in *Erewhon* [24]—an upside-down world in which patients are made to feel guilty about their illnesses—would seem to have become reality. In chapter XI of his book, Butler describes a judge sentencing a patient for the serious crime of pulmonary tuberculosis.

## 6. Are the Sick Really to Be Held Responsible?

In an article entitled *The Undeserving Sick?* [25], Christin Clavien and Samia Hurst draw a distinction between “lifestyle choices” and “states of affairs”. Adopting a certain lifestyle—becoming a smoker, for example—is a choice. Getting cancer, which is to say finding oneself in a certain situation, instead depends on many factors, including a certain genetic predisposition to develop the disease. After all, there are heavy smokers who never get sick, although their number is smaller than that of healthy non-smokers. If this is a valid distinction, then it would be fairer to punish certain lifestyles, for example by imposing heavy taxes on cigarettes, than to attack people who have got sick with cancer. The two authors write:

If we attribute responsibility solely based on the health outcome, it is not possible to discriminate between these two categories of patients, or to make a distinction between the decision to take a health-related risk and the actual bad luck of seeing that risk materialized [25] (p. 177).

A second element to be taken into account, according to Clavien and Hurst, is the fact that lifestyles are often heavily influenced by one's culture and the habits within one's family. Living in a family of heavy smokers, within a socio-cultural context in which cigarettes are associated with images of success, can heavily influence one's freedom of choice. The same holds true for alcohol drinking, the consumption of foods rich in saturated fats, and any other unhealthy lifestyle habit. In my view, this could even apply to terrorism, the case we examined above. The terrorists might be young men who have been heavily indoctrinated and subjected to genuine brainwashing by the fundamentalist communities within which they have always lived. These young men may never have had access to world-views other than that in which they have been raised.

A third element highlighted by Clavien and Hurst is the fact that we cannot know to what degree people who have adopted an unhealthy lifestyle have been correctly informed about the possible risks. Their choice might even be based on false and incorrect information; therefore, they might not be fully responsible. In my view, this might also apply to the case of vaccines, in relation to which I quoted Singer's opinion at the beginning of the present article. How many of the unvaccinated patients at the hospital have received correct information about the vaccines? How many are only the victims of misinformation, ideological propaganda, and fake news?

A fourth element highlighted by Clavien and Hurst is the fact that we do not know what degree of control a person has over her actions. A patient might be well informed about the risks of a poor diet or smoking, for example, yet be driven to eat or smoke by a compulsive urge caused by various forms of anxiety or psychological stress.

A fifth element to be taken into account, according to Clavien and Hurst, has to do with responsibility, understood in a more strictly moral sense. Certain behaviours are understood and judged as right or wrong by certain individuals or cultures. Such judgements, however, vary from culture to culture, and from individual to individual. In some cultures, certain harmful dietary habits may be part of fundamental rites of passage and become *de facto* mandatory, whereas in other cultures they are totally banned. The same kind of ambiguity may apply to the issue of terrorism: history is full of cases in which the same individual has been judged, at the same time, to be a terrorist and a hero by two conflicting sides<sup>4</sup>.

Regardless, policies aimed at punishing those responsible for hazardous behaviours would prove discriminatory, since unhealthy lifestyles are more widespread among the lower strata of the population [26].

To all these points we should add that, sometimes, choices that are hazardous to one's health may be regarded as praiseworthy:

Medical professionals choose a lifestyle that puts them at risk of catching infectious diseases, but few would deny them proper care on the grounds that they should be held responsible for thus becoming ill. We consider unhealthy work that benefits others such as masonry, pregnancy, or high risk sports (such as boxing or hockey playing) to be praiseworthy rather than a reason for liability or even worthy of punishment [25] (p. 186).

However, it is truly difficult to draw a clear-cut distinction between praiseworthy and blameworthy hazardous activities. Opinions on the topic may be widely diverging.

Finally, it is far from certain that punishing unhealthy lifestyles is an effective policy in terms of the sought-for consequences. If anything, in certain cases, stigmatising unworthy patients can have unexpected and unforeseen practical consequences [27].

## 7. Aristotle and the Concept of *Epieikeia* (Equity)

In order to try to solve some of the tragic dilemmas that have remained unsolved in the reflection conducted so far, I would like to add one last element, which I regard as crucial. Rules are important and need to be followed, but in some exceptional situations, slavish respect for the rules may lead to disastrous consequences. Therefore, common sense—or, in other words, a moral nose—is important [29].

A rule is always applied in a particular situation, which must be interpreted and can be interpreted in various ways. The rule itself may be the object of different interpretations. Finally, the agents involved in the situation and in the application of the rule may have very different personal histories, and this aspect too may have significant repercussions in terms of how the rule is applied.

