The Quandaries of the Principle of Triage

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Introduction

Triage (from the French, trier to sort out, to orientate) means that in certain circumstances a doctor is obliged to determine who will be treated or not and/or what type of treatment will be offered or denied. ***(SA Fam Pract 2005;47(2): 47-49)***

Discussion

Much of the credit for modern day triage has been attributed to Baron Dominique Jean Larrey, a French surgeon in Napoleon's army who devised a method to quickly evaluate and categorise the wounded in battle; soldiers were sorted according to who was able to return to battle, and who were not. Larrey instituted these practises while battles were in progress and patients were triaged with no rank distinction. Implicit in his idea of triage was the determination of which patients would receive the benefit of limited medical resources, as only those requiring the most urgent medical attention were evacuated.[1]

In contemporary times, the concept has evolved to include non-military doctors triaging patients in disasters and other situations associated with limited medical resources. Casualty departments now use triage to prioritise the need for urgent emergency care.

Generally, we could define the current use of the term 'triage' to refer to a system used by medical personnel to ration limited medical resources when the number of injured needing care exceeds the resources available to perform care. The overall objective of triage is to treat successfully the greatest number of patients possible.

Triage

As it happens in most conflict situations, there is no easy, simple, straightforward, or unambiguous recipe. Furthermore, in emergencies the practice of triage requires a quick but fair and impartial decision-making process. Notably, and perhaps arguably, contemporary use of the term has come to include "triage" processes involved in matters such as renal dialysis and organ transplant. We will focus on emergency situations, in which doctors are obliged to determine that some severely injured individuals should not receive care because they are unlikely to survive. The available care is then directed to those with some hope of survival. This clearly has ethical implications because treatment is intentionally withheld from some people with a small chance of survival so that others with a better chance are more likely to survive. When swearing the Hippocratic Oath, the physician substantially renounces the explicit choice of saving certain lives rather than others.[2] The principle of triage, however, requires a choice to be made.

At first glance, the implementation of the principle of triage flies in the face of the so cherished principle most physicians hold to: to put the individual well-being his or her patient(s) first. However, this, in turn, may conflict with the social obligations that underpin the practice of medicine. The absolute or relative scarcity of resources and distributive justice are the two imperatives that necessitate the practice of triage. In order for it to be justified, triage must be efficient and impartial.[3] What is required is a body of rational guidelines for making a choice.

Justice as fairness

Morality requires that the allocation of scarce resources should not be made on grounds of partiality and biases. Triage is a matter of distributive justice. It is worth mentioning that Aristotle's concept of justice still prevails: justice means fair and proportionate treatment. Equals should be treated equally and unequals unequally in proportion to the relevant inequalities. Justice demands equal consideration, fairness, and impartiality. Triage asks what are the relevant inequalities that justify giving more to some and less to others. Triage must find out how scarce resources can best be allocated to maximise the number of lives saved or health / well-being restored. As pointed out by Beauchamp and Childress, "the traditional and contemporary rationale for triage is the utilitarian maxim do the greatest good for the greatest number".[4]

Decision-making processes

What are the possible choices guiding decision-making with triage? Four are usually listed: 1) "first come first served"; 2) lottery or randomisation; 3) if not all, then no one; and 4) the principle of social utility and desert.

The difficulty with most of the above is to justify the choice of the option. Amongst them, we note that the social utility criterion has received most attention from bioethicists.[2,5]

Let us now turn to some of the pertinent points present in possible triage decision-making options.

- The slogan ***first come first served*** can, arguably, not even be considered a moral principle. It may well apply when queuing at the taxi rank or the post office, but even there it would be at least morally considerate to give priority to an elderly, a handicapped, or a pregnant woman. Nonetheless, the advocates of the principle maintain that it safeguards the rights of individuals. Rights, however, are not the last words and often lead to an impasse when they collide. The counterargument is that this principle

not only turns away otherwise eligible people but also fails to consider the consequences. For instance, if the first in line at the casualty department suffers from an ingrown toenail it would be inconsiderate and morally repulsive to claim priority over a patient with an MI who was brought in after.

