

Article

# Ethics in Emergency Times: The Case of COVID-19

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**Abstract:** A disaster is an occurrence disrupting a community's normal functioning and existence. The disruption may render it impossible to comply with principles and to respect, protect, and fulfill rights as it happens in ordinary times; it may induce an overwhelming shortage of resources and make tragic decisions unavoidable. From its very beginning, the COVID-19 pandemic evoked the scenario of disaster medicine, where triage is likely to imply not simply postponing a treatment but letting someone die. However, it is not only the health care system that faces disruption risks. Lockdown measures and other restrictions were imposed to curb the pandemic, impinging upon individual freedom as well as economic activities. The proposal of mandatory vaccination implied a suspension of the principle of autonomy, which is a fundamental pillar of modern medicine. *Out of the ordinary* balancing efforts may be required, and two questions arise. Do such exceptional circumstances suggest reconsidering the criteria to apply, especially when essential, life-saving treatments are at stake? Who should decide? Science offers the premises to build on, but the last word does not belong to science. It remains the province of ethics and politics.

**Keywords:** emergency ethics; COVID-19; triage; allocation of resources



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## 1. Introduction

A disaster is “a serious disruption of the functioning of a community or a society” that tests or exceeds the community's capacity to cope by relying on its resources and whose effects “could last for a long period of time”. The impact of a disaster “may include death, injuries, disease and other negative effects on human physical, mental and social well-being” [1]. A disaster is, by definition, something *out of the ordinary* that is far beyond the experience of everyday life. According to this definition<sup>1</sup>, the pandemic caused by SARS-CoV-2 can be classified as a disaster: “In the first place, a health crisis, with millions of dead and infected in the world. Next, an economic crisis, since the decisions taken by the different governments have led to restrictions in various sectors of the economy (tourism, hospitality, hotels, leisure, etc.) and, finally, a social crisis, affecting millions of people in different countries of the world” [2] (p. 2). As to the health crisis, the scenario of a disaster medicine situation was explicitly evoked from the very outbreak of the pandemic, when ventilators and beds in ICUs, even in the wealthiest countries, were not available for all those who needed them. At the same time, the pandemic drew attention to deep, persisting inequalities: the stress that clinicians in high-income settings have experienced “is the life-and-death (dis)stress that clinicians in many low and low-middle income settings face every day under routine circumstances”, where “even masks, water and soap are hard to come by in clinics and hospitals, and therefore detailed triage strategies for admission to a handful of ICU beds in the pandemic seem out of context” [3] (p. 958).

COVID-19 was also a disaster because its impact was not just on health. To pursue the goal of curbing the pandemic, governments were forced to squeeze essential freedoms and economic activity, getting to the point, at least for some time, of turning health into a kind of “tyrant that crushes all other rights” [4] (p. 315). The imperative to protect the lives of citizens was the absolute priority. At the same time, however, governments were called on to keep their guard up in the face of other “systemic threats”, including

socio-psychological impacts and consequences for the basic conditions of democratic life [5]. The health emergency subjected fundamental rights to restrictions and even suspensions, fueling worries about the risk of permanent shifts in legislation and policies and the possibility of citizens changing the value they accord to freedom [6].

Two points are worth highlighting as premises for further consideration. The first observation is that different kinds of emergency measures raise different ethical and political problems. The introduction of limitations such as social distancing or restrictions on freedom of movement can be demanding in terms of existential burden and societal impact. However, under the pressure of exceptional circumstances, it is easier to consider them consistent with principles long well-established in many constitutions and the international doctrine of human rights. For example, article 15 of the European Convention on Human Rights allows derogations from certain obligations “in time of war or other public emergency threatening the life of the nation”, specifying that such exceptions are allowed “to the extent strictly required by the exigencies of the situation”. In contrast, no derogation is allowed with respect to the right to life (except for consequences of lawful acts of war); the prohibition of torture, slavery, or servitude; or the “no punishment without law” principle [7]. The absolute, yet purely *negative*, duty to respect everyone’s life is hard to decouple from the *positive* obligations stemming from the recognition of the right “to the enjoyment of the highest attainable standard of physical and mental health” [8] (art. 12). Therefore, when life itself is at stake, any difference between the ethics of normal times and the ethics of emergency ones may appear to be a dangerous breach.

The second observation points to the principle that is most at risk of being jeopardized in the exercise of prioritizing. By calling each State Party to take steps “to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the text” [8] (art. 2.1), the Covenant on Economic, Social and Cultural Rights of 1966 made it clear that the issue of resources and their scarcity can never be used as an excuse to pave the way for violations of the principle of nondiscrimination: “the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” [8] (art 2.2). Even in normal times, what is *attainable* is predicated on different conditions and determinants and therefore involves matters of (in)equality. The exceptional lack of resources during a pandemic makes rationing ever more constraining. It can increase the risk of discrimination and make its consequences worse, especially for the most vulnerable. This challenge appears stretched to the extreme when rivalry is immediately and directly about getting or being denied a chance of survival. Such a case is not about prioritizing. It is about letting someone die. This is why the commitment to rationing without discrimination is imperative and was assumed as a crucial issue in many documents, especially by institutional bodies.

The allocation of lifesaving treatments and policies regarding vaccines provided very significant test cases for the continuity between the ethics of everyday life and emergency ethics. What happens when we are confronted with an event that disrupts a society’s normal functioning and puts the principles it relies on under strong pressure, including the principles and functioning of health care? Raising this question does not amount to proposing the dismissing of these principles but rather to seeking a deeper insight into what coping with a disaster means. This reflection appears all the more relevant in relation to rules, choices, actions, and criteria that are considered unacceptable in normal times. Does a disaster open a breach for considering some different ways to balance conflicting considerations or to accept exceptions precisely as a matter of emergency ethics?

## 2. A Disaster Medicine Situation Is Not a “Supreme Emergency”-However . . .

The terminology of war has often been used to describe the pandemic. War is certainly one of the most disrupting experiences the everyday life of a community can undergo. It is so in terms of destruction: the images of a bombing can easily recall those of an earthquake. It is so in terms of loss of human lives and economic and social well-being. It is so in terms

of impacts on essential services such as education and health care, with immediate and long-term effects. The notion of triage itself was born on the battlefields, where physicians were faced with the necessity to choose which wounded to treat since it was impossible to cure all of them.

