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Unstable Ethical Plateaus and Disaster Triage

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Disasters are defined medically as mass casualty incidents in which the number of patients presenting during a given time period exceeds the capacity of the responders to render effective care in a timely manner. During such circumstances, triage is instituted to allocate scarce medical resources. Current disaster triage attempts to do the most for the most, with the least amount of resources. This article reviews the nature of disasters from the standpoint of immediate medical need, and places into an ethics framework currently proposed utilitarian triage schema for prioritizing medical care of surviving disaster victims. Specific questions include whether resources truly are limited, whether specific numbers should dictate disaster response, and whether triage decisions should be based on age or social worth. The primary question the authors pose is whether disaster triage, as currently advocated and practiced in the western world, is actually ethical.

The key concepts of this article are as follows:

- Disasters are defined medically in terms of relative scarcity of medical resources, as opposed to absolute patient numbers.
- Subsequent disaster triage decisions are inherently utilitarian in nature, attempting to do the most for the most, with the least resources.

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- Most modern triage schemes use a tiered response, in which one group is deemed expectant and, therefore, not deserving of resuscitation because of consumption of scarce resources.
- Data from recent mass casualty events seem to contradict the concept of scarce resources, and suggest that these expectant patients can be managed aggressively.
- Because current triage schemes essentially constitute a societally mandated Do Not Resuscitate order, broad-level discussions involving all elements of the community should be undertaken to determine the appropriateness of these decisions.

The numbers are staggering. In the past 30 years, millions of lives have been lost to disasters, and billions of lives affected [1,2]. Approximately 62,000 people per annum die as a result of large-scale global disasters [3]. As defined by the Merriam-Webster dictionary [4], a disaster is "a sudden calamitous event bringing great damage, loss, or destruction." From a global perspective, the World Health Organization defines a disaster as a "sudden ecological phenomenon of sufficient magnitude to require external assistance" [5]. However, this definition does little to provide insight and guidance into the specific medical needs of a disaster.

The American College of Emergency Physicians' definition of disasters as "situations in which destructive effects of an event provoked by nature or human beings exceed the available resources required by a community or region in need of medical care" once again provides very little guidance to the medical community [6]. At what point are resources exceeded, for example? Moreover, a disaster may result in mass fatalities but few patients. At the institutional level, a working definition of a disaster might be a situation in which "the number of patients presenting within a given time period are such that the emergency department (or field responding units) cannot provide care for them without external assistance" [7]. More precisely, care cannot be rendered in a timely manner. For the remainder of this article, the authors will use this working definition in discussing medical care during disasters.

The principle underlying these definitions is the concept of *relative* scarcity of available resources. For example, a small community hospital may have fewer resources available to manage a multi-vehicle accident involving multiple victims than a tertiary care referral center. What constitutes a disaster for the former may in fact be routinely managed by the latter. In this way, a mass casualty incident can be distinguished from a multiple casualty incident by virtue of the former, either by the number of patients or by the nature of their injuries, exceeding the capability of the facility or responding services to adequately render care to the victims [8].

In contrast to these more subjective definitions, prehospital emergency medical services frequently define a mass casualty incident as an event involving three or more patients, or two or more responding ambulances [9]. Alternatively, a tiered system based on number of reported victims

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