

Reverse Triage and People Whose Disabilities Render Them Dependent on Ventilators: Phenomenology, Embodiment and Homelikeness

Nathan Emmerich^a & Pat McConville^b

^aAustralian National University, College of Health & Medicine, nathan.emmerich@anu.edu.au

^bMonash University, Monash Bioethics Centre, pat.mcconville@monash.edu

Early View publication date: 17 December 2021

DOI: <http://dx.doi.org/10.5324/eip.v15i2.4092>



This is an open access article distributed under the terms of the Creative Commons Attribution 4.0 International License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

The COVID-19 pandemic has occasioned a great deal of ethical reflection both in general and on the issue of reverse triage; a practice that effectively reallocates resources from one patient to another on the basis of the latter having a more favourable clinical prognosis. This paper addresses a specific concern that has arisen in relation to such proposals: the potential reallocation of ventilators relied upon by disabled or chronically ill patients. This issue is examined via three morally parallel scenarios. First, the standard reallocation of a ventilator in accordance with reverse triage protocols; second, the reallocation of a personal ventilator from a chronically ill patient ordinarily reliant on it; and, third, the reallocation of a personal ventilator owned by a financially privileged individual but who is not ordinarily reliant on it. This paper suggests that whilst property rights cannot resolve these scenarios in a satisfactory manner, it may be possible to do so if we draw on the resources of phenomenology. However, in contradistinction to a recent paper on this topic (Reynolds et al. 2021), we argue that ethical claims to ventilators are not well grounded by the overly demanding notion that they are embodied objects. We suggest that the alternative phenomenological notion of homelikeness provides for a more plausible resolution of the issue. The personal ventilators of individuals who commonly rely upon them become part of their ordinary, everyday or homelike being. They are a necessary part of the continuation or maintenance of their basic state of health or wellbeing and the reallocation of such objects is unethical.

Keywords: Phenomenology, COVID-19, Pandemic, Triage, Reverse triage, Ventilation, Chronic illness, Allocation of resources

Introduction

As many researchers have discussed, protocols for reverse triage are likely to be implemented if and when a pandemic overwhelms healthcare institutions and resources (Emmerich 2011; Truog et al. 2020; Wilkinson 2020; Sprung et al. 2020). The concept of reverse triage encompasses two distinct undertakings (Emmerich

2011, pp. 95–96). On the one hand there are reverse triage policies that free up resources by discharging patients either from the hospital or from Intensive Care Units (ICUs). The aim is to create additional surge capacity *in anticipation* of imminent and potentially overwhelming demand. The patients affected will be those who are, perhaps, not quite ready to be discharged but who are highly unlikely to be adversely impacted by such decisions. This is not the kind of reverse triage that concerns us here.

Here we are concerned with the kind of reverse triage that might be practiced *during* a disaster, such as when a pandemic has overwhelmed tertiary healthcare services in a particular location.¹ In this context resources—specifically care in an ICU and/or use of a ventilator—might be withdrawn from patients who are highly unlikely to recover without continued access to such resources. This would be done in order that another patient, one with greater potential for recovery, could receive treatment that would otherwise not be available to them.² Were the relevant conditions to arise, such policies would be implemented without regard for the patient's specific ailment. Those suffering from, say, a brain injury would be considered alongside those suffering from the symptoms of SARS-CoV-2. On the face of it, this would suggest that someone living with a chronic illness or disability such that its proper management requires the ongoing support of a ventilator, could have that ventilator taken from them and allocated to another patient if they were to attend a hospital when such reverse triage policies were in effect.

That such circumstances might actually occur is not entirely theoretical. For example, although a member of the Task Force that produced it rejects the interpretation, a guideline issued by the New York State Department of Health arguably adopts such a policy (New York State Task Force on Life and the Law 2015). This has clearly been a source of concern for some (Ne'eman 2020a, b; Wong 2020).³ The fact that this issue does not seem to have been addressed by other triage protocols could be taken to imply that it is not a major concern. Equally it might be taken to imply that there is a lacuna in our thinking, and that we should take care to ensure that we fully consider the implications of such protocols, particularly when it comes to disadvantaged and vulnerable groups. Thus, the notion that a ventilator that belongs to—or has been in long-term use by⁴—a chronically ill or disabled individual might be removed from them in order to treat another patient is an issue that demands further reflection.