The parallel also looks appropriate considering the trade-off between the duty of governments to protect the lives of their citizens and their duty not to dismiss other constitutional essentials, starting with fundamental freedoms and rights: there are curfews in times of war as in times of pandemic. As cautious as these analogies should be (given all the differences between the threat posed by a virus and the threat posed by an enemy army), it is easy to recognize the burden of significant personal and social constraints and controls in both situations. The *new* wars against international terrorism are no exception. And we could continue, highlighting the role of the vocabulary of fear or the tendency to turn information and public debate into a one-issue activity.

I will focus on an aspect that concerns the ethics of war (*jus in bello*), which can perhaps illuminate the role of circumstances in emergency ethics and thus in disaster medicine. More specifically, the focus is on the possibility of recognizing, depending on the specific domain of actions considered, some obligations and prohibitions that must apply *in all circumstances*, regardless of how severe, challenging, and dilemmatic they may be. Article 51 of the First Additional Protocol to the Geneva Conventions of 12 August 1949 sets out an absolute ban: civilians, “unless and for such time as they take a direct part in hostilities”, shall not be “the object of attack”, and “acts or threats of violence the primary purpose of which is to spread terror among the civilian population are prohibited” *in all circumstances* [9]. In this case, there seems to be no space for a consequentialist approach, according to which the decisive criterion to consider is the state of affairs that an action brings about. *This* action is always forbidden, no matter how good or desirable its consequences or how challenging the circumstances. As is well known, many bioethical controversies rage around the existence of such actions. To offer just one example: according to the traditional doctrine of the Catholic Church, euthanasia “is an intrinsically evil act, in every situation or circumstance [ . . . ] Therefore, euthanasia is an act of homicide that no end can justify and that does not tolerate any form of complicity or active or passive collaboration” [10] (V, 1).

The notion of a supreme emergency, as defined by Michael Walzer and revived by John Rawls, challenges this idea while at the same time reaffirming the undeniable, paramount importance of the underlying principles. The reasons for not confusing the challenge posed by a supreme emergency with the challenges posed by disaster medicine are apparent. Disaster medicine forces governments to face the risk of not being able to guarantee *their* citizens some constitutionally fundamental rights. In contrast, a supreme emergency concerns the rules governments must observe in relation to the populations of *other* states in wartime. The duty involved is different. The obligation to respect the civilian population of another state falls into the category of negative duties. In contrast, disaster medicine is a tragic magnifier of the constraint always implied in the commitment to realizing the right to health: the necessity of coming to terms with available resources. A supreme emergency prompts the reevaluation of the legitimacy of killing unarmed people to win a war. Disaster medicine implies lacking the ability to assist all who could be saved and therefore deciding who will be let die.

In both cases, however, the question is whether *circumstances* (the context) can make a difference. In the case of war, which is in itself an emergency, this could happen when the emergency becomes *supreme*, jeopardizing the principle of *normal* warfare. According to Walzer, the conditions for considering a possible suspension of the ban against directly targeting “innocent people” are very extreme. The danger must be “of an unusual and horrifying kind”, threatening consequences so “immeasurably awful” that they can be described as “evil objectified in the world” or, even though “not without hesitation and worry”, about “enslavement or extermination directed against a single nation” [11] (pp. 252–253). The duty to safeguard the future existence of a community thus goes together with that of avoiding the crimes of objectified evil rebounding beyond one’s own borders. The

most striking and seemingly indisputable example of a supreme emergency is the United Kingdom's standing alone to face the Nazi threat: "Germany could not be allowed to win the war, and this for two basic reasons. First, Nazism portended incalculable moral and political evil for civilized life everywhere. Second, the nature and history of constitutional democracy and its place in European history were at stake" [12] (p. 99). At first glance, this seems to strengthen the impression of a forced, and perhaps simply unfounded connection. Facing atrocities carried out by human beings, which jeopardize the future not only of a single country but of the entirety of humankind, is obviously not the same as being unable to assist all those who need immediate care after a natural disaster or a public health crisis.

Despite these obvious differences, the notion of a supreme emergency can shed light on three points that are also important for health professionals, institutions, and society when grappling with a disaster-medicine situation. The first reiterates the quite common idea that abiding by a principle, no matter what the circumstances or the consequences, may require too much. At some point, the *benefit* of violation could be too great to resist. This awareness does not at all mean giving up the principle; it simply means considering the possibility of making an exception in very extreme circumstances<sup>2</sup> (see also [13,14]). Disaster medicine provides an example that is illustrative indeed. Age as a criterion for the allocation of scarce resources (especially when associated with quality of life) is very controversial even in normal times because of the risk of discrimination it introduces. Yet, could and should age *as such* really play no role in the tragic decision whether to make the only ventilator available to an adolescent or a person older than 80, lest a role of age undermine the idea that all individuals have the same worth? This worry is obviously unfounded for those who opt for a utilitarian approach from the beginning. Suppose Qalys are explicitly deemed acceptable in standard policies. In that case, they will be automatically applied in case of emergency, even though this is not enough to solve all problems of (dis)continuity between everyday situations and disasters. There is the issue concerning the use of these criteria to determine not simply some limitations or positions on a waiting list but an exclusion that immediately means death for the person concerned. There is the doubt about the possibility of further extending the number of criteria, including for instance social utility or desert.

A second relevant observation in the debate on supreme emergency is the importance of clarifying what a violation is and what conditions must obtain for the violation of the principle to be considered. Bellamy argues that there may be alternatives to simply dismissing non-combatant immunity. When confronted with situations of "immense stress" for their community, a military commander may apply a principle of proportionality, "which places limits on the number of foreseen but unintentional non-combatant casualties" and is consistent with the principle of the "absolute prohibition on the intentional targeting of non-combatants" [14] (p. 847). The key is the reference to *unintentional* effects, which is in line with the ban on attacking civilian populations set in the First Additional Protocol to the Geneva Convention, which applies when targeting civilians constitutes *the primary purpose* of military action. The double-effect theory could also be mentioned, according to which, for a harmful effect to be imputable, it is not enough that it can be foreseen. The agent must want it "either as an end or as a means of an action" and have "the possibility of avoiding it" [15] (1737)<sup>3</sup>. Whether this argument is persuasive is widely debated, even with reference to well-known bioethical issues [16] (pp. 89–97). The controversy over age as a criterion in triage obviously raises very different issues. There remains, however, the need to clarify *when* one can really speak of a risk of discrimination, and thus the violation of the principle that is at stake. For example, there could be no violation of the principle (I will come back to this later) if clinical criteria by themselves provide a solid basis for understanding why it may well happen that the young come first in most cases.

