

# Pandemic, equality, and vulnerability

## *Pandemia, igualdad y vulnerabilidad*

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### Abstract

*The ongoing COVID-19 pandemic is a real “stress test” for the ability of a public justice system to guarantee equality. In this paper we will look at some relevant issues: in what measure does the pandemic risk undermining the principle of equality? Can this global disruption event undermine the delicate balance between equality and inequality? These are not abstract questions, because the furrow of inequalities has actually widened, and the measures adopted at various levels, especially in the area of emergency care, are not always effective. The most widespread ethical approaches do not take into consideration the hypothesis that the least expendable subject is the most vulnerable. However, a society that does not save the weakest first will fail to save itself from its own frailties and atomistic drift. Discrimination of vulnerability leads to the loss of equality of dignity and the common good.*

**Key words:** Pandemic. Equality. Vulnerability. Ethics. Emergency.

### Resumen

*La presente pandemia de enfermedad por coronavirus 2019 (COVID-19) es una verdadera «prueba de estrés» de la capacidad de un sistema de justicia pública para garantizar la igualdad. En este artículo veremos algunos temas relevantes: ¿En qué medida el riesgo de la pandemia amenaza el principio de igualdad? ¿Puede este evento disruptivo global socavar el delicado equilibrio entre igualdad y desigualdad? No se trata de cuestiones abstractas, porque el surco de desigualdades efectivamente se ha ensanchado y las medidas adoptadas a distintos niveles, especialmente en el ámbito de la atención de urgencias, no siempre son eficaces. Los enfoques éticos más extendidos no toman en consideración la hipótesis de que el sujeto menos prescindible es el más vulnerable. Sin embargo, una sociedad que no salve primero a los más débiles no podrá salvarse de sus propias debilidades y deriva atomística. La discriminación de la vulnerabilidad conduce a la pérdida de la igualdad de dignidad y del bien común.*

**Palabras clave:** Pandemia. Igualdad. Vulnerabilidad. Ética. Emergencia.

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Date of reception: 12-02-2021

Date of acceptance: 24-02-2021

DOI: 10.24875/BUP.M21000007

Disponible en internet: 21-05-2021

BIOETHICS UPdate 2021;7(1):25-34

www.bioethicsupdate.com

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## Equality, justice, and vulnerability

The theme of human nature inevitably meets, on the political level, the issue of plurality, and the nature/plurality dichotomy, in turn, impacts on the functional dialectic between equality and inequality. Assuming that human beings are equal by nature (but on the definition of human nature the debate is still very open) also the fact that human beings are different from many points of view cannot be ignored. Hence, the problem: how to translate the axiom of equality of nature on the political level, where individuals in their plural condition confront each other? Naturalistic or essentialistic egalitarianism, as Amartya Sen has well pointed out, can generate profoundly anti-egalitarian effects: the poor consideration of the dynamics of plurality has led to a minimalistic simplification, elements of which can be found in the proposals of redefining or transcending the human and which discriminate disabilities and handicaps of various kinds.

On the issue of inequalities, no discourse is able to express itself better than the facts which the world has witnessed in recent times. Two divergent movements emerge clearly. On the one hand, and with increasing virulence, the extreme struggle, in many ways also violent, aimed at defending particularities and differences; on the other hand, the movement pushing toward a sort of essentialistic universalism, neutral with respect to particularities and with a marked reference to the so-called genotypic properties of the human. The two movements coexist and are socially relevant, and both originate from components coming so to speak from the fringe, that is, external to the cold core of the so-called political society which has governed itself on the balance, although unstable and dynamic, between equality and inequality. It is important to point this out at a time like the present one. The pandemic underway is a real “stress test” for the ability of a public justice system to guarantee equality. This is not the place for a review of the positions that, in the context of ongoing discussions in liberal democracies, are expressed with theses and arguments in favor of equity and equality in the social and health field. We will limit ourselves to examining a few questions: to what extent might the pandemic undermine the principle of equality? Can this global disruption event undermine the delicate balance between equality and inequality? These are not abstract questions, because the furrow of inequalities has actually widened, and the measures adopted at various levels are not always effective. Our aim is not to offer conclusive answers, but to reflect on the inadequacy of the actions taken by the actors in the social and health field in dealing fairly with the serious pandemic crisis.

