

# On the Proposal Not to Vaccinate the Aged for COVID-19



By Barbara Pfeffer Billauer JD MA (Occ. Health) PhD — September 21, 2020

*As the possibility of a vaccine for COVID-19 draws nearer, so does the consideration of who is "first" in line to receive it. Should we protect the vulnerable, like the elderly, or reduce the spread by prioritizing "superspreaders"? More importantly, beyond this utilitarian consideration are there additional ethical concerns? Let's take a look.*



Image courtesy of pasja1000 on Pixabay [1]

To everything, there is a season

A time to be born, a time to die

A time to plant, a time to reap

A time to kill, a time to heal

A time to laugh, a time to weep

Ecclesiastes ch. 3 v. 8

There is, in the words of King Solomon, a time for everything. Most of us believe the time to die is directed by God, fate, or our own hand. In the upside-down world of COVID-19, alas, that's no

longer true. In parts of Italy, blanket decisions denied ventilators (thereby imposing a death sentence) on those over 65. In Sweden, elderly nursing home residents were denied hospital admission, even if indicated. In America, some hospitals predicated ventilator allocation decisions on a patient's disabilities until the Department of Human Services stepped in and ruled the practice illegal. [1]

Ventilator allocation has been a sweet subject for bioethicists and lawyers, whose job is to determine the legality of such actions given the myriad of statutes outlawing discrimination. While much of the literature focuses on disability rights, the analysis applies equally to the aged. The prevailing consensus is that maximizing the number of lives saved should be the primary goal in triage decisions, and neither age nor disability should lead the inquiry. Various objective methods help determine survivability – both to the medical intervention involved and longer-term. Dr. Dinerstein has written about the US medical approach [here](#) [2] and I have written more about the legal and bioethical approach when policy is based on flawed data. [2]

Till now, not much has been written about vaccine allocation in the context of COVID-19, although a comprehensive plan was just released by the National Academy of Sciences, entitled [Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID19 Vaccine](#) [3]. The document largely coalesces prevailing wisdom, concluding that the prime objective is to provide “the greatest benefit to the greatest number of individuals while the fewest resources are used.” In the context of COVID-19, the NAS authors conclude that “prioritization should balance two aims: saving the greatest number of lives and maximizing improvements in people’s length of life after treatment, ...for people with similar likelihood of benefit, resources should be allocated to those with the greatest urgent or acute need.” This would include older adults living in “congregate living quarters.”

There’s nothing new here. The report merely reminds us of the key function of health endeavors: to save as many lives as possible.

But in a September 4<sup>th</sup> article in *The Conversation*, entitled [Why COVID-19 vaccines need to prioritize ‘superspreaders’](#) [4], three professors (two economists and a biostatistical expert in genetic epidemiology) claim that when dealing with a novel virus, we need a new approach. Instead of prioritizing those with the greatest vulnerability, they argue that we should prioritize based on those most likely to spread the disease.

Arguing that the elderly aren’t spreading the disease (ignoring the fact that most oldsters are staying home because they are freaked out), these authors advocate vaccinating the “superspreaders,” who they claim are apparently all “young [and] ... highly social people with large circles of friends [and] who become fertile ground for spreading COVID-19.” (I guess oldsters don’t have large circles of friends or families or social and religious networks?).

Next, they claim that the younger group “have[sic] a much lower risk of death or even severe symptoms, which means they are more likely to infect others.” But here, their argument gets a bit fuzzy. First, they advocate prioritizing vaccination to the *vulnerable young* but then conclude that we should focus on transmission potential, not vulnerability.

But the overall point is plain. Lock up the old and vaccinate the young.– It’s logic is insidious. if we

can stop the spread, then we reduce disease and mortality. Right?

### **Not so fast.**

Let's not lose sight of the ethical constructs, the legal principles and public health practice. Because this proposal blanketly disfavors the aged, it is illegal. Because it focuses on group prioritization instead of individualized determinations, it is also unethical. [3] And because it is erroneously premised on containing spread, rather than prolonging life or reducing hospital load, it undermines the avowed purpose of public health law and practice.

Now, if vaccinating a unique subgroup could entirely eradicate the disease, it might have some merit. But their charming plan, itself, is flawed.