If we suppose that it is ethical to reallocate a ventilator from one patient to another who would otherwise go untreated, but unethical to reallocate a ventilator belonging to an individual who is chronically dependent on it, then there must be some morally relevant difference between such cases. One intuitive distinction we might make between such cases has to do with the role of *ownership* of a ventilator. This intuition is challenged, however, when considering the possibility of an otherwise healthy and financially privileged individual who holds a ventilator in reserve.⁵ It seems to us that most people would be reluctant to embrace the idea that an individual who happens to own a ventilator should have privileged access to it during a pandemic rather than it being used for the greatest good on the basis of clinical need. Thus, analysis of this issue should enable us to differentiate between chronically ill patients who are dependent on ventilators and those who simply happen to possess a ventilator.

The account presented in this essay begins with an exploration of a type of property rights that Sulmasy and Sugarman (1994) have previously drawn upon in their attempt to show that withdrawing and withholding treatment are not morally equivalent actions. Examining the claims they have made makes it clear that if chronically ill patients have a moral claim to the ventilators they rely on, then that claim cannot be dependent on a potentially defeasible property right alone. Our discussion then proceeds by examining the more promising terrain of phenomenology, something recently explored by Reynolds et al (2020). Their essay draws on the prominent phenomenological notion of embodiment and the idea that objects can be literally incorporated into an individual's body and thereby into their corporeal sense of self. As a result, they argue that additional moral significance can be attached to the personal ventilators of chronic users, meaning that it is not permissible to reallocate them for the purposes of reverse triage. However, we argue that it is difficult to demonstrate that ventilators either can be or are in fact embodied in the manner supposed by phenomenological theory. Nevertheless, we suggest that alternative ground on which a comparable moral claim can be made by chronically ill patients to their own ventilators. This ground is the phenomenological notion of *homelikeness*, in which health can be interpreted in relation to the whole context of ease—or disease—related meaning and not exclusively as a matter of embodiment (Svenaeus 2011, 2019). First, however, let us more clearly sketch the three scenarios that illustrate the matter at hand.

Three Scenarios

Let us suppose the following. In the midst of a pandemic the ICU in a hospital has reached capacity. All the beds are full, all the ventilators are in use. Protocols for reverse triage are now being implemented.⁶ A new patient who requires an escalated level of care arrives. Their condition is such that if they do not receive mechanical life support it is highly likely that they will die. Furthermore, they are more likely to recover than at least one of the patients currently receiving mechanical ventilation and they will likely recover in a shorter period of time.

- A. Although it remains possible that all those currently receiving treatment could recover, ventilation is nevertheless withdrawn from the patient with the least favourable prognosis in order to treat a newly arrived individual whose prognosis is better.
- B. Although it remains possible that all those currently receiving treatment could recover, the patient with the least favourable prognosis has a chronic condition. They are ordinarily supported by the ventilator to which they are currently attached. They brought this ventilator to the hospital with them and they commonly rely on it to maintain their everyday existence. Treatment is withdrawn from this patient in order that *their* ventilator can be used to treat the newly arrived individual who has a better prognosis.
- C. Although it remains possible that all those currently receiving treatment could recover, the patient with the least favourable prognosis happens to own the ventilator being used to treat them. Treatment is withdrawn from

this patient in order that *their* ventilator can be used to treat the newly arrived individual who has a better prognosis.

We suppose that it is permissible to act in the manner described by cases A and C, but not in B. However, if scenario B should be considered different to A, then it is not obvious why scenario C cannot be considered in similar terms.

A Theory of Entitlement

In setting forth an argument for the moral non-equivalence of withdrawing and withholding, Sulmasy and Sugarman appeal to Nozick's Principle of Original Acquisition of Holdings. They seek to claim that ownership or simple possession generates a moral claim to an object and, therefore, to its continued use. Given that this claim applies only once ownership or possession has been established, it is not relevant to decisions to commence or withhold treatment. However, it is a relevant, albeit defeasible, consideration in deciding whether to withdraw treatment. It is for this reason that Sulmasy and Sugarman claim withdrawing and withholding cannot be considered morally equivalent undertakings. Simple possession carries some kind of moral weight, thus withdrawing treatment always removes something of moral significance whilst withholding does not. Nevertheless, the claim is a relatively weak one. Even if it does militate against withdrawing treatment for *arbitrary* or clinically irrelevant reasons, such as those raised by Sulmasy and Sugarman's thought experiment, the imperatives generated by clinical reality can overcome moral claims to continued treatment based on ownership or simple possession. Therefore, Nozick's principle does not rule out the withdrawal and reallocation of treatment when doing so is justified by sound clinical reasoning; it does not rule out the practice of reverse triage *per se*.

