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Allocating Hospital Beds in the Pandemic

Słowa kluczowe: Covid-19, pandemia, racjonowanie pomocy medycznej, ograniczone zasoby, godność człowieka

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Abstract

The Covid-19 pandemic put the views of bioethicists on the allocation of scarce health care resources to the test. We consider positions taken by medical organizations and national ethics councils in Italy, Spain, United Kingdom, Germany and Sweden. In several statements from these bodies, the concept of human dignity plays a central role. We argue that the use of this concept does not stand up to ethical scrutiny, and instead defend the view that decisions on the allocation of scarce resources should be guided by the goal of maximizing the net benefits to those affected. We conclude by asking whether the fact that, in some regions, after vaccination became widely available, the scarcity of hospital beds was largely caused by members of the community choosing not to be vaccinated against the virus that causes Covid-19 should play a role in allocating resources to unvaccinated people who subsequently became ill from that virus.

Introduction

It must be rare for a work of philosophy to be put through stringent testing in the way that Torbjörn Tännsjö's *Setting Health Care Priorities* was tested by the pandemic that hit us within a few months of the book's publication (2019). One of our aims in this paper is to examine the positions Tännsjö takes in the light of the pandemic and the decisions that had to be made for setting health care priorities, at a time when setting health care priorities was in the national and global media spotlight to an unprecedented degree. Observing the priorities of governments and health care providers in this extraordinary situation can shed light on the extent to which Tännsjö's views are part of the thinking of health care providers. And if they are not, and the providers did not follow the views that Tännsjö defends, we can ask: would they have done better to follow them?

Tännsjö's comments on crisis situations, and our situation today

Chapter 10 of *Setting Priorities in Health Care* is entitled "Triage in Situations of Mass Casualty" and in the introduction, Tännsjö writes:

> I think of crisis situations where people are dying en masse. It could happen because of natural disasters such as an earthquake or a war, or it could be because of a pandemic outbreak of infectious disease. Here the scarcity is undeniable and there is no way to avoid the problem of allocation. When there are no ICU places available for people whose lives could be saved if they were taken care of properly, or if we have long ago run out of our supply of ventilators, then we have to face hard choices. Who should be saved?

In some parts of the world, the situation Tännsjö describes is here and now – and we are not talking about impoverished nations either. The *New York Times* published a guest essay headed: "I'm an E.R. Doctor in Michigan Where Unvaccinated People Are Filling Hospital Beds." The author, Rob Davidson, went on to say:

> As of last Monday, nine hospitals in Michigan were 100 percent full, and at least 20 others were at or above 90 percent capacity. Statewide, nearly one in four hospital patients, has a confirmed or suspected case of Covid-19. In the last few weeks, my hospital has

> been consistently at or near capacity and nearly every day the vast majority of those patients are sick with Covid-19. Nearly all have been unvaccinated…

Davidson is more precise about the acute critical care patients: 98% of them, he says, are unvaccinated. As a result:

> On some shifts, the stress in the air is palpable. My colleagues and I know the patients are piling up, but there just are not enough nurses to properly triage everyone. A patient experiencing heart failure waits in an emergency room because inpatient rooms upstairs are all occupied. Patients who need surgery can't be transferred because nearly every hospital within a two-hour drive is near or at capacity, too.

Similar situations exist in other parts of the US where vaccination rates are low, and in some other countries as well. One can, and should, deplore the fact that insufficient resources were invested in hospital capacity to prepare for the situation that Tännsjö had envisaged – and of course, Tännsjö was not alone. For a decade, public health experts like Dr Michael Greger have been warning us of the likelihood of a pandemic caused by a virus transmitted to us from the animals we raise and kill for food.[1] Now that we are in this situation, however, without having heeded these warnings or prepared adequately for what was foretold, what should we do? We shall put aside, for the moment, the specific question Davidson raises, about those who are unvaccinated, and instead begin with the more general question: Who should we attempt to save, when we cannot attempt to save all?

