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Utilitarian Triage in Disasters

Alyssa Nielsen

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Alyssa Nielsen*

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Flatten the curve. Part of the vernacular during the COVID-19 pandemic, this phrase encapsulates slowing the spread of COVID – 19 through preventative measures, such as stay-at-home orders, social distancing, and face masks.¹ Flattening the curve is necessary to prevent the overwhelming of medical staff, facilities,

* J. Reuben Clark Law School, J.D. Candidate 2021. Brigham Young University, B.A. 2017. I would like to thank Professor Lisa Grow Sun for her invaluable feedback during the drafting. I want to also thank the team of BYU Law Review editors who helped shape this Note. Because this paper discusses the COVID-19 pandemic while it is ongoing, I want to make clear that I finalized this Note on October 26, 2020. Any COVID-19 triage developments that happened after that date will not be accounted for in this Note.

1. *Covid-19 Is Now in 50 Countries, and Things Will Get Worse*, ECONOMIST (Feb. 29, 2020), <https://www.economist.com/briefing/2020/02/29/covid-19-is-now-in-50-countries-and-things-will-get-worse> [hereinafter *Things Will Get Worse*, ECONOMIST].

and resources.² If COVID-19 overwhelms emergency departments, medical professionals will have to make difficult triage decisions about whom to admit, whom to treat, and whom to surrender; and more people will die.³

In early March 2020, reports out of Lombardy, Italy, said that because hospitals were so overwhelmed there, doctors were already at the point of deciding to forego treating older patients in favor of treating younger patients more likely to survive.⁴ Some Italian officials and doctors disputed such reports,⁵ but the Italian College of Anesthesia, Analgesia, Resuscitation and Intensive Care (SIAARTI) quickly issued triage guidelines to prioritize treatment of younger patients for hospitals at capacity.⁶ Italy became a “grim glimpse of what awaits countries if they cannot slow the spread,”

2. *Id.*; Eliza Barclay & Dylan Scott, *How Canceled Events and Self-Quarantines Save Lives, in One Chart*, VOX (Mar. 10, 2020, 9:50 AM), <https://www.vox.com/2020/3/10/21171481/coronavirus-us-cases-quarantine-cancellation>; Harry Stevens, *Why Outbreaks Like Coronavirus Spread Exponentially, and How to “Flatten the Curve,”* WASH. POST (Mar. 14, 2020), <https://www.washingtonpost.com/graphics/2020/world/corona-simulator/> (simulating the effects of different social distancing and quarantine strategies).

3. Jason Horowitz, *Italy’s Health Care System Groans Under Coronavirus – A Warning to the World*, N.Y. TIMES (Mar. 17, 2020), <https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html>. Limited testing capacity forced choices about whom to test. See Roni Caryn Rabin & Katie Thomas, *Coronavirus Testing Offered with Just a Doctor’s Approval, C.D.C. Says*, N.Y. TIMES (Mar. 5, 2020), <https://www.nytimes.com/2020/03/04/health/coronavirus-test-demand.html> (“Under the new criteria, patients who have fevers, coughs or difficulty breathing qualify for diagnostic testing, depending on their doctor’s judgment. But with flu season in full swing, tens of millions of Americans already have respiratory symptoms, and doctors have no quick way to discern who should be tested.”); Abby Goodnough & Sheila Kaplan, *C.D.C.’s Dr. Robert Redfield Confronts Coronavirus, and Anger*, N.Y. TIMES (Mar. 14, 2020), <https://www.nytimes.com/2020/03/13/health/robert-redfield-cdc-coronavirus.html> (“[T]he C.D.C. initially set very narrow criteria for deciding who should be tested for the virus—only those who had a fever and breathing issues and had traveled from the outbreak’s origin in Wuhan, China—which most likely impeded early efforts to contain it. Many jurisdictions are still using restrictive criteria, largely because they are so low on test kits.”).

4. See, e.g., Horowitz, *supra* note 3; Yascha Mounk, *The Extraordinary Decisions Facing Italian Doctors*, ATLANTIC (Mar. 11, 2020), <https://www.theatlantic.com/ideas/archive/2020/03/who-gets-hospital-bed/607807/>; Nicole Winfield, *‘Not a Wave, a Tsunami,’ Italy Hospitals at Virus Limit*, PBS NEWS HOUR (Mar. 13, 2020, 4:45 PM), <https://www.pbs.org/newshour/health/not-a-wave-a-tsunami-italy-hospitals-at-virus-limit>.

5. Horowitz, *supra* note 3; Winfield, *supra* note 4.

6. *Raccamdazioni di Etica Clinica per L’Ammissione a Trattamenti Intensivi e per la Loro Sosphensione, in Condizioni Eccezionali di Squilibrio tra Tecessità e Risorse Disponibili*, SIAARTI, (Mar. 6, 2020) [hereinafter SIAARTI], <http://www.siaarti.it/SiteAssets/News/COVID19%20-%20documenti%20SIAARTI/SIAARTI%20-%20Covid19%20-%20Raccomandazioni%20di%20etica%20clinica.pdf>.

showing that “even hospitals in developed countries with the world’s best health care risk becoming triage wards, forcing ordinary doctors and nurses to make extraordinary decisions about who may live and who may die.”⁷

Triage is the process of assigning patients a priority level for treatment.⁸ Ordinarily, hospitals and healthcare professionals triage patients to prioritize treating those with more serious injuries or illnesses.⁹ However, when disasters overwhelm hospitals and healthcare resources, emergency circumstances pressure hospitals to adopt a more “utilitarian” triage system, prioritizing those who are most likely to survive and abandoning those who are less likely to survive.¹⁰ Other factors may also affect the prioritization—such as the patient’s age and quality of life, and the decisionmakers’ prejudices and biases.

A legal framework is necessary in order to outline when, if ever, utilitarian triage decisions may be made and how. Currently, few states have laws addressing disaster triage, leaving healthcare workers and patients in limbo about what will happen should resources be overwhelmed and what remedies are available if healthcare workers deny or suspend a patient’s critical care during an emergency. I argue that, in cases where utilitarian triage is necessary, medical professionals and hospitals must have legal immunity insofar as they triage their patients according to protocols formally adopted by state legislators and that such protocols should omit all factors other than the patients’ present medical statuses.

Part I of this Note explains standard triage and utilitarian triage—their origins and justifications. Part II then examines how utilitarian triage has been and could be implemented during disasters. Part III recommends that states adopt laws regulating the triage process, including immunity for medical professionals from lawsuits regarding their triage decisions.

7. Horowitz, *supra* note 3.

8. Kenneth V. Iserson & John C. Moskop, *Triage in Medicine, Part I: Concept, History, and Types*, 49 ANNALS EMERGENCY MED. 275, 275 (2007) [hereinafter Iserson & Moskop, *Part I*].

9. *Id.* at 278 (“ED [emergency department] triage systems are typically designed to identify the most urgent (or potentially most serious) cases to ensure that they receive priority treatment, followed by the less urgent cases on a first-come, first-served basis.”).

10. *See, e.g., supra* note 6 and accompanying text.

I. THE TWO STRATEGIES OF TRIAGE

There are two primary options for triage: prioritize treatment of the patients at the greatest health risk or prioritize treatment of the patients at the lowest health risk.¹¹ This Note focuses on the pressure in disasters to switch from triage prioritizing those with the most severe illnesses or injuries to prioritizing those with less severe conditions. To begin, it is first helpful to understand the origins of triage and the underlying justifications for utilitarian triage.

A. History of Triage

The concept of “triage” is often traced back to Napoleon Bonaparte’s French Army.¹² The chief surgeon of Napoleon’s Imperial Guard, Dominique Jean Larrey, created a system “to treat and evacuate those requiring the most urgent medical attention.”¹³ He wrote later about his triage theory:

Those who are dangerously wounded should receive the first attention, without regard to rank or distinction. They who are injured in a less degree may wait until their brethren in arms, who are badly mutilated, have been operated on and dressed, otherwise the latter would not survive many hours; rarely until, the succeeding day.¹⁴

In the mid-1800s, John Wilson, a British naval surgeon, argued that efficiency required that “surgeons . . . focus on those patients who need immediate treatment and for whom treatment is likely to

11. This is of course a simplified reduction of complex systems, algorithms, and choices that make up triage. In other contexts, *triage* does not refer to prioritization at all but rather to labeling patients based on severity. See, e.g., *Triage and the Art of Mass Casualty Sorting*, UNIV. OF MD. SCH. OF MED.: DEP’T OF EMERGENCY MED., <https://em.umaryland.edu/page/ems/triage> (last visited Sept. 26, 2020) (explaining that the SALT (Sort-Assess-Lifesaving Interventions-Treatment and/or Transport) system, commonly used by emergency departments in the United States, is a “non-proprietary triage system [developed] in 2008 to allow national standardization of initial triage in all-hazards mass casualty incidents.”).

12. Iserson & Moskop, *Part I*, *supra* note 8, at 277; Katharyn Kennedy, Richard V. Aghababian, Lucille Gans & C. Phuli Lewis, *Triage: Techniques and Applications in Decisionmaking*, 28 ANNALS EMERGENCY MED. 136, 137 (1996); Iain Robertson-Steel, *Evolution of Triage Systems*, 23 EMERGENCY MED. J. 154, 154 (2006).

