Dividing the Beds: A Risk Community under ‘Code Black’?*

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1. Introduction

During the second week of March, disturbing images from the North of Italy were broadcasted the world over. Patients were waiting in makeshift wards because of shortages of ventilators, beds and personnel. Nurses collapsed after working for ten hours straight and cried because they needed to take decisions of life and death and the mayor of one town complained that the very old could not receive treatment.\(^1\) The images from Italy were a stark warning. The coronavirus could lead to the collapse of healthcare services, also those of well off ‘western’ nations.

The footage reached the Netherlands quickly, but initially people were more amazed than worried. Diederik Gommers, the chairman of the Dutch Association of Intensive Care (NVIC), mentioned the possibility that senior citizens of 80 and over might not receive treatment, if hospitals were to overflow. He still expected the COVID-19 pandemic to be mild though, and predicted a total of 8,000 cases of infection in the Netherlands.\(^2\)

However, when the province of Brabant started to experience a surge of patients, the scenario that not everyone could receive treatment due to acute shortages became a real possibility. This scenario became known in the Netherlands as ‘code black’. The choice doctors needed to make in deciding who was eligible for treatment and who was not in such a situation, became known as ‘triage’, a term from the field of military health care.\(^3\)

It was a nightmare scenario for potential patients, but also for doctors as well as for politicians because it meant that the Dutch healthcare system could not cope with this crisis. The code black scenario also spawned an ethical debate on the pages of the newspapers among doctors, ethicists, politicians and many others voicing their opinion. If there was just one bed available for two new patients and if medically

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1 Jason Horrowitz, ‘Italy’s Health Care System Groans Under Coronavirus – a Warning to the World’, New York Times, 14 March 2020.

2 Jop van Kempen, ‘Meer dan 20.000 geïnfecteerden? Dan moeten artsen harde keuzes maken’, Het Parool, 15 March 2020.

3 Michel Debacker, ‘De ontwikkeling van triage sinds Napoleon’, Tijdschrift voor Geneeskunde 59 (2003): 269-299.
the patients were in the same condition, what would be the criteria to determine who would receive treatment? Was age a fair criterion for selection or would a lottery be more fair? Code black became a matter of intergenerational tension.

In this article, I do not intend to discuss the ethical dilemma of triage per se. A lot has been written already on the dilemma from a perspective of health care ethics. This article presents a discourse analysis of the public discussion of code black. The discourse is methodically analyzed using the concepts of political discourse analysis provided for by Maarten Hajer and interpreted using the framework of the sociologist of risk Ulrich Beck.

I have chosen Beck’s framework because he provides one of the most comprehensive theories of how communities react to risk. Beck maintains that existential risks open up spaces to question existing institutions. Moreover, he hold that risks create new opportunities for community building. When the threat is sufficiently urgent, boundaries separating people, such as nationality, class and age, will become fluid. Beck envisions a new type of solidarity to emerge, which he calls ‘cosmopolitan’ and described as solidarity among strangers and ‘un-equals’ as opposed to a traditional form of solidarity, based around identity and nationality. Currently authors try to rethink solidarity with the elderly in domains such as healthcare. Such novel ways of thinking might receive an impetus by the shared experience of risk in the wake of COVID-19 and might be further informed by a Beckian analysis of solidarity and community building in the face of risk.

A second reason to use Beck is that the crisis presents a whole new constellation of risks, unimagined by Beck. It therefore provides an opportunity to test whether Beck’s concepts hold up in different contexts from risks he did consider such as climate change or terrorism. The code black scenario is in this case particularly apt as a research object because it is a ‘catastrophe that is still to come and that we have to anticipate and forestall in the present’. Those situations are crucial for Beck’s theory, because they could lead to new actor networks across class, nationality and ethnicity forming risk communities and ‘breaking open’ existing institutions.

4 See, for instance, Susanne Jöbges et al., ‘Recommendations on COVID-19 triage: international comparison and ethical analysis’, Bioethics 34 (2020): 948-959; Rauf Jaziri and Saleh Alnahdi, ‘Choosing which COVID-19 patient to save? The ethical triage and rationing dilemma’, Ethics, Medicine and Public Health 15 (2020). For a discussion among Dutch ethicists, see the blogpost, ‘Bij Nader Inzien’, https://bijnaderinzien.com/.
5 Ulrich Beck, ‘The cosmopolitan perspective: sociology of the second age of modernity’, British Journal of Sociology 51 (2000): 92-93.
6 Rob Houtepen and Ruud Ter Meulen, ‘The Expectation(s) of Solidarity: Matters of Justice, Responsibility and Identity in the Reconstruction of the Health Care System’, Health Care Analysis 8 (2000): 355-376; Chris Phillipson, ‘The political economy of longevity’, The Sociological Quarterly 56 (2015): 80-100; Bruce Jennings, ‘Solidarity and Care Coming of Age: New Reasons in the Politics of Social Welfare Policy’, in Citizenship and Justice in Aging Societies (Hastings Center Report 48, no.5, 2018), 19-24.
7 Ulrich Beck, Risk, class, crisis, hazards and cosmopolitan solidarity/risk community – conceptual and methodological clarifications (Paris: Fondation maison des sciences de l’homme 2013), 8.
8 Hartmut Rosa, Social Acceleration (West Sussex: Columbia University Press, 2013), 211.
The question this article addresses is to what extent the discussion paved the way for the formation of a risk community among medical personnel, the mostly elderly patients and politicians. After having reviewed the discourse around code black, my claim is that it altered the regulation of this situation in a way that is more sensitive to the risk position of the elderly, displaying tentative signs of the formation of a risk community. However, eventually the discourse was transformed from an ethical one to a managerial one on how to avoid an acute shortage of beds. Afterwards, questions about the position of the elderly within the health care system and within society a large were not seriously raised anymore.

The Dutch case shows that Beck’s consideration of responsibility in the risk society is one sided. He treats responsibility as obfuscated and diffused between many actors because he supposes nobody wants responsibility. However, the case of code black demonstrates that responsibility can be ‘outsourced’ to specific experts and professionals who do want it. Assuming responsibility allows for a degree of regulatory control and with it control over the allocation of risk positions.

The following sections discuss the theoretical framework, followed by the research methodology. Afterwards the discourse is thematically analyzed, followed by reflection and conclusion.

2. Risk solidarity and risk community

Beck’s seminal work The Risk Society is well known. Beck advances the thesis that gradually industrial society evolves into a risk society, which means that the focus of social action is no longer primarily on increasing material welfare, but on reducing the large-scale risks that accompany it. Risk and danger are experienced in different ways than before, because the risks of current societies are considered the result of human action. The flooding of New Orleans caused by hurricane Katrina for instance is not considered an act of God, but a result of neglect of the dikes and water works. Likewise, we view the corona pandemic as the result of the way we handle animals, the frantic pace of our mobility and the encroachment of humanity on natural habitats. In the risk society, the production of risks starts to occupy a more prominent place in our consciousness than the benefits of industrial production.