Finally, the notion of a supreme emergency, although referring to a very extreme hypothetical situation, is a strong argument for acknowledging that, at some point, there might really be no way to avoid the experience of a "moral tragedy", which Igor Primoratz recommends addressing as a matter of "moral conflict" rather than "moral dilemma". When the latter obtains, the conflicting requirements "are equally weighty, the two possible

courses of action equally wrong. There is no solution to the conflict, nothing that, in the end, we ought to choose". In the case of moral conflict, instead, there is one option "we ought to choose", *all things considered*, and "this does not wipe out the prima facie wrongness of our action as a violation of the moral requirement that has been overridden" [17] (p. 381)<sup>4</sup>. This is not about affirming that killing innocents is morally right. It is about acknowledging that the emergency is supreme because we cannot help but face the choice between "recommend standing by while the bad guys wipe out or enslave entire peoples" and "say 'No' to this recommendation and reluctantly go back and revise the philosophical doctrines that led to it" [18] (p. 79). Thus, we come to the point of divergence between political liberalism and the doctrine of the Catholic Church highlighted by John Rawls: "Political liberalism allows the supreme emergency exemption. The Catholic doctrine rejects it, saying that we must have faith and adhere to God's command" [12] (p. 105). If we affirm the imperative to abide by this principle *without exception*, we must be ready also to acknowledge that if a person can make his or her life a success "by dying rather than doing evil", we should perhaps accept the same for "a whole people". Rejecting the supreme emergency exception "carries a high price" indeed, but "perhaps the moral is, as Kant said, precisely that which is beyond price. *Fiat justitia, pereat mundus?* Provided that we set aside the petty sentiments often associated with this saying, perhaps so" [19] (p. 561).

Strictly abiding by the principles of good everyday practice during a public health emergency could imply consequences that are strongly counterintuitive for many. This is why a different approach to balancing could appear legitimate or even required. The crucial question remains: does *context* matter, so that making decisions in emergency times is predicated on an emergency ethics<sup>5</sup>? [20].

### 3. A Decision Based on Clinical Criteria Remains a Decision

Physicians are trained in a patient-centered approach, which entails respect for autonomy and the correct assessment of the appropriateness of the treatment they are considering. It is not a given that the appropriate treatment can be offered. As I have already underlined, this mismatch is the everyday condition in which many physicians in many regions of the world are still operating, even when the treatment in question is cheap and readily available elsewhere. In a wealthy context, triage amounts not to denying a treatment but simply postponing it, according to a criterion of urgency.

A disaster medicine situation forces physicians to take on a different role. They now must answer no longer merely a question of appropriateness but one of *rivalry* so that the triage principle may become "that care be given to the patient with a higher likelihood of survival" rather than "the most severely injured" [21] (p. 4). Someone will be denied the treatment (the ventilator) not because of its futility but because the resources available are insufficient. In normal times, according to clinical criteria for an attempt to be considered reasonable, that person too would have been admitted to an ICU. Lower chances would not ordinarily be equivalent to zero chance.

How to cope with this challenge? Two main options have emerged in the debate. The first is the proposal to consider clinical criteria while abiding by a principle of "egalitarian equality" (*egalitäre Basisgleichheit*) in times of emergency not less than in normal times: "Any [...] unequal allocation of chances of survival and risks of death in acute crisis situations is inadmissible. Every human life enjoys the same protection" [5] (p. 3). The Spanish Ministry of Health—to quote just one among many documents and guidelines—mentions the possible setting of an age limit as an example of a criterion based on discrimination that should be absolutely prohibited as contrary to the fundamental principles of the rule of law [22] (p. 9)<sup>6</sup> (see also [23]). From the beginning of the pandemic, age as a criterion became a burning issue for debate. The Deutscher Ethikrat, considering the possible death of young people as a consequence of the ban on the age criterion, concludes that they "are simply not saved from disease-related death for reasons of tragic impossibility. Here, the principle applies that nobody can be obliged to do the impossible" [5] (p. 4). At least *prima facie*, egalitarian equality should apply to all those who pass the appropriateness test.

The immediate alternative is to openly recognize that “there are no egalitarians in a pandemic” and that “the scale of the challenge for health systems and public policy means that there is an ineluctable need to prioritize the needs of the many” [24] (p. 620). Utilitarianism is the obvious candidate to provide effective solutions to both the question of triage and that of lockdown and other restrictions. As to the first: an algorithm for the allocation of ventilators can be worked out, starting “by giving highest priority to those with the highest chance of surviving and needing the lowest duration of treatment”, and introducing at a later stage, if necessary, additional principles, including setting “a threshold of length and quality of life worth saving” [24] (p. 626). As to the second: for utilitarianism, “well-being is all that matters”, and “liberty and rights are only important insofar as they secure well-being”. This premise allows one “to override the right to privacy or liberty” and can imply support for the choice “of constraining liberty and privacy to promote security and well-being” [24] (p. 628).

The *only medical criteria* approach (considering such things as prognosis in case of infection, ability to tolerate burdensome treatments and come back home, and length of stay in an ICU<sup>7</sup> [25]) was widely discussed as a way out of the painful doubts of disaster medicine triage. This approach is deemed consistent with the effort to save as many lives as possible, without infringing on the principle of nondiscrimination. Still required are two further observations, which pave the way to a better understanding of the role of ethics in the exceptional circumstances of a pandemic.

The first is the consequence of someone being denied the treatment that would be offered in a normal situation. Such a denial is literally a *de-cision*, a *de-caedere* (cutting off) through which something (someone) worth protection is lost: a human being is excluded from access to a life-saving treatment that is not necessarily futile. As unavoidable as this decision may be, it is apparent that using medical criteria for excluding and letting die is entirely different from their standard use. This kind of exclusion requires an ethical justification. The problem is that it is exactly when tiebreaking is more challenging that assuming medical criteria as the *only* legitimate ones is likely to produce strongly counterintuitive outcomes.