It is necessary to take a short step back and highlight some inconsistencies and weaknesses inherent in the current representations of public justice, which have repercussions on social and health policies, frequently giving rise to a heated confrontation between the demands of efficiency and the needs of solidarity. Martha Nussbaum gave an excellent account of this: «our political discourse is pervasively shaped by the idea of society as based on a contract for mutual advantage, an idea that has dominated political theory in the Western tradition. All social contract theories adopt a fictional hypothesis that appears innocent: the fiction of competent adulthood. The parties to the social contract are assumed, as John Locke wrote, to be “free, equal, and independent”»<sup>1</sup>. In the framework of many liberal theories of justice, is prevailing the idea that the citizen is a self-sufficient individual, not conditioned by bonds of various kinds, not dependent on those who take care of her needs. In reality, Maria Zanichelli reminds us in her beautiful essay on disabled people, «every human being, as such, is inevitably characterized, to some extent, by dependence and vulnerability. Autonomy, strength, rationality, independence, and efficiency cannot be absolutize

to the point of making them the primary hallmarks of humanity: a similar view would not only be inadequate to fully recognize and understand the humanity of disabled people, but it would not even grasp the specificity of the human condition in general»<sup>2</sup>. Taking care of someone or, reciprocally, being cared for by someone is the most common condition of human existence. It is a condition that we all live in childhood, and it is the one that, more or less, we go through in old age. Many Western nations, such as Italy or Japan, have a large portion of elderly population and this simple fact forces us to open a window on the condition of disability in which most of the populations find themselves. An Italian scholar observed well: «Periods of disability are, in fact, part of the statistical probabilities of a human life of different length and evolution, but aging involves in any case, when the threshold that defines a “great elderly” is crossed, elements of disability. Disability is the name of a condition, not of a category of people, and the possibility of becoming disabled is an integral part of the human condition in general»<sup>3</sup>.

But the concept of care implies much more: in general, no one can live without some kind of emotional support (family, friend, and sentimental), and therefore the issue of affective interdependence must be taken seriously within the framework of a consistent theory of justice, as a complement, if not even as a foundation, of any other consideration on primary goods and their redistribution. In the most widespread contractualist conceptions, the needs to which primary goods respond are not calibrated on the most difficult situations of dependence in which human beings naturally find themselves and which inevitably redefine their capabilities. The error inherent in many elaborations has its root, Nussbaum appropriately argued, in that dualism between dignity and nature that Kant advocated. Dividing the ought, the value of the human being, from what the human being really is, with its elements of deprivation, fragility, transience, is equivalent to privileging an abstract and in the long run unsustainable perspective on a practical and political level. Nussbaum notes suggestively: «What’s wrong with Kant’s distinction? Quite a lot. First, it ignores the fact that our dignity is that of a certain sort of animal; it is a dignity that could not be possessed by a being who was not mortal and vulnerable, just as the beauty of a cherry tree in bloom could not be possessed by a diamond. Second, the split wrongly denies that animality can itself have dignity; thus it slights aspects of our lives (our bodily desires and our sensory response to beauty) that have worth, and distorts our relation to the other animals. Third, it makes us think of the core of ourselves as self-sufficient, not in need of the gifts of fortune; in so thinking we misrepresent the nature of our own morality and rationality, which are thoroughly material and animal themselves. We learn to ignore the fact that disease, old age, and accident impede the moral and rational functions, just as they impede mobility and dexterity. Fourth, it makes us think of ourselves as not subject to the effects of time. We forget that the usual human lifecycle brings with it periods of extreme dependency, in which our functioning is similar to that of the mentally or physically handicapped throughout their lives»<sup>1,4</sup>. It is, therefore, quite clear that it is necessary to reintegrate a vision of human dignity that takes into account the effective capabilities of each one, with a view to care and empowerment and in view of greater social equity. After all, those who take care of the vulnerable person not only do not discriminate, but care for the common good of which they are themselves a part.