Choosing who to treat

Tännsjö begins his discussion by assuming that in a crisis situation, saving infected physicians and paramedics, in preference to others, will increase the resources available to benefit others, and so, in these circumstances, this is what ought to be done. We agree. He then considers the "hard choice" of how to allocate ICU beds when there are not enough available for all the people whose lives might be saved by them. In his discussion of how utilitarianism approaches this situation, he notes that it holds that "we should allocate medical resources to the patient who can make the best use of them" and

[1] https://www.livekindly.co/dr-michael-greger-warning-pandemics-decade/.

adds that one popular way of assessing this is to use the resources so as to maximize the number of quality-adjusted life-years, or QALYs, that can be gained from them. This would, other things being equal, mean that younger patients would have preference over older patients, as they can be expected to live longer and thus gain more QALYs.

We agree with this general view, and in what follows, will address some objections to it. But QALYs, as they are presently used in assessing the benefits of particular forms of health care, focus only on the life of the patient. They do not take into account the benefits that the treatment may have on others, including the patient's family, if any, or on broader society. Tännsjö accepts that the fact that a patient has young children is a reason for giving them priority over an otherwise similar patient without children. He also asks if we should consider the impact a particular patient may have on society. As we have already noted, he accepts this idea for health care personnel in a pandemic, but thinks that to assess broader social benefits is simply too difficult. Staff admitting people to an ICU in an emergency can look at a patient's age, and perhaps some other relevant medical factors, and whether the patient is a parent, but they will not be able to assess social importance, and should not be asked to do so.

That seems right, for the difficulty lies not only in assessing an individual patient against agreed-upon criteria, but in setting the criteria for what it is to have a positive impact on society – something on which we are likely to get disagreement that goes as deep as the values on which such a judgment must rest. Nevertheless, in extreme cases, the situation will be clear enough. For example, if the local maximum-security prison calls up and asks if the already full ICU can find room for a recently convicted serial killer, we think the answer should be no, and we believe most people would support that decision. Conversely, in a crisis, we may give priority not only to health care workers but to other essential workers, for example, those who are keeping the electricity network running or the water safe and the sewage flowing.

What should we do when the ICU does not have the capacity to take all the patients whose chances of survival would be improved by admittance? Tännsjö notes that Robert Veatch, in discussing the utilitarian approach to such situations, argues that while utilitarian thinking may be acceptable in the United Kingdom, it would not be so in France or the United States. There, if the allocation of scarce resources is to gain public support, it would need to incorporate some principle of equity. Tännsjö indicates that

he has some doubts about this claim. He writes: "My experience is that most people 'become' utilitarians when they consider a situation of mass casualty."

Does the experience of the coronavirus pandemic confirm or falsify Tännsjö's observation? We cannot claim to have made a systematic global survey of what happened in the pandemic, but we can make a start by considering what happened in some European countries.

European Responses to the 2020 Coronavirus Pandemic: Italy and Spain

In March 2020 Northern Italy was the epicenter of the developing global pandemic. There were not enough intensive care beds or ventilators for all the patients who needed them. In these circumstances, the Italian Society of Anesthesia, Analgesia, Resuscitation, and Intensive Care set up a working group that came up with a radical solution: the traditional "first come, first served" rule for admittance to the ICU should be replaced with a system of triage designed quite explicitly to maximize the benefits that could be obtained with the limited health care resources available. The working group recommended admitting to the ICU those who have the greatest chance of survival and are likely to have the most years of life ahead of them. Not only age, but also the broader health status of the prospective patient is relevant. Patients who are elderly, frail, or have other health problems in addition to the virus may occupy an ICU bed for a much longer time than younger and healthier patients. Even if the more vulnerable patients survive, the time they spend on the ventilator may come at the cost of the deaths of two, three or even more patients who would have been in and out of the ICU during that time.

