A Matter of Interpretation? Critical Considerations on SIAARTI's Recommendations on Age Discrimination and Healthcare Emergency

Maria Giulia BERNARDINI[*]
Università di Ferrara

ABSTRACT: During the pandemic emergency, the adoption by the Italian Society of Anaesthesia, Analgesia, Resuscitation and Intensive Care (SIAARTI), of the document "Clinical Ethics Recommendations for the Allocation of Intensive Care Treatments in exceptional, resource-limited circumstances" (Recommendations) and the adoption of preventive and containment strategies for the virus that transformed many institutions in segregation and 'deadly' places, have been mainly considered revealing of a structural discrimination against elderly persons (ageism). The following remarks try to integrate the debate on the Recommendations, purporting to understand if and insofar such an inference is justified

1. Pandemic and elderly persons: an introduction

Recently, the common need to understand the qualifying features of the SARS-CoV-2 pandemics (also known as CoViD-19), to identify the instruments aimed at tackling it, as well as its effects on people's lives has promoted a lively debate on a number of relevant issues. Some topics were already under the shed light of public debate before the beginning of the emergency, although the degree of consciousness of the relevance of the phenomenon was

[*] Contatto: Maria Giulia BERNARDINI | brnmgl@unife.it

mainly inadequate; in these cases, the pandemic has represented a magnifying glass, allowing the 're-proposal' of relevant questions, thus amplifying already existing criticalities[1].

On the contrary, other topics had been removed from contemporaneity: as far as these topics is concerned, the pandemics has (im)posed to public attention issues that – mainly for cultural reasons – were object of debate only in narrow circles. Many of them converged towards the elderly condition, meant as a specific declination of the nexus among bodies, rights, subjectivity (and 'subjectivation')[2]. As a matter of facts, elderly persons have been particularly hit by the first phase of the pandemic emergency: although the indexes of infection and mortality varied profoundly among different States, it has emerged how, almost everywhere, their mortality rate was very much higher than the one of other individuals[3]. In this respect, the agreement on age (normally, not *per se* considered, but associated to comorbidity) as constituting a source of major vulnerability to the virus was almost unanimous[4]. However, the analysis of the data on infections also reveals further aspects, hindering the possibility to identify in the nexus between the increased 'ontological' vulnerability[5], on the one hand, and the ageing, on the other, the sole reason underlying a similar, higher, exposition to contagion (and to mortality) of those people, as it is testified by

[1] For instance, issues relating to inequalities (especially the gender ones) or care inclusion within the democratic project. On the topic, as far as the institutional framework is concerned, see the UN policy brief, *The impact of COVID-19 on women*, available at https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-the-impact-of-covid-19-on-women-en.pdf?la=en&vs=1406, 9th April 2020 and European Commission, *The impact of sex and gender in the COVID-19 pandemic*, at https://op.europa.eu/en/publication-detail/-/publication/4f419ffb-a0ca-11ea-9d2d-01aa75ed71a1/language-en, May 2020. In a more general perspective, *ex multis*, see G. Serughetti (2020) *Democratizzare la cura, curare la democrazia*, Milano, Nottetempo; C. Saraceno (2020) "Politiche per le famiglie e disuguaglianze", *Politiche sociali*, 1: 103-124.

[2] The reference to subjectivation recalls the Foucauldian lexicon and, specifically, the idea that power transforms individuals into objects, classifying them into categories, marking, fixing them to their identity, thus imposing a 'law of truth' they and other people are compelled to recognise. M. Foucault (1982) "The Subject and Power", *Critical Inquiry*, 8(4): 777-795.

[3] This trend remains valid even in this phase of the pandemic. However, the age of infection has significantly decreased since the summer. For further and updated information, cf. https://www.epicentro.iss.it/coronavirus/

[4] *Ex multis*, cf. the data widespread by the World Health Organization at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports.

[5] In literature, this is referred to as the form of universally shared vulnerability, having to deal with the corporal nature of human beings, rendering them in need of food, vulnerable *vis-à-vis* others, exposed to injury and death.

the news reports concerning guests of long-term care structures[6]. Those data, rather, lead to consider that vulnerability is, firstly, 'pathogenic', *i.e.* related to the system of relationships surrounding elderly people. The pandemics seems therefore to have 'exacerbated' the vulnerability of these individuals in several aspects, such as the medical, psychological and relational ones[7].

In particular, as far as elderly condition is concerned, two aspects arouse the interest of experts and public opinion. The first one is the choice of age as a possible and controversial criterion for admission to intensive care units, due to the inability of health systems to meet the demands received within contexts characterized by the exceptional imbalance of health resources. In this respect, the pandemic has not only amplified the crisis already affecting the national healthcare system, due to the underfunding and privatization that have characterized the last decades[8]. It has also revealed inefficiencies and delays in the update of the Italian National Pandemic Plan (*Piano Pandemico Nazionale*), recommended by the WHO as of the end of 2003, when outbreaks of the avian flu started to become endemic, therefore increasing the possibility of a reprisal of a pandemic. Inefficiency and underfunding rendered therefore the national healthcare system unable to tackle the health needs of the collectivity.

Secondly, attention has been focused on institutions hosting elderly persons – especially dependants – such as residential care homes, secure residences, nursing homes, *i.e.* the archipelago of institutions devoted to long-term care. While the latter have long been

[6] With regard to the Italian legal system, see at least *Survey nazionale sul contagio COVID-19 nelle strutture residenziali e sociosanitarie*, Istituto Superiore di Sanità. Epidemia COVID-19, https://www.epicentro.iss.it/coronavirus/pdf/sars-cov-2-survey-rsa-rapporto-finale.pdf, 5th May 2020.

[7] 'Pathogenic vulnerability' is one of the sources of vulnerability identified in C. Mackenzie, W. Rogers, S. Dodds (2014) *Vulnerability. New essays in ethics and feminist philosophy*, New York, Oxford University Press, 7 ff. It embraces all sources having the effect to exclude, discriminate or oppress some individuals, exacerbating already existing or creating new ones. On the debate, particularly rich after the *vulnerability turn*, see at least B. Pastore, O. Giolo (2018) *Vulnerabilità. Analisi multidisciplinare di un concetto*, Roma, Carocci; G. Zanetti (2019), *Filosofia della vulnerabilità. Percezione, discriminazione, diritto*, Roma, Carocci and A. Furia, S. Zullo (2020), *La vulnerabilità come metodo*, Roma, Carocci.

[8] Cf. for instance *Report Osservatorio GIMBE n. 7/2019, Il definanziamento 2010-2019 del Servizio Sanitario Nazionale*, Bologna, 2019, https://www.gimbe.org/osservatorio/Report_Osservatorio_GIMBE_2019.07_Definanziamento_SSN.pdf.

under scrutiny because of their potentially segregating nature[9], during the pandemic they have become fundamental for the institutional strategies aimed at tackling and containing the spread of the virus outside hospitals. News reports reveal that – almost in any State – the decisions to close the institutions hosting elderly people and even to transfer into them people tested positive to the coronavirus have been taken, thus significantly contributing to what has been effectively defined as a 'silence slaughter'[10].

The attention towards these places – already impermeable to the territory before being close to public due to the pandemic (this is the reason for the frequent use of the institutionalization and segregation lexicon) – has therefore allowed focus to be put on the lasting criticalities of the contemporary welfare systems, according to a different, although complementary, logic as opposed to the one connected with the impossibility of satisfying admission requests to intensive care units. In both cases, it has violently emerged how the incapacity of protecting to the utmost level the people's right to life and health (not exclusively elderly) is 'only partially' due to the pandemic, being rather caused by pre-existing structural deficiencies, primarily connected with a neo-liberal management of the welfare State[11]. Both in the access to intensive care units and in the management of long-term care, the issue concerns primarily the area of distributive justice, although not being limited

[9] G. Merlo, C. Tarantino (2018) *La segregazione delle persone con disabilità. I manicomi nascosti in Italia*, Santarcangelo di Romagna, Maggioli.

