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Viewpoint

COVID-19 Vaccine Refusal and Fair Allocation of Scarce Medical Resources

Govind Persad, PhD, JD; Emily A. Largent, PhD, JD, RN

When hospitals face surges of patients with COVID-19, fair allocation of scarce medical resources remains a challenge. Scarcity has at times encompassed not only hospital and intensive care unit beds—often reflecting staffing shortages—but also therapies and intensive treatments. Safe, highly effective COVID-19 vaccines have been free and widely available since mid-2021, yet many Americans remain unvaccinated by choice. Should their decision to forgo vaccination be considered when allocating scarce resources? Some have suggested it should,¹ while others disagree.² We offer a framework for evaluating when it is ethical and briefly discuss its legality in American law.

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Relevant Considerations

The typical justification for considering past choices in scarce resource allocation is reciprocity—granting priority to individuals who have acted to protect the community or ameliorate scarcity. Reciprocity informs organ allocation: for instance, the US prioritizes past kidney donors, and several countries also prioritize pledged donors. Some hospitals' pandemic triage policies proposed to prioritize frontline health care professionals for ventilators in recognition of their assumption of risk to care for others.³ Though reciprocity looks backward, it can also create forward-looking incentives: prioritizing frontline health care professionals, whether for ventilators or vaccines, may incentivize them to continue working rather than quitting to avoid infection.⁴

Reciprocity's proper place in scarce resource allocation rests on its interplay with 2 core ethical values: (1) benefiting people while preventing harm and (2) mitigating health inequities.⁵ For simplicity, we assume reciprocity is less important than these 2 core values, appropriate only if its use aligns with both and only then for breaking ties among similarly situated patients. This simplifying assumption leaves open the possibility, however, that reciprocity may do more than break ties, just as in organ transplantation where prior donors receive more substantial priority.

Determining whether consideration of past choices aligns with benefiting people and preventing harm requires comparing different candidates' expected improvements in outcome from receiving a scarce resource. Here, science can be a guide: does the past choice directly influence outcomes? For example, vaccination status might affect likelihood of benefit from a scarce resource, just as other medical differences might. Moreover, even if a choice—such as becoming vaccinated—does not affect likelihood of benefit, its consideration could still indirectly benefit people and prevent harm by incentivizing people to ease scarcity by becoming vaccinated.

Second, whether considering past choices will mitigate inequities depends on determining how past choices and need for the scarce resource track disadvantage. Assessing whether disadvantaged people are overrepresented among, for instance, unvaccinated adults depends on how *disadvantage* is defined. In 2022, Americans who are members of racial and ethnic minority groups report higher-than-average vaccination rates, as do women and people with serious medical conditions.⁶ This raises the concern that prioritizing unvaccinated adults for COVID-19 therapies may exacerbate access disparities for some disadvantaged groups. Additionally, the association between disadvantage and non-COVID-19 health disparities means that disadvantaged people may be overrepresented among patients with serious conditions other than COVID-19 who would benefit from scarce resources needed by all (eg, intensive care unit beds). Aiming directly to prioritize those

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who are disadvantaged—for instance, by incorporating vulnerability indices into allocation⁷—may be preferable to ignoring vaccination status in the hope of not exacerbating disadvantage.

The National Institutes of Health (NIH) treatment guideline for the scarce therapy Paxlovid (Pfizer), authorized for treatment of mild-to-moderate COVID-19,⁸ illustrates the interplay between benefit, mitigation of inequities, and reciprocity. Tier 1 includes immunocompromised adults, who may be unable to mount a robust immune response to vaccination, alongside unvaccinated adults 75 years and older or 65 years and older with 1 chronic condition. Tier 2 includes the remaining unvaccinated individuals 65 years and older and anyone unvaccinated and younger than 65 years with risk factors. Tiers 3 and 4 include vaccinated individuals at heightened risk. We argue, contrary to the NIH treatment guideline, that tier 1 should be restructured to place immunocompromised adults—particularly those older and with additional chronic conditions—before unvaccinated adults. Tiers 2 and 3 should be reorganized to prioritize vaccinated adults who are older or have chronic conditions, particularly if unboosted, over younger unvaccinated adults. This restructuring would better align the NIH treatment guideline with preventing harm, mitigating health inequities, and reciprocity. Reciprocity's proper place, however, is limited: prioritizing vaccinated younger adults, currently in tier 4, over unvaccinated older adults in tier 1 would be difficult to justify because reciprocity sharply diverges from preventing harm.

Objections to Considering Vaccine Refusal

Those categorically opposed to consideration of past choices, particularly COVID-19 vaccination, to limit access to scarce medical resources make 4 general arguments. First, some claim that weighing past choices violates physicians' duty of nonjudgmental loyalty to their patients.² While physicians do have special duties to their patients, appeals to such duties cannot resolve questions of fair allocation of scarce resources in a pandemic. These are questions of public health, guided by different ethical considerations and appropriately resolved by policy makers—institutional or governmental—rather than by bedside clinicians. Considering past choices as one factor in a uniformly applied pandemic triage policy differs from denying care on an ad hoc basis.

Second, consideration of past choices might be criticized as inappropriately driven by negative feelings—vengeance, anger, or blame. But weighing past choices need not appeal to negative emotions, as evidenced by prioritization of past organ donors or frontline health care professionals. Reciprocity may be an appropriate response to the socially valuable contributions made by those who are vaccinated, or an appropriate consequence for the exacerbation of scarcity caused by those who refuse vaccination.

Third, some worry that allowing consideration of specific past medical choices, such as vaccination, will result in permission to consider all past choices, which could produce bias or arbitrariness. Yet, limiting principles exist to arrest a slide down this slippery slope. For example, relevant behaviors should be readily verifiable, broadly accessible, and directly linked to the outcome of interest. Vaccination status is well documented; moreover, COVID-19 vaccines are widely available, safe, and alleviate preventable scarcity by dramatically reducing severe disease, hospitalization, and death.

Fourth, cumulative opportunities and experiences shape choice. This has been a challenge with vaccine access and uptake,⁹ leading to worries that considering past choices will further harm victims of misinformation or reinforce mistrust in the health care system. Because political identity now appears more strongly associated with vaccination choices than do socioeconomic variables such as race and ethnicity and income group, this concern is distinct from mitigating inequities.⁶ We do not believe the politicization of vaccination decisions justifies categorically ignoring past choices, but rather justifies evaluating ethical and practical consequences before incorporating past choices into allocation frameworks.

Legal Dimensions

Policies considering past conduct do not violate the Americans with Disabilities Act so long as they include reasonable accommodations for those medically ineligible to engage in the requisite conduct. Voluntarily forgoing vaccination is legally distinct from medical ineligibility. Meanwhile, though the legal status of religious objections to vaccination remains unclear, it is settled that physicians making treatment decisions may consider whether a patient has committed to refuse treatments, such as blood transfusions, even for religious reasons. The most likely basis for legal challenges to policies considering past choices would be novel antidiscrimination laws, such as a recent Montana law that treats vaccination status similarly to race or sex.¹⁰

Conclusions

When allocating resources under conditions of scarcity, considering past choices may sometimes be ethically defensible. Its appropriateness depends on the details of the past choice in question, the local context, and whether doing so prevents harm and adequately mitigates inequities.

ARTICLE INFORMATION

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