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The fair innings of rationing intensive care

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The Fair Innings of Rationing Intensive Care

A research report which studies the opinion of Dutch society about the possible use of an age criterium, based on the fair innings argument, when there will be a shortage of ICU beds due to the COVID-19 pandemic.

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Abstract

Introduction:
Since 2020, over one million Dutch citizens reported to have been infected with COVID-19. As a result, ten percent more people died in the Netherlands in 2020 than in the years before that. People with COVID-19 need special ICU care and resource scarcity disproportionately affects older adults. In the Netherlands, there was and still is a big discussion about which criteria should play a role in triaging COVID-19 patients for the available ICU beds. One of the main points of this debate is whether the age criterium based on the fair innings argument should play a role in triaging ICU beds.

Theoretical framework:
In the case of a pandemic, a disease crosses international boundaries. Regarding COVID-19, 5-25 percent of the infected people are in need of hospitalization. On top of that, 2-4 percent of these people need mechanical ventilation at an ICU. Although the ICU capacities increased, the capacity may still not fully meet the demand and other criteria to ration ICU care were needed. A script, named *"Draaiboek Triage op basis van niet-medische overwegingen voor IC-opname ten tijde van fase 3 in de COVID-19 pandemie"*, consists of several criteria to triage COVID-19 patients when there is a scarcity of ICU beds. One of these criteria is the age criterium based on the fair innings argument, that will be used when it is no longer possible to triage patients based on medical criteria. Age has always been a depending factor in rationing lifesaving treatments in the past. Bognar (2015) is convinced that the fair innings argument is a justified argument that does not contain any discrimination and that a lot of people agree that younger generations should take precedence over older generations. At the same time, others claim that using the fair innings argument is unjustified discrimination against elderly and that the length of someone's life depends on luck and circumstances. Furthermore, elderly can feel discriminated because of the age criterium, but it is often seen that they wish for young people to get the treatment before they do.

Methods:
The first part of the study consisted of qualitative desk research and the second part of the study of quantitative empirical research. To collect data for the first part, online data sources as well as offline data sources were used. To collect data on the second part of the study, a questionnaire with casuistry was spread among the researcher's network. Furthermore, SPSS (version 25) was used for data analysing.

Results:
Of the 394 respondents (N = 394), 310 (78,7%) people had never heard of the fair innings argument before. A definition of the fair innings argument was provided in the questionnaire, and 147 (37,3%) said that this definition matched with what they thought it meant. Most of the respondents (57,6%), agreed that using an age criterium based on the fair innings argument would be fair, while 111 (28,2%) disagreed. For the casuistry, it can be stated that when the age difference becomes smaller, less people agree that a younger person should take precedence and more people answer that they do not know who to choose. The associations between the variables *education* and *children* on *thinking that an age criterium based on the fair innings argument is fair*, both were statistically significant ($p < 0,05$). For the associations between the background characteristics and the answers people gave for the various

cases was seen that for the variable *children* there was a statistically significant relationship ($p < 0,05$) with all the various cases.

Discussion/ conclusions:

The questionnaire was in Dutch which could have affected the reliability of the study due to translation mistakes, miscommunication and differences between literal translation and what is actually being said. Although, the necessary response of 384 was achieved, the study is not generalizable to the whole Dutch population. Further research is needed to collect more extensive information about the opinion of Dutch society, have a representative sample and collect information about improving policy making. Taking into account that the sample size is not representative for the whole Dutch population, it can be said that the surveyed respondents think that an age criterium based on the fair innings argument is fair to use, to ration a shortage of ICU beds due to the COVID-19 pandemic. Respondents would say that a younger person should take precedence over an older person but it depends on how the question is asked. Also, there might be a relationship between the answers that respondents gave and having (grand)children.

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Abbreviations

COVID-19	Corona virus (also called SARS-CoV-2)
EU	European Union
FI	Fair innings
FMS	Federatie Medisch Specialisten (Federation of Medical Specialists)
HBO	Hoger Beroepsonderwijs (Higher professional education)
ICU	Intensive Care Unit
IGJ	Inspectie gezondheidszorg en jeugd (Health and Youth Inspectorate)
KNMG	Koninklijke Nederlandse Maatschappij tot bevordering der Geneeskunst (Royal Dutch Society for the Promotion of Medicine)
MBO	Middelbaar beroepsonderwijs (Secondary vocational education)
RIVM	Rijksinstituut voor Volksgezondheid en Milieu (National Institute for Health and Environment)
WHO	World Health Organization
WWII	World War 2

Chapter 1: Introduction

In this chapter, the subject of the research report is introduced. First, the actuality, scientific and societal relevance of the subject are described. Then, the aim of the study is given, followed by the research question and relevant sub questions. Furthermore, the reading guide describes where the reader can find certain information.

1.1. Actuality

On 27 February 2020, the COVID-19 pandemic started in the Netherlands. Since that day, over one million Dutch citizens reported to have been infected with COVID-19 (RIVM, 2021). Additionally, ten percent more people died in the Netherlands in 2020 than in the years before that (CBS, 2021b). Many people with COVID-19 need special ICU care. Due to the high number of COVID-19 patients, an absolute shortage of ICU beds was imminent at one moment. According to Cardoso et al. (2020), elderly with COVID-19 will only have access to ICU care when there is enough ICU capacity. Resource scarcity disproportionately affects older adults, but in particular elderly who experience serious consequences because of COVID-19. These are ranging from severe illness and hospitalization to increasing mortality risk (Farrell et al., 2020).

Due to the COVID-19 pandemic, only 49 percent of all Dutch hospitals could deliver critical plannable care as usual (Wilman, 2021). Healthcare needed to be rationed differently. In the Netherlands, a script has been made that helps doctors decide which patients have priority in getting a bed at the ICU when *code black* initiates (KNMG, 2020b). "Code black" means that there is a shortage of ICU beds because of the demand of COVID-19 patients. This script includes different criteria but also an age criterium which is based on the *fair innings argument*. The "fair innings argument" requires that everyone has had an equal chance in life to live his or hers "fair innings" (Adler, Ferranna, Hammitt, & Treich, 2021). This means that a person should have a chance to reach the appropriate threshold in life. After reaching this threshold, the extra life years can be seen as sort of bonus time, which may be cancelled to help others reach the threshold (Adler et al., 2021). There was and still is a big discussion about which criteria should play a role in triaging COVID-19 patients for the available ICU beds (Cardoso et al., 2020). One of the main points of this debate is whether the age criterium should play a role in the distribution of ICU beds. In fact, this is a pressing discussion which is being held in several countries around the world.

M'hamdi stated in the Dutch newspaper *Trouw* on 14 January 2021 that the age criterium is not as fair as it seems. A disabled person of 22 years old may not have had the same chances in life as a 17 years old athlete. Also, the Dutch Cabinet and house of representatives are scared that an age criterium would lead to age discrimination (Klaassen & Zwienen, 2021). The minister of medical care states that all lives are equal and that a lottery would be a more fair approach to ration ICU care. In contrast to that, Bredenoord and Derde say that there can only be age discrimination if section would be based on irrelevant criteria (Kloosterhuis, 2021). With the age criterium, that will be used to ration ICU care, there is no age discrimination because age is a relevant criterium. No one's health care needs should be fully ignored, but when resources are scarce, one have to limit the share of elderly (Bognar, 2015). Especially, when they are competing with younger generations. Bognar (2015) explains that the problem of a "greying" population is increasing because of the rising health care costs that arise due

to the expensive care for elderly. Furthermore, Bognar (2015) is convinced that most people would agree that the needs of younger generations should be preferred.

1.2. Scientific & Societal Relevance

Various sources can be found that contain arguments why the fair innings argument should or should not be used. Rationing health care due to the COVID-19 pandemic poses difficult ethical questions. In the Netherlands, policy makers answered these questions without asking societies input. No literature can be found about whether Dutch society thinks that the fair innings argument should be used to ration ICU beds. This thesis will investigate the opinion of Dutch society on the use of the age criterium based on the fair innings argument for rationing ICU beds. This research is relevant for society because COVID-19 dominates the whole world and decisions about who should have priority in obtaining an ICU bed concern the entire Dutch population. Furthermore, it is important to have information about the view of Dutch society against these kinds of ethical questions so that policy makers can learn from it for the future. It is scientifically relevant to conduct this research in the Netherlands because many people are still getting infected with COVID-19 every day. The director of the RIVM is expecting a third wave of the COVID-19 pandemic in April and a fourth wave in June (Keulemans, 2021). Both waves will increase the pressure on health care and so ICU care, which means that code black is still a possible scenario in the Netherlands.