## **Pandemic and inequalities**

The heavy demographic decline and an insufficient migratory flow, which was strongly weakened during the pandemic, make a long-term sustainability of welfare in the terms known up to now

unthinkable. Inequalities are on us, and the emergency management of the pandemic crisis has given dramatic documentation. As the Statement on European Solidarity and the Protection of Fundamental Rights in the COVID-19 Pandemic of the European Group on Ethics in Science and New Technologies states: «Not everyone is affected equally by the pandemic. Some have access to life-saving healthcare while others do not. Some experience quarantine in comfortable homes with gardens, while others are confined in small apartments, or even slums or refugee camps. We have to recognize and address the significant imbalances in terms of economic and social resources, during as well as after the outbreak. This also means considering the downstream effects of the measures taken now, from economic recession to increases in domestic violence, child abuse, and suicide. In turn, this means that instituting immediate supporting measures such as financial and psychosocial assistance is vital. All policies and measures must invariably be based on the basic idea of equal worth of all human beings, rooted in a common human dignity»<sup>5</sup>.

Some examples bear witness with some roughness to the validity of certain concerns. First of all, unequal access to emergency therapies among subjects affected by COVID-19; second, unequal access to emergency therapies or normal clinical practice between groups of people affected by COVID-19 and groups of people affected by other serious diseases (cancer, diabetes, neurodegenerative diseases, and rare diseases); and third, it could be mentioned the difficult accompaniment of people with disabilities in the various social, health and welfare contexts, deprived of the necessary relationship with family members and guardians, in the absence of protocols and guidelines that in time of COVID put the issue of family and emotional relationships. This last example, in particular, clearly shows how the disabled person who lives at home with family members is in some ways, in times of a pandemic, a privileged person compared to the disabled guest in a care facility, who is instead denied the visit of family members. A condition, paradoxically, the reverse of pre-pandemic times, in which many disabled people enjoyed the advantages of professional assistance and at the same time the affection of their loved ones. By way of example, a protest document drawn up by some organizations regarding the decision of the state of Connecticut to prevent family members from visiting patients with disabilities, effectively limiting communication with medical staff and the possibility of asserting the rights of equal access to medical care: «Strict no-visitor policies put in place at hospitals have prevented patients with disabilities from safely receiving support from family members or staff necessary for them to effectively communicate with medical personnel or otherwise receive equal access to medical treatment»<sup>6</sup>. It is one initiative among many, which highlights a problem that has occurred in numerous contexts.

Unfortunately, in many regions of the world there is a worrying increase in deaths of disabled people due to the pandemic, in particular due to the recurring proximity to other people, conditions of fragility, economic difficulties (also due to the lower chances of obtaining a job, especially in the most backward areas), of equal access to healthcare and hygienic conditions that are not always optimal. As Human Rights Watch highlighted, «Globally, more than 1 billion people - roughly 15% of the world's population - live with some form of disability. People who are older, people with chronic health conditions, or people with disabilities – that, for example, affect their respiratory capacity – may be at particular risk of serious illness or death from COVID-19 infection»<sup>7</sup>. Disabled people who stay at home during the pandemic experience real difficulties in being cared for by caregivers, figures often lacking adequate training or professional placement, fearful of contracting infection, not always equipped with those adequate PPEs that the health system has not planned to provide them. As mentioned above, the deepening of inequalities in contexts already severely