13. Iserson & Moskop, *Part I*, *supra* note 8, at 277.

14. D.J. LARREY, MEMOIRS OF MILITARY SURGERY, AND CAMPAIGNS OF THE FRENCH ARMIES VOL. 2, 123 (Richard Willmott Hall trans., 1814).

be successful.”¹⁵ Those with less severe conditions and those whose conditions were so severe that they were likely unsavable had to wait.¹⁶

During the military conflicts of the 19th and 20th centuries, triage systems continued to develop on the battlefield.¹⁷ World War I introduced a new triage theory—one more utilitarian than Larrey’s or Wilson’s.¹⁸ Dr. William W. Keen, a major in the U.S. Army Medical Reserves Corps, was commissioned to write a report about how the war was different with respect to military casualties.¹⁹ He observed that this war was different in part because of the size of the armies (more soldiers means more wounded), the newly developed weapons, and the “[r]ampant infection of wounds.”²⁰ These factors “cause[d] sudden flooding of the hospitals.”²¹ He explained that “a hospital with 300 or 400 beds may suddenly be overwhelmed by 1000 or more cases.”²² This gap pressured a switch from Larrey’s triage (prioritize the most critical) and Wilson’s triage (prioritize the most critical so long as they are savable) to a utilitarian triage system. Keen wrote:

It is often . . . physically impossible to give speedy and thorough treatment to all. A single case, even if it urgently requires attention, — if this will absorb a long time, — may have to wait, for in that same time a dozen others, almost equally exigent, but requiring less time, might be cared for. *The greatest good of the greatest number must be the rule.*²³

In World War II, medical professionals used triage systems similar to Wilson’s and Keen’s in different contexts. For instance, nurses commonly divided patients into the following categories: “(a) those with wounds so minor they do not need immediate attention; (b) those who are critical and can receive significant benefit from immediate attention; and (c) those beyond hope, for

15. Iserson & Moskop, *Part I*, *supra* note 8, at 277.

16. *Id.*

17. Robertson-Steel, *supra* note 12.

18. Iserson & Moskop, *Part I*, *supra* note 8, at 277.

19. W. W. KEEN, *THE TREATMENT OF WAR WOUNDS* 11 (1917).

20. *Id.* at 12.

21. *Id.* at 13.

22. *Id.*

23. *Id.* (emphasis added).

whom resources should not be wasted.”²⁴ This method was akin to Wilson’s. However, in 1943, military physicians used limited penicillin doses “to treat and return to duty soldiers with gonorrhea rather than soldiers with infected war wounds.”²⁵ This method was more akin to Keen’s utilitarian approach.

As triage systems developed during the 19th and 20th century wars, they also began appearing in Western civilian emergency departments.²⁶ These systems were adapted from those in military contexts, bringing over their methods and justifications.²⁷

B. Ethics of Utilitarian Triage

Utilitarian triage ethics seem, at least on their face, quite simple: maximize the number of lives saved by foregoing one patient who will need more resources or is less likely to survive and treating instead the patient or patients who need fewer resources or are more likely to survive. A triage officer under this model would categorize patients as (1) “immediate,” (2) “delayed,” (3) “minimal,” or (4) “expectant,” or in some other similar fashion.²⁸ Under most circumstances, treatment would go first to the “immediate” patients—those who face an urgent threat but who have a reasonable chance of recovery.²⁹ However, “minimal” patients may be prioritized if after their treatment they would be able to help address the threat at hand.³⁰ For instance, prioritizing treatment of an injured healthcare professional triaged as “minimal” may be beneficial because, following treatment, the healthcare professional could help others.³¹ Of all the utilitarian

24. Robert M. Veatch, *Disaster Preparedness and Triage: Justice and the Common Good*, 72 MOUNT SINAI J. MED. 236, 236 (2005). During the Pearl Harbor attack, nurses marked wounded soldiers with lipstick to help quickly identify the triage order. Katie Lange, *The Pearl Harbor Attack, as Remembered by the Nurses Who Were There*, U.S. ARMY (Dec. 2, 2016), https://www.army.mil/article/179038/the_pearl_harbor_attack_as_remembered_by_the_nurses_who_were_there.

25. Iserson & Moskop, *Part I*, *supra* note 8, at 277 (footnote omitted).

26. Robertson-Steel, *supra* note 12. The history of triage outside the modern Western civilization is less known. Iserson & Moskop, *Part I*, *supra* note 8, at 278.

27. Iserson & Moskop, *Part I*, *supra* note 8.

28. See Thomas B. Repine, *The Dynamics and Ethics of Triage: Rationing Care in Hard Times*, 170 MIL. MED. 505, 506 (2005).

29. *Id.*

30. *Id.* (using a military scenario to demonstrate this).

31. John C. Moskop & Kenneth V. Iserson, *Triage in Medicine, Part II: Underlying Values and Principles*, 49 ANNALS EMERGENCY MED. 282, 284 (2007) [hereinafter Moskop & Iserson,

triage categories, “expectant” is the most dreaded. The “expectant” category includes those patients whose care would take resources and time away from a greater number of patients.³² “These patients have minimal chances for any meaningful survival without heroic efforts, and sometimes despite heroic efforts.”³³ When there are enough resources, this “expectant” category is not used.³⁴ Instead, all resources and “heroic measures” are deployed to help the patient.³⁵

Professor Steve Calandrillo has argued that utilitarianism through cost-benefit analysis should be applied in health policies more broadly.³⁶ Not writing about triage specifically, he opined that “given the reality of limited public resources, America must efficiently reformulate its . . . health regulatory policies in order to save and improve the most lives possible given the accompanying costs.”³⁷ He believes that “fear of the repercussions experienced by those who voice such opinions”³⁸ prevents us from achieving “our ultimate goal[—]the betterment of society and the maximization of scarce resources.”³⁹

Professor Cass R. Sunstein has argued that when allocating scarce resources, we ought to preserve “decently-livable life-years” rather than lives alone.⁴⁰ In the military context, this approach is less relevant since the range of ages is much smaller than in the civilian context, so it is unsurprising that Keen’s utilitarian approach did not account for age even though prioritizing number of “decently-livable life-years” is arguably more utilitarian than prioritizing number of lives.

Part II] (“[I]t has been proposed that, during pandemics or weapons of mass destruction events, emergency health care and public service workers receive priority for treatment, since they will, when they have recovered sufficiently, act as ‘multipliers’ of beneficial effects for future patients.” (footnote omitted)).

32. *Id.*

33. Repine, *supra* note 28.

34. Kennedy et al., *supra* note 12, at 140.

35. *Id.*

36. Steve P. Calandrillo, *Responsible Regulation: A Sensible Cost-Benefit, Risk Versus Risk Approach to Federal Health and Safety Regulation*, 81 B.U. L. REV. 957, 961 (2001).

37. *Id.*

38. *Id.*

39. *Id.* at 969.

40. Cass R. Sunstein, *Which Risks First?*, 1997 U. CHI. LEGAL F. 101, 113 (1997).

Under a life-years utilitarian triage model, it would make sense to prioritize a COVID-19 patient who was 55 years old over one who was 85 years old. Reports suggest physicians in Lombardy, Italy, used this practice.⁴¹ The SIAARTI guidelines explain that emergency departments may need to use age limits, arguing that the most people benefit when patients with the highest chance of living and with the most life years left are prioritized.⁴²

And yet these utilitarian principles do not apply under ordinary circumstances when there are enough resources⁴³ nor did they apply when triage originated on the battlefield.⁴⁴ Why then should they ever apply?⁴⁵

In his oft-cited article, *Should the Numbers Count?*, philosopher John Taurek argued that it is no better to sacrifice one life to save five others than to save the single life and sacrifice the five others.⁴⁶ If this were about saving equally valuable objects, he would agree that saving five is better than saving one, but he argues saving objects is not analogous to saving humans:

But when I am moved to rescue human beings from harm in situations of the kind described, I cannot bring myself to think of them in just this way. I empathize with them. . . .

. . . For each of these six persons it is no doubt a terrible thing to die. Each faces the loss of something among the things he values most. His loss means something to me only, or chiefly, because of what it means to him. It is the loss to the individual that matters to me, not the loss of the individual.⁴⁷

In discussing the morality of utilitarian triage models, Dr. Nora K. Bell agreed with Taurek that it is not necessarily moral to “save the greater number of lives.”⁴⁸ However, she argues that

41. Mounk, *supra* note 4 and accompanying text.

42. SIAARTI, *supra* note 6.

43. Iserson & Moskop, *Part I*, *supra* note 8, at 278.

44. LARREY, *supra* note 14.

45. Moskop & Iserson, *Part II*, *supra* note 31, at 285 (“If this practice is justifiable on the basis of greater net benefit, one might ask, would it not also be justifiable to remove multiple organs from an otherwise healthy person, thereby causing that person’s death, in order to save the lives of multiple patients in need of organ transplants?”).

46. John M. Taurek, *Should the Numbers Count?*, 6 PHIL. & PUB. AFF. 293, 294 (1977).

47. *Id.* at 306–07. *But see generally* Frances Myrna Kamm, *Equal Treatment and Equal Chances*, 14 PHIL. & PUB. AFF. 177 (1985) (responding to and disagreeing with Taurek).

48. Nora K. Bell, *Triage in Medical Practices: An Unacceptable Model?*, 15 SOC. SCI. & MED. 151, 154 (1981).

utilitarian triage is acceptable, even if not morally required, so long as factors other than salvageability of life are excluded.⁴⁹

But it is not always easy to separate salvageability from suspect factors such as race, gender, and class. For instance, in the 1980s, doctors discovered that the worse the histocompatibility antigens (HLA antigens) match, the more likely the kidney transplant rejection.⁵⁰ Thus it made sense initially to allocate kidneys based on HLA match; however, “HLA antigens are racially correlated, and the organ donor pool matched one race better than others.”⁵¹ Other factors including age, socioeconomic group, and gender also predicted the likelihood of success or rejection.⁵² Under utilitarianism, “[w]e would give kidneys preferentially to young, white middle-class males.”⁵³ Because of the gross discrimination, the allocation formula was eventually changed.⁵⁴

Moreover, it is impossible to assess the true utility of a triage decision before making it. Triage can *try* to maximize lives or life-years, but how well that goal was accomplished is unclear even with hindsight.⁵⁵ In disaster situations, this may be even truer “since these circumstances may be unfamiliar, chaotic, rapidly changing, and resistant to information gathering.”⁵⁶ The premise of triage is to quickly sort patients without a comprehensive assessment, and those sorting methods are not fully accurate.⁵⁷ “[T]riage methods have been found to be only 80% accurate in determining a patient’s needs,”⁵⁸ let alone whether a patient would ultimately survive if treated.

