

# Ventilator Triage: Patient Features & Attitudes

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## Introduction to Ventilator Triage and Ethical Dilemmas

Ventilator triage protocols are implemented during catastrophic public health emergencies, such as widespread pandemics, when the demand for critical life support resources, specifically mechanical ventilation, significantly exceeds the available supply. These protocols necessitate difficult decisions regarding which patients will receive access to potentially life-saving treatment and which will be denied, often leading to ethically fraught situations where the core principles of medical beneficence and justice clash severely. The attitudes held by healthcare professionals, policymakers, and the general public toward the specific **patient features** used in these triage frameworks are crucial, as they determine the perceived fairness and legitimacy of the system. Understanding these attitudes involves examining deep-seated psychological biases, cultural values regarding life and death, and adherence to foundational ethical principles like maximizing utility versus ensuring equity. The selection of criteria for prioritization is not merely a clinical exercise; it is a profound moral statement about whose lives are deemed most valuable or salvageable under extreme duress, making public acceptance contingent upon the perceived neutrality and objectivity of the features employed.

The psychological weight associated with triage decision-making is immense, often resulting in severe moral injury among frontline providers who must implement these demanding policies. Consequently, the criteria chosen must be transparent, justifiable, and applied consistently to mitigate provider distress and maintain public trust, which is essential for compliance and social cohesion during a crisis. Patient features typically fall into two broad categories: clinical factors (e.g., immediate prognosis, severity of illness, likelihood of recovery) and non-clinical factors (e.g., age, pre-existing conditions, social role, dependents). While clinical factors are generally accepted, non-clinical factors are significantly more controversial and elicit strong negative attitudes due to concerns about discrimination and inherent bias. Public attitude studies often reveal a complex tension: while individuals generally support maximizing the number of lives saved (a utilitarian approach focused on efficiency), they simultaneously express profound discomfort with criteria that seem to discriminate against vulnerable populations, such as the elderly, the chronically ill, or those with existing disabilities. This tension underscores the difficulty in designing protocols that are both optimally effective in resource allocation and ethically palatable to a diverse, rights-respecting society.

The primary objective of most ethically sound triage protocols is to allocate resources to patients who have the highest probability of surviving the immediate critical illness and achieving a meaningful recovery, thereby maximizing the population benefit derived from scarce resources. However, the operationalization of this goal requires explicit consideration of specific patient attributes, which inevitably generates intense public and professional debate. For instance, relying heavily on predicted outcomes inevitably involves assessing baseline health status and physiological reserve, which can inadvertently penalize individuals who have lived longer or who

entered the crisis with pre-existing chronic conditions. Furthermore, the attitudes surrounding these features are inherently dynamic, shifting based on the perceived immediacy and severity of the crisis, the media representation of affected populations, and the prevailing societal narrative about individual responsibility for health outcomes. Therefore, rigorous psychological and ethical analysis of these attitudes is mandatory before any triage system can be considered ethically robust and socially acceptable, ensuring that the chosen features reflect a commitment to justice as well as utility.

## The Role of Prognosis and Likelihood of Survival

The most widely accepted patient feature in ventilator triage protocols is the short-term prognosis--the estimated likelihood of the patient surviving the acute illness with the support of mechanical ventilation and being discharged from the hospital. This criterion is inherently utilitarian, designed to maximize the efficacy of the scarce resource by directing it toward those who are most likely to benefit, thereby saving the greatest number of lives overall. Attitudes toward using strict clinical scoring systems, such as the Sequential Organ Failure Assessment (SOFA) score or similar predictive models, are generally positive among clinicians and the public, primarily because these tools are perceived as objective, evidence-based, and directly related to the medical necessity and potential success of the intervention. The psychological acceptance of this criterion stems from the rational belief that investing critical resources in patients with near-zero survival odds constitutes a wasteful depletion of resources that could otherwise offer a high probability of success to another patient in need, violating the core principle of resource stewardship.

However, even the reliance on prognosis is fraught with psychological complexity and potential for bias. The assessment of likelihood of survival is often based on predictive models that may be imperfect, especially early in an emerging pandemic where disease characteristics, response to treatment, and long-term outcomes are not fully understood, leading to significant diagnostic uncertainty. Furthermore, the time constraints inherent in a crisis environment pressure clinicians to make rapid, high-stakes assessments, which can introduce cognitive biases, such as anchoring to initial impressions of severity or availability heuristics related to recent, memorable patient outcomes. Attitudes towards prognosis criteria must therefore account for the potential for error and the necessary inclusion of a robust mechanism for periodic reassessment of the patient's clinical trajectory. If triage protocols are perceived as inflexible or overly reliant on initial, potentially flawed data, public and professional trust in the system erodes rapidly, regardless of the criterion's foundational ethical justification rooted in utility maximization.