[10] According to the official date provided by some States, the number of deaths connected to CoViD-19 in institutions hosting elderly persons is very high, attesting itself between 19% and 27% of all deaths for CoViD-19. A similar, wide, range is due to the fact that, in many cases, no checks on the causes of the deaths have been made. One of the first international studies dealing with evidences of death rate linked to Covid-19 within institutions, periodically updated, us A. Comas-Herrera, J. Zalakain, C. Litwin, A.T. Hsu, N. Lane, L.-L. Fernandez (2020) *Mortality associated with COVID-19 outbreaks in care homes: early international evidence*, in *LTCcovid.org – International LongTerm Care Policy Network*, https://ltccovid.org/2020/04/12/mortality-associated-with-covid-19-outbreaks-in-care-homes-early-international-evidence/ (Last update 26th June 2020; last access 1st October 2020).

[11] In this respect, it is useful to highlight how, although in the framework of a decision of a primarily technical nature, recently the Italian Constitutional Court has explicitly recalled the specificity of the Italian healthcare system and its irreducibility to a mere private management: cf. Corte cost., sent. 157, 21st July 2020. Thomas Passey writes of a 'war' engaged by neo-liberalism against the Welfare State: cf. T. Passey (2018) "Re-theorizing the Welfare State and the Political Economy of Neoliberalism's War Against It", FFM Working Paper, online publication available at https://www.boeckler.de/pdf/p_fmm_imk_wp_16_2018.pdf. In the Italian literature concerning neoliberalim, cf. O. Giolo (2020) *Il diritto neoliberale*, Napoli, Jovene.

to it. The pandemic emergency revealed the condition of ontological, epistemological and practical invisibility that elderly persons are experiencing, thus placing the issue of 'recognition'[12] in the foreground, because of the diffused and structural disregard of their subjectivity, still nowadays observed.

Recently, it has clearly emerged how, during the pandemic, the safeguard of fundamental rights of elderly persons was particularly at risk, if not denied at all: the selective access to CoViD-19 tests or to healthcare facilities, the isolation, the increase of the risk of being subject to abandonment or violence, the tightening of the inter-generational conflict, the stigma and exposition to hate speech are but some of the aspects leading to consider that 'ageism'[13], meant as a peculiar form of structural discrimination[14] affecting elderly individuals, has been worsening, thus leading to an increasing institutional attention[15]. The outburst of the subjectivity of elderly persons in the public sphere, regrettably favoured by the dramatic recent events, has therefore compelled the different legal systems to rethink both on the accepted institutionalized cultural models, and on the responsibility to render them explicit.

The debate has involved also the Italian legal system: the adoption by the Società Italiana di Anestesia, Analgesia, Rianimazione e Terapia Intensive (hereinafter SIAARTI), of the document "Clinical Ethics Recommendations for the Allocation of Intensive Care Treatments in exceptional, resource-limited circumstances"[16] (hereinafter,

---

[12] Nancy Frasers' thesis according to which recognition is a matter of justice, and that both recognition and distribution constitute two equally fundamental dimension of justice is well known, at least as of N. Fraser, A. Honnet (2003) *Redistribution or Recognition? A Political-Philosophical Exchange*, New York, Verso.

[13] Coined at the end of the Seventies by Robert Butler, the term *ageism* indicates the result of the interaction among three components: the presence of prejudices against elderly persons, seniority and aging; the implementation of discriminatory practices towards elderly persons; the diffusion of institutional practices and policies fostering these stereotypes. See. R. Butler (1969) "Ageism: Another Form of Bigotry", in *The Gerontologist*, 9(4): 243-246.

[14] Normally, the notion of 'structural discrimination' is used as opposed to 'voluntary discrimination'. While the latter is intentionally perpetrated by some subjects against others or is present within rules aiming at obtaining discriminatory effects, on the contrary structural discrimination disregards an intention to discriminate and derives from the social system and the social conditions characterizing excluded groups.

[15] Among the most recent documents, see, i.e., Fundamental Rights Agency (FRA), *Coronavirus Pandemic in the EU – Fundamental Rights Implications: With a Focus on Older People*, Luxembourg, June 2020.

[16] Cf. Version n. 01, released on 6th March 2020: http://www.siaarti.it/SiteAssets/News/COVID19%20-%20documenti%20SIAARTI/SIAARTI%20-%20Covid19%20%20Raccomandazioni%20di%20etica%20clinica.pdf

Recommendations) and the adoption of preventive and containment strategies for the virus that transformed many institutions in segregation and 'deadly' places, have been mainly considered revealing of a structural discrimination against elderly persons. The following remarks try to integrate the debate – sometimes strongly polarized – on the Recommendations, purporting to understand if and insofar such an inference is justified[17].

2. The SIAARTI's Recommendations

Much has been written on the Recommendations[18], so it appears sufficient to provide only a synthetic framework of their general features, in order to focus on the relevant question for the purpose of the present essay, *i.e.* the relevance of age as a criterion for intensive care units admission (hereinafter, ICU admission).

The Recommendations were adopted by SIAARTI[19] with a view to provide a support to clinicians who, in conditions of "imbalance between the real clinical needs of the population and the effective availability of intensive resources"[20], are compelled to select patients for ICU admission, guiding them in an emotionally burdensome decision-making

[17] In this regard, a significant data should be recalled: while the debate concerning the relevance of age as a criterion for ICU admission is traceable to elderly people *tout court* (although with relevant uncertainty margins as regards the identification of the 'moment of passage' to the elderly condition), the one regarding the slaughter within care institutions mainly concerns dependant elderly people.

[18] Among the most recent contributions to the Italian debate, see at least P. Borsellino (2020) "Covid-19: Quali criteri per l'accesso alle cure e la limitazione terapeutica in tempo di emergenza sanitaria?", *Notizie di Politeia*, 36(138): 5-25.

[19] As the validation procedure provided for by the Law no. 64/2017 (known in the Italian system as 'Gelli-Bianco Law') has not finalized yet, up to now SIAARTI's Recommendations are deprived of the Guidelines' binding nature. More in general, their legal relevance is disputed, although it seems possible to ascribe them to *soft law*. On the debate concerning their (binding) nature, see C. Ingenito (2020) "Le raccomandazioni SIAARTI del 6 marzo 2020: una nuova occasione per riflettere sul rapporto tra scienza e diritto, *Studi di teoria e ricerca sociale*, 2, available at http://rtsa.eu/RTSA_2_2020_Ingenito.pdf, 9 ff. On *soft law*, cfr. B. Pastore (2016) "Principio di legalità, positivizzazione giuridica, soft law", in G. Pino, V. Villa (eds.), *Rule of law. L'ideale della legalità*, 153-176, Bologna, il Mulino.

[20] Recommendations, cit., 3. It is worth noting that the Italian and the English versions of the document differ in some relevant aspects. My analysis will focus on the Italian document, which is the original version of the Recommendations; in this essay, I will also highlight some differences between the two texts, which in my opinion should be considered relevant.

process, due to the exceptional features of the current situation. In particular, it is stated that in emergency situation – such a pandemic – extraordinary and flexible admission and discharge criteria of patients (affected or not by CoViD-19), potentially in need of ICU admission, can be adopted, thus derogating to the 'first come, first served' criterion.