A comprehensive review of international documents and guidelines highlights significant agreement as to the relevant principles and issues to take into consideration: medical criteria are mentioned together with maximizing benefit, equality and equity, life-span considerations (assuming that age as the only criterion is, however, inappropriate for a triage decision), fair decision-making, the patient’s will (to the extent possible), re-evaluation of triage decisions and changes in the therapeutic goal, the burden of triage, and staff support. Some potential tiebreakers (such as lotteries and the *first come, first served* criterion) are identified as highly controversial, while no guideline suggests prioritization based on merit or social status. The problem arises when two patients are likely to benefit equally from the treatment. Such a rivalry inevitably generates profound moral unease. This is where disagreement starts and where—according to some—giving special consideration to specific patient groups could be considered: younger patients or, in other documents, disadvantaged populations or workers essential to the public health system [3] (p. 956). Insisting on medical criteria is an option: complete overlap will be impossible, and some difference will always come out. Is it yet persuasive that a slight and practically almost irrelevant difference should be the trump to decide who will be given a chance of surviving? Should we not rather accept that it is a matter of ethical responsibility, which a SOFA score<sup>8</sup> [26] cannot entirely replace?

A second observation points directly to the debate over age as a possible criterion and elaborates on the difference between setting an age-limit explicitly for offering scarce life-saving treatments and considering age-related comorbidities and impairments as elements for the prognosis and assessment of the prospects for success: “It would be discriminatory to include criteria in allocation that are not ethically relevant (e.g., race, sexuality, religion, or political beliefs). However, it is not discrimination to use patient characteristics to estimate prognosis unless a characteristic is used to systematically disadvantage a group” [27]

(p. 257). From the very beginning of the pandemic, age-related mortality rates came out to be very different: in an emergency situation, when wards are overrun with patients requiring immediate intervention and all other possibilities have been explored [28], if and only if there is no time for a detailed clinical evaluation, the goal of the best possible clinical decision could itself perhaps suggest setting an age limit, precisely to get as close as possible to the outcome of the *only medical criteria* approach. Applying the latter, in any case, the young will come almost always first, and the unpleasant, troubling consequences of the nondiscrimination argument that it should make no difference whether one is 20 or 80 years old will be avoided.

Age is probably the strongest candidate for integrating medical criteria for disaster-medicine triage. It is important to understand why, particularly since the underlying arguments can be very different. From this perspective, considering the issue of disability may be helpful. Disability, too, represents a serious risk of discrimination. Suffice it to mention the Order by the German Federal Constitutional Court of 16 December 2021, which reaffirms that the law shall ensure that decisions on the allocation of scarce resources consider “only the patient’s short-term likelihood of surviving the acute medical episode”. The Court also underlines that “where persons are at risk of being disadvantaged on the basis of disability in triage situations” there is “a specific duty on the state to take effective measures protecting against such risks” [29]. The principle of reasonable accommodation is recalled as a means of ensuring such special protection. This principle is enshrined in the UN Convention on the Rights of Persons with disabilities and defined in article two as the “necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms” [30]. Based on this premise, the fact that for people with disabilities “the risk of death from respiratory failure is greater compared with the general population” may be something to consider within the clinical assessment. Other criteria that overlap with those usually mentioned as unacceptable with reference to the elderly are excluded: long-term survival, expected quality of life, and usefulness to society [31] (p. 365).

The obligation to work out a reasonable accommodation as a matter of equity is predicated on recognizing a special vulnerability. It categorically excludes any judgment on the quality of life as a judgment (imposed on the person concerned) on the conditions that make life worth living or less worth living when compared to others. The age criterion refers to a more articulated background. It was introduced in this debate building not only on the utilitarian rule of the *total* number of (quality-adjusted) life-years saved but also on considerations precisely concerning equity and fairness. The concept of “intergenerational solidarity” does not imply a degrading of the value of the elderly and their lives. From this perspective, it has been considered an acceptable non-medical criterion to be integrated into disaster triage decisions, at least at some point [32]. Everyone is confronted with the prospect of getting old and almost everyone hopes to do so, thereby evoking an egalitarian claim. Thus, intergenerational solidarity is about giving everyone an equal opportunity [33], as exemplified by the fact that social programs, “which prioritise those who have not yet received a valuable good and recognise that limited resources should go to those who have had fewer”, do not necessarily convey a message of “lesser worth”, but simply the idea that the advantages and benefits that people have already enjoyed affect “their claims to limited resources” [34] (p. 837)<sup>9</sup> [35].

It is essential to reaffirm that we are considering what combination of criteria could be applied in emergencies, not what principles should be implemented in normal times, within constitutional frameworks conceived of to respect, protect, and fulfill the right of every individual to the highest attainable standard of health, regardless—among other considerations—of the individual’s age. Recognizing that coping with a disaster means coping with exceptional (*out of the ordinary*) circumstances and responsibilities is important precisely to avoid a carry-over effect on everyday life. Building on the premise that the elderly are equal in worth to those who are younger, any preliminary exclusion can only

be rejected. It must also be remembered that age as such will appear irrelevant when the difference is too small. However, the same is likely to happen with medical criteria. When the prospects for success and the chances of returning to one's previous life are comparable, thinking about the extremes forces the recognition that some role for age as a tiebreaker is probably difficult to deny.

This *reasonable* awareness may be consistent with a strong defense of the principle of equality. John Harris unambiguously states that "we suffer the same injustice" whenever our wish to live out the rest of our lives is deliberately frustrated, "however long that turns out to be" [36] (p. 406). His Value of Life Principle seems to exclude as irrelevant not only the difference between, for example, being 17 years old and being 70 but even that between being "in perfect health or suffering from a terminal disease" [36] (p. 406). In the face of a pandemic, the principle must be held firmly of "choosing without preferring", which allows a very restricted scope of legitimate possibilities: "In *extremis* drawing lots is one such method, the principle of first come first served is another, altruism, allowing people the option of giving away (if and only if they freely so choose) their equal priority to others is a third" [37] (pp. 7–8).

Based on this clear statement, it is significant to recall what Harris had written about the "fair innings argument" in his book *The Value of Life*. What the argument needs to do "is to capture and express in a workable form the truth that while it is always a *misfortune* to die when one wants to go on living, it is not a *tragedy* to die in old age" [38] (p. 93). It is important to underline that this difference between what is only a misfortune and what is a tragedy is defined as a *truth*. It is as true that the notion of *old age* is "irredeemably vague". However, this acknowledgment paves the way to considering the possibility that it "might hold that people who have achieved old age or who were closely approaching it would not have their lives further prolonged when this could only be achieved at the cost of the lives of those who were not nearing old age" [38] (pp. 93–94). In other words: the validity of the anti-ageist argument could be suspended when it is impossible "to postpone the deaths of all those who wanted to go on living", and the fair innings argument would operate in these circumstances as a "counsel of despair". The vagueness objection is overcome precisely by a judgment based on reasonableness, that is, the judgment of "reasonable people" who are "in no doubt" about what needs to be done [38] (p. 94).