A key ethical and psychological distinction in triage involves separating those who are too sick to benefit (poor short-term prognosis, where intervention is futile) from those who are healthy enough not to need the ventilator immediately. Attitudes strongly favor providing resources to the middle group--those who are critically ill but have a reasonable chance of survival with intervention.

Clinical scores attempt to quantify this middle ground objectively. Yet, controversy arises when prognosis is extended beyond immediate survival to consider **long-term life expectancy** post-recovery, a feature often grouped implicitly with age or pre-existing conditions. While maximizing immediate survival is widely accepted, attitudes diverge significantly when protocols suggest prioritizing patients who are expected to live longer post-recovery, moving the focus from immediate utility to the maximization of "life-years saved." This shift introduces a deeply complex psychological evaluation of the relative duration of life, which many find highly objectionable as it risks approaching explicit social worth judgments and devaluing the lives of older individuals or those with chronic conditions.

## Age as a Triage Criterion: Ethical and Psychological Implications

The use of **chronological age** as a distinct criterion for ventilator triage is arguably the most ethically charged and psychologically difficult feature to manage. Attitudes toward age-based rationing vary dramatically depending on cultural context and the framing of the crisis. Some proponents argue that age serves as a reasonable, easily quantifiable proxy for physiological reserve, frailty, or overall life expectancy, suggesting that prioritizing younger individuals maximizes future life-years saved, aligning strictly with a strong utilitarian framework focused on societal benefit over individual equity. Proponents often cite the controversial concept of the "fair innings" argument, suggesting that older individuals have already had the opportunity to live a full life, whereas younger individuals have not. This perspective, however, faces fierce opposition rooted in the constitutional and ethical principle of equal concern and respect for all persons, irrespective of their age, a cornerstone of non-discriminatory medical practice.

Public and professional attitudes often reveal significant discomfort with explicit age cutoffs, viewing them as arbitrary and fundamentally unjust. Psychologically, denying care purely based on age feels discriminatory and violates the fundamental medical principle that treatment decisions should be based on clinical need and expected benefit, not demographic characteristics alone. While age is certainly correlated with frailty and comorbidities, using it as a standalone exclusionary feature is viewed by many as a form of institutionalized ageism. Surveys frequently show that while the public might reluctantly accept criteria related to physiological reserve (which correlates with age), they strongly reject policies that mandate withholding treatment solely because a patient has reached a specific chronological milestone, such as 75 or 80 years old. The intensely negative attitudes stem from a fear of devaluing the lives of the elderly, a group already significantly vulnerable during health crises, and undermining the sanctity of life across all stages.

Furthermore, the use of age introduces complexity regarding how it interacts with other patient features. A protocol might not use age directly but might rely heavily on comorbidity or frailty scores that disproportionately affect older populations, achieving age-based rationing indirectly. The psychological impact of indirect ageism is subtle but pervasive, leading to accusations of

systemic bias. To counteract negative attitudes and legal challenges, many modern triage guidelines explicitly prohibit chronological age as a primary exclusionary criterion, instead requiring that any age consideration must be filtered through a clinical assessment tool, such as the Clinical Frailty Scale (CFS). The acceptance of the CFS, which measures physiological reserve and functional status rather than years lived, is generally higher because it shifts the focus back toward the patient's biological capacity to survive the trauma of critical illness, which is perceived as a more relevant and ethically defensible clinical feature.

## Attitudes Towards Comorbidities and Underlying Health Status

Underlying health status, encompassing chronic conditions (**comorbidities**) such as severe congestive heart failure, advanced end-stage renal disease, or chronic obstructive pulmonary disease (COPD), is a standard patient feature considered in triage protocols. Attitudes towards using severe, life-limiting comorbidities are generally positive among clinicians, as these conditions significantly reduce the physiological reserve needed to tolerate mechanical ventilation, recover from acute respiratory distress syndrome (ARDS), and survive long-term. The ethical justification here rests firmly on maximizing short-term survival probability: patients with severe, life-limiting comorbidities are substantially less likely to survive the acute illness, making the allocation of the scarce ventilator resource less effective and potentially futile in their case.

