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**WHAT THE HARM PRINCIPLE SAYS ABOUT
VACCINATION AND HEALTHCARE RATIONING**

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What The Harm Principle Says About Vaccination and Healthcare Rationing

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ABSTRACT

Clinical ethicists hold near consensus on the view that healthcare should be provided regardless of patients' past behaviors. In classic cases, the consensus can be explained by two key rationales – a lack of acute scarcity and the intractability of the facts around those behaviors, which make discrimination on past behavior gratuitous and infeasible to do fairly. Healthcare providers have a duty to help those who can be helped. In contrast, the COVID-19 pandemic suggests the possible recurrence of a very different situation, where a foreseeable acute shortage of healthcare resources means that some cannot be helped. And that shortage is exacerbated by the discrete decision of some to decline a free, safe, and highly effective vaccine, where the facts are clear. In such a future case, if healthcare must be denied to some patients, rationers who ignore vaccination status will become complicit in externalizing the consequences of refusing vaccination onto those who did not refuse. I argue that giving the unvaccinated person healthcare resources that would have otherwise gone to other patients is to wrongfully setback the interests, or harm, those patients. The article considers rejoinders around the voluntariness of the vaccination choice, which impinges both access and information, and how to scale this criterion proportionally with other rationing criteria that serve utility. Ultimately, the article speculates on why there will be some cognitive dissonance under this approach, while upholding a more general solidarity with and concern for all those seeking healthcare.

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I. Introduction

Those working in clinical bioethics hold a near consensus *against* what might be called, “retrospective moral discrimination in healthcare” (“RMDH”).¹ On this view, physicians and other healthcare providers should provide care consistently, without inquiring into the morality or prudence of their patients’ lifestyles or behaviors that precipitated the need for healthcare. Thus, someone brought to the emergency room with injuries from an automobile accident deserves the same care regardless of whether they are the innocent, sober victim in one vehicle or the guilty, drunken driver of the other vehicle.² Skiers with broken bones deserve the same care, regardless of whether they were carefully skiing on the proper groomed slopes or trespassing for thrills off-piste.³ Patients are owed the same cardiac care, regardless of whether one is morbidly obese due to a lifetime of overeating or is a fit and trim marathoner suffering from an overuse syndrome.⁴ In extremis, even terrorists or adversaries in war are thought to deserve the same impartial care as their victims.⁵

In accordance with this near consensus, the field of public health embraces an inclusive “ethic of solidarity,” largely rejecting the view that individuals should be held “personally responsible” for their own health, as “blaming and shaming” is neither fair nor effective for maintaining social bonds that are essential for health.⁶ From a somewhat different tack, political liberals also recognize that there is no

¹ In addition to sources cited below, *see e.g.*, Phoebe Friesen, *Personal Responsibility within health policy: unethical and ineffective*, 44 J. MED. ETHICS 53 (2008); Carissa Veliz, *Not the doctors business: Privacy, personal responsibility and data rights in medical settings*, 34 BIOETHICS 712 (2020); Robert M. Veatch, *Voluntary Risks to Health: The Ethical Issues*, 243 JAMA 50 (1980).

² Hugh V. McLachlan & J. Kim Swales, *A Drunk Driver, a Sober Pedestrian and the Allocation of Tragically Scarce and Indivisible Emergency Hospital Treatment*, 7 HEALTH CARE ANALYSIS 5 (1999); Martens Willem, *Do alcoholic liver transplantation candidates merit lower medical priority than non-alcoholic candidates?* 14 TRANSPL INT. 170 (2001) (arguing it is unwise to link medical priority to a patient’s responsibility as this would enable unfair discrimination between persons where we cannot assess validly the extent to which a patient is responsible for their condition).

³ Daniel Wikler, *Personal and Social Responsibility for Health*, in PUBLIC HEALTH, ETHICS, AND EQUITY 107 (Sudhir Anand et al. eds., 2004).

⁴ Eli Feiring, *Lifestyle, Responsibility and Justice*, 34 J. MED. ETHICS 33 (2008).

⁵ Michael Davis, *Terrorists are just Patients*, 9 AM. J. BIOETHICS 56 (2009) Michael L. Gross & Don Carrick, *The Limits of Impartial Medical Treatment during Armed Conflict*, in MILITARY MEDICAL ETHICS FOR THE 21ST CENTURY 71 (2013).

⁶ Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control*, 47 U.C. DAVIS L. REV. 121 (2013).

single metric by which a good life can be evaluated, and are thus hesitant to finger-waggingly blame people who choose one way or another.⁷

During the COVID-19 pandemic, U.S. hospitals announced that they must cancel surgeries and other procedures due to an overwhelming number of patients seeking treatment for COVID-19.⁸ And, during the surges when healthcare scarcity was real, those seeking healthcare for COVID-19 were almost all unvaccinated, even after the vaccines were proven safe and effective, and distributed broadly for free.⁹ If such a case arises again and difficult choices must be made about who does and does not consume acutely scarce healthcare, one must ask whether a patient's vaccination status in this situation is a special case, which should be distinguished and excluded from the general consensus against RMDH. The popular press has featured opinions going both ways on this question.¹⁰ In the scholarly literature, one

⁷Robert Crawford, *You Are Dangerous to Your Health: The Ideology and Politics of Victim Blaming*, 7 INT'L J. HEALTH SERVS. 663 (1977); Athmeya Jayaram & Michael Kates, *Political Liberalism and Public Health*, 21 AM. J. BIOETHICS 45 (2021); A W Cappelen & O F Norheim, *Responsibility in healthcare: a liberal egalitarian approach*, 31 J. MED. ETHICS 476 (2005).

⁸See e.g., Kay Lazar & Hanna Krueger, *Hospitals Postponing Thousands of Surgeries Amid Onslaught of COVID and Other Patients*, BOSTON GLOBE (Jan. 14, 2022), <https://www.bostonglobe.com/2022/01/14/metro/hospitals-postponing-thousands-surgeries-amid-onslaught-covid-other-patients/?event=event12> (stating the pandemic is “forcing hospital administrators to make heartbreaking choices to limit all but the most urgent surgeries and procedures. This extends even to some cancer surgeries, forcing doctors to weigh which tumors are growing faster and which slow enough to postpone care.”); Ariana Eunjung Cha & Meryl Kornfield, *Four Patients, Two Dialysis Machines: Rationing Medical Care Becomes a Reality in Hospitals Overwhelmed with Covid Patients*, WASH. POST (Sept. 17, 2021), <https://www.washingtonpost.com/health/2021/09/17/hospitals-ration-care-covid/> (“[A] critical care task force in Texas floated the idea of taking vaccination status into account — but the authors dismissed their own suggestion as a theoretical exercise following a public backlash.”); Drew Armstrong, *The Unvaccinated are Pushing Hospitals Past the Brink*, BLOOMBERG (Dec. 15, 2021), <https://www.bloomberg.com/graphics/2021-covid-surge-shows-overwhelming-cost-of-being-unvaccinated-america/> (“There are consequences to a health system locked up by Covid patients. There were still strokes, heart attacks and accidents coming in. (Two weeks after these interviews, a tornado struck the other side of the state, killing more than 70 people.) But hospital beds around the state were full, and transfers to other hospitals were nearly impossible.”).

⁹Krutika Amin & Cynthia Cox, *Unvaccinated COVID-19 Hospitalizations Cost Billions of Dollars*, HEALTH SYSTEM TRACKER, PETERSON KKF (Dec. 22, 2021), <https://www.healthsystemtracker.org/brief/unvaccinated-covid-patients-cost-the-u-s-health-system-billions-of-dollars/> (“[E]stimate that 98.6% of people hospitalized with a COVID-19 diagnosis between June and August 2021 were unvaccinated.”).

¹⁰Ruth Marcus, Opinion, *Doctors Should Be Allowed to Give Priority to Vaccinated Patients When Resources Are Scarce*, WASH. POST (Sept. 3, 2021), <https://www.washingtonpost.com/opinions/2021/09/03/doctors-should-be-allowed-give-priority-vaccinated-patients-when-resources-are-scarce/>; Daniel Wikler, Perspective, *When Medical Care Must Be Rationed, Should Vaccination Status Count?*, WASH. POST (Aug. 23, 2021), <https://www.washingtonpost.com/outlook/2021/08/23/refuse-covid-treatment-unvaccinated-triage/>; Teneille Brown, Opinion, *Of Course Hospitals in Crisis Mode Should Consider Vaccination Status*, WASH. POST (Sept. 23, 2021), <https://www.washingtonpost.com/opinions/2021/09/23/hospitals->

paper relies heavily on the classic RMDH view to argue against vaccine prioritization.¹¹ Another important albeit short piece has provided a framework for considering vaccination as a form of reciprocity.¹² Other peer-reviewed scholarly work has largely ignored or just mentioned in passing this potential criterion for rationing in a pandemic.¹³

Part II of this essay explores two key rationales – lack of acute scarcity and intractability of factual discernment – that support and explain the consensus in those classic RMDH cases. Without challenging the truth of RMDH in classic cases, I ask whether those same concerns apply to vaccination in a pandemic. When there *is* an acute shortage of healthcare resources that requires rationing at the point of care, and where vaccination status *is* readily verifiable and interpretable, there would seem to be valid distinctions from RMDH. The field is then open to evaluate vaccination on its own merits.