The transition to the risk society entails that conflicts over risks become more important than other areas of conflict, such as class. Actors will try to occupy favourable ‘risk positions’, making them less susceptible to the effects of risk and therefore safer. The transition also creates social anxiety, because the institutions of the past, notably the (nation) state, science and the market, have proven to be accomplices in the production of risks. As Anthony Giddens put it, risks have a

9 Ulrich Beck, Anthony Giddens and Scott Lash, Reflexive Modernization (Stanford CA: Stanford University Press, 1994), 11.
‘disembedding’ effect. They uproot us from the comfort of our traditional institutions towards a new future.10

In his early work, Beck discusses how risks will affect our notions of solidarity. In a provocative section titled ‘from solidarity of need to solidarity motivated by anxiety’, Beck raises the question whether it is possible for communities to emerge based on shared fear rather than shared need.11 While Beck does not give a definition of solidarity, he implicitly adopts a sociological definition, which I adopt in this article as well. Solidarity is defined as ‘the feeling of reciprocal sympathy and responsibility among members of a group which promotes mutual support’,12 a definition that essentially goes back to Durkheim. However, Beck identifies two different bases for solidarity; solidarity based on shared need and solidarity based on shared risk, henceforth ‘risk solidarity’. Both can lead to the formation of communities. A community held together by shared need tries to limit scarcity and does so by using instrumental rationality, which Beck associates with the state, the market and technology. Shared fear may also induce people to form communities, but he is unsure how exactly and sceptical of the chances of success.13

In his later work, Beck’s interests shift. He turns to the inclusive potential of risk and becomes more optimistic. He proposes that risk solidarity can make a new form of community possible in which people bond together because they fear a common threat.14 Risk solidarity is extended to people who do not partake in a shared history, ethnicity or identity, but with whom we share the same vulnerability. In order to confront the risks that threaten us, cultural, ethnic and class-based borders are lifted. Beck wrote: ‘people will have to find meaning in their lives in exchange with others and not primarily with people like themselves’.15 A community based on risk solidarity therefore pertains to a different way of associating with ‘others’ in our midst. In a risk community, the other will remain other, but will lose its character of ‘enemy’, in Schmittian terms. Instead, the other becomes a companion in a community based on mutual defence against risk.

In risk communities, people realize that risk is the product of our institutional organization and will therefore demand change. Reason loses its primarily instrumental character, and will become reflexive, incorporating notions such as pity, suffering, responsibility and self-awareness.16 A risk community is based on a form

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10 Anthony Giddens, *The Consequences of Modernity* (Cambridge: Polity Press, 1990), 21-29.
11 Ulrich Beck, *Risk Society. Towards a New Modernity* (London: Sage Publications, 1992), 49.
12 Lawrence Wilde, ‘The concept of solidarity: Emerging from the theoretical shadows?’, *The British Journal of Politics and International Relations* 9 (2007): 171-181.
13 Beck, *Risk Society*, 49.
14 In this paper, the term risk solidarity signifies the type of solidarity that is the result of experiencing the same risk. It should not be confused with the concept of risk solidarity used in social insurance literature.
15 Ulrich Beck, *De Wereldrisicomaatschappij, Op zoek naar verloren zekerheid* (Amsterdam: Wereldbibliotheek, 2015), 23.
16 Ulrich Beck, ‘Critical Theory of World Risk Society: A Cosmopolitan Vision’, *Constellations* 16 (2009): 12; Klaus Rasborg, ”(World) risk society” or “new rationalities of risk”?, *Thesis Eleven* 108 (2012): 16.
of empathy in the sense of a shared knowledge that we all suffer the same fate and on a common struggle to change old habits that produce risk.\(^{17}\)

Beck uses the notion of a risk community mostly in relation to people of another nationality or ethnicity. However, risk communities can be formed with many kinds of ‘others’ and can be researched on a national level.\(^{18}\) I consider the other to refer to the one traditionally ‘excluded’ by solidarity based on ethnic, national, religious, sexual or gendered identity. Giving meaning to our lives in exchange with others, implies recognizing others as partners without requiring them to assimilate. Beck describes it as a recognition of the other as both different and the same.\(^{19}\) The overcoming of the either/or dichotomy entails changing institutions that either tend to assimilate the other, or absolutize its difference.

3. Operationalization and methodology

To be of use in an interpretative analysis of data, the ideal typical notion of a risk community needs further unpacking. At the core of the concept lies the notion of risk solidarity, which means relating to the other as a companion. The other is a person worthy of autonomy, an end in itself to borrow the Kantian phrase, but also an ally with whom we stand side by side with in the face of risk. Granting autonomy is therefore not enough, showing concern for each other’s fate is necessary as well. The solidarity of risk differs from the solidarity of need, which refers to groups forming around certain \textit{a priori} identities that try to increase their total share of resources.

To further flesh out the type of relationships that make up a cosmopolitan risk community, we need to turn to three other thematic concepts in Beck’s work, ‘reflexivity’, ‘sub-politics’ and ‘organized irresponsibility’. Reflexivity refers to the realization that risks are consequences of our technological progress and cannot be controlled through instrumental rationality.\(^{20}\) As Beck puts it, modernity has become a problem for itself.\(^{21}\) This leads to the questioning of instrumental rationality and technocratic decision-making, but also to the realization that the risks that befall us are the consequences of modern society itself. A change towards a risk community entails questioning existing institutional structures and the way they allocate risk positions.

Sub-politics refers to the necessity to bring risk management into the political sphere in order to open up its practices to participation by a better-informed public.

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17 Beck, \textit{Risk, class, crisis, hazards and cosmopolitan solidarity/risk community}, 8/9; Joy Y. Zhang, ‘Cosmopolitan risk community in a bowl: a case study of China’s good food movement’, \textit{Journal of Risk Research} 21 (2018): 77.

18 Ulrich Beck, \textit{Cosmopolitan Vision} (Cambridge: Polity Press 2006), 91; Zhang, \textit{Cosmopolitan risk community in a bowl}, 69.

19 Beck, \textit{Cosmopolitan Vision}, 58.

20 Magnus Boström, Rolf Lidskog and Ylva Uggla, ‘A reflexive look at reflexivity’, \textit{Environmental Sociology} 3 (2017): 6-16.

21 Ulrich Beck, \textit{World Risk Society} (Cambridge: Polity Press 1999), 20.
and socially aware firms.\textsuperscript{22} Decision-making processes on risk that are usually considered as apolitical practices, become politically salient. Some examples include the internal auditing mechanisms of corporations, the covenants between polluters and the government or the guidelines used by doctors to allocate resources. In the scope of this article, sub-politicization refers to processes by which decision-making on risks becomes transparent and people subjected to those risks get to participate in them.