In disaster situations, scarce resources may necessitate these triage choices. Not everyone can be treated in these extreme situations, and though utilitarian triage is morally precarious, it is a necessary evil to save more lives. The medical professionals

49. *Id.* at 155.

50. Veatch, *supra* note 24, at 239.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.* at 240.

55. Moskop & Iserson, *Part II*, *supra* note 31, at 284 (critiquing utilitarian triage on the ground “that it is often very difficult to predict the consequences of one’s actions accurately”).

56. *Id.*

57. Kennedy et al., *supra* note 12, at 138.

58. *Id.*

forced to make those choices did not cause the disaster, and they should not be faulted for doing what they can to save as many lives as they can. That said, giving broad discretion and immunity to medical professionals to triage however they see fit in a given situation may lead to additional evils. Thus, clear triage rules can mitigate the evils of utilitarian triage while providing legal protection to those who are forced to triage patients.

II. UTILITARIAN TRIAGE IN DISASTERS

Utilitarian triage is a last resort; as such, medical professionals should try to maintain an ordinary triage system until a switch to utilitarian triage is absolutely necessary.⁵⁹ To do so, emergency planners can implement preventative measures, such as storing more medical resources, adding more hospital beds, training more medical professionals, and refining hospital evacuation procedures. Nevertheless, while we should do what we can to prevent having to switch to utilitarian triage, we cannot afford to ignore its possibility. To help demonstrate what triggers utilitarian triage and its consequences, this Part discusses how utilitarian triage was used during Hurricane Katrina, the development of disaster triage guidelines, and the ongoing COVID-19 pandemic.

A. Hurricane Katrina and Memorial Hospital

During Hurricane Katrina, Memorial Hospital in New Orleans switched to utilitarian triage after the hospital's generators stopped working.⁶⁰ Too few Coast Guard helicopters were available to evacuate all the patients, and the helipad was five flights of stairs away from the patients in critical need.⁶¹ The doctors and nurses triaged the patients into three categories.⁶² Category 1 would be evacuated first.⁶³ These were those in the best relative health.⁶⁴ Category 2—which included those who needed more help—

59. *Id.* at 140 (“It is usually advisable to adhere to the normal everyday routine as far as possible while accepting that some modifications will be necessary.”).

60. Sheri Fink, *The Deadly Choices at Memorial*, N.Y. TIMES MAG. (Aug. 25, 2009), <https://www.nytimes.com/2009/08/30/magazine/30doctors.html>.

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

was next.⁶⁵ Category 3 would be evacuated last, if ever, and it included those who were the most ill and who had “do not resuscitate” orders.⁶⁶ Forty-five people died in Memorial Hospital—“more than from any comparable-size hospital in the drowned city.”⁶⁷

Memorial Hospital’s Katrina legacy goes beyond its utilitarian triage decisions. Four of the deaths were ruled homicides.⁶⁸ Investigators believed that Memorial Hospital staff injected at least some of the Category 3 patients with lethal doses of drugs.⁶⁹ Dr. Ann Pou⁷⁰ was arrested for these homicides, but the grand jury did not indict her.⁷¹ After the charges were dropped, Dr. Pou admitted in a *Newsweek* article that she administered these injections with the intent to help ease patients’ pain.⁷² She explained: “The intention was to help the patients that were having pain and sedate the patients who were anxious. That was it. Reverse triage meant the sickest would be the last to be triaged. We didn’t know how much longer they would be there.”⁷³ She compared it to giving morphine to relieve the pain of a dying cancer patient: though the morphine may speed up the death, “usually disease and illness . . . is responsible for [the] patient’s death.”⁷⁴ Dr. John Thiele, who also injected Category 3 patients, told a reporter that by giving these drugs to these patients, he *did intend* for them to die, but while it went against “every fiber in [his] body,” he believed what he did was right.⁷⁵

The injections were not part of the actual triage, but they do illuminate the question that follows utilitarian triage: What, if anything, should medical professionals do for the patients who will

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

69. Though only four deaths were ruled homicides, “it appear[ed] that at least 17 patients were injected with morphine or the sedative midazolam, or both, after a long-awaited rescue effort was at last emptying the hospital.” *Id.*

70. Dr. Ann Pou was not the only staff member involved with the injections, but she was the only one arrested. *Id.*

71. *Id.*

72. Julie Scelfo, *Vindicated Katrina Doc Tells Her Story*, NEWSWEEK (Aug. 24, 2007), <https://www.newsweek.com/vindicated-katrina-doc-tells-her-story-99333>.

73. *Id.* (quoting Dr. Ann Pou).

74. *Id.* (quoting Dr. Ann Pou).

75. Fink, *supra* note 60.

likely die as a consequence of triage? This Note does not attempt to answer that question, but it is important to understand what choices will follow the switch to utilitarian triage.⁷⁶

Things escalated quickly at Memorial Hospital. On Sunday, the New Orleans mayor ordered mandatory evacuation in anticipation of Hurricane Katrina.⁷⁷ Monday morning the power went out.⁷⁸ Wednesday morning the generators failed.⁷⁹ And on Thursday, the Category 3 patients were injected.⁸⁰ To survive, patients would have needed to be evacuated by helicopter or for the generators or power to come back on.⁸¹ None of these scenarios seemed likely under the circumstances, and even if evacuation was possible, Category 3 patients' health statuses were such that they may not have survived an arduous evacuation.⁸² So to maximize life, Memorial Hospital's staff prioritized those who had the best chance at surviving through evacuation.

B. Development of Triage Guidelines for Disasters

After Hurricane Katrina and the arrest of Dr. Pou, New York health officials began to think about what its doctors should do if faced with triage decisions.⁸³ They used hypothetical influenza pandemic scenarios to work through triage problems.⁸⁴ In these pandemic simulations, the officials had to grapple with the state's short supply of ventilators.⁸⁵ Of course, the officials also recommended that New York purchase more ventilators (which it did) and develop ways to "stretch supply" such as canceling

76. After Hurricane Katrina, Louisiana adopted immunity laws for doctors who triaged patients during a disaster. The National Academy of Medicine has interpreted this law to not immunize doctors from liability for intentionally "hastening" death. INST. OF MED. OF THE NAT'L ACAD., CRISIS STANDARDS OF CARE: A SYSTEMS FRAMEWORK FOR CATASTROPHIC DISASTER RESPONSE, 1-78 (2012) ("[N]either the law nor ethics support the intentional hastening of death, even in a crisis.").

77. SHERI FINK, FIVE DAYS AT MEMORIAL 29 (2013).

78. Fink, *supra* note 60.

79. FINK, *supra* note 77, at 5.

80. Fink, *supra* note 60.

81. *Id.*

82. *Id.*

83. FINK, *supra* note 77, at 452.

84. *Id.* at 452-53.

85. *Id.* at 453.

elective surgeries if simulated scenarios were to really happen.⁸⁶ Even so, the officials knew then that these “two measures alone would not be nearly enough to meet demand in the most dire scenario.”⁸⁷ So they created “rationing plans.”⁸⁸

New York’s “Ventilator Allocation Guidelines” have since been updated, most recently in 2015.⁸⁹ The goal of the guidelines is utilitarian: “to save the most lives in an influenza pandemic where there are a limited number of available ventilators.”⁹⁰ Under the guidelines, “[p]atients with the highest likelihood of survival *without* medical intervention, along with patients with the smallest likelihood of survival *with* medical intervention, have the *lowest* level of access to ventilator therapy.”⁹¹ For adults, there are three steps to the triage process:⁹²

Step 1 – Exclusion Criteria: A patient is screened for exclusion criteria, and if s/he has a medical condition on the exclusion criteria list, the patient is not eligible for ventilator therapy. Instead, a patient receives alternative forms of medical intervention and/or palliative care. . . .

Step 2 – Mortality Risk Assessment Using SOFA (Sequential Organ Failure Assessment): A patient is assessed using SOFA, which may be used as a proxy for mortality risk. A triage officer/committee examines clinical data from Steps 1 and 2 and allocates ventilators according to a patient’s SOFA score. . . .

Step 3 – Time Trials: Periodic clinical assessments at 48 and 120 hours using SOFA are conducted on a patient who has begun ventilator therapy to evaluate whether s/he continues with the treatment. The decision whether a patient remains on a ventilator is based on his/her SOFA score and the magnitude of change in

86. *Id.*

87. *Id.*

88. *Id.*

89. N.Y. STATE TASK FORCE ON LIFE AND THE L. & N.Y. STATE DEP’T OF HEALTH, VENTILATOR ALLOCATION GUIDELINES (2015) [hereinafter VENTILATOR ALLOCATION GUIDELINES], https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf.

90. *Id.* at 12. While the COVID-19 pandemic is not an influenza pandemic, the ventilator guidelines would still apply.

91. *Id.* (emphasis in original).

92. The guidelines differ slightly for children, but the color code system as later described is the same. *See id.* at 82–156.

the SOFA score compared to the results from the previous official clinical assessment.