Part III presents the heart of the affirmative, seemingly-novel, argument. I will explore how a person’s decision to not vaccinate in a pandemic, when severe healthcare shortages are foreseeable, creates a risk of harm to other persons. When that harm materializes, healthcare providers must avoid becoming complicit in harm-doing. They should not assist unvaccinated individuals in externalizing consequences onto other persons by displacing their access to healthcare. Accordingly, these considerations suggest that for adult competent adults, vaccination status (or the application of a valid exemption) should be a valid criterion for the allocation of scarce healthcare resources in the pandemic.

ration-covid-vaccination-status/; Ed Yong, *It’s a Terrible Idea to Deny Medical Care to Unvaccinated People*, ATLANTIC (Jan 20, 2022), <https://www.theatlantic.com/health/archive/2022/01/unvaccinated-medical-care-hospitals-omicron/621299/>; Govind Persad & Emily Largent, Opinion, *In the Line for Scarce Covid Treatments, Immunocompromised Americans Should Go Before the Unvaccinated*, WASH. POST (Jan. 26, 2022), <https://www.washingtonpost.com/opinions/2022/01/26/line-scarce-covid-treatments-immunocompromised-americans-should-go-before-unvaccinated/>.

¹¹Olivia Schuman, Joelle Robertson-Preidler & Trevor M. Bibler, *COVID-19 Vaccination Status Should Not Be Used in Triage Tie-Breaking*, J. MED. ETHICS (2022).

¹²Govind Persad & Emily A. Largent, *COVID-19 Vaccine Refusal and Fair Allocation of Scarce Medical Resources*, 3 JAMA HEALTH FORUM (2022).

¹³Ezekiel J. Emanuel et al., *Fair Allocation of Scarce Medical Resources in the Time of Covid-19*, 382 NEW. ENG. J. MED. 2049 (2020); G. Srinivas et al., *Ethical Rationing of Healthcare Resources During COVID-19 Outbreak*, 16 ETHICS, MED. AND PUB. HEALTH 100633 (2021); Govind Persad, Monica E. Peek & Seema K. Shah, *Fair Allocation of Scarce Therapies for COVID-19*, CLINICAL INFECTIOUS DISEASES (2021).

This part of the article draws moral insights from analogous areas of law, especially torts. This framework is useful because it focuses on questions of harm, foreseeability, and causation, without aiming to punish, in its primary application, deployed here. I put aside more technical questions of whether and how various healthcare laws regulations might require or circumscribe the use of vaccination status in rationing.¹⁴

Part IV clarifies the application of the harm principle, in consideration of both fair competition and the act-omission distinction. Part V considers rejoinders around voluntariness of the vaccination choice, which impinges both access and information. We see that the problems are contingent, and in any case do not override the harm principle.

Part VI briefly considers how to scale this consideration proportionally with other rationing criteria, including those that serve utility. Finally, Part VII considers whether and why there will be some residual resistance to this approach in a deeply seated commitment to social solidarity, contrary to the reasoned analysis presented here. In this part, I explain why the pandemic context is so peculiar and how the slippery slope to outright patient-blaming can be avoided. Part VIII concludes.

Before launching into that argument, let me clarify the scope. First, the impermissibility of RMDH is exclusively because it is focused on *past* behavior. Nonetheless, the ethical consensus allows that for organ transplants, past behavior (e.g., an untreated ongoing alcohol addiction) could be ethically considered if it validly predicts *future* behavior, specifically behaviors that would cause the organ to be wasted.¹⁵ Similarly, there are also forward-looking reasons why vaccination status might be relevant to healthcare rationing. For example: if an unvaccinated person is unlikely to benefit from an intervention,

¹⁴See Persad & Largent, *supra* note 12 (arguing that vaccine priority would not violate the Americans with Disabilities Act or other U.S. laws).

¹⁵But see Peter V. Ubel, *Transplantation in Alcoholics: Separating Prognosis and Responsibility From Social*, 3 LIVER TRANSPLANTATION & SURGERY 343 (1997) (arguing the only reason to give alcoholic patients lower priority for transplantation is if they can be shown to have unacceptably poor transplant prognoses, which they have not.)

that would be a reason for instead providing the treatment to someone vaccinated.¹⁶ Or, being unvaccinated may actually predict greater marginal benefit, if a vaccinated person is likely to recover without the treatment. Outside the clinical moment, one could make a consequentialist argument that a policy of denying healthcare to unvaccinated people will cause more to get vaccinated *ex ante*. I am setting all these aside, in part because they rely on contestable and contingent empirical claims.¹⁷ Instead, let us focus on whether the backwards-looking fact that someone presents to a hospital having previously not been vaccinated could be relevant to a rationing decision.

Second, the thesis protects access to healthcare by all persons (vaccinated and unvaccinated) for both pandemic-related and other healthcare, that they would have received in a counterfactual world where there is a pandemic but where unvaccinated persons did not make disproportionate claims on scarce healthcare resources. This thesis says to unvaccinated people that healthcare rationers will try to minimize the externalization of harmful consequences of your decision to decline vaccination, by limiting you to the same levels of healthcare resources in the pandemic that you would have consumed, if you had not refused vaccination. At least in this domain where healthcare rationers must decide who gets what, you may gamble with your life, but not the life of others. Careful attention to this counterfactual emphasizes that the goal here is not to punish or express outrage against those choosing to decline vaccination, but only to cabin their harms.

Third, I repeatedly refer to “healthcare rationers” as whomever is performing the gatekeeping role of deciding who does and does not receive healthcare. In some cases these could be individual physicians acting with professional discretion. But there could also be hospital policies, payer policies, state crisis standard of care policies, or even federal regulations purporting to apply relevant laws (e.g. the Emergency Medical Treatment and Active Labor Act (EMTALA)). The present argument is fully

¹⁶Russell Teagarden & Arthur L. Caplan, Opinion, *If Covid Vaccine Refusers Are Turned Away at Hospitals and Doctor Offices, Is That Ethical?*, NBC NEWS (Aug. 24, 2021), <https://www.nbcnews.com/think/opinion/if-covid-vaccine-refusers-are-turned-away-hospitals-doctor-offices-ncna1277475>.

¹⁷See Schuman, Robertson-Preidler & Bibler, *supra* note 11; Persad, Peek & Shah, *supra* note 13.

normative, suggesting that whomever is doing this rationing has an obligation to consider vaccination status to avoid harming other patients.

II. True Scarcity and Factual Intractability

Social resources are always scarce in a general sense, and there has long been discussion about health policy and the need to set priorities, including the adjustment of insurance rates or the setting of taxes on this behavior or another.¹⁸ Nonetheless, outside a pandemic the sort of acute or absolute scarcity that requires rationing at the point of care is quite rare in affluent countries like the United States, primarily just applying to organ transplantation in normal times.¹⁹ In the other classic and ubiquitous opportunities for RMDH -- such as the drunken driver, the off-piste skier, or the overeater -- a healthcare provider is in fact able to provide reasonable healthcare to all those who need it. Rationing is not the issue, but rather just moral judgment as to their behaviors.

Several normative lenses show why RMDH would be wrong when no acute shortage requires rationing at the point of care. In terms of professionalism, the healthcare provider's role is not to judge and smite those who behave badly, but rather simply heal those who need help.²⁰ There is also the idea

¹⁸Alena M. Buyx, *Personal Responsibility for Health as a Rationing Criterion: Why We Don't Like it and Why Maybe We Should*, 34 J. MED. ETHICS 871 (2008); James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345 (1980); Maxwell J. Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, WIS. L. REV. 239 (1985); N. Eyal, P. L. Romain & C. Robertson, *Can Rationing Through Inconvenience Be Ethical?*, 48 HASTINGS CENT. REP. 10 (2018).

¹⁹Srinivas et al., *supra* note 13; Robert H. Jerry, *COVID-19: Responsibility and Accountability in a World of Rationing*, 7 J. L. AND BIOSCIENCES (2020).