Characteristic of a risk community is the idea that people take responsibility for the shared fate of its members. This is what I take Beck to mean by a rationality based on empathy. The notion of responsibility is almost never treated positively in Beck’s work. Instead, Beck coined the term ‘institutional irresponsibility’.\textsuperscript{23} This is the tendency of institutions to shirk their responsibility and obfuscate it when crises materialize. Through a variety of systemic loopholes, especially in legislation, institutions escape liability when they fail to protect us.\textsuperscript{24} Through institutional irresponsibility, they manage to uphold the semblance of success by marginalizing their own role in risk production. In response to societal criticism and further democratization though, Institutions can learn and transcend this reflex to shift responsibility away. Beck calls this process ‘institutional metamorphosis’.\textsuperscript{25}

The four notions discussed above function as the interpretative framework to be used on the body of texts described below. For further clarification, I have constructed the ideal typical model of a risk community below and compared with the ‘modern’ model of community.

\textsuperscript{22} Beck, World Risk Society, 108.
\textsuperscript{23} Beck, De Wereldrisicomaatschappij, 32.
\textsuperscript{24} Gabe Mythen, ‘Thinking with Ulrich Beck: security, terrorism and transformation’, Journal of Risk Research 21 (2018): 17-28; Anthony Giddens, ‘Risk and Responsibility’, The Modern Law Review 62 (1999): 1-10.
\textsuperscript{25} Ulrich Beck, The Metamorphosis of the world (Cambridge UK: Polity 2016), 76; Mythen, Thinking with Ulrich Beck, 25.
Table 1

|                       | Modern community                                                                 | Risk community                                                                 |
|-----------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Solidarity            | Solidarity of need. Based on a shared history. Communities are formed on certain ethnic, national or class-based identities and they try to reach common goals and acquire common goods. | Solidarity of risk. Based on a shared future. Communities are not formed based on identity, but are based on a common struggle against shared risk and danger. |
| Reflexivity           | Unreflexive: Risks will be overcome by technological rationality, state control and market relations | Reflexive: risks result from our institutionalized way of life. Technological rationality, state control and market relations cannot provide a solution. Calls for structural deliberative reform. |
| Politics              | Parliamentary politics: deliberation on all levels of the administration, but within the boundaries of designated administrative circles | Sub-politics: politicization of and broad participation in decision-making procedures, especially regarding risk-producing activities. |
| Responsibility        | Organized irresponsibility: risk producers shirk responsibility. Law and other structures of accountability abet it. | Institutional metamorphosis: institutions integrate responsibility and accountability into their operations |

3.1 Research methodology and data selection

The social and regulatory reaction to the dilemma of code black has been examined in a qualitative content discourse analysis of Dutch newspaper articles and regulatory documents. In an article of this scope, only a slice of the media landscape can be investigated. Newspaper articles have been chosen as the unit of analysis, because Ulrich Beck himself attributes a strong significance to the mass media for the dissemination of risk perceptions. Newspapers are staffed by professionals, appear daily and serve a large audience. Different from for instance television shows, they also leave room for reflection and publish letters of readers. A number of periodicals has been included, because periodicals publish more investigative journalism. Newspapers lose ground to online publications; therefore, the newspaper websites have been included in the survey.

The corpus of texts is retrieved from the ‘Lexis uni’ database. The search terms used are ‘triage’ and ‘code zwart’, meaning ‘code black’ in Dutch. Different versions of the guidelines that govern triage in the case of code black are analyzed, in order to evaluate how the discourse around the issue affects the regulation. Articles that have appeared between the 1 March 2020 and the 17 March 2021 are included. This interval represented roughly a year of discussion. March 2020 is chosen because that month marks the start of the COVID-19 crisis within the Netherlands. The 17 March 2021 serves as a cut-off point because there was a general election in

26 Uwe Flick, An introduction to qualitative research (London: Sage Publications, 2018), 501.
27 Rasborg, “‘(World) risk society’ or ‘new rationalities of risk’?”, 15; Ulrich Beck, ‘Cosmopolitanism as Imagined Communities of Global Risk’, American Behavioral Scientist 55 (2011): 1349.
the Netherlands on that day, allowing us to evaluate whether code black played a role in the election campaign.

Articles published in the six biggest mainstream newspapers and in three periodicals have been included: *de Volkskrant*, *De Telegraaf*, *NRC Handelsblad*, *Het Parool*, *Algemeen Dagblad* and *Trouw*. The three periodicals examined are *Vrij Nederland*, *De Groene Amsterdammer* and *Elsevier’s*.Together they cover most of the political spectrum, except for the extreme fringes. This operation yields a dataset of 734 results.

Gradually the term ‘triage’ became used to refer to mundane situations such as being allowed to go to the hairdresser or to visit bars. Such articles are left out, as are the many ‘doubles’ – articles published multiple times. Eventually a dataset including 255 articles and four different versions of the guidelines is left to interpret, using the concepts described above.

3.2 Discourses, storylines and discourse coalitions

The aim of the analysis is to show whether the discussion led to the formation a risk community among medical personnel, the mostly elderly patients and politicians, as represented by their respective associations. The discourse analytic methodology construed by Dutch political scientist Maarten Hajer is employed in order to analyse the discussion with the above question in mind.

The term ‘discourse’ is an overarching concept, defined as: ‘a specific ensemble of ideas, concepts, and categorisation that are produced, reproduced and transformed in a specific set of practices and through which meaning is given to social and physical realities’. 28 In this case the discourse – which includes the regulatory documents – on code black is the object of research.

In this analysis, I sometimes speak of ‘doctors’, ‘the elderly’ and ‘politicians’. This is shorthand for the various organizations by which they are represented. The elderly are represented by organizations like the *Algemene Nederlandse Bond voor Ouderen* (General Dutch Association for the Elderly or ANBO) or the *Katholieke Bond voor Ouderen* (Catholic Union of the Elderly or KBO). Medical doctors have their organizations as well, such as the Dutch Association for Intensive Care (NVIC) or the Federation of Medical Specialists (FMG). The politicians are representatives in Parliament and members of the government.

Within a discourse, not every actor discusses the problem in the same way. Actors tell stories, narratives that give meaning to specific phenomena by supplying a more or less coherent explanation for them. 29 ‘Storylines’ are middle range concepts that ascribe meanings to certain phenomena, but often also articulate possible solutions to problems and who is responsible for solving them. Often they compete with each other, offering contrary solutions and assigning responsibility differently. Some storylines become dominant while others fade away.