The SIAARTI purported to provide clinicians with criteria[21] that could help them in making decisions characterized by an inevitable tragedy rate, connected with the values at stake (specifically, not only health, but life itself)[22].

In this regard, SIAARTI assimilated the pandemic scenario to those representing the precondition for the application of 'disaster medicine'[23], in order to refer to a consolidated ethical discussion, although not so renowned outside the sectorial scientific community. Nevertheless, as it is well-known, the adoption of the Recommendations prompted a lively debate, that has soon crossed national borders[24], allowing to register at least two opposite tendencies.

---

[21] *Ivi*, recommendation n. 3, p. 5, where SIAARTI writes "Non si tratta di compiere scelte meramente di valore", thus suggesting that the choices concerning the clinical assessment are of technical nature and are not merely choices regarding value. This passage, however, is completely missing in the English version of the recommendation n. 3.

[22] These are tragic choices that, as extensively emerged recently, reveal real moral dilemmas, ending up to pose 'mortal questions'. As far as mortal questions are concerned, see T. Nagel (1979) *Mortal Questions*, New York, Cambridge University Press, where the American philosopher wonders on the value, the meaning, the purpose and the end of life. On tragic choices, see the famous G. Calabresi, P. Bobbitt (1978) *Tragic Choices*, New York, W.W. Norton & Company, whose topicality is confirmed, see Roberto Conti, Philip Bobbit, "Tragic Choices, 42 anni dopo. Philip Bobbitt riflette sulla pandemia", *Giustizia insieme*, 1049 (17th May 2020), available at: https://www.giustiziainsieme.it/it/diritto-dell-emergenza-covid-19/1049-tragic-choises-43-anni-dopo-philip-chase-bobbitt-riflette-sulla-pandemia. In relation to tragic cases, cf. also V. Nitrato Izzo (2019), *Dilemmi e ragionamento giuridico. Il diritto di fronte ai casi tragici*, Napoli, ESI.

[23] The two situations at stake are not completely similar: in case of mass-emergencies (caused by earthquakes, fires, etc.) the duration of the event is limited; hence it is possible to have a tendentially precise picture of the total number of patients and, consequently, of the adaptation of the available resources to the emerged needs. On the contrary, as there is no certainty as regards the duration of the emergency status in case of a pandemic, no similar evaluation is possible.

[24] See, by way of an example, Grupo de Trabajo de Bioética de la SEMICYUC (Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias), *Recomendaciones éticas para la toma de decisiones en la situación excepcional de crisis por pandemia COVID-19 en las unidades de cuidados intensivos* (March 2020); N. Berlinger, M. Wynia, T. Powell, D. Micah Hester, A. Milliken, R. Fabi, F. Cohn, L.K. Guidry-Grimes, J.C. Watson, L. Bruce, E.J. Chuang, G. Oei, J. Abbott, N.P. Jenks, *Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19). Guidelines for Institutional Ethics Services Responding to COVID-19. Managing Uncertainty, Safeguarding Communities, Guiding Practice*, The Hastings Center (16th March 2020).

On the one hand, the analysis of similar documents adopted within different States led some scholars to highlight a significant convergence in the identification of the criteria to resort to in order to choose among patients for ICU admission, thus revealing an "emerging international consensus"[25] on the issue. On the other hand, the practical agreement reached by numerous scientific communities cannot be considered as a hint of a full, common, ethic convergence on the issue. Rather, a comparison between the documents at stake and those adopted by the Bioethics National Committees reveals different ethical settings, hindering the reach of a shared position, especially as regards the individuation of age and co-morbidity as relevant criteria for ICU admission[26].

An example of this tension is represented by the Italian legal system, where the identification of the criteria arouses a vivid debate. Some of the provisions set forth by the Recommendations attracted critics and concerns, both within the community of experts and in public opinion, due to the – at least potentially – discriminatory effects their application may entail. In particular, reference goes to the recommendations (respectively, n. 3 and 4) establishing age, the presence of comorbidity and the functional status as criteria for ICU admission. As in this regard ageism and disabilism have been evoked, it seems worth dwelling on this profile, especially focusing on the age criterion.

2.1. The age criterion: understandings

According to recommendations n. 3 and 4, "[a]n age limit for the admission to the ICU may ultimately need to be set" with a view, primarily, to save the limited resources for those who have a much greater probability of survival and, subsequently, for those who can

[25] See S. Joebges, N. Biller-Andorno (2020) "Ethics Guidelines on COVID-19 Triage: An Emerging International Consensus", *Critical Care*, 24: 201-205. Analogous criteria were proposed also in the US: see E. Ezekikiel, G. Persad, R. Upshur, B. Thome, M. Parker, A. Glickman, C. Zhang, C. Boyle, M. Smith, J.P. Phillips (2020) "Fair Allocation of Scarce Medical Resources in the Time of Covid-19", *The New England Journal of Medicine*, 382(21): 2049-2055.

[26] A picture of the positions adopted by national and international bioethics committees is offered by L. Palazzani (2020) "La pandemia CoViD-19 e il dilemma per l'etica quando le risorse sono limitate: chi curare?", in *BioLaw Journal*, Special issue 1: 359-370, in particular 367 ff.

benefit of a higher life expectancy, in order to maximise the benefits for the largest number of people.

According to SIAARTI, in a context of serious shortage of healthcare resources, allocation is needed also taking into account that the longer the duration of ICU stay, the less patients can be admitted and saved. As elderly people (or people with comorbidity or having an impaired functional status) might be more 'resource-consuming', given the exceptionality of the circumstances other individuals might be preferred.

In identifying the criteria to allocate the scarce available resources (*i.e.* intensive care beds, medicines, technologies, clinicians), SIAARTI addresses a problem of distributive justice (more precisely, micro-distributive justice)[27]. The same SIAARTI explicitly refers to the problem, in particular when observing that the extreme imbalance between needs and availability may justify an evaluation of appropriateness in the allocation of limited healthcare resources, thus assuming distributive justice as the 'sole' relevant criterion, therefore derogating to the operation of the four internationally agreed ethical principles (besides distributive justice, autonomy, beneficence and non-maleficence). In this respect, SIAARTI considers that in normal conditions, allocation of resources does not have an influence on the decision-making process; such evaluation becomes however 'inevitable' in case of an exceptional imbalance between need and availability[28].

It is well-known that allocation represents a traditional topic in philosophy and bioethics, and the various theories of justice have reached different stances thereto, also thanks to the ethic pluralism increasingly characterizing Western societies. The emergency allows therefore to pose further questions, re-proposing the relevance of a debate that sees (at least) libertarianism, utilitarianism and egalitarian theories as being in opposition[29].

[27] For an introductory theoretical framework of the relevant issues, see at least L. Forni (2014) *La sfida della giustizia in sanità. Salute, equità, risorse*, Torino, Giappichelli and L. Palazzani (2014) *La filosofia per il diritto. Teorie, concetti, applicazioni*, Torino, Giappichelli, 177 ss.

[28] It should be noticed that it represents an imbalance referring to a serious and grave problem of distributive justice at a macro-allocative level, imposing a reflection on both the financing and the structure of the Welfare State, and which is however inevitable in case of a pandemic. The issue, therefore, is of 'grade'.

