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Kantian Dignity and the Allocation of Scarce, Life-Saving Resources

SUMMARY

This article explores how we ought, morally speaking, to allocate scarce, life-saving resources such as ventilators or intensive care beds. When there are not enough resources to distribute to all who want and need them, who should receive them? Through an examination of several cases, the article probes the implications regarding this question of two Kantian accounts of respect for the dignity of persons, one an orthodox Kantian account based on an interpretation of the Formula of Humanity and the other an unorthodox reconstruction of part of this formula. The article also investigates the implications of a contemporary triage scheme developed during the COVID-19 pandemic, the Pittsburgh Framework. Each of these three bases for scarce resource distribution has some plausible and implausible results regarding cases that involve patients of various ages, future lifespans (if given the resource), and socioeconomic status (disadvantage). While the article does not intend to vindicate or condemn any one method of distribution, it does aim to illustrate that Kantian thinking can play a salutary role in making hard decisions about scarce medical resource allocation.

Keywords: triage, Kant, dignity, COVID-19, equity, respect for persons, scarce resource allocation.

INTRODUCTION

The COVID-19 pandemic brought to the fore ethical issues concerning the distribution of scarce, life-saving resources. Shortages of ventilators and intensive care beds, for example, forced hospitals and governments to tackle the question: Who, morally speaking, ought to receive life-extending interventions when there are not enough to go around? This article focuses on Kantian responses and compares them to answers offered by allocation guidance designed by physicians during the

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pandemic. Through an examination of several cases, the article tries to illustrate implications, plausible and implausible, of an orthodox Kantian account of respect for the dignity of persons, an unorthodox Kantian account of such respect, and a triage scheme developed by the University of Pittsburgh School of Medicine. The article aims to show that Kantian thinking brings a distinctive perspective to debate on the vexing question of who, in the context of a public health emergency, should receive life-extending medical assistance when not everyone can.

Here is how the paper unfolds[1]. Section 1 very briefly sketches an orthodox Kantian view of what it means to respect the worth or, equivalently, dignity of persons. This account has implausible implications in some cases of allocation of scarce, life-saving resources, as Section 1 tries to show. Section 2 presents an unorthodox Kantian account regarding what it means to respect the dignity of persons and tries to illustrate that its implications are sometimes more plausible than those of the orthodox account. Section 3 summarizes a leading U.S. scheme for the allocation of scarce critical care resources during a public health emergency, the "Pittsburgh Framework". Section 4 explores the three accounts' implications in three different cases, exposing possible strengths and weaknesses in each as a basis for scarce resource allocation. Two of the cases involve patients who come from highly disadvantaged communities, raising the question of whether equity or justice requires that they receive higher priority than others to receive a life-saving resource.

To my knowledge, no principles in normative ethics, including Kantian ones, escape having implications that are intuitively unwelcome to some people in particular cases of scarce resource allocation. For example, the unorthodox Kantian account of respecting the dignity of persons developed in Section 2 implies that individuals who are severely demented likely fall below the threshold of personhood. As a result, it would likely fail to respect the dignity of persons to use a scarce resource to save five such individuals rather than one person (assuming the impossibility of saving both the five and the one). Some would find this result hard to accept. In a similar vein, no schemas designed expressly for medical triage are free from generating implausible results. The article does not intend to argue or suggest that a normative principle or even an allocation scheme be dismissed as overall unacceptable based on the shortcomings identified here. The article's aims are more modest: to reveal implications of three distinct ways of deciding who gets a scarce resource and to illustrate that Kantian principles can have a salutary role to play in such decisions.

We will, in short order, apply Kantian moral principles and a contemporary triage framework to several cases. Before proceeding, it is important to specify some

[1] Some material in this paper, especially in Sections 1 and 2, stems from work I have published elsewhere (see Kerstein, 2013, 2017, 2019).

background assumptions. Readers of this article are, in effect, invited to assess the plausibility of the implications in particular cases of Orthodox Kantianism, Unorthodox Kantianism, and the Pittsburgh Framework. Part of that assessment will involve readers comparing their judgments to the implications of the moral principles and triage framework. In each case, an allocator's task is to distribute a life-saving resource between different persons. Each person needs and wants to get the resource. But, since the resource is scarce, it cannot be made available to all. In helping these persons (or a subset of them), allocators are not discharging an imperfect duty of beneficence. Each person has a claim on the resource, at least in the sense that it would be wrong for allocators to refrain from giving it to them on morally arbitrary grounds (e.g., because they do not like the person) or on grounds inappropriate to the context (e.g., because the person is not an allocator's close friend). No person in our cases is morally responsible for their need of the resource in any way that would affect their claim on it. If an individual gets the scarce resource, they will survive and maintain their personhood. In assessing the plausibility of implications the moral principles and the triage framework have in particular cases, readers are asked to abstract from institutional, legal, or governmental considerations. For example, they are requested not to judge an implication as unwelcome solely because it would violate some hospital policy or national regulation.