²⁰Daniel Strech et al., *Are Physicians Willing to Ration Health Care? Conflicting Findings in a Systematic Review of Survey Research*, 90 HEALTH POL'Y 113 (2009); Wayne Shelton & John A. Balint, *Fair Treatment of Alcoholic Patients in The Context of Liver Transplantation*, 21 ALCOHOL CLINICAL & EXPERIMENTAL RSCH. 93 (1997); Paul McMaster, *Transplantation for alcoholic liver disease in an era of organ shortage*, 355 THE LANCET 424 (2000) (such policies would violate the patient-physician relationship by reducing trust); Leonard Glantz, *Should smokers be refused surgery?* 334 BRITISH MED. J. 21 (2007) (arguing that even if one is responsible for a negative health outcome, this should not result in restrictions of medical care, as such policies are asking the physician to play an inappropriate role in judging and blaming patients); Epiphany Cruz-Maxwell, Ian D. Wolfe & Liz Stokes, *Vaccination Discrimination Goes Against Nursing Ethics*, HASTINGS CTR. (Dec. 17, 2021), <https://www.thehastingscenter.org/should-covid-vaccinated-patients-get-priority-treatment/>; Douglas P. Olsen, *When the patient causes the problem: the effect of patient responsibility on the nurse-patient relationship*, 26 J. ADVANCED NURSING 515 (1997) (arguing that patients deserve the best nursing skill available, including a caring concern for them as persons regardless of any real or imagine culpability for their suffering).

that we should have solidarity with all persons or that all patients have a “right” to healthcare (even if that right is otherwise unrealized in the USA). Even without fleshing out the basis for solidarity or the source of such a rights-claim, we can suppose that it is not waived by mere imprudent, immoral, or illegal behavior. Perhaps most compellingly, from another perspective, in these routine cases, discrimination against some patients would be gratuitous – it harms those patients, without providing material benefits to anyone else. A simple consequentialist analysis (such as utilitarianism) counsels against RMDH in many of the standard cases.

In contrast for vaccination, at various times during a pandemic, hospitals may face acute (absolute) scarcity, whether of ICU beds, ventilators, drugs, or personnel, and they are accordingly cancelling procedures. In such situations of bed rationing, we may well feel solidarity with every single person who needs healthcare, but that does not undermine the practical necessity of denying a needed treatment to some. Under these conditions of acute scarcity, some patients will be deprived of needed treatments and perhaps die as a result, while other patients will receive the treatment and perhaps survive as a result. The question is not *whether* to deny patients, but unavoidably, *which* patients to deny. Thus, the first explanation for RMDH, which explains the vast majority of classic cases, does not fit so clearly with pandemic vaccination with acute scarcity.

Nonetheless, in cases like the liver-transplant, where there is real scarcity, the consensus against discriminating on past behavior needs another basis. That explanation is found in the difficulty of a healthcare rationer resolving the underlying facts, a problem I call “factual tractability.”

Philosophers debate an approach called “luck egalitarianism,” which would hold individuals responsible for the consequences of their culpable choices, unlike those that arise from brute luck, such as the genetic lottery.²¹ But for various reasons, luck egalitarianism is not the mainstream approach in

²¹See RONALD DWORKIN, SOVEREIGN VIRTUE: THE THEORY AND PRACTICE OF EQUALITY (2002); Richard Arneson, *Rawls, Responsibility, and Distributive Justice*, in JUSTICE, POLITICAL LIBERALISM, AND UTILITARIANISM: THEMES FROM HARSANYI AND RAWLS 80 (2008).

clinical bioethics. As I have argued, the primary problem is that for most practical bioethics and health policy questions, luck egalitarianism is just impossible to apply reasonably.²²

In classic RMDH cases, like the liver transplant, where rationing is actually necessary, the underlying facts are scalar (how much) rather binary (yes or no), and they are difficult to ascertain (exactly when did the liver cancer patient start drinking and in what amounts over the course of her lifetime, and what sorts of evidence can answer these questions). Generally these determinations must be made in relative terms, comparing the patient's (alleged) behavior to some normalized benchmark, which then requires ascertainment of whether the behavior was more or less than the customary amount (customary in given times and places where the patient may have lived). Moreover, in cases like alcohol use, there are epistemic questions about what was known or knowable about the risks at the various points in time the patient was making behavioral choices. Linking these difficulties are complex causal questions of fact, since it is not as if alcohol consumption is designed specifically to cause (or prevent) the disease in question, which is instead driven by a host of other behavioral, genetic, and environmental factors not all of which are fully known, generally or as applied to any one case.

If taken seriously by healthcare rationers, as befits a life-or-death decision, these sorts of investigations and determinations would require an entirely different set of personnel, skills, training, and institutional infrastructure, if they are possible at all. These questions are all factual, and thus require reliable evidence, including eyewitnesses, expert witnesses, and documents—as well as cross-examination and judgments as to their reliability and other indicia of admissibility. Parsing these problems would make the hospital look something like a court system, with investigators and prosecutors, a body of jurisprudence, and defense counsel (one hopes), along with the weeks, months, or even years to

²²See CHRISTOPHER T. ROBERTSON, *EXPOSED: WHY OUR HEALTH INSURANCE IS INCOMPLETE AND WHAT CAN BE DONE ABOUT IT*, ch. 4 (2019).

investigate and try such a case. All of that investment would distract from the core healthcare mission and would be utterly infeasible in emergent or even somewhat timely healthcare situations.²³

Thus, lacking the herculean investment and time to perform this judgment task appropriately, healthcare providers who proceeded nonetheless would largely be relying on their ignorant assumptions and subjective preferences. Such highly ambiguous and discretionary decisions are breeding grounds for bias. As Dan Wikler has said, “proposals to attach importance in health policy to imprudent health-related behaviour involve a great deal of hand-waving.”²⁴ In the classic cases of RMDH, it is better to not even go down that road.

In contrast, in a pandemic, a competent, adult patient’s decision to get fully vaccinated (or not) is a discrete medical decision, a fact that is either present in the medical records for many patients, or readily confirmable in jurisdictions that have vaccination registries.²⁵ States without such registries present a more difficult question, because vaccine cards can be lost (creating false negatives) or forged (creating false positives). Nonetheless, the lack of vaccine registries has not stopped many from advocating (even outside the pandemic context) for vaccine mandates tied to schools, employment, or travel and the implementation of some of these. Further work should explore whether reliance on cards could be supplemented by sworn statements, under penalty of perjury, perhaps backed up by audits. (Moreover, if the remainder of this argument goes through, it will provide a strong basis for creating universal registries so that this morally-salient fact can be more reliably tracked.)

Unlike a patient’s more-or-less, now-or-then practice of drinking alcohol, vaccine status is within the competence and capacity of healthcare providers to determine. The causal connection between being unvaccinated and getting the disease is quite clear and quantifiable, since of course vaccines are designed

²³ John Harris, *Could We Hold People Responsible for Their Own Adverse Health*, 12 J. CONTEMP. HEALTH L. & POL’Y 147 (1995).

²⁴Wikler, *supra* note 3 at 128.

²⁵Gail A. Horlick, Suzanne Feikema Beeler, & Robert W. Linkins, *A Review of State Legislation Related to Immunization Registries*, 20 AM. J. PREVENTIVE. MED. 208 (2001).

and tested with randomized trials, specifically for the purpose of quantifying their effects on preventing the specific disease. And we see those effects right in the very same hospital, in the disparate numbers of the vaccinated and unvaccinated presenting themselves for treatment.

For these reasons, the facts around a decision not to vaccinate can be ascertained. Of course, such a determination could be subject to certain well-specified and familiar exemptions, including for patients for whom vaccination is medically contraindicated. One such exemption could be for those who have sufficient immunity due to prior infection.²⁶

So far, I have only suggested that the facts around vaccination can be fairly ascertained by healthcare rationers, unlike the facts around other behaviors on which they may seek to discriminate. Nonetheless, there will be questions about how to morally evaluate the decision to not vaccinate. Some will yield relatively straightforward exemptions, including for those such as children, who were not competent to make an intelligent choice about whether to accept the vaccine. These sorts of factors are also squarely within the competence of healthcare providers to evaluate, since they make similar determinations routinely in evaluating competence to accept healthcare.

More broadly, some may seek to question the voluntariness of the vaccination decision, arguing that in a particular time and place, there is not enough access to the shots or that there is too much misinformation to hold people accountable for their vaccination decisions. These issues are best addressed below (Part V) after laying out a moral framework for vaccination, in the next part.