28 Maarten Hajer, *The Politics of Environmental Discourse* (Oxford: Oxford University Press, 1995), 44.
29 Hajer, *The Politics of Environmental Discourse*, 56.
The last organizing concept used is ‘discourse coalition’. A discourse coalition occurs when different actors representing different groups start using the same storylines, presenting a united front. They share the perception of the problem, the ideal solution and the ascription of responsibility to certain actors. Discourse coalitions are important because they may cause one storyline to achieve a level of hegemony, becoming the only acceptable way to interpret a certain situation. Storylines are analytically neatly separable, but of course, in practice we will see elements of storylines interwoven with each other. Actors can draw on multiple storylines, even in the same argument. Analytically it is often useful to separate them though, because it makes clear how a discourse develops and which line of argument becomes dominant.

In the following subsections the analysis proper is offered. First, the initial regulation regarding code black is described and afterwards the discursive reaction is mapped.

4. The discourse analysis

4.1 The first guidelines for the first wave

When it became clear that the Netherlands might be severely hit by the COVID-19 pandemic, the Taskforce Infectious Threats of the Dutch Association for Intensive Care (NVIC) created guidelines on what to do in case of acute shortages. These guidelines only formulated a number of ethical maxims. They proclaimed that people would not be treated on a first come, first serve basis, but based on incremental probability of survival. People with the best chances of survival would receive treatment first. This notion was based on the idea ‘to do good for as many patients as possible’, understood in utilitarian fashion. When treatment was considered to have very little or no chance, ICUs should withhold it. A number of possible criteria for exclusion were listed. One of which was ‘Very advanced age’.

In April 2020, the NVIC released a new version of these guidelines. This document was more detailed. It would come into force after the government declared ‘phase three’, a situation later called ‘code black’. In this situation, the ICUs would be so overwhelmed that they needed to make choices on which patients to treat. This phase itself was subdivided in three blocks. Among other criteria, the ‘clinical frailty score’ was used to determine from whom treatment would be withheld. In the least severe case, block 1, patients with a clinical frailty score of 7 to 9 would be excluded. That category included patients who were completely dependent on others for their survival, such as elderly patients who could not leave their beds anymore. They were, under normal circumstances, not in immediate risk of dying though.

30 NVIC, Draaiboek Pandemie Deel 1, versie 1.2 (Nederlandse Vereniging voor Intensive Care, March 2020), 6.
Block 2 would enter into force in case of even more pressure on ICUs. At that point, patients with a clinical frailty score of 5 or higher might not be eligible for a bed. The score of 5 indicated ‘mildly frail’, which was described as: in need of help to perform higher order activities, such as ‘finances, transportation, heavy housework or medications’. In such a situation, there was also an age limit listed: patients over 70 would not be eligible.\[31\]

The document did not yet include criteria for the third block. During this block, the shortages would be so severe that there were no medical selection criteria left. Criteria for this situation would be forthcoming. The code black scenario was considered a scenario of last resort. Everything should be done to prevent a situation where choices have to be made which patient to treat and who to leave behind.

The ethical maxim emphasized in these versions of the guidelines, ‘to do good for as many patients as possible’, indicated an approach according to the solidarity of need. The good – in this case health care – should be maximized in order to yield the most benefit for the most people. Questions of risk position were not raised, such as the risks run by mentally handicapped, or other people who could be considered frail solely based on their handicap. Neither was fairness towards the elderly as a group mentioned. The age limit especially became the nexus of an intense debate in the newspapers.

4.2 The emerging of a public issue: three storylines
The first mentioning that age might play a role in IC treatment was in mid-March. Diederik Gommers, the chairman of the NVIC, mentioned the possibility that senior citizens would not receive treatment. However, he still expected the COVID-19 pandemic to be mild.\[32\] When images of overcrowded hospitals from Italy reached the Netherlands, public concern rose. ‘Code black’ was mentioned for the first time on 12 March.\[33\]

From that date onwards, code black became a topic of concern. The problem was quickly cast in ethical terms, predominantly by medical ethicists and philosophers. On 19 March, two articles were published in two different newspapers. In the first one, ethicists Roland Pierik and Marcel Verweij defended the guidelines, because giving priority to the young would save the most lives. Moreover, they argued that it is a bigger loss for a patient in the early stages of life to die than it would be for someone in her or his last stage. They explicitly intended to provoke a public debate on the issue, because they felt criteria should have a broad societal backing.\[34\] Professor Ulli D’Oliveira also published an article the same day titled: ‘Who should

\[31\] NVIC, Draaiboek Pandemie Deel 1, versie 1.4 (Nederlandse Vereniging voor Intensive Care, April 2020), 17.

\[32\] Jop van Kempen, ‘Meer dan 20.000 geïnfecteerden? Dan moeten artsen harde keuzes maken’, Het Parool, 15 March 2020.

\[33\] Peter Ullenbroeck, ‘Nieuwe coronadode in Amphia, ziekenhuis waarschuwt: “Over een paar dagen ligt de ic vol”’, Algemeen Dagblad, 12 March 2020.

\[34\] Roland Pierik en Marcel Verweij, ‘Geef Jong en fit voorrang op de intensive care’, de Volkskrant, 19 March 2020.
be left to drown and why?’ He criticized the rationale behind the rules and referred to the famous ethical dilemma of the lifeboat that can only rescue a limit number of drowning people.35

The ethical problem at stake was readily understandable and made it easy for people to take position. It quickly developed into a public issue.36 Two key questions emerged. The first question was to whom should a bed on an ICU go if there is only one bed available for two patients? The second question was who has the authority to make this choice? This first question gave rise to two distinct storylines. According to the first, preference should be given to the young. Ethicist Guy van Widdershoven called this a matter of ‘medical realism’.37 Doctors needed to make choices and then it was fair to give preference to people with more chances of a longer life. This approach would save life years. The style of these contributions was often rational and analytical, drawing on a scientistic register.38

The storyline that emerged in response was visceral and personal in style and came down to a demand for equal treatment of the young and the old. The ethicists were accused of holding dark and pernicious views, willing to sacrifice the elderly and the weak.39 Human dignity dictated a lottery when two patients are eligible for only one bed.40 From the end of March to mid-April, many letters to newspapers rejected the age criterion. Newspaper De Telegraaf conducted an inquiry among its readers and published that 70% rejected it.41 Papers reported that doctors discussed ICU treatment with their elderly patients over the phone before they were even ill. Parents of handicapped children sometimes received such a call as well.42

Both these storylines showed signs of reflexivity because they politicized the intra-institutional choices made by the health care associations and called for debate. A third, even more reflexive storyline emerged in April and May and was developed further in the summer of 2020. It was characterized by the realization that the attention for code black deflected attention from other dire situations, such as the plight of the elderly in nursing homes. An article in Algemeen Dagblad put it cyni-