For this reason, Aristotle distinguishes justice in a general and abstract sense from *epieikeia*<sup>5</sup> (equity), which he describes as:

the sort of justice which goes beyond the written law. Its existence partly is and partly is not intended by legislators; not intended, where they have noticed no

defect in the law; intended, where they find themselves unable to define things exactly, and are obliged to legislate universally where matters hold only for the most part; or where it is not easy to be complete owing to the endless possible cases presented [30] (p. 2188 [1374a18–1374b23]).

This is a very important notion, because it enables us to fill in certain gaps—for which the general norms make no provision—in the light of concrete cases. *Epiékeia*, in other words, lends dynamism to the law and makes it possible to apply the law even to unexpected concrete cases. *Epiékeia* means “situational justice”.

Given this premise, we may draw the following conclusion: in exceptional contexts, there may be reasonable exceptions to the rule according to which a doctor must treat everyone on the basis of clinical criteria and regardless of their merit or blame.

Take, for example, the aforementioned case of a terrorist breaking into a kindergarten and opening fire on the children there. Let us imagine that the terrorist is taken to the hospital along with the children, after having been shot by the police. Let us imagine that, from a clinical perspective, there are very slight reasons to give precedence to the terrorist over a child when it comes to assigning the last available bed in the intensive care unit. Finally, let us also imagine that, in this case, there is irrefutable evidence that the patient in question is the terrorist who opened fire (all those present have seen him, as have the police, which is why they shot him). In this case, would anyone be willing to apply clinical criteria literally, by settling the issue of precedence on the basis of a difference that is almost irrelevant from a medical perspective?

In cases such as this, where it is difficult to apply the rule in a rigid way, we can appeal to the opinion of “reasonable people” [31] (p. 94). If reasonable people agree that, in a specific case, the rule can be bent, then we can accept its bending. If, on the contrary, the reasonable people involved disagree, then we must apply the rule literally. In other words, the appeal to reasonable people’s moral nose can only work as a last resort: as what John Harris calls the “council of despair” [31] (p. 94).

The issue of the relationship between rules and exceptions is a very delicate one. An exception cannot be arbitrary, for otherwise it would deny the law itself. Paul Ricoeur has reflected extensively on this point, reaching the conclusion that a rule is always necessary in order to justify exceptions to the rule [32]. In other words, a sort of rule of suspension is required that has the same legitimacy as the basic rule. For unless we find a rule governing exceptions to the rule, we will end up regarding individual cases as being completely detached from the general rule, and hence, end up having to draft a detailed list of all possible exceptions. But, such a list would ultimately be marked by the same kind of inflexibility as universal and abstract rules.

The rule governing exceptions to the rule that I wish to propose here is precisely the one put forward by John Harris and consisting in the unanimous agreement of all the reasonable people involved. In the case examined above, this might mean the doctors on the care team, or some ethical consultant who is immediately available, or—if there is more time to reach a decision—the hospital’s ethical committee, or patients’ representatives and associations<sup>6</sup>.

To avoid misunderstandings, it seems to me important to emphasize that an agreement between “reasonable people” is something more than a simple agreement between people. The reasonableness to which I am referring implies the ability to offer an adequate and transparent justification for the choice one has made. By contrast, if an individual doctor were to decide to make an exception to the rule without consulting anyone else, this would turn the exception into a matter of arbitrariness. This arbitrary act would amount to an exception to the rule made without there being any rule governing exceptions.

## 8. Conclusions

Having reached the end of our journey, I believe it is possible to derive the following theses from the considerations advanced so far:



1. Doctors are not judges: it is not their job to judge people, nor do they have the competencies to do so. Moreover, the judge's role is hardly compatible with the tasks and duties that medical ethics assigns to doctors, starting from the duty to treat all patients who need help, regardless of their personal characteristics. If a doctor were to act as a judge, this would also jeopardise the relationship of trust between the doctor and his/her patients [34].

If a doctor were to act as a judge, he/she would be a summary judge and his/her patients would not receive a fair trial, which respects their rights. In this sense, it is easy to understand Gino Strada's remorse and the discomfort he experienced at the thought of having acted as a "ruthless judge".

2. While it is unfair to punish patients by denying them medical care or postponing their treatment, it is possible to take certain measures to modify or discourage specific choices and lifestyles that can be hazardous to oneself and other people. In the case of vaccines, it is certainly possible—and indeed useful—to impose a range of limitations on the unvaccinated. This is a way to discourage a "lifestyle choice", not to punish a "state of affairs". It is certainly useful to provide in-depth and correct information to people who do not want to get vaccinated, so as to encourage a choice that is good for individuals and the people around them.