²⁶ Compare Jonathan Pugh, et al. *The Unnaturalistic Fallacy: COVID-19 Vaccine Mandates Should Not Discriminate Against Natural Immunity*, _ J MED ETHICS 1,3 2022, published online ahead of print (“on the basis of existing data, it is plausible that naturally acquired immunity may be as good as the degree of vaccine-mediated immunity required by proposed mandates”); Thiago Cerqueira-Silva, et al., *Effectiveness of CoronaVac, ChAdOx1 nCoV-19, BNT162b2, and Ad26.COV2.S Among Individuals With Previous SARS-Cov-2 Infection In Brazil: A Test-Negative, Case-Control Study*, _ LANCET INFECTIOUS DISEASE 1 (2022), published online ahead of print (“All four vaccines conferred additional protection against symptomatic infections and severe outcomes among individuals with previous SARS-CoV-2 infection. The provision of a full vaccine series to individuals after recovery from COVID-19 might reduce morbidity and mortality.”) While public health experts remain divided on the value of getting vaccination if previously infected, for the present purposes the issue may be largely moot. If in fact, those relying on natural immunity receive equivalent protection as to vaccines, then they would very rarely need hospitalization for the pandemic illness, and thereby would not harm other persons.

III. Complicity in Foreseeable Harms

Together, these two points—lack of acute scarcity and factual intractability—explain the ethical consensus against RMDH in the classic situations, where de-prioritizing healthcare for “bad” patients would be gratuitous and infeasible to do reasonably well anyway. But, as we have seen, these considerations do not apply nearly so clearly to vaccination in a pandemic, where scarcity is real and facts are clear. In my view, without undermining its general status, we have largely neutralized the force of the consensus against RMDH as applied to the case of pandemic vaccination.

But we should go further than neutrality if there is an affirmative, moral argument in favor of deprioritizing healthcare for unvaccinated people seeking care for the very same illnesses that the vaccine would have prevented or at least mitigated the need for so much healthcare, if doing so can protect the access to healthcare for other persons who would have received that access, but for others refusing to vaccinate. This argument arises from the moral nature of the vaccination decision, as one that can be fairly viewed as consequential. This argument has three subpoints, recognizing that being unvaccinated (a) risks harms to others, (b) which are foreseeable, and (c) which are perpetrated through the healthcare rationing.

This argument demands clarity about whether and how we should judge the decision to not vaccinate under the specific circumstances of a pandemic where it is proven safe and effective and offered conveniently and for free. As noted, many ethicists embrace political liberalism, recognizing that there is not a single overarching conception of the good life, and that individuals have a liberty to choose whatever path they may prefer, within certain bounds.²⁷ In the classic cases, this liberalism brings a normative buttress to the consensus view against RMDH, making it not just hard to resolve the facts, but conceptually impossible to pass judgment over those who might ski off-piste, overeat, or drink too much wine. Those skiers, eaters, and drinkers may have (and apparently do have) different conceptions of the

²⁷See sources cited *supra* note 7.

good life compared to those sitting in judgment. In this sense, it is not just hard, but wrong, to pass judgment.²⁸

In contrast, many ethicists, and even liberal ethicists, favor certain mandates for vaccination.²⁹ Liberal ethicists who embrace mandates must reject the premise that the choice to vaccinate is one of sheer liberty, deserving of liberal deference. Instead, it is permissible to attach consequences to the vaccination decision (via “mandates”), whether losing the privilege of flying on airlines or perhaps even losing one’s job. In making such judgments, liberals need not purport to deliver cosmic justice, evaluating the entire worth of a person. Instead, we deliver discrete justice, attaching specific consequences to specific behaviors, as is routine in a legal system. For this reason, unvaccinated persons can lose their jobs, without inquiry into other aspects of their moral worth—for example, whether they also kick puppies or donate to charities. Such policies are routinely implemented with a narrower lens.

Why would such vaccine mandates be permissible, even to liberal ethicists? The rationale is not primarily paternalistic (“do it because it is good for you”). It is hard to justify the role of the state in protecting people from themselves, since adults of sound mind are typically in the best position to know and promote their own interests. Instead, the liberal rationale for a mandate is that vaccination protects *other people*.³⁰ In the language of economics, we would say that if unvaccinated persons spread infections to others, or deny them access to healthcare, it is an “externality,” the classic example of a market failure that demands state intervention.³¹ In the language of political philosophy as developed by John Stuart Mill and Joel Feinberg, those denied healthcare due to pandemic rationing have their interests set back,

²⁸Daniel I. Wikler, *Persuasion and Coercion for Health: Ethical Issues in Government Efforts to Change Life-Styles*, 56 THE MILBANK QUARTERLY 303 (1978).

²⁹RACHEL KATZ, LEADING HEALTH CARE EXPERTS AND PROFESSIONAL ORGANIZATIONS: BUSINESSES SHOULD SUPPORT OSHA’S COVID VACCINATION MANDATE (Nov. 18, 2021) (available at <https://www.amcp.org/sites/default/files/2021-11/Statement%20Supporting-OSHA-COVID-Requirement.pdf>).

³⁰ See *Jacobson v. Massachusetts*, 197 U.S. 11, 29 (1905) (“[I]n every well-ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand.”).

³¹ Christopher T. Robertson et al., *Indemnifying Precaution: Economic Insights for Regulation of a Highly Infectious Disease*, 7 J. L. AND BIOSCIENCES 1 (2020).

due to the wrongful behavior of others declining to vaccinate.³² That is to say that the other patients are “harmed” by the unvaccinated.

To be clear, the thesis here is not that unvaccinated people should be blamed for failing to take “personal responsibility.” For this same reason, public health scholars support laws that limit smoking in the workplace, because second-hand smoke is harmful to others, even if the smokers should not be shunned and shamed when they seek treatment for chronic obstructive pulmonary disease.³³ The consequences *for others* raise a quite distinct question.

Morally and legally, we do not hold people accountable for *all* the consequences of their behaviors, and especially not when the behavior is due to mere negligence. This is another reason why we do not hold a liver cancer patient accountable for drinking too much, even when there is true scarcity of organs for transplantation. *Ex ante*, if a doctor or a friend were listing all the reasons to moderate your drinking, they might mention the risk of cancer. But they would not typically go further to say that a reason to be moderate is to avoid needing an organ transplant, and specifically taking an organ that someone else needed.³⁴ While that may be a factual consequence, it is not one that is foreseeable in the sense that it creates a reason to moderate your drinking in the first place. In the old language of tort law, we could say that the drinking is not a “proximate cause” of the organ scarcity and exacerbating the organ shortage is not a “foreseeable risk” of drinking immoderately. In this context of allocating scarce organs, we may overlook the patient’s history of drinking.

Here again, we see a contrast with vaccination. The consequences of being unvaccinated in a pandemic are much more clearly foreseeable, in part due to the literal immediacy of cause and effect.

³² JOEL FEINBERG, *HARM TO OTHERS* (1987). *See also* JOHN STUART MILL, *J.S. MILL: 'ON LIBERTY' AND OTHER WRITINGS* (1989) (“The only purpose for which power can be rightly exercised over any member of a civilized community against his will, is to prevent harm to others. . . . The only part of the conduct of anyone, for which he is answerable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his body and mind, the individual is sovereign.”).

³³ Matthew Shiu, *Refusing to treat smokers is unethical and a dangerous precedent*, 306 *BRITISH MED. J.* 1048 (1993).

³⁴*See* RESTATEMENT (THIRD) OF TORTS § 29 (“An actor’s liability is limited to those harms that result from the risks that made the actor’s conduct tortious.”).

Specifically, the acute scarcity in the healthcare system is a foreseeable part of being in a pandemic, and that threat is among the key reasons to be vaccinated in a pandemic.³⁵ This fact becomes more obvious every day that the pandemic proceeds.³⁶

Of course, the risk materializes through aggregate action—a single person’s decision to be unvaccinated does not alone create a shortage of ICU beds, but once the risk materializes the given unvaccinated person at the hospital demanding healthcare for COVID-19 is quite proximately threatening to take healthcare that would otherwise be consumed by another patient. And of course, it is not necessary that the unvaccinated person know the specific identity of the person(s) whom they risk harming; we have no problem recognizing that highway deaths are a foreseeable risk of drunk driving or drag racing, even if the driver does not know who specifically they will kill.

Recognizing the existence of foreseeable harms due to rationing, at this point our lens shifts back to the healthcare provider, or other policymaker, who must ration in a pandemic. The familiar, ancient principle of *primum non nocere* advises to *do no harm*. A healthcare provider need not judge or punish those seeking care, but if she must ration, she must do so in a way that avoids complicitly harming patients.³⁷

In fact, healthcare providers already recognize the duty to implement policies and practices to protect patients from harm due to behaviors by fellow patients.³⁸ In nursing homes, theft seems to be a

³⁵Joseph Biden, President, Remarks on Fighting the COVID-19 Pandemic (Sept. 9, 2021) (“The unvaccinated overcrowd our hospitals, are overrunning the emergency rooms and intensive care units, leaving no room for someone with a heart attack, or pancreitis [pancreatitis], or cancer.”); Dakin Andone & Susannah Cullinane, *Omicron 'Is Going to Take Over' this Winter, and Fauci Says Americans Should Brace for a 'Tough Few Weeks to Months'*, CNN (Dec. 20, 2021), <https://www.cnn.com/2021/12/19/health/us-coronavirus-sunday/index.html> (“We need to protect our health care system . . . and that's why every American needs to mask up and vax up right now because our health care infrastructure is at stake right now.”); *see also* Nikki Bromberger, *Paying for Risky Decisions: Civil Liability of Non-Vaccinators*, 24 J. L. AND MED. 662 (2017).

