A proposal for formal fairness requirements in triage emergency departments: publicity, accessibility, relevance, standardisability and accountability

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ABSTRACT

This paper puts forward a wish list of requirements for formal fairness in the specific context of triage in emergency departments (EDs) and maps the empirical and conceptual research questions that need to be addressed in this context in the near future. The pandemic has brought to the fore the necessity for public debate about how to allocate resources fairly in a situation of great shortage. However, issues of fairness arise also outside of pandemics: decisions about how to allocate resources are structurally unavoidable in healthcare systems, as value judgements underlie every allocative decision, although they are not always easily identifiable. In this paper, we set out to bridge this gap in the context of EDs. In the first part, we propose five formal requirements specifically applied for ED triage to be considered fair and legitimate: publicity, accessibility, relevance, standardisability and accountability. In the second part of the paper, we map the conceptual and empirical ethics questions that will need to be investigated to assess whether healthcare systems guarantee a formally just ED triage. In conclusion, we argue that there is a vast research landscape in need of an in-depth conceptual and empirical investigation in the context of ED triage in ordinary times. Addressing both types of questions in this context is vital for promoting a fair and legitimate ED triage and for fostering reflection on formal fairness allocative issues beyond triage.

INTRODUCTION

The pandemic has brought to the fore the necessity of establishing criteria on how to allocate scarce resources in a situation of disaster. During the COVID-19 health crisis, public debate emerged around two issues: substantive and formal fairness. Regarding the former, the debate focused on the type of criteria which should be in place and on which basis a decision regarding the allocation of scarce resources should be made.[1–3] Regarding the latter, discussions emerged about who should make these decisions, how and when.[4 5] They were, literally, decisions about life and death: whom to allocate the ventilator or the last available intensive therapy bed, and whether and when to discontinue an intensive treatment and offer it to someone else who might have a better chance of survival, among others.

Decisions about how to allocate resources are structurally unavoidable in healthcare systems not only in disaster scenarios but also in ordinary conditions. There are waiting lists for surgeries, organ transplants and specialised appointments, and waiting lists are based on underlying allocative criteria. Accordingly, the problem of allocating scarce healthcare resources and the criteria on which basis they should be allocated is not a new issue.[6] However, it is an issue which has remained confined within two main contexts: public health ethics and economics, and disaster ethics, with limited encroaching onto the public discussions of national health systems. This can be explained because healthcare rationing is a topic of controversy carrying a long-standing societal taboo beyond the contexts of disaster management or health management; and has resulted in very little sustained public, political or medical debate on the topic and a longstanding although incorrect perception that the only ethical issues in medicine are those pertaining to doctor/patient relationships, self-determination and autonomy.[7–9]

The ethical discussion around underlying criteria mainly emerges when life-saving treatments *with immediate effect* are allocated. This is particularly evident in the case of triage for admission to emergency departments (EDs), since the papers discussing the ethics of triage refer mainly to disaster medicine,[10–12] thus focusing on situations in which saving a person's life means it is impossible to save another, as if non-disaster situations do not require in-depth ethical reflection. In this vein, Eijkholt *et al* recently argued that as long as triage is not a *rationing* effort but only a *prioritising* one (hence, it is possible to save all lives, only at a later stage), then triage has to do only with medical practice and not with values as long as everyone can access treatment.[13]

As we explicitly argue throughout this paper, there are strong reasons to challenge this way of thinking, as both rationing and prioritising efforts involve values. Although it may not always be easily identifiable due to a lack of publicity of the criteria or a lack of discussion from an ethical perspective, prioritising one patient over another implies a normative dimension. This dimension involves the ethical enterprise of choosing which criteria a healthcare system should adopt in order to allocate scarce resources. The fact that allocation criteria and priority rankings are not contested or perceived as controversial by the public does not mean that they are not based on value judgements.[i] Even in ordinary contexts, there are value judgements underlying allocative decisions, which may lead to problems of substantive and formal fairness.