In discussing cases, I will sometimes offer my own view on common reactions to them. For example, I will contend that according to the judgment of many of us (i.e., those who have reflected on these matters), it would be morally permissible to give life-saving treatment to a 13-year-old who, with it, would live many decades rather than a 60-year-old who, with the treatment, would live a few years. My assessments are based on extensive discussions of these matters with students and professional colleagues. Readers are, of course, free to reject them. For what it is worth, however, the assessments gain some support from empirical investigation of lay-person judgments. For example, a recent review of research spanning five continents found that for the general public during the COVID-19 pandemic, patient age appeared to be a major allocation criterion, with priority given to the younger (Dowling, 2022).

SECTION 1: ORTHODOX KANTIANISM

Kant's Formula of Humanity commands, "So act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means" (Kant, 2012 [1785], p. 428). To "use" persons as ends, or ends in themselves, is, it seems, to treat persons as having dignity. Some scholars have interpreted the Formula of Humanity to amount (roughly) to the command "So act that you always treat persons as having dignity", or to the command "So act that

you always respect persons' dignity" (Wood, 1999). That is not the only plausible interpretation of the Formula of Humanity, of course (Sensen, 2011).

What I call "Orthodox Kantianism" embraces the idea that the Formula of Humanity amounts to a categorical command to always respect the dignity of persons (Hill, 1992; Velleman, 1999; Wood, 1999)[2]. According to Orthodox Kantianism, if an action fails to respect the dignity of persons, then it is morally wrong. To be a person is to have a rational nature or, equivalently, humanity or the capacity of rational choice; it is to have a set of capacities. Among them are the capacity to set and rationally pursue ends by conforming one's conduct to rational rules (e.g., hypothetical imperatives) and the capacity to act from duty—roughly to act in accordance with moral imperatives purely out of respect for these imperatives[3]. To affirm that persons have dignity is to affirm that they have unconditional, incomparable worth. Persons and persons alone have such worth. To say that a person's worth is unconditional is to say that the person has intrinsic value—a positive value in any context in which they exist. Moreover, this worth depends not at all on the person's health, happiness, well-being, intelligence, beauty, achievement, or even conformity to the moral law. A person's worth is incomparable in that it is beyond price; not even all of the wealth in Silicon Valley amounts to the value of a single person. Moreover, if a being has incomparable worth, then one set of such beings has no more or less worth than any other set of such beings. It would not be legitimate to judge that five persons, for example, have more worth than one.

Let us now turn to our first case, which we label "Different Age/Different Lifespan". We have one indivisible life-saving treatment (e.g., a ventilator) and two patients. One is 13 years old, and the other is 60 years old. The patient who does not get the treatment will die. If the younger person gets the treatment, she will live for many decades; if the older person gets it, she will die of natural causes in a few years.

According to the considered judgment of many (though not all) of us, it would be morally permissible to give the treatment to the 13-year-old straightaway, that is, without any intervening procedure designed to ensure fairness, such as a lottery. Orthodox Kantianism is at odds with this considered judgment. Without pretense to exhaustiveness, here is an explanation of why.

2 In labelling this interpretation of the Formula of Humanity "Orthodox Kantianism," I do not intend to suggest that the interpretation captures the richness or detail of Kant's conception of the supreme principle of morality in its various formulas.

3 There is disagreement among interpreters of Kant regarding the scope of his notion of persons, for example, whether it incorporates fetuses or individuals in a persistent vegetative state. See, for example, Kain (2009) and Sussman (2001).

Suppose we give the intervention straightaway to the 13-year-old on the grounds that we thereby maximize person years, that is, the net number of years of life as a person yielded by our treatment allocation. In treating the 13-year-old, we would be gaining decades more person years, of course. However, this basis for treating the 13-year-old would fail to respect the incomparable value of persons. Saving the younger straightaway would imply that the younger has more value than the older. But if they both have incomparable worth, the younger cannot legitimately be said to have more worth than the older.

Alternatively, suppose we give the intervention straightaway to the 13-year-old on the grounds that the 60-year-old has already had a full human life, that is, her "fair innings." Doing this would suggest that an instance of rational nature that has endured sufficiently long (making for a full human existence) has less value than an instance that has been around for a shorter time. This suggestion contradicts the notion that the value of humanity is unconditional: whether a life has been long enough to constitute a full human life does not affect this value. Moreover, again, the value of rational nature is incomparable: the value of a full rational existence cannot legitimately be judged to be lower than that of a less full life as a person.

SECTION 2: UNORTHODOX KANTIANISM

Orthodox Kantianism has implausible implications in the Different Age/Different Lifespan Case, or so many of us believe. Of course, if Kant or contemporary Kantians had sound arguments for the validity of the Formula of Humanity, interpreted in terms of Orthodox Kantianism, then reason would compel us to abandon our considered judgments regarding the case. But I doubt whether they have such arguments. Against the background of that doubt, I have developed an unorthodox reconstruction of aspects of Kant's Formula of Humanity (Kerstein, 2013). The account aims to capture some of Kant's insights into the special status of persons, but to avoid problematic implications of Orthodox Kantianism in the realms, for example, of self-defense and heroic self-sacrifice, as well as that of the allocation of scarce, life-saving resources (Kerstein, 2013). This section sketches an abridged version of this account: a version that differs from the original in some ways that I will not specify here. Since the unorthodox account is one of respect for the dignity of persons, let us call it RDP:

The dignity of persons is a special status that they possess by virtue of having the capacities constitutive of personhood. This status is such that:

1. A person ought not to use another merely as a means. This first aspect of persons' special status is lexically prior to the following aspect:

2. If a person treats another in some way, then she ought to treat him as having unconditional, preeminent value.

An agent's treatment of a person respects the dignity of that person only if it accords with the special status just described.