[29] See L. Palazzani (2020), cit. With specific reference to allocation during a public health emergency, see also D.B. White, M.H. Katz, J.M. Luce, B. Lo (2009) "Who Should Receive Life Support During a Public Health Emergency? Using Ethical Principles to Improve Allocation Decisions", *Ann. Intern. Med.*, 150(2): 132-138; C. Sprung, M. Danis, G. Iapichino, A. Artigas, J. Kesecioglu, R. Moreno, A. Lippert, J.R. Curtis, P. Meale, S.L.

The reference to the higher life expectancy and to the maximization of benefits for the largest number of people induced many commentators to consider the SIAARTI Italian version of the document as adhering to utilitarian ethics[30] and to criticize it from both a moral and a legal point of view[31].

Simplifying the debate, the various positions seemed nevertheless to agree on highlighting that, although utilitarianism *per se* does not necessarily justify the gradation of human lives differentiating among them those more or less worth living, it does not seem adequate to constitute a hinder to such operation, also because of the frequent reference to econometric indexes aimed at measuring the quality of life itself, such as QALYs (and DALYs)[32]. As such evaluation may easily be used to justify the non-essentiality of some lives, as old (or with disabilities) ones, the Recommendations have been inferred an ageist (and disablist) character. For this reason, they would conflict (besides with the code of medical ethics) with the personalistic and equality principles, granted by the Italian Constitution, and with the supranational and international law sources, equally imbued with principles like – amongst others – the respect of the intrinsic dignity of each individual, the

---

Cohen, M.M. Levy, R.D. Truog (2013) "Triage of Intensive Care Patients: Identifying Agreement and Controversy", *Intensive Care Med.*, 39: 1916-1924.

[30] *Ex multis*, promote this interpretation M. Piccinni A. Aprile, P. Benciolini, L. Busatta, E. Cadamuro, P. Malacarne, F. Marin, L. Orsi, E. Palermo Fabris, A. Pisu, D. Provolo, A. Scalera, M. Tomasi, N. Zamperetti, D. Rodriguez (2020) "Considerazioni etiche, deontologiche e giuridiche sul Documento SIAARTI 'Raccomandazioni di etica clinica per l'ammissione a trattamenti intensivi e per la loro sospensione, in condizioni eccezionali di squilibrio tra necessità e risorse disponibili'", *Recenti Prog. Med.*, 111: 212-222, in particular 218.

[31] While in the Italian version of the recommendation n. 3 it is written "riservare risorse che potrebbero essere scarsissime a chi ha *in primis* più probabilità di sopravvivenza e secondariamente a chi può avere più anni di vita salvata […]", the English text presents slight differences: "[…] to save limited resources which may become extremely scarce for those who have a much greater probability of survival and life expectancy". Therefore, the Italian and the English texts diverge in two relevant points: in the first case, a criterion of priority between probability of survival and years of life saved is introduced (cf. "e secondariamente"), while in the second one the clinician should evaluate the probability of survival and the life expectancy jointly. Furthermore, I am not convinced that the expressions "più anni di vita salvata" (more years of life saved) and "life expectancy" can be considered synonyms; on the contrary, the latter seems to be related to a statistical provision, since it is normally considered a pure indicator of a population's survival levels.

[32] Acronyms, respectively, of Quality Adjusted Life Years and Disability Adjusted Life Years.

equity, equality and universality of the right to health, and the prohibition of discrimination on grounds of age (and disability)[33].

After the publication of the document, the debate became a serious confrontation[34], probably exacerbated by the – sometimes simplistic – discussion on the issues proposed by the media. The event might be caused by an original lack in communication: although SIAARTI's intentions are to be considered worthwhile[35], the urgent need to provide a quick response to the questions posed by the clinicians probably induced to underestimate that the community reacting to the message would have profoundly differed. While ICU clinicians were able to understand the relevant terms of the matter, higher communicative efforts should have been made *vis-à-vis* civil society, explaining more in details the rationale of the proposed criteria, in order to promote (if not the acceptability) their proper understanding.

This is particularly true considering that, when disaster medicine needs to be applied, the clinician's community tends to justify a derogation to the criterion of equal opportunity of health access, in line with the shift from individual medicine to community medicine, necessary due to the contingent situation, while normally no exceptions to the principle are admitted at a socio-political level[36].

---

[33] L. D'Avack (2020) "Covid-19: criteri etici", in *BioLaw Journal*, Special issue 1: 371-378; C. Di Costanzo, V. Zagrebelsky (2020) "L'accesso alle cure intensive fra emergenza virale e legittimità delle decisioni allocative", in *BioLaw Journal*, Special issue 1: 441-446. This was also my first interpretation of the Recommendations: let me please refer to M.G. Bernardini (2020) "Dilemmi mor(t)ali. Scelte etiche, *ageism* e diritti fondamentali ai tempi del Covid-19", in *Diritto virale. Collana del Dipartimento di Giurisprudenza dell'Università di Ferrara*, 1: 38-45, at http://www.giuri.unife.it/it/coronavirus/diritto-virale/dilemmi-mor-t-ali-scelte-etiche-ageism-e-diritti-fondamentali-ai-tempi-del-covid-19. However, I have reconsidered some of my previous stances. Lucilla Conte affirmed from the beginning the compatibility of the document at stake with the constitutional framework, in L. Conte (2020) *Covid-19. Le Raccomandazioni di etica clinica della SIAARTI. Profili di interesse costituzionale*, in *Federalismi.it – Osservatorio emergenza Covid-19*, at https://www.federalismi.it/ApplOpenFilePDF.cfm?artid=41659&dpath=document&dfile=01042020202411.pdf&content=Covid%2D19%2E%2BLe%2BRaccomandazioni%2Bdi%2Betica%2Bclinica%2Bdella%2BSIAARTI%2E%2BProfili%2Bdi%2Binteresse%2Bcostituzionale%2E%2B%2D%2Bstato%2B%2D%2Bpaper%2B%2D%2B (last accessed on 1st October 2020).

[34] See, for example, the multidisciplinary debate on the *Quotidianosanità.it* journal.

[35] The purpose was twofold: providing support to clinicians in the accomplishment of tragic choices, and explaining the health resources allocation, with a view to enhancing transparency.

[36] The issue is highlighted, as for the American context, by Robert Veatch, although the analysis seems to apply also to the Italian experience, where the inadmissibility of the derogation appears even more clear cut, due to the constitutional relevance of the right to heath within our legal system. See R.M. Veatch (2005) "Disaster Preparedness and Triage: Justice and the Common Good", *The Mount Sinai Journal of Medicine*, 72(4): 236-241.

In any case, the debate after the end of the ICUs overload allowed to clarify some of the most significant profiles, blurring the original conflict, also in relation to the individuation of age as a criterion (its clinic or extra-clinic nature will be further discussed below) that 'might' become relevant in the triage decision. It should be stressed that this decision needs to be considered as having an ethic, and non-technical, character, as the SIAARTI seems to suggest when stating that the choice of adopting an age limit for ICU admission would not merely be of a value nature[37]. It should also be remarked that decisions of this kind should be framed within a contingent, exceptional situation compelling the necessary and indispensable balance between the interests of the community and the ones of the individual. In particular, it seems necessary to admit that the emergency situation itself might – albeit respecting predetermined and limited conditions – justify the choice to give priority to the first, rather to the second, without it being considered discriminatory.