These steps are used to then color code the patients: blue, yellow, red, or green.⁹³ The blue patients are the “worst off” patients who, under a standard triage system, would be treated first, but under these utilitarian guidelines, will not receive ventilators and may lose their ventilators if they had them before being reassigned blue.⁹⁴ The yellow patients have intermediate priority because “their likelihood of survival is intermediate and/or uncertain.”⁹⁵ They too could lose their ventilators.⁹⁶ The red patients have top priority for ventilators “because they are most likely to recover with treatment.”⁹⁷ Triage officers may take a ventilator from a blue or a yellow patient and give it to an incoming red patient.⁹⁸ Green patients do not need ventilators and thus are mostly irrelevant to the difficult triage questions.⁹⁹

A patient is automatically blue if he or she has an exclusionary condition, meaning any medical condition “associated with immediate or near-immediate mortality even with aggressive therapy.”¹⁰⁰ The color code is reassessed as treatment proceeds.¹⁰¹

Triaging might be necessary even among the color codes. Not every red is guaranteed a ventilator. Who among the yellow patients gets a ventilator first? Who loses his or her ventilator first? After considering a variety of options, New York officials decided on a lottery system for eligible patients, with the exception that a child would get, or keep, a ventilator over an adult in the same category.¹⁰²

These guidelines do not take into consideration patients’ occupations, social or familial statuses, or ages (with the exception of the separate guidelines for children).¹⁰³ In theory, medical factors

93. *Id.* at 6.

94. *Id.* at 6–7.

95. *Id.* at 7.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.* at 14.

101. *Id.* at 59, 64, 66 (translating SOFA scores from step 2 and changes from step 3 into color codes).

102. *Id.* at 7.

103. *Id.* at 44–46.

are all that matter for assessment, though other factors may indirectly have weight in how they affect the medical factors.¹⁰⁴ The task force specifically contemplated prioritizing healthcare workers and first responders but ultimately did not do so in any iteration of the guidelines in part because it was too difficult to determine who is a healthcare worker.¹⁰⁵ Regarding status, the task force said that such triage criteria “are biased by personal values and raise concerns about biases and unfair discrimination.”¹⁰⁶ And “to exclude older adults discriminates against the elderly, especially where there is a greater likelihood that the advanced-aged patient will survive.”¹⁰⁷ Age may of course affect the person’s overall health, but New York’s approach rejects the idea of prioritizing “life-years” over lives.¹⁰⁸

Under the guidelines, a triage officer or committee should be insulated from knowing the patients they are triaging.¹⁰⁹ The New York task force that wrote the guidelines included doctors, lawyers, scholars, health administrators, and religious leaders.¹¹⁰ For a while, New York considered involving community members through focus groups, but those focus groups never happened.¹¹¹

A New York hospital came close to having to use these guidelines during Superstorm Sandy.¹¹² Flooding was predicted to wipe out the hospital’s backup generators, so if there was a power outage, nearly fifty ICU patients would be completely dependent on a single generator located in the building next door that was better protected from the flooding.¹¹³ That generator could support only six electrical outlets, and there were around fifty patients who relied on electric-powered equipment.¹¹⁴ Doctors, hospital ethicists, and nurses formed an ad hoc committee and came up with a

104. *Id.*; see *infra* notes 192–194 and accompanying text.

105. *Id.* at 44–45. The task force also reasoned that healthcare workers who were receiving treatment could not at the same time treat patients and that many other people faced significant health risks because of their non-health-related occupations.

106. *Id.* at 46.

107. *Id.* at 45.

108. *Id.*; cf. SIAARTI, *supra* note 6; Sunstein, *supra* note 40.

109. VENTILATOR ALLOCATION GUIDELINES, *supra* note 89, at 37–38.

110. *Id.* at i–ii.

111. FINK, *supra* note 77, at 464.

112. *Id.* at 462–63.

113. *Id.* at 452.

114. *Id.*

priority list based on the New York guidelines.¹¹⁵ Fortunately, the hospital was able to evacuate all of its patients just in time.¹¹⁶

New York's guidelines became a template for other states when federal agencies began conditioning disaster preparedness grants on having disaster triage guidelines.¹¹⁷ But the guidelines largely "have not been publicized, perhaps out of fears of how the public will react; even many medical professionals aren't aware that their states or hospitals have them in place."¹¹⁸ That is until the COVID-19 pandemic.

The COVID-19 pandemic has prompted states to review their disaster triage guidelines and adjust them to focus on COVID-19.¹¹⁹ This has brought new public attention to the guidelines.¹²⁰ Below is a small sample – not a comprehensive survey – of the guidelines:

115. *Id.* at 462.

116. See Rachel Z. Arndt, *Five Years After Superstorm Sandy, NYC Hospitals May Be as Ready as Houston's Were for Harvey*, MOD. HEALTHCARE (Sept. 9, 2017, 1:00 AM), <https://www.modernhealthcare.com/article/20170909/NEWS/170909889/five-years-after-superstorm-sandy-nyc-hospitals-may-be-as-ready-as-houston-s-were-for-harvey>.

117. FINK, *supra* note 77, at 457.

118. *Id.* at 464.

119. Mike Baker & Sheri Fink, *At the Top of the COVID-19 Curve, How Do Hospitals Decide Who Gets Treatment?*, N.Y. TIMES (Mar. 31, 2020), <https://www.nytimes.com/2020/03/31/us/coronavirus-covid-triage-rationing-ventilators.html>; Suzy Khimm, *Who Gets a Ventilator? Hospitals Facing Coronavirus Surge Are Preparing for Life-or-Death Decisions*, NBC NEWS (Mar. 19, 2020, 9:26 AM), <https://www.nbcnews.com/health/health-care/who-gets-ventilator-hospitals-facing-coronavirus-surge-are-preparing-life-n1162721>.

120. See, e.g., Baker & Fink, *supra* note 119; Khimm, *supra* note 119; Liz Essley Whyte, *State Policies May Send People with Disabilities to the Back of the Line for Ventilators*, CTR. FOR PUB. INTEGRITY (Apr. 8, 2020), <https://publicintegrity.org/health/coronavirus-and-inequality/state-policies-may-send-people-with-disabilities-to-the-back-of-the-line-for-ventilators/>; Andrea Gallo, *In Doomsday Coronavirus Scenario, Louisiana Hospitals Would Prioritize Patients. See How It'd Work.*, NOLA.COM (Apr. 24, 2020, 12:56 PM), https://www.nola.com/news/coronavirus/article_08230ed8-84a0-11ea-b04e-ff04bf5a5fd4.html.

States commonly have exclusionary criteria.¹²¹ Often these include terminal cancers and organ failures.¹²² Minnesota's list of exclusionary criteria also includes severe chronic lung disease and cirrhosis.¹²³ Louisiana's and Utah's lists include severe dementia and advanced neuromuscular diseases, such as multiple sclerosis and Lou Gehrig's disease.¹²⁴

By contrast, Pennsylvania rejects using the term "exclusion criteria" altogether because it "may be interpreted by the public that some groups are 'not worth saving.'"¹²⁵

In Arizona, age is technically excluded from the analysis; however, the likelihood that the patient would die within one to five years is weighted.¹²⁶

121. E.g., KAN. DEP'T OF HEALTH & ENV'T, *Guidelines for the Use of Modified Health Care Protocols in Acute Care Hospitals During Public Health Emergencies*, in TOOLKIT FOR COVID-19 (2020), <https://int.nyt.com/data/documenthelper/6847-kansas-triage-guidelines/02cb4c58460e57ea9f05/optimized/full.pdf#page=1> (Kansas's guidelines); LA. DEP'T OF HEALTH, STATE HOSP. CRISIS STANDARD OF CARE GUIDELINES IN DISASTERS 35 (Feb. 2018), <https://int.nyt.com/data/documenthelper/6856-louisiana-triage-guidelines/d95555bb486d68f7007c/optimized/full.pdf#page=1> (Louisiana's guidelines); MINN. DEP'T OF HEALTH, PATIENT CARE STRATEGIES FOR SCARCE RESOURCE SITUATIONS 6-2 (May 2020), <https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf> (Minnesota's guidelines); Phoebe Wall Howard, *Henry Ford Health Officials Confirm Letter Outlining Life and Death Protocols for COVID-19*, DETROIT FREE PRESS (Mar. 27, 2020), <https://www.freep.com/story/money/business/michigan/2020/03/27/coronavirus-covid-19-henry-ford-life-death-protocols-letter/5085702002/> (discussing Michigan's guidelines); UTAH HOSP. ASS'N & UTAH DEP'T OF HEALTH, UTAH CRISIS STANDARDS OF CARE GUIDELINES 30 (June 2018), <https://int.nyt.com/data/documenthelper/6852-utah-triage-guidelines/02cb4c58460e57ea9f05/optimized/full.pdf#page=1> (Utah's guidelines).

122. See sources cited *supra* note 121.

123. MINN. DEP'T OF HEALTH, *supra* note 121.

124. LA. DEP'T OF HEALTH, *supra* note 121; UTAH HOSP. ASS'N & UTAH DEP'T OF HEALTH, *supra* note 121.

125. PA. DEP'T OF HEALTH & HOSP. HEALTHSYSTEM ASS'N OF PA., INTERIM PENNSYLVANIA CRISIS STANDARDS OF CARE FOR PANDEMIC GUIDELINES 31 (Mar. 22, 2020), <https://int.nyt.com/data/documenthelper/6850-pennsylvania-triage-guidelines/02cb4c58460e57ea9f05/optimized/full.pdf#page=1>.

126. ARIZ. DEP'T OF HEALTH SERVS., COVID-19 ADDENDUM: ALLOCATION OF SCARCE RESOURCES IN ACUTE CARE FACILITIES RECOMMENDED FOR APPROVAL BY STATE DISASTER MEDICAL ADVISORY COMMITTEE (SDMAC), (June 12, 2020), <https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/sdmac/covid-19-addendum.pdf>.