Clarification of RDP is in order, beginning with a few initial points. First, RDP does not offer jointly necessary and sufficient conditions for honoring persons' dignity. It sheds light on some, but not all, ways that we can fail to honor others' dignity. Second, RDP does not specify a categorical imperative to refrain from all conduct that would fail to respect someone's dignity. Failing to respect someone's dignity is wrong pro tanto, according to RDP, but it might not be wrong, all things considered. Third, we need not concern ourselves here with RDP's first plank, namely the prohibition of treating others merely as means. We are, of course, concerned with the allocation of scarce, life-saving resources. One might think that the prohibition would come into relevance in that we could count as using merely as means those to whom we deny the resource. However, as I explain elsewhere, in the cases we consider denying someone a resource does not involve using him or treating him as a means and so does not involve using him or treating him merely as a means (Kerstein, 2013, p. 159)[4].

RDP incorporates a Kantian notion of a person. According to RDP's conception, a being is a person only if it has the capacities to: set and pursue ends; strive for coherence among its ends; be self-aware; conform its actions to practical rules that specify means to ends; and act in accordance with moral imperatives, even when it believes that it would gain more satisfaction by acting contrary to them. Moreover, to count as a person, a being must not only possess, but have *exercised* the capacity Kant himself seems to associate most directly with humanity: the capacity to set and pursue ends. If a being fulfills all the conditions mentioned above, then it is a person. The account incorporates a broad interpretation of what it means to possess a capacity. According to the account, for example, a typical toddler has the capacity to act in accordance with moral imperatives given that, if her development proceeds as expected, she will be able to do so. But a being who, practically speaking, cannot and will not be able to exercise one or more of the capacities is not a person. A human being who has died or is alive but whose cerebrum can no longer function is not a person in the sense of the term employed here since he can, practically speaking, no longer exercise the capacities. I will not try here to answer the question

[4] It is worth noting that RDP incorporates a moral constraint: in effect, it prohibits treating others merely as means in cases where doing so is necessary to bring about the best results overall. RDP is thus not a consequentialist principle.

of precisely when, in the course of its development, a typical human being becomes a person. If human embryos and first- or second-trimester fetuses do not engage in goal-directed activity, then they are not persons. If infants do engage in such activity, as appears to be the case (Woodward, 2014), then they presumably are persons. Finally, personhood is meant to be a threshold concept here. If one has the features constitutive of it, one has personhood, no matter how well- or ill-developed those features may be.

According to RDP's second plank, if a person treats another in some way, then she ought to treat him as having unconditional, preeminent value. RDP embraces the same notion of unconditional value as that embedded in Orthodox Kantianism. To say that an unconditionally valuable being of a particular kind has preeminent value is to say that no amount of anything that is not a being of that kind can have a value equal to or greater than the value of a being of that kind. For example, if persons have unconditional, preeminent worth and cats do not have the capacities constitutive of personhood, then no number of cats has a value equal to or greater than that of a single person. It is important to underscore the following: treating persons as having unconditional, preeminent value does not commit one to treating them as having a value closed to all aggregation. It would not necessarily violate RDP, for example, to save twenty people rather than one person on the grounds that twenty have more worth than one. But doing this would not be consistent with Orthodox Kantianism.

If we treat a person in some way, then, according to RDP, we ought to treat him as having unconditional, preeminent worth. Our treatment ought to reflect the notion that the person has such worth. If the treatment also reflects the idea that the person has or lacks (or promotes or hinders) any conditional value, it must be consistent with what the treatment would be if it did not reflect the latter (Kerstein, 2017).

Let me illustrate this last point. Suppose for a moment that all living species have unconditional, preeminent worth. (This is not a Kantian view, of course.) Our job is to preserve species, but we can prevent only one of two different plant species from going extinct. We would not honor the worth of each species if we chose to save straightaway one rather than the other on the sole basis that one of the species but not the other can be used to make blue pigment. The capacity to serve as an ingredient in blue pigment is a conditional value. If no one wants or needs the pigment, then this capacity lacks value. Moreover, preserving the species with this capacity straightaway, allowing the other to go extinct, is not consistent with what our treatment of the two species would be in the absence of one having this capacity. In that scenario, we would presumably give each species an equal chance for preservation.

Let us now apply RDP to the Different Age/Different Lifespan case in which we must choose between treating a 13-year-old who will live for many decades if he

receives the intervention and a 60-year-old who, if he receives it, would live for just a few years more. Unlike Orthodox Kantianism, RDP is free of the implication that it would fail to respect the dignity of persons to give the treatment to the 13-year-old straightaway.