Somewhere between 30% and 50% of Americans plan on refusing any vaccine. In terms of efficacy, the FDA isn't holding its breath for more than 50% gaining vaccine-induced immunity. [4] Best case scenario is that we control disease transmission by 25%. Now that's good, but what happens when you release the oldsters (you guys were going to, weren't you – at some point?). We now have 75% of these kids, still susceptible to COVID-19, traipsing around, ready to infect the “virgin” elderly.

So– what have you accomplished? At some point, you'll infect a vulnerable group of oldsters --- who will overrun the hospitals -- and who had the conventional approach been used, would have been vaccinated, arguably saving their lives and preventing hospital overload.

Qui Bono –who benefits? A group of kids with a 97% chance of surviving without the vaccine -- and maybe even the fifty-something-year-old professors who wrote the article.

### **When we become evaluated by group/class, we lose our humanity**

In making triage decisions involving allocation of scarce resources, I suggest the approach needs to be holistic, encompassing ethical constructs legal principles, and public health practice. In more global terms, the question of who should be the first to receive the COVID-19 vaccine might be couched in terms of individual rights (including autonomy) versus a collaborative justice, doing “right” for society writ large. Bioethically speaking, I would prefer a more nuanced paradigm as articulated in the UNESCO Declaration on Bioethics and Human Rights. [5] As it applies to vaccination priority, several articles stated there are relevant:

- Article 3: The right of human dignity “The interests and welfare of the individual should have priority over the sole interest of science or society.”
- Article 11: Freedom from Discrimination and Stigmatization “No individual or group should be discriminated against or stigmatized on any grounds in violation of human dignity, human rights and fundamental freedom.”

In both instances, the rights of the individual are balanced with those of the groups. An emphasis on the welfare of the aggregate, by necessity, diminishes the importance of the individual. While this is a helpful heuristic, it breaks down in the moment of application. Decisions made on a group level descend to the level of ‘stereotyping,’ the arch offense of discrimination, and the subject of a legal inquiry. Selection of vaccine candidates by group-categories, especially when using age as a

replacement for individual qualifications, such as frailty or resilience, may be illegal.

In sum, “[t]he law [only] allows such discrimination based on a determination that the *individual* poses “a significant risk” that “cannot be eliminated by reasonable accommodation.” Such a determination must rest on “...an expressly ‘individualized assessment’ of the disabled person.” [6] Ethics requires us to consider the dignity of individuals. And public health practice mandates us focusing on saving as many lives as possible.

[1] [U.S. Civil Rights Office Rejects Rationing Medical Care Based on Disability, Age](#) [5] New York Times

[2] [The Bioethics of CoVid Care in the Elderly: Ventilation and Vaccines](#) [6] Social Science Research Network

[3] [Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 \(COVID-19\)](#) [7], Department of Health and Human Services

[4] [When Will There Be a COVID-19 Vaccine and Should You Trust That It's Safe?](#) [8], Newsweek

[5] [UN Declaration on Bioethics](#) [9] United Nations Educational, Scientific and Cultural Organization (UNESCO)

[6] [Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols](#) [10] Yale Law Journal

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**Links**

[1] <https://pixabay.com/photos/senior-elderly-people-couple-3336451/>

[2] <https://www.acsh.org/news/2020/04/06/how-do-we-ration-ventilators-14690>

[3] <https://www.nationalacademies.org/our-work/a-framework-for-equitable-allocation-of-vaccine-for-the-novel-coronavirus>

[4] <https://theconversation.com/why-covid-19-vaccines-need-to-prioritize-superspreaders-145232>

[5] <https://www.nytimes.com/2020/03/28/us/coronavirus-disabilities-rationing-ventilators-triage.html>

[6] [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3647276](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3647276)

[7] <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf>

[8] <https://www.newsweek.com/2020/09/25/when-will-there-covid-19-vaccine-should-you-trust-that-its-safe-1531604.html>

[9] <https://en.unesco.org/themes/ethics-science-and-technology/bioethics-and-human-rights>

[10] <https://www.yalelawjournal.org/forum/who-gets-the-ventilator>