1.3. Aim

The research aim of this study is to obtain information about the opinion of Dutch society on using an age criterium based on the fair innings argument to ration ICU beds due to the COVID-19 pandemic. The practical aim of this study is for policy makers to learn from the opinion of Dutch society for future policy making.

1.4. Research Question & Sub Questions

To conduct this research the following research question has been formed:

"What are the opinions within Dutch society about the age criterium based on the fair innings argument that will be used to ration ICU beds due to the COVID-19 pandemic?"

To find an answer to the research question the following sub questions were formulated:

- *How did the COVID-19 pandemic influence ICU care and ICU rationing?*
- *How will the fair innings argument be used to ration ICU beds?*
- *Does Dutch society know what the fair innings argument means?*
- *What is the opinion of Dutch society about the age criterium?*
- *Do people with different background characteristics* have different opinions about the age criterium?*

*With "background characteristics" is meant: age, sex, education, marital status, if someone has (grand)children, work sector and in which province someone lives.

1.5. Reading guide

In the next chapter, background information on the main concepts of this study will be given. Additionally, sub questions one and two will be answered in the next chapter. Chapter 3, will describe the used research methods of this study and how data was collected and analysed. In chapter 4, the results of the empirical research will be presented and sub questions three, four and five will be answered. In the last chapter, chapter 5, some discussion point about the research report are discussed and the final conclusion is given. Furthermore, references used for this study are listed in the bibliography. The questionnaire used and the comments people left at the end of the questionnaire are included in the appendices.

Chapter 2: Theoretical framework

In this chapter, some background information on the main concepts of this study is given. The concepts covered are: pandemic, COVID-19, ICU, the fair innings argument and the age criterium. The research question of this research report is a descriptive ethical question. So, this study's framework will be built on an ethical perspective. Furthermore, sub questions one and two are answered in this chapter.

2.1. Pandemic & COVID-19

The classical definition of a pandemic is "an epidemic occurring worldwide" (Grennan, 2019). An epidemic means that a disease is spreading among people, which affects a large number of people in a certain area or country. When speaking of a pandemic, a disease crosses international boundaries (Grennan, 2019). The label "pandemic" is based on how many cases of the disease occur. The disease can, for example, consist of a contagious virus that people will not (yet) be immune for. Since the 14th century, history has presented 19 pandemics with more than 100.000 deaths (Jordà, Singh, & Taylor, 2020). The biggest pandemics were the *Black Death* (1331-1353) and the *Spanish Flu* (1918-1920). All the 19 pandemics caused negative effects on the economy. Besides a virus infection crossing international boundaries, economic shocks cross country borders as well because of trade and market integration. Usually, it is seen that the highest activity of a pandemic virus occurs in the same season as normally the influenza virus occurs, but every virus has its own characteristics (Singhal, 2020). The same holds for COVID-19. This virus is also known as "coronavirus", "SARS-CoV-2" or "the severe acute respiratory syndrome coronavirus 2". This contagious virus comes from bats and spreads fast among humans through inhalation or contact with infected droplets (Singhal, 2020). The disease first occurred in Wuhan, China in December 2019. On 11 March 2020, the WHO officially declared the outbreak of COVID-19 a pandemic (Jeffrey, 2020). In three months' time, one million infections with COVID-19 and 65.000 deaths due to the virus were reported around the globe (Cohen, et al., 2020). Common symptoms of COVID-19 are fever, cough, sore throat, breathlessness, headache, fatigue and malaise. Mostly, elderly or people with co-morbidities develop more severe symptoms like pneumonia, acute respiratory distress syndrome (ARDS) and multi organ dysfunction which can lead to death (Singhal, 2020). Furthermore, people can be infected with COVID-19, but have no symptoms at all which is one of the reasons that the virus spreads so fast around the world.

The whole world was surprised by the pandemic and countries introduced restrictions to stop the virus from spreading. Authorities sent conflicting messages, people were urged to maintain socially distanced and the media showed hygiene campaigns and news about overcrowded hospitals (Laventhal et al., 2020). Surgeries and other procedures that were not urgent were delayed. All these factors caused extra stress and affected the mental health of society in a negative way (Pfefferbaum, & North, 2020).

2.2 ICU

In the beginning, intensive care was set up for severely injured soldiers who needed intensive nursing care (Marshall, et al., 2017). After WWII, medical techniques developed fast and in that time mechanical ventilation was created to support polio patients. This was done at a special department: the ICU. Over time, an ICU became a crucial aspect of a hospital where patients could be put on organ support, ventilation, kidney dialysis and cardiovascular monitoring (Marshall, et al., 2017). Sometimes,

ICUs also go by the name “Critical Care Units” (CCUs) or “Intensive Therapy Units” (ITUs) (NHS, 2019). The meaning of an ICU bed differs around the world. Mostly, an ICU is standard in hospitals of high-income countries while it is normal to not have an ICU in hospitals in a low-income countries (Marshall, et al., 2017).

There can be different reasons why someone needs ICU care. In a modern hospital, the ICU is designed for critically ill patients that need special medical care and attention (Marshall, et al., 2017). Normally, people who need oxygen, monitoring, intensive nursing care and/ or life support are placed at the ICU. Often it is seen that a person at the ICU has problems with one or more organs. An example of such a problem is one with the lungs and therefore not being able to breath on their own (NHS, 2019). The ICU is a department in a hospital, but usually its activities extend beyond the walls of its department to include the emergency department and follow-up clinic. At the ICU, different specially trained disciplines work together to prevent further physiologic deterioration while treating the underlying disease (Marshall, et al., 2017). Besides treating the patient, ICU physicians are also trained in supporting the family of patients and providing care at the end of life. Normally, there is one nurse for one till two patients (NHS, 2019).

For most people, staying at the ICU is a stressful event. People suffer from failing organs which result in loss of trust in their own body (Engström, Nyström, Sundelin & Rattray, 2013). When a person does not need ICU care anymore, they will be transferred to another department to recover and eventually go home. Generally, people do the last phase of recovering at home. In some cases it will take months to fully recover from an ICU admission (NHS, 2019).

In case of COVID-19, five to twenty-five percent of the infected people are in need of hospitalization. On top of that, two to four percent of these people need mechanical ventilation at an ICU (Haas, de Lange, van Dijk, & van Delden, 2020). During the COVID-19 pandemic, the demand for ICU care increased and consequently more ICU capacity was needed. A new distribution of ICU beds was needed and in May 2020 the first version of *“Draaiboek Triage op basis van niet-medische overwegingen voor IC-opname ten tijde van fase 3 in de COVID-19 pandemie”* came out. This is a script that describes how doctors can decide who should be placed at the ICU when there is not enough space for everyone (FMS, 2020). With the big COVID-19 outbreak in Italy, it was seen that the health care system could not manage the demand of ICU beds (Volpato, Landi, & Incalzi, 2020). The system counted 3,2 hospital beds for 1.000 citizens, while the average for the EU is 5,0 hospital beds for 1.000 citizens. In Bangladesh they even have less than one ICU bed per 100.000 citizens. Valley and Noritomi (2020) argue that instead of expanding the ICU capacity, there are also three other strategies without needing more ICU beds, namely: improving advanced care planning, regionalizing critical care and enhancing primary care.