Here is why. Acting with respect for the special value of beings can and often does involve trying to preserve those beings as best we can. Think of a painting that has exceptional worth as a work of art. At least one clear way of respecting its worth would be to protect the painting from destruction by insects or excessive heat. Indeed, one way to respect its worth would be to try to preserve the painting for a longer rather than a short time. Or consider Wollemi pines. The fossil record indicates that these trees were around at the time of the dinosaurs. Believed to be extinct, a grove of them was discovered in Australia in the mid-1990s. One way to respect these trees is surely to try to keep them in existence. It is no surprise that the Australian government has developed a "Wollemi Pine Recovery Plan," which "identifies the future actions to be taken to ensure the long-term viability in nature of the Wollemi Pine" (Department of Environment and Conservation (NSW), 2006, p. i).

Returning to our case, in Kantian thinking, the special value of persons differs from that of great paintings or rare trees. It would, of course, be unKantian to embrace the idea that such beings have unconditional, preeminent worth. Nevertheless, one way to respect the worth of persons is roughly akin to the way we have specified of respecting the worth of other beings of special value. It is, other things being equal, to preserve them, to keep them in existence for more time rather than less. In this tragic case, furthering the goal of preservation would amount to saving the 13-year-old. In doing this, we would *not* be committing ourselves to the view that the 60-year-old's intrinsic value has diminished, say, because of poor health. It is just that we happen to have the capacity to preserve the 13-year-old for longer than the 60-year-old. Compare a roughly analogous case involving great artworks. Suppose that we could preserve one for many decades, but the other for only a few years. If we preserve the former, we would not thereby commit ourselves to the view that the latter has forfeited some of its aesthetic value. But we would be implying that the potential for greater endurance does give the former more value in some sense. In Different Age/Different Lifespan, we cannot preserve both persons. However, we can maximize our overall preservation of the years an individual lives as a person (i.e., person years) by saving the 13-year-old straightaway. Doing this would clash with the orthodox Kantian view that persons have incomparable worth. As noted in Section 2, in saving the 13-year-old, we would be implying that, in some way, she is more valuable than the 60-year-old. However, saving her would be in accordance with the notion, embedded in RDP, that persons have preeminent worth, that is, roughly, worth greater than that of any non-person.

A few clarificatory points are in order. It might be that it is just as important to the 60-year-old that he get the treatment as it is to the 13-year-old that she get it. But RDP does not entail that, in this case, respecting the dignity of persons demands that we balance what is important to persons, say, by giving each an equal chance. RDP allows us (roughly speaking) to try to preserve as far as possible the worth in persons. And this can be done by saving the life of the person who will live longer. But note: RDP does not rule out as disrespectful treating persons as having unconditional, incomparable worth. After all, one way to treat persons as having unconditional, preeminent worth is to treat them as having unconditional, incomparable worth. Treating someone as having unconditional, incomparable worth always involves treating her as having unconditional, preeminent worth; for, in effect, incomparable worth is a kind of, but not the only kind of, preeminent worth. Therefore, RDP does not rule out the legitimacy in this case of conducting a lottery and giving the 13-year-old and the 60-year-old equal chances to survive[5]. Nevertheless, the implications of RDP differ significantly from those of Orthodox Kantianism. Unlike RDP, Orthodox Kantianism implies that it would fail to respect the dignity of persons and thus be morally impermissible to save the 13-year-old straightaway.

SECTION 3: THE PITTSBURGH FRAMEWORK

Ethical issues concerning the allocation of scarce, life-saving resources became particularly salient during the COVID-19 pandemic. At various times and places during it, shortages of critical care beds and/or ventilators occurred. Physicians at the University of Pittsburgh School of Medicine developed a framework to guide triage decisions, specifically during the pandemic, when demand for critical care resources (e.g., ventilators) exceeds supply (White, 2021). The Pittsburgh Framework, as we will refer to it, aims “To ensure that no one is denied care based on stereotypes, assessments of quality of life, or judgments about a person’s “worth” based on the presence or absence of disabilities or other factors” (p. 2). According to the framework, long-term life-expectancy does not factor into the priority for resources (e.g., ventilators). The framework aims to avoid “disadvantaging individuals with life-shortening disabilities and those whose life expectancy is lessened due to unfair distribution of the social determinants of health” (p. 3). An example of a social determinant of health is whether someone has access to good and affordable medical care.

[5] Someone who embraced RDP and, in addition, stipulated that treating an individual as having preeminent worth amounts to treating them as having incomparable worth would presumably conclude that it would be pro tanto wrong *not* to conduct such a lottery. But making this stipulation would yield a principle that suffers from the sort of seriously implausible implications which, I argue, plague Orthodox Kantianism (Kerstein, 2013). Suppose, for example, that only one of two sets of persons can be saved: a set of 50,000 or a set of 5. The principle in question would imply that it would violate the dignity of persons if, on the grounds that many people have more worth than a few, one straightaway saved the 50,000.

Before presenting details of the Pittsburgh Framework, it makes sense to consider some of the conditions in the United States before it was formulated. Early in the pandemic, the mortality among U.S. minority populations was dramatically higher than it was for Whites. For example, during the spring of 2020, the COVID-19 mortality rate for Black Americans was over twice as high as that for Whites (Centers for Disease Control and Prevention, 2024). One basis for the disparity in mortality rate might be preexisting poorer health among Blacks than Whites (e.g., conditions such as diabetes and kidney disease) as a result in part, for example, of dangerous environmental conditions or lack of routine healthcare (Baid, 2023). Later in the pandemic, COVID-19 mortality rates for Blacks and Whites were on a par (Centers for Disease Control and Prevention, 2024).