Not only did the working group recommend utilitarian criteria for admitting patients to the ICU when not all can be admitted, it also recommended moving out of the ICU patients who are not responding well in order to make room for others for whom there is hope of a better response. Of course, this recommendation was to be applied only in a time of extreme shortage of resources and the working group insisted that when patients are moved out of the ICU, this must not mean that they are simply abandoned. They must be given palliative care to reduce their suffering.[2]

[2] Il Consiglio Direttivo di Italian Resuscitation Council, *Raccomandazioni di etica clinica per l'ammissione a trattamenti intensivi e per la loro sospensione, in condizioni*

In the same month, March 2020, the Spanish Society of Intensive Medicine, Critical and Coronary Units published a document that is strikingly similar to that of their Italian colleagues. This statement also permitted departing from the usual rule of "first come, first served." The Spanish society stated that: "In dealing with two similar patients, priority must be given to the person with more years of life, adjusted for quality… Give priority to life expectancy with quality."[3]

Thus, the statements from the Italian and Spanish organizations of intensive care specialists do not shy away from bold recommendations, nor do they try to hide what they are doing in obscure or ambiguous language. They both demand transparency about what is being done in the emergency, and why. So far, then, we might consider that Tännsjö's observation has been borne out, at least in its application to medical personnel: in an emergency, they follow utilitarian principles. But the sequel to these initial statements suggests something different. In Italy, the Order of Physicians issued a statement opposing that of the working group of intensive care specialists, stating that "our guide, before any document that subordinates ethics to rationing principles and that should in any case be discussed collegially by the profession, remains the Code of Medical Ethics. And the Code is clear: for us, all patients are equal and should be treated without discrimination."[4] Later, in October, the Italian National Committee for Bioethics issued a statement that refers to the fundamental principles of the Italian constitution as including a right to protection of health, the principle of equality, and the duty of solidarity, as well as "the universalistic and egalitarian criterion on which the National Health Service is based," and then states that the Committee "recognizes the clinical criterion as the most appropriate point of reference,"

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eccezionali di squilibrio tra necessità e risorse disponibili, https://www.ircouncil.it/per-sanitari/raccomandazioni-etica-clinica-lammissione-trattamenti-intensivi-la-sospensione-condizioni-eccezionali-squilibrio-necessita-risorse-disponibili/.

[3] SEMICYUC (Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias). Recomendaciones éticas para la toma de decisiones en la situación excepcional de crisis por pandemia Covid-19 en las unidades de cuidados intensivos, https://semicyuc.org/wp-content/uploads/2020/03/%C3%89tica_SEMICYUC-COVID-19.pdf. We owe this reference, and the translation, to MP Faggioni, FJ González-Melado, ML Di Pietro, "National health system cuts and triage decisions during the COVID-19 pandemic in Italy and Spain: ethical implications," *J Med Ethics* 2021; 47:300–307.

[4] As cited by MP Faggioni, et al., "National health system cuts and triage decisions during the COVID-19 pandemic in Italy and Spain: ethical implications."

and considers "ethically unacceptable" any other selection criteria. The committee then lists these unacceptable criteria. The list includes age, sex, social role, ethnicity, disability, cost, and responsibility for behaviors that induced the pathology. The committee does say that it accepts the validity of triage, but it must be based on the premise of "preparedness" – that is, advance planning on the management of emergency situations – and then on the two "key concepts" of clinical appropriateness and the actual situation.

The committee's premise of "preparedness" is, we noted earlier, good advice for the future, but as it was not heeded prior to the outbreak of the Covid-19 pandemic, it could not have been of any assistance when it was released in the midst of that pandemic. The committee's explication of its two key concepts emphasizes the importance, in its view, of avoiding discrimination against people on the basis of the previously established categories it has listed. Thus, the only form of triage it accepts as valid, it seems, is triage on the basis of clinical judgement about the usefulness or futility of the treatment – in this case the ICU bed – for the individual patient. The committee acknowledges that its position creates a conflict between the collective public health goal of ensuring the maximum benefit for the greatest number of patients, and what it describes as "the ethical principle of ensuring the maximum protection of the individual patient." This is, it says, "a difficult dilemma to resolve when it comes to make concrete choices" and notes that there is a vast literature on this topic, but it leaves the dilemma unresolved.