affected by inequalities and socio-economic gaps is an element that is all too evident during the pandemic crisis. The answers to these phenomena are slow to arrive, since the welfare and health-care systems that have been conditioned by efficiency and savings for years are unable to develop and implement alternatives quickly, despite the recent recommendations of the World Health Organization which in the 2020 document on “Ethical principles for optimum care during the COVID-19 pandemic” expressed itself in a clear way: «Equal moral respect: Every person is equally valuable. Treatment and care decisions should be based on medical need and not on irrelevant or discriminatory features such as ethnicity, religion, sex, age, disability, or political affiliation. Patients with similar health problems or symptoms must receive equal treatment and care. Showing moral respect means involving patients and their caregivers in decision-making to the greatest extent possible, explaining options and limitations in treatment»<sup>8</sup>.

At the same time, public justice, in the absence of resolute legislative actions, seems unable to adequately and quickly sanction those responsible for discrimination or negligent and omissive behavior. Finally, we must not neglect to include among the most vulnerable population also the high number of fragile people (including many minors) locked up in prisons, or the serious condition of minors and disabled minors in particular who are unable to take advantage of this phase from inclusive education. The Human Rights Watch has clearly highlighted this, even issuing a warning to governments: «Children with disabilities in many countries face barriers to accessing a quality, inclusive education. As governments close schools, many are implementing online instruction. Children with different disabilities maybe excluded if online instruction is not made accessible to them, including through adapted, accessible material, and communication strategies. Governments should also ensure accessible material and lesson plans are also available to students who do not have access to the internet. Without government support, parents or caregivers may struggle to provide the full range of services their children may receive in schools»<sup>7</sup>.

In the current situation, other measures taken put a strain on the foundations of democracy and the principle of equality. Beyond the possible and numerous considerations relating to the limitations of the movement of persons, in generalized lockdowns and quarantine periods, to the limitations of privacy and violations of confidentiality rights due to the so-called contact tracing apps, none can deny the seriousness of the discriminatory potential of the introduction of immunity certificates. In contravention of the laws in force in democratic countries that regulate equal opportunities and access to services, the immunity certificate constitutes in fact an effective basis for discrimination. Alan Greene rightly observes: «It is, in principle, feasible to imagine that a potential employer would ask a person for their immunity certificate during a job interview. The employer may then choose not to hire the person on the basis that they may get sick or may have to self-isolate in the future, thus making themselves unavailable for work»<sup>9</sup>. In addition, some people, especially in old age, may not be able to be vaccinated, precisely because of particular health reasons, but for this very reason they would find themselves in a situation of evident social inferiority, in clear contrast with the needs of the respect for the disability that the regulatory systems have now sanctioned everywhere. Moreover, it is no exaggeration to imagine that these are precisely the same groups of people (elderly and/or with disabilities) most exposed to the risk of contagion and the danger of death, and already penalized in terms of the use of technologies both during the lockdown and in the subsequent phases: «If the lifting of lockdown is dependent on the availability of technology and persons being both able to afford it and competent enough to operate it, then a potential gap may open up between those who can and cannot afford the technology and also with those who are incapable of working it – for example, older people»<sup>9</sup>.