³⁶*See* sources cited *supra* note 8.

³⁷CHIARA LEPORA & ROBERT E. GOODIN, ON COMPLICITY AND COMPROMISE (2013).

³⁸One could clarify that in the rationing scenario the dilemma may sometimes be between potential patients, neither of whom has yet formed a doctor-patient relationship. More generally, law and ethics has recognized a duty to protect third parties from foreseeable harms as well. *See Tarasoff v. Regents of Univ. of California*, 17 Cal.3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (Sup. Ct. 1976).

real problem, and lax security could make a provider complicit.³⁹ In psychiatric care, patient-to-patient violence, and even homicide, is a known problem to manage.⁴⁰ Beyond thievery and overt violence there are other mechanisms for patient-to-patient harm. If a hospital knowingly placed a patient or other person in a shared room to smoke cigarettes next to another patient recovering from lung surgery, the hospital would be complicit in the harm caused. Likewise, if a hospital worker left a computer terminal unattended and thereby provided a person's access to a patient's medical records, the hospital would be complicit in the eventual breach of privacy. As explained in further detail below, for pandemic rationing, the mechanism for avoiding such complicity in harm is to, as close as possible, give patients the same level of care they would have in the counterfactual world in which the unvaccinated persons were not creating or exacerbating the resource scarcity.

Accordingly, when advising that physicians may decline to serve unvaccinated patients, the American Medical Association (AMA) has contemplated an interpatient harm mechanism via infection, *viz*, “the risk the patient may pose to other patients in the physician’s practice.”⁴¹ Indeed, even more on point, the AMA seems to recognize that physicians may decline to treat unvaccinated patients “if meeting the individual’s medical needs would ‘seriously compromise’ the physician’s ability to provide care needed by their other patients.”⁴² Even outside the pandemic, some pediatricians decline to have unvaccinated children in their waiting rooms, where they could pose a risk to others. In 2016 the American Academy of Pediatrics set a policy in support of such an approach.⁴³

³⁹Diana K. Harris & Michael L. Benson, *Nursing Home Theft: The Hidden Problem*, 12 J. AGING STUDIES 57 (1998).

⁴⁰Olav Nielssen & Matthew Large, *Homicides in Psychiatric Hospitals: Absence of Evidence or Evidence of Absence?*, 32 CRIM. BEHAV. AND MENTAL HEALTH 60 (2022).

⁴¹*Can Physicians Decline Unvaccinated Patients?*, AM. MED. ASS’N (Sept 15, 2021), <https://www.ama-assn.org/delivering-care/ethics/can-physicians-decline-unvaccinated-patients>.

⁴²*Id.*

⁴³Kathryn M. Edwards et al., *Countering Vaccine Hesitancy*, 138 PEDIATRICS e9 (2016) (“[T]here are dilemmas for the many pediatricians who continue to care for these families, including potentially exposing other patients to vaccine-preventable diseases from those who are unimmunized. . . . The individual pediatrician may consider dismissal of families who refuse vaccination as an acceptable option.”). Note that this policy automatically expired after five years, and as of this writing is under review.

We have, then, the *prima facie* case for understanding that when a person declines vaccination and then seeks to take scarce healthcare resources to treat the very illness that vaccination would have prevented, displacing others who would have received those healthcare resources -- it is a wrongful setback to their interests. That is a harm that rationers should not facilitate. In what follows, I consider a range of rejoinders to this harm-based approach.

IV. Fair Competition and Affirmative Duties

Here I explore two (technical) objections that press against the harm-based approach. First, one could deny that there are harms at all when competing for healthcare resources. Second, one could emphasize that harm requires action, and claim that declining to act, in this case declining to get vaccinated, cannot be harmful to all. Both objections are misplaced.

The first objection concerns the nature of the competition for scarce healthcare, and seeks to deny that in this context there can be harms, properly conceived. Both Mill and Feinberg recognized that persons have their interests set back ubiquitously—every time we lose a tennis match or a job to some other competitor, we would of course prefer to have won it ourselves.⁴⁴ Even though losing hurts, these “fair competitions” (as Feinberg calls them) do not constitute harms, because they are not wrongful. One might argue that everybody has a *prima facie* right to healthcare in a society, and thus a right to compete when healthcare resources are scarce. There are no wrongs, in such a situation, and no harms.

Nonetheless, as both Mill and Feinberg recognize, the classic cases of these fair competitions have either of two key indicia: voluntariness or unavoidability.⁴⁵ Some fair competitions, like the tennis match, are entered voluntarily by both parties through something resembling informed consent, which implies the possibility of coming out with fewer points, and thus being the loser. But a pandemic is not a game: vaccinated folks in no way consented to being in a death match with unvaccinated persons. Other

⁴⁴FEINBERG, *supra* note 32, at 219; *see also* Hamish Stewart, *Harms, Wrongs, and Set-Backs in Feinberg's Moral Limits of the Criminal Law*, 5 BUFF. CRIM. L. REV. 47 (2001).

⁴⁵FEINBERG, *supra* note 32, at 220.

fair competitions, like the job search, are unavoidable, part of the very nature of having only one job available for two (or more) applicants. In contrast, in the pandemic case, the acute healthcare shortage is created or exacerbated specifically by one group of persons, the unvaccinated, who dramatically increase their claims on healthcare resources. By assumption in the limited scope of the current argument, if the unvaccinated had simply gotten vaccinated, the death match for this particular person at the hospital door could have been avoided. Thus for these two reasons we understand why a victim is harmed when they get punched in the face on the street; we do not creatively reinterpret every such mugging as if it were a fair and voluntary boxing match.

The implicit principle can be made explicit: system healthcare capacity is a collective resource to which each person has a right to claim their fair share of access in a pandemic, and in doing so they must compete with others on neutral rationing criteria, even if their personal interests are instead to receive maximal healthcare. Losing in such a fair rationing competition is just a setback, not a harm, strictly speaking. But when some refuse to take the reasonable step of vaccination, they claim more than their fair share of the limited healthcare resources. In such a case, displacing others would be a *wrongful* setback to their interests, or a harm.

Still, why does vaccination define the moral baseline for fair competition, both as necessary and sufficient? It is necessary, because failing to do so creates foreseeable, proximate harm to others. It is sufficient because it seems to be the only tractable criterion. An alternative, more capacious baseline would be to argue that patients must behave *reasonably* in the pandemic all-things-considered. Perhaps we would be tempted to de-prioritize a patient who attended a crowded wedding, for example? Factually, how many people attended the wedding? Was the patient closely related to the bride or groom, or just attending for fun? How good was the ventilation? When did the patient go to the event and what was the local COVID-19 case rate at the time? Did the patient wear a mask, and if so which type, and how well fitted was it? Resolving these sorts of facts would be impractical for the healthcare rationer, even if she were competent to then evaluate them. As explained above, vaccination is a discrete medical decision,

often present in the medical record itself, with clear and consistent public health direction about the reasonableness of undertaking the behavior.

As a second rejoinder, one might invoke the (controversial) distinction between acts versus omissions or misfeasance versus nonfeasance.⁴⁶ Maybe, as some have suggested, persons who decline to get vaccinated do not harm anyone, but merely decline to take “an action that presents a benefit to others” against the exogenous threat of the pandemic.⁴⁷ Even on these terms, one could argue for a “reciprocity” system, where people give a benefit (vaccination) to get a benefit (priority access to healthcare), and would perhaps end up in the same policy place.⁴⁸ But that is not the argument here.

Concededly, the harm principle, like the law of negligence, does not generally require that people take affirmative steps to help other people (that is the principle of beneficence instead).⁴⁹ Yet, to be sure, culpable omissions are often the basis for liability—a surgeon may fail to wash her hands against the exogenous risk of bacteria, a landlord may fail to shovel her steps covered by snow that fell overnight, or a manufacturer may fail to properly warn users of risks when a product is used in certain circumstances. When there are broader policy reasons to impose a duty to act, these are unproblematically understood as cases of harmdoing. The theory of breach is that a person failed to take a precaution she should have taken. Accordingly, reframing the terms somewhat, the contemporary legal approach, reflected in the Restatement Third of Torts, resolves that liability for misfeasance applies to those who *create risks*.⁵⁰

⁴⁶J. Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975); Marc Stauch, *Causal Authorship and the Equality Principle: A Defence of the Acts/Omissions Distinction in Euthanasia*, 26 J. MED. ETHICS 237 (2000); see also Julian Savulescu, Ingmar Persson & Dominic Wilkinson, *Utilitarianism and the Pandemic*, 34 BIOETHICS 620 (2020) (“For utilitarians, how an outcome arises is morally irrelevant. It makes no difference if it is the result of an act, or an omission.”).