2.2. The age criterion: misunderstandings

Paying specific attention to recommendation n. 3 (in its Italian version), the allegedly discriminatory profile of the age criterion seems evident as regards at least three different profiles: *i*) contextual, *ii*) in the reference to the probability of survival and to life expectancy, and *iii*) because it is explicitly mentioned in the document. As far as the context in which the choice is made is concerned, the provision at stake is *prima facie* at odds with art. 3 of the Italian Code of Medical Ethics (and with the Italian constitutional principles). Indeed, life and health protection constitute duties for the clinician, who is obliged to respect the patient's dignity and freedom, as well as is prohibited in discriminating, irrespective of the institutional or social (*i.e.* the contextual) conditions in which s/he operates, in times of peace or of war. Having regards to the text of the provision, it seems that taking into account age may constitute a derogation to the egalitarian principle and that the clinician adopting such criterion may realize a discriminatory conduct (at least, this is the conclusion reached in public debate).

[37] Recommendation n. 3, only in the Italian version.

However, this is not the sole possible interpretation, because either it is well-known that recognizing a specificity does not entail *per se* a discrimination, and contextual analysis offers an alternative evaluation. It seems likely to consider that the conditions referred to in the Italian Code of Medical Ethics are the 'ordinary' ones, as such not characterized by the tragic nature of a pandemic. The exceptionality of the latter might – *per se* – open to the 'necessity' (and not to the mere 'possibility') of making choices *in concreto* affecting an individual in relation to the safeguard of health (and, likely, of life) being on an equal standing with the involved interests, after a global evaluation that might lead the clinician to consider also (and never exclusively) the age.

It is important to notice that this happens because, in maxi-emergency situations, the universality of treatments of care – while remaining, together with equity, a fundamental principle (and, in normal conditions, inderogable) of our legal system – might *in concreto* not be granted at all, thus rendering a deviation to the Hippocratic Oath necessary, in the interests of the community[38].

The preamble of the document itself clarifies that an alternative is not possible:

> the application of rationing criteria is justifiable only after all the subjects involved […] and all possible efforts have been made to increase the availability of resources existing (especially the Intensive Care beds) and after assessing any possibility of patient transfers to centres with greater availability of resources[39].

Furthermore, the justifiability of the choice depends on further elements, such as – only to name a few – the necessity to consider the possible existence of advance healthcare directives[40], the duty to adequately motivate the decision of ceiling of care[41], the daily reassessment of the clinical appropriateness, of the goals and proportionality of ICU care[42],

---

[38] C. Petrini (2010), "Triage in Public Health Emergencies: Ethical Issues", in *Intern. Emerg. Med.*, 5: 137-144, 138.
[39] *Recommendations*, cit., 3 (of both the Italian and the English versions of the document).
[40] Cf. recommendation n. 5.
[41] Cf. recommendation n. 6.
[42] Cf. recommendation n. 11.

the reference to distributive justice and to the appropriate allocation of healthcare resources[43].

The SIAARTI explication that the choices of distributive justice in the allocation of healthcare resources need to be made taking into account the principle of clinical appropriateness and their daily re-evaluation seems to have blurred the contrast – highlighted by many – with what stated by the Italian National Committee for Bioethics (hereinafter CNB) in the document approved on 8th April 2020, where it is clarified that clinic appropriateness should lighten clinicians' tasks[44].

The terms of the matter seem as follows: given the necessity to evaluate the efficacy of the treatment with the clinical need of each patient (having also regard to the seriousness of the illness and the chances of therapeutic success), and excluded any form of aggressive treatment, how is allocation of resources that, in the actual circumstances are inevitably and extremely scarce, possible? SIAARTI recalls the "greater probability of survival" and the "greatest life expectancy", while CNB refers to the possibility of survival, which might not be a hazard to assimilate to the first criterion adopted by the SIAARTI in recommendation n. 3, although a more egalitarian yearning might be found in CNB's position[45]. Embracing the interpretative hypothesis suggesting a tendency towards a convergence between the two phrases, it has been sustained that the divergence would deal with the (in)admissibility of the

[43] Cf. recommendation n. 7. (Only) under exceptional circumstances, a decision to deny access to one or more life-sustaining therapies, based solely on distributive justice, 'may' ultimately be justified. Otherwise, distributive justice cannot be the only criterion which has to be considered. Also in relation to distributive justice, a difference between the formulation of the Italian and the English texts should be noted: in the first one, reference is made to "criteri di giustizia distributiva", while the second one recalls "the principle of distributive justice".

[44] CNB (2020) "Covid-19: la decisione clinica in condizioni di carenza di risorse e il criterio del 'triage in emergenza pandemica'", http://bioetica.governo.it/media/3987/p136_2020_covid-19-la-decisione-clinica-in-condizioni-di-carenza-di-risorse-e-il-criterio-del-triage-in-emergenza-pandemica.pdf, 8th April.

[45] In case of sanitary emergencies, the triage can be in fact inspired by both a utilitarian and an egalitarian ethical stance: in the first case, the purpose is to save those having the major life expectancy, while in the second the more disadvantaged, among those having a possibility of survival. On the difference between the two perspectives, see at least R. Baker, M. Strosberg (1992) "Triage and Equality: An Historical Reassessment of Utilitarian Analysis of Triage", *Kennedy Institute of Ethics Journal*, 2(2): 103-123.

reference to extra-clinic criteria in the decision-making process, thus highlighting the greater attitude of the Recommendations to provide appropriate criteria to guide clinicians' operate[46].

In this respect, two remarks need to be made. Firstly, when establishing the exclusively nature of 'age' (i.e. if it is a clinical or extra-clinical criterion), it seems to me that it is difficult to trace a clear cut line; rather, age is a hybrid criterion, both clinical and extra-clinical, which always becomes relevant when evaluating the patient's condition. On the one hand, medical evidence reveals how, as age increases, the physiological capacity to prevent physical decay diminishes, due to the fact that human beings accumulate functional deficits that act as biological stressors, making them more vulnerable to death[47]; in this sense, the criterion is clinic. On the other hand, it is now well known that biological age and chronological age do not always coincide (think of the difference between active ageing and non-self-sufficiency)[48], and that elements conditioned by the socio-cultural perception of a given subjective condition, which inevitably end up opening the field also to considerations of an extra-clinical nature, also influence the evaluation of individual psychophysical well-being.

Within the Recommendations, SIAARTI reveals to be perfectly aware of both aspects. The reference to age in order to evaluate the patient's probability of survival seems in fact to recall a clinical evaluation, in order to establish a priority for admission to ICU. CNB and SIAARTI seem therefore to converge on this point.

However, the reference to the 'highest number of years of life saved' (which is present only in the Italian version of the document, as earlier observed) may give rise to

[46] *Posizione di minoranza del Prof. Maurizio Mori: le Raccomandazioni Siaarti puntano nella direzione giusta*, as an appendix to the mentioned document CNB (2020), 12-13.

[47] This is the modified Gompertz Formula. See G.R. Gristina, L. Orsi, M. Vergano (2020) "Pandemia da Covid-19 e triage: la filosofia e il diritto talvolta guardano l'albero mentre la medicina prova a spegnere l'incendio della foresta", in *BioLaw Journal*, Special issue 1: 379-397, in particular 385. The authors also specify that, in the framework of the clinical evaluation of the elderly patients potentially in need for intensive care, in case doctors, patients and relatives discuss care purposes, an interpretative model of the relations among age, frailty and mortality is widespread, leading to consider chronological age as a surrogate of biological age. The two evaluations should however remain separate, also according to what has until now here emerged.

[48] The relation between chronologic age and probability of survival is proportionally inverse, as the older the individual, the less the functional reserves, the more psycho-physic frailty, thus implying a weaker response to treatments and a higher probability of side effects in case of intensive care treatments. Without comorbidity, biologic age coincides with chronological age and it is therefore connected to life expectancy.

extra-clinic considerations, and not by chance has led to foreshadow the configurability of ageism, due to the presence of an (alleged) necessary correlation with the patient's age[49].