It seems a particularly fine balance will have to be struck if the notion of property rights, which is what the principle of original acquisition of holdings seeks to capture, is to offer some assistance when it comes to resolving the three scenarios outlined above. Given that the principle of original acquisition can be overridden when a relatively minor degree of greater benefit would be derived by reallocating treatment to another patient, the principle is not inconsistent with scenario A. Whilst the principle militates against arbitrary reallocation, it does not prevent it when there is a sound clinical justification for doing so. The only real concern is the relative prognosis of the patients and the degree to which they need to differ in order to justify the withdrawal and reallocation of a ventilator from one patient to another. However, on the face of it, this line of reasoning also applies to scenario B. Unless one thinks that duration of possession strengthens the moral claim generated, it would seem permissible to take a ventilator used by a chronically ill patient and reallocate it to someone else if the requisite differential in prognosis existed. Indeed, issues remain even if one supposes duration of possession to carry significance; a stronger moral claim would still be defeasible by a greater difference in prognosis. Furthermore, a chronically ill patient may have only recently acquired a ventilator, or they may have recently acquired a replacement machine. It would be odd to suppose that either of these facts could influence a decision to reallocate their machine to another patient who is more likely to recover.

Whilst the principle of original acquisition of holdings does not seem to differentiate between scenario A and B, both it and the notion of property rights

more generally might have greater influence on scenario C. It may be that actual ownership, as opposed to simple possession, of a ventilator would generate a *stronger* (if not necessarily *strong*) moral claim to its continued use. Nevertheless, ownership is not absolutely inalienable. In the same way that land is acquired for the purposes of public infrastructure, a government could compel private owners of ventilators to give up possession of them and provide whatever compensation it deemed appropriate. However, presuming no such rules are in place, if someone without any pre-existing clinical reason for possessing a ventilator should arrive at a hospital with a unit of their own, should that mean they have priority over its use? Let us suppose that (1) immediate ventilation is the clinically indicated course of action for the owner of the machine but that (2) on clinical grounds, they are a less promising candidate for ventilation support than another patient already admitted to the hospital who could be treated with this new machine. Who should be ventilated: the patient who owns the ventilator or the patient with the better prognosis?

It seems to us that the property rights of ownership provide insufficient moral reason to neglect the just allocation of ventilators in accordance with clinical need. Any healthcare professionals encountering this set of circumstances would be justified in simply adding the new ventilator to the hospital's own resources. After all, the ventilator is of little use without the necessary staff and expertise needed to care for patients attached to them. This point is underscored by the fact that the individual who owns the ventilator has arrived at the hospital. Even if ventilator-owning patients have some moral claim to their property, they have no moral claim when it comes to healthcare professionals, nor are they in a position to direct clinical practice or its underlying principles. This includes the principles that govern the social organization and delivery of care as well as those that direct the allocation of resources such as ventilators. Just because someone owns a ventilator does not mean healthcare professionals are required to help them use it.⁷ Furthermore, even if they elect to do so, as might be the case if the owner of the ventilator also happened to have the better prognosis, it continues to be ethically mandatory for healthcare professionals to assist in accordance with their own protocols and to treat the ventilator-owning patient in exactly the same way as patients who do not own such machines.

Given these comments we might conclude that, whilst Sulmasy and Sugarman may have helped to draw distinctions between withdrawing and withholding treatment, property rights are not that helpful when it comes to the actual (re)allocation of life-saving resources. Whilst the principle of original acquisition of holdings may favour the status quo, once this is disturbed by some clinically relevant factor withdrawing and reallocating treatment seems justified. Indeed, given that owners of ventilators cannot expect to control how their property is allocated not least because they cannot expect to redirect established protocols regarding resources and professional practice. Property rights do not seem to count for very much when it comes to the allocation and reallocation of treatment under conditions of reverse triage. This being the case, however, means that reallocating ventilators from long term users remains ethically possible.