Figure 1 below is the Pittsburgh Framework's allocation scheme (White, 2021, p. 9). It will be helpful to highlight some of its main features. When resources (e.g., ventilators) are scarce, that is, there are not enough to accommodate everyone who might benefit from receiving them, the Framework prioritizes individuals with lower point totals, that is, lower "triage scores". Suppose, for example, two people want and need a ventilator to survive, but only one is available. If one patient has a score of 3 points and the other a score of 5 points, the ventilator would go to the patient with 3 points.

One of the main principles the Framework employs is promoting "population health outcomes." The Framework presumably promotes these outcomes by having expert physicians evaluate patients' prognosis for survival along two dimensions. The first is the prognosis for hospital survival, that is, living through their current hospital stay. Patients who are, according to Laboratory-based Acute Physiology Scores version 2 (LAPS2) or some other scoring rubric, at the highest risk of death receive 4 points, while those at lowest risk receive 1 point. The other dimension is prognosis for near-term survival, as judged by clinicians. Patients expected to die within 1 year (e.g., from cancer) receive 4 points; patients expected to live longer than 1 year receive 0 points.

The other main principle the Framework uses is that of promoting "justice/equity." According to the Framework, justice or equity requires that some priority in receiving a scarce medical resource go to "frontline essential workers," including custodians, bus drivers, and nurses, who do things crucial to the societal response to the emergency and whose work puts them at greater risk of infection (White, 2021, p. 4). Frontline essential workers' priority amounts to their score being reduced by 1 point. For example, if a frontline pulmonologist hospitalized with COVID-19 has a total score of 1 point without considering her status as such a worker, then she would end up with a score of 0 points.

Table 1. Principles for allocating critical care/ventilators during a pvublic health emergency

Principle	Criterion	Point System			
		+1	+2	+3	+4
PROMOTE POPULATION HEALTH OUTCOMES	Prognosis for hospital survival (LAPS2 or other severity of illness score)	**Quartile 1** (i.e., risk of death <25%) lowest risk of death	**Quartile 2** (i.e., risk of death 25-49%)	**Quartile 3** (i.e., risk of death 50-75%)	**Quartile 4** (i.e., risk of death > 75%) highest risk of death
	Prognosis for near-term survival (individualized clinical judgment)				**Death expected within 1 year from end stage condition**
PROMOTE JUSTICE/ EQUITY	Priority to frontline essential workers	**Subtract** one point from triage priority score if the patient is an essential worker in a high-risk occupation.			
	Correction to lessen disadvantage from structural inequities	**Subtract** one point from triage priority score if the patient resides in a highly disadvantaged community (i.e., ADI score= 8,9, or 10).			
	Priority to those who've had the least chance to live through life's stages	**Tiebreaker:** In the event that two patients have identical triage priority scores, give priority to the younger patient when a significant age difference exists.			
	Equal chances	**Second tiebreaker:** In the event that two patients have identical triage priority scores and are of similar ages, use random selection to determine who receives the resource.			

Note. Reprinted from White (2021, p. 9).

The Framework also requires "correction to lessen disadvantage from structural inequities" (White, 2021, p. 9). At issue is a disadvantage in terms of health—a disadvantage that, according to the authors of the Framework, gives certain patients higher triage scores (and thus lower likelihood of, say, getting a scarce ventilator). This health disadvantage stems from factors such as less access to health care, fewer job opportunities, lower income, worse housing, and racial discrimination (p. 4). According to the Framework, 1 point is subtracted from a patient's total triage score if the patient resides in a highly disadvantaged community. The Framework suggests determining whether the patient lives in such a community by consulting the Area Deprivation Index (ADI) (Center for Health Disparities Research, 2022). The ADI measures neighborhoods' socioeconomic conditions regarding income, education, employment, and housing quality. The higher a neighborhood's ADI score on a scale from 1 to 10, the more disadvantaged it is. According to the Framework, a point should be subtracted from a patient's score to lessen disadvantage from structural inequities only if the area the patient resides in has an ADI score of 8 or above.

Finally, the Framework provides two tiebreakers to decide between patients who have the same triage scores. The first tiebreaker specifies that priority should go to the younger patient "when a significant age difference exists" (White, 2021, p. 9). For example, if a 45-year-old and an 85-year-old are vying for a ventilator and have the same score, it will go

to the 45-year-old. If patients have the same scores and there is no significant age difference between them, then the second tiebreaker gets implemented. If, for example, two 25-year-olds both have 2 points, the Framework implies that a lottery be held in which each would get a 50% chance of receiving the scarce resource.

SECTION 4: MORE CASES, MORE CHALLENGES

Let us now examine the implications of Orthodox Kantianism, RDP, and the Pittsburgh Framework in some further scarce-resource allocation cases. In the Same Age/Short Lifespan case, Edward and Fran, both 70 years old, are vying for a single available ventilator. Both have a greater than 75% chance of not surviving hospitalization. If Edward gets through his hospital stay, he is expected to live 10 more years in decent health. If Fran gets through, she is expected to die from an end-stage condition (e.g., a brain tumor) within 1 year. Neither Edward nor Fran is an essential worker, and neither resides in a highly disadvantaged community.

