



Saving the Babies or the Elderly in a Time of Crisis?

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**Saving the Babies or the Elderly in a Time of Crisis?**

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In their important article, Haward et al. (2020) discuss whether guidelines for treating extremely premature babies should be altered to free up ventilators during crises such as COVID-19 pandemic.¹ The authors' claim is that premature babies do not deserve special consideration for ventilator treatment but merely equal consideration. In this brief commentary, I continue their discussion by considering additional factors that may help us determine whom we should save in a crisis: babies or the elderly.

To illustrate the problem, we can summarize the imaginary but very plausible case Haward et al. (2020) raises as follows:

Jim, 75, has developed worsening respiratory distress from the COVID-19. He will likely die unless he is soon intubated and ventilated. At the same time, Louise gives birth to her and her husband's first, very eagerly awaited child: a healthy but premature newborn infant, Judy. Judy, like all infants at her age and stage of development (23 weeks old and weighing only 600 g) needs to be intubated and ventilated or

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¹On March 2020, it was claimed that no matter which estimate we use, there simply are not enough ventilators for U.S. patients with COVID-19 in the upcoming months (Ranney et al. 2020).

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else she will likely die. Judy and Jim are in the same hospital. The adult ICU is full. There is only one ventilator left, and it can be used for either Jim or Judy. Who should get the ventilator?

Haward et al. (2020) raise several possible criteria for making the decision. One such criterion is the total number of life years lost when dying. For instance, a newborn infant that dies can be expected to lose roughly 80 life years, while a 75-year-old is likely to lose just a few years. However, because some adults who need ventilators have a survival rate higher than some extremely premature infants, it is not obvious which we should save.

Accounts that consider only the total life years lost—such as the deprivation account—cannot successfully explain which loss of life is the greatest loss to the one who dies. That is because what must also be considered, in addition to the life years lost, is the possible psychological connectedness and continuity of the one dying to his or her future self.

For instance, healthy 75-year-olds have strong psychological connections to their past and future selves. They remember what has happened to them, and they anticipate and care what will happen to them in the future.² However, in the relation between premature newborn infants and their future, adult selves, there is a much weaker degree of psychological connectedness.

McMahan (2002) has developed perhaps the most sophisticated theory relating the psychological continuity of one's future self to the ethics of killing and saving. According to McMahan, because of the very weak psychological link between infants and their future selves, an infant's time-relative interests in continuing to live are extremely weak. What this means is that death matters less for an infant at the time than it matters for the otherwise healthy septuagenarian.

The belief that death is not seriously bad for the fetus or the premature infant itself, explains, for instance, why we do not generally use more medical resources to prevent miscarriages (Ord 2008; Simkulet 2017). None of this necessarily means that the death of an infant does not matter at all, only that it does not matter much in comparison to the death of what can be called a standard human adult.³

²However, this is likely to change if the elderly is, for example, in an advanced stage of Alzheimer's disease. Then, his time-relative interests to live are reduced, perhaps to the level that of an infant. In related to this, it is argued elsewhere that according to utilitarianism we should save a patient who has normal brain function but fewer years to live than an unconscious dementia patient if we cannot treat them both (Savulescu et al. 2020).

³This view has some significant implications for the abortion debate as well, with regard to how much killing fetuses and infants harms them (see, for instance, McMahan 2007; Räsänen 2016).

This line of reasoning would further mean that if, during pandemics such as COVID-19, we decide whom we should save based on the intrinsic features of humans, we should prioritize adults over premature infants, since the death of an adult harms that adult more than the death of an infant harms the infant.⁴

Be that as it may, when we take into account other, extrinsic features, such as the distress and grief of the parents of the dying baby and the similar emotions of the relatives of the beloved dying elder, things get more complicated.

While the death of someone aged 75 undoubtedly brings sorrow and grief to those left behind, such death often is anticipated and considered a natural occurrence. However, the death of a young child is a very different thing. Many feel it is unnatural to outlive one's child. Losing a child might feel like the ultimate violation of the rules of life; people should die when they are old, not when they are young.

Losing a young baby, especially, can be emotionally overwhelming. At least one study shows that even six years after the loss of an extremely premature infant, the parents still suffer a lot from their bereavement (Büchi et al. 2007). The emotional impacts on the relatives can thus be assumed to be more severe when a premature baby dies than when an elder dies – despite the fact that according to the time-relevant interest account death harms an infant less than it harms an adult.

Taking into account the grief, distress, and sorrow that others will experience when Jim or Judy dies, there seems to be a compelling moral reason to save the infant rather than the elder: the death of the latter is less painful to his family members.

Therefore, whether we should save infants or the elderly in time of crisis depends, at least in part, on how much weight, if any, we give to the emotional impact of people's deaths on others or whether we make the decisions based solely on the intrinsic features of those at the risk of dying.

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⁴Another point worth mentioning is that if we understand resuscitating extremely preterm infants as creating life rather than saving it, as previously suggested by Rieder (2017), since we normally have a stronger reason to save a life than to create one, we should save the elderly.

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Racial Disparities in Premies and Pandemics

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As COVID-19 related hospitalizations surged in other countries and began to rise sharply in the United States, hospitals, healthcare systems, and states began to grapple with the terrifying question of what to do if ventilators became scarce. Centers began to develop protocols to guide how scarce resources would, if necessary, be allocated among different patients. Extremely preterm infants continue to be born during the pandemic and require critical care resources, including ventilators (not because of COVID-19 but because of their immature organ systems). Haward and colleagues address the question of how these fragile newborns should factor into scarce resource allocation protocols (Haward et al. 2020). The authors address important realities commonly encountered by the neonatology community. Their compelling arguments for supporting the claims of extremely premature infants to continued ventilator provision within these protocols include: existing bias against extremely premature infants, the difficulty in predicting the

outcome of a given extremely premature infant, and the absence of acceptable tools to compare long or short-term prognoses for an extremely preterm baby (“Judy”) against those of an adult (“Jim”). The authors rightly caution against the use of QALYs as potentially leading to ableist and ageist discrimination.

Haward and colleagues acknowledge that many groups have historically and currently encounter discrimination, however, the conversation of scarce resource allocation is not complete without addressing such inequities. Healthcare disparities are too closely intertwined with prematurity and COVID-19 outcomes to discount in hopes of “leveling the field” when considering whether Judy (the premature infant) or Jim (the septuagenarian) gets the ventilator. We must recognize disparities as they pertain to ventilator allocation protocols and wish to highlight racial disparities that have been exposed by the COVID-19 pandemic, and how these same disparities affect premature newborns.

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