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HEAD TO HEAD

Is it wrong to prioritise younger patients with covid-19?

With services overburdened, healthcare professionals are having to decide who should receive treatment. **Dave Archard** says this is no excuse for wandering blindly into discrimination, but **Arthur Caplan** argues age is a valid criterion when supported by data

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Yes—Dave Archard

Prioritisation—that is, deciding who should and should not receive potentially life saving treatment—is inevitable once demand for such treatment exceeds the supply of resources. Various guidelines for making such decisions have been made public, in the UK and elsewhere, and from official organisations, advisory bodies, and academics.

The guidelines are informed by various moral principles, all of which have been subject to reasoned criticism. It is easy then to see why age might be proposed as a simple, clear, and definitive basis on which to decide matters: when there are no other relevant differences between two patients in equal need of care, choose the younger.

The obvious problem with using age is that it may just serve as a marker of relevant differences, such as clinical frailty and the likelihood of survival, or of the prospect of fewer years of life after treatment. However, if age is being used in this way, this should be recognised. As should the crudeness and unreliability of doing so.

If it is not a marker of something else then it is hard to see why age should be used as the determinative criterion. It becomes exposed as wrongly discriminatory because it licenses differential treatment based on "unwarranted animus or prejudice" against old people.[1]

Where is the line?

There are three reasons why age should not be used. The first is that a simple "younger than" criterion is clearly unsatisfactory. It cannot be that an 18 year old is preferred to a 19 year old on the grounds of one year's difference in age. This would be not much better morally than tossing a coin or a crude "first come, first served" principle using the time of arrival at a hospital to determine whether care is given.

If young people as a demographic group are to be preferred to old people then there are problems of distinguishing in a non-arbitrary way between two patients who differ only in being just above and just below the agreed threshold of age. Equally it may be hard to justify generalisations across a whole group.

Fair innings

Secondly, there is the fair innings argument.[2] This holds that everyone should have an opportunity to lead a life of a certain duration. Resources should then be distributed (and care given selectively) to ensure that those who have yet to live that length of life are prioritised over those who have already managed to do so. It has an intuitive appeal: why shouldn't those who have not had an opportunity to lead a life of decent duration be preferred to those who have already done so? Lucretius in his *De Rerum Natura* offered the compelling metaphor of diners overstaying their time at the table and properly being asked to give way, having had their chance to eat their fill, to those yet to eat.[3]

Nevertheless, there is no agreement on what counts as a fair innings. Even if we can agree, it is not clear why we should speak of fairness in this context.[4] Luck and circumstances have a big role in how long we live, and it is not clear that we can speak of the length of a life as a good that can, and should be, distributed. The need for care, irrespective of age, might arise from bad luck. But it might also arise from choices, the consequences of which an individual should rightly be held responsible for. Some people—to use Lucretius's dining metaphor—deserve to carry on eating; others do not. It is hard not to think that it matters what kind of life has been led and might still be led. Someone who has had her fair innings may yet have much to give the world that another who has not may be unable to offer.

Value

Finally, to discriminate between patients in the provision of care on the grounds of age is to send a message about the value of old people. Such discrimination publicly expresses the view

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that older people are of lesser worth or importance than young people. It stigmatises them as second class citizens. We already discriminate against old people in so many ways, and they are socially disadvantaged in numerous respects (social care and employment, for instance). It would be an egregious moral error to compound such injustice. And it would be hard not to think—even if it was not intended—that a cull of elderly people was what was being aimed at.

No—Arthur Caplan

As protective gear, ventilators, beds, and staff remain scarce in many healthcare settings during the covid-19 pandemic, much attention has focused on what principles ought to be followed in allocating these resources. The question of what role age ought to play has set off both concern and contentious debate.

This is not inappropriate. People who are elderly, disabled, poor, or from ethnic minorities have faced much discrimination within and outside healthcare systems all over the world. No one ought to fear that morally irrelevant properties would be invoked to determine whether they are denied the opportunity to receive potentially life saving care.

Established criterion

The key ethical question is whether age by itself is ever a morally relevant factor in deciding who gets care when rationing is unavoidable. Many reports have indicated that in some countries, including Italy,[5] age over 65 years was invoked as an exclusionary criterion for accessing scarce intensive care services. However, this is hardly the only instance of age being used to distribute scarce resources.

Access to renal dialysis has been restricted to those under 65 in some parts of the UK,[6] while in Europe, Canada, Israel and the US it is almost unheard of for anyone over 80 to receive a solid organ transplant from a dead donor.[7] Age has played a role for many decades in limiting access to care when rationing life saving treatments.

That said, even in conditions of extreme scarcity it would be discriminatory to simply invoke age to exclude those in need from services. Blanket exclusion based simply on age of an entire group with no additional rationale or justification is wrong. Many American rationing policies formulated in response to the pandemic begin, reasonably, with an explicit warning against blanket discrimination based on age, disability, race, gender, gender orientation, or religion.

But there are many instances of rationing where age alone is used to permit access, including “women and children first” in access to lifeboats during shipping disasters and in many policies regarding rationing of resources in a pandemic where children are accorded first access simply because of their age. Giving priority to the very young seems to evoke broad consensus.

Opportunity

So what makes age in itself morally relevant? There are two main principles which ground the use of age.

The first is the notion of fair innings—that each existing person ought to enjoy an opportunity to live a life. This commitment to equality of opportunity has nothing to do with the relative contributions of old people versus young people. Rather, the principle of fair opportunity to live a life is rooted in the idea that a very old person has had a life, middle aged people have had the chance at part of a life, and babies and young children deserve to have such a chance.

While there is no hard and fast rule for what is an “unfulfilled” life age for a person, most policies distributing life saving resources look to those under 18 as gaining priority while those in their 80s and beyond, who have had a chance to experience life, pursue their goals, and flourish as human beings, receive lower priority .

The other reason for using age is if the overarching principle for rationing is to maximise the number of lives saved. Most rationing policies do posit this as a fundamental principle.

If the goal is to save the most lives with scarce resources then age may matter if there is a diminishing chance of survival with increased age. And for ventilators and renal dialysis that is precisely what the data show.[8] Lung and kidney function decline with age, and especially among the oldest people. So does overall response to ventilators and dialysis machines. Older age is often associated with an increase in chronic morbidity, which may also compromise the efficacy of scarce acute care resources, and there is evidence that older age itself can compromise the response a patient is capable of making.[9]

To the extent to which data support the risk of failure or the odds of success, age can justifiably be used to ration care if maximisation of lives saved is the overarching goal. Indeed, the relevance of old age as a predictive factor of efficacy—combined with the powerful principle of healthcare affording equality of opportunity to enjoy a life—makes age an important factor in making the terrible choice of who will receive scarce resources in a pandemic. Ageism has no place in rationing, but age may.

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