Orthodox Kantianism implies that it would be morally wrong to give the ventilator straightaway to Edward. Doing so would fail to respect Fran's dignity as a person. It would amount to treating her as having less worth than Edward. According to Orthodox Kantianism, whether Fran or Edward gets the treatment should presumably be determined in a lottery in which each has an equal chance.

In contrast to Orthodox Kantianism, RDP does not imply that it would be wrong to give the ventilator straightaway to Edward. RDP is compatible with the view that in this difficult case, a way to treat persons as having unconditional, preeminent worth is to preserve as many person years as possible. And doing that would amount to saving Edward straightaway.

It is easy to see that the Pittsburgh Framework would give the ventilator straightway to Edward. Edward would receive 4 points based on his prognosis for hospital survival, and Fran would get 8 points based on her prognosis for hospital survival and for near-term survival. Since a lower point total prevails, the treatment would go to Edward.

Considered judgments differ regarding scarce, potentially life-saving resource allocations. But I and, I suspect, many others find the verdict of Orthodox Kantianism in this case hard to accept. One reason, which the authors of the Pittsburgh Framework would presumably endorse, is that the verdict is indicative of a failure of Orthodox Kantianism to sufficiently promote population health outcomes, one of which is extending the length of life. Another, related reason why, I venture, is that Orthodox Kantianism does not allow us to act in a way that would honor or respect

the worth inherent in a person, namely to try to keep the person in existence for a longer rather than for a shorter time.

Let us now turn to another case. In Same Age/ Different Lifespan/ Different Community, both Abby and Bethany need a ventilator to make it through a viral illness. Both are 7 years old. Only one ventilator is available. Both Abby and Bethany are in the lowest quartile of risk in terms of prognosis of hospital survival. Bethany, but not Abby, lives in a highly disadvantaged community, one that has an ADI score of 8. If Abby survives this incident, her expected lifespan is 80 years, and if Bethany survives, hers is 60 years, because of a preexisting condition (e.g., Type 2 diabetes).

The dictates of Orthodox Kantianism and of the Pittsburgh Framework are not hard to discern in the Same Age/ Different Lifespan/ Different Community. Since Abby and Bethany's worth as persons is unaffected by how long they are expected to live if given access to a ventilator and by whether they come from a disadvantaged community, Orthodox Kantianism would presumably propose deciding between them through a lottery with equal chances for each. The Pittsburgh Framework would give 1 point overall to Abby, on the grounds of her being in the lowest quartile of risk of not surviving hospitalization. To Bethany, it would give 0 points. Though Bethany would get 1 point for being at the same risk of dying in the hospital as Abby, this point would be subtracted because of her community's ADI score. According to the Pittsburgh Framework, Bethany would get the ventilator straightaway.

The implications of RDP regarding the Same Age/ Different Lifespan/ Different Community case require more work to discern. Does giving the ventilator straightaway to Bethany fail to respect the dignity of persons, according to RDP? One might think that the following reply is in order: According to RDP, we must treat both Abby and Bethany as having unconditional, preeminent worth. Other things being equal, doing that would entail giving them equal chances to get the treatment. But in this case, things are not equal. There is a tie-breaker at work. By saving Bethany but not Abby we can correct the likelihood that Bethany has been subject to an unmerited health disadvantage[6]. Using this tie-breaker, thereby saving Bethany straightaway, is consistent with RDP, concludes the reply.

This reply does not work. Saving Bethany straightaway fails to respect the dignity of persons and so is pro tanto morally impermissible according to RDP. The value of correcting for the likelihood that someone has been subject to an unmerited health disadvantage is conditional. There are contexts in which it is not good, in Kantian terms. Suppose, quite reasonably, that Abby bears no responsibility for

[6] Merited health disadvantages would, intuitively speaking, include ones individuals brought on themselves by freely choosing to assume enormous health risks. Health disadvantages suffered by American stuntman Evel Knievel from his attempt to jump via motorcycle over the Snake River Canyon were presumably merited.

Bethany living in a highly disadvantaged community, let alone for any unmerited health disadvantage Bethany suffers. In this specification of the case, the correction in question is not good.

Why not? Without acceptable reason from the standpoint of RDP, it denies Abby any chance at a ventilator and thereby treats her as having less worth than Bethany. It is not the case that, as a result of neighborhood-related advantages/disadvantages, Abby's intrinsic worth decreases or Bethany's increases[7]. Now, as argued in Section 2, in the tragic contexts we are considering, it would be consistent with RDP to treat one individual as having less worth than another if, upon receiving a scarce resource, this individual would have a significantly shorter existence as a person than the other would have upon receiving it. Yet, in this case, Abby would live a lot longer than Bethany. Correcting for the likelihood that Bethany has been subject to an unmerited health disadvantage would result in Abby and Bethany's total combined lifespan (and corresponding person-years) being around 74 rather than around 94 years. As noted, treating persons as having unconditional, incomparable, as opposed to preeminent, worth is consistent with RDP. Saving Bethany straightaway does not do this, of course. Therefore, in the Same Age/ Different Lifespan/ Different Community case, specified such that Abby bears no responsibility for Bethany's disadvantage, there are grounds for concluding that saving Bethany straightaway would not be good. It thus follows that correcting for unmerited health disadvantage is merely conditionally valuable.