Before the COVID-19 pandemic, the Netherlands counted 1.150 ICU beds (van Aartsen, 2021). Normally, about 70 till 75 percent of these beds are occupied. During the first wave of the COVID-19 pandemic, the ICU beds have been scaled up to 1.424 beds for COVID-19 patients and 350 beds for patients with other serious health issues (Volksgezondheidenzorg.info, 2021). By scaling down plannable care, more ICU beds can be made available and the capacity can be scaled up to a maximum of 2.000 beds (van Aartsen, 2021). Furthermore, the Ministry of Defence is willing to supply hospitals with additional respiratory equipment when they cannot succeed with purchasing respiratory

equipment themselves. At the beginning of the COVID-19 pandemic, in February 2020, patients spent on average 22 days at the ICU (Engels, 2020). Later in the pandemic, this average was halved and patients admitted after July only spent nine days at the ICU. Because of this halving, new COVID-19 patients could be admitted earlier to the ICU, which also increased the ICU capacity. According to Klaassen and Zwienen (2021), the maximum of ICU beds that can be made available when code black initiates will lay around 2400 beds.

Furthermore, the pressure on the health care providers increased. There already was a shortage of health care providers in the Netherlands, but because of the COVID-19 pandemic this shortage became an even bigger problem (NOS, 2020). At least one nurse is needed per two ICU beds. Nurses need a special training to provide care at an ICU. This made it hard to fill up the gaps at the ICU's with nurses from other departments; their flexibility was needed. On top of this, there also was a shortage because health care providers got infected with COVID-19 themselves (Lodha & Kabra, 2020). For this reason, the Netherlands started a cooperation with Germany (NOS, 2020). When all the ICU beds in the Netherlands are filled, it is possible to transfer COVID-19 patients to Germany.

2.3. The fair innings argument

Due to the COVID-19 pandemic, the ICU capacities were increased. Still, the capacity may not fully meet the demand and other criteria to ration ICU care were needed (Haas, de Lange, van Dijk, & van Delden, 2020). One of these criteria is the age criterium based on the fair innings argument. The fair innings argument holds that all people should have an equal chance to live a life of a certain duration. There are no hard written rules about how long this life duration should be, but regularly those under 18 have priority and those of 80 and above have had their chance to experience life (Haas et al, 2020).

The discussion about using an age criterium in health care existed prior to the COVID-19 pandemic. In 1997, Alan Williams first introduced the concept of fair innings in health care because of the fast growing older population (Hazra, Gulliford, & Rudisill, 2018). Elderly were seen as a burden to society by younger generations, because the elderly demanded all the health care and not enough resources were left for the younger people. According to Alan Williams, the fair innings argument helped to ration health care in a fair and efficient way and reduced the health inequalities over the course of life (Hazra et al., 2018). Bognar (2015) stated that less life years would be saved if health care would focus on elderly. Younger people have more life years to live with opportunities to do good, achieve goals and complete a full life. The more life years saved, the greater the benefit. People who are over the 'fair innings threshold' and live in their bonus time, are more expensive in terms of life-saving treatments, doctors' appointments or drugs for chronic diseases. Bognar (2015) is convinced that lots of people agree that it is reasonable that younger generations take precedence over older generations.

An age criterium as described above is based on an utilitarian view (Haas et al, 2020). A very large number of people benefit from this criterium and probabilities of survival after ICU admission are higher for younger people than for older ones, which is important for this utilitarian view. However, the literature argues whether it is fair to use an age criterium based on the fair innings argument to ration health care. Wareham (2015) is against this beneficence utilitarian approach. He claims that if this view is accepted, one should also discriminate against people with a lower life expectancy like smokers and people with obese. In addition to that, Castro-Hamoy and Castro (2020) claim that using the fair innings argument is unjustified discrimination against elderly. Elderly have a higher chance to

die because of COVID-19, so this vulnerable group should be protected and not be excluded from ICU care. Decisions to ration ICU beds should focus on medical indications and this focus should be on short-term benefits instead of long-term benefits - as is the case with the fair innings argument - to avoid unfair age discrimination (Castro-Hamoy & Castro, 2020). When people are divided in age groups, some people's lives are worth less than other people's lives, while all the lives of all human beings should weigh equal to each other.

This is in contrast with Bognar (2015), who states that the fair innings argument is a justified argument that does not contain any discrimination because people are divided into different age groups. As a person gets older, he or she will go through the different stages of life that belong to the different age groups. This means that in life everybody has the same chance to reach all the age groups and everybody will experience the advantages and disadvantages of a certain age group. Using the fair innings argument, one should look at a person's 'whole life-time experience' and not just look at a person's state at any particular age (Hazra et al., 2018). It is recommended to prioritize the persons at high risk first. This is what is done with rationing the vaccines for COVID-19, but when a young and an old person are equally at risk this recommendation changes to prioritizing the younger person first (Farrell, Francis, & Lundebjerg, 2020).

Archard and Caplan (2020) argue that the length of someone's life depends on luck and circumstances. There is nothing fair about treating someone's length of life like it is a good. It puts a stigma on elderly, that they are second class citizens. Older generations are already discriminated by society, for example at the employment market. Nineteen percent of the care providers for people aged 18 or above, are adults older than 65 years (Farrell, Francis, & Lundebjerg, 2020). Often is seen that grandparents take care of grandchildren or even take on fulltime parenting responsibilities when parents of the children have died or are not capable of parenting. So, the elderly keep families together. During the COVID-19 pandemic, there is an ongoing debate about who is essential to society (Farrell, Francis, & Lundebjerg, 2020). For example, caregivers and teachers want to get priority in the vaccination program. In the Western world, there is this view which accents independence in autonomy. Relational autonomy - meaning an individual looks at itself embedded in a social context - is at risk nurturing a selfish view of autonomy (Jeffrey, 2020).

According to Fisher OP (2013), the problem does not lie with older people, but with the market, budget and mainly the scarcity. While elderly can feel discriminated because of the age criterium, it is often seen that they wish for young people to get the treatment before them (Wareham, 2015). Jeffrey (2020) states that the COVID-19 pandemic is an exceptional situation and an age criterium can be justified if it saves a large number of human lives. Age has always been a depending factor in rationing lifesaving treatments in the past (Archard & Caplan, 2020). For example, in Europe it is very unusual for someone of 80 years and above to get an organ transplant. Age discrimination does not play a role in rationing ICU care and age may in times of crisis be used as criteria to triage patients (Laventhal et al., 2020). At first, hospitals should increase in space, staff and supplies. Additionally, cooperation with other hospitals is important so that patients can be transferred easily as well. Than a triage team can be put together to make the decisions about the allocations (Laventhal et al., 2020). This team mostly exists of a triage officer, who leads the team, and other health care providers. All brought-in patients should be stabilized before the triage team makes any rationing decisions. It is important that triage team members can clearly explain the choices they have made to family members and others.

According to Laventhal et al. (2020), a system used for triaging patients should always be transparent, focus on the greatest benefits and be applied constantly. Demographic factors and socioeconomic status should never be used. Furthermore, patients should always be assessed with the same criteria (Jeffrey, 2020). When the choice is between two patients and all else is equal, rationing should be done based on randomization (Laventhal et al., 2020).

2.4. The Age Criterium

As mentioned before, the Netherlands has made a script for when *code black* presents itself. Code black is also named *phase 3* and means that all capacity is fully utilized (van Aartsen, 2021). In phase 3, no more local or regional solutions are possible to guarantee the continuity of care. Currently, the COVID-19 pandemic in the Netherlands is in phase 2 (van Aartsen, 2021). Phase 3 can only be proclaimed nationally after all options in phase 2, as described in the script, have been used.

The script, named *"Draaiboek Triage op basis van niet-medische overwegingen voor IC-opname ten tijde van fase 3 in de COVID-19 pandemie"*, is made by the FMS, KNMG, IGJ and an advisory group of medical ethicits and professors of medical ethics (KNMG, 2020a). The script consists of several criteria to triage COVID-19 patients when there is a scarcity of ICU beds (FMS & KNMG, 2020). People in need of ICU care have life-threatening conditions and it is not possible to put them on a waiting list for the ICU. For as long as possible the rule 'first come, first serve' will be applied. Phase 3 can be divided in step A, B and C. In step A and B, decisions of rationing ICU beds are made based on medical related criteria. There will be looked at other illnesses, the chance of a good recovery, life expectancy and expected treatment time (Klaassen & Zwienen, 2021). Patients who are expected to spend a short time at the ICU, for example after a car accident, have priority over COVID-19 patients who are likely to spend a longer time at the ICU. When it is no longer possible to triage patients based on medical criteria, non-medical criteria will be used (FMS & KNMG, 2020). For this non-medical criteria, the script uses the following general ethical principles: all humans are equal; the premise to save as many lives as possible; and a form of justice saying that equals should be treated equal and unequal should be treated unequal. There are also some considerations that may not play a role in triaging patients to ICU care, namely: social position and status, mental or physical disability, personal relationships, ability to pay, ethnicity, nationality, legal status, gender, prior quality of life and 'own fault' (FMS & KNMG, 2020).