Of course, one of the elements to consider is that, once it is recognized that age can function as a tiebreaker, at least in some circumstances, other candidates could be proposed for a multi-principled approach. Even though such candidates appear more problematic, thinking about the extremes draws attention to other possibilities<sup>10</sup> (see also [36,39]). In an article first published in 1970, James Childress suggests applying the *first come, first served* principle (or artificial chance such as a lottery) "to determine who among the medically acceptable patients shall live". This procedure is deemed in accord "with our sense of individual dignity, trust, and fairness", and Childress underlines the risk of opening Pandora's box "if we recognize exceptions". At the same time, however, he acknowledges that an "obvious advantage" of the utilitarian approach is that there are "occasionally circumstances" that can make it necessary to say that one specific person is "indispensable for society". Even though Childress does not recommend this procedure, some (very rare) exceptions could be considered. The President, "when the nation is waging a war for survival", is offered as an example [40] (pp. 249–250).

#### 4. From Scarcity to Duty: Strong Pushes and Option Luck

The allocation of ventilators and distribution of vaccines are obviously two different issues. First and foremost, vaccination is not related to an immediate, tragic life-or-death dilemma: the focus is on prevention. Vaccines—unlike ventilators—do not "help" only the person who receives the treatment: "a single dose protects both the recipient and the community by preventing viral spread as herd immunity develops" [41]. What are the implications of these observations for vaccination policies designed to address a pandemic that was not a mere seasonal flu but a disaster for societies worldwide?

As soon as competent bodies such as the FDA or the EMA approved the first vaccines, they too became scarce resources, especially from a global point of view. Once again, the huge mismatch between availability and need highlighted the effects of blatant, persistent inequalities, while the idea of the ineluctability of some “reasonable national partiality” [42] (p. 1309) or “moderate nationalism” [43] (p. 309) gained ground. In fact, things went even farther than that. The run to vaccines by the wealthier countries prompted a perverse dynamic beginning with the accumulation of millions of doses well beyond the threshold of necessity and ending with their destruction once expired.

As to this first phase, two points are easy to make and explain the broad overlap of documents, roadmaps, and priority decisions. Age was again at the forefront of the debate, not as presenting a risk of discrimination but as a decisive criterion for prioritization. Contending ethical perspectives converged towards the same conclusion when confronted with the evidence of the macroscopic age-related differences in the risk of hospitalization, need for treatment in an ICU, and death. In the US, the National Academies of Sciences, Engineering, and Medicine considered the choice between the number of years of life lost (YLL) and the number of deaths avoided and underlined the difficulties with the former. The fundamental objection is that the YLL approach infringes on the principles of equal concern and nondiscrimination, which weakens the “social consensus” around it. However, in the case of COVID-19, “the YLL approach does not provide substantial additional advantage”, precisely in view of the evidence of higher risk in older age groups [44] (p. 101). Therefore, this alternative and the related moral conflict could be simply dismissed *from a pragmatic perspective*.

The second point is the wider acceptance of a balancing approach, aiming at reducing both “severe morbidity and mortality” and the “negative societal impact due to the transmission of SARS-CoV-2”. This approach could imply, for example, considering the *instrumental* value of some other groups as a sound reason for ranking them higher on the priority list, starting with healthcare sector workers but not limited to them [44] (pp. 102 and 94–95). The line is difficult to draw, especially when the distinction between a *narrow* and a *broad* social utility tends to loosen, with the first indicating “a person’s short-term value to society during a public health crisis or other emergency” and the second “a person’s overall value to society” [43] (p. 312). Using “societal value” as a criterion for allocating scarce resources sounds “ethically suspicious to many people” [45] (p. 355), if not radically inconsistent with respect for everyone’s equal dignity, although thinking about the extreme cases (Childress’ example of the President, provided he or she be really irreplaceable) seems to suggest that in emergency times even this exception might be considered, at least by some. An *experience*-adjusted life years (EALY) approach, looking at the amount of service to society that could be saved, has indeed been proposed, with the clarification that in situations other than “times of major emergencies, epidemics and war” it “might prove to be too elitist to merit its application” [46] (pp. 565–566). This approach can easily appear too audacious or simply unacceptable under any circumstances, especially in the case of an immediate intervention to save a person’s life. With prevention, however, things look different, which could legitimize granting greater importance to the protection of roles and functions relevant to the general well-being of society, together with people living in conditions of special vulnerability<sup>11</sup> [47,48].

When vaccines became available for the whole population (which in wealthy countries occurred relatively quickly), the fact that vaccination protects others as well as the one who receives the injection meant that the main challenge for decision-makers became one of informing, convincing, pushing, and, as a last resort, imposing. As I said above, an emergency such as a public health crisis allows governments to limit the enjoyment of some freedoms and rights. There is agreement on the criteria to respect: proportionality, which considers the impact on everyday life and the levels of intrusiveness; social tolerability, especially with an eye to the risk of exacerbating inequalities; time limitations; and, of course, effectiveness [49]<sup>12</sup> (see also [50]). The refusal of vaccination by a significant percentage of the population raised an issue that once again revealed the difficulty of

strictly abiding in emergency times by principles and rules that are constitutional essentials: “undermining individual autonomy corresponds to directly depriving an individual of his or her personhood status”, but “actions for the safety of community [ . . . ] are morally necessary” [51] (p. 301). Is it legitimate to turn this duty of solidarity into legal coercion?

The obvious premise is complete, updated, and transparent information on the safety and efficacy of vaccines. Then, different kinds of measures are possible, which may have the purpose of facilitating access and correspond to different levels of “pressure” on citizens: centralized reminders; default appointments; standing orders; presumptive provider communication; onsite vaccination; incentives and mandates [52] (p. 2188). The lower the pressure, the easier the adoption. This observation explains why governments favored strategies based on incentives rather than mandatory vaccination. However, it is important to underline that some ideas, even though they were not transformed into concrete operational decisions, were introduced into the debate that are categorically excluded in ordinary times and could be interpreted as a very harsh application of the *option luck* approach.