Health beyond the body: a phenomenology of homelikeness

In contrast to the dualism of Cartesian philosophy, which imagines the world separated into idealised mental and material substances, the phenomenological tradition takes as its starting point the concrete experience of embodied beings (Smith 2018). Such enquiries also demonstrate the degree to which our bodies are experienced as cultural, and not simply biological, objects (Csordas 1999). They are shaped, manipulated and augmented in accordance with social, cultural and political norms (Shilling 2004). Today, we inhabit a scientific, technological and biomedical culture, the achievements of which allow us to intervene in our bodies with increasing degrees of precision. Thus, we use running machines, gyms and diets to direct aspects of our physicality, whilst using smartphones to monitor our progress. Equally, we reshape ourselves with the techniques of plastic surgery. However, what is of most significance, at least for the present purposes, are the ways in which we integrate technologies such that they and their effects become indistinguishable from fundamental attributes of our bodily selves. We wear spectacles or contact lenses in order that we might perceive the world more clearly, enhancing our ability to inhabit and navigate it. Not only do we clothe ourselves in garments, we implant pacemakers to regulate the beating of our hearts and Intra-Uterine Devices (IUDs) to control our fertility, and we merge our bodies with devices such as wheelchairs and stoma bags, cochlear implants and prosthetic limbs.

It is possible, then, for technological devices to be incorporated into our bodies and to become part of our bodily schemas or our subjective sense of corporeal self. These objects may cease to be perceived as objects, separate and distinct, and instead be understood through a unified lens of embodiment (De Preester and Tsakiris 2009; Ihde 2010; De Preester 2011; Aas 2021). When it comes to subjective awareness of our own bodies and our embodiment more generally, including any 'external' devices which have been brought into or incorporated into our embodiment, we commonly experience a kind of phenomenological transparency. Indeed, from a phenomenological perspective, illness can be thought of as something that entails the body ceasing to have the kind of transparency it ordinarily has.⁸ As a result, medical treatment and therapy more generally can be understood as attempts to enable the body to once again fade into the background of our subjective experiences.

Technologies like cars or bicycles can extend our bodies and their abilities, but either they are always seen—or regularly reappear—as objects in themselves, separate from our body schema. Other technologies, including wheelchairs, white canes, prostheses or cochlear implants, can extend the body and can be brought into the body schema on a more durable basis. These technologies can be so intimately embedded in bodily capacities that they cease to be seen as separate, manipulable objects in our ordinary perception and action. By coming to be seen in this way objects become part of our subjective sense of corporeal self and part of our internal bodily schemas. However, this integration does not always occur, and some individuals who use wheelchairs, prostheses or cochlear implants may not come to see such objects as a basic part of their corporeal existence. While the presence of these technologies may become important in terms of a person's self-perception or body image, they may do so as objects endowed with personal significance and, rather than being mere objects, become bound up with a subjective body schema.⁹

On the basis of such phenomenological perspectives, Reynolds et al argue against reallocating personal ventilators, understood as an embodied or ‘integrated technology’ (2021, p. 273). In their view the contribution that such devices make to one’s *relational narrative identity* and their importance for continued functioning across one’s future life course accords personal ventilators an ethical significance greater than that which attaches to mere items of property (2021, pp. 275–276). However, whether personal ventilators commonly become embodied or corporeally integrated technologies remains uncertain. Whilst ventilators are used regularly, this use is intermittent, usually when shortness of breath intrudes on the individual’s consciousness, that is, when the body becomes opaque and not transparent. Given the attention required to operate the technical, safety and alarm systems of personal ventilators, it is unclear whether they could meet the hurdle of transparent habituation, let alone the more demanding requirements for phenomenological incorporation and thereby embodiment in the fullest sense. Thus, although initially plausible, the idea of personal ventilators as embodied objects is on uncertain ground, and moral claims that rest on these criteria cannot entirely resolve the problem of reallocating personal ventilators.

Nonetheless, we share the instinct that phenomenology may provide novel justification for the intuition that the chronically ill have a moral claim to the continued use of their personal ventilators beyond that offered by mere possession. A number of phenomenologists whose thoughts have been applied to medicine understand illness as an alienation from one’s own body. A loss of transparency represents one way in which we can be alienated from our own bodies. However, this is not the only way and, furthermore, we might situate the body in its broader ecology. For most of us, including some who live with biomedical technologies such as pacemakers, our bodies can generally be thought of as existing either *in* or *as* the background of our subjective experiences or phenomenological awareness. Changing focus from precisely what makes up embodiment to what is required to generate tolerable background conditions allows new phenomenological approaches to exploring health and illness. Svenaeus, for example, has developed an account of illness in which alienation is ‘interpreted in relationship to the whole world of illness, and not only in relationship to the lived body’ (2011, p. 336).