⁴⁷Voo Teck Chuan et al., *Should Covid Vaccination Status be used to make Triage Decisions?*, HASTINGS CTR. (Aug. 31, 2021), <https://www.thehastingscenter.org/should-covid-vaccination-status-be-used-to-make-triage-decisions/>.

⁴⁸Persad, Peek & Shah, *supra* note 13; Persad & Largent, *supra* note 12; see also Christopher Tarver Robertson, *From Free Riders to Fairness: A Cooperative System for Organ Transplantation*, 48 JURIMETRICS 1 (2007).

⁴⁹See generally Kenneth S. Abraham & Leslie Kendrick, *There's No Such Thing as Affirmative Duty*, 104 IOWA L. REV. 1649 (2018) (reviewing this law).

⁵⁰RESTATEMENT (THIRD) OF TORTS § 37 (“An actor whose conduct has not created a risk of physical or emotional harm to another has no duty of care to the other unless a court determines that one of the [affirmative duty exceptions] is applicable.”).

Thus, a driver who declines to step on her brakes at a red light cannot claim that it was a mere omission, since the very act of driving created the foreseeable risk of collision in the first place.⁵¹ Analogously here, a person who unreasonably declines vaccination creates various risks, including the risk of getting infected and the risk of passing along those infections to others, but also the risk of exacerbating healthcare shortages.⁵² When such vaccine refusers later make a greater claim on the healthcare resources than they otherwise would, the displacing of other patients counts as a harm to them.

Concededly, such talk of affirmative duties again begs questions about the moral baseline, though not perhaps any more than any other moral theory.⁵³ Ultimately, the harm principle rides on more fundamental questions of social policy, to solve collective action problems, specifically here, the taking of optimal precautions to minimize the overall cost of the pandemic.⁵⁴

While more could be said about the act-omission distinction (for whatever it is worth) as applied to the primary decision about whether to vaccinate oneself, the problem disappears altogether when thinking of the role of the healthcare provider, or whomever does rationing of scarce healthcare resources. When undertaking (the act) of rationing, failing to attend to a morally-relevant criterion (vaccination) is no different than applying a morally-irrelevant criterion (such as race), when deciding who will and will not receive care.⁵⁵ When serving as the gatekeeper, deciding who lives or dies for lack of healthcare, one can hardly demur claiming to do nothing at all.

⁵¹See John C. P. Goldberg and Benjamin C. Zipursky, *The Restatement (Third) and the Place of Duty in Negligence Law*, 54 VAND. L. REV. 657, 691 (2001) (“The driver's careless failure to apply the brakes is negligent driving, not negligent failure to rescue, and we do not need a specialized vocabulary to tell us that.”).

⁵²See RESTATEMENT (THIRD) OF TORTS § 39 (“When an actor's prior conduct, even though not tortious, creates a continuing risk of physical harm of a type characteristic of the conduct, the actor has a duty to exercise reasonable care to prevent or minimize the harm.”).

⁵³See Richard A. Epstein, *The Harm Principle - and how It Grew*, 45 U. TORONTO L. J. 369, 378 (1995) (discussing edge cases that cause “embarrassment to the straightforward harm principle[, which] Mill gets to the right answer . . . by his appeal to the ‘common admission of mankind.’”).

⁵⁴See generally CHARLES FRIED & DAVID ROSENBERG, *MAKING TORT LAW* (2003).

⁵⁵ARISTOTLE, *NICHOMACHEAN ETHICS* 118-20 (1962) (treat like cases alike; different cases differently); H.L.A. HART, *CONCEPT OF LAW* 155-64 (1994) (same).

V. Voluntariness with Limited Access and Information

These three considerations—true scarcity, a discrete medical choice, and the problem of complicity in harming other persons via healthcare rationing—suggest that allocating healthcare to unvaccinated persons is quite different than the classic cases of retrospective moral discrimination in healthcare (RMDH). Nonetheless, one might argue against application of this criterion to a healthcare rationing situation, by suggesting that the decision to decline vaccination is not really a free, informed choice for which one can be held accountable.

As Dan Wikler has said, “actions only rarely have all the attributes—informed, voluntary, uncoerced, spontaneous, deliberated, etc.—that, in the ideal case, are preconditions for full personal responsibility.”⁵⁶ This could be yet another reason why clinical ethicists do not hold people who use addictive substances accountable for their behaviors. On the other hand, if actions rarely have all those idealized attributes of voluntariness, we must not routinely require ideal conditions when we allow choices that have consequences.

For the present argument, the particular concern is that some persons may not have reasonable access to the vaccine, and thus do not really make a choice to decline it. At least at certain times and places during the COVID-19 pandemic this concern was substantial, when sheer scarcity made it onerous on some populations to find an available dose. This problem was exacerbated for homebound, disabled, and other persons who are so busy working or providing childcare that it was difficult to find time to get vaccinated. At other times and places, this concern was largely mitigated by the facts that the vaccine had been provided at zero cost out-of-pocket and was widely available, not just via healthcare providers but also at a range of neighborhood sites. Indeed, economic gradients appeared in vaccine uptake, and we can infer that some of this disparity reflects access rather than choice.⁵⁷ Still, later in the pandemic, as

⁵⁶Wikler, *supra* note 3.

⁵⁷Govind Persad, *Allocating Medicine Fairly in an Unfair Pandemic*, 2021 U. ILL. L. REV. 1085.

vaccination vans roam neighborhoods and cities pay people to get vaccinated, the lack of “access” seems increasingly theoretical, as survey evidence bears out.⁵⁸

A second concern that undermines the moral force of the choice not to vaccinate is that the decision may be made on the basis of misinformation. One could imagine extreme situations where a patient had no relationship with a trusted healthcare provider, were locked in a room with only propagandistic television blaring 24-hours a day, and no access to the internet to consult reliable sources. Such a person could be viewed more as a victim of indoctrination than as a perpetrator of wrongdoing. This problem may well cut along political lines in the future, just as it did under COVID-19.⁵⁹ For many, the choice not to vaccinate is the choice to buy into an ideology and identity that prizes a contrarian perspective that disvalues the risk to vulnerable persons, and then curates media to reinforce that belief, while avoiding or downplaying contrary evidence.

Aside from politics and ideology, one might also be concerned with educational disparities and lack of trust in the healthcare system, driven by historic exclusion and exploitation.⁶⁰ In this light, one might worry that vaccination priority would worsen disparities. Nonetheless, as Persad and Largent review the empirical evidence later in the COVID-19 pandemic, it becomes clear that “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.”⁶¹ Thus, the racial disparity story is not borne out. Moreover, in constructing a fair rationing policy, one must remember that disadvantaged persons could be

⁵⁸Nicholas Holtkamp, Jessica Marus and Tamia Ross, *Trends in COVID-19 Vaccination Intentions*, ASPE (Apr. 5, 2022), <https://aspe.hhs.gov/reports/trends-covid-19-vaccination-intentions> (“Survey responses indicate that over the time period of our study vaccine cost and accessibility have not been major impediments to vaccine uptake.”).

⁵⁹Christopher T. Robertson et al., *Effects of Political Versus Expert Messaging on Vaccination Intentions of Trump Voters*, 16 PLOS ONE e0257988 (2021).

⁶⁰Compare Gregory L. Hall & Michele Heath, *Poor Medication Adherence in African Americans is a Matter of Trust*, 8 J. RACIAL AND ETHNIC HEALTH DISPARITIES 927 (2021), with Hala T. Borno, Ghilamichael Andemeskel & Nynikka R. Palmer, *Redefining Attribution from Patient to Health system—How the Notion of “Mistrust” Places Blame on Black Patients*, 7 JAMA ONCOLOGY 780 (2021) (“Amplifying the influence of mistrust implicitly places blame on patients without acknowledgment of the larger structural determinants, such as racism, that create circumstances of disadvantage for certain populations receiving care in the US health system.”).