Utah has a point system: the lower the total score, the higher the priority for treatment.¹²⁷ It takes into account age, health score, estimated survival, and pregnancy.¹²⁸

Alabama's protocol gives those with severe mental disabilities lower priority.¹²⁹

C. The COVID-19 Disaster Triage Threat

Part of the state and federal response to the COVID-19 pandemic has been aimed at preventing the overwhelming of hospitals and avoiding the switch to disaster triage.¹³⁰ Throughout the pandemic, there has been close monitoring of hospitals' capacities.¹³¹ The threat of switching to disaster triage is not fictitious even though it has to this point during the pandemic been avoided in the United States.

In Italy, because of the coronavirus pandemic, "[r]egular doctors . . . suddenly shift[ed] to wartime footing."¹³² The mayor of Bergamo, one of the cities in the heavily hit Lombardy region, said that the number of patients had overwhelmed the system, "forc[ing] the doctors to decide not to intubate some very old patients."¹³³ Dr. Flavia Petrini, the president of SIAARTI, explained that the SIAARTI triage guidelines are needed "[i]n a context of

127. UTAH HOSP. ASS'N & UTAH DEP'T OF HEALTH, *supra* note 121, at 29.

128. *Id.*

129. ANNEX TO ESF 8 OF THE STATE OF ALABAMA EMERGENCY OPERATIONS PLAN 8 (2010), <https://www.documentcloud.org/documents/6824966-Alabama-Ventilator-Triage.html>; see also Whyte, *supra* note 120; Amy Silverman, *People with Intellectual Disabilities May Be Denied Lifesaving Care Under These Plans as Coronavirus Spreads*, PROPUBLICA (Mar. 27, 2020), <https://www.propublica.org/article/people-with-intellectual-disabilities-may-be-denied-lifesaving-care-under-these-plans-as-coronavirus-spreads?fbclid=IwAR2BUF8XfX9ol9hPGjXIQXpzftAtixlAbKypOUx6xzAAmko5BGQgVD7FB-A>.

130. See *supra* notes 1–3 and accompanying text.

131. See, e.g., *COVID-19 Hospital Dashboard*, CNTY. OF SANTA CLARA EMERGENCY OPERATIONS CTR., <https://www.sccgov.org/sites/covid19/Pages/dashboard-hospitals.aspx> (last visited Sept. 22, 2020); Jim Spiewak, *Here's What Utah's COVID Case Surge Means for Hospital Capacity*, KUTV (Sept. 18, 2020), <https://kutv.com/news/coronavirus/heres-what-utahs-covid-case-surge-means-for-hospital-capacity>; Katherine Fung, *Arizona ICU Capacity Reaches 80 Percent as State Records Single-Day High*, NEWSWEEK (June 12, 2020), https://www.newsweek.com/arizona-icu-capacity-reaches-80-percent-state-records-single-day-high-1510594?utm_term=Autofeed&utm_medium=Social&utm_source=Twitter#Echobox=1592018292.

132. Horowitz, *supra* note 3.

133. *Id.* (quoting Giorgio Gori, Mayor of Bergamo, Italy).

grave shortage of health resources.”¹³⁴ After Italy centralized communication coming out of this region, doctors and nurses stopped openly discussing what triage decisions they faced in the hospitals, and officials maintained that all patients have received care, though they admitted this pandemic has been like war and that they *may* have to compare and prioritize patients differently.¹³⁵ While we know little for sure yet about the extent to which Italy employed utilitarian triage, the SIAARTI guidelines make clear that when the number of patients who need intensive care and ventilators surpasses the resources, then emergency departments will need to turn away patients who have a lower chance of living and who have fewer years left to live if they do survive.¹³⁶ The guidelines report that approximately ten percent of all infected patients need intensive care and ventilation, and intensive care means two to three weeks in the hospital.¹³⁷ This puts a tremendous amount of strain on the local healthcare systems.

Italy has 3.2 hospital beds per 1,000 people, slightly more than the United States’ 2.8 beds per 1,000 people.¹³⁸ By contrast, South Korea has 12 beds per 1,000 people, and China has 4.3 beds per 1,000 people.¹³⁹ Thus to stave off the triage dilemma in the present or future pandemics, the United States needs more beds and less demand for those beds. Flattening the curve gets at lowering the demand, and states have made efforts to get more beds.¹⁴⁰ For

134. *Id.* (quoting Flavia Petrini).

135. *Id.*

136. SIAARTI, *supra* note 6, at 5.

137. *Id.* at 4; Horowitz, *supra* note 3.

138. William Wan, Ariana Eunjung Cha & Lena H. Sun, *This Is the Coronavirus Math That Has Experts So Worried: Running Out of Ventilators, Hospital Beds*, WASH. POST (Mar. 13, 2020), <https://www.washingtonpost.com/health/2020/03/13/coronavirus-numbers-we-really-should-be-worried-about/>. Early on, the United States’ rise in cases seemed very similar to Italy’s rate, so the two countries were regularly compared. However, the rates have since diverged with the United States surpassing Italy’s number of confirmed cases. Dylan Scott & Rani Molla, *How the US Stacks Up to Other Countries in Confirmed Coronavirus Cases*, VOX, <https://www.vox.com/policy-and-politics/2020/3/13/21178289/confirmed-coronavirus-cases-us-countries-italy-iran-singapore-hong-kong> (May 11, 2020, 9:25 AM).

139. Wan et al., *supra* note 138.

140. See, e.g., Erin Ross, *Coronavirus Patient Surge in Oregon Prompts Joint Hospital Efforts, Delayed Medical Treatments*, OR. PUB. BROAD. (Mar. 16, 2020), <https://www.opb.org/news/article/coronavirus-patient-surge-in-oregon-prompts-joint-hospital-efforts/> (outlining Oregon efforts to maximize the number of beds available for coronavirus patients); Shimon Prokuecz (@ShimonPro), TWITTER (Apr. 1, 2020), <https://twitter.com/ShimonPro/>

instance, the Department of Defense ordered the Navy to activate two hospital ships, each with a 1,000-bed capacity.¹⁴¹ However, these efforts may not be enough: one study predicted that if 40 percent of adults were infected by COVID-19, then hospitals “[i]n 40 percent of markets around the country . . . would not be able to make enough room for all the patients . . . even if they could empty their beds of other patients.”¹⁴²

As for ventilators, the United States had an estimated 160,000 available before the pandemic started.¹⁴³ On March 17, the Pentagon announced it would make an additional 2,000 ventilators available from its stockpile.¹⁴⁴ A New York task force in 2015 found that there were a total of 9,150 ventilators in the state and only 2,800 of those were available.¹⁴⁵ In a pandemic like the 1918 Spanish Flu, roughly “18,600 New York patients would need ventilators each week at the peak.”¹⁴⁶ Of course, the two pandemics are not the same. But with ventilator shortages in Italy, it was not hard to imagine a similar shortage here at the start of the pandemic.¹⁴⁷ Such shortages are a top concern for officials, though most do not say what they would do if they ran out.¹⁴⁸ In March, New York doctor Akshay Ganju said he was nervously preparing for the worst: “the possibility that at some point [he is] going to have to look a

status/1245449789204021259 (“Elmhurst hospital in this short period grew from 29 ICU beds to 111. That is incredible work by staff there.”).

141. Sam LaGrone, *Pentagon Preparing Navy Hospital Ships Mercy, Comfort for Coronavirus Response*, USNI NEWS, <https://news.usni.org/2020/03/17/pentagon-preparing-navy-hospital-ships-mercy-comfort-for-coronavirus-response> (Mar. 17, 2020, 4:10 PM).

142. Margot Sanger-Katz, Sarah Kliff & Alicia Parlapiano, *These Places Could Run Out of Hospital Beds as Coronavirus Spreads*, N.Y. TIMES: THE UPSHOT (Mar. 17, 2020), <https://www.nytimes.com/interactive/2020/03/17/upshot/hospital-bed-shortages-coronavirus.html?action=click&module=Top%20Stories&pgtype=Homepage>.

143. Wan et al., *supra* note 138.

144. Amanda Macias, *Pentagon to Free Up 5 Million Respirator Masks and 2,000 Ventilators for Coronavirus Efforts*, CNBC (Mar. 17, 2020), <https://www.cnbc.com/2020/03/17/pentagon-to-give-5-million-masks-and-2000-ventilators-for-coronavirus.html>.

145. Brian M. Rosenthal & Joseph Goldstein, *N.Y. May Need 18,000 Ventilators Very Soon. It Is Far Short of That.*, N.Y. TIMES (Mar. 26, 2020), <https://www.nytimes.com/2020/03/17/nyregion/ny-coronavirus-ventilators.html>.

146. *Id.*

147. See Sarah Kliff, Adam Satariano, Jessica Silver-Greenberg & Nicholas Kulish, *There Aren't Enough Ventilators to Cope with the Coronavirus*, N.Y. TIMES (Mar. 26, 2020), <https://www.nytimes.com/2020/03/18/business/ventilator-shortage-coronavirus.html?action=click&module=Top%20Stories&pgtype=Homepage>.