35 Ulli D’Oliveira, ‘Coronacrisis roept de vraag op, wie laat men verzuipen en waarom?’, Het Parool, 19 March 2020.
36 For an argument on the importance of issue formation, see Noortje Marres, ‘The Issues Deserve More Credit: Pragmatist Contributions to the Study of Public Involvement in Controversy’, Social Studies of Science 37 (2007): 759–780.
37 Sander Becker, ‘Wat als de ic’s straks helemaal vol liggen?’, Trouw, 23 March 2020.
38 For the importance of style in scientific reasoning, see Ian Hacking, ‘Styles of Scientific Thinking or Reasoning: A New Analytical Tool for Historians and Philosophers of the Sciences’, in Trends in the Historiography of Science, ed. Kostas Gavroglu et al. (Dordrecht: Springer, 2007), 31–48.
39 Ascha Ten Broeke, ‘Achteloos ging de deur op een kier’, de Volkskrant, 3 April 2020; Martin Sommer, ‘Bestuurders durven burgers niet aan te spreken, uit angst voor staatspaternalisme’, de Volkskrant, 27 March 2020; Nadia Ezzeroili, ‘Ruziemaken met je partner gaat prima via WhatsApp’, de Volkskrant, 5 April 2020.
40 Rien Eijzendoorn, ‘Wie mag wel aan de beademing en wie niet? Pak de dobbelsteen maar’, Trouw, 26 March 2020.
41 Sophie Zimmerman, ‘Uitslag stelling: Zorgen om druk op IC’s’, De Telegraaf, 4 April 2020.
42 Wout Woltz, ‘Helaas mijnheer, het leven is nu op rantsoen’, NRC Handelsblad, 11 April 2020. Nau-sicaa Marbe, ‘Moreel leiderschap tegen code zwart’, De Telegraaf, 3 April 2020.
cally: ‘There is no triage because there is no treatment’. Some commentators pointed out that there was a lot of talking of how ‘we’ were trying to save the elderly, but that their point of view was hardly heard; they were portrayed as people in need of our charity. These commentators posed the question who should be making these life and death decisions. Decision-making in this crisis was a political matter and should be made transparent for all of society to discuss.

The articles became more sensitive to the fact that the way the Dutch healthcare system was institutionalized over the last twenty years exacerbated the threat of code black. This third storyline presented code black as an institutional problem, instead of a problem of doctors or politicians.

This sentiment increased when more became known about how the Netherlands managed to ward off code black. The daily NRC Handelsblad published a long reconstruction of the early days of the pandemic and the periodical De Groene Amsterdammer outlined all the ethical considerations. According to this periodical, the solidarity of the health care system based on equal access for all was at stake. At the end of the day, this healthcare crisis was caused by a lack of capacity, capacity that other countries did have. All of these articles contributed to a storyline about how the Dutch approach to health care was in need of reform.

This third storyline is considered the most reflexive, because it questioned the existing structures that the other storylines tacitly took for granted. It called for public participation and exposed existing institutional arrangements to criticism, potentially opening them up.

4.3 The regulatory reaction: new guidelines
The discussion about what to do in case of code black reached the political arena during parliamentary debates on 1 and 8 April 2020. In response to the social discussion around code black, Parliament declared that age should never be a criterion. The NVCI, the Dutch Federation of Medical Specialist (FMS) and the Royal Society of Health Care (KNMG) started work on revising the guidelines. Initially, they worked under severe time constraints, but by mid-April, it became clear that the code black scenario would not emerge at present. Instead of releasing the new

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43 Margreet Fogteloo, ‘Wie krijgt dat schaarse ic-bed?’, De Groene Amsterdammer, 9 April 2020; Hanneke van Houwelinge and Tonny van der Mee, ‘De ‘stille ramp’ in het verpleeghuis’, Algemeen Dagblad, 17 April 2020.
44 Wilma de Rek, ‘“We” moeten “ze” redden? Laat ouderen over hun eigen lot beschikken’, de Volkskrant, 5 May 2020.
45 Inanthe Sahadat, ‘Heiligt het doel de middelen? Filosoof Marli Huijer: “Ik weet eigenlijk niet wat het doel is”’, de Volkskrant, 9 April 2020; Christa Kompas, ‘Maak ethische keuzes rond corona transparant’, Algemeen Dagblad, 3 April 2020; Ruben van den Bosch, ‘De economie redt geen levens wij kunnen dat wel’, de Volkskrant, 17 April 2020.
46 Derk Stokmans and Mark Lievisse Adriaanse, ‘Corona in Nederland: hoe een overmoedig land raazendsnel de controle verloor’, NRC Handelsblad, 20 June 2020; Margreet Fogteloo, ‘Intensieve ethiek; Corona: Zwartboek in de zorg’, De Groene Amsterdammer, 25 June 2020.
47 Johan Legemaate and Maartje de Jong, ‘Arts hoeft geen juridische straf te vrezen bij code zwart’, de Volkskrant, 13 April 2020.
guidelines quickly, they opted to consult a variety of societal and medical organizations, but also organizations of the handicapped and the elderly.

Medical associations released the new set of guidelines on 15 June 2020. In case of acute shortage, the rule remained that people with higher chances of survival received treatment first. However, the guidelines were reformed in many respects. Firstly, they granted a preferential position to medical personnel. Medical personnel in direct contact with patients would be treated first, in case of equal chances of survival. Secondly, the age criterion was still present, but would only come into play as a last resort. Hard cut-offs in age were avoided and instead different ‘generations’ were bracketed. Generations were counted in intervals, so from 0-20, 20-40, 40-60 etc. If all medical conditions were equal, a person from a younger age group has preference.

The ethical assumptions in the guidelines changed substantially. The utilitarian line of argumentation in reference to age was discarded and instead the age criterion was justified on the basis of intergenerational solidarity and the ‘fair innings argument’. This argument entered the initial public discussion through articles by, among others, Marcel Verweij. It held that every person is entitled a chance to enjoy his or her fair share of life. The young, who enjoyed less of life than the old, should – provided that medical chances of survival are equal – have preference. The point of the argument was not to relegate the lives of the elderly to a status somehow less worthy of protection, but to justify preference for the young on the basis of fairness. Life was a boon that we should grant to people who did not have their fair share yet. The argument was not based on efficiency, but affirmed the dignity of life. Moreover, it was made explicit that preceding quality of life or disability should not play a part in the decision to provide care. This was important because on the basis of the old guidelines, this could theoretically be a factor.

The difference in argumentation displayed the impact of the discussion and the reflexive processes it triggered. The arguments in these guidelines were predominantly based on risk solidarity instead of a solidarity of need. The younger generations were at a greater risk of losing their fair share of life and, therefore, they deserved to be treated first in case of shortages. Additionally, the policy-making process displayed characteristics of sub-politicisation and reflexivity. Associations of various social groups, first and foremost the elderly, were consulted and involved in the process.