The non-medical criteria, apply to COVID-19 patients as well as other patients requiring ICU care. Again, people predicted to only need a short ICU admission have priority compared to people who probably need a longer ICU admission. A person who already holds a place at the ICU will not be compared to someone newly brough in and requiring ICU care (FMS & KNMG, 2020). Furthermore, physicians who have a high risk of getting infected with COVID-19 (because they are exposed to it a lot and work at a place which has scarcity of material for personal protection) take precedence if they are in need for ICU care. Another non-medical criterium, is the age criterium based on the fair innings argument (FMS & KNMG, 2020). This age criterium does not consist of an absolute age limit, but uses a relative limit. The generation in which someone is classified is decisive and not their exact age. The following classification of generations is used: 0 to 20 years, 20 to 40 years, 40 to 60 years, 60 to 80 years and 80 years and older. Categories of 20 years are used in this classification because this connects to the biological generations and offers sufficient distinctive power (FMS & KNMG, 2020). Nevertheless, it is possible that this classification will cause difficulties in practice at the 'edges' of the categories. For

example, if priority is given to a 39 year old over a 41 years old, the difference is only two years and can lead to friction. This inconvenience is inescapable because it will always occur with any classification including categories with limits. When the non-medical criteria above are inconclusive, there will be a drawing of lots to decide who will get a bed at the ICU.

The script gives the Netherlands a national protocol for physicians to follow. It is seen that other countries did not prepare for a crisis situation like code black. For example, in Belgium decision making about who will get a bed at the ICU can differ per hospital (Skipr Redactie, 2021). The KNMG did not want this decentralised approach for the Netherlands. Everyone should have an equal chance to gain (life)experiences and achieve goals. It is about the opportunity in the sense of time that someone has had (FMS & KNMG, 2020). This justifies that younger generations can take precedence over older generations. For this reason, health care providers who make decisions based on the script cannot be prosecuted. The Dutch Public Prosecution Service (OM) calls phase 3 “a crisis situation” and any declaration against health care providers will be dropped (Baltesen, 2021).

Generally speaking, the literature only gives suggestions about what society will think of an age criterium based on the fair innings argument. No previous empirical research can be found specifically including the opinion of Dutch society about the use of an age criterium based on the fair innings argument to ration ICU beds due to the COVID-19 pandemic.

Chapter 3: Research methods

The study can be divided into two parts. The first part of the study, consisted of qualitative desk research that answered the first two sub questions. This part of the study had to be done, before the second part of the study could start. The second part consisted of quantitative empirical research. The collected data from part one was used to formulate a questionnaire which helped answer sub questions three, four and five.

3.1. Desk research

To collect data for the first part of the study, online data sources as well as offline data sources were used. For example, databases like Google, Google Scholar, Pubmed and SpringerLink were used as well as data from newspapers and books. To improve reliability, in- and exclusion criteria were stated before starting the desk research. These criteria can be found in table 1. Important was to look critically at so called "grey literature" such as internal documentation and reports by different organisations because these can be biased. Also, it was important to realise that all literature is different and can vary in depth, quality and rigour. Drawbacks of desk research are that results might be biased and that there might be scarcity of data sources. Generally speaking, desk research is an effective way of collecting information (Guerin, et al., 2018).

Inclusion criteria	**Exclusion criteria**
Scientific articles or studies	Non-scientific articles or studies
Written in English or Dutch	Other languages
Literature from 2011 or later	Literature older than ten years old
Articles or studies available in full text	Articles or studies that are only partial available
Articles or studies that are relevant for this research and to answer the sub questions	Articles or studies that are not relevant for this research

Table 1: In- and exclusion criteria of the desk research.

When the collected data met the in- and exclusion criteria, the data analysis was started by looking at the abstract and conclusion of the article. Based on this, it was determined if the source could be used for this study. When a source could be used, the whole article was read and useful parts of the text were copied to a Microsoft Word document. After all data collection was complete, the copied texts were compared with each other and the best texts were summarized and re-written. This helped to create an overview about a certain topic. It gave information about what is available about that certain topic and what could be used before further research, like a questionnaire, was undertaken (Guerin, Janta & Gorp, 2018). All used resources were listed following the American Psychological Association (APA) guidelines in the bibliography. An exception to the in- and exclusion criteria was made for the book of Kirkwood & Sterne (2003). This book explains medical statistics and is also used as mandatory literature by the Erasmus University Rotterdam. For that reason, this book is found relevant as a data source for this research report.

3.2. Empirical research

In addition to desk research, an online questionnaire is an efficient way to collect data. It is practical and large amounts of information can be collected from a large number of people in a short period of

time (McLeod, 2018). To make an online questionnaire, a questionnaire website was needed. For this study *www.enquetesmaken.com* was used, because this website adapts to any mobile device.

The research population of this study consisted of citizens of the Netherlands that were above 18 years old. When conducting this research, about 14 million citizens of the Netherlands were above the age of 18 (CBS, 2021a). To calculate the sample size the following formula was used (Taherdoost, 2017):

$$n = \frac{P(100-P)Z^2}{E^2} \qquad 384{,}16 = \frac{50(100-50)1{,}96^2}{5^2}$$

Where,
n = the required sample size
P = the percentage occurrence of a state or condition
E = the percentage maximum error required
Z = the value corresponding to level of confidence required

According to Taherdoost (2017), a margin of error (E) of 5 percent is acceptable for questionnaire studies. The smaller the E, the greater the sample size required. Regular levels of confidence (Z) are 95 percent or 99 percent. For this study a Z of 95 percent was used, which meant that 95 out of 100 consisted of the true population value within the margin of error (E). The standard value for P, the occurrence of a state or condition, is 50 percent. When using this numbers in the formula above, it showed that a response of 384 respondents was needed for the questionnaire of this study.

The questionnaire consisted of 20 closed and half open questions. Respondents were obligated to fill in all these 20 questions. After the obligated questions were finished, there was some space for respondents to leave a comment. Furthermore, casuistry was included in the questionnaire. Two different case setups were made (Case A and B), with both four different case variants. The use of casuistry was inspired by the article of Bognar (2015). For case A, the respondent had to choose if he or she agreed that the younger person takes precedence over the older person. The age difference between person A and B was different for every variation of case A. Additionally, for case B, the respondent had to choose which person they would give the last ICU bed to. Again, the age differences between person A and B were different for all variants of case B. To collect data on the questionnaire, social media devices like Facebook, Instagram, LinkedIn and WhatsApp were used. In addition to that, the platform “Surveyswap” was used. This is a platform were one will receive response on ones questionnaire by filling in the questionnaires of others. To increase the reliability of the study, a pilot version of the questionnaire was tested before the questionnaire was distributed to make sure the questionnaire was free from errors and understandable for respondents. The full questionnaire that was used for collecting data is included in appendix 1. Respondents were able to fill in the questionnaire from 26-04-2021 till 25-05-2021. After the questionnaire was rounded, 451 respondents had started filling in the questionnaire.

The website *www.enquetesmaken.com,* has an option to download a Microsoft Excel document with all responses to the questionnaire. At first, the raw data in Excel was checked for unusable response. Only, 395 respondents fully finished the questionnaire. The 56 respondents that did not finish the questionnaire were excluded from the dataset. When something in the data needed to be excluded or

adjusted, a new document under a new name was saved every time something was changed. This way, it would always be possible to go one step back when something were to go wrong. One criteria for participating in the study was that a respondent needed to be 18 years or older. One person who filled in the questionnaire was 17 years old and for that reason excluded from the dataset. For analysing data, SPSS (version 25) was used. So, the Microsoft Excel document needed to be converted to SPSS. Also, the answers had to be coded to be able to perform analysis with SPSS. The included variables and their code name are shown in table 2. SPSS was used for the descriptive statistics as well as for performing the Pearson Chi-Square. With this test it is possible to analyse if there is an association between two nominal variables (Kirkwood & Sterne, 2003).