148. See *id.*

daughter in the eye and tell her [he does not] have a ventilator for her father.”¹⁴⁹

Sharing across state lines may be a partial solution,¹⁵⁰ but given the length of time patients may require these resources and the nationwide spread, a state with fewer cases and more resources will likely be reluctant to give away what it soon might need itself.¹⁵¹

New York is not the only state to face the threat of disaster triage. For instance, in July 2020, hospitals in Starr County, Texas, were so full that the county created a committee to determine the likelihood that COVID-19 patients in its overwhelmed hospital would die.¹⁵² Those who had a high likelihood of death would be sent home.¹⁵³ Then near the end October 2020, Utah hospitals prepared to switch to a utilitarian triage system as cases dramatically rose in the state and hospital capacity filled.¹⁵⁴

149. Rosenthal & Goldstein, *supra* note 145 (quoting Dr. Akshay Ganju).

150. Indeed, some sharing between states has happened. *See, e.g.,* Kathleen Ronayne, *California Lends 500 Ventilators to 4 States, 2 Territories*, ASSOCIATED PRESS (Apr. 6, 2020), <https://apnews.com/b38e338e8dc5742a874e32602854a1b1>; *Washington State Returns Ventilators for Use in New York*, ASSOCIATED PRESS (Apr. 5, 2020), https://apnews.com/853dcf44c20d9183f71b6c6ad5443a60?utm_source=Twitter&utm_campaign=SocialFlow&utm_medium=APWestRegion; Talal Ansari & Allison Prang, *Nurses Travel From Coronavirus Hot Spot to Hot Spot, From New York to Texas*, WALL ST. J. (Aug. 9, 2020, 12:00 PM), <https://www.wsj.com/articles/nurses-travel-from-coronavirus-hot-spot-to-hot-spot-from-new-york-to-texas-11596988800?mod=e2tw>; Andrew Cuomo (@NYGovCuomo), TWITTER (Apr. 15, 2020, 11:19 AM), <https://twitter.com/NYGovCuomo/status/1250473835121520640> (“In our hour of need, other states stepped up to help us. We promised we would do the same. We will be sending 100 ventilators to Michigan and 50 ventilators to Maryland.”).

151. *See* Moskop & Iserson, *Part II, supra* note 31, at 284 (“An initial question, however, is whether the triage officer’s focus should be on those patients needing care at a particular time, or on all of the patients projected to need care, both now and in the near future.”).

152. Chacour Koop, *COVID-19 Patients Will Be ‘Sent Home to Die’ If Deemed Too Sick, Texas County Says*, FORT WORTH STAR-TELEGRAM (July 24, 2020, 4:58 PM), <https://www.star-telegram.com/news/coronavirus/article244443257.html>; Sinéad Baker, *A Texas Hospital Is So Overrun with Coronavirus Cases That Officials Say It Will Send the Patients Least Likely to Survive Home to Die*, BUS. INSIDER (July 24, 2020, 6:42 AM), <https://www.businessinsider.com/texas-starr-county-hospital-forced-choose-who-sent-home-die-2020-7>; Nicole Chavez & Kay Jones, *A Texas Hospital Overwhelmed by the Coronavirus May Send Some Patients Home to Die*, CNN (July 25, 2020, 12:02 AM), <https://www.cnn.com/2020/07/24/us/texas-starr-county-hospital-coronavirus/index.html>.

153. *See* sources cited in *supra* note 152. At the time of this Note’s publication, nothing suggests that any patients from this hospital had been sent home to die.

154. Erin Alberty & Sean P. Means, *Utah’s Hospitals Prepare to Ration Care as a Record Number of Coronavirus Patients Flood Their ICUs*, SALT LAKE TRIB. (Oct. 25, 2020), <https://www.sltrib.com/news/2020/10/25/with-coronavirus-cases/>; Hannah Knowles & Jacqueline Dupree, *Full Hospitals, Talk of Rationing Care: New Wave of Coronavirus Cases Strains*

In pandemic situations, whether COVID-19 or another, surges of patients requiring hospital beds, ventilators, medical staff, and other resources may push hospitals to the point of utilitarian triage. National and local governments, health agencies, hospitals, and other stakeholders, including the public, should take steps to protect healthcare resources and prevent surges, but when the system is overwhelmed, there is no choice but to triage patients¹⁵⁵ — the choice becomes whether to stick to the status quo of treating the most ill or whether to prioritize those with better chances of recovery.

III. UTILITARIAN TRIAGE AND THE LAW

The states' guidelines are not legally binding and offer minimal, if any, legal protection. With only minor exceptions,¹⁵⁶ disaster triage is left untreated by the law. Should hospitals or medical professionals resolve to triage their patients, even in adherence to existing guidelines, they would be vulnerable to civil suits and possibly even criminal charges. There must be greater legal clarity for patients and for medical professionals about what will happen when hospitals face disaster triage decisions. Laws should specify that during a disaster where utilitarian triage is needed to maximize number of lives saved, medical professionals should triage their patients on the sole basis of patients' health in respect to the current disaster. These laws would provide legal protection to medical professionals who implemented these measures.

A. Risk of Liability

A variety of medical malpractice claims could be levied against triage decisionmakers in the absence of immunity or clear legal direction about how to triage.

First, under the general theory of malpractice, a plaintiff could claim that the medical professionals failed to act as a reasonable

Resources, WASH. POST (Oct. 25, 2020), <https://www.washingtonpost.com/nation/2020/10/25/coronavirus-cases-hospitalizations-surge/>.

155. See Moskop & Iserson, *Part II*, *supra* note 31, at 282 ("Failing to act due to moral uncertainty is unacceptable, however, since inaction is often the worst of the available options.").

156. After the events at Memorial Hospital and the arrest of Dr. Pou, Louisiana did adopt a statute protecting medical professionals from liability for following "triage protocol" during a disaster. LA. STAT. ANN. § 29:735.1 (2006). See also *infra* Section III.A.

professional would act under the same circumstances. Under everyday circumstances, utilitarian triage would not be permitted, but disaster scenarios that compel these decisions are exceptionally rare and raise the question of what would be reasonable for doctors to do in these unique contexts. Even where there are formal guidelines on utilitarian triage, those guidelines do not offer a complete defense to suit. New York's guidelines expressly state that without legislation to make following the guidelines a defense, any hospital or doctor who follows the guidelines is vulnerable to malpractice claims.¹⁵⁷

Survey data shows that doctors approve of utilitarian triage in disasters at a much greater rate than laypersons.¹⁵⁸ This heightens the risk that a jury of such laypersons would not accept the defense that under the disaster circumstances, this was a reasonable decision. Hindsight bias may also favor the plaintiff over the defendant medical professionals. For example, if helicopters come to evacuate patients just hours after doctors decide to end life-saving treatment for a patient in critical condition,¹⁵⁹ hindsight bias may make it difficult for the jury to assess reasonableness of the decision at the time it was made.

Utilitarian triage could also lead to successful abandonment claims. Physicians have a duty to continue necessary treatment, and can be sued for abandonment if they discontinue necessary treatment without consent.¹⁶⁰

The authorities are uniform in holding that where a physician is employed to attend a patient, it is his duty to exercise reasonable and ordinary care and skill in determining when to discontinue

157. VENTILATOR ALLOCATION GUIDELINES, *supra* note 89, at 8–9 (“Voluntary guidelines issued by the Department of Health for ventilator allocation provide evidence for an acceptable modified medical standard of care during the dire circumstances of a pandemic. However, there is no guarantee that a court will accept adherence to the Guidelines as a defense . . .”).

158. Veatch, *supra* note 24, at 238–40; *see also* FINK, *supra* note 77, at 469.

159. “One of the greatest tragedies of what happened at Memorial may well be that the plan to inject patients went ahead at precisely the time when the helicopters at last arrived in force, expanding the available resources.” FINK, *supra* note 77, at 471.

160. *See, e.g.,* King v. Zakaria, 634 S.E.2d 444 (Ga. Ct. App. 2006); Granek v. Tex. State Bd. Med. Exam’rs, 172 S.W.3d 761 (Tex. App. 2005); Johnson v. Vaughn, 370 S.W.2d 591 (Ky. 1963).

his treatment, and for a failure to exercise such skill he is liable for any damage caused thereby.¹⁶¹

Palliative care—that is, care focused on relieving symptoms and providing comfort¹⁶²—in place of curative care might be enough to stem off abandonment claims, but it is far from a surety. Moreover, if the disaster is such that there are not enough medical professionals to treat the influx of patients, even palliative care may be foregone in utilitarian triage.

Removal of life-supporting mechanisms without patient or guardian consent is basis for a wrongful death claim against the hospital and individuals responsible for the removal.¹⁶³ Even when treatment is futile, consent is required.¹⁶⁴

The above claims would be available only to *existing* patients. Federal law does mandate hospitals to accept all patients but only to point of capacity.¹⁶⁵ However, state laws may not make such an exception. For example, New York City general hospitals are required under state law to “provide emergency medical care and treatment to *all* persons in need of such care and treatment who arrive at the entrance to such hospital therefor.”¹⁶⁶ Failure to adhere is a misdemeanor.¹⁶⁷ The assumption is that New York City general hospitals will never exceed capacity, and thus should treat all who need care.

Homicide charges are also on the table. Though the grand jury chose not to indict Dr. Pou, her arrest and the investigation of Memorial Hospital are evidence that medical professionals cannot be certain that their decisions—particularly those that have the

161. C. T. Drechsler, Annotation, *Liability of a Physician Who Abandons Case*, 57 A.L.R.2d 432 § 15 (1958).

162. *About Palliative Care*, CTR. TO ADVANCE PALLIATIVE CARE, <https://www.capc.org/about/palliative-care/> (last visited Sept. 29, 2020); *WHO Definition of Palliative Care*, WHO, <https://www.who.int/cancer/palliative/definition/en/> (last visited Sept. 29, 2020).

163. Ann K. Wooster, Annotation, *Tortious Maintenance or Removal of Life Supports*, 100 A.L.R.6TH 477 § 38 (2014).

164. There is great debate about medical futility cases. See generally Meir Katz, *When Is Medical Care “Futile”? The Institutional Competence of the Medical Profession Regarding the Provision of Life-Sustaining Medical Care*, 90 NEB. L. REV. 1 (2011).

165. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd.

166. N.Y. PUB. HEALTH LAW § 2805-b (2019) (emphasis added).

167. *Id.*

effect of accelerating a patient's death—will not lead to criminal prosecutions for homicide.

After Hurricane Katrina, Louisiana passed laws that limit the civil and criminal liability for triage decisions in disasters.¹⁶⁸ Medical personnel are not liable “as a result of an evacuation or treatment or failed evacuation or treatment conducted in accordance with disaster medicine protocol and at the direction of military or government authorities.”¹⁶⁹ *Disaster medicine protocol* is the “recognized triage process” for “when the number of patients exceeds the normal medical capacities, facilities and personnel.”¹⁷⁰ As for criminal liability, Louisiana has created a panel review process to determine whether the medical personnel acted in good faith and advise prosecutors whether criminal charges are appropriate.¹⁷¹

B. Necessary Action

Because of the uncertainty surrounding triage decisions and their accompanying liability, states need to act to clarify by statute what their triage standards are and to eliminate liability for following those standards.

1. Why healthcare workers should receive immunity for following triage guidelines

Under current law, medical professionals who use triage guidelines face legal jeopardy, even though state policymakers wrote, or commissioned, those guidelines. Every state has guidelines, though of varying specificity, yet states generally do not provide legal protections for following these guidelines since they are not law.

There must be statutory provisions recognizing the grim reality of disaster triage and formally adopting a triage strategy—utilitarian or otherwise. Adhering to guidelines is only one of three key reasons for immunity.

168. LA. STAT. ANN. § 29:735.1 (2006) (applying to civil liability); LA. STAT. ANN. § 40:1237.4 (2015) (applying to criminal liability).

169. LA. STAT. ANN. § 29:735.3 (2008).

170. *Id.*

171. LA. STAT. ANN. § 40:1237.4 (2015).

The second reason is that the medical professionals who are triaging and treating patients are in crisis mode. The emotional burden of these choices on top of the extreme stress that these disasters place on health workers cannot be estimated.¹⁷²

Finally, the third reason is that the conditions that lead to these dilemmas often are, at least in part, preventable by other actors. Blame for *how* hospitals ration ventilators cannot be severed from blame for *why* hospitals must ration. Governments' policy decisions—whether about levies, hospital generators, disaster evacuation planning, stockpiling, stay-at-home orders, mask mandates, etc.—invariably mitigate or aggravate disasters, so those policymakers are at least partly responsible for the triage decisions happening in the first place.¹⁷³

2. Why triage criteria should be adopted by politically accountable leaders

While each state has some form of soft triage guidelines, politically accountable leaders still need to formally adopt those

172. See Ariana Eunjung Cha, Lenny Bernstein, Frances Stead Sellers & Shane Harris, *Faced with a Crush of Patients, Besieged NYC Hospitals Struggle with Life-or-Death Decisions*, WASH. POST (Mar. 31, 2020), <https://www.washingtonpost.com/health/2020/03/31/new-york-city-hospitals-coronavirus/>; Sheri Fink, *"We're in Disaster Mode": Courage Inside a Brooklyn Hospital Confronting Coronavirus*, N.Y. TIMES (Mar. 26, 2020), <https://www.nytimes.com/2020/03/26/nyregion/coronavirus-brooklyn-hospital.html>; Brian Mahoney & John Minchillo, *AP Exclusive: "It's Been a Nightmare" for Yonkers ER Doc*, ASSOCIATED PRESS (Apr. 21, 2020), https://apnews.com/e8cc5f5b3b62b22df348ab2a249896ee?utm_campaign=SocialFlow&utm_medium=AP&utm_source=Twitter&utm_campaign=SocialFlow&utm_medium=AP&utm_source=Twitter (detailing the conditions in a Yonkers hospital where staff were out sick and a doctor pronounced six people dead in a single shift); Sigal Samuel, *Doctors and Nurses Are Risking Their Mental Health for Us*, VOX (Mar. 26, 2020), <https://www.vox.com/future-perfect/2020/3/26/21193122/coronavirus-mental-health-doctors-nurses-covid-19>; Lizzie Widdicombe, *The Growing Chaos Inside New York's Hospitals*, NEW YORKER (Mar. 23, 2020), <https://www.newyorker.com/news/our-local-correspondents/shits-really-going-to-hit-the-fan-inside-new-yorks-overburdened-hospitals>.

173. See Michael Biesecker, *US "Wasted" Months Before Preparing for Coronavirus Pandemic*, ASSOCIATED PRESS (Apr. 5, 2020), <https://apnews.com/090600c299a8cf07f5b44d92534856bc>; Majlie de Puy Kamp, *Federal Officials Repeatedly Warned that US Hospitals Lacked Enough Ventilators*, CNN (Mar. 27, 2020), <https://www.cnn.com/2020/03/27/cnn10/ventilators-supply-government-warnings-coronavirus-invs/index.html> ("In at least 10 government reports from 2003 to 2015, federal officials predicted the United States would experience a critical lack of ventilators and other lifesaving medical supplies if it faced a viral outbreak like the one currently sweeping the country.").

guidelines into law or replace them with other lawfully enacted triage criteria.¹⁷⁴

Triage theory may be less about science than it is about values.¹⁷⁵ Studies suggest that utilitarian triage may in some instances fail to meet its goal of saving more lives,¹⁷⁶ which means that though utilitarian triage may be premised on saving *more* lives, in practice it may be more about saving *which* lives. These value decisions need to have political consequences and be subject to change based on public input.

Calls for formal legislation have been made for years.¹⁷⁷ For example, the New York Task Force has consistently called for legislation to mitigate liability since the inception of the guidelines.¹⁷⁸ But there is political reluctance. After all, articulating a preference for a triage method has a high political cost, and disaster triage is so rare that it may not seem worth that cost.¹⁷⁹ However, COVID-19 may increase political momentum to resolve this in the coming years just as Hurricane Katrina prompted Louisiana to adopt its immunity laws.

When policymakers actually grapple with these decisions, there is an added bonus to public health: recognition of hospital resources and disaster plans. Recognition of scarcity will likely prompt state legislatures and agencies to take more mitigation

174. Disaster triage guidelines are typically utilitarian, but that does not mean that state legislators and agencies would necessarily adopt utilitarian triage if they faced the issue. Research shows that laypersons are far more likely to reject utilitarian triage altogether than medical professionals. Veatch, *supra* note 24, at 238–40; *see also* FINK, *supra* note 77, at 469. *But see* Sunstein, *supra* note 40, at 104 (arguing that laypersons' judgments "are frequently based on confusion, ignorance, and selective attention" and so should be used only to a certain extent).

175. FINK, *supra* note 77, at 468.

176. *See generally* Sheri L. Fink, *Worst Case: Rethinking Tertiary Triage Protocols in Pandemics and Other Health Emergencies*, 14:103 CRITICAL CARE (2010); Michael D. Christian, Cindy Hamielec, Neil M. Lazar, Randy S. Wax, Lauren Griffith, Margaret S. Herridge, David Lee & Deborah J. Cook, *A Retrospective Cohort Pilot Study to Evaluate a Triage Tool for Use in a Pandemic*, 13:R170 CRITICAL CARE (2009); Z. Khan, J. Hulme & N. Sherwood, *An Assessment of the Validity of SOFA Score Based Triage in H1N1 Critically Ill Patients During an Influenza Pandemic*, 64 ANAESTHESIA: J. ASS'N ANAESTHETISTS GR. BRIT. & IR. 1283 (2009).

177. *See, e.g.*, Fink, *supra* note 60 (discussing Dr. Pou's advocacy for legal reform); VENTILATOR ALLOCATION GUIDELINES, *supra* note 89, at 4.

178. VENTILATOR ALLOCATION GUIDELINES, *supra* note 89, at 4.

179. Political opponents may allege that the other is creating or is responsible for "death panels." *See* Michelle Goldberg, Opinion, *Here Come the Death Panels*, N.Y. TIMES (Mar. 23, 2020), <https://www.nytimes.com/2020/03/23/opinion/coronavirus-hospital-shortage.html>.

efforts so as to avoid the triage dilemma.¹⁸⁰ If the goal is to save more lives, preventative steps will be more effective than triage:

What will save more lives in an overwhelming emergency probably won't be refining how a set number of patients is triaged, essentially shuffling the same deck of cards so that different numbers and suits come up on top. What will save more lives will be doing everything possible to avoid having to deal the hand, by taking steps to minimize the need to compromise standards, and promote the ability to rebound as quickly as possible to normalcy.¹⁸¹

3. *What factors policymakers should consider in developing triage guidelines*

A host of factors could potentially weigh into the triage calculation directly or indirectly: comparative ages, familial status, occupation, social status, quality of life, wealth, race, “Do Not Resuscitate” orders, and present health status. Ultimately, this is a choice about whose life is more worth saving. We do not all assign equal weight to these factors,¹⁸² and different factors have different legal implications. While I believe disaster triage decisions should be made based solely on the comparative medical status of the patients, such as SOFA scores, it is important to consider, even if only to reject, the other potential factors.

Italy's guidelines, as mentioned before, adopt a policy that explicitly prioritizes the young over the old.¹⁸³ Professor Sunstein has argued that “[o]ther things being equal, many years should be chosen over few.”¹⁸⁴ He further explained that this calculation of “decently-livable life-years should be adjusted upward when the costs of risk avoidance are especially high, and adjusted downward when the costs of risk avoidance are especially low.”¹⁸⁵ The cost of risk avoidance in the utilitarian triage context is the estimated amount of resources it would take to preserve the patient's life relative to the life-years of other patients that would otherwise be preserved by those same resources.