In Beckian terms, the new guidelines and the way they were drafted could be considered indicative of the formation of a risk community. Different groups remained different, but they left antagonism behind in order to solve an imminent crisis and divided risk positions in a way that was based on fairness and not utility. However,
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it was a tentative community only, because as Jongepier noted it was still a document that was imposed ‘top down’, driven by medical organizations.\(^{50}\)

At the time of their release in June 2020, the new guidelines could still be revised, depending on their social reception. The infection rate looked good and the main worry about code black receded into the background. Nonetheless, the new guidelines sparked new rounds of discussion and controversy between politicians and doctors. The politicians insisted on taking out any reference to age, but the doctors were intent on keeping it.

4.4 A new discourse coalition: the victory of medical men

The days after the release of the new guidelines, various ethicists and journalists weighed in. Ethicist Fleur Jongepier and influential commentator Sheila Sitalsing, for instance, argued that a lottery was the only fair principle.\(^{51}\) They held on to the ‘equal treatment’ storyline. Medical associations immediately established a media presence as well and explained their choices.\(^{52}\) Their main line of argument was the fair innings argument and they predicted that many of the elderly would understand why an age criterion as a last resort was fair. The ethicists avoided terms like ‘medical realism’ or other harsh expressions. In general, the ethical dilemma itself was discussed without the emotional appeals that characterized the early months of the crisis.

Politically, the matter became thornier. The Dutch government announced it would veto an age criterion. All mainstream newspapers mentioned that the Minister would like to see it removed. In a letter to Parliament the Minister of Health stated that the age criterion comes down to age discrimination. However, the government did not immediately push for regulation. It only asked medical associations to ‘reconsider’ the age criterion, in light of the unrest among the public.\(^{53}\) The government appeared to be supported by the biggest association for the elderly, the ANBO, who also rejected the age criterion.\(^{54}\)

Medical associations did not give in. Gradually the storyline of ‘young first’ gained more traction, especially because doctors voiced support for the guidelines and

50 Fleur Jongepier, ‘Voor de IC selecteren op leeftijd is en blijft ongegrond’, *NRC Handelsblad*, 12 January 2021.
51 Fleur Jongepier, ‘Jongeren voorrang geven op ic? Het draaiboek van “code zwart” rammelt aan alle kanten’, *de Volkskrant*, 17 June 2020; Sheila Sitalsing, ‘Is het “fair-inningsprincipe” niet gewoon een chique variant op “kap het dorre hout”?’, *de Volkskrant*, 17 June 2020.
52 Mark Misérus, ‘Draaiboek overvolle ic’s: is hier draagvlak voor onder de bevolking?’, *de Volkskrant*, 16 June 2020; Pim van den Dool, ‘Artsen, geef jongeren voorrang bij extreem tekort aan IC-bedden’, *NRC Handelsblad*, 17 June 2020.
53 Wilma Kieskamp, ‘Kabinet hoopt dat artsen van mening veranderen’, *Trouw*, 18 June 2020.
54 Arianne Mantel, ‘“Kwetsbare” senioren zijn het beu: “Aan ons ouderen wordt niets gevraagd”’, *De Telegraaf*, 27 June 2020.
claimed that they would be left out in the cold without them.\textsuperscript{55} The final version was published in November and the age criterion was not changed.\textsuperscript{56}

This caused political problems for Tamara Van Ark, the responsible Secretary of State in the Dutch Cabinet. She stated that she did not want to react yet but that the guidelines seemed contrary to her political commitments.\textsuperscript{57} In December 2020, infections were on the rise again and because non-corona health care was not scaled back this time, code black once again became a possibility. In January 2021, Van Ark made known her decision. She intended to prohibit the doctors from using any age criterion by law.\textsuperscript{58} She proposed a lottery as the fairer, least discriminatory alternative.

The political winds had, however, changed. Parliament was reluctant to go against the wishes of medical professionals. Van Ark’s plan for a lottery was both attacked and supported. Medical doctors generally saw nothing in a lottery, while especially the big daily newspaper \textit{de Volkskrant} came out in favour. The united front of the elderly broke down when one of the stake holding associations, the KBO, stated that they stood side by side with medical organizations and that many of the elderly considered a lottery abhorrent.\textsuperscript{59} This line was quickly picked up on by the associations of doctors in order to point out that even the elderly were on their side.\textsuperscript{60} Even the ANBO seemed to have changed its position and now stated on its website that the decision on how to conduct triage should be up to the doctors.\textsuperscript{61}

With support in Parliament crumbling, and growing opposition against a lottery, the Cabinet withdrew its plan to prohibit the age criterion. The political argument for this new position was that in this dark time politics should not get in the way of medical professionals. They needed support and it was inopportune to interfere.\textsuperscript{62} This did not mean that they explicitly endorsed the solution proposed by medical organizations, \textit{i.e.} a criterion of age based on ‘fair innings’. The politicians did not take responsibility for the resolution of the ethical problem, but they ab-

\textsuperscript{55} Niels Klaassen, ‘Wie krijgt straks het laatste bed?’, \textit{Het Parool}, 17 June 2020; Frederiek Weeda, ‘Mag leeftijd meetellen bij laatste IC-bed?’, \textit{NRC Handelsblad}, 5 January 2020.
\textsuperscript{56} FMG/KNMG, \textit{Draaiboek Triage op basis van niet-medische overwegingen voor IC-opname ten tijde van fase 3 in de COVID-19 pandemie versie 2.0} (Federatie Medisch Specialisten/ Koninklijke Nederlandse Maatschappij tot bevordering der Geneeskunst, November, 2020).
\textsuperscript{57} Niels Klaassen, ‘Nieuw draaiboek bij ic-tekort: uiteindelijk gaan jongeren voor’, \textit{Algemeen Dagblad}, 1 December 2020.
\textsuperscript{58} Flori Hofman, ‘Kabinet wil einde aan IC-triage op basis van leeftijd bij extreme schaarste’, \textit{NRC Handelsblad}, 4 January 2021. Raoul Du Pré, ‘Kabinet houdt voet voet bij stuk: geen voorrang jongeren op de intensive care’, \textit{de Volkskrant}, 4 January 2021.
\textsuperscript{59} Vanda van der Kooi, ‘Kabinet wil jong en oud laten loten als IC overstroomt; KBO Brabant vindt juist dat arts bij gelijke kansen wel jongere voorrang moet geven’, \textit{Algemeen Dagblad}, 5 January 2021.
\textsuperscript{60} Raymond Boere, ‘Ouderen willen helemaal niet loten om laatste ic-bed’, \textit{Algemeen Dagblad}, 5 January 2021; Vanda van der Kooi, ‘Code zwart bij overvolle IC: in geval van nood is het recht op een vol leven leidend’, \textit{Algemeen Dagblad}, 6 January 2021.
\textsuperscript{61} ANBO, ‘ANBO Artsen aan zet bij Code Zwart’, https://www.anbo.nl/nieuws/anbo-artsen-aan-zet-bij-code-zwart, last accessed 11 September 2021.
\textsuperscript{62} Niels Klaassen, ‘Kabinet: jongeren gaan toch voor ouderen bij acuut tekort aan IC-bedden’, \textit{Algemeen Dagblad}, 11 January 2021.
solved themselves and passed it to the organizations of doctors. This concession ended the long political discussion on what to do when code black emerged. There were still commentators who declared the age criterion ill-advised, but the discussion of this aspect of code black died down.

