People are currently living in a world of uncertainty. Within a matter of weeks, the life that everyone knew has been taken from them. People are struggling to retain a semblance of normality within their daily lives as their routines are stripped from them. People can no longer hang out with friends, sit down in a restaurant, go to a park, safely go grocery shopping, and even go to work. This is all due to the Coronavirus, or COVID-19, that is spreading across the world. This global pandemic has halted life for everyone. Although people are mourning the loss of their daily routines, some people are mourning something much greater; the loss of their loved ones. Hundreds of thousands of people are infected with the coronavirus, and tens of thousands have died in the United States alone. This surge of COVID cases has left many people sick and in need of care. However, it has also left hospitals overwhelmed and underprepared. Due to the large number of patients in need of ventilators and a low number of ventilators available, many hospitals have been left with an exceptionally hard decision: who gets ventilators and who doesn’t? Essentially, that question boils down to a much more grim one. Who gets to live and who doesn’t?

Obviously, it seems like the clear answer is that enough ventilators should be made available to treat everyone effectively. Currently, a lot of hospitals, such as Strong Memorial Hospital in Rochester, NY, have enough ventilators for all COVID-19 patients. However, in the case of a spike of a sudden onset of thousands of cases of COVID-19, this is not a realistic goal. Rationing measures must be put in place for if there are not enough ventilators to treat everyone. So this raises the bioethical question we are examining: How do we decide who gets a ventilator? As of now, The federal government is not providing national rationing guidelines for the coronavirus outbreak. That means that hospitals are having to decide who gets the most treatment. There are many proposed ways to navigate this issue, but first, we must examine why exactly this is a bioethical issue.

The decision to deny one person treatment in order to provide someone else with that treatment is the relevant issue in question. To begin, we can examine human rights as they relate to healthcare. Many people in the United States debate whether health care is a human right. However, the rights to health care is a legal right that is embodied in many different healthcare systems. Many people also believe that a legal right to something should be a reflection of what the government is morally obligated to provide for its citizens, in this case healthcare. Access to healthcare can be seen as a positive right. A positive right is one that involves action. They are the rights that require people to assist you. Healthcare requires other people such as doctors and medical workers to assist you in matters of your health. It can be safely argued that healthcare is a human right, and the government is obligated to provide it for its citizens, and that each person has a right to some form of healthcare and health protection.

Norman Daniels, a bioethicist at Harvard University explains that the function of healthcare is to keep people functioning as close to normally as possible. That is, no controllable physical or emotional boundaries impeding your everyday functioning. He claims that “The healthcare we have strongest claim to is care that effectively promotes normal functioning by reducing the impact of disease and disability.” In the case of rationing ventilators and other treatment for COVID patients, hospitals are inevitably violating that right to reduce the impact of disease for patients. However, they are not doing this by choice. Due to the fact that supplies are low, hospitals and medical workers have virtually no choice but to violate some of their patients’ right to equal and effective healthcare. As unfortunate as it is, during this extremely uncertain time, it is a necessity to ration ventilators and treatment.

When people become doctors, they take the hippocratic oath. This oath requires all doctors to do no harm to their patients, and to benefit their patients according to their greatest judgement and abilities. When a doctor has one ventilator and two extremely sick COVID patients in need, whom does he give the ventilator to? How do health care workers make the decision of who gets treatment in the first place?

