Agencies such as the NIH and NSF have promoted public and community engagement with science and technology. Public engagement goes beyond public education and involves the exchange of information, ideas, and opinions among scientists, policy-makers, and the public. Public engagement is an ongoing dialogue that promotes mutual understanding of values, worldviews, and concerns and shared decision-making. Although engagement can build public trust in and acceptance of science and technology, the main goal of engaging the public is to ensure that policy decisions are just, fair, and democratic.

While much has been written about public understanding of science and science communication, public engagement of science is a relatively new topic in science and technology studies, and there are many empirical, practical, and theoretical questions that need to be investigated in greater depth. Research ethicists and philosophers of science can make important contributions to public engagement of science and technology by examining the ethical, social, and philosophical issues related to public engagement. By doing this, they can help to ensure that research ethics addresses the political philosophy of science.

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Prioritizing the Prevention of Early Deaths during Covid-19

I respectfully disagree with the ethical and legal analysis of the use of age to allocate scarce medical resources during the Covid-19 pandemic offered in “When Is Age Choosing Ageist Discrimination?,” by Tenelle Brown, Leslie Francis, and James Tabery (January-February 2021). Following the authors’ recommendation to remove the use of age as a tiebreaker in critical care allocation will worsen disparities and is not mandated by law.

One compelling reason to prioritize the prevention of death at earlier ages is that preventing early deaths will help address ethically unacceptable disparities in Covid-19 outcomes, a point Steven Joffe and I examine more extensively in an article forthcoming in the Journal of Medical Ethics. Minorities have been more than twice as likely to die before age sixty-five than have White Americans. Early deaths from Covid-19 among Black Americans have been so disproportionately frequent that, although this group makes up less than 15 percent of the U.S. population, a 2020 study by Mary Bassett, Jarvis Chen, and Nancy Krieger found that Black Americans have lost more total life years prior to sixty-five than White Americans. Early deaths from Covid-19 among Black Americans have existed both for critical care resources during the Covid-19 pandemic along with scarce resources and for vaccines, allocating resources for everyone, obviating the need for trade-offs among individuals or groups. But given that scarcity has (see “Variation in Racial/Ethnic Disparities in COVID-19 Mortality by Age in the United States: A Cross-Sectional Study,” PLoS Medicine); Native Americans and Hispanic and Pacific Islander Americans have also faced disproportionate burdens of early death. Seventy-eight percent of U.S. Covid-19 deaths before age twenty-one were those of minorities. Other vulnerable groups are also likelier to die earlier: people with Down syndrome, although they do not often live past seventy, face enormously greater risk. Rather than juxtaposing a fictional wealthy, well-educated person facing early death with a poor and oppressed person facing death at seventy, which is one scenario Brown et al. present, it would have been preferable to recognize the actual, unjust distribution of early Covid-19 deaths, which have overwhelmingly befallen minorities and people with life-shortening disabilities.

The authors may have been led to their conclusion—that age should not be used even as a tiebreaker—by regarding the “hallmark of unjust discrimination” as differentiation “between patients based solely on their membership in a group” (p. 13). But unjust discrimination involves the exacerbation of preexisting disadvantage, not the mere classification of individuals by group membership. Policies preventing early deaths prevent an outcome widely recognized as worse—dying earlier in one’s life rather than later—while counteracting intersecting forms of injustice. Literacy tests—the authors’ proposed analogy to age-based policies that prevent early deaths—are starkly different: they intentionally exacerbated disadvantage to promote racial exclusion.

The authors do not mention the widespread use of age cutoffs that favor older, rather than younger, adults in vaccine allocation. Age is a reasonable vaccine allocation criterion given the increasing risk of Covid-19 hospitalization and death in older Americans, though it is better used as one criterion among many than as a cutoff. Certainly, it would be preferable to have sufficient resources for everyone, obviating the need for trade-offs among individuals or groups. But given that scarcity has existed both for critical care resources and for vaccines, allocating critical care resources to prevent early deaths could valuably counterbalance the disproportionate exclusion of minority patients and those with life-shortening disabilities that age-based
vaccine allocation produces. The authors also overlook that regulations implementing antidiscrimination law explicitly permit using age as one criterion, whether for vaccines or critical care treatments: the U.S. Department of Health and Human Services explains that, under the nondiscrimination provision of the Affordable Care Act, it is permissible for a “transplant center to consider age as one factor in assessing the allocation of transplants” (see https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html).

The authors praise Utah’s removal of a tiebreaker that prioritized the prevention of early deaths. The law did not mandate this, and ethics should not welcome it. Utah later decided to deprioritize people under seventy for Covid-19 vaccines, even though around half of minority Covid-19 deaths happen before seventy. The tiebreaker whose removal the authors laud would have helped offset the inequities that age-based vaccine prioritization exacerbates, without costing lives.

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Teneille Brown, Leslie Francis, and James Tabery respond: We welcome Govind Persad’s thoughtful response to our essay and indeed any opportunity to highlight the many health disparities exposed by Covid-19. We agree that triage policies must be evaluated not just by their intent, but by their impact on vulnerable populations. However, Persad fundamentally misunderstands our legal and ethical points about this evaluation: we explicitly resisted pitting marginalized groups against one another and, rather, stated that decisions being made at the microlevel about which individual gets care must rest on individualized assessments of their condition, not assumptions about how people who fall into their category will fare.

Regarding our legal claims: We did not say that U.S. law explicitly prohibits any use of age in allocating care. Rather, the Age Discrimination Act prohibits “discrimination on the basis of age” (emphasis added). Uses of age are permitted that “reasonably take age into account” for the normal operation or achievement of statutory purposes or in “programs or activities established under authority of any law” that provide benefits based on age or establish criteria for participation based on age. The use of reasonable factors other than age is also not discrimination. Our contention was that the legal question is open whether age as a tiebreaker in crisis care standards meets this standard, particularly as crisis care committees do not have legislative authority.

Regarding our ethical claims: It may be “widely recognized” that “dying earlier in one’s life rather than later” is worse, but ethical and legal requirements do not always follow popular intuitions. But crucially, nowhere did we advocate for prioritizing age over race or other factors in a way that ignores how policies can lead to the “exacerbation of preexisting disadvantage.” Indeed, the risk of exacerbating disadvantage was our point (and incidentally, also relies on classifying individuals into groups). We just highlighted a different population, one that has received less attention as a victim of discrimination during the pandemic. That this group also happens to be dying in the greatest percentages and absolute numbers does not make our selection oblivious to disparities. Rather, it calls for more careful examination of whether a factor in these disparities may be discriminatory assumptions about whether the elderly members of society are worth saving.

Persad’s repeated references to preventing early death suggest that he has selected a distribution rationale that does pit one marginalized group against others. How far, we wonder, is he willing to go? Ignoring concerns about ageist discrimination in prioritization schemes would allow for combating racial health disparities because the older Covid patients are more often White. But so too would ignoring concerns about ableist discrimination against patients with cystic fibrosis in prioritization schemes combat racial health disparities because cystic fibrosis patients are more often White.

We reject the idea that bringing attention to one marginalized group necessarily entails deprioritizing or ignoring others. The concept of social determinants of health is broad enough to accommodate inequities related to age, poverty, race, and disability. Indeed, shining a light on the dangers of discriminatory actions toward one group can draw attention to that problem generally. The zero-sum-game approach to discrimination is an unfortunate byproduct of how antidiscrimination statutes developed, a theme we explore in a forthcoming article in the Saint Louis University Journal of Health Law and Policy.

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