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BIOETHICS FORUM ESSAY

Why I Don't Support Age-Related Rationing During the Covid Pandemic

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Scarcity, the mother of rationing, is forcing society to consider how in an unfolding pandemic to allocate limited resources like ventilators. If more people fall critically ill with Covid-19 than can be adequately cared for, then lifesaving interventions must be withheld from some individuals to give others a chance to survive. It is imperative we ply just criteria to ration resources in these terrible situations, should they arise.

In this context Franklin Miller recently suggested using age as a criterion for rationing ventilators. Miller argues for an initial age cutoff of 80 years; if the need for ventilators exceeds the supply, then all individuals 80 years or older would forgo mechanical ventilation. If the situation worsens, ventilators could also be

withheld from those over the age 70 and another comorbidity, and in a worst-case scenario, from all individuals 70 years or older.

In this essay I make no attempt to survey alternative rationing policies for the Covid-19 pandemic. Nor do I judge the normative merits of rationing by age. My focus here is to show that one of Miller's motivating aims—saving the most lives—might be better realized without strict age cutoffs.

The argument for rationing by age begins with the observation that elderly people suffer the worst outcomes in Covid-19. Miller points to two retrospective studies from two of the first cities affected by Covid-19. The larger study included 1,591 people admitted to a regional ICU in Lombardy, Italy. These data “demonstrated considerably higher rates of mortality depending on age: 29% for those 61-70; 40% for those 71-80; and 55% for those 81 and older. The second study included 52 patients admitted to a single ICU in Wuhan, China. As Miller wrote, “Of 10 patients aged 70 and older, only 1 survived.” These studies demonstrate older patients have greater risk of death from Covid-19; scarce resources like ventilators should not be distributed to those above a certain age since, by comparison, younger patients are more likely to survive.

But if the goal in allocating scarce resources is to prioritize those most likely to survive, then age cannot always take precedence. A healthy 82-year-old may have the same or better chances on a ventilator for Covid-19 as a 62-year-old who has multiple underlying comorbidities or is in septic shock or is hypoxemic on supplemental oxygen, or as a 42-year-old who develops acute cardiac injury. Were age allowed to override all other prognostic considerations—as with a cutoff of 70 or 80 years—then more consequential risk factors might not be reflected in rationing decisions. As a result, those most likely to survive Covid-19 with intervention will not always be prioritized for scarce resources. If the goal in the pandemic is to save the greatest number of lives, why not distill age-based criteria down to risk factors for survival?

To be clear, I agree that age correlates with mortality in Covid-19. But the available information is too incomplete to justify a universal age cutoff on the basis of outcome. The Lombardy study, for instance, which was the larger of the two reports, provided outcomes for just 22 individuals over 80 years old. The Wuhan study included 2. All 22 of the patients in Lombardy had at least one comorbidity. What is the risk of mortality in Covid-19 among patients above the age of 80 with no other comorbidity? This remains uncertain. Until the relationship between age and comorbidity in Covid-19 is better understood, it would be premature for exclusion criteria to use age cutoffs (or any other bright-red-line criteria) on the basis of population outcome.

As a final note, I wonder if the earliest Covid-19 data need to be interpreted with added caution in this context: the published rates of mortality might already reflect the consequences of scarcity. The reports from Lombardy described a catastrophic surge of patients suffering from Covid-19 that overwhelmed the Italian health care infrastructure and required critical care resources to be rationed. Some hospitals are reported to have implemented ad hoc age cutoffs; in one topical case, a healthy 80-year-old with Covid-19

did not receive mechanical ventilation on the basis of his age. Until we have data from more fronts of the pandemic, we may not know the extent to which the observed trends in mortality were caused by (and thus can only circularly serve as justification for) rationing on the basis of age.

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