This paper aims to highlight the issues of formal fairness in the specific context of triage in EDs

[i]In the USA, healthcare may also be rationed by money price, which is common. We argue that, even in this case, there are value judgements underlying the decision about how the market allocates healthcare resources that must be analysed from an ethical perspective

and to map out the empirical and conceptual research questions that need to be tackled in the near future in this context, thus calling for an in-depth bioethical debate on this topic. The paper is structured as follows. The section 'Background on triage in EDs' provides the necessary background and context to our discussion. In this section, we present the reasons why we chose to focus on triage in ED, and the main types of triage systems used in this context. In 'Substantive and formal fairness issues in ED triage' section, we argue that ethical issues that pertain to the fair allocation of healthcare resources can be of two types: substantive and formal fairness. In 'Substantive and formal fairness issues in ED triage' section, we propose a wish list of formal conditions for ED triage to be considered fair and legitimate. In 'A formal fairness wish list of requirements for ED triage' section, we map the conceptual and empirical ethics questions that will need to be investigated to assess whether or not healthcare systems guarantee ED triage in line with the conditions presented in 'Substantive and formal fairness issues in ED triage' section. We conclude by arguing that there is a need for an in-depth conceptual and empirical analysis of ED triage in ordinary times. Addressing both types of questions in this context is vital for promoting a fair and legitimate ED triage in non-disaster circumstances.

BACKGROUND ON TRIAGE IN EDS

There are three main reasons why we chose to focus on the topic of triage in EDs.

The first is that we have identified a gap in the literature insofar as the ethical discussion of ED triage criteria has received little attention in the literature with the exception of at the peak of the pandemic[14 15] and from the angle of disaster management.[10 16]

The second reason is that EDs are the context in which triage questions are most explicit and well-recognised, although they are not the only context in which such decisions need to be made.[7] Moreover, little is known about patients' conceptions of the triage encounter; however, the little empirical data available show that patients do *not* know the purpose of triage.[17]

The third reason is that an increasing number of data show that, although in the first phase of the pandemic the number of daily admissions to ED went down, for a variety of factors including fear of contagion and fear of overcrowding a system already at its limits,[18] the number of admissions to emergency room increased postpandemic with respect to prepandemic levels.[19–21] Across Italy, for example, an increasing number of data points to a stretched system at the ED level with increasing wait times. A recent paper by Cianci[22] shows how in Italy on average there are 20 million ED admissions every year, of which between 25 000 and 30 000 are considered 'inappropriate admissions'. The work by Zaboli *et al*,[20] which focused on the hospital of Merano in the Alto Adige/Südtirol province, is particularly interesting as it shows a progressively increasing trend in the number of non-urgent admissions from January 2020 to June 2022 as recorded by the type of codes assigned to each admission (white and green[ii]), while the number of urgent admissions (codes orange and red) remained stable before and after the pandemic. This suggests that the pandemic has not impacted the proportion of daily visits for symptomatic conditions, which are truly urgent or life-threatening. The statistically significant increase in the number of admissions to ED for non-urgent codes can be explained by several social changes due to the pandemic, including the fact that many health services at the community level have seen dramatic reductions or closures. Zaboli *et al* also point to the fact that the EDs always being open, without the need for an appointment, with face-to-face delivery, could have contributed to a substantial shift for a portion of patients.[20] This has increased the pressure on EDs, with important repercussions on the quality of the service at the national level.

SUBSTANTIVE AND FORMAL FAIRNESS ISSUES IN ED TRIAGE

Ethical issues that pertain to the fair allocation of healthcare resources at the level of triage in EDs can focus either on: (a) questions of substantive fairness (responding to the question: which criteria should be used?) or (b) questions of procedural or formal fairness (responding to the question: how should these criteria be chosen? And by whom?). Substantive fairness issues concern outlining one or more allocative criteria for triage according to the principles of distributive fairness. This choice is defined as substantive because it necessarily embodies an evaluative judgement of what is the right choice from an ethical standpoint, in a given situation. For example, for a utilitarian, the appropriate substantive allocative choice will be one that will maximise aggregate well-being in a given population, while for an egalitarian, or at least for some forms of egalitarianism, the choice will be one that promotes an equal chance of being treated. Needless to say, many allocative choices in healthcare will diverge depending on which distributive principle is considered to be the most appropriate.