However, public attitudes introduce necessary caveats regarding the nature and severity of the comorbidity. There is a psychological distinction made between conditions that are terminal or immediately life-limiting (e.g., metastatic cancer with a prognosis of weeks) and chronic, managed conditions (e.g., well-controlled diabetes or mild, stable hypertension). While most stakeholders agree that triage resources should not be allocated to those already dying from an irreversible, non-COVID-related cause, attitudes are much less accepting of policies that penalize individuals for having common, manageable chronic diseases that do not directly impede recovery capacity from the acute illness. This resistance reflects a strong societal belief in equity, demanding that people should not be denied care simply because they have chronic health issues, especially if those issues do not fundamentally alter their chance of surviving the critical care episode.

The psychological and ethical challenge lies in ensuring that the use of comorbidities does not unintentionally exacerbate existing health disparities. Populations that experience systemic disadvantages due to socioeconomic status, race, or geography often have higher rates of comorbidities due to factors like chronic stress, poverty, and lack of access to preventative care. If triage protocols strictly prioritize those with the fewest comorbidities, they risk disproportionately excluding marginalized groups, leading to intense negative attitudes regarding fairness and equity in healthcare access. Consequently, expert consensus and public acceptance favor protocols that assess comorbidities only when they are severe enough to independently and significantly reduce the likelihood of surviving the acute critical care episode, rather than using them as a broad

exclusionary criterion based on perceived general health or pre-crisis lifestyle status.

## Disability Status and Perceived Quality of Life

The inclusion of **disability status** or subjective assessments of **perceived quality of life (QoL)** as a patient feature in triage protocols generates some of the most profound ethical conflicts and negative psychological reactions. Attitudes are overwhelmingly against using pre-existing disability as a criterion for denying life-saving treatment. The primary concern is that such policies institutionalize ableism, substituting a subjective, value-laden judgment about the worth of a disabled person's life for an objective clinical assessment of their capacity to benefit from ventilation. Disability rights advocates argue strenuously that life with a disability, even a severe one, is not inherently a life of lesser value, and triage decisions must be based solely on immediate medical prognosis, not on long-term functional status or societal assumptions about QoL.

Psychologically, the public and, sometimes, decision-makers struggle to separate the concept of critical illness prognosis from perceived long-term QoL, a reflection of deep-seated societal biases. Decision-makers, under extreme stress, may unconsciously favor patients who are expected to return to a baseline level of function perceived as "normal" or "high quality." This bias is deeply problematic, as it reflects societal prejudices against disability rather than clinical reality concerning acute survival. For example, a patient with a severe but stable intellectual disability or a chronic, stable mobility impairment should not be denied a ventilator if their physiological capacity to survive the acute respiratory failure is equivalent to that of a non-disabled patient. The prevailing positive attitude is that triage must be "disability-neutral," focusing strictly on the likelihood of surviving the hospitalization and achieving recovery to the patient's individual baseline, irrespective of what that baseline entails.

The only context where pre-existing disability might legitimately factor into triage is if the underlying condition makes mechanical ventilation physiologically futile (e.g., severe, rapidly progressive neurodegenerative disease leading to inevitable, imminent respiratory failure regardless of acute intervention). Even in these narrow cases, the focus must remain strictly on the certainty of futility related to the intervention itself, not on the general quality of the patient's life, which is ethically irrelevant to the triage decision. Policies that fail to maintain this strict distinction face intense public scrutiny, legal challenges, and profound negative psychological attitudes, as they violate the core principles of non-discrimination and equal treatment in medicine, potentially leading to the systemic marginalization of a protected class.

## Social Value and Instrumentalizing Patient Features

The concept of using **social value** or instrumental patient features--such as occupation, societal contribution, or dependents--is consistently met with widespread negative attitudes and moral

outrage in democratic societies. While some extreme utilitarian arguments suggest prioritizing individuals critical to the societal response (e.g., frontline healthcare workers, essential infrastructure staff) to maximize the collective good during a crisis, the vast majority of ethical frameworks and public opinion polls reject this approach for general triage. The primary psychological objection is that assessing social worth is inherently subjective, discriminatory, and violates the fundamental democratic principle that all lives have equal moral value in the eyes of the state and the healthcare system, regardless of profession or economic contribution.