Since the value of correcting for the likelihood that someone has been subject to an unmerited health disadvantage is conditional, Abby's treatment in our case must be consistent with what it would be if it did not further this conditional value. But in the absence of the aim of furthering this conditional value, Abby would, according to RDP, at the least receive a 50% chance of having her life prolonged. Her treatment, as prescribed by the Pittsburgh Framework, would thus fail to respect her worth as a person, according to RDP.

It is consistent with RDP in the Same Age/ Different Lifespan/ Different Community either to save Abby straightaway or to give Abby and Bethany equal chances. But RDP condemns it as disrespectful of the dignity of persons to save Bethany straightaway, as the Pittsburgh Framework requires. The implications of RDP here strike many of us as plausible.

However, a different case might put more pressure on RDP. In Different Lifespan through Injustice, we need to choose between giving life-saving anti-viral treatment

[7] Here, someone might reply: 'so much the worse for RDP'; for Abby's worth does diminish. But that reply strikes me as very implausible. Abby is 7 years old and, as specified, bears no responsibility for Bethany living in a disadvantaged community. So why would her worth go down?

to either 60-year-old Cindy or 60-year-old Danny. If treated, Cindy would live for 10 years. Cindy, who has spent her whole life in a disadvantaged community, developed diabetes at 50. If treated, Danny, who has never resided in such a community and who has until now had excellent health, would live for 20 years. Danny bears some responsibility for Cindy's truncated lifespan. To further his land speculation scheme, he has intentionally blocked the establishment of health clinics in Cindy's neighborhood. Had such clinics been in operation, Cindy's diabetes would have been treated sooner, resulting in better health for her. Both Cindy and Danny have the same, relatively good, prognosis for hospital and near-term survival should they get treatment.

It is evident, I hope, that the Pittsburgh Framework would prescribe that Cindy get the treatment straightaway. Moreover, Orthodox Kantianism would imply that it would be wrong for either Cindy or Danny to receive the treatment straightaway; it would presumably demand that each get an equal chance to receive the scarce resource.

What would RDP imply in this case? It would not run afoul of RDP to give Cindy and Danny equal chances. As noted above, one way to treat persons as having unconditional, preeminent value is to treat them as having unconditional, incomparable value. And doing the latter might involve conducting a fair lottery to decide who gets the treatment.

However, it would also not fail to respect the dignity of persons, according to RDP, to give Danny the treatment straightaway. In our cases, RDP implies that we, scarce resource allocators, must treat persons as having unconditional, preeminent worth. One way to do that is to maximize the preservation of person years. According to RDP (as well as to Orthodox Kantianism), a person's worth diminishes not at all even if he has done bad things such as, for his own profit, contributing to the diminishment of another's lifespan. And a person's worth increases not at all due to having been the victim of bad actions. One way to treat personhood as having unconditional preeminent worth in Different Lifespan through Injustice is to save Danny straightaway. Doing that preserves the most person years. So RDP does not generate the conclusion that giving Danny the treatment straightaway is wrong, even pro tanto. Some will surely find this to be a strike against RDP. The idea that persons ought to be treated as having unconditional worth has weighty implications. It might be easy to embrace the notion that someone's worth as a person does not vary according to her looks or accomplishments; it seems harder to accede to the idea that this worth diminishes not a whit even if she acts wrongly and harms others. Of course, RDP does not purport to be a complete account of respect for the dignity of persons. It identifies some conditions under which actions fail to treat persons

as having dignity; it leaves open the possibility that actions might not fulfill any of these conditions, yet in some way fail to treat persons as having dignity and so be pro tanto wrong.

RDP does imply that it would fail to respect the dignity of persons to give the treatment straightaway to Cindy. Danny is, in part, at fault for the shorter lifespan Cindy can expect if she gets through the viral illness. But this fact neither increases her worth as a person nor decreases his. Despite that, one might be tempted to contend that RDP would not condemn as disrespectful giving the treatment straightaway to Cindy. It would not condemn this because, as a result of Danny's misdeeds, doing so would give him his just desert, and doing that is itself unconditionally and preeminently valuable. For the sake of argument, let us suppose that in saving Cindy straightaway, we would be giving Danny what he deserves. Still, RDP would condemn this action as disrespectful of the worth of persons and thus pro tanto wrong. For inherent to RDP is the view not only that persons are preeminently valuable, but also that they are the only beings that are. Recall that to say that an unconditionally valuable being of a particular kind has preeminent value is to say that no amount of anything that is not a being of that kind can have a value equal to or greater than the value of a being of that kind. To say that persons have preeminent value is thus to imply that no amount of anything that is not a person, including no amount of someone getting what he deserves, can have a value equal to or greater than that of a person. There does not seem to be a way for a defender of RDP to avoid the conclusion that it would be disrespectful of the dignity of persons and thus pro tanto wrong to give the treatment to Cindy straightaway. But since it does not set out an absolute constraint, RDP does leave open the possibility that giving it to her is not wrong, all things considered.