In this paper we focus on the formal justice issues, noting that in the case of ED, there seems to be a consensus at least from a theoretical point of view to prioritise the person most urgently needing treatment, looking at the severity of the patient's condition and the potential for deteriorating rapidly if not addressed promptly. Let us call this 'the sickest first' criterion.[23] In the ED ordinary context, such a criterion is justifiable from several approaches, among which are utilitarianism, fair equality of opportunity and prioritarianism. According to utilitarianism, the sickest first criterion may contribute to maximising the aggregate well-being. Suppose we have two patients awaiting to be treated in ED: one with a broken leg and another with a severe heart attack. The sickest first criterion guides us in choosing to treat the one with a severe heart attack. If we use another criterion, say, a coin is tossed to decide whom to treat first, and we end up prioritising the patient with a broken leg, the patient whose life is most at risk would most likely die and this would lead to a decrease in aggregate well-being. The sickest first criterion is even more justifiable from a utilitarian perspective if we acknowledge that, generally speaking, the resources in the ED are allocated between those who need it very quickly, and those who can wait some time without risking their lives (those whose condition is not 'time-dependent' or not subject to rapid deterioration, such as those with a broken leg). Thus, in contexts other than those considered by disaster medicine literature, the ED decisions are often not about deciding who to let live and who to let die, but whom to give priority and who to let wait. Giving priority to those whose lives are at most risk allows practitioners to save the lives of those in need of immediate care, and to treat those who have minor needs. With regard to the equality of opportunity perspective, as Baker and Strosberg have pointed out,[24] Rawls' difference principle can serve as a justification for ED triage systems insofar as rational decision-makers under the veil of ignorance would prefer a triage system that prioritises the most urgent and, thus, saves more lives. Consequently, they would have a better chance of being saved if they were in a position to

[ii]Blue and green codes in emergency departments in Alto Adige/Südtirol correspond to white and green codes in the rest of Italy.

need treatment in the ED.[10 24 25] Finally, according to prioritarianism, dealing with the most urgent patient is justified by the need to promote the choice that benefits those who are worse off.[23]

The sickest first criterion in ED is not controversial, or at least not as controversial as other allocative criteria, principally because it can be justified by different distribution principles. There is however another reason why the principle is not as controversial as other allocative criteria: as already recognised above, favouring those who are currently sickest happens in a context in which resource scarcity is generally temporary—that we can save the person who is now sickest and then save the less-ill person later since the life of the latter is not at stake. Since in ordinary conditions, specifically for milder cases, ED is at best a matter of waiting and not a matter of life or death, the potential discontent relating to the choice of allocation is less acute. From this perspective, an alleged inappropriate allocation choice could be perceived primarily as a nuisance rather than a profound injustice. Or, at least it could be understood as an injustice but not as something about which it would generally be worth publicly protesting. For example, when a person walks past you in line for the university cafeteria, you get angry but most of the time you do not think it is worth a fight. You know that sooner or later you will be able to have your coffee. However, it is clear that when the preponderance of choices an ED has to make on a daily basis are those of life and death, then the sickest first criterion would no longer be sufficient and further reflection would be needed. This is the reason why the literature on ethics and triage focuses mainly on disaster situations, as indeed happened during COVID-19.[1 4 23]

While it is certainly encouraging—and not obvious at all[26]—that there is a general consensus around the sickest first criterion for allocating resources during ED triage, independently from substantive fairness issues, formal fairness issues strongly emerge. Addressing formal fairness issues is extremely relevant in order to provide a fair and legitimate triage system. Morally relevant values and principles are necessary for an appropriate allocation; however, it cannot be such if the aspects of formal fairness are not met as well. Although the reasons why people decide to use a fair process of allocative resource management is often the impossibility of finding substantive allocative principles shared among all[26], in the case of triage in ordinary times, where instead there seems to be a certain convergence with respect to the distributive principles, formal issues which can prevent a fair and legitimate allocation of scarce resources are particularly important.

A FORMAL FAIRNESS WISH LIST OF REQUIREMENTS FOR ED TRIAGE

To ensure formal fairness, the first necessary step involves outlining a 'wish list' of conditions or requirements that must be satisfied for ED triage to be considered fair and legitimate. Notice that none of these conditions is novel or surprising,[27] since many are widely recognised features of good governance. Moreover, they are compatible with the more general conditions of the 'accountability for reasonableness' account proposed by Daniels and Sabin.[26 28] The conditions we propose below, however, are constructed specifically for the ED issue, zooming in from a general perspective to a context-specific one.

Publicity

Publicity is considered by Rawls as one of the 'formal constraints of the concept of right',[29] which should be met by any moral theory that addresses issues of justice. The publicity condition requires that a principle of justice must be publicly recognisable as one of the fundamental rules of society. This constraint arises spontaneously from a contractualist conception of society: the parties, called to decide on the fundamental terms of their association in an initial position of equality, assume that everyone knows the principles of justice, and that these are the result of a public agreement. For society to impose 'just' rules on individuals, those rules should at least be public and transparent.