Variable Description	**Measurement entity**	**Coding**
Age	Scale	-
Sex	Nominal	(0) Male (1) Female (2) Different/ do not want to say
Education	Nominal	(0) No education (1) Primary education (2) High school (VMBO/HAVO/VWO) (3) MBO (4) HBO (5) University (6) Masters or doctorate
Marital status	Nominal	(0) Single (1) Married (2) Living together (3) Widow (4) Divorced (5) Do not want to say
Children	Nominal (dummy)	(0) No (1) Yes
FI	Nominal (dummy)	(0) No (1) Yes
FI_meaning	Nominal (dummy)	(0) No (1) Yes
FI_meaning_check	Nominal	(0) No (1) Yes (2) I did not know what it meant
FI_fairness	Nominal	(0) No (1) Yes (2) I do not know/ no opinion
Case_A_1	Nominal	(0) No (1) Yes (2) I do not know/ no opinion
Case_A_2	Nominal	(0) No (1) Yes (2) I do not know/ no opinion
Case_A_3	Nominal	(0) No (1) Yes (2) I do not know/ no opinion
Case_A_4	Nominal	(0) No (1) Yes (2) I do not know/ no opinion
Case_B_1	Nominal	(0) Person A (1) Person B (2) I do not know/ no opinion
Case_B_2	Nominal	(0) Person A (1) Person B (2) I do not know/ no opinion

Case_B_3	Nominal	(0) Person A (1) Person B (2) I do not know/ no opinion
Case_B_4	Nominal	(0) Person A (1) Person B (2) I do not know/ no opinion
Work_sector	Nominal	(0) No job (1) Healthcare and well-being (2) Trade and services (3) IT (4) Justice, security and public administration (5) Agriculture, nature and fishing (6) Media and communication (7) Education, culture and science (8) Engineering, production and construction (9) Tourism, recreation and catering (10) Transport and logistics (11) Retired (12) Cleaning (13) Other
Province	Nominal	(0) Brabant (1) Drenthe (2) Flevoland (3) Friesland (4) Gelderland (5) Groningen (6) Limburg (7) Noord-Holland (8) Overijssel (9) Utrecht (10) Zeeland (11) Zuid-Holland

Table 2: Overview of the included variables.

At the end of the questionnaire, 110 respondents left a comment which are included in appendix 2. For analysing, the comments were copied from the dataset to a Microsoft Word document. Certain keywords in the comments were marked with a certain colour. All keywords with the same colour were labelled with the same label. For each label was counted how many times it occurred and presented in figure 6 in the results chapter. Tables presented in this chapter as well as in the next chapter were made with Microsoft Word. Figures presented in the results chapter were made with Microsoft Excel.

Disadvantages of a questionnaire are that emotions cannot be measured. Also, it might be possible that a respondent is biased about the questionnaire's subject which can affect the reliability and validity of the research. Furthermore, it is always unknown how truthful a respondent is. Respondents will be more honest when they cannot be identified (McLeod, 2018). This is why at the beginning of the questionnaire, it was stated that collected data is confidential and only used for this study. Additional limitations and potential treats of the study were that there could be not enough responses to the questionnaire which could affect the validity and reliability of the study. Furthermore, the structure of the answer options was the same for every question so that a respondent would not accidentally answer a question incorrectly (Verhoeven, 2014). This increased the validity of the study. To make sure a respondent's attention was kept while filling in the questionnaire, *routing* was used (Verhoeven, 2014). This means that simple general questions are asked at the beginning of the questionnaire, difficult questions in the middle and again simple questions at the end of the questionnaire. To increase the response, the questionnaire was in Dutch.

Chapter 4: Results

In this chapter, the results of sub questions three, four and five are presented. Empirical research has been conducted with the use of a questionnaire. The questionnaire that was used is included in appendix 1. The results in this chapter are described with the help of figures and tables.

The N of this study is 394 respondents. In table 3, the descriptive statistics of the response group are presented. Of the included respondents, 75 (19%) are male and 318 (80,7%) are female. The youngest respondent is 18 years old and the oldest respondent is 79 years old. The mean age of the respondents is 37,53 years old (SD = 15,726). Most of the respondents have a MBO (39,6%) or HBO (33,8%) education. The biggest share of the respondent group is single/ unmarried (38,8%), closely followed by married (36,5%). Furthermore, 215 (54,6%) respondents do not have children, while 179 (45,4%) respondents do have children. More than half of the respondents (57,9%) work in the healthcare and well-being sector. Additionally, the most respondents (48,7%) live in the province Zuid-Holland.

Characteristic	Answer option	Mean	SD	Count	Percent
Age		37,53	15,726		
Sex	Male			75	19%
	Female			318	80,7%
	Different/ do not want to say			1	0,03%
Education	High school (VMBO/HAVO/VWO)			39	9,9%
	MBO			156	39,6%
	HBO			133	33,8%
	University			33	8,4%
	Masters or doctorate			33	8,4%
Marital status	Single/ unmarried			153	38,8%
	Married			144	36,5%
	Living together			70	17,8%
	Widow			5	1,3%
	Divorced			20	5,1%
	Do not want to say			2	0,5%
Children	No			215	54,6%
	Yes			179	45,4%
Work sector	No job			24	6,1%
	Healthcare and well-being			228	57,9%
	Transport and logistics			15	3,8%
	Retired			5	1,3%
	Cleaning			2	0,5%
	Trade and services			31	7,9%
	IT			10	2,5%
	Justice, security and public administration			9	2,3%
	Agriculture, nature and fishing			9	2,3%
	Media and communication			17	4,3%
	Education, culture and science			17	4,3%
	Engineering, production and construction			16	4,1%
	Tourism, recreation and catering			6	1,5%
	Other			5	1,3%
Province	Brabant			28	7,1%
	Drenthe			10	2,5%
	Zeeland			5	1,3%
	Zuid-Holland			192	48,7%
	Flevoland			4	1%
	Friesland			11	2,8%

	Gelderland			28	7,1%
	Groningen			12	3%
	Limburg			11	2,8%
	Noord-Holland			53	13,5%
	Overijssel			16	4,1%
	Utrecht			24	6,1%

Table 3: Descriptive statistics. (N = 394).

The first sub question that needed to be answered by empirical research was the sub question "*Does Dutch society know what the fair innings argument means?*". In the questionnaire, people were asked if they had ever heard of the fair innings argument before. Of the 394 respondents (N = 394), 310 (78,7%) people had never heard of the fair innings argument, while 84 (21,3%) people had (figure 1). This question was followed by the question if people knew what the fair innings argument meant. Only 75 (19%) respondents claimed that they knew what it meant (figure 1).

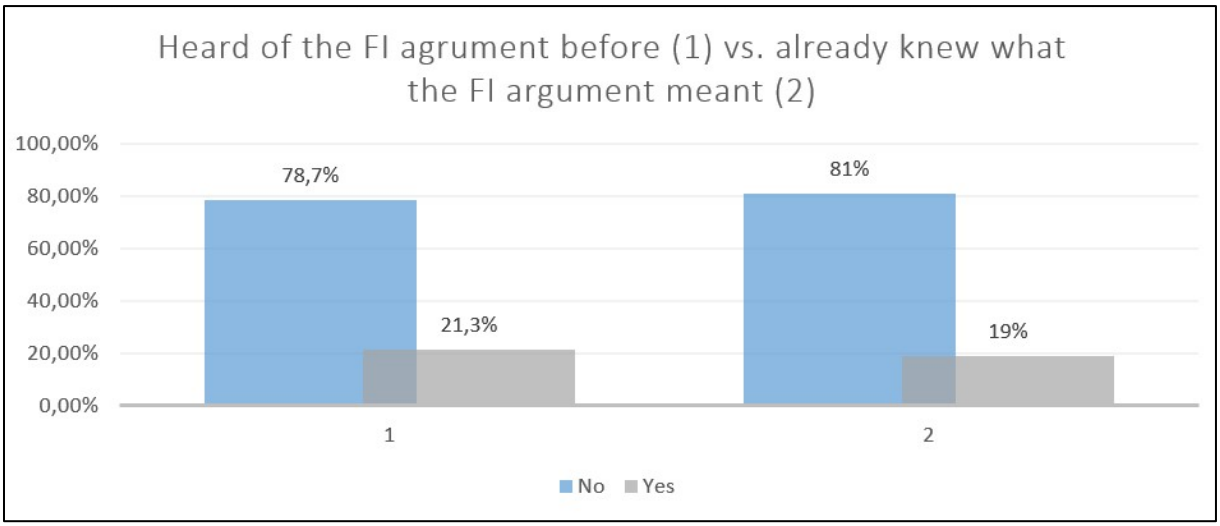

Figure 1: The first graph (1) shows how many people heard of the fair innings argument before. The second graph (2) shows how many people already knew what the fair innings argument meant. FI = fair innings. (N = 394).