## Ethics of the emergency

There has been much discussion about the inequality of treatment in emergency therapy reserved for COVID-19 patients. In the first phase of the pandemic, when the effective protocols had not yet been authorized and validated, the emergency structures were subjected to a very high demand for intervention. Triage was done by introducing new acceptance criteria, but the system's ability to take charge of all subjects soon showed its limitations. In the first instance, and the situation of some particularly affected Italian regions has shown this dramatically, this was to be attributed both to the absence of an updated pandemic plan and to the progressive reduction in the number of hospitals and their overall capacity, caused by the austere health policies of the previous years and structural staff shortages. The death rate from COVID-19 in the period March-May 2020 was very high, also in consideration of the selection made, which favored the treatment of younger patients over older and more vulnerable ones. However, the vulnerability recorded in those phases and the consequent mortality were also related to comorbidity: most of the deceased subjects were already suffering from one or more serious pathologies. Intensive care has therefore in fact abdicated its own primary function, namely, that of operating towards subjects made vulnerable, not only by traumatic events, but above all by the evolution of serious pre-existing pathologies (cardiological, endocrinological, oncological, and neurological). In this case, those same subjects were penalized, from the point of view of that type of intervention, to rather favor relatively younger subjects and not affected by particular ancillary and antecedent pathological conditions. Some<sup>10</sup> have recalled the fact that hydroxychloroquine, commonly indicated for the therapy of lupus, during some phases of the pandemic proved difficult to access precisely for patients suffering from lupus. Moreover, according to reports, in Alabama people with intellectual disabilities have been denied access to ventilators due to policies that have selected people according to the type of disability, effectively introducing a sort of disability hierarchy not legitimized by any current legislation. However, even on a more general level, the contradictions are marked. The United States, which did not sign the 2006 Convention on the Rights of Persons with Disabilities (CRPD), «stands out as having comparatively higher numbers of COVID-19 cases while continuing austerity policies toward healthcare resources and having strong national disability rights legislation»<sup>10</sup>. The WHO has openly criticized the practice of discriminatory triage and the contextual absence of adequate policies for the distribution of necessary medical supplies. An article that appeared in the Harvard Law Review blog in July 2020 described other discriminatory practices in a perspicuous way: «Washington State's triage guidelines have encouraged frontline healthcare workers to deprioritize patients with low baseline functional status, namely patients with "loss of reserves in energy, physical ability, cognition, and general health," even when it is unlikely to affect their response to COVID-19 treatment. Similarly, Tennessee's triage guidelines exclude from ventilation certain people with dementia, traumatic brain injury, and advanced neuromuscular disease who require "assistance with activities of daily living." As a result of these guidelines and others, the Department of Health and Human Services' Office for Civil Rights has launched investigations in Washington State, Alabama, Kansas, Tennessee, Utah, and Oklahoma»<sup>11</sup>. The solution proposed by the authoritative journal, taking into account the objective difficulties and risks associated with abuses deriving from arbitrary and prejudicial application of overly selective triage criteria is to introduce individualized assessments: «A relatively simple recommendation is to fold medical specialists, clinical ethicists, and disability advocates into the process of making individualized judgments about survival and resource need whenever possible. Already, the most accepted triage guidelines require individualized assessment of patients by an independent committee located within hospitals and directed by an acute care physician.

Clinical ethicists, patient representatives, ethics committee members, and on-call specialists who already belong to hospital staff should be incorporated into these committees. A further step would be to include community members with disabilities (or university faculty working in disability studies programs)<sup>11</sup>.

Many of the recommendations that the intensive care doctors themselves had issued were largely disregarded in practice. As an example, it is enough to cite the document of the Italian intensivists: «In emergency situations, the doctor finalizes the optimal use of resources to safeguard the safety, effectiveness and humanization of care, avoiding any discrimination. The doctor must also carry out every possible action to obtain the necessary additional resources, especially in relation to intensive and sub-intensive treatments. In the event that the imbalance between needs and available resources persists, priority is given for access to intensive treatments to those who can obtain a concrete, acceptable, and lasting benefit thanks to them. To this end, rigorous, explicit, concurrent, and integrated criteria are applied, always evaluated case by case, such as: the severity of the clinical picture, the comorbidities, the previous functional state, the impact on the person of the potential side effects of intensive care, the knowledge of previous expressions of will as well as the biological age itself, which can never assume a prevalent character»<sup>12</sup>.