In Western countries, the most common form of incentive was the possibility of enjoying greater freedom of movement, exemplified by access to leisure spaces or cultural sites, access to public transport, and travel domestically or abroad. Direct financial or material incentives (money or consumer goods, in any case of small value) have also been discussed in the literature, with reference to vaccination. Nobel laureates Abhijit Banerjee and Esther Duflo, for example, described in their book *Poor economics* the effect of incentivizing the population targeted by a vaccination campaign in India by offering two pounds of dal (dried beans) for each immunization and a set of stainless-steel plates for completing the course [53] (p. 62). There were examples of this approach during the pandemic. However, this was not the solution that governments focused on, possibly for context-related reasons: in wealthy countries, the level of satisfaction obtained thanks to greater spaces of freedom is a *good* that is likely to offer a stronger motivation. Another reason may be the fact that material incentives are perceived as a more insidious and immediate attempt to *buy* something enshrined in the domain of what should never be given a price. Banerjee and Duflo discuss, among other possible criticisms, the risk of degrading “both what is given and the person who gets it. Instead, we should focus on trying to convince the poor of the benefits of immunization” [53] (63).

In any case, when governments realized that persuasion did not work or was not as effective as had been hoped, they shifted more and more from a strategy recalling the idea of a “gentle nudge”<sup>13</sup> (see also [54,55]) to strong pushes that could anticipate mandatory vaccination (in most cases limited to specific groups<sup>14</sup> [56]) or restrictions that directly infringed on essential aspects of life, for example limiting the possibility of entering one’s own workplace or a university classroom. The argument, already applied precisely to nudging in the health domain, is that the state cannot dismiss its responsibility towards behaviors that have consequences for other people. This responsibility obtains even though opponents “dislike the thought of government intruding into areas of personal responsibility” and, in some cases, when what is *objectively* better for health is at stake, even “irrespective of whether they want or like it” [57] (pp. 556–557).

As I have said, a comprehensive review of documents addressing the issue of the allocation of intensive care resources during the pandemic underlines the exclusion in all of them of considerations based on *merit*. However, it is significant to observe that it was precisely the recurrence of an emergency situation in ICUs after some months of the vaccination campaign that prompted a debate on the possibility of triaging based “on what people ‘deserve’ (i.e., ‘desert-based considerations’) based on their past choices”. Considering vaccination status, at least at some point, could appear “like a just or equitable response that compensates vaccinated patients for safeguarding their health, the health of others and accepting public health recommendations” [58] (p. 2).

Health issues have been an illustrative, disputed example of the brute/*option luck* approach from its first definition: “Option luck is a matter of how deliberate and calculated

gambles turn out—whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined. Brute luck is a matter of how risks fall out that are not in that sense deliberate gambles [ . . . ] If someone develops cancer in the course of a normal life, and there is no particular decision to which we can point as a gamble risking the disease, then we will say that he has suffered brute bad luck. But if he smoked cigarettes heavily then we may prefer to say that he took an unsuccessful gamble” [59] (p. 293). When we consider vaccination against SARS-CoV-2, which guarantees strong protection (especially against the most severe consequences of the infection), even though it does not guarantee complete immunization, the example of the grasshopper and the ant recalled by Gerald Cohen seems easy to apply. People had “exactly the same initial advantages” (the opportunity to get vaccinated when more than enough doses of vaccines became available to cover the whole population). Why, then should those “who merely chose differently, be forced back to equality if an inequality ensues? Why should one person pay for another’s truly optional choices?” [60] (p. 444). In the case of refusing vaccination, the lack of solidarity it implies seems to add to the lack of attention to safeguarding one’s own health an aggravating circumstance in the form of a *responsibility* whose consequences the individual should not escape.

The limits of the option luck criterion and the criticisms of it are well-known<sup>15</sup> [61]. According to Elizabeth Anderson, it fails in three ways to comply with the principles of “equal respect and concern for all citizens”. First, “it excludes some citizens from enjoying the social conditions of freedom on the spurious ground that it’s their fault for losing them”. Second, it “makes the basis for citizens’ claims on one another the fact that some are inferior to others in the worth of their lives, talents, and personal qualities”. Third, “equality of fortune, in attempting to ensure that people take responsibility for their choices, makes demeaning and intrusive judgments of people’s capacities to exercise responsibility and effectively dictates to them the appropriate uses of their freedom” [62] (p. 289). Harshness, stigmatization, and intrusiveness are incompatible with the concept of “democratic equality” that Anderson advocates, which guarantees “effective access to the social conditions of freedom to all citizens, regardless of how imprudently they conduct their lives”, and “does not deprive negligent or self-destructive citizens of necessary medical care” [62] (pp. 326–327)<sup>16</sup>.

Other arguments deserve in-depth reflection before one considers including responsibility for one’s own choices as a criterion or tiebreaker for allocating and rationing health resources. There is the problem of “epistemic and control conditions”: agents could have inadequate awareness of the consequences of their actions, perhaps because of misleading information or fake news; they could also have an inadequate degree of control over their actions: “some struggle may be required”, and “occasional failure to enact behaviour as intended” is possible [63] (pp. 637 and 639). Rebecca Brown and Julian Savulescu, elaborating on the “dyadic” responsibility arising in intimate relationships, also underline the importance of considering a “communitarian account”, as “people’s behaviour, values, projects and efforts are deeply wrapped up in social relationships” [63] (p. 642)<sup>17</sup>. The problem of the “social gradient” of responsibility, highlighted by other scholars, is connected to this observation. One’s social-cultural milieu influences behaviors and choices. Therefore, the State should first “seek to ameliorate the broader impacts of the social determinants of health” rather “than making controversial assumptions about the moral responsibility that people bear for their health-related decisions”. These improvements may include gentle nudges or stronger pushes, such as “heavily taxing products that could be harmful to a person’s health” [64] (pp. 68, 72, and 70). The reference to the social milieu is certainly to be agreed upon, and education should always be the first option compared with “sin taxes”.

Dworkin himself admitted an “openly paternalistic” principle for correcting the option luck criterion: “a decent society strives to protect people against major mistakes they are very likely to regret, like not fitting and wearing seatbelts, and not providing for emergency medical care” [65] (pp. 114–115). It is noteworthy that paternalism is introduced as a corrective to an approach building on the radically non-paternalistic assumption of full

responsibility for one's own actions. Schuman et al., with reference to the pandemic, underline that "even people who cause harm or endanger others, such as those who drink and drive, are given consideration based on their need and potential to benefit": the standard that applies "in times of convention" must be applied also "in times of crisis" [58] (p. 2).