After this, a definition of the fair innings argument was provided in the questionnaire. Then, the respondents were asked if this definition was the same as what they thought that the fair innings argument meant. Figure 2 shows that 233 (59,1%) respondents answered that they did not know what the fair innings argument meant. Additionally, 14 (3,6%) respondents answered that this definition was different from what they thought it meant and 147 (37,3%) said that this definition matched with what they thought it meant.

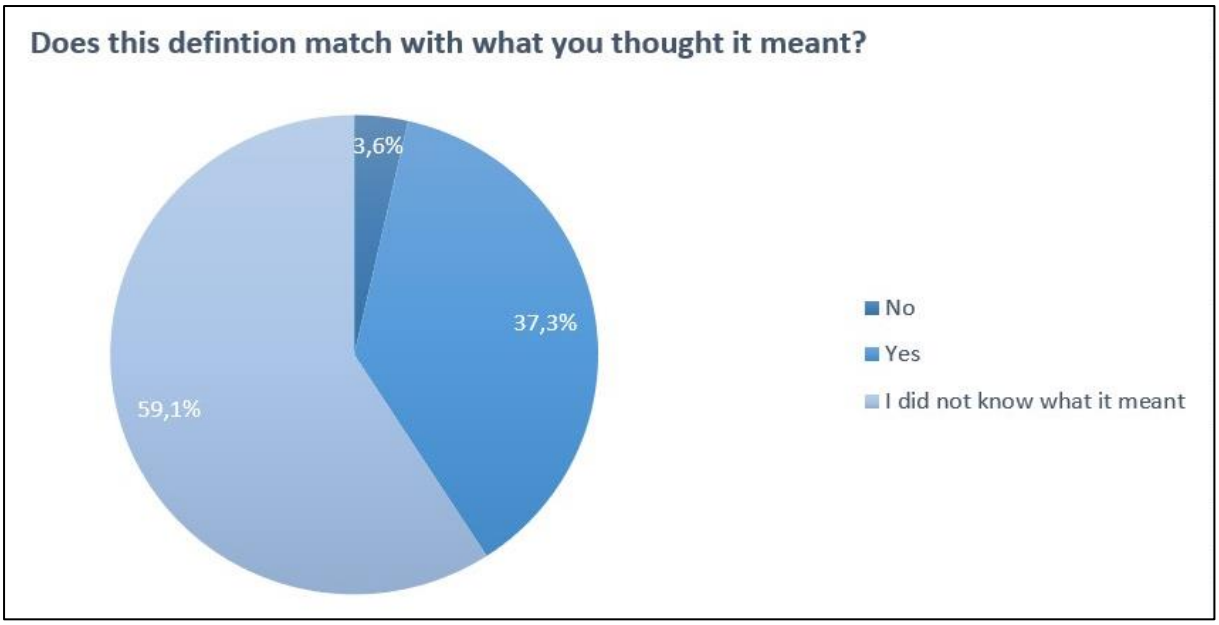

Figure 2: Does the definition of the age criterium based on the fair innings argument match what you thought it meant? (N = 394).

The second sub question was "*What is the opinion of Dutch society about the age criterium?*". To answer this, the respondents were asked if they thought that, should there be a shortage of ICU beds due to the COVID-19 pandemic, rationing ICU care by using an age criterium based on the fair innings argument would be fair. Most of the respondents (57,6%), did thought that this would be fair, while 111 (28,2%) of the respondents thought that this would not be fair. Furthermore, 56 (14,2%) respondents answered that they did not know or had no opinion on this question (figure 3).

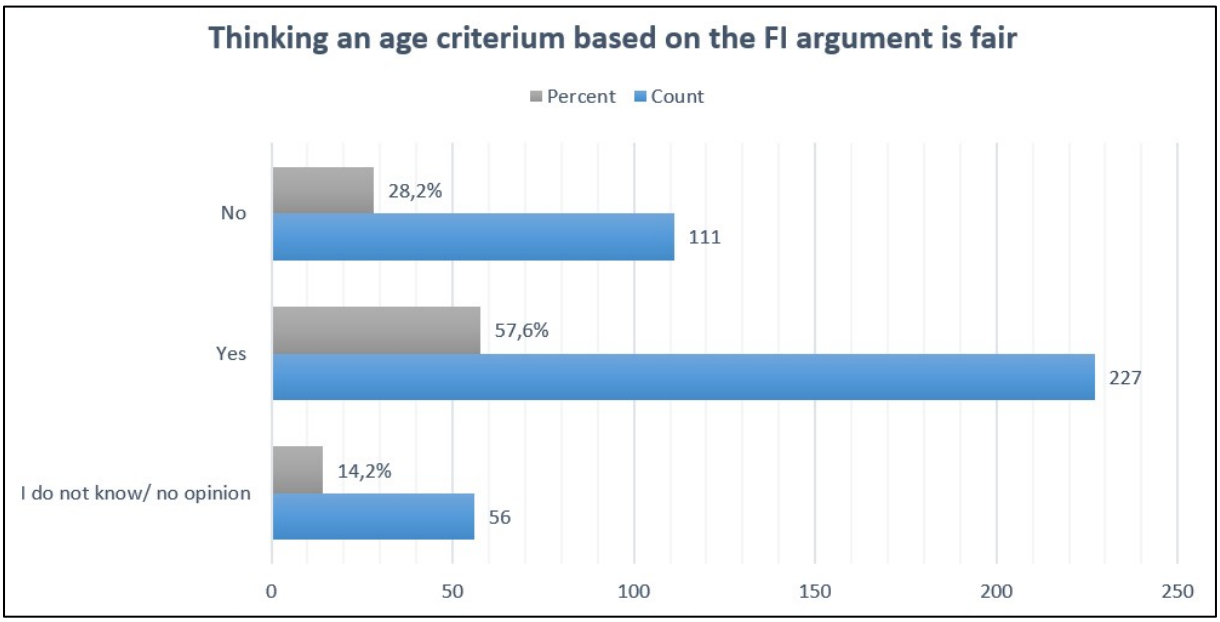

Figure 3: Do you think an age criterium based on the fair innings argument is fair? FI = fair innings. (N=394).

To further study the opinion of Dutch society, casuistry was used as mentioned in chapter 3. Two different case setups were made (Case A and B), with both four different case variants. In case A, the respondent had to choose if he or she agreed that the younger person takes precedence over the older person. The age difference between person A and B was different for every variation of case A. For

case B, the respondent had to choose which person they would give the last ICU bed to. Again, for all variants of case B the age difference between person A and B were different. The full cases are included in the questionnaire in appendix 1. The results per case are described below.

In case A.1, the age difference between person A and B is the largest, namely 20 years. More than half of the respondents (58,3%) agreed that the person who is 20 years younger should take precedence over the older person. In contrast to that, 109 (27,7%) respondents did not agree and 55 (14%) respondents said they did not know (figure 4). For case A.2, the age difference between person A and B is 10 years. Here, the response is divided differently (figure 4). This time, 159 (40,3%) respondents agreed that the person who is 10 years younger should take precedence, while 163 (41,4%) respondents did not agree. Also, 72 (18,3%) respondents answered that they did not know. In case A.3, person A and B have an age difference of 5 years. In this case, which is also presented in figure 4, more than half of the respondents (62,4%) did not agree that the younger person takes precedence. Only, 76 (19,3%) respondents did agree that the younger person takes precedence and 72 (18,3%) answered that they did not know. The last version of case A, A.4, only has an age difference of 2 years between person A and B. Again, more than half of the respondents (66,8%) did not agree that the younger person takes precedence. Figure 4 shows that less people (13,9%) agreed that the younger person should take precedence and more people (19,3%) answered that they did not know.