The Committee's report does have a strong dissenting opinion from one member, Maurizio Mori, who regards the initial recommendations of the working group of Italian intensive care specialists as pointing in the right direction. We agree with Mori when he describes the majority report of the committee as moved more by the intent to provide reassurance than to address the reality of the need to make hard choices in an exceptional situation.[5]

[5] Our account of the report of the Italian Committee for Bioethics draws on MP Faggioni et al., "National health system cuts and triage decisions during the COVID-19 pandemic in Italy and Spain: ethical implications," supplemented with our own (Google assisted) translation and paraphrase of additional passage. The report itself, "Covid 19: la decisione clinica in condizioni di carenza di risorse e il criterio del 'triage in emergenza pandemica,'" (8 April 2020) is available here: https://bioetica.governo.it/it/pareri/pareri-e-risposte/covid-19-la-decisione-clinica-in-condizioni-di-carenza-di-risorse-e-il-criterio-del-triage-in-emergenza-pandemica/.

The recommendations of the Spanish Society of Intensive Medicine, Critical and Coronary Units, were similarly disavowed by the Spanish Bioethics Committee, which said: "Although the adoption of an allocation criterion based on the patient's ability to recover can be justified in a context of scarce resources, in any case the spread of a utilitarian mentality, or, worse still, negative prejudices towards elderly or disabled people, should be prevented." The document also attacks the use of the term "social utility," saying that it is "extremely ambiguous and ethically debatable, because every human being by the mere fact of being so is socially useful, in view of the ontological value of human dignity." The Spanish Bioethics Committee explicitly rejects the recommendation of the medical society that "any patient with cognitive impairment, from dementia or other degenerative diseases, would not be on invasive mechanical ventilation", suggesting that this puts "disability-free survival" ahead of mere survival and ends up discriminating against the disabled, particularly the mentally disabled.[6]

Human Dignity: A Problematic Concept

Although we recognize, as we have already mentioned, that what counts as socially useful is a contested idea and taking it into account in admitting patients to an ICU may place an excessive burden on medical personnel, to us the concept of social utility is far clearer than the concept of "the ontological value of human dignity." We note that Laura Palazzini, who is a member of the Italian National Bioethics Committee, and in contrast to Maurizio Mori, supported its recommendation, also appeals to the concept of human dignity, which she describes as "the dignity of every human being recognised as a person without making extrinsic distinctions between lives with dignity or without dignity, lives with greater dignity or lesser dignity, based on conditions regarding quality of life, number of years left to live, or productivity" (Palazzani, 2020).

We have searched in vain for some explanation why every member of the species *Homo sapiens* should be regarded as possessing a dignity

[6] Drawing on Faggioni et al., whose source is Comité de Bioética de España. Informe sobre los aspectos bioéticos de la priorización de recursos sanitarios en el contexto de la crisis del coronavirus, 2020. Available at: http://assets.comitedebioetica.es/files/documentacion/Informe%20CBE-%20Priorizacion%20de%20recursos%20sanitarios-coronavirus%20CBE.pdf [Accessed 30 Dec 2020].

that members of other species apparently lack. To be more specific, why should an anencephalic human infant, born without a cerebral cortex, and therefore permanently lacking conscious experiences, have greater dignity than Alex, an African grey parrot, who could express his own preferences, answer questions showing that he possessed the concepts of shape and color, and even, when looking in a mirror, ask "What color?" and learn the word "gray" after being told it only six times? We believe that there is no satisfactory answer to this question. Palazzini talks of "every human being recognized as a person" but should we recognize every human being as a person? In the seventeenth century, John Locke defined a person as "a thinking intelligent Being, that has reason and reflection, and can consider itself as itself, the same thinking thing in different times and places" (Locke, 1689). As the examples of anencephalic infants and Alex indicate, not all members of the species *Homo sapiens* are capable of this, whereas some nonhuman animals are.