In the context of EDs, the publicity criterion requires transparency about the rationing criteria, and about the process that leads to the decision of such criteria by the authority. Notice that with regard to ED triage in ordinary, non-disaster times, it is possible to achieve greater transparency than in other situations in which rationing is practised (eg, think of some forms of implicit rationing).[7] People waiting in the emergency room, for instance, when assigned a colour or a number on admission in EDs as is common practice worldwide,[iii] can make a reasonable prediction on how long they will have to wait; or at least can ascertain from their colour or number that someone else has been given a higher or lower priority.

The publicity requirement for ED triage is not limited to making allocative decisions transparent.[30] It extends also to making explicit how such decisions were reached, and the grounds on which they were reached. This, of course, involves outlining the underlying value-judgements, or ethical commitments. Another important aspect to consider in ED triage with respect to the publicity criterion is the fact that in order to satisfy the sickest first criterion, healthcare systems employ functional criteria that are usually systematised in methods such as the Manchester Triage Method or the Emergency System Index. We argue that should the reasons and the evidence supporting the methods be made explicit to the patients, but also the way the methods are applied.

Accessibility

This requirement is clearly related to the publicity one, and although some authors speak of this in reference to the publicity condition,[26–28] we argue that in the ED context it deserves a separate discussion. It is plausible to think that a healthcare system could make the functioning of triage methods public and formally accessible (hence meeting the first requirement), but, at the same time, this information is formulated in an unclear way or is difficult to access. In other words, the information could be made public, but remain inaccessible. This is even more evident if we consider that the publicity condition requires that the functioning of triage methods, which can be complex for laypeople, are also made explicit. Therefore, the accessibility requirement appears more demanding, since it is important to make the functioning of triage methods public and transparent and to make it communicable and accessible by those subjected to the allocation choice. Here, an analogy can be drawn with regard to informed consent. If for each treatment it is appropriate that there is a consensus delivered in an understandable way from the healthcare professional, any allocation choice that can be considered legitimate presupposes that the patient is at least put in a position to be easily able to access information regarding triage functioning. This does not mean that the triage nurse must explain it to each patient; alternative communications may be evaluated, such as posters in the waiting room or brochures to be

[iii]The application of emergency codes only in colour, or colour-based emergency codes including some plain language, is still a common practice worldwide,[39] although the use of colour-based emergency codes differs between countries and sometimes even within the same countries such as the case of Italy.

distributed at the time of triage, or even accessible information on the healthcare systems website.

Relevance

According to Daniels and Sabin, it is not enough that allocative decisions and rationales for them are public and accessible. Reasons supporting them should also meet certain conditions: they should be accepted as 'relevant by fair-minded people who are disposed to finding mutually justifiable terms of cooperation'.[26] Reason-giving is a way to show respect for persons and to involve them in an 'open conversation' on the allocation of scarce healthcare resources in search of legitimation of the allocative rules imposed on people by the healthcare system. This explains why justifications provided by decision-makers should be relevant and suitable for all individuals impacted by the decisions that are made, ensuring that everyone affected can understand and accept the reasoning behind them.[28]

Applied to the context of ED, the relevance requirement asks that the criteria and methodologies are supported by both scientific evidence and moral reasons that can be accepted by all fair-minded potential ED patients. For example, if there is strong evidence that one triage method is better than others at identifying people in need of immediate care and that is more effective in allowing physicians to treat them more promptly and effectively, this would certainly be a good reason to choose this triage system over another. In this sense, it would also be a reason that other reasonable people would accept.

It is worth noting that the relevance requirement does not necessarily lead to the definition of the same criteria for all contexts, since there may be more than one reasonable way to allocate resources fairly and legitimately in triage. For example, some may propose to include characteristics such as age in the definition of 'the sickest patient' based on prioritarianism justification, since age may constitute an additional element in the evaluation of the frailty of patients. From this perspective, older people may be considered worse off, therefore they should be prioritised. Others may object from some kind of egalitarian perspective, and prefer that younger people—specifically in a disaster situation where there is a severe scarcity of resources—should be prioritised over older people since they would not have had a *fair inning* yet, namely the opportunity to live a 'normal' span of years in good health.[31]

This example allows us to show that we may have more than one way to weigh reasons and evidence in establishing fair and legitimate criteria and methods of triage in ED and, as a consequence, more than one fair outcome in the allocation of such healthcare resources.

