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Letter in reply to Bernard Prusak, et al.

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Publication Statement

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ICU Care in a Pandemic

We thank the editors for soliciting Other Voices commentaries in response to our article, "Life-Years and Rationing in the Covid-19 Pandemic: A Critical Analysis" (September-October 2021), and we are grateful to the respondents for engaging our criticisms and alternative strategy. We briefly respond here to the commentaries by Douglas B. White and Bernard Lo, by Govind Persad, and by Virginia A. Brown.

White and Lo protest too much. December 2020, when they published "several important modifications" (p. 44) to the set of triage procedures known as the "Pittsburgh framework," was already late into the pandemic, and many states and systems had already drawn from the framework's earlier iterations. A model policy developed by White, Lo, and colleagues and dated April 3, 2020, explicitly "attempts to increase overall survival by giving some priority to patients who do not have a very limited life expectancy even if they survived the acute critical illness." Up to five years is counted as "very limited." Similarly, in "A Framework for Rationing Ventilators and Critical Care Beds during the COVID-19 Pandemic," published online in the *Journal of the American Medical Association* on March 27, 2020, White and Lo write that "[i] t is also relevant to consider the number of years of life saved," a position they seek to justify by appeal to "[t]he moral intuition of many people." In addition to seeking to save life-years, they endorse a life-cycle principle, prioritizing younger people on the grounds that they have not lived through as many stages of life. This principle, White and Lo assert in response to our article, is supposed to follow from "the overarching goals of health care and public health: to help individuals secure a fair opportunity to formulate and carry out their conception of a meaningful life over a life span" (p. 44). But it is disingenuous to claim that helping individuals secure this opportunity warrants prioritizing the young over the old in the context of a public health emergency. A good argument is needed to support that conclusion, and we have found the arguments lacking.

Similarly, Persad claims that "[r]egarding . . . additional years of human life as irrelevant to proper decision-making is inconsistent . . . with the value that medicine typically accords to extending life" (p. 47). Medicine does value extending life, but it is an illogical leap to the conclusion that, in a pandemic, medicine should therefore seek to maximize life-years saved. We agree that an early death is a great misfortune, but we reiterate that the old do not wrong the young by living longer—the old do not thereby take more than their fair share of life, as if it were a pie—and so we remain unimpressed by Persad's claim that maximizing survival "is not only wasteful but also unjust" (p. 47). As an aside, Persad is incorrect to reduce Norman Daniels's prudential life span account to the vague observation that "other factors may sometimes outweigh the importance of preventing an early death" (pp. 49-50).

Brown, Persad, and White and Lo all express concerns that pandemic response plans not compound racial injustice. We likewise lament the health inequities exposed by the Covid-19 pandemic. We do not see intensive care units, however, as the proper place to try to redress social injustices, especially when there is deep and persistent controversy over the appropriate remedies. At this moment of the pandemic, health care institutions badly need to encourage public trust. Looking to factors other than need, prognosis, and effectiveness in making rationing decisions seems designed to undermine public trust further. As Brown contends, health care institutions do need to reckon seriously with "structural inequality and the resulting inequity . . . for Black and Latinx communities." But in a pandemic, the ICU is not the place to do so.

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Govind Persad replies: Scarce medical resource allocation should aim to prevent harm, especially to those who would be most disadvantaged if not helped. Bernard Prusak et al.'s letter reveals a narrow vision of which harms and disadvantages matter, one that overlooks opportunities to simultaneously prevent important harms and avoid exacerbating disadvantage.

My commentary argued that "exclusive survivalism," for which only short-term survival matters, wastefully "regards preventing ten years of lost life as no better than preventing one" and unjustly regards "preventing death at forty as no better than preventing death at eighty" (p. 47). If, as Prusak et al. state, "[m]edicine does value extending life," it is hardly illogical to believe that preventing years of life lost remains a legitimate allocation objective—not to be exclusively maximized, but weighed against other aims. Yet Prusak et al. merely repeat their attack on the straw man that "medicine should . . . seek to maximize life-years saved,"

never explaining how their acknowledgment that extending life matters is reconcilable with their position that saving many life-years should be altogether ignored in allocation decisions.

That older adults "do not wrong the young by living longer" cannot support exclusive survivalism. Nobody believes that an eighty-year-old wrongs a forty-year-old by living longer. But this is irrelevant to whether *allocation policy* wrongs a critically ill forty-year-old facing the concededly "great misfortune" of early death, someone who both has lived much less long and has more life ahead if she survives, by placing her behind an eighty-year-old with slightly better odds of immediate survival. That severe Covid-19 earlier in life is correlated with various forms of structural disadvantage makes matters worse.

"[T]he ICU is not the place," say Prusak et al., to "reckon seriously with 'structural inequality'"; instead, only "need, prognosis, and effectiveness" count. But determining which needs, prognoses, and forms of effectiveness matter requires ethical reckoning—as indicated by the authors' original complaint that including age and life expectancy in definitions of need and prognosis would "actively discriminate" against older adults. To subsequently dismiss structural inequality's relevance to allocation seems at best arbitrary and at worst prejudiced. Omitting age, for instance, further disadvantages poorer and minority patients, who have, on average, lost more years of life and died earlier. Evidence also contradicts Prusak et al.'s speculation that addressing structural inequality would "undermine public trust" (see W. Buckwalter and A. Peterson, "Public Attitudes toward Allocating Scarce Resources in the COVID-19 Pandemic," *PLoS One*, 2020).

Fortunately, new empirical research suggests a path to reconciliation. According to Sarah M. Kesler et al., "Incorporation of age into [ventilator allocation] . . . would more accurately predict those patients expected to survive" while mitigating racial disparities ("Operationalizing Ethical Guidance for Ventilator Allocation in Minnesota: Saving the Most Lives or Exacerbating Health Disparities?," *Critical Care Explorations*, 2021). In addition, Sivasubramanium V. Bhavani et al. report in "Simulation of Ventilator Allocation in Critically Ill Patients with COVID-19" that "[y]oungest-first saved the most lives and did not exacerbate racial disparities" (*American Journal of Respiratory and Critical Care Medicine*, 2021). Prioritizing younger patients in allocation better predicts near-term survival while also reducing lost future life, early deaths, and the exacerbation of structural disparities. Even if Prusak et al. dismiss the latter objectives, they may still be willing to save more lives.

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Virginia A. Brown replies: I thank Bernard Prusak and colleagues for their thoughtful letter. There is no doubt that when systems are stressed, inequality becomes profoundly acute, not just for those directly affected but also for the systems that serve all involved. "[L]ament[ing] the health inequities exposed by the Covid-19 pandemic" does little to address lifetimes of structural health and health care inequality. And to "not see intensive care units . . . as the proper place to try to redress social injustices" raises the question, if not there, where?

Social justice demands acting on the understanding that, in the words of James Baldwin, "[n]ot everything that is faced can be changed; but nothing can be changed until it is faced."

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