Anencephalic infants are not, in practice, relevant to the allocation of ICU beds in a pandemic. Let us instead consider a severely demented adult, equally unable to function at a comparable level to Alex. The most important difference between the severely demented adult and an anencephalic infant is that the adult was capable of having preferences about whether to live or die in conceivable future circumstances, and the infant was not. But this cannot justify a blanket refusal to allow medical specialists to give priority to those with good life prospects, rather than those with dementia, including those who would not have wished to go on living in such circumstances. Clearly, on this issue, much depends on the degree of cognitive impairment, but many people do not wish to live in a state of severe dementia. To avoid this fate, when dementia is first diagnosed, they take steps to end their lives while they still can, even though this means foregoing some period of life when they are not severely demented and are still enjoying spending time with their families.[7] It is bad enough that the law does not permit people in this situation to give advance directives permitting someone else to end their life when they are no longer able to do so themselves. (The Canadian parliament is currently discussing this possibility.) It would be worse still for a patient with good prospects of living a long and full life to be denied

[7] For example, the case of Gillian Bennett: https://www.cbc.ca/news/canada/british-columbia/gillian-bennett-suffering-with-dementia-dies-leaving-right-to-die-plea-1.2742440.

the ICU bed they need to survive Covid-19 because the bed is occupied by a Covid-19 patient with dementia who, when competent, would not have wished to live in such a condition. We should recognize that discrimination, in the sense of choosing to give priority to some people rather than others, is not always wrong. Criteria for resource allocation *should* give priority to those people with better life prospects, when everything else is equal. To deny this is to follow a rule rigidly, without considering its consequences, and that can lead to outcomes that no one wants.

In one famous example of such an application of the concept of human dignity, in 2006 the German constitutional court was asked to decide about a hypothetical situation like that which arose in the United States on September 11th, 2001, when Al-Qaida terrorists hijacked four planes. At one point during that terrible day's events, two of those planes had been crashed by the hijackers into the World Trade Center killing thousands of people, and a third into the Pentagon. The fourth was still in the air, and a US air force fighter plane was moving into a position where it could consider shooting down the aircraft. That never happened because the passengers on that aircraft stormed the cockpit, tried to overpower the pilot, the pilot put the plane into a dive and everyone on board was killed. Now the German constitutional court was asked to decide whether in circumstances like that it would be appropriate for the German Air Force to shoot down a plane. The court ruled that to shoot down the plane would be a violation of the dignity of innocent people – the passengers on board the plane – and therefore a violation of the first article of the German basic law, which states that human dignity is inviolable.[8] The fact that a group of German judges interpreted the concept of human dignity in that way is, in our view, evidence of the fact that the concept is so vague that it gives no guidance at all. Imagine that the plane is hijacked during the World Cup and the plane is heading for a football stadium jammed with 80,000 fans, many of whom will die if a plane full of jet fuel crashes into it. Remember, too, that the passengers in the plane certainly have only minutes to live, given that everybody is going to die when the plane crashes. Would it not be right to save the lives of thousands of people in the football stadium, at the cost of shortening the lives of the passengers who will otherwise live only for a few, terrifying, minutes? Does not the dignity of the football fans

[8] https://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/EN/2006/02/rs20060215_1bvr035705en.html.

count too? Is the fact that there are so many more of them at risk than the passengers completely irrelevant to determining what is the right thing to do?

As utilitarians, instead of making vague, empty and typically undefended references to "human dignity" we prefer to speak of equal consideration for similar interests. This idea was captured with greatest precision by Henry Sidgwick when he wrote:

> …the good of any one individual is of no more importance, from the point of view (if I may say so) of the Universe, than the good of any other; unless, that is, there are special grounds for believing that more good is likely to be realised in the one case than in the other (Sidgwick, 1907, 382).

This principle is not only more defensible than appeals to human dignity. It also gives us a much clearer idea of what we should do in order to implement it.