The problem is precisely with affirming that what applies in normal times can apply in the same way in emergencies such as that prompted by the waves of the pandemic, which followed rapidly one after the other, even when a large percentage of the population had been vaccinated. Simply as a matter of fact, such a uniform application of standards did not and could not happen. The COVID-19 crisis led to a shortage of resources that affected "all patients, including those with heart failure, cancer, and other serious and life-threatening conditions requiring prompt medical attention". The subsequent indication that fair allocation "that prioritizes the value of maximizing benefits applies across all patients who need resources" [66] (p. 2054) sounds as obvious as it is abstract.

The *disaster* of ERs and ICUs stormed by an unprecedented number of patients needing immediate life-saving treatments forced health personnel and institutions to postpone "until better times" what was not as urgent, even when it was very urgent according to the criteria applied in normal times. The obvious risk was that the conditions and diagnoses of some patients might deteriorate, reducing their chances for a good outcome "in comparison to the prepandemic era" [67] (p. 2). This increase in "indirect mortality" may have many different causes<sup>18</sup> [68] and the figures, which are in any case impressive<sup>19</sup> (see also [69–71]) are not easy to work out, because both short-term and long-term outcomes need considering. The fact remains that a pandemic such as that prompted by SARS-CoV-2 unavoidably entails the risk of some patients' being "left behind" [72], precisely because the healthcare system cannot work as it does in *normal* times.

If no effective tool is available to combat the virus, such a disruption can be considered a combination of brute luck and lack of preparedness. When an effective tool is available, preventing the collapse of hospitals and the recurrence of disaster medicine triage becomes, to a much larger extent, a matter of option luck rather than a matter of individual and collective choice. Therefore, governments could impose mandatory vaccination precisely to preserve the equality of citizens and avoid the risk that some criteria deemed unacceptable for normal times might become at least a *temptation* in emergencies.

A case can be imagined that may recall some age-related dilemmas. As we have seen, it is a *narrow* notion of social utility, strictly pandemic-related, that makes it legitimate or even appropriate to also include this criterion when allocating scarce resources, such as vaccines, for prevention. The notion of pandemic-related desert could be introduced by building on the same premise and pointing to a specific behavior (the refusal of vaccination) whose consequences rebound precisely on the development of the pandemic and its effects on other people. It is under, and strictly related to, a condition of health emergency that this temptation is most likely to insinuate itself. Two people of the same age enter an ER at the same time. Both need immediate help to breathe, and the prospects of success are the same for both. One has been invited many times to get vaccinated and has received all the relevant information. In spite of this, he has insisted all along on refusing the vaccine without any medical reason for exemption. The other has scrupulously followed all the recommendations of the health authorities. Only one ventilator is available. Is lottery the only way to avoid dismissing the principles of equal respect and equity?

## 5. Conclusions

The ethics of emergency times can be demanding. Transparent and open discussion is needed in a democratic society to set rules for emergency situations. Such discussion is a fundamental pillar of a consistent strategy of *preparedness*. Ethical challenges "arise when there is uncertainty about how to 'do the right thing' in a clinical decision when duties or values conflict", and healthcare professionals must be given "clear and fair rules to follow" [73] (p. 305). Of course, the same applies to setting restrictions on fundamental

constitutional rights. Something more than “follow the science” [74] is required for competent authorities to make such decisions and point out priorities. Scientific evidence is the premise for exercising a responsibility that necessarily involves “society as a whole” [75] (p. 33). A pandemic entails the risk of jeopardizing not only the health of many citizens but also the fundamental tenets of democratic institutions and the principles of equal respect and justice<sup>20</sup> [76]. Therefore, it is not science that can have the last word. Such decisions remain a matter for ethics and politics.

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## Notes

- 1 In ordinary language, we speak of a “disaster” also in a more restricted meaning, when an event causes significant damage or loss of life but not necessarily disruption effects on society as a whole.
- 2 *Just and Unjust Wars* was first published in 1977, the same year that the Additional Protocols to the Geneva Conventions were adopted. From the very beginning, it was discussed as a book devoted to supporting a rights-based approach, according to which some fundamental rights “cannot simply be set aside; nor can they be balanced, in utilitarian fashion, against this or that desirable outcome” [13] (p. 25). At the last moment, however, Walzer seems to put aside the need for an inescapable consistency between the means and the ends, and the reason is that what we are confronted with is a case of moral tragedy: “if one violates *jus in bello*, one commits murder and perhaps other crimes. On the other hand, if one does not violate *jus in bello*, one’s omissions may contribute causally to the death and devastation of one’s people at the hands of a brutal, rights-violative aggressor” [13] (p. 28). Alex Bellamy criticizes Walzer for contradicting his “deontological account of the just war tradition” [14] (p. 830) yet making clear that his position is not to be confused with some kind of realism of “dirty hands”. Even though a shift towards utilitarianism appears undeniable, Walzer “still holds that there are binding moral constraints on leaders which may be temporarily overridden in extreme cases but may never be ignored” [14] (p. 836).
- 3 The “strict conditions for legitimate defense by military force” entail a principle of proportionality openly: “the damage inflicted by the aggressor on the nation or community of nations must be lasting, grave, and certain; all other means of putting an end to it must have been shown to be impractical or ineffective; there must be serious prospects of success; the use of arms must not produce evils and disorders graver than the evil to be eliminated” [15] (2309).
- 4 According to Primoratz, the moral disaster position “is structurally similar to that of supreme emergency”. However, it includes “only extermination and ethnic cleansing of an entire people from its land” as a legitimate reason for the exception, thus preserving its “rarity value” [17] (p. 383).
- 5 “And when treasured principles of justice direct us in opposing directions, it is important to choose the course or goal that reasons support as being right under the circumstances. In those situations, we have to acknowledge that upholding some principle(s) of justice may be inappropriate for making the particular kind of decision at hand” [20] (p. 624).
- 6 The same argument was supported by the Italian Committee for Bioethics, which listed age together with “sex, condition and social role, ethnicity, disability, responsibility for behaviours contributing to the pathology, costs” as a criterion that should be deemed “ethically unacceptable” [23] (p. 3).
- 7 When a disaster determines different urgent health needs, it naturally also becomes important the ability of a team “to address the victim’s main problem (e.g., a team of orthopaedic surgeons may be unsuited to care for a child with second degree burns)” [25] (p. 59). Barilan et al. discuss the clinical and the utilitarian schemes of triage and propose a “hybrid” version, which they believe can “preserve (at least to a degree) the independence of medical care and the value of fiduciary duties in medical ethics (non-abandonment and continuity of care” [25] (p. 56).
- 8 “The Sequential Organ Failure Assessment (SOFA) score is a simple and objective score that allows for calculation of both the number and the severity of organ dysfunction in six organ systems (respiratory, coagulatory, liver, cardiovascular, renal, and neurologic)”. The score “can measure individual or aggregate organ dysfunction” [26] (p. 1649).
- 9 Daniel Callahan, approaching the issue of “setting limits”, assumes that our “common social obligation to the elderly” could be limited “only to help them live out a natural life span”. At the same time, he reaffirms “the inestimable value of individual human life, of the old as much as the young, and the value of old age as part of our individual and collective life” [35] (p. 116).
- 10 John Harris, for example, argues that the frustration of the wish to live out the rest of our life is an injustice “if we do not deserve to die” [36] (p. 406). I had the opportunity to ask him what exactly he meant by this expression. He mentioned as examples those who are murdered while attempting to murder an innocent person or a terrorist badly injured by the bomb he had planted in a hospital competing for first responder aid with his victims when scarce resources for rescue are available. It is worth underlining that such an extreme case may not only be an abstract hypothesis, especially in a war scenario. Gino Strada was a surgeon and the founder of Emergency. On the website of this humanitarian non-governmental organization, medical treatment is defined as a “fundamental human right”, which as such “must be available to everyone”. In a book in which he recounts his experience as

