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Rebuttal From Drs Sulmasy and Maldonado



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We argued against the unilateral withdrawal of life-sustaining treatments for reallocation on two grounds: theoretical, because we believe that such reallocation does not conform with widely accepted bioethical principles, and practical, in that implementation would be fraught with difficulties in the real world such that judgment errors and biased decisions would be unavoidable. Drs. Bishop and Eberl only address the former, and while we agree that strict utilitarian considerations are inadequate, we disagree with them on several points.¹

Their main argument is one of ethical exceptionalism—that we are in a war against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and that norms must change. We argue that it is precisely in situations of stress that we need to rely on norms so that we do not lose sight of our ethical duties. Analogizing the struggle against SARS-CoV-2 to a war has its own problems, but even if the analogy were to work, just as the “War on Terrorism” does not justify torture, so the struggle against the SARS-CoV-2 virus does not justify taking ventilators away from patients to give them to others that we think have a greater chance of benefit.

In fairness, Bishop and Eberl do not suggest that, even in war, “anything goes.” Two main principles in support of unilateral withdrawal within this “just war” have been proposed: the

rule of the double effect (RDE) and the equivalence thesis.^{2,3} We briefly addressed both but will focus on the former because it constitutes the cornerstone of their argument.

Not every difficult choice is governed by the RDE. The RDE only applies when one discrete action has two direct effects. For example, when administering morphine, the one act has the potential both to relieve pain and to slow respiration, so the RDE applies. This is what “double effect” means.⁴ Taking one patient off a ventilator, however, does not, of itself, do anything to save another patient's life. One must assess another patient, transfer that patient to the ICU, and hook that patient up to the ventilator. The RDE therefore cannot be invoked to try to justify reallocating ventilators. Under Eberl and Bishop's construal of the scope of the RDE, one could say that one only intended to help a needy family when one stole an automobile from a wealthy owner, and that one did not intend to deprive the owner of her property, provided the former needed it more. The RDE works only if it is kept within proper bounds. It is a category mistake to apply the RDE to ventilator reallocation.

Moreover, proponents of unilateral withdrawal of ventilators for reallocation purposes do not seem to appreciate that it is practically unrealistic and has the potential to exacerbate inequalities and biases already threatening currently proposed allocation frameworks.⁵ Just imagine explaining to a Black family that you are taking their mother off the ventilator even though she still has a fighting chance because a 21-year-old white man has just shown up and has a better chance of survival. Time-limited trials of intensive care are reasonable and ethically defensible, as are individual decisions including all relevant stakeholders and taking into account the particulars of each case. But capricious reallocations of life-giving treatments based on unproven algorithms are impractical and not ethically justifiable.

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FINANCIAL/NONFINANCIAL DISCLOSURES: None declared.

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DOI: <https://doi.org/10.1016/j.chest.2021.01.031>