The same applies to all unhealthy lifestyles. It is better to tax cigarettes and alcohol than it is to deny treatment to people who are sick because they have been smoking or drinking. It is useful to ban smoking in many places and to set limits on the consumption of alcohol. It is a good idea to ban the advertising of unhealthy products. All this, however, has nothing to do with punishing the sick. On the contrary, such policies are designed to prevent illnesses.

As regards terrorists, they must certainly be treated, but after receiving treatment they must be handed over to the authorities and be given a fair trial—before a competent judge, not a doctor.

3. Finally, rules are important, and it is necessary to follow them. They also increase trust among the patients, who know they will be treated fairly through the general application of rules. Nevertheless, applying the rules in the real world, in situations one could not have foreseen, is not so easy. In the sixth book of *Nicomachean Ethics* [35], Aristotle introduces another important notion in this regard, namely that of *phronesis* (prudence or practical wisdom), which concerns particulars, as it has to do with how one must act in particular situations. But, as Aristotle observes, *phronesis* requires experience and training. Consequently, in order to ensure that the triage rules are applied well, it is necessary for all the persons involved, starting from the doctors, to be adequately trained to deal with these particular situations.

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## Notes

<sup>1</sup> By "triage conducted on the basis of strictly clinical criteria" I mean that described by the World Health Organization as follows: "Patients must be split into groups based on the seriousness of their injuries and decisions must be made about the treatments they can be given according to the resources available and their chances of survival" [2] (p. 14) [3].

<sup>2</sup> Edward Luttwack has stated: "Strada is the man who was running the hospital in Afghanistan and was proud to be treating the Taliban, who would then leave the hospital to kill again. I do not have his moral standing: for him it's all the same—the Islamic State is the same as the Swedish Red Cross. For him there are no terrorists. Under communism they used to call people like

him useful idiots. Islam takes no notice of Gino Strada, but they would call him a useful idiot, a technical term. Useful to the terrorists". My own translation. [4].

- 3 For example, his injuries might be only slightly more severe (an almost imperceptible or almost insignificant difference, but one that is nevertheless real).
- 4 Among the many possible cases that one might mention, that of Nelson Mandela comes to mind. In a 1987 interview, Margaret Thatcher referred to the African National Congress (ANC) as "a typical terrorist organisation". Up until 2008 Mandela and other ANC leaders were on the US's terrorist watchlist.
- 5 I prefer to leave the Greek term *epiékēia* alongside the English "equity", to distinguish the Aristotelian meaning of equity from the prevailing moral meaning of "equity", which is quite different and influenced by John Rawls' thought [28]. Rawls refers to equity as fairness and distinguishes it from equality: fairness, unlike equality, admits whatever degree of inequality might serve as a means to increase the welfare of society's least advantaged members. In this sense, unlike equality (where each individual or group of people is given the same resources or opportunities), equity recognizes that each person finds themselves different circumstances and allocates the resources and opportunities needed to reach an equal outcome.
- 6 Here I am referring to so-called "reasonable people" in general. In this same special issue, however, there is an interesting article [33], to which I shall refer, in which the pros and cons of entrusting the decision to the treating physicians, to an ethics consultant, or to an ethics committee are examined in more detail.