What, then, caused criteria of another nature to intervene instead? A possible interpretation is to be identified in the equation between emergency triage and war triage, partly justified by some fundamental texts. Article 15.1 of the European Convention on Human Rights reads as follows: «In time of war or other public emergency threatening the life of the nation any High Contracting Party may take measures derogating from its obligations under this Convention to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with its other obligations under international law»<sup>13</sup>. However, even in times of war or emergency there are non-derogable rights. As Alan Greene stresses: «Non-derogable rights are those rights whose standards cannot be lowered, even during a state of emergency. Some of these rights may be termed “absolute rights,” meaning that no interference with this right is ever justified. States can interfere with the right of life; however, save for lawful acts of war, no derogation from this rights is permissible, meaning that during a pandemic, the obligations for a state remain the same, regardless of whether an emergency is declared or not. The standard of rights protection required by non-derogable rights was thus the same across all states, regardless of not they declared emergencies under Article 15 ECHR in response to COVID-19»<sup>9</sup>. Similarly, the right to life (art.2 ECHR) and the prohibition of torture (art.3 ECHR), two cornerstones of the protection of human rights in Europe (and beyond) that seem to have been violated during the emergency phases of the pandemic. Greene notes that «states canceling treatments to free up hospital space in an emergency pandemic situation must put in place decision-making procedures to reflect this complexity and these rights. A blanket discharge of everybody, regardless of the severity of their condition, for example, would constitute a clear breach of Article 3 and potentially Article 2, if it results in the loss of life»<sup>9</sup>. To better understand the responsibilities of those who, exercising the function of care, have not taken into account the individual rights of all those involved, it must be considered, as has been appropriately indicated, that «non-derogable rights are not just manifestations of ‘negative liberty’; instead, they place burdens on the state to take steps to protect these rights»<sup>9</sup>. The problem is therefore, given the non-negotiability of those principles of protection of rights, the way in which the persons in charge are actively involved in their protection. However, here the ethical criteria that guide practical choices inevitably come into play.

A 2007 article dedicated to the principles and values that guide the practice of triage highlights the fundamental difference in how to describe the actions and decisions taken in that area: actions can be described from a procedural or from a substantive point of view. Under the first profile, the description takes into account the implementation of all the procedures required by the protocols and regulations. In the second case, «an action is fair if it conforms to an accepted standard or principle of justice. Because triage systems distribute scarce medical resources among people in need, they typically appeal to one or more principles of distributive justice»<sup>14</sup>, in particular the principle of utility, the difference principle, and the principle of equal chances. According to the utilitarian point of view, triage is not comparable to any clinical procedure: the care relationship that triage provides is inspired neither by the principle of autonomy, nor by the trust between patient and operator, but by the principle of general or aggregate utility, measured with the calculation of future consequences. Just as in times of war priority is given not to the most seriously injured or life-threatening soldiers, but to those who, predictably, will be able to become operational again, so in times of pandemic or disaster priority is guaranteed to those who must, presumably, provide for general utility in the medium to long term. The theory of justice inspired by Rawlsian contractualism is of the opposite tendency, substantiated by the so-called principle of difference: if the objective, within this precise perspective, is to distribute the goods shared by public society to the most disadvantaged, then it follows that also the objective of the triage will be to favor the group of more serious patients, not without prejudice to the overall outcomes which in this way can only correspond to a higher mortality. Since most of the resources cannot be used for the other groups of patients, the mortality of the less severe will record a significant increase, exclusively following this principle. A third guiding principle of an ethical nature is the principle of equal chance, which consists in offering all patients who undergo triage an equal chance of survival, regardless of costs, and general outcomes. Which of these criteria to privilege, in emergency therapeutic choices, when the narrowness of means and times does not allow to guarantee equal chances or even a just redistribution? Already in 2009, the French Comité Consultatif National d'Éthique (CCNE), expressing itself on a possible flu pandemic, invited to weigh between equality and equity: «To fight against the spread of the virus by reconciling strategic efficiency and ethical requirements, we must bear in mind the values to which our society is attached. Everyone agrees that the implementation of a plan to fight a pandemic should not exacerbate existing situations of injustice. Justice is a principle which admits two meanings: equality and equity: to be just in the sense of equality is to act so that each person is recognized in their dignity, that is to say, so that its individual value is recognized as absolute. From the point of view of justice in the egalitarian sense, decision-making bodies must help each of those whose dignity is abused by precarious living conditions. It is this principle of egalitarian justice that inspires policies to combat social discrimination, measures to protect the weakest and minorities. Justice understood in the sense of equity balances absolute egalitarianism with a concern to ensure the hope and quality of life of the whole community. It is not contradictory with the requirement of equality but makes it possible to prevent unconditional respect for a person's value from translating into an investment of collective resources for her benefit without taking into account the consequences on the quality of life of other members of society. The concern for equity appears particularly in the context of a shortage of resources. Since, on a temporary basis, the occurrence of an influenza pandemic would put the population in a situation of limited health resources (the time to develop and distribute vaccines), equity should invariably weigh egalitarianism. In the ethical argument, the committee believes that the plan to combat such a health scourge should be based on the demand for justice in the egalitarian sense of the term, balancing it with the temporary need for prioritization of resources»<sup>15</sup>. And in this same direction, for example, moved the Department of Health of the Republic of Ireland, which in 2020 published the document "Ethical Framework for