In his view, health is a condition of *homelikeness* while illness is not only a matter of the body losing its transparency in some way but also alienates patients from their world, rendering their whole sense of being inhospitable and unhomelike. Therapy seeks to make the world liveable again for the patient, ‘to understand such unhomelike being-in-the-world and bring it back to homelikeness again, or, at least, closer to home’ (2011, p. 336). This phenomenological home encompasses a network of relations of meaning: with others, with life projects, with one’s body, and also with things outside the body to the extent that they are constitutive of a certain meaning for that patient. On this account, objects need not literally be integrated, incorporated or embodied to contribute important and constitutive elements to the homelike background conditions of being. Thus, the question here is not whether a certain device is incorporated or dwells in us, but rather whether the patient’s general domain of being, their immediate ecology, includes the device: whether it is a condition of health-related normality that a patient dwells with or in the vicinity of that technology, object or item.

In this context one might consider Kolmes' (2020) view that some emotional support animals are sufficiently 'body-like' to attract the same kind of status and rights as other embodied objects, such as prosthetic arms and legs. Her view is similar to the argument being made by Reynolds et al (2021). However, the claim that such an animal—itself an embodied being—can form part of our or another's embodiment seems misguided on the face of it. However, similar to the account presented here, there is no need for Kolmes to suppose support animals form part of the embodiment of those who rely on them. The argument can instead be reconstructed in terms of the way such animals are a necessary condition of homelikeness for those who rely on them. Thus, we believe it is more plausible to consider a chronically ill patient's ventilator as forming a constitutive part of their homelike being than the less intuitive and more demanding proposition that it forms part of their body. Ventilators make life possible for those who are dependent on them. Whilst it is not obvious that a ventilator makes it possible for users to traverse the city in the way a wheelchair might, as an organ of action, it is the case that without their ventilators at least some chronically ill patients would not be able or prepared to leave their homes. At least insofar as it is achievable for those who are reliant upon them, personal ventilators permit patients to maintain their sense of homelike being.¹⁰ Should the relationship a patient has to their personal ventilator make a constitutive contribution to their health-related normality, then reallocating a personal ventilator does not simply risk unhomelikeness but represents an active threat to it. As such, non-maleficence may provide a sufficient *prima facie* reason not to reallocate a device that constitutes a basic element of a patient's healthy being.

Given that the concern at hand is a question of the ethical significance of personal ventilators, we suggest it is prudent to err on the side of a broader sense of 'integrated technology' than Reynolds et al's (2021) criterion of incorporation. Furthermore, whilst this is arguably the strategy adopted by Aas (2021) when he notes that whether or not an item is granted bodily status is not simply a matter of phenomenological integration but also a matter of the social practices surrounding such items, the notion of homelikeness moves beyond embodiment *per se* and facilitates recognition that bodies require ecologies. As a result, homelikeness also facilitates proper recognition of the moral significance of objects that form part of the ecology of our embodiment. The central question then is not whether this, that or the other object in fact counts as embodied for this, that or the other individual or the particular social practices that surround them. Rather the question is one of configuring our embodiment, the fact that it *inhabits* a particular ecology.

Were we to adopt this perspective in regards to the scenarios outlined above, it would seem possible to draw a clear and ethically significant distinction between the chronically ill patients for whom the proximity of a ventilator is central to the homelike constitution of their embodiment, and those financially privileged individuals who happen to own a ventilator but for whom it ordinarily contributes little to their embodiment and its ongoing maintenance. Thus, we need not distinguish between an individual who considers their ventilator to be an aspect of their embodiment and another person who does not, as we can appeal to the notion of homelike being in its stead. As such, and in parallel to the notion that items of property are public or private goods, ventilators belonging to chronically ill patients can be constitutive of their conditions of healthy or homelike being. This can be

taken to mean that chronically ill patients who rely on ventilators have a moral claim that outweighs the clinical needs of others and, therefore, the imperatives generated by reverse triage protocols.