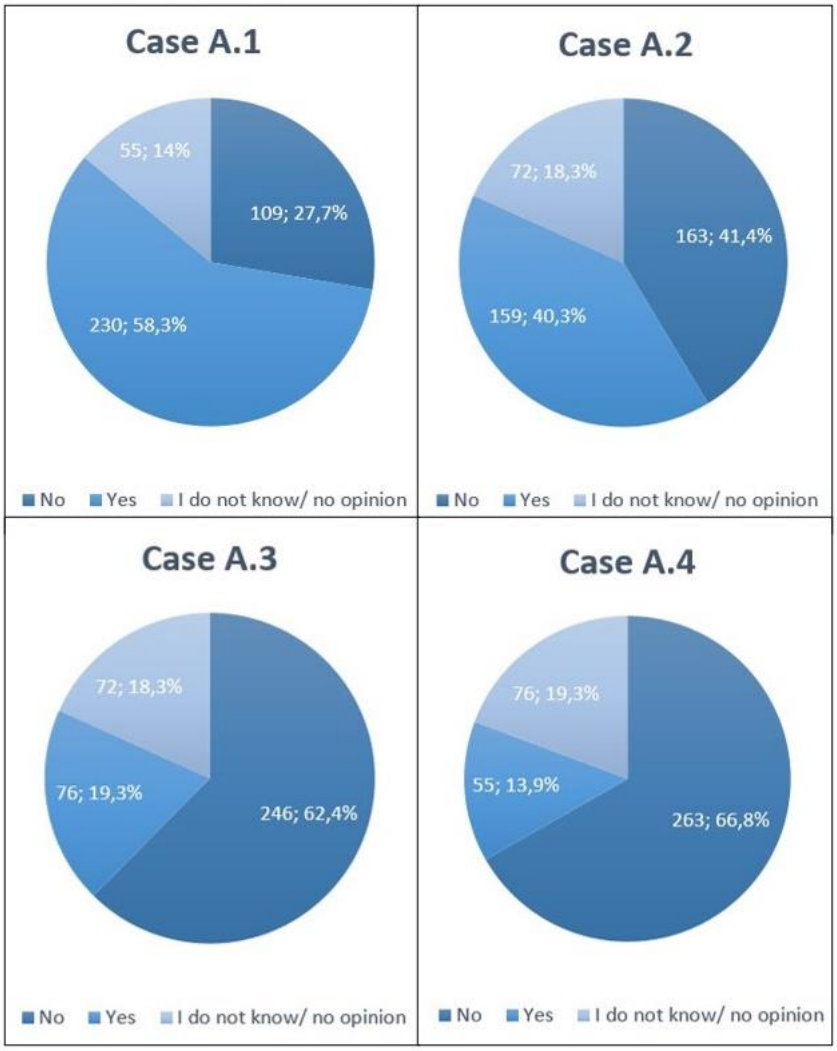

Figure 4: Case A. (N = 394).

In case B.1, person A is 20 years old and person B is 70 years old. Both persons would live equally as long after getting the last ICU bed. The biggest share of respondents (71,1%), chose person A. The older person is chosen less (4,8%) and 95 (24,1%) respondents answered they did not know (figure 5). For case B.2, many more people (61,2%) answered that they did not know. In this case variant, person A is 30 years old and person B is 40 years old. Still, 137 (34,8%) respondents chose person A and 16 (4%) respondents chose person B. In case B.3, the age difference is again larger. Here, person A is 30 years old and person B is 60 years old. Figure 5 shows that 229 (58,1%) respondents chose person A and only 12 (3,1%) respondents chose person B. Also, a big share (38,8%) answered that they did not know. In the last case variation of case B, person A is 25 years old and person B is 30 years old. The age difference is small and 299 (75,9%) respondents answered that they did not know which person to choose. Of the respondents who did decide, more people chose the younger person A (20,6%) over the older person B (3,5%) (figure 5).

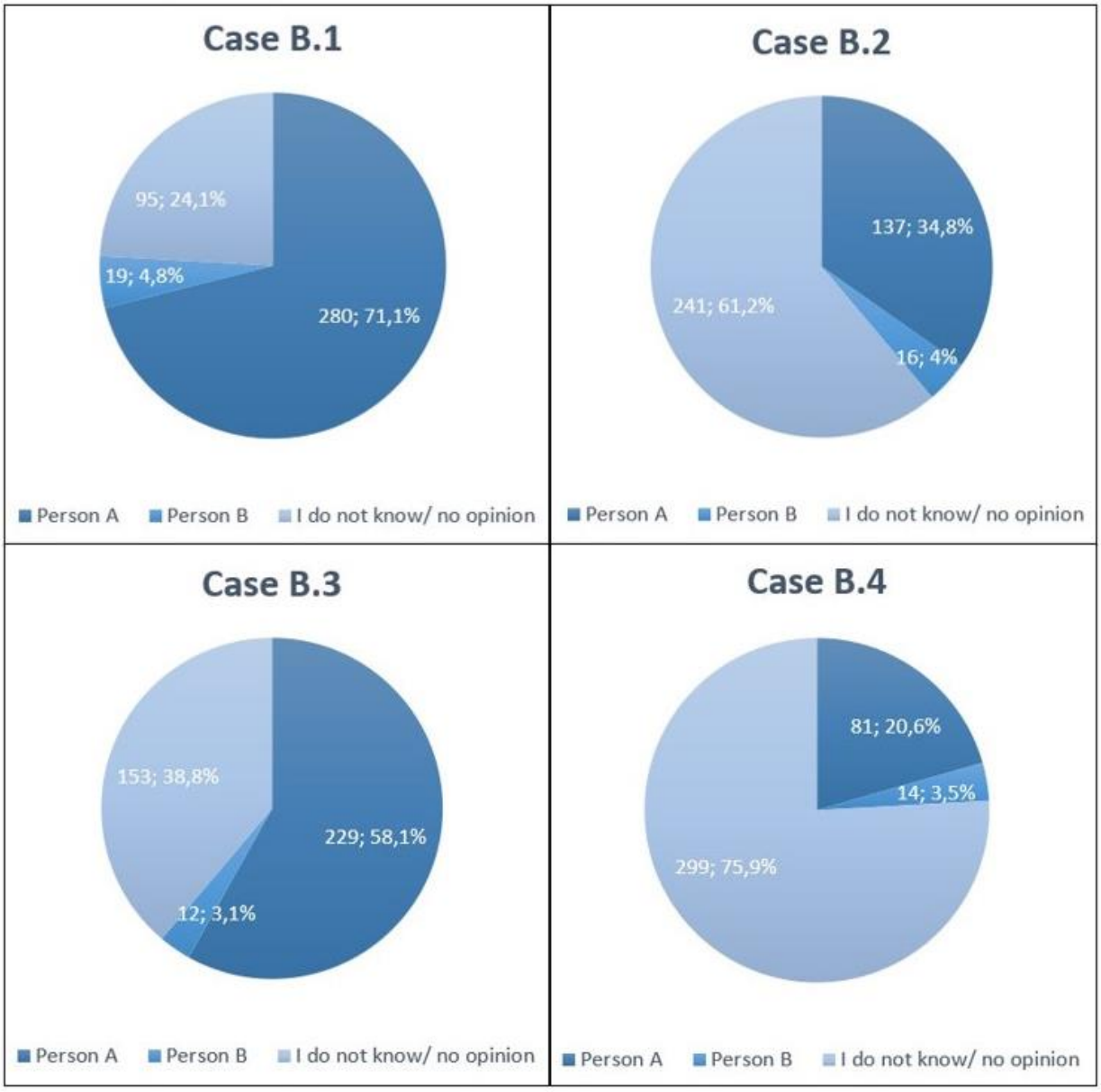

Figure 5: Case B. (N = 394).