Standardisability

We argue that a healthcare system must have a standard triage method in place; this is justifiable on the basis of at least two reasons. Let us first mention a reason that is not directly related to issues of formal fairness, but still relevant. According to the scientific literature, standardisation is a value that promotes the efficiency and effectiveness of the system. Di Laura *et al* performed a systemic review of efficiency measures in ED in Italy and concluded that there are no standard measures of efficiency. The authors advocate for the implementation of a standard set of ED performance metrics that could be uniformly implemented across the country or the state and which, the authors postulate, could increase 'the efficiency of services, reduce waste in terms of waiting times and improve the quality of the working environment for both patients and operators'.[32]

In addition, and more relevant for the purposes of our paper, meeting the standardisability requirement allows first to satisfy the principle of formal fairness according to which *similar cases should be treated similarly*, which presupposes a certain equality of citizens with respect to the law and allocation choices. By standard, we therefore refer to a method that prevents healthcare professionals from arbitrarily determining during triage that similar cases are treated in a different way. Notice that we do not mean that two people with the same condition must always access the service within a fixed amount of time. This will of course depend on available resources and other factors available at a specific moment. Nonetheless, a standard method can ensure, as far as possible, that under the same conditions, two patients are treated following the same process and criteria. Standardisation can be *internal*, that is, a single hospital can adopt a method to prevent two nurses from reaching different decisions in similar cases, or *external* when there is a standard method shared by all the hospitals of a specific healthcare service. The requirement of standardisability does not protect against the systematic inequality between services in two different hospitals for people with equal rights to access healthcare due to inequality of resources. It is beyond the scope of this paper to address such a problem. Here, we limit ourselves to maintaining that a standard method is still necessary between hospitals belonging to the same healthcare system (where, by 'same', we mean healthcare systems that fall within the same governance jurisdiction such as national or state level systems) to meet formal justice requirements.

Notice that the standardisability requirement does not ensure that triage nurses evaluate each patient according to exactly the same criteria and modalities. Indeed, as argued by Zaboli *et al*,[33] there are several studies exploring nurses' concordance in the application of the triage system on selected clinical cases which have reported inconsistent accuracy, reliability and inter-rater reliability values. Hence, different triage nurses may arrive at a different result using the same triage system. For this reason, we can define the standardisability requirement that we propose as a form of 'weak standardisability', bearing in mind the complexity and problems of the actual application of the triage method in specific circumstances. We recognise however that this can cause damage to the health of patients and have real implications on fairness that should be addressed. In this line, a recent study conducted by Zaboli *et al* shows that daily triage auditing may be a suitable tool for partially overcoming this problem, since it can reduce error rates and improve triage performance overall[33] and, accordingly, improving stronger standardisability.

Accountability

Accountability is a central virtue and one of the cornerstones of medical practice. Novelli *et al* note that it is a multifaceted concept, which has many definitions, although at its core it is a context-dependent specific relation of answerability, where there is an obligation imposed on a party or parties to inform about and justify one's conduct to an authority.[34] Peetet *et al* look at the three main components of accountability: loci (*who are the parties involved in being held accountable? Who is held accountable and to whom?*); the domains involved (*what are they accountable for?*) and the procedures involved (*in what ways are the parties held accountable?*).[35] They also argue that we are still far from a culture of accountability in medicine, and lay out different steps that should be made towards that direction, considering accountability an intrinsic virtue of medical practice. This paper is also a step in that direction. In which ways could we think of accountability in the context of triage in ED? We could think of the medical profession as the 'loci'

who should be held accountable to the patients (*who are the parties involved in being held accountable? Who is held accountable and to whom?*). In terms of the domains being involved in this process of accountability, we could think that they would be the choice and the implementation of the triage methods. In terms of the procedures involved (*in what ways are the parties held accountable?*), we leave this question open as a matter of empirical research that needs to be conducted in this arena.