A Final Objection

Whilst this stance might provide a satisfying explanation for our differing intuitions about scenarios B and C, we should also consider what it might mean for scenario A. If our social practices should adopt the view that the chronically ill patient's ventilator forms part of their embodiment or their homelikeness, then perhaps something similar could be said of those who are comatose or in a Persistent Vegetative State (PVS) and attached to such machines. Accounts such as those presented here and by Reynolds et al (2021) might be thought of as calling into question the ethical permissibility of withdrawing treatment from such patients. However, whilst potential for embodiment or homelikeness exists in relation to chronic patients, this is not the case for those who are in PVS. It is not possible for a ventilator to become an embodied part of the patient's sense of self or a facet of homelikeness, because these patients have been ventilated in response to an injury that has rendered them permanently unconscious. Furthermore, the nature of such injuries means a continued lack of consciousness. Thus, the condition of acute patients is such that their first-person perspective is *necessarily* absent or suspended. Whilst the possibility of phenomenological or first-person awareness remains a topic of debate when it comes to those in Minimally Conscious States (MCS), it seems legitimate to suppose that patients who require acute ventilation have little ongoing sense of their own embodiment. Therefore, they cannot be thought of as adopting the machines they are attached to into their corporeal schema or their sense of homelikeness.

Conclusion

The analysis offered in this article proceeded in light of what we take to be common moral responses to the three scenarios outlined. First, if we accept the implementation of reverse triage policies that withdraw treatment from those who will not survive without it, we acknowledge the propriety of reallocating ventilators to patients with a better chance of recovery. Second, we question the propriety of reallocating a ventilator belonging to a chronically ill patient who is reliant upon it in an ongoing manner. We feel they should have priority over its use even if its reallocation would likely mean that another patient would derive greater benefit. Third, we accept the propriety of allocating a privately owned ventilator in accordance with established protocols, meaning that its owner need not be given priority access if and when they need to be ventilated. We have argued that the moral significance of property rights, such as those elucidated by Sulmasy and Sugarman, do not resolve these three scenarios satisfactorily.

A phenomenological perspective provides resources that are more adequate to the task. Drawing upon them provides us with the means to recognise the ethical significance of embodiment as well as that which attaches to particular objects if and when they form part of our basic, health-related or embodied homelikeness. Seen in this light, the chronically ill patient's ventilator should not be considered just another possession; it is not something that can be taken in order to pursue some other good, purpose or end in the way that is permissible for other ventilators,

such as those owned by financially privileged individuals. Thus, a policy that reallocates a chronically ill person's ventilator to another patient might be thought of as no more legitimate than one which reallocates an individual's kidney, their prosthetic limb, or any other aspect of their embodiment to another person, even if it is more easily removed.

Notes

¹ This kind of reverse triage is sometimes called Selective Limitation of Treatment (SLT) or Selective Withdrawal of Treatment (SWT) (Emmerich 2011, n. 20), whilst a document published by the Deutscher Ethikrat in response to the emerging pandemic distinguishes refers to it as *Triage in ex post situations* (Deutscher Ethikrat 2020, p. 4). In a recent paper focused on COVID-19, Emmerich (2020) has also recently argued that there may be a case for the acceptance of conscientious refusals to reverse triage. Again, this only concerns the kind of reverse triage that involves withdrawing treatment from those who may yet derive benefit from its continued provision in order to treat another who is more likely to do so.

² What 'potential for recovery' means will be a matter for local policies and triage protocols. Suffice to say that in recent discussions the focus has generally been on the likelihood of survival and recovery in the short term (i.e. being discharged from hospital) and the number of days ventilation will be required. The patient's prior and subsequent quality of life is generally seen as not being a relevant factor although, as is made clear in the penultimate section of this paper, some kind of continued biographical life is a prerequisite.

³ Although see the rejoinder by Fins (2020), a member of the Taskforce.

⁴ Although it is common to speak of a ventilator as something that 'belongs to' the chronic user what is meant is that it is in their possession and they have exclusive use of it, or so we would suggest. Chronic users may or may not own the machines they rely on and it seems more likely that they in fact belong to a company providing care services. Indeed, the point in this essay is that chronic users can extend a moral claim to the continued use of such machines and that this has greater significance than mere property claims.