CONCLUSION

We have examined Orthodox Kantianism, Unorthodox Kantianism (RDP), and a contemporary triage schema as bases for the allocation of scarce, life-saving resources in a variety of specific cases. Considered judgments differ, of course, but each of these bases seems to have some plausible and some implausible implications, as Table 2 illustrates.

Table 2. Implications of different perspectives on the allocation of scarce resources

Some Implications			
	Orthodox Kantianism (based on interpretation of Formula of Humanity)	**Unorthodox Kantianism (RDP)**	**Pittsburgh Framework**
Different Age/ Different Lifespan 13-year-old vs. 60-year-old, if treated, younger would live decades, older 3 years	Give 50% chance for 13-year-old and for 60-year-old	Designates as failure to respect dignity neither treating 13-year-old straightaway nor giving 50% chance for each	Treat 13-year-old straightaway, based on tiebreaker of priority to younger[8]
Same Age/Short Lifespan both age 70, if treated Edward 10 more years, Fran less than 1 more year	Give 50% chance for Edward and for Fran	Designates as failure to respect dignity neither treating Edward straightaway nor giving 50% chance for each	Treat Edward straightaway
Same Age/ Different Lifespan/ Disadvantaged Community both age 7, if treated, Abby 80 more years, Bethany 60 more, Bethany from disadvantaged community	Give 50% chance for Abby and for Bethany	Designates as failure to respect dignity neither treating Abby straightaway nor giving 50% chance for each, pro tanto wrong to treat Bethany straightaway	Treat Bethany straightaway
Different Lifespan through Injustice both age 60, if treated, Cindy 10 more years, Danny 20 more, Danny partly responsible for Cindy's lower expected lifespan if treated, Cindy from disadvantaged community	Give 50% chance for Cindy and for Danny	Designates as failure to respect dignity neither treating Danny straightaway nor giving 50% chance for each, pro tanto wrong to treat Cindy straightaway	Treat Cindy straightaway

[8] We are assuming that both individuals have the same prognosis, if treated, for surviving their hospital stay and that neither are essential workers or reside in a disadvantaged community.

For example, as just noted, some will surely balk at the implication of RDP that it would be wrong pro tanto in Different Lifespan through Injustice to treat Cindy straightaway. Some will also be very uncomfortable with the implications of Orthodox Kantianism in Different Age/Different Lifespan. Recall that in this case, the initial one we examined, we must choose between treating a 13-year-old expected to go on living for decades and treating a 60-year-old expected to die of natural causes in a few years. Many of us believe that contrary to Orthodox Kantianism, it should at least be an option, morally speaking, to give the treatment straightaway to the 13-year-old. I suspect that those with Kantian leanings will object strongly to the Pittsburgh Framework's verdict in the Same Age/ Different Lifespan/ Disadvantaged Community case involving two 7-year-olds. Recall that one of them, from a disadvantaged community, would live 60 years if treated while the other, not from such a community, would live 80. The Pittsburgh Framework's implication that the child who would, if treated, live much longer should receive no chance at the treatment is difficult for us to embrace.

The article has not aimed to settle the question of which (if any) of the three bases it discusses for scarce resource allocation ought to be employed. It has illustrated the implications of two Kantian accounts of respect for the dignity of persons and one contemporary triage schema regarding a range of cases. It is evident, I hope, that the contemporary triage schema generates results every bit as controversial as those of the Kantian accounts. If judged in terms of the intuitive plausibility of its implications, Kantian thinking should have a place in the debate regarding how, ethically speaking, we ought to distribute scarce resources in public health emergencies.

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Kantovsko dostojanstvo i raspodjela oskudnih resursa koji spašavaju život

SAŽETAK

Rad istražuje kako bismo s gledišta morala trebali raspodijeliti oskudne resurse koji spašavaju živote, kao što su respiratori ili kreveti za intenzivnu njegu. Kad nema dovoljno resursa za raspodjelu svima koji ih žele i trebaju, tko bi ih trebao dobiti? Pregledom nekoliko slučajeva rad ispituje implikacije u vezi s ovim pitanjem dvaju kantovskih prikaza poštovanja dostojanstva osoba, jednog ortodoksnog kantovskog prikaza temeljenog na tumačenju Formule čovječnosti, a drugog neortodoksne rekonstrukcije dijela ove formule. Rad također istražuje implikacije suvremene trijažne sheme razvijene tijekom pandemije COVID-19 (engl. Pittsburgh Framework). Svako od ova tri uporišta za raspodjelu oskudnih resursa ima neke vjerodostojne i neuvjerljive rezultate vezano za slučajeve koji uključuju pacijente različite dobi, budućeg životnog vijeka (ako im se dodijele resursi) i socioekonomskog statusa (nedostatak). Iako rad nema namjeru opravdati ili osuditi bilo koju od metoda distribucije, cilj mu je ilustrirati da kantovska misao može imati značajnu ulogu u donošenju teških odluka o raspodjeli oskudnih medicinskih resursa.

Ključne riječi: trijaža, Kant, dostojanstvo, COVID-19, pravednost, poštovanje osoba, raspodjela oskudnih resursa.