- ***Lottery or randomisation*** is an egalitarian approach that claims that it gives everyone a chance. It also claims that for example, by tossing a coin, the Kantian concept of respect for persons is vindicated (as opposed to the social worth theory that implies that some people are worth more than are others). Utilitarians would agree with tossing a coin if the benefits are equal. However, as mentioned earlier, individual needs may not be equal. Hence, by applying the principle of lottery the consideration of the benefit of the allocation is entirely eschewed. Moreover, random selection makes it possible to give an unfair advantage to under serving people. However, that, the advocates will argue, is the price to pay for egalitarianism and impartiality. The weakness of the lottery is that it does not consider the two basic tenets of triage: efficiency and fairness. The lack of efficiency of lottery is exemplified by the fact that it could result in prolonging lives of extremely poor quality at the expense of much longer lives of much higher quality.
- "***If not all, then no one***" means that if not all can benefit no one should. This is simply a negation of the principle of triage.
- ***Social utility or worth*** is a utilitarian principle that refers to services to be rendered to maximise their consequences in terms of the greatest utility / happiness to society. In the context of triage, it is closely associated with the principle of justice that calls for recognition of services that have been rendered. Moral considerations demand recognition of these two principles.

The concept of social worth involves a medical facet (the identification of candidates with best chances of good results) and an ethical facet (the identification of candidates with the highest social worth). Some critics argue that social worth is generally so difficult to judge (not to mention that the concept implies that some people are worth more than are others) that only medical criteria should be applied. Therefore, the allocation should be based on who will benefit the most on medical grounds.[5] Beauchamp and Childress argue, "judgements of comparative social value should be limited to *specific* qualities and skills that are essential to the community's protection. They should not attempt to assess the *general* social worth of persons".[4]

Reischer[2] has proposed the following criteria for selection in triage. It must be noted, however, that it is contextualised addressing the issue of renal dialysis, which gives medical personnel ample time to deliberate on the candidates' suitability. In case of emergency, this may well not be feasible. Nonetheless, his proposed criteria concern judgements made on biomedical, familial, and social factors. The biomedical factors are: the relative-likelihood-of-success (i.e. is the condition potentially reversible by the treatment, or is there a reasonable chance that the treatment will be successful), and the life-expectancy factor. The familial factor refers to the family-role; for instance, the mother of minor children should take priority over a middle-aged bachelor. The social factors include the potential-future-contributions factor and the past-service-rendered factor. The former considers age, talent, training, and past

record of performances; it is a matter of prospective return of an investment. The latter is the recognition and reward of services rendered.

In triage situations, Alexander points out a major objection in the determining of social worth as such decisions are often made under the name of a "God committee".[6] What she refers to is that committees empowered with triage decision-making play a godlike role in deciding who lives and who dies. This fuelled the debate about the social worth standard and the implication that some candidates are more valuable than are others. In addition, it raises the controversy over the question of who should be given a role in the selection. According to Rescher, the identification of medically suitable candidates rests in the hands of doctors. Once all the medical questions have been faced, "there is good reason why laymen should also be involved…as representatives of social interests Strictly social issues of justice and utility …where laymen can and should play a substantial role." [2] Another difficulty involved in the described selection system is the rating of criteria. For instance, if the relative likelihood of success is given weight, should the chances be high, good, or average? If life expectancy is considered, how many years should be acceptable and what are the chances of living the desired number of years? Are the patient's past services to the community excellent, good, or average? What is the probability that, given the treatment is successful, the future services rendered will be as good, better, or worse?[2]

Conclusion

In the end, we should perhaps return to the original intent and application of the term 'triage'. Recall that it was used impartially in emergency conditions in which only scarce medical resources were available and grounded upon a *medical determination of successful outcome* (Minor - walking wounded; Delayed - non-life threatening injury; Immediate - life-threatening injury; Deceased- pulseless, non-breathing). Triage then, in its original context focused on the fact of an *emergency*. In such situations, the option and debate (while not negating the idea of social worth), practically limits it. Ethically, then because of the inherent problems in discovering an acceptable way to give consistent moral priority for the allocation of scarce resources, the best we can hope for remains as Gillon identifies: To remain respectful of the four principles: autonomy, beneficence, and non-maleficence and incorporate Aristotle's formal principle of justice with its demands of formal equality, impartiality, and fairness.[7] Less should not be acceptable. In situations of triage, more may not be possible.

References

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