Although this correlation appears to be more probabilistic than necessary[50], it is however difficult not to admit that, in most cases, the adoption of a similar criterion will lead to privilege the younger on the older. The issue, therefore, is to establish whether, in its tragedy, such choice is reasonable and, as such, justifiable.

Among the arguments posed to contrast the Recommendations, reference was made to the inadmissibility of every reference to quality (eventually adopting QALYs as internationally recognised standard tool) and/or to the unworthiness of elderly life, to the impossibility of reducing individuals to mere 'containers of utility' and to the implausibility of the so-called 'fair innings argument', according to which everyone should be given the equal opportunity to live its own life, so that the one who has already lived a conspicuous part of it should leave space to those who have lived less.

In my view, it seems that these arguments, with which I completely agree, cannot be usefully applied to the Recommendations. Firstly, within the document no reference is made to evaluations concerning the quality (or the worthiness) of patient's life; on the contrary, the reference to quality in the documents there recalled[51] – considered by SIAARTI as an interpretative support – is linked to the 'subjective perception' of the individual at stake, with the aim of enhancing her/his will, so that any measure according to objective parameters appears to be excluded. Moreover, in a utilitarian perspective, elderly condition *per se* does not necessary negatively influence on an individual's life quality: the relevant issue, from an ethical perspective, is rather to understand what renders an individual's life 'good' (or 'worthy') and what she/he considers as 'wellness'[52].

---

[49] C. Del Bò, "L'accesso ai posti letto in terapia intensiva. Qualche spunto di riflessione dopo l'emergenza", in *La Rivista Il Mulino*, https://www.rivistailmulino.it/news/newsitem/index/Item/News:NEWS_ITEM:5221 (11th June 2020, last accessed 1st October 2020).

[50] This would happen in case of two subjects with a relevant age difference and a similar clinical course; the situation is more hypothetical than real.

[51] See SIAARTI's recommendation n. 4.

[52] Highliting the issue, although regarding the disabled and not the elderly condition, J. Savulescu, I. Persson, D. Wilkinson (2020) "Utilitarianism and the Pandemic", *Bioethics*, 34: 620-632, 624.

Likewise, in the Recommendations no reference is made to role and/or social utility of the individual in order to deny the equal moral value of someone and, consequently, establish a priority order for admission to ICU[53].

According to the text of the document, the reference to utility might be made only having regards to the necessity, clearly stated, of saving 'as many years of life as possible'[54] – and of lives, reading recommendations n. 3 and 4 in conjunction – given the fact that an elderly clinical course may be longer, and therefore prevents the saving of more people's lives, in the broader perspective required by community medicine.

In this regard, the reference to the greatest number of years of life saved may certainly appear critical and difficult to accept on an ethical level, but when facing "mortal dilemmas"[55] which impose "immoral choices"[56], it is necessary to ask ourselves what alternatives are concretely feasible, bearing in mind that the shift towards community medicine necessarily requires reference to the community as well as to the individual.

Indeed, unlike the scenarios that have been presented more frequently at a theoretical level in recent months, the conflict that clinicians actually face is not between two

[53] On the contrary, with a view to saving more lives as possible, the utility argument (*rectius*, the argument of the higher instrumental value) is widespread in the American debate, especially as far as vaccines access is concerned. In this respect, it is not an issue of entrusting some lives with an intrinsic major value, but to privilege those lives having a major instrumental value. During a pandemic, health workers should be saved as priorities, as they are indeed individuals capable of saving further lives. This criterion can however be used by individuals having a socially privileged condition, thus appearing discriminatory. See, for example, J.F. Childress (2003) *Triage in Response to Bioterrorist Attack*, Cambridge (MA), MIT Press; J. Savulescu, I. Persson, D. Wilkinson (2020), cit., 625. It should be observed that the inopportunity to refer to the social value of an individual might come into play conversely: indeed, it has been suggested that the reference to age introduces an asymmetry in the realm of distributive justice, because on equal terms, the older patient that is (or might be) denied access to care is the one that has more contributed more to the fiscal sustainment of a given legal order (see G. Delvecchio, "Etica e scelte di fine vita in epoca di Covid-19", https://www.quotidianosanita.it/studi-e-analisi/articolo.php?articolo_id=83432, last accessed 1st October 2020). However, if we consider that in order to grant the fundamental right of an individual the arguments concerning the contribution this individual can provide now or in the future, are potentially discriminatory towards elderly persons, we should also take into account that the same argument could be applied when considering an already given contribution, thus revealing itself as equally discriminatory, *a contrario*.

[54] Again, cf. the Italian version of the SIAARTI's document.

[55] The thought-provoking expression was used by Marco Revelli, when commenting the SIAARTI's *Recommendations*. See M. Revelli (2020) "Siamo arrivati ad una sorta di *ground zero*", *Il Manifesto*, 11th March 2020.

[56] Expression effectively used by Jürgen Habermas. Cfr. J. Habermas (2020) *Dans cette crise, il nous faut agir dans le savoir explicite de notre non-savoir*, *Le Monde*, 10th April 2020.

fundamental goods (not only health, but two patient's lives), but among an indefinite number of them (plenty of patients' lives at risk), so that a choice – although dramatic – based 'also' on the attempt to provide assistance to the higher number of people does not seem unreasonable.

Rather, it would be worth noting that the prognostic evaluation of the saved life years shall be made in concrete (although with the specificities of 'prospective' triage[57]) and, probably, to consider the opportunity to identify a reference time-limit for the assessment at stake, given the fact that a fundamental element in triage is the short-term prognosis, which entails the priority admission of those patients who, in ICU, have sound probabilities of recovery.

In the same utilitarian perspective, another argument originated by the reference to age may be discussed. Scholars debated whether the chronological criterion may be culturally mediated and, therefore, whether it inevitably mirrors the socially diffused negative images concerning the ageing process and the uselessness of elderly people, thus appearing discriminatory. Such an eventuality does not seem at all to be excluded, precisely because of the dual profile – clinical and extra-clinical – of age (on closer inspection, among other things, adopting a reasonable constructivism, it seems difficult to identify non-culturally mediated criteria).

Nevertheless, a systematic reading allows to understand how SIAARTI is not only aware of the issue, but purports to counter the socially diffused stereotypes. In the 2003 document, referred to in recommendation n. 4, SIAARTI keeps clinical appropriateness criteria still, considering them insurmountable, precising that "[c]hronological age in itself is not a criterion to decide appropriateness of intensive care, because it is not always correlated with biological age"[58]. Furthermore, it clarifies that "[e]valuation of the clinical appropriateness of intensive care must not in any case be influenced by the negative image

[57] In the 'prospective triage', the individual's condition is evaluated in conjunction with the condition of other patients (be they present, or clinically evaluated although not present in emergency room).

[58] SIAARTI (2003) "Guidelines for Admission to and Discarge from Intensive Care Units and for the Limitation of Treatment in Intensive Care", *Minerva Anestesiol.*, 69: 101-118, in particular 105.

that society has of old age”[59], thus – apparently – entrusting age with a clinical reference for the purpose of the evaluation at stake.

Lastly, from the text of the Recommendations it does not seem possible to infer that the reference to age could be justified in the need to grant equal opportunities to live one’s own life, privileging the younger (the so-called ‘fair innings argument’). After the reference to the higher probability of survival, the referral goes in fact to a numerical criterion (the highest number of years of life saved in the Italian version), that seems to disregard any consideration of intergenerational justice, to which the argument at stake seems instead to substantially refer. Once again, it is worth noting that this eventuality (the preference accorded to the younger rather than to the older), although statistically more probable, is not featured by any element of necessity, as demonstrated by the news stories occurred in recent months.