MAPPING OUT PRESSING CONCEPTUAL AND EMPIRICAL ETHICS RESEARCH QUESTIONS PERTAINING TO FORMAL FAIRNESS IN ED TRIAGE

The bioethics community needs to tackle whether, and to what extent, the aforementioned requirements are satisfied at the level of national healthcare systems, and at the local level. During the writing of this paper, we experienced some difficulty in accessing triage policy information, particularly when asking what type of triage is implemented in a particular healthcare system. Even when that information was available, in the form of national guidelines, it is not clear that it is communicated in an accessible way to the public using the ED. This difficulty seems to suggest that the aforementioned conditions, or at least some of them, are not actually satisfied. Of course, this hypothesis will have to be validated by empirical studies aimed at effectively evaluating whether these criteria are met or not. Moreover, future research should focus on empirical questions, and on those that are conceptual. An example is clearly a better definition of which is the most appropriate accountability model for decisions in the ED. Below we draw a list of six research questions (by no means an exhaustive list) that we believe should be addressed in the near future.

The overarching research question which we believe should be addressed to provide the necessary background for the emerging research questions is the following: what are the allocative criteria and methodologies used in a nation's or state's healthcare system? Building on this overarching research question, we outline six subresearch questions that address whether triage in EDs, in particular national or state-specific context, respond to the five requirements of formal fairness we have outlined in this paper. In other words, we are mapping out a new research context for bioethical analysis, which is not aimed at analysing a specific triage choice that satisfies the proposed formal fairness conditions, but is aimed at analysing the procedures put in place by the healthcare system for managing the EDs triage. As we argued above, we believe that the appropriateness of specific choices during triage in the EDs largely depends on the satisfaction or otherwise of the requirements proposed at a more general level.[iv] In light of this, this analysis is particularly suitable for evaluating the EDs triage bearing in mind a single national health system, such as the Italian or UK one, even if it could benefit from a comparative perspective with other health systems.

It is beyond the scope of this paper to offer a detailed analysis of each research question. Our aim with this section is to map out the empirical and conceptual research landscape in this underinvestigated area of bioethics and pave the way for a new area of research with a strong health policy impact potential.

1. To what extent are allocative criteria and methodologies used in a given context transparent? (ie, a descriptive research question that investigates the extent to which the criteria and methodologies used in a particular context meet the requirement of *publicity*). If, for example, in the healthcare system under evaluation it came out that information regarding the values informing EDs triage, the methodology used (eg, Manchester Triage Method, Emergency System Index or others), and the reasons behind these choices were not transparent to the population, this health system would not comply with the publicity requirement.
2. Following 1, to what extent are allocative criteria and methodologies used in a given context accessible and understandable and easy to get access? (ie, a descriptive research question which addresses to what extent the criteria and methodologies used meet the requirement of *accessibility*). If the EDs information were public but conveyed through technical language or if accessing that public information required a lot of effort, time and skills that a layperson does not reasonably possess, there would be an accessibility problem.
3. Following 1 and 2, in what ways are the allocative criteria and methodologies used in a given context justified from a moral and scientific point of view? (ie, a descriptive research question that addresses the ways in which the allocative criteria and methodologies used in a given context meet the requirement of *relevance*).
4. To what extent are the triage methodologies applied in a given context standardised? Or in other words, what is the level of heterogeneity in the triage methodologies applied in a given context? (ie, a descriptive research question that investigates the ways in which allocative criteria and methodologies used in a given context meet the requirement of *standardisability*). If, for example, within a healthcare system, different triage methodologies are used in two or more hospitals (eg, Manchester Triage Method and Emergency System Index or more generally 5-colour and 6-colour systems), there could be a violation of external standardisability. For example, in Italy, there is no single triage system that is the standard for EDs in different regions; as a result, each department employs a contextual method with limited supporting scientific evidence.[36] Similarly, a healthcare system may not meet this requirement if there is a shared method within it but there are still differences in the way scores are assigned for triage prioritisation. If, on the other hand, in a single hospital there is a lack of sufficiently standardised triage procedure, this could lead to a failure to comply with the internal standardisability requirement.
5. To what extent, if at all, are allocative differences in criteria and in EDs triage methodologies in a given context justified? (*relevance* and *publicity*). It is possible to imagine that within a specific healthcare system, there are context-dependent factors that lead to allocative differences which are not related to the triage methodology, but dependent on the contextual factors. A disaster scenario in a specific area under the control of the health system under investigation may require different criteria. Conversely, a university hospital with a large number of medical residents may not even need triage in the ED. If these context-specific differences are not publicly reported and justified with relevant reasons, the system may fail to respect the publicity and relevance requirements.
6. What is the appropriate accountability model for EDs triage? In other words, who is involved in the decision-making of methods and criteria? What is the most appropriate process by which decisions should be reached? (ie, a conceptual research question which investigates the extent to which allocative criteria and methodologies applied respond to the requirement of *accountability*).