a war surgeon, Strada recalls a difficult decision he made. In Kabul, when faced with a hundred wounded in a courtyard and forced to carry out triage, he had decided to prioritize the children and women without hesitation. He did not compare their clinical condition with that of the guerrillas, also in need of treatment, who had held him and his hospital at gunpoint for days, “without any respect for the other wounded and for those like us who were only there to provide care”. However, this decision left Strada with a heavy heart. In time, he could not avoid feeling the moral unease for a choice that was perhaps, after all, “just a kind of revenge” and had, in any case, nothing to do with his “job” [39] (pp. 56–58).

- 11 For a detailed illustration of the choices made in many countries, see [47] (pp. 70–76). As to the specific point concerning the difference between prioritizing vaccines and prioritizing immediate life-saving treatments, see [48].
- 12 Such restrictions “must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected [ . . . ], in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society”. Beyond that, they “must be proportional, i.e., the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review”. The reason for this clarification is that the limitation clause “is primarily in-tended to protect the rights of individuals rather than to permit the imposition of limitations by States” [50] (§§ 28 and 29).
- 13 The term “nudge” was first used in a book with the same title [54] to describe “any aspect of the choice architecture that alters people’s behaviour in a predictable way without forbidding any options or significantly changing their economic incentives”. The appeal of nudging relies on the possibility of developing “a set of seemingly simple, low-cost solutions that do not require legislation and can be applied to a wide array of problems” [55] (p. 263). Of course, the parallel cannot be pushed beyond a certain point because it was precisely through legislative measures that restrictions and freedoms related to vaccination status were set.
- 14 “In the event that the seriousness of the health situation and the long-term unsustainability of the limitations on social and economic activities persist, the Committee also believes that—in the face of a vaccine that is validated and approved by the competent authorities—its being made mandatory should not be excluded, especially for professional groups that are at risk of infection and transmission of viruses” [56] (p. 11).
- 15 See, also for an introduction to this approach [61] (pp. 72–80 and 97–105).
- 16 This conclusion is not to be confused with a warrant for whatever kind of irresponsibility. Democratic equality “avoids bankruptcy at the hands of the imprudent by limiting the range of goods provided collectively and expecting individuals to take personal responsibility for the other goods in their possession” [62] (p. 289). For example, in the case of smoking, this approach provides that “a person who smokes would be entitled to treatment for resulting lung cancer, regardless of their degree of responsibility for smoking. But she would not be entitled to compensation for the loss of enjoyment of life brought about by her confinement in the hospital and reduced lung capacity, for the dread she feels upon contemplating her mortality, or for the reproach of her relatives who disapprove of her lifestyle” [62] (327).
- 17 Together with the dyadic perspective, Brown and Savulescu insist on the “diachronic responsibility”, which entails making a judgment on the agent’s behavior over time: some health behaviors, such as vaccination, are one shot; others, such as smoking, are to be repeated frequently to produce health consequences. Of course, this observation implies referring to the well-known debate on the notion of “identity” over time. They acknowledge they are “sympathetic to arguments that responsibility should not play a role in healthcare”, but also that “responsibility practices are a commonplace feature of almost all areas of human life and interpersonal relationships” and that such questions demand, therefore, “further interrogation” [63] (636).
- 18 The increase “may arise from altered access to healthcare services secondary to the profound reorganization of hospitals and the effects of lockdown on physical, psychological, and social wellbeing. Moreover, lockdown and the fear of contracting the infection in hospitals could have prevented patients from calling emergency medical services (EMS) or presenting to emergency departments” [68] (p. 242).
- 19 In Italy, for example, the death count doubled in March and April 2020 compared with the average of the same months from 2015 to 2019. According to the model proposed by Odone et al., “within excess mortality that was not captured by COVID-19 surveillance [ . . . ] more than two-thirds of excess deaths might be due to causes other than COVID-19” [69] (p. 113). A study carried out in Paris and its suburbs in the same months showed a transient two-times increase in “out of hospitals cardiac arrest” incidence, coupled with a significant reduction in survival and only partially directly related to COVID-19, followed by a return to normal towards the end of the study period [70]. Between March and May 2020, there was a significant decrease in new cancer diagnoses in Germany, with the subsequent risk of poorer outcomes because of many undiagnosed cases or cases diagnosed with some delay [71].
- 20 The idea of COVID-19 as an equality of opportunity disease has been contested as a myth to be dispelled: “It has killed unequally, been experienced unequally and will impoverish unequally [ . . . ] We need to learn from COVID-19 quickly to prevent inequality growing and to reduce health inequalities in the future” [76] (p. xiv).

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