In discourse analytic terms, a discourse coalition emerged in the winter of 2020 around the notion that doctors and their organizations have the responsibility for the code black situation and that it is up to them to solve it. Here, the fundamental ethical question was still unresolved but the matter was settled by a discursive agreement that it was up to the doctors how to deal with the situation. Even the elderly tended to agree with that sentiment.

Despite this development, in the period between January and March 2021 ‘code black’ was mentioned in the articles even more often than before. Raising the spectre of code black became a crowbar to force other policies. This turn of events is described in the following section.

4.5 Doctor’s marching orders, the breakdown of the tentative risk community

After the final version of the code black regulation was issued late November, the prospect of code black started to play a subtle, but significantly different role in the discourse. Especially in the hands of some medical experts and organizations, mentioning code black became part of arguments they used to force their favoured policies.

In both the storyline of equal treatment and the storyline of ‘young first’ code black was cast as an existential ethical dilemma. Both storylines provided different answers, but the part played by the threat of code black was the same. In the storyline of institutional change, it played the part of an existential threat as well. Its emergence displayed that Dutch society needed to re-examine the basic assumptions on which its healthcare system was based. In the first two storylines, the argument had the following form: ‘when code black is upon us, we need to do X’. In the third storyline, the argument had this form: ‘to avoid the possibility of code black in the future we need to do X’. At roughly the same time as the discussion on the age criterion was decided in favour of medical associations, the notion of code black started to be used in an instrumental fashion. The problem was cast as a contingent situation that should be avoided right now: ‘to avoid code black now we need to do X now’. From an existential dilemma with implications for the future of health care, ‘code black’ became a situation that necessitated the right managerial choices now.

The first time that code black was used in this fashion occurred around New Year’s Eve 2020. The Cabinet as well as medical experts urged the people to stay home because the hospitals were nearing their full capacity again.63 Contrary to March and April of 2020, regular health care was not scaled down to such extent and per-

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63 NN, ‘Ziekenhuis Assen dicht bij code zwart: “Nog tien bedden”’, Algemeen Dagblad, 22 December 2020; Maud Effting and Willem Feenstra, ‘Coronacijfers bieden experts weinig hoop: Kerst in lockdown lijkt onvermijdelijk’, de Volkskrant, 13 December 2020.
sonnel in the hospitals became scarce. The government was sensitive to arguments that claimed code black was near and in order to avoid it, something had to be done. This became especially apparent when vaccines became available, just after New Year’s. The vaccine discussion was the corollary of the code black discussion; the question was not who had to be left behind, but who should be aided first. There were good arguments for the view that the ‘losers’ of the code black policy should be the winners of the vaccination policy. The elderly were by far the people most at risk. Consequently, the government planned to vaccinate the elderly first.

On 31 December a lobby was started by Gommers and Kuipers, two of the most prominent medical faces in the Dutch media during the corona crisis. They claimed that in order to avoid code black, healthcare personnel had to be vaccinated first and vaccination had to start earlier than planned.\(^\text{64}\) Other prominent intensive care practitioners echoed their plea.\(^\text{65}\) Initially, the Cabinet intended to hold on to its own scenario, but here too the doctors won. On 2 January the Minister of Health announced that medical personnel would be vaccinated first. The fear of code black struck a sensitive nerve.\(^\text{66}\) A week later, Kuipers reported to the newspapers that code black is not in sight.\(^\text{67}\)

Experts were divided on whether it was a good idea to treat medical personnel first. The arguments in favour were not very convincing. There was increased absenteeism, but that was due to fatigue, not corona. Infection rates among hospital personnel were not significantly higher. The influential government advisory board, the Health Council, recommended vaccinating the elderly and the weak first.\(^\text{68}\) Following in the footsteps of the intensive care practitioners, the general practitioners claimed they should be vaccinated as well.\(^\text{69}\) The vaccination strategy became a lobby game over which the government lost control.\(^\text{70}\)

Ulrich Beck predicted that in the risk society struggles would erupt over risk positions and the vaccination discussion in January 2021 followed his predictions. Medical associations came out on top in the discussions with the politicians and they managed to determine policy. In both situations, the risk positions of medical personnel improved. Doctors, nurses and others who worked in health care would receive preferential treatment in the case code black materialized and they were vaccinated first.

\(^{64}\) Jop van Kempen, ‘Ic-arts Amsterdam UMC: “Hopelijk kunnen we langs de rand van afgrond sche ren”, Het Parool, 31 December 2020.

\(^{65}\) Dion Mebius, ‘De Jonge gaat overstag: duizenden ziekenhuismedewerkers vervroegd gevaccineerd’, de Volkskrant, 2 January 2021.

\(^{66}\) Sebastiaan Quekel, ‘Ernst Kuipers: code zwart voorlopig niet aan de orde’, Algemeen Dagblad, 11 January 2021.

\(^{67}\) Michiel van der Geest en Charlotte Huisman, ‘Vaccins moeten nu écht naar de ouderen, vindt de Gezondheidsraad’, de Volkskrant, 11 January 2012.

\(^{68}\) Hans van den Ham, ‘Huisarts Carin verbijsterd over uitblijven vaccinaties: “Als wij omvallen is dat een rampscenario”’, Algemeen Dagblad, 17 January 2021.

\(^{70}\) Belia Heilbron, Karlijn Kuipers and Linda van der Pol, ‘Ikke prikken – en de rest kan stikken’, De Groene Amsterdammer, 19 May 2021.
Moreover, the change of code black from an ethical dilemma to a management problem took the sting out of the public discussion. As an ethical dilemma, it became palpable and elicited a political and social debate on the way we treat each other fairly. As a management problem, it became just one of the many risks to be solved by experts. Medical associations took charge and a broad risk community that was tentatively forming around healthcare policies broke down. The vaccination policy became a lobbying arena in which the groups that wielded the most power could secure the best risk position.

According to Ulrich Beck, organized irresponsibility stymies reflexivity. In this case, we see organized irresponsibility especially on the level of the state. The government gave away ownership of the problem and could not stand up to medical organizations, allowing them to determine policy to a large extent. Discursively, the problem was transformed from an ethical to a managerial problem. The solution by way of a technical fix became seen as satisfactory. The storyline emphasizing the need for structural changes gradually lost momentum.