⁵ Let us suppose that the machine was purchased as a kind of doomsday preparation and at a time when the global demand for such machines did not outstrip the supply available. Thus, the obvious ethical issues one might raise about the *purchase* of such an item—stockpiling and/ or attempted price-gouging—are circumvented. There may be a further issue regarding its retention in circumstances when its owner had no immediate use for it and when others were in need or when hospitals were trying to increase their stock of such machines. However, we leave this to one side.

⁶ It is worth noting that most triage protocols that emerged in the early stages of the pandemic generally focus on the prognosis of each patient vis-à-vis their immediate clinical status and do not take account of a patient's life expectancy or their (perceived) quality of life (Riva and Petrini 2021). Nevertheless, there are those that suggest age or life expectancy ought to be considered relevant, if only as second order or tie breaker criteria (Vinay et al. 2021).

⁷ One might point out that sufficient financial privilege may allow one to buy a hospital and employ the staff required to run it. However, this would raise additional ethical or, perhaps, ethico-political issues and so we leave it to one side.

⁸ Thus phenomenological perspectives have particular significance when it comes to fully grasping the social reality or 'lived experience' of illness (Zaner 1981; Leder 1990; Toombs 1993; Carel 2008, 2016; Svenaeus 2019) including work that has focused on conditions that affect our ability to breathe (Toombs 2001; Carel 2010; Williams and Carel 2018).

⁹ An account of the distinction between body schema and body image can be found in Gallagher (1986).

¹⁰ An objection might be that homelikeness is inappropriate to expect of or pursue for chronically ill persons. Svenaeus recognises that homelikeness implies neither happiness nor stability, but '...the normal, unapparent, things-as-usual ways of everyday life' (2011, p. 337). The term's use in critical phenomenology acknowledges that comforts can be found in the touchstones of home and practices of homemaking without requiring the reification of the mythic home (Ortega 2020).

References

- Aas, S. (2021). Prosthetic embodiment. *Synthese* 198, 6509–6532. <https://doi.org/10.1007/s11229-019-02472-7>
- Carel, H. (2008). *Illness*. Acumen Publishing.
- Carel, H. (2016). *Phenomenology of Illness*. Oxford University Press.
- Carel, H. (2010) *Phenomenology and its application in medicine*. Theoretical Medicine Bioethics. <https://doi.org/10.1007/s11017-010-9161-x>
- Csordas, T. (1999). Embodiment and Cultural Phenomenology. *Perspectives on Embodiment: The Intersections of Nature and Culture*, 143–62. Routledge.
- De Preester, H. (2011). Technology and the Body: the (Im)Possibilities of Re-embodiment. *Foundations of Science* 16, 119–137. <https://doi.org/10.1007/s10699-010-9188-5>
- De Preester, H. & Tsakiris, M. (2009). Body-extension versus body-incorporation: Is there a need for a body-model? *Phenomenology and the Cognitive Sciences* 8, 307–319. <https://doi.org/10.1007/s11097-009-9121-y>
- Deutscher Ethikrat. (2020). *Solidarity and Responsibility during the Coronavirus Crisis* [Press release]. <https://www.ethikrat.org/en/press-releases/press-releases/2020/solidarity-and-responsibility-during-the-coronavirus-crisis/>
- Emmerich, N. (2011). Anti-theory in action? Planning for pandemics, triage and ICU or: how not to bite a bullet. *Medicine Health Care and Philosophy* 14, 91–100. <https://doi.org/10.1007/s11019-010-9289-5>
- Emmerich, N. (2020). Ought Conscientious Refusals to Implement Reverse Triage Decisions be Accommodated? *Journal of Bioethical Inquiry* 17, 783–787. <https://doi.org/10.1007/s11673-020-10042-7>
- Fins, J.J. (2020). Disabusing the Disability Critique of the New York State Task Force Report on Ventilator Allocation. The Hastings Center. <https://www.thehastingscenter.org/disabusing-the-disability-critique-of-the-new-york-state-task-force-report-on-ventilator-allocation/>. Accessed 19 November 2021