## References

1. Singer, P. *Victims of the Unvaccinated*; Project Syndicate: Prague, Czech, 2022. Available online: <https://www.project-syndicate.org/commentary/health-care-priority-for-vaccinated-covid19-patients-by-peter-singer-2022-01> (accessed on 27 July 2022).
2. World Health Organization. Emergency Situations Working Group—Transmissible diseases: Surveillance and action, WHO Americas Regional Office, WHO office in Haiti. In *Évaluation des Risques Pour la Santé Publique et Interventions*. Séisme: Haïti. 2010. Available online: <https://apps.who.int/iris/handle/10665/70222> (accessed on 8 August 2022).
3. Pan American Health Organization. Pan American Sanitary Bureau, Regional Office of the World Health Organization. In *Establishing a Mass Casualty Management System*; Pan American Health Organization: Washington, DC, USA, 1995. Available online: <https://www.eird.org/isdr-biblio/PDF/Establishing%20a%20mass%20casualty.pdf> (accessed on 8 August 2022).
4. Attentati Bruxelles: Luttwak, Bombardiamo Molenbeek, Risparmiamo Denaro. Gino Strada Utile Idiota. *Il Fatto Quotidiano* 25 March 2016. Available online: <https://www.ilfattoquotidiano.it/2016/03/25/attentati-bruxelles-luttwak-bombardiamo-molenbeek-risparmiamo-denaro-gino-strada-utile-idiota/499402/> (accessed on 27 July 2022).
5. Strada, G. *Pappagalli Verdi. Cronache di un Chirurgo di Guerra*; Feltrinelli: Milan, Italy, 2011.
6. Semplici, S. Ethics in Emergency Times: The Case of COVID-19. *Philosophies* **2022**, *7*, 70. [CrossRef]
7. Dworkin, R. What is equality? Part 2: Equality of resources. *Philos. Public Aff.* **1981**, *10*, 283–345.
8. Cohen, G.A. Luck and equality. A reply to Hurley. *Philos. Phenomenol. Res.* **2006**, *72*, 439–446. [CrossRef]
9. Ashcroft, R. The Psychology of Repugnance and the Duty to Trust. *Am. J. Bioeth.* **2009**, *9*, 51–52. [CrossRef] [PubMed]
10. Agamben, G. *State of Exception*; University of Chicago Press: Chicago, IL, USA, 2005.
11. Schmitt, C. *Political Theology: Four Chapters on the Concept of Sovereignty*; MIT Press: Cambridge, MA, USA, 1986.
12. Davis, M. Terrorists are Just Patients. *Am. J. Bioeth.* **2009**, *9*, 56–57. [CrossRef] [PubMed]
13. Brassington, I. Separating the "Rights Of" and "Justice For" Bombers. *Am. J. Bioeth.* **2009**, *9*, 59–61. [CrossRef] [PubMed]
14. Beecher, H.K. Scarce Resources and Medical Advancement. *Daedalus* **1969**, *98*, 275–313. [PubMed]
15. Underwood, M.J.; Bailey, J.S. Coronary bypass surgery should not be offered to smokers. *Br. Med. J.* **1993**, *306*, 1047–1049. [CrossRef] [PubMed]
16. Moss, A.H.; Siegler, M. Should alcoholics compete equally for liver transplantation? *JAMA* **1991**, *265*, 1295–1298. [CrossRef] [PubMed]
17. Sharkey, K.; Gillam, L. Should patients with self-inflicted illness receive lower priority in access to healthcare resources? Mapping out the debate. *J. Med. Ethics* **2010**, *36*, 661–665. [CrossRef] [PubMed]
18. Delumeau, J. *La Peur en Occident*; Fayard: Paris, France, 1978.
19. Delumeau, J. *Le Péché Et La Peur. La Culpabilisation En Occident*; Fayard: Paris, France, 1983.
20. Sontag, S. *Illness as Metaphor*; Farrar, Straus & Giroux: New York, NY, USA, 1978.
21. Kanner, L. Autistic disturbances of affective contact. *Nerv. Child* **1943**, *2*, 217–250.
22. Kanner, L. Problems of nosology and psychodynamics of early infantile autism. *Am. J. Orthopsychiatr.* **1949**, *19*, 416–426. [CrossRef] [PubMed]
23. Spinsanti, S. Malato? Colpevole! *Janus* **2006**, *22*, 5.
24. Butler, S. *Erewhon, or, Over the Range*; Trübner & Co.: London, UK, 1872.
25. Clavien, C.; Hurst, S. The Underserving Sick? An Evaluation of Patients' Responsibility for Their Health Condition. *Camb. Q. Healthc. Ethics* **2020**, *29*, 175–191. [CrossRef] [PubMed]
26. Hosseinpoor, A.R.; Stewart Williams, J.A.; Itani, L.; Chatterji, S. Socioeconomic inequality in domains of health: Results from the World Health Surveys. *BMC Public Health* **2012**, *12*, 198. [CrossRef] [PubMed]

27. Mulder, L.B.; Rupp, D.E.; Dijkstra, A. Making snacking less sinful: (counter-) moralising obesity in the public discourse differentially affects food choices of individuals with high and low perceived body mass. *Psychol. Health* **2015**, *30*, 233–251. [[CrossRef](#)] [[PubMed](#)]
28. Rawls, J. *A Theory of Justice*; Belknap: Cambridge, MA, USA, 1999.
29. Turolfo, F. On Moral Nose. In *Cambridge Quarterly of Healthcare Ethics*; Cambridge University Press: Cambridge, UK, *in press*.
30. Aristotle. Rhetoric. In *Aristotle, The Complete Works*; Barnes, J., Ed.; Princeton University Press: Princeton, NJ, USA, 1984.
31. Harris, J. *The Value of Life*; Routledge: London, UK, 1985.
32. Ricoeur, P. *The Just*; The University of Chicago Press: Chicago, IL, USA, 2000.
33. Battisti, D.; Picozzi, M. Deciding the Criteria Is Not Enough: Moral Issues to Consider for a Fair Allocation of Scarce ICU Resources. *Philosophies* **2002**, *7*, 92. [[CrossRef](#)]
34. Hansson, S.O. The ethics of making patients responsible. *Camb. Q. Healthc. Ethics* **2018**, *27*, 87–92. [[CrossRef](#)] [[PubMed](#)]
35. Aristotle. *Nicomachean Ethics*; Hackett: Indianapolis, IN, USA, 2019.