In 2015, the New York State Department of Health released ventilator allocation guidelines in the event of a public health emergency. Throughout this paper, I will present many different opinions and solutions, but in the end, I will advocate for these guidelines. Although these guidelines exist for New York State, they are not necessarily implemented, there are no federal regulations, and other states may not have similar guidelines to look to during this time. The guidelines state that “patients for whom ventilator therapy would most likely be lifesaving are prioritized.” What this means is that people who are most and least likely to survive without ventilators are the ones who have the lowest level of access to them. This is in order to maximize the patients who are most likely to survive without ventilator therapy,
Peter Singer, a bioethicist at Princeton University, advocates for the use of rationing healthcare based on Quality-Adjusted Life-Year, or QALY. Let’s say we have an 85 year old COVID patient, and a 15 year old COVID patient. Both are in need of a ventilator, but there is only one to give out. According to Singer, we should look at the number of life years saved. If the 85 year old will only live for another five years, whereas the 15 year old is expected to live for another 70 years, “saving one teenager is equivalent to saving 14 85-year-olds.” To him, the death of a teenager is much more tragic than the death of an elderly patient. He argues that priority should be given to the younger people who fall sick in order to save the most “years.”

QALY also takes into consideration the quality of life. Say you present a perfectly healthy individual with the choice of living 10 more years as a quadraplegic, or only 5 years perfectly healthy. Singer argues that many people would choose to live a shorter number of years as long as they are not disabled. He argues that this shows that the perceived quality of life should also play a role in decisions such as these. Due to the fact that most people would choose to live half the amount of time without a disability, Singer concludes that “restoring to nondisabled life two people who would otherwise be quadriplegics is equivalent in value to saving the life of one person, provided the life expectancies of all involved are similar.” Essentially, Singer argues that we should give treatment priority to those that are already young and healthy, because these options maximize the quality of life of the patients that will survive.

Singer’s ideas for the rationing of treatment are ageist at best, and discriminatory at worst. Where examining QALY in order to make a decision may take quality of life into consideration, Singer ignores that quality of life does not equal moral standing. To him, refusing a ventilator to a 15 year old in favor of an 80 year old may seem like a tragedy. However, Singer seems to ignore the fact that both the 80 year old and the 15 year old are people of equal moral standing. Likewise, people with disabilities are worth no less than people without them. Being disabled makes you no less morally deserving of human rights and treatment than your non disabled counterparts. Every life is worth living. As a matter of fact, many disabled people would choose to remain living disabled if given the chance, because it is integral to their identities and their livelihoods. Therefore, there has to be a solution that takes people’s full moral personhood into account.

Researchers at Johns Hopkins have engaged residents of Maryland with questions about ventilators. They presented numerous options for the distribution of ventilators. Most people agreed that assigning ventilators at a first come first serve basis would unfairly disadvantage those that lived further away from hospitals, or those that got sick later than others. Therefore, we can rule out assigning ventilators on a first come first serve basis. Another option that was presented was to assign ventilators based on a random lottery system. However, I would argue that assigning ventilators randomly is not the most fair solution, since it could end up killing more people than it saves.

I advocate for the solutions presented in the New York State guidelines for ventilator distribution. Although this method may seem to gloss over certain factors, I would argue that it is more ethically sound to evaluate people based on their anticipated response to treatment rather than disabilities, age, etc. If a hospital refuses a ventilator to someone with a disability in favor of someone without a disability based on QALY, it is an act of discrimination and ignores people’s moral personhood. However, if a hospital denies someone a ventilator because they will not respond well to it in favor of someone who will, it is simply an act in the best interest of the greater good. All people have equal moral standing, and an equal right to life and treatment. Therefore, evaluating people on factors other than response to treatment diminishes their personhood: it tells them they are less than others due to their age or their disability. Having a system in place that only takes response to treatment into account seems to be the only way to save the most patients without people feeling like they are “less than.” The only way to ensure full equality in this difficult decision making process is to evaluate everyone equally based on one thing: their response to treatment.

The job of public health officials and health care workers is to do the best they possibly can by their patients. In a time like this where helping everyone is nearly impossible, the best that doctors can do is keeping as many people alive as possible. Therefore, despite ethical implications surrounding the rationing of ventilators, it is important to understand that everyone is equal morally, and the decision to give
a patient a ventilator should be based on nothing but their anticipated response to treatment. Including any other factors in the decision making process will inevitably lead to discrimination and a denial of a patient's worth.

References