The Right to the Protection of Health

In addition to the appeal to human dignity, Palazzini also criticizes utilitarian criteria for the allocation of scarce resources in a pandemic on the grounds that they "are in contrast with fundamental human rights, including the right to the protection of health, expressed in international constitutions and regulations, as well as in deontological codes." Utilitarians support the idea that everyone's health should be protected, to the maximum extent compatible with using our resources as effectively as possible to increase well-being for all sentient beings. But again, the idea of a right to the protection of health is vague and in situations in which it is not possible to protect everyone's health, it gives us little guidance. In our view, such a right should be construed as directing authorities to use the available resources to produce the greatest health benefits. A recent study by Richard Wood, et al., shows that using triage is an effective way of doing just that. Wood and his colleagues drew on data from more than 9,000 admissions to UK intensive care units and used computer simulation to compare the effect of triage on the basis of age, admitting younger patients and rejecting those above an age cut-off, with the traditional "first come, first served" rule. They found that triage had negligible impact on total deaths, but did lead to more life-years saved.

Triage at the point of entry to the ICU would have reduced life-years lost by 8.14%. Moreover, if more controversially, admitted patients were promptly discharged if they subsequently failed to meet the criteria, and admission for new patients who did meet the criteria for admission could not otherwise be guaranteed, the reduction in life-years lost rose to 11.7% (Wood, 2021) Thus, if there is a right to the protection of health, then during a pandemic even a crude form of age-related triage may do more to guarantee that right than avoiding triage. We hasten to add that we are not in favor of a purely age-related form of triage, although this may usefully be one factor to consider, along with other clinical indications of the likelihood of a good outcome.

We note that the British Medical Association appears to share this view that the state's health care system best protects health by using its health care resources "to their best effect." The BMA's *Covid-19 – ethical issues. A Guidance Note*, offers the opinion that that while it would not be lawful to deny a healthy 75-year-old access to treatment on the basis of age, "older patients with severe respiratory failure secondary to COVID-19 may have a very high chance of dying despite intensive care, and consequently have a lower priority for admission to intensive care." The *Guidance Note* then says that in the view of the authors, in the circumstances of a serious pandemic it would be lawful to use "capacity to benefit quickly" as a criterion for admission, "because it would amount to 'a proportionate means of achieving a legitimate aim', under s19 (1) of the Equalities Act – namely fulfilling the requirement to use limited NHS resources to their best effect."[9]

The BMA's *Guidance Note* also addresses the issue of removing patients from an ICU when that will reduce their prospects of survival, but makes a bigger difference to the survival prospects of patients who would otherwise not be admitted to an ICU at all. The note asserts that "there is no ethically significant difference between decisions to withhold life-sustaining treatment or to withdraw it, other clinically relevant factors being equal – although health professionals may find decisions to withdraw treatment more challenging." The authors go on to suggest that "in a setting of overwhelming demand" it may be necessary to consider the idea of a time-limited trial of therapy, so that if a patient is not responding to therapy within a specified period, treatment "should be withdrawn and the same facility offered to another patient reasonably believed to have the capacity to benefit quickly."

[9] British Medical Association, *Covid-19 – ethical issues. A Guidance Note*, p. 6.

European Responses: Germany and Sweden

We agree with these recommendations, and they could be taken as confirmation of Veatch's suggestion that utilitarian thinking is more readily accepted in the UK than in some other countries. We note, however, that this at the level of the recommendations of medical societies, the thinking in Italy and Spain was also along broadly utilitarian lines, and it was only at the level of a national bioethics committee that there was strong opposition to utilitarian thinking. In Germany, one source says that "For reasons of justice, all patients who require intensive care treatment should be considered equally in the prioritization," and adds that it "may touch legal limits" to withdraw intensive care measures on the grounds that another patient would benefit more from such care. The same document adds, however, that "as there are currently no specific legal regulations in Germany, the decision-makers bear the responsibility for these decisions" (Marckmann, 2020).

