It is not wrong to prioritise younger patients with Covid-19

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Dear Editor,

We read with great interest the “head to head” about prioritisation of younger patients with Covid-19 [1], and we would like to make a few remarks, both factual and normative.

We think that age is one among many factors that have to go into any allocation decision. The claim that such a strategy is discriminatory can be challenged by both utilitarian and nonutilitarian objections.

First of all, in Archard’s premise, the statement that using age as a marker of clinical frailty and likelihood of survival is “crude and unreliable” is not supported by scientific evidence. Age per se is not only a reliable predictor of mortality, according to Gompertz law [2]; it is also associated with frailty, regardless of other chronic illness.

There is relevant literature supporting the idea that aging occurs as an emergent phenomenon: people do not die from old age, rather they accumulate age-related illnesses and become increasingly vulnerable to death. Thus vulnerability (frailty) can be quantified through mathematical models and is strongly associated with mortality [3].

In the case of Covid-19, in particular, from a clinical perspective, preliminary outcome data [4,5] show a strong correlation between age and Covid-19 lethality.

Archard's first argument ("where is the line") can be challenged by two objections. The first one is that in the example used (of an 18 year old versus a 19 year old), the age criterion is of course very weak; but this does not at all imply that the criterion may be equally weak when preferring an 18 year old to a 92 year old.

Also, Archard, as other scholars, views this as a line-drawing exercise, trying to identify some point when a life should be seen as complete. This could be seen as a kind of Dorian Gray view of the world, where one maintains a "full" claim up to a cut off and then precipitously falls off a cliff. This is not defensible, either in theory or as a practical matter. A person of 74 years 11 months cannot precipitously lose claim on his 75th birthday. As a practical matter that doesn't work in any case, since we may not have enough ventilators or other scarce resource to meet the needs of everyone below the cut off or may have enough resources to spare to take care of some above the cutoff. Even if for practical reasons we need to temporarily draw a line, that line should continually be adjusted as demands and resources require.

Regarding the fair innings argument [6], a similar problem arises. He and others take the fair innings argument to entail a cutoff between those who have (to continue the sports analogy) completed the game (say 9 innings in baseball) and those who have not. Instead, the concept should be better defined as a continuum through life, as suggesting that whoever has had fewer opportunities for living deserves a priority in a forced choice over those who have had more opportunities. So at all points along the continuum of life the younger deserves opportunity over the older when there is a forced choice between them. This is also one of the factors that should feed into organ allocation decisions as well as allocation of ventilators.

While using age as a criterion, there are two quite different perspectives. We may not agree on which is more appropriate. One uses age as a crude place-holder for utility on the belief that, in general, older people are more difficult to treat and get less benefit from medical intervention. This is partly because they predictably have fewer years left and therefore get fewer life-years from a given successful treatment. Utilitarians focus on this first perspective. Justice theorists either offer a simple view that all people regardless of age or life-expectancy have equal moral claim or they rely on fair innings arguments that focus on the number of calendar years one has had. Holders of this view focus on chronological age rather than physiological age. In much of the age-based allocation discussion, the two perspectives, utilitarian and non utilitarian, may lead to similar allocation positions and thus can form a coalition when it comes to allocation policy.

Lastly, while Archard stigmatizes value judgements in his third argument, he inadvertently makes a value judgement in describing people who deserve to carry on eating in Lucretius's dining metaphor. When he states that the need for care "might arise from choices, the consequences of which an individual should rightly be held responsible for", we believe his claim be unethical and discriminatory. "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" is a statement that does seem a value judgement and therefore should be avoided.

In summary, we believe there are strong reasons, both clinical and ethical, supporting the claim that prioritising younger patients with Covid-19 is not discriminatory.

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