[iv]Note that this condition is not sufficient. Inappropriate triage could still occur, for example, due to the fraudulent conduct of a healthcare professional who decides not to follow the procedure established by a fair process and therefore gives priority to acquaintances or relatives.

CONCLUSIONS

With the pandemic, it has come to the fore of public debate that there are unavoidable ethical tensions in healthcare systems between the duty to care the individual and how to ethically allocate finite resources.[37] This is particularly evident in Italy, where the 'right to health' is enshrined in the Italian Constitution[v]; however, it is not limited to the Italian context.[vi] In the UK, this problem is becoming particularly acute with the increasing number of strikes which raised public awareness about the health system's finite resources.[38]

In this paper, we analysed an underexplored area which has emerged strongly in the pandemic, and which points to the existing tensions in the healthcare systems. We focused on a specific area, the EDs, however our considerations are valid also in other contexts. We think that for an in-depth analysis of the legacy of the pandemic, it is necessary to tackle these questions that become an absolute priority in the context of the issues that require the input of experts belonging to emergency medicine, ethics, healthcare management, sociology and patients and their family members regarding the motivations that push them towards the emergency room. In this paper, we mapped out several conceptual and empirical questions, which are important to tackle in the near future and which have obvious implications and impact on the level of the political decision-making.

Making allocative fairness issues explicit even in non-disaster contexts is vital to promote greater public awareness about how funds for healthcare are allocated and distributed, and to enable public deliberation and democratic oversight of healthcare limits.