The contingent character of the link allows also to rebut the thesis according to which an approach aiming at maximizing the number of years saved should ‘always’ give preference to women[60]. Age, in fact, is neither (and cannot be) the ‘sole’ relevant criterion for the assessment to be made[61], nor is it a ‘certain’ predictor of an individual’s life expectancy. Once again, the clinical course of the individual should be taken into account, upon which age and comorbidity certainly have an impact, through combined with other factors[62].

---

[59] *Ibidem.*

[60] Cfr. Del Bò (2020), cit., 2.

[61] This point is particularly evident when confronting the Italian and the English versions of the recommendation n. 4. The Italian version states: “La presenza di comorbidità e lo status funzionale devono essere attentamente valutati, in aggiunta all'età anagrafica. È ipotizzabile che un decorso relativamente breve in persone sane diventi potenzialmente più lungo e quindi più ‘resource consuming’ sul servizio sanitario nel caso di pazienti anziani, fragili o con comorbidità severa”. The English one says “Together with age, the comorbidities and functional status of any critically ill patient presenting in these exceptional circumstances should carefully be evaluated. A longer and, hence, more ‘resource consuming’ clinical course may be anticipated in frail elderly patients with severe comorbidities, as compared to a relatively shorter, and potentially more benign course in healthy young subjects”. As it is easy to see, the Italian version considers patients “anziani, fragili o con comorbidità severa”, while in the English one the reference is to “frail elderly patients with severe comorbidities”. This difference is particularly significant, as the English formulation effectively restricts the margins of interpretation. It can be assumed that, following the criticism received in relation to the Italian version, the SIAARTI sought a formulation that was more capable of avoiding ageist interpretations.

[62] This aspect emerges in the Italian as well as in the English version of the document: “La presenza di comorbidità e lo status funzionale devono essere attentamente valutati, in aggiunta all'età anagrafica” and “Together with age, the comorbidities and functional status of any critically ill patient presenting in these

The fact that age is not assumed by SIAARTI as the sole relevant criteria allows to briefly focus on the last possible discriminatory profile, *i.e.* the one concerning its nomination. Can the sole explicit reference to age with a view to ICU admission justify the ageism charge? Although tendentially negative, the response cannot be clear-cut. As already specified, the reference to age, in and of itself considered, cannot be considered discriminatory, as it only represents one of the parameters that SIAARTI urges to take into consideration for the purposes of the assessment [63], being it relevant (primarily) as a clinical criterion (for the formulation of the appropriateness judgement). Furthermore, the formulation of recommendations no. 3 and 4 does not explicitly states a clear-cut, aprioristic exclusion from ICU on the basis of age.

However, the first phrase of recommendation n. 3 – "An age limit for the admission to the ICU may ultimately need to be set"[64] – reveals some criticalities[65]. While a mere possibility of selection based upon age – not *per se* discriminatory – is stated, it can be also interpreted as opening for the successive setting of the threshold, thus inducing to find in the wording a justification for the operation at stake[66]. In this case, age would become a cut-off criterion for acceding ICU and the choice among the different care paths would be aprioristic, instead of being based on prospective triage (requiring an evaluation, although referred to the "community of patients" rather than to the individual). Although the aim of the introduction

exceptional circumstances should carefully be evaluated" (cf. recommendation n. 4). It could also be argued that the two texts are slightly different: the Italian version seems to solicit to give priority to the evaluation of age, while the English one 'puts' age, comorbidities and functional status on the same level.

[63] This opportunity is admitted by the CNB (2020, cit., 7), although focusing attention on the need for this reference not to be applied discriminatorily: "L'età […] è un parametro che viene preso in considerazione in ragione della correlazione con la valutazione clinica attuale e prognostica ma non è l'unico e nemmeno quello principale. La priorità andrebbe stabilita valutando, sulla base degli indicatori menzionati, i pazienti per cui ragionevolmente il trattamento può risultare maggiormente efficace, nel senso di garantire la maggiore possibilità di sopravvivenza".

[64] The choice not to set an age limit is very appropriate, as if it had been fixed, discrimination would have been occurred.

[65] This is particularly true where read in disjunction with the reference in the successive phrase, where the SIAARTI recalls the possibility of survival and life expectancy.

[66] This happened with the Lombardy Regional Council deliberation n. XI/3013 of 30 March 2020, and similar news were diffused as regards the initiatives taken by the Protezione Civile in Piedmont: E. Di Blasi (2020), "Italians over 80 'Will Be Left to Die' as Country Overwhelmed by Coronavirus", *The Telegraph*, 14th March.

of similar expression is dramatically understandable (the lack of time to evaluate the cases in need of ICU and, hypothetically, the extrinsecation of an already in place policy, due to the emergency situation), a similar case would be outright discriminatory and, as such, in contrast with the principles upheld by the Italian legal system, and with those derived from the supranational sources[67].

3. After the emergency

In the debate developed in the last few months, regarding the recognition of elderly people's subjectivity and the protection of their fundamental rights, the Recommendations issued by SIAARTI have often been considered one of the manifestations of the phenomenon of structural discrimination known as 'ageism'. The reference, within the document, to age, probability of survival and years of life saved – and, more generally, its ethical inspiration, considered utilitarian[68] – has in fact induced many to individuate in the Recommendations one of the poles that, in connection with long-term care system management, has dramatically revealed the lower social value accorded to the lives of elderly people and their consequent dispensability.

The proposed analysis allows to depart from this interpretation, even though the observations on the problematic nature of the incipit of recommendation no. 3 remain valid; perhaps, a constitutionally oriented reading of the document, taken as a whole, can help to contain it. In particular, the Recommendations do not appear to be directly discriminatory, as the age criterion does not assume a cut-off character.

Hence, it could be assumed that the reference to the probability of survival and to the years of life saved makes the Recommendations indirectly discriminatory, as it is reasonable to presume that, on the basis of these criteria, elderly people are more frequently denied access to ICU.

Once having recalled that such an eventuality does not necessarily occur in practice, it should be considered that proportionality comes into play: only the evaluation of the

[67] See as an example art. 21 of the Charter of Fundamental Rights of the European Union.
[68] As it has been recalled, the document only has *some* utilitarian elements.

'concrete case' at stake can reveal whether extremely scarce resources have been used efficiently and effectively[69]. In this respect, if the Recommendations were to be inscribed in a utilitarian theoretical framework, where life quality is referred to, then the allegation of being discriminatory could be grounded. However, they resemble what has been theorized ad 'precautionary utilitarianism', a consequentialist perspective its same proponents recognize as not being utilitarian, although naming it accordingly because the term 'utilitarianism' – contrary to 'consequentialism' – is well known[70]. In this perspective, rationing is aimed at maximising scarce resources, but the clinical evaluation of the person and the analysis of the benefits that will derive from the treatment remain a priority, in an attempt to balance equality and utility, hence referring to probability of survival and life expectancy[71]. In this way, it is undeniable that individuals belonging to some groups *in concreto* might be disadvantaged in accessing ICU, but this possibility will be justified only and insofar if they would benefit from treatments in a significantly inferior manner than other patients[72].

These remarks, together with the SIAARTI's warning to ensure that the evaluation of appropriateness of the intensive care treatments is not influenced by the socially diffused negative imagines of old age previously emerged, induce to believe that the documents of 6th March 2010 is not part of the system of structural discrimination that is currently in place against the elderly, as revealed in particular by the episodes that occurred within long-term care facilities.