Decision-Making in a Pandemic.” Among the ethical principles that guide decision-making are the principles of fairness, equity, and proportionality: the approach to the “prioritization of medication and medical care” goes in the direction of mitigating utilitarianism, orienting itself rather towards acting that combines autonomy and general advantage: «A multi-principled approach takes into account estimates or projections of: the total number of lives saved; the total number of life years saved; and long-term functional status should patients survive; these estimates or projections may be made based on empirical data if they are available, or on sound clinical rationale. Such an approach can act as a tool to facilitate fair decisions, as it seeks to balance utility and equity considerations. Utilizing a multi-principle approach can temper the classic utilitarian approach of the allocating resources based on “the greatest good for the greatest number,” taking into account a fair distribution of benefits and burdens. Categorical exclusion, for example, on the basis of age should be avoided as this can imply that some groups are worth saving more than others and creates a perception of unfairness. The principle of solidarity dictates that while all patients may not receive critical care, those who do not should continue to be cared for with alternative levels of care, including palliative care. It is not appropriate to prioritize on the basis of social status or other social value considerations, for example, income, ethnicity, and gender. However, it may be ethical to prioritize certain at-risk groups and those essential to managing a pandemic for treatment. This conforms with the principles of minimizing harm, fairness, and reciprocity»<sup>16</sup>.

As can be seen, none of the ethical approaches examined so far takes into consideration the hypothesis that the least expendable subject is the most vulnerable, the most fragile. Although hybrid solutions are mitigated or weighted to avoid excessive social discrimination, the principle of general utility still prevails. There is still a long way to go to build a new common sense and a new awareness: a society that does not save the weakest first, will not be able to save itself from its own fragility and atomistic drift. Discrimination of vulnerables leads to the loss of equality, of dignity and of the common good, and «it cannot but entail, even only as a categorical residue, a discrimination of oneself: while caring for the other, physically and manually caring, it can lead to a well-being reflected on the operator»<sup>3</sup>. And on this issue, in the present crisis as in the future, the delicate balance between equality and inequality that political society is called on to renew is played out.

## **Clarification note**

Translations of the texts cited in this article have been carried out by the author himself.

## **Funding**

This research has not received any specific grant from agencies in the public, commercial, or non-profit sectors.

## **Conflicts of interest**

The author declares that he has no conflicts of interest.

## Ethical disclosures

**Protection of human and animal subjects.** The authors declare that no experiments were performed on humans or animals for this study.

**Confidentiality of data.** The authors declare that they have followed the protocols of their work center on the publication of patient data.

**Right to privacy and informed consent.** The authors declare that no patient data appear in this article.

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