⁶¹See Persad & Largent, *supra* note 12.

on either side of the ledger, either as the unvaccinated patient making disproportionate claims on healthcare resources or as that other patient who would have gotten the care instead.⁶²

These two concerns about voluntariness have facial validity, but they are contingent and defeasible. In a future pandemic, these sorts of contingent facts will need to be evaluated before assessing that all persons can be held accountable if they decline to vaccinate, but it seems dogmatic to suggest that a reasonable degree of access and choice could never be attained. To be sure, at any point on these gradients of information and access, policymakers should consider additional efforts to maximize access and minimize disinformation.⁶³ For example, vaccinations can be delivered door-to-door. The government might also do a better job of communicating to diverse sectors of society, for example, using spokespersons that have broader political appeal. In addition, prior to implementation, a policy that vaccination status will be considered in rationing decisions should be announced and disseminated broadly, which may (or may not) further increase the rate of vaccinations or at least add another informational opportunity.⁶⁴ Before such a policy should be implemented, a more systematic approach to recording vaccine status might also be required.⁶⁵

Fundamentally, however, there is a normative mismatch between this concern about voluntariness and the problem at issue here. When scholars say, “it may be difficult to know the true reasons a patient is unvaccinated,” it is true enough.⁶⁶ But also completely inapposite, because for preventing one person harming another, we employ an objective, rather than subjective standard.⁶⁷ Accordingly, the question is

⁶²*Id.* (“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 (e.g., intensive care unit beds).”).

⁶³*Evidence-Based Strategies for Clinical Organizations to Address COVID-19 Vaccine Hesitancy*, 699-707 (2021 Mayo Clinic Proceedings).

⁶⁴Peter Singer, *Victims of the Unvaccinated*, PROJECT SYNDICATE (Jan. 5, 2022), <https://www.project-syndicate.org/commentary/health-care-priority-for-vaccinated-covid19-patients-by-peter-singer-2022-01>.

⁶⁵Schuman, Robertson-Preidler & Bibler, *supra* note 11.

⁶⁶*Id.*

⁶⁷David G. Owen, *Figuring Foreseeability*, 44 WAKE FOREST L. REV. 1277 (2009) (discussing “why negligence law holds actors responsible for foreseeable harm, rather than limiting responsibility to harms they actually foresaw at the time of acting”).

not what the person believed or intended when she refused vaccination, but what a reasonable person *would* have done. We do not tolerate one person harming another merely because they had good intentions or were suffering from confusion.

The analysis may be different if the argument were about *punishing* the unvaccinated, rather than avoiding complicity in their harm-doing.⁶⁸ In the COVID-19 pandemic, we might then imagine and worry about counterfactuals where Fox News had made different programming choices, or going further back, that the Tuskegee Airmen Study had never happened, such that citizens for whom those facts are salient to their trust in government or healthcare institutions would now make different vaccination decisions. Similarly in other cases of interpersonal harm, we may wish that cult leaders or mob leaders had never influenced their followers, who go on to harm others. We might wish that some people with psychosocial disorders had had better access to mental healthcare or addiction recovery services, prior to harming others. But none of these counterfactuals, in any of these cases, would undermine the argument for acting in real-time to prevent the doing of harm to others. Even more, none of these counterfactuals would excuse healthcare rationers from becoming complicit in doing their harms to others. When someone goes to rob a bank, we do not hand them the keys to the safe or give them a gun to shoot the bank teller, just because they have some confused ideology or false beliefs or lacked good access to something they needed. And the mere fact that there is some other wrong-doer in the background, using the bankrobber as a mere puppet for her own nefarious ends, does not change the analysis about our complicity or intervention in harmdoing.

Recall that many ethicists still favor vaccination mandates, even for profound consequences like losing one's livelihood. This embrace of mandates suggests on the one hand that vaccination is not the sort of thing where voluntariness is all that worrisome, and moreover we are willing to impose profound negative consequences (such as loss of a job) notwithstanding these sorts of concerns about access and

⁶⁸HERBERT LIONEL ADOLPHUS HART, PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW 162 (2008) (“[C]ausing harm intentionally must be punished more severely than causing the same harm unintentionally.”).

information. This, again, is because being unvaccinated foreseeably risks harms *to other persons*. In this context, the voluntariness concern loses its force.

Similarly, we might worry that nicotine addiction makes a patient's choice to smoke another pack of cigarettes less than fully voluntary. But that does not mean that the hospital should be complicit in facilitating the smoker to pollute the air of the patient recovering from a lung transplant. Likewise, perhaps a person is mentally ill, suffering from some sort of obsessive disorder, which compels him to review and publicize a patient's medical records. Here likewise, the lack of voluntariness does not reduce the healthcare provider's duty to avoid complicity in harm.

Still, even in the context of harm to others, we can implement rare exemptions for the vaccination priority in healthcare rationing, clearly some medical, and perhaps others religious or based on the foregoing considerations about access and information. One key exemption would be for minors or others who are incompetent to decide for themselves, but whose parents or other surrogates refused vaccination. Perhaps the best conception is to make priority for those vaccinated a default rule subject to these exemptions only in special cases, which are well-defined and procedurally fair. Any such rule will be imprecise, but not nearly as crude as the alternative rationing policy that systematically ignores vaccination status altogether, and thereby wrongfully perpetrates consequences of being unvaccinated on those who are vaccinated.

VI. Proportionality and Utility

It bears emphasis that the analysis so far only applies to cases of acute healthcare scarcity, where rationing at the point of care is necessary. This situation generally does not apply outside of pandemics, and even then only at times when healthcare demand is highest. Moreover, this thesis only applies to unvaccinated patients who are seeking care specifically for the illness for which safe and effective vaccines are available (though it may protect other patients' access to healthcare for a range of ailments that could be impinged by acute healthcare shortages).

Even in this narrow scope, one must determine *how much* to deprioritize unvaccinated patients, especially given other broadly-utilitarian rationing criteria like medical efficacy and efficient use of limited resources, and still other criteria such as priority for the worst-off. According to the harm-prevention argument herein, when performing that rationing function, healthcare providers must avoid being complicit in externalizing the foreseeable consequences of being unvaccinated upon others. The rule then is to give the patients the same level of care that they would have in the counterfactual world in which there is a pandemic, but the unvaccinated persons were not creating or exacerbating the resource scarcity due to their decision to be unvaccinated. This net equivalence counterfactual lodestar is similar to that which has been argued for giving healthcare workers priority access to healthcare.⁶⁹

While counterfactual reasoning is essential to any causal analysis, we cannot know with certainty the details of the counterfactual. Nonetheless, review of metrics, including the proportion of patients seeking treatment for COVID-19 who are unvaccinated compared to those vaccinated, gives a clear sense of the number of beds being occupied on the basis of the choice to be unvaccinated. For the sake of illustration, one can imagine a case where the unvaccinated patients are taking eight out of the ten ICU beds for pandemic-related care, but we estimate if fully vaccinated, those same persons would only consume one ICU bed. This suggests that the unvaccinated patients have a full claim on the one bed, but that the other patients should have priority access to the remainder of the beds at least to the point that they are not at risk of serious harm for lack of such a bed. This analysis is complicated by the idea that one goal of this proposal is to protect healthcare access even for healthcare needs that are not related to the pandemic (e.g., an ICU bed for someone who suffers from a drowning). Both vaccinated and unvaccinated patients have a full claim on such healthcare resources, and thus both receive protection under the harm principle.

⁶⁹Marcel Verweij, *Moral Principles for Allocating Scarce Medical Resources in an Influenza Pandemic*, 6 J. BIOETHICAL INQUIRY 159 (2009) (“If there is an increased risk to health care workers, then reciprocity supports giving priority access to protection and treatment in such a way that their risk will be similar to that of other citizens.”).

These sorts of back-of-the-envelope analyses should be discomfoting, when life and death are at stake. In some cases, like those in classic RMDH, if a moral determination is too hard, then it is best simply avoided. Here however, when undertaking to ration care, this is not a situation where a healthcare provider can simply avoid the problem by ignoring vaccination status, anymore than they can just ignore other rationing criteria like maximizing benefits, which can be sometimes hard to predict.

At the very least, this analysis suggests that the harm prevention principle should take priority over largely arbitrary criteria such as lottery-based allocations, and arguably other rationing tools like ability-to-pay or rationing-through-inconvenience, which may have systemic value, even if poorly calibrated.⁷⁰ “First-come first-served” is a ubiquitous rationing criterion that is similarly arbitrary, but it also implicates a broader question about whether rationing decisions must be continually updated to maximize criterion achievement, or whether interests in healthcare resources become vested upon formation of a doctor-patient relationship or upon receipt of another resource. For example, if a patient has been properly allocated a ventilator, but is no longer the best use of the limited resource (under any rationing criterion), should she be extubated to allow reallocation?⁷¹ Such hard questions are not peculiar to any particular rationing criterion, including vaccine priority, so I set them aside here.

The present argument becomes more difficult if the default criteria for rationing healthcare instead reflect utilitarian concerns, specifically who would get the most benefit from a healthcare resource on the margin, compared to not getting the healthcare resource. Accordingly, the present proposal could be counter-utilitarian as applied, giving healthcare to another patient when it would do more good for the unvaccinated person, reducing overall health and social welfare.⁷² Strikingly, beyond this case of pandemic vaccination, if we supposed that utility outweighed the harm principle, then we ought to allow some to harm others as long as they get more utility than the harm they cause, which presents something

⁷⁰Eyal, Romain & Robertson, *supra* note 18.