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REFERENCES

1 Emanuel EJ, Persad G, Upshur R, *et al*. Fair allocation of scarce medical resources in the time of COVID-19. *N Engl J Med* 2020;382:2049–55.
2 Craxì L, Vergano M, Savulescu J, *et al*. Rationing in a pandemic: lessons from Italy. *Asian Bioeth Rev* 2020;12:325–30.
3 Mannelli C. Whose life to save? Scarce resources allocation in the COVID-19 outbreak. *J Med Ethics* 2020;46:364–6.
4 Camporesi S, Mori M. Ethicists, doctors and triage decisions: who should decide? And on what basis? *J Med Ethics* 2020:medethics-2020-106499.
5 Battisti D, Picozzi M. Deciding the criteria is not enough: moral issues to consider for a fair allocation of scarce ICU resources. *Philosophies* 2022;7:92.
6 Bognar G, Hirose I. *The ethics of health care rationing*. London: Routledge, 2022.
7 Bhatia N. We need to talk about rationing: the need to normalize discussion about healthcare rationing in a post COVID-19 era. *J Bioeth Inq* 2020;17:731–5.
8 Breyer F. *Implicit versus explicit rationing of health services, vol. 11*. CESifo DICE Report, 2013: 7–15.
9 Gonzato O. Bedside rationing in cancer care: patient advocate perspective. *Clinical Ethics* 2022;17:358–62.
10 Moskop JC, Iserson KV. Triage in medicine, part II: underlying values and principles. *Ann Emerg Med* 2007;49:282–7.
11 Christian MD, Farmer JC, Young BP. Disaster triage and allocation of scarce resources. In: *Fundamental disaster management*. 2009: 1–13.
12 Hinson JS, Martinez DA, Cabral S, *et al*. Triage performance in emergency medicine: a systematic review. *Ann Emerg Med* 2019;74:140–52.
13 Eijkholt M, de Snoo-Trimp J, Ligtenberg W, *et al*. Patient participation in dutch ethics support: practice, ideals, challenges and recommendations-a national survey. *BMC Med Ethics* 2022;23:62.
14 Baines P, Draper H, Chiumento A, *et al*. COVID-19 and beyond: the ethical challenges of resetting health services during and after public health emergencies. *J Med Ethics* 2020;46:715–6.
15 Huxtable R. COVID-19: where is the National ethical guidance? *BMC Med Ethics* 2020;21:32.
16 Hick JL, Hanfling D, Cantrill SV. Allocating scarce resources in disasters: emergency department principles. *Ann Emerg Med* 2012;59:177–87.
17 Möller M, Fridlund B, Göransson K. Patients' conceptions of the triage encounter at the emergency department. *Scand J Caring Sci* 2010;24:746–54.
18 Santi L, Golinelli D, Tampieri A, *et al*. Non-COVID-19 patients in times of pandemic: emergency department visits, hospitalizations and cause-specific mortality in northern Italy. *PLoS One* 2021;16:e0248995.
19 Bocci M. Influenza E Covid, Ambulanze in CODA E Pazienti in Attesa: Il Dicembre Nero Dei pronto Soccorso. La Repubblica; 2022. Available: https://www.repubblica.it/cronaca/2022/12/13/news/pronto_soccorso_caos_affollamento_influenza_covid-378918833/ [Accessed 13 Dec 2022].
20 Zaboli A, Brigo F, Sibilio S, *et al*. The impact of COVID-19 pandemic on the urgency of patients admitted to the emergency department. *Int Emerg Nurs* 2022;65:101229.
21 Savioli G, Ceresa IF, Gri N, *et al*. Emergency department overcrowding: understanding the factors to find corresponding solutions. *J Pers Med* 2022;12:279.
22 Cianci V. Gli Indicatori Di Medicina D'Urgenza Quali proxy Dell'Efficienza Territoriale. 2022. Available: https://www.simeu.it/w/congresso2022/presentazioni/view/2022/587
23 Persad G, Wertheimer A, Emanuel EJ. Principles for allocation of scarce medical interventions. *Lancet* 2009;373:423–31.
24 Baker R, Strosberg M. Triage and equality: an historical reassessment of utilitarian analyses of triage. *Kennedy Inst Ethics J* 1992;2:103–23.
25 Winslow GR. *Triage and justice*. Berkeley, CA: University of California Press, 1982.
26 Daniels N, Sabin JE. *Setting limits fairly. 2nd ed*. New York, NY: Oxford University Press, 2008.
27 Daniels N. *How to achieve fair distribution of ARTs in 3 by 5: fair process and legitimacy in patient selection*. World Health Organization, 2004.
28 Daniels N, Sabin J. Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers. *Philos Public Aff* 1997;26:303–50.
29 Rawls J. *A theory of justice. 2nd ed*. London, England: Belknap Press, 2009.
30 Schuklenk U. Covid19: why justice and transparency in hospital triage policies are paramount. *Bioethics* 2020;34:325–7.
31 Williams A. Intergenerational equity: an exploration of the "fair innings" argument. *Health Econ* 1997;6:117–32.
32 Di Laura D, D'Angiolella L, Mantovani L, *et al*. Efficiency measures of emergency departments: an Italian systematic literature review. *BMJ Open Qual* 2021;10:e001058.
33 Zaboli A, Sibilio S, Magnarelli G, *et al*. Daily triage audit can improve nurses' triage stratification: a pre–post study. *J Adv Nurs* 2023;79:605–15.
34 Novelli C, Taddeo M, Floridi L. Accountability in artificial intelligence: what it is and how it works. *AI & Soc* 2023:1–12.
35 Peteet JR, Witvliet CVO, Glas G, *et al*. Accountability as a virtue in medicine: from theory to practice. *Philos Ethics Humanit Med* 2023;18:1.
36 Zaboli A, Sibilio S, Cipriano A, *et al*. Italian validation of the manchester triage system towards short-term mortality: a prospective observational study. *Emerg Care J* 2023.
37 Frith L, Draper H, Fovargue S, *et al*. Neither 'crisis Light'Nor 'business as usual': considering the distinctive ethical issues raised by the contingency and reset phases of a pandemic. *Am J Bioeth* 2021;21:34–7.
38 Redhead CAB, Fovargue S, Frith L, *et al*. Relationships, rights, and responsibilities:(Re) viewing the NHS constitution for the post-pandemic 'new normal *Med Law Rev* 2023;31:83–108.
39 Lee H-J, Lee O. Perceptions of hospital emergency color codes among hospital employees in Korea. *Int Emerg Nurs* 2018;40:6–11.
40 Daniels N. *Just health*. Cambridge, UK: Cambridge University Press, 2009.

[v]Here, we do not distinguish the right to health and the right to healthcare, despite, as Daniels notes,[40] there may be differences between these two concepts.

[vi]This is not the case in the USA, where there is no constitutional right to healthcare, despite the Emergency Medical Treatment and Labor Act, a federal law passed in 1986, that promotes an entitlement to emergency care. However, this is not funded by the state and relies on the ability of doctors and hospitals to provide uncompensated care to people without the financial means to pay.