In the election debates, code black did not feature prominently. There were debates on the future of health care, but none of the politicians vigorously expressed the need for a thorough revision. The three initial storylines gradually faded. Articles still appeared, arguing that the healthcare system and perhaps even our societal outlook is in need of change. Especially the role of the market in health care was questioned, which is in line with Beck’s theory on reflexivity. However, the tone was rather despondent.⁷¹

5. Conclusion and discussion

5.1 Risk solidarity gave way to solidarity of need

The possibility of code black was a confrontational moment for Dutch health care. The country had to relinquish the myth that its healthcare system was superior to that of the rest of the world. As the many letters to Dutch mainstream newspapers make clear, the fear that some people might not be cared for provoked outrage. When we compare the empirical findings with the ideal typical risk community described earlier, we may conclude a number of encouraging shifts towards risk solidarity and risk community between the elderly, medical professionals and politicians were initially realized.

While the first guidelines proceeded in utilitarian fashion, largely disregarding considerations of fairness, ageism or ableism, they changed significantly with the publication of the revised guidelines proposed in June and as eventually accepted by Parliament in January 2021. There was still an age criterion but no hard cut off point. Arguments that belonged to the solidarity of need were downplayed. Arguments that fit with risk solidarity on the other hand, such as giving preferential

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⁷¹ Raoul du Pré, ‘Een jaar later: bevrijding uit de lockdown lonkt, mits we nog even volhouden’, de Volkskrant 26 February 2021; Niels Klaasen, ‘Na corona wil iedereen “minder markt” in de zorg. Maar hoe dan?’, Het Parool, 8 March 2021.
treatment to medical workers at the front line and to the young, based on fairness were emphasized. The younger generation ran a bigger risk of losing their fair share of life and, therefore, deserved to be treated first. There was concern for handicapped people and other weaker groups, concerns that were not mentioned in the first version. Even though the result was similar, i.e. there was still an age criterion, the basis for it shifted, from concerns of utility to concerns of fairness and risk.

In many respects the conclusion can be drawn that, seen from a Beckian perspective, the crisis created opportunities to increase solidarity between ‘others’. The discussions in the first months displayed concern over the fate of the elderly. A reflexive storyline emerged in the public discussion, questioning the state of Dutch health care and pointing to the detrimental effects of an approach to health care grounded too much in efficiency. The guidelines drafted by healthcare providers became an object of political and participatory discussion, a sign of sub-politicization. The elderly themselves participated and played a decisive political role by supporting the age criterion in the end, showing solidarity with younger generations and medical organizations.

Nonetheless, a risk community between the various actors did not emerge. Medical organizations did not reciprocate by supporting the elderly, but pushed early vaccination for medical personnel, contrary to government policy and the advice of the Health Council. The impact of the ethical dilemma regarding code black was blunted after the political dust settled. The possibility of code black did not have much traction in the end as a sign that different approaches to health care were needed. That is remarkable for a situation that constituted the gravest healthcare crisis post-WW2. Despite the changes in the argumentative structure of the regulations, risk solidarity was not emphasized in the later stages of the discussion. Code black became a management problem, to be solved through efficient use of resources, an approach grounded in the solidarity of need.

5.2 Outsourcing responsibility
I consider that the key to understanding the rapid social inoculation against the existential doubt imposed by the dilemma lies in the fact that responsibility for the situation was outsourced to medical associations. They provided an alternative to the state as an institution to put one’s faith in. The elderly themselves and politicians eventually ascribed to a discourse coalition around the storyline that ‘the doctor knows best’. The storyline made the healthcare system itself impervious to critique, because their representatives were called upon to find a way out. Medical associations assumed all responsibility and with it significant control over policy-making.
What I call outsourced responsibility, is the corollary to Beck’s ‘organized irresponsibility’, instead of institutional metamorphosis. Beck theorizes about responsibility only in a negative way. In modern society, institutions will obfuscate responsibility, because they do not want to be seen as failing. Beck assumes that corporations and governments have mechanisms that deflect reflexive criticism on their policies and risk producing behaviour. Through law and other strategies, they shield themselves from public concern. However, Beck’s one-sided treatment causes him to miss that in the risk society it may also be very beneficial to assume responsibility. Traditional institutions deflect responsibility, but it does land somewhere else. It is outsourced to groups for whom responsibility may be advantageous to have. The assumption of responsibility allows for a big say in setting the agenda. Through organized irresponsibility the public loses sight of the true loci of risk production, but outsourced responsibility provides for a figure head in the eyes of the public that will solve the issue of risk currently at hand.

The discussion on code black displayed this dynamic. The government tried to retake control in view of public concern, but were in the end all too happy to leave responsibility with medical associations, such as the FMG and the NVIC. This became especially apparent in the reaction of Parliament to the guidelines. Parliament did not state whether it endorsed the recommendations in their final version, but instead that it did not want to get in the way of medical professionals. That is a strange argument when a dilemma is at stake that has such broad social, ethical and political overtones.

The organized irresponsibility of Parliament allowed medical organizations to assume responsibility. Throughout the discourse, the position of medical expert organizations strengthened and the government’s position became weaker. Gradually these professional organizations ‘won’ control over the code black discourse and used the fear of code black as an argument to obtain a better risk position for medical personnel.

It would be a mistake to consider this dynamic as a conscious strategy by medical organizations or individual doctors, as if there was some sort of conspiracy to make sure vaccines landed with healthcare personnel. There was no such conscious strategy. Such a dynamic is inherent in the logic of the risk society itself. Just as social conflict over class positions is a perennial feature of social organization in modern society, so is conflict over risk positions in the risk society. According to Beck’s later work, risks will give birth to risk communities, because everyone is susceptible to the negative effects of global risks. However, that notion is problematic. Risks do not affect people evenly. Risks are not democratic, as Beck holds them to be. They discriminate just as much as class does and people hold unequal risk positions. In the case at hand, the risk position vis-à-vis COVID-19 can be improved by

72 The term ‘outsourcing’ is borrowed from Pauline Westerman. According to Westerman, the legislator ‘outsources’ law making to subordinate organizations. Similarly, the government outsourced responsibility to medical organizations. Pauline Westerman, Outsourcing the Law (Cheltenham: Edward Elgar, 2018).
a vaccine. In such a situation, conflict over vaccine distribution occurs naturally and taking responsibility when responsibility is outsourced is a key move in this conflict. With responsibilities come rewards in the form of being able to determine the risk positions of oneself and others.

At the end of his life, Beck embraced an optimistic view of risk and the possible emergence of risk communities. One may wonder, however, whether his theory is not at its most useful as a theory of conflict over risk. The theory of Beck is more apt to explain why risk communities do *not* emerge, namely because of the enduring struggle over risk positions. According to Beck, institutions diffuse responsibility, leading to criticism and, eventually, a transformation. This view may be too optimistic. In the code black discussion, other institutions seized responsibility, which allowed them to obtain a stronger position in the debate and to determine policy. This dynamic did not lead to the opening up of institutions or the establishment of a risk community.