⁷¹Kenneth Rockwood, *Rationing Care in COVID-19: If We Must Do It, Can We Do Better?*, 50 AGE AGEING 3 (2021).

⁷²LOUIS KAPLOW & STEVEN SHAVELL, *FAIRNESS VERSUS WELFARE* (Harvard Univ. Press paperback ed. 2006).

of a *reductio ad absurdum* for simplistic utilitarianism. Of course, one classic way out of this dilemma is to suppose that equilibrium effects will cause a policy of harm-prevention to also turn out to be utility-maximizing, in the spirit of rule utilitarianism. For example, a policy of deprioritizing those who refuse vaccination may cause more people to get vaccinated, thereby avoiding such extreme scarcity of healthcare, and saving more lives in the end. This is an empirical claim, of course, and while plausible cannot be defended conclusively here.

In any case, the need to maximize medical benefits is particularly important, and arguably must be balanced against this need to avoid being complicit in doing harm.⁷³ One plausible approach is to first rank patients by likelihood of benefit, before applying any other criteria.⁷⁴ Alternatively, there are other proposals for allocation mechanisms that can incorporate multiple values.⁷⁵ The present thesis is just that, in certain circumstances, vaccination status is a valid, obligatory criterion among others.

VII. Solidarity and Cognitive Dissonance

In a systematic review of the literature on rationing criteria, scholars have commented that, “As the COVID-19 outbreak is potentially life-threatening, the need to stick to the universal rules of ethics – justice, benevolence, and distributive justice are of paramount importance.”⁷⁶ The foregoing arguments could be wrongly read as seeking to set aside fundamental moral principles in a time of pandemic crises. Instead, these arguments have sought to take the large principles reflected in the consensus view against RMDH seriously on their own merits, but find them to yield surprisingly different conclusions in the rare and peculiar case of pandemic vaccination. Avoiding harm is arguably the first rule of justice.

Nonetheless, the solidaristic consensus against blaming patients (defined as “RMDH” above) may be so strong that readers may seek to maintain the consensus universally, against the force of these harm-

⁷³Emanuel et al., *supra* note 13.

⁷⁴Schuman, Robertson-Preidler & Bibler, *supra* note 11.

⁷⁵Tayfun Sönmez et al., *Categorized Priority Systems: A New Tool for Fairly Allocating Scarce Medical Resources in the Face of Profound Social Inequities*, 159 CHEST 1294 (2021).

⁷⁶Srinivas et al., *supra* note 13.

based arguments.⁷⁷ The resistance may be almost instinctual functioning at the level of identity. As Dan Wikler has written, it is important to maintain “. . . the very useful and virtuous first instinct of the doctor or nurse, that of sympathy and care for the suffering patient, [which] might be attenuated.”⁷⁸ Zooming out, Wikler suggests that, “The same point can be made for societies as a whole: it is not salutary for people to become used to withholding sympathy for sick fellow-citizens. . . .”⁷⁹ From the eyes of patients, White and Lo strike a similar note when they write that, “Categorically excluding patients [from receiving healthcare] will make many feel that their lives are ‘not worth saving,’ which may lead to perceptions of discrimination.”⁸⁰

As a threshold question, it is not particularly clear why this vaccination criterion for rationing implicates such concerns any more than any other rationing criterion, where someone will be denied care. Lines will be drawn, and care will be denied, regardless of the criterion.

To be sure, we should indeed feel sympathy for and solidarity with all those needing healthcare. It is, concededly, divisive and perhaps even corrosive, to carve a line between fellow humans, all of whom desperately seek healthcare. Clearly, in some ideal sense, the most virtuous course would be to give the unvaccinated persons a dispensation, an exercise of grace, or an indulgence in the spirit of forgiveness. Generosity is a moral virtue after all, and as Gheaus echoes Socrates, “only a morally good life can be a good life.”⁸¹

As courts have often said, however, “one must be just, before being generous.”⁸² Justice requires avoidance of wrongful setbacks to interests, and in any case, is not generous to help one by harming

⁷⁷ See Yvonne Denier, *On Personal Responsibility and Human Right to Healthcare*, 14 CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS 224 (2005) (arguing that refusing care to those responsible for their condition would be unjust as contributing to fair equality of opportunity is a should remain a fundamental moral goal of healthcare).

⁷⁸Wikler, *supra* note 2.

⁷⁹*Id.*

⁸⁰Douglas B. White & Bernard Lo, *A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic*, 323 JAMA 1773 (2020).

⁸¹Anca Gheaus, *Solidarity, Justice and Unconditional Access to Healthcare*, 43 J. MED. ETHICS 177 (2017).

⁸²*Bishop v. McPherson*, 168 So. 675, 677 (Ala. 1936); *see also Keenan v. Eshleman*, 2 A.2d 904, 912 (Del. Ch. 1938).

another. In this sense, the impulse to help all patients is not wrong, it is just overridden by a stronger moral command in times of acute scarcity. It bears emphasis that the ancient principle of *primum non nocere* is aptly put because compared to beneficence, the overriding *first* duty is to *do no harm*.

While I think correct in this case, this simplistic notion of value-ranking, where one value trumps another, may be unsatisfactory. Indeed, the moral dilemma is real, and both sides should be felt, even if hard. Such a conflicts of values creates cognitive dissonance, which feels bad.⁸³ As Dan Brock has explained, the field of bioethics has from its inception had a dual role, on the one hand, resolving issues arising in clinical medicine, and on the other hand defending “a general moral right to healthcare.”⁸⁴ However, “the focus on establishing a right to health care has contributed to a failure to address difficult issues in developing ethical standards for equitably prioritizing limited resources in health care,” the present inquiry.⁸⁵ Indeed, even the word “rationing” has been avoided by some scholars, playing into the politicians’ game of pretending “that rationing did not occur, was not necessary, was politically dangerous, and would be morally wrong if it did occur.”⁸⁶ This is one way to avoid the cognitive dissonance, but it is not right.

The best answer to these concerns may be to emphasize the limited scope of the present argument, and thereby to suggest that it will not override broader commitments to solidarity as applied in millions of everyday cases. In classic cases, the lack of acute scarcity and intractability of factual discernment are bright lines that distinguish vaccination priority in a pandemic, and thus avert worries of a slippery slope. At the same time, I also want to normalize the current argument, invoking common-sense examples (like a patient smoking in a hospital or viewing another’s medical records) where

⁸³See generally LEON FESTINGER, A THEORY OF COGNITIVE DISSONANCE 3 (1957) (“The existence of dissonance, being psychologically uncomfortable, will motivate the person to try to reduce the dissonance and achieve consonance. . . . [T]he person will actively avoid situations and information which would likely increase the dissonance.”).

⁸⁴Dan W. Brock, *Broadening the Bioethics Agenda*, 10 KENNEDY INST. ETHICS J. 21 (2000).

⁸⁵*Id.*

⁸⁶*Id.* at 24.

healthcare providers already act to protect patients from others harming them. Denial of healthcare should be a last resort, but unfortunately during a pandemic, such a grim reality may become unavoidable.

If that conclusion seems strange and unfamiliar, it is because the factual circumstances are thankfully exceedingly rare. We do not have the moral practice or habit formation that supports these sorts of decisions.⁸⁷ That is why it is useful to make these sorts of analyses from the luxury of time between one instance of pandemic scarcity and another, which will predictably arise in the future.

VIII. Conclusions

This is not an argument about personal responsibility for healthcare. Concededly, however, one could arrive at the same thesis via other routes, such as luck egalitarianism or sheer utilitarianism, with certain empirical assumptions and broader implications. Instead, I have tried to construct this argument in a way that does no violence to the general consensus against retrospective moral discrimination in healthcare, and thereby maintain as many of our status quo commitments as possible. I view the harm principle as something of a minimum, where there may be more overlapping consensus, and thus a potential firmer footing.

These considerations apply in very specific circumstances, which will not often arise outside certain pandemic situations. These circumstances are: a vaccine is widely available for free and proven safe and effective, where it is foreseeable that actual rationing decisions will need to be made, where in fact that extreme scarcity arises, where an unvaccinated patient seeks care that would have been unnecessary if vaccinated, where vaccination status can be reliably confirmed, and where exemptions do not apply.

⁸⁷See Warren A. Kinghorn, *Medical Education as Moral Formation: An Aristotelian Account of Medical Professionalism*, 53 *PERSPS. BIOLOGY AND MED.* 87 (2010).

In those cases, however, to prevent harm to others, it is appropriate to consider vaccination as a criterion for the allocation of healthcare resources, and indeed wrong to not do so. Ultimately after all, somebody will be denied healthcare. The question is, who?