---

[69] J. Savulescu, J. Cameron, D. Wilkinson (2020) "Equality or Utility? Ethics and Law of Rationing Ventilators", *British Journal of Anaesthesia*, 125(1): 10-15.

[70] *Ivi*, 13.

[71] Contrary to what happens in the *Recommendations*, a reference to quality of life is made in this approach, which the SIAARTI did not make (and appropriately so). It should however be recalled that, in precautionary utilitarianism, this criterion is admitted only if the quality of life at stake is deeply impaired. As an example, it should be applicable in case a person were kept alive, although in unconsciousness; conversely, no evaluation leading to prefer an individual to another solely because of age or the absence of disabilities would be justifiable (hence, in the case of two individuals, one of which is a sighted person and the other one blind, blindness would not constitute, per se, a criterion to prefer the first individual on the second).

[72] "If the difference in the benefit they would derive would be marginal, it may not be acceptable to differentiate between people on this basis. This means more minor differences in probability, length, or quality of life should be ignored, but more significant differences should be relevant" (J. Savulescu, J. Cameron, D. Wilkinson (2020), cit., 13). From this passage, it is self-evident how even in this ethical perspective age does not lead automatically to prefer a younger person.

On the contrary, the Recommendations contributed to fostering the emergence of already existing structural macro-allocative problems in the Italian legal system, as well as to revitalizing the debate concerning the need to re-think the welfare system, strengthening prevention and, hopefully, adopting a 'territorial' or 'proximity' model, where the link with the territory and the coordination of the available resources may lead to an improvement of the (public) services offered, also with a view to a further integration between the social and the sanitary components[73].

Similar attention has also an impact under a socio-cultural point of view: the Recommendations have in fact contributed in redeeming elderly people from invisibility, imposing them on public attention as subjects of justice and fundamental rights bearers.

Unfortunately, the debate has just begun and, once faded the pandemic emergency, seems to have lost its initial strength. However, this circumstance confirms the urgency of rescuing the issue of the subjectivity – *rectius*: subjectivities – of the elderly from marginalization, in order to put it at the centre of the public debate concerning justice and the protection of fundamental rights. And this is certainly not a matter of interpretation.

4. *Postscriptum*: surfing the 'second wave'

As I was completing this essay, the "cry of pain"[74] of which the SIAARTI Recommendations were the result, seems to have produced concrete results, which I will briefly consider below. Following the great uproar caused by the adoption of the document analyzed in these pages, the National Institute for Health (ISS) has favoured the opening of a dialogue among experts, aimed at the devising possible guidelines for CoViD-19 triage to be adopted by the ISS itself.

The new document, elaborated following a reflection extended to the legal and medical-legal sphere, is the result of a critical review of the experiences matured in the field

[73] On these aspects, see also the CNB Opinion, "Covid-19: salute pubblica, libertà individuale, solidarietà sociale", 28th May 2020. In the Third Sector, reference is often made to this type of welfare also with the expression 'Welfare 4.0'.
[74] Available at: https://portale.fnomceo.it/anelli-fnomceo-su-documento-siaarti-nostra-guida-resta-il-codice-deontologico/.

during the 'first wave' of the CoViD-19 pandemic, both at the Italian and at the international level, as well as of the reflections stimulated by the pandemic in the ethical, deontological and bioethical spheres. They are contained in a draft, published on the ISS website[75] for public consultation among health professionals, citizens and stakeholders. The draft follows the SIAARTI Recommendations and constitutes the following step of the joint document drawn up by SIAARTI and FNOMCEO at the end of October[76].

The draft therefore seems to overcome some of the critical aspects highlighted in relation to the SIAARTI Recommendations, due both to the contribution of experts from various sectors and to the decision to make the text the subject of public discussion, so as to obtain the broadest possible consensus on its content.

Furthermore, the effects of the public debate raised by the SIAARTI Recommendations are also visible in its content. The draft states that in case of a complete saturation of resources, which makes it impossible to guarantee intensive care to all patients for whom the clinical indication for such treatments is given, priority criteria must be used.

Expressly rejecting the 'first come, first served' criterion as contrary to the principle of equity, it is argued that triage is necessary and operational indications are given in this regard. Before that, the document specifies that the application of triage cannot lead to exceptions to the relevant constitutional principles (healthcare, self-determination, equality and equal dignity, solidarity) and to the deontological and founding principles of the NHS (universality and fairness), nor to the need for appropriateness of care despite the extraordinary situation.

With specific reference to the 'age factor', which I have discussed in this contribution, the document currently open for discussion seems to go beyond the more controversial aspects of the Recommendations, substantially reiterating its content and, it seems to me, going in the direction of the interpretation I have here proposed. Indeed, it avoids repeating the initial part of recommendation no. 3 analyzed above and, more generally, clarifies some

[75] Available at: https://snlg.iss.it/?p=2706. As stated, the document was sent to the ISS on 11.11.2020.
[76] Available at: http://www.quotidianosanita.it/allegati/allegato2093345.pdf.

of the critical points of the recommendation in question, allowing the significant ambiguities that were found in the Recommendations to be overcome.

After recalling that the purpose of intensive care triage is to guarantee life support treatment to as many patients as possible who can benefit from it (statement 5), the document clarifies (statement 6) that triage must be based on clinical-prognostic parameters, as objective and shared as possible, and that the evaluation must be based on the overall assessment of each single patient's conditions. The comparative assessment of the patients' conditions is functional to understanding who is most likely to overcome the critical condition in which they find themselves, thanks to the support of intensive care. It is only in this regard[77] that both the possibility of survival in intensive care and the reasonable expectation of living outside it are highlighted.

The assessment is to be made with reference to certain relevant parameters, which are set out in the draft with the specification that there is no hierarchical relationship between them and that they must be balanced and contextualized in relation to the specific case (p. 11). These parameters include (as in the SIAARTI Recommendations) comorbidities, previous functional status, fragility, the severity of the current clinical situation, and the presumed impact of intensive care, also with regard to the patient's age, as well as the patient's willingness to undergo intensive care. Age, therefore, is made reference to 'in the context of the overall assessment of the sick person', and – as explicitly stated – is not taken as a cut-off criterion.

In response to the criticism levelled at recommendation no. 3, the draft properly states that age is not in itself a sufficient criterion to establish which patients can benefit most from intensive care. It also omits any reference to the possible imposition of an age limit on entry into intensive care (which was, as emerged in this essay, the most critical aspect of recommendation no. 3 of the Recommendations). However, this does not exclude that, all other conditions being equal, age 'can' come to the fore.

In this regard, the draft specifies that the age-related data may play a role in the overall assessment of the clinical condition of the person, but any doubt is removed as to whether it can be detected for ageist reasons, related to the socio-cultural significance

[77] And, we could add, not with reference of a supposed quality of life.

attributed to age itself. In fact, the possible relevance of age is solely due to the fact that, with increasing age, the probability of response to intensive care is reduced. Once again, therefore, it does not seem that any discriminatory character can be found in this evaluation, also because among the principles that guide the work of professionals there is that of equality, which requires opposing all forms of discrimination – including age-based discrimination – in access to care.

What said above does not disprove the fact that the pandemic has revealed (and is still revealing) the ageist nature of our system and confronts us with the need to question ourselves about our (institutional and social) responsibilities in the slow – but hitherto unstoppable – process of marginalization and discrimination against older people, especially those who are not self-sufficient. Once again, therefore, the urgency of putting the elderly's subjectivity at the centre of the public debate, in order to protect her fundamental rights, should not be considered a matter of interpretation.