- Gallagher, S. (1986). Body image and body schema: A conceptual clarification. *The Journal of mind and behavior*, 7, 541–554.
- Ihde, D. (2010). *Embodied Technics*. Copenhagen, Denmark: Automatic Press/VIP.
- Kolmes, S. (2021). Are emotional support animals prosthetics or pets? Body-like rights to emotional support animals. *Journal of Medical Ethics*, 47(9), 632–638. <https://doi.org/10.1136/medethics-2020-106205>
- Leder, D. (1990). *The Absent Body*. University of Chicago Press.
- Ne’eman, A. (2020-03-23). ‘I Will Not Apologize for My Needs’. The New York Times. <https://www.nytimes.com/2020/03/23/opinion/coronavirus-ventilators-triage-disability.html>
- Ne’eman, A. (2020). Do New York State’s Ventilator Allocation Guidelines Place Chronic Ventilator Users at Risk? Clarification Needed. The Hastings Center. <https://www.thehastingscenter.org/do-new-york-states-ventilator-allocation-guidelines-place-chronic-ventilator-users-at-risk-clarification-needed/>. Accessed 19 November 2021
- Mucci, F., Mucci, N., & Diolaiuti, F. (2020). Lockdown and isolation: psychological aspects of COVID-19 pandemic in the general population. *Clinical Neuropsychiatry* 17(2), 63–64. <https://doi.org/10.36131/CN20200205>
- New York State Task Force on Life and the Law. (2015). Ventilator Allocation Guidelines. New York State Department of Health, New York. https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf
- Ortega, M. (2020). Hometactics. *50 Concepts for a Critical Phenomenology*, 169–174. Northwestern University Press.
- Reynolds, J.M., Guidry-Grimes, L., & Savin, K. (2020). Against Personal Ventilator Reallocation. *Cambridge Quarterly of Healthcare Ethics*, 30(2), 272–284. <https://doi.org/10.1017/S0963180120000833>
- Riva, L., Petrini, C. (2020). Ethics of triage for intensive-care interventions during the COVID-19 pandemic: Age or disability related cut-off policies are not justifiable. *Clinical Ethics* 16, 228–233. <https://doi.org/10.1177/1477750920971803>
- Shilling, C. (2004). *The Body in Culture, Technology and Society*. SAGE.
- Smith, D.W. (2018). Phenomenology. *The Stanford Encyclopedia of Philosophy, Summer 2018 Edition*. Metaphysics Research Lab, Stanford University.
- Sprung, C.L., Joynt, G.M., Christian, M.D., et al. (2020). Adult ICU Triage During the Coronavirus Disease 2019 Pandemic: Who Will Live and Who Will Die? Recommendations to Improve Survival. *Critical Care Medicine* 48(8), 1196. <https://doi.org/10.1097/CCM.00000000000004410>
- Sulmasy, D.P., Sugarman, J. (1994). Are withholding and withdrawing therapy always morally equivalent? *Journal of Medical Ethics*, 20(4), 218–224. <https://doi.org/10.1136/jme.20.4.218>
- Svenaesus, F. (2011). Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. *Medicine, Health Care and Philosophy*, 14(3), 333–343.
- Svenaesus, F. (2019). A Defense of the Phenomenological Account of Health and Illness. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, 44(4), 459–478. <https://doi.org/10.1093/jmp/jhz013>

- Toombs, S.K. (1993). *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient*. Springer.
- Toombs, S.K. (2001). Introduction: Phenomenology and medicine. *Handbook of phenomenology and medicine*, 1–26. Springer.
- Truog, R.D., Mitchell, C., & Daley, G.Q. (2020). The Toughest Triage — Allocating Ventilators in a Pandemic. *New England Journal of Medicine* 382(21), 1973–1975. <https://doi.org/10.1056/NEJMp2005689>
- Vinay, R., Baumann, H., Biller-Andorno, N. (2021). Ethics of ICU triage during COVID-19. *British Medical Bulletin*, 138(1), 5–15. <https://doi.org/10.1093/bmb/ldab009>
- Wilkinson, D. (2020). ICU triage in an impending crisis: uncertainty, pre-emption and preparation. *Journal of Medical Ethics*. <https://doi.org/10.1136/medethics-2020-106226>
- Williams, T., Carel, H. (2018). Breathlessness: From Bodily Symptom to Existential Experience. *Existential Medicine*. London, UK: Rowman & Littlefield International.
- Wong, A. (2020). I'm disabled and need a ventilator to live. Am I expendable during this pandemic? <https://www.vox.com/first-person/2020/4/4/21204261/coronavirus-covid-19-disabled-people-disabilities-triage>. Accessed 19 November 2021.
- Zaner, R.M. (1981). *Context of Self: A Phenomenological Inquiry Using Medicine as a Clue*. Ohio University Press.