Given the strength of utilitarian thinking among Swedish philosophers, we were surprised to discover that Sweden seems to be among the countries where utilitarian thinking regarding the allocation of scarce resources is explicitly rejected at the national level. The Swedish Council on Medical Ethics, in its report *Ethical Choices in a Pandemic*, notes that the ethical platform for priority setting by the Public Health Agency of Sweden, as specified in 1997 by the Riksdag, "takes as its starting point the principle of human dignity and the principle of need and solidarity, which take precedence over the principle of cost-effectiveness." The document links human dignity with the idea that people are "of equal worth, with the same entitlement to have their rights upheld, adding that human dignity is "not bound up with the circumstances of the individual, but is afforded to every person, irrespective of their performance, characteristics, or their social or economic status in society."[10] We have already noted the problems with such invocations of human dignity.

It seems, then, that Tännsjö's observation, quoted earlier, that "that most people 'become' utilitarians when they consider a situation of mass casualty," has not been widely shown to be true of the Covid-19 pandemic. We have already indicated that Veatch may be correct to say that it is nearer to the truth

[10] The Swedish Council on Medical Ethics, *Ethical Choices in a Pandemic*, Stockholm, 2020, pp. 61–62.

in the United Kingdom than most other countries. But it is also possible that the pandemic, bad as it has been and still is, is not quite the crisis situation that Tännsjö had in mind. It could have been much worse. In most countries – in part because of strict lockdowns, which of course have their own costs – it has not completely overwhelmed the health care system. Perhaps if the situation were much worse, most people would be prepared to abandon the deontological principles that stand in the way of obtaining the greatest health benefit from the available resources.

A Practical Summary and Conclusion

Obviously, we should already be striving to reduce the risk of future pandemics. Ending factory farming, which has already caused several epidemics of variations of avian influenza, and the 2009 swine flu pandemic, would be a great way to do that, and it would have other benefits, for tens of billions of animals and for the environment of our entire planet. Assuming, however, that we will not implement such a significant step, and we will also not extend our critical care facilities to the point at which they will be able, when the next pandemic arrives, to treat everyone who needs to be treated, how should we allocate our limited health care resources?

We support the utilitarian goal of minimizing, not lives lost, but years of life lost. We would take some account of quality, but only in extreme cases of lack of quality of life. Therefore, we would not give an ICU bed to someone with advanced dementia, nor to a patient in a persistent vegetative state with no realistic prospect of recovering consciousness. We have no objection, in principle, to the use, as a tie-breaker, of more fine-tuned judgments of the quality of life, but in practice moving to quality-adjusted life-years, or some similar set of criteria, would put an intolerable burden on the health care professionals required to make such decisions. We would, however, give priority to members of needed professions, for example health care workers, and those employed to maintain essential infrastructure.

Finally, what of the issue with which we began, raised by Rob Davidson, the desperately struggling Michigan physician with unvaccinated patients with Covid-19 making up 98% of the acute critical care cases in his hospital? Here is another passage from his essay:

> With every shift, I see the strain people sick with Covid-19 put on my hospital. Their choice to not get vaccinated is not personal. It forces patients with ruptured appendixes and broken bones to wait for hours in my emergency department; it postpones surgeries for countless other people and burns out doctors and nurses.

We agree that the choice to get vaccinated is not personal. We have long known that it harms others by making it more likely that the virus will spread; and as Davidson points out, it deprives others of access to medical resources that would be adequate if everyone were vaccinated, but are scarce in regions where many people refuse to get vaccinated.

What can be done? One option could be for hospitals such as Davidson's, operating in regions with many unvaccinated people who take up a disproportionate share of health care resources, to make public announcements that, after a given date (say, one month from the date of the announcement) people who choose not to be vaccinated will receive lower priority than patients who have been vaccinated and have a similar need for an ICU bed. This policy could also be extended to withdrawing treatment facilities from unvaccinated patients when a vaccinated patient has a greater or equal need for the facility. Such a policy would be likely to increase vaccination rates, which would be a good thing for everyone. If that were to happen, such an announcement would benefit the unvaccinated as well as the vaccinated, and save more lives than are currently being saved. On the other hand, such a policy could, at least in the short-term, lead to more lives being lost. That possibility is a strong argument against it, but it could be seen as a price that has to be paid to enable people to understand, in full, the consequences of their choices, and thereby in the long run, to save more lives.

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