Attempts to instrumentalize patient features--treating individuals as means to an end rather than ends in themselves--create massive ethical hazards and undermine the foundational trust between patients and providers. The question of who determines the "value" of a person's contribution is unanswerable in a fair manner; should a teacher be prioritized over an artist, or a CEO over a sanitation worker? Allowing such criteria opens the door to biases based on socioeconomic status, race, and profession, leading to a breakdown of public trust and fueling social division during a time when unity is most needed. While there is often grudging acceptance for prioritizing healthcare workers who contracted the illness while actively saving others (often framed as a duty to protect essential responders), this exception is not a general endorsement of using social worth as a triage feature.

Triage protocols that attempt to incorporate features related to dependents (e.g., prioritizing the sole caregiver of minor children) also face mixed attitudes. While there is a strong psychological pull toward protecting those with dependents, this feature is difficult to apply fairly, can inadvertently discriminate based on family structure or marital status, and shifts the focus away from the patient's clinical need. Consequently, most mainstream ethical guidelines, including those from major medical societies, strongly advise against using any social value or instrumental features, advocating instead for criteria that are purely clinical and outcome-focused to ensure fairness, maintain the moral integrity of the medical profession, and affirm the equal moral status of every patient.

## Fairness, Equity, and the Principle of Equal Concern

The overarching attitude guiding the selection and application of ventilator triage patient features must be centered on the principles of **fairness and equity**, ensuring that protocols adhere strictly to the concept of equal concern for all individuals. While classical utilitarian ethics demands maximizing overall population health outcomes, justice ethics requires that the mechanism for achieving those outcomes does not systematically disadvantage already vulnerable or marginalized groups. Attitudes strongly favor criteria that treat all patients equally at the starting line, barring only those clinical factors that make intervention medically futile or highly unlikely to succeed. This commitment to non-discrimination is essential for maintaining social order during a resource crisis.

Equity requires careful scrutiny of patient features that correlate highly with socioeconomic status or systemic disadvantage. For example, if low health literacy, lack of access to preventative care, or systemic racism leads to higher rates of severe comorbidities in certain populations, relying solely on these scores without adjustment risks perpetuating health inequities through the triage system. Public attitudes demand that triage protocols incorporate measures to mitigate these structural biases, ensuring that the system does not punish individuals for disadvantages outside of their control. The pursuit of equity necessitates minimizing the use of non-clinical features and maximizing reliance on objective, immediate clinical indicators of survival that are independent of socioeconomic or demographic background.

Ultimately, the psychological and ethical acceptability of any triage framework hinges on its ability to demonstrate that the choice of patient features is necessary, non-discriminatory, and applied with compassion and procedural justice. The principle of equal concern dictates that, when resources are scarce and clinical factors cannot distinguish between two patients with similar high probabilities of survival, selection should be determined by a random process (e.g., a lottery system), rather than introducing secondary, non-essential differentiating criteria. This randomization approach, often favored in tie-breaking situations, is psychologically appealing because it affirms the equal moral standing of individuals when clinical factors cannot resolve the prioritization dilemma, preventing the painful need for subjective value judgments.

## Policy Recommendations and Future Directions in Triage Ethics

Future ethical frameworks for ventilator triage must proactively integrate psychological insights into public and professional attitudes toward specific patient features to enhance legitimacy and compliance. Policy recommendations emphasize the need to develop and rigorously test clinical scoring systems that are transparent, validated across diverse populations, and strictly focused on short-term prognosis and physiological reserve capacity. The explicit rejection of highly controversial features like social value, long-term life expectancy, and pre-existing stable disability is essential for maintaining ethical integrity and public trust during a crisis. These guidelines must be established well in advance of a crisis to avoid hasty, ethically compromised decisions made under pressure.

Specific policy guidelines should mandate the use of objective assessment tools, such as SOFA scores or validated frailty scales, explicitly stating how these tools measure physiological reserve rather than functioning as proxies for age or disability status. Furthermore, policies must include clear, rapid appeal processes and mandatory multidisciplinary triage committees to diffuse the moral burden on individual clinicians and ensure consistent, unbiased application of the chosen patient features. This structure addresses the psychological need for procedural justice, providing checks and balances against individual bias and promoting collective responsibility for tragic outcomes.

Finally, continuous public engagement and education are necessary to shape positive attitudes towards triage necessity and fairness. This involves moving the public conversation away from assessing individual worth and toward the tragic reality of resource scarcity and the necessary goal of maximizing population survival through ethical means. Future research should focus intensely on the psychological consequences of implementing various triage criteria on both providers and communities, ensuring that protocols are not only ethically sound but also psychologically sustainable and resilient during prolonged health emergencies, fostering acceptance through transparency and adherence to equity principles.

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