180. See *supra* notes 83–88 and accompanying text.

181. FINK, *supra* note 77, at 471.

182. *Id.* at 467–70; Veatch, *supra* note 24, at 240.

183. SIAARTI, *supra* note 6, at 5.

184. Sunstein, *supra* note 40, at 113.

185. *Id.* at 105.

There are significant problems with an approach focused on prioritizing the young over the old. While age discrimination is reviewed under only the rational basis standard and thus almost certainly allowable under the Fourteenth Amendment,¹⁸⁶ it is still morally questionable to say that the life of a younger person is worth saving over the life of an older person even if the math bears out. After Katrina, Maryland officials brought focus groups, sampling the general population, to discuss what triage rules there should be for disasters.¹⁸⁷ They grappled with the age question, and while some people felt strongly that age should factor in, others had different perspectives.¹⁸⁸ As one person explained, “If a significant generation, if the senior citizens were cut in half, that would alter our society.”¹⁸⁹ The elderly have value inherent to their individuality and humanity, but they also have value to all of us — as family members, as community members, as part of our shared social fabric.¹⁹⁰

Social value is impossible to quantify in any non-biased way, and that is also true of “quality of life.” That said, social value as defined by wealth is calculated for purposes of wrongful death actions.¹⁹¹ Even if initially there is some consensus on broad beliefs that some people are more important to save than others (and there may not be any such consensus), where should the line be drawn? Some moral discomfort is inevitable in any disaster triage decision, but basing that decision on a “score” derived from social value and quality of life is more problematic given the moral and scientific uncertainty about which and how different factors should be weighed.

Calculations of social utility may have the effect of further harming already disadvantaged populations. Of course, there is a real risk that even with triage rules that explicitly reject looking to

186. *Gregory v. Ashcroft*, 501 U.S. 452, 470–71 (1991).

187. FINK, *supra* note 77, at 467–68.

188. *Id.*

189. *Id.* at 467.

190. Russell Moore, Opinion, *God Doesn't Want Us to Sacrifice the Old*, N.Y. TIMES (Mar. 26, 2020), <https://www.nytimes.com/2020/03/26/opinion/coronavirus-elderly-vulnerable-religion.html?smtyp=cur&smid=tw-nytopinion>; Maryellen Stewart, *Most People Dying from Covid-19 Are Old. Don't Treat Them Just as Statistics*, VOX (Apr. 22, 2020), <https://www.vox.com/first-person/2020/4/22/21228680/coronavirus-covid-19-deaths-old-elderly-people>.

191. See, e.g., CONN. GEN. STAT. §§ 52-225d, 52-572h.

these factors, certain disadvantaged populations may be harmed. For instance, people of color and those in lower socioeconomic populations have disparately worse health as compared to white people and those in higher socioeconomic populations.¹⁹² Moreover, persons of color generally receive lower quality medical care.¹⁹³ During the COVID-19 pandemic, people of color have contracted the virus and died at higher rates than white people.¹⁹⁴

192. Hope Landrine & Irma Corral, *Separate and Unequal: Residential Segregation and Black Health Disparities*, 19 *ETHNICITY & DISEASE* 179, 179 (2009).

193. NEIL CALMAN, CHARMAINE RUDDOCK, MAXINE GOLUB, & LAN LE, *BRONX HEALTH REACH, SEPARATE AND UNEQUAL: MEDICAL APARTHEID IN NEW YORK CITY* 8 (2005), <https://nyccolliantodismantleracism.files.wordpress.com/2016/03/separate-and-unequal-medical-apartheid-in-new-york-city.pdf>.

194. Richard A. Oppel Jr., Robert Gebeloff, K.K. Rebecca Lai, Will Wright & Mitch Smith, *The Fullest Look Yet at the Racial Inequity of Coronavirus*, N.Y. TIMES (July 5, 2020), <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latino-african-americans-cdc-data.html?smtyp=cur&smid=tw-nytimes>; Allison Aubrey, *Who's Hit Hardest by COVID-19? Why Obesity, Stress and Race All Matter*, NPR (Apr. 18, 2020), <https://www.npr.org/sections/health-shots/2020/04/18/835563340/whos-hit-hardest-by-covid-19-why-obesity-stress-and-race-all-matter>; Zeeshan Aleem, *New CDC Data Shows Covid-19 Is Affecting African Americans at Exceptionally High Rates*, VOX (Apr. 18, 2020), <https://www.vox.com/coronavirus-covid19/2020/4/18/21226225/coronavirus-black-cdc-infection>; Deborah Barfield Berry, *Black People Dying from Coronavirus at Much Higher Rates in Cities Across the USA*, USA TODAY (Apr. 9, 2020), <https://www.usatoday.com/story/news/nation/2020/04/07/who-dying-coronavirus-more-black-people-die-major-cities/2961323001/>; Kenya Evelyn, *"It's a Racial Justice Issue": Black Americans Are Dying in Greater Numbers from Covid-19*, GUARDIAN (Apr. 8, 2020), https://www.theguardian.com/world/2020/apr/08/its-a-racial-justice-issue-black-americans-are-dying-in-greater-numbers-from-covid-19?utm_term=Autofeed&CMP=tw_t_gu&utm_medium&utm_source=Twitter#Echobox=1586347293; Akilah Johnson & Talia Burford, *Early Data Shows African Americans Have Contracted and Died of Coronavirus at an Alarming Rate*, PROPUBLICA (Apr. 3, 2020), <https://www.propublica.org/article/early-data-shows-african-americans-have-contracted-and-died-of-coronavirus-at-an-alarming-rate>; Courtney Tanner, *Utahns of Color Far More Likely to Be Sick, Hospitalized from Coronavirus than White Residents*, SALT LAKE TRIB. (Apr. 15, 2020), <https://www.sltrib.com/news/2020/04/14/utahns-color-far-more/>; Zachary Wolf, *How the Coronavirus Is Devastating Communities of Color*, CNN (Apr. 18, 2020), <https://www.cnn.com/2020/04/18/politics/what-matters-april-17/index.html>; Carter Williams, *A 'Perfect Storm': New CDC Study Shows Large Racial Disparity in Utah's COVID-19 Workplace Outbreaks* (Aug. 18, 2020), <https://www.ksl.com/article/50007813/a-perfect-storm-new-cdc-study-shows-large-racial-disparity-in-utahs-covid-19-workplace-outbreaks>; Samantha Schmidt & Rebecca Tan, *The Number of Pregnant Latinas with Covid-19 is Staggering. And a Warning Sign, Doctors Say*, WASH. POST (Aug. 16, 2020), https://www.washingtonpost.com/dc-md-wa/2020/08/16/latina-pregnant-women-covid/?utm_source=twitter&utm_campaign=wp_main&utm_medium=social; Matthew S. Schwartz, *Children Can Get Severe COVID-19, CDC Says – Especially Black and Hispanic Children*, NPR (Aug. 8, 2020), <https://www.npr.org/2020/08/08/900494834/children-can-get-severe-covid-19-cdc-says-especially-black-and-hispanic-children>.

Occupation as a determinative factor is problematic in much the same way as social status, but there may be additional justifications for it. One of the goals in military utilitarian triage is to return able soldiers to the battlefield as soon as possible.¹⁹⁵ Perhaps under similar logic, emergency workers should be given priority.

What about doing what Memorial Hospital did regarding patients with “Do Not Resuscitate” orders? Are these orders in anyway patients’ election to move down the list for saving resources? No. “[These] orders reflect foresight and personal preferences about end-of-life planning”¹⁹⁶ They do not accurately reflect the likelihood of surviving with current treatment, and they are not consent to have current treatment stopped.

Each state should consider these and other factors carefully in determining their own triage legislation and regulations. However, because of the biases innate in determining the weight of certain factors, I believe these triage decisions should be done blindly—to the greatest extent possible under the circumstances—based solely on the comparative medical status of the patients, such as SOFA scores. Disparate treatment on the bases of age, gender, disability, race will inadvertently happen under such a framework. However, the pressures innate to disaster triage scenarios restrict ability to solve those inequalities. These decisions are made under intense time pressure and require the comparison of individuals rather than classes. Health care inequality should certainly be addressed and corrected, and decreasing health care inequality in the everyday world will decrease the disparate effects in utilitarian disaster triage. But utilitarian disaster triage itself does not provide workable options to correct those inequalities—not if the goal is to save as many lives as possible.

CONCLUSION

The focus of this Note is medical triage, but it would be amiss to ignore the relationship between triage and other ethical issues.

195. Repine, *supra* note 28, at 506; Iserson & Moskop, *Part I, supra* note 8, at 277 (explaining that during World War II the U.S. military gave limited doses of penicillin to soldiers with gonorrhea instead of giving it to soldiers with infected wounds because the soldiers with gonorrhea could more quickly return to action).

196. FINK, *supra* note 77, at 470.

In the COVID-19 pandemic, some of the related issues include inequities in diagnostic testing, access to healthcare, and vaccine distribution and also inequities in who bears the cost of loosening restrictions. Underlying these issues are many of the same ethical problems underlying triage. Parallels can also be drawn outside of the pandemic context. In a world of limited resources, there will always be choices about who should sacrifice.

Triage is a necessity even if it is fraught with the most challenging of moral questions. Disaster circumstances might prompt a switch from ordinary triage where the most severe patients are treated first to utilitarian triage where the most severe patients are treated last, if at all. States need to recognize the reality of disaster triage and adopt immunity laws based on rules carefully considered by democratically accountable policymakers. It is always best to take preventative measures first, but when disasters force the issue of triage, we need legal certainty about what comes next.