Overall, it can be stated that when the age difference became smaller, less people agreed that a younger person should take precedence and more people answered that they did not know who to choose. This is in line with the comments that 110 people left at the end of the questionnaire (N = 110). Of these people, 41 left a comment saying that they thought the questionnaire was difficult or that making decisions about the casuistry was inhuman (figure 6). One person wrote 'ridiculous questionnaire' as a comment and 11 people thought that, besides the age criterium, there should be looked at lifestyle (e.g. smoking or obese), if someone complies to the COVID-19 restrictions and if someone has children or not. Furthermore, 25 people wished the researcher luck in finishing the research and 32 people left an opinion or other comment about the subject. The comments are included in appendix 2.

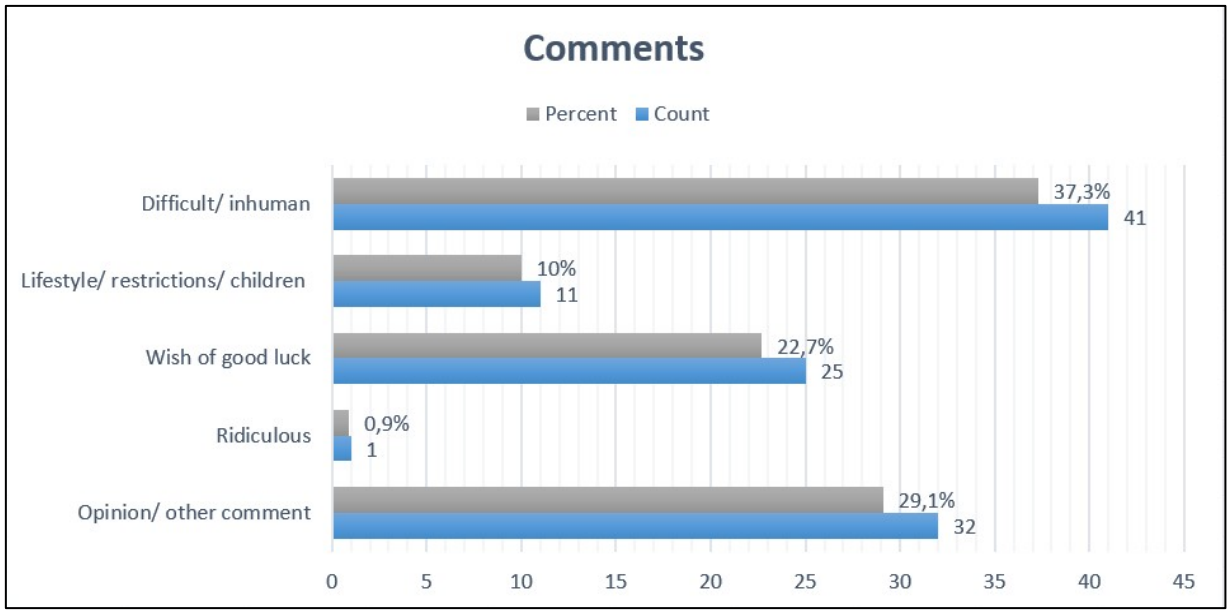

Figure 6: Comments left at the end of the questionnaire. (N = 110).

The last sub question was "*Do people with different background characteristics have different opinions about the age criterium?*". The different background characteristics asked are shown in table 2. To analyse if there is an association between the background characteristics and people's opinions the Pearson Chi-Square test was used. First, the associations between the different background characteristics and the variable *thinking an age criterium based on the fair innings argument is fair* were looked at. The variables *age*, *sex*, *marital status*, *work sector* and *province* did not meet the requirements for the Pearson Chi-square because more than 20% of the cells have an expected count of less than 5 and the minimum expected count is less than 1. Table 4 shows the results for *education* and *children* compared to *thinking that an age criterium based on the fair innings argument is fair*. For both, *education* ($X^2(8, N = 394) = 16{,}70$, $p < 0{,}05$) and *children* ($X^2(2, N = 394) = 14{,}03$, $p < 0{,}05$), there is a statistically significant relationship to thinking that an age criterium is fair. There was also looked into the association between people who *heard of the fair innings argument before* ($X^2(2, N = 394) = 1{,}28$, $p > 0{,}05$) and people who said they *already knew what the fair innings argument meant* ($X^2(2, N = 394) = 1{,}84$, $p > 0{,}05$) compared to *thinking that the age criterium based on the fair innings argument is fair*. For both variables, there was no statistically significant relationship (table 4).

Relationship	X^2	Df	P- value	Star* if significant
Education -> thinking an age criterium based on the fair innings argument is fair	16,695	8	0,033	*
Children -> thinking an age criterium based on the fair innings argument is fair	14,030	2	0,001	*
Heard of the fair innings argument before -> thinking an age criterium based on the fair innings argument is fair	1,284	2	0,526	
Already knew what the fair innings argument meant -> thinking an age criterium based on the fair innings argument is fair	1,848	2	0,397	

Table 4: Pearson Chi-Square results of background characteristics compared to thinking an age criterium based on the fair innings argument is fair. (N = 394).

Finally, the associations between the background characteristics and the answers people gave to the various cases were looked into. Again, the variables *age*, *sex*, *marital status*, *work sector* and *province* did not meet the requirements for the Pearson Chi-square. Also, for case B.3 and B.4, the variable *education* did not meet the requirements because more than 20% of the cells have an expected count less than 5. Additionally, the variable *thinking an age criterium based on the fair innings argument is fair* did not meet the requirements for case B.2, B.3 and B.4. Table 5 shows that for the variable *children,* there is a statistically significant relationship ($p < 0,05$) comparing to all the various cases. For *education* is shown that only compared to case A.1 ($X^2(8, N = 394) = 14,30$, $p < 0,05$) and case B.1 ($X^2(8, N = 394) = 15,76$, $p < 0,05$) there is a statistically significant relationship. Furthermore, it is seen that when *thinking an age criterium based on the fair innings argument is fair* did meet the requirements for the Pearson Chi-Square, the association showed a statistically significant relationship ($p < 0,05$). The variables *heard of the fair innings argument before* and *already knew what the fair innings argument meant* showed no statistically significant association ($p > 0,05$) comparing to all the various cases.

Relationship	X^2	Df	P- value	Star* if significant
Education -> Case A.1	14,303	8	0,074	*
Children -> Case A.1	29,655	2	0,000	*
Heard of the fair innings argument before -> Case A.1	1,004	2	0,605	
Already knew what the fair innings argument meant -> Case A.1	0,427	2	0,808	
Thinking an age criterium based on the fair innings argument is fair -> Case A.1	166,149	4	0,000	*
Education -> Case A.2	12,369	8	0,136	
Children -> Case A.2	36,930	2	0,000	*
Heard of the fair innings argument before -> Case A.2	0,711	2	0,701	
Already knew what the fair innings argument meant -> Case A.2	2,515	2	0,284	
Thinking an age criterium based on the fair innings argument is fair -> Case A.2	127,484	4	0,000	*
Education -> Case A.3	5,789	8	0,671	
Children -> Case A.3	18,116	2	0,000	*
Heard of the fair innings argument before -> Case A.3	0,566	2	0,754	
Already knew what the fair innings argument meant -> Case A.3	2,127	2	0,345	
Thinking an age criterium based on the fair innings argument is fair -> Case A.3	55,030	4	0,000	*
Education -> Case A.4	5,650	8	0,686	
Children -> Case A.4	22,357	2	0,000	*
Heard of the fair innings argument before -> Case A.4	0,392	2	0,822	
Already knew what the fair innings argument meant -> Case A.4	0,951	2	0,622	
Thinking an age criterium based on the fair innings argument is fair -> Case A.4	38,677	4	0,000	*

Education -> Case B.1	15,756	8	0,046	*
Children -> Case B.1	13,193	2	0,001	*
Heard of the fair innings argument before -> Case B.1	1,893	2	0,388	
Already knew what the fair innings argument meant -> Case B.1	7,702	2	0,021	
Thinking an age criterium based on the fair innings argument is fair -> Case B.1	73,251	4	0,000	*
Education -> Case B.2	12,968	8	0,113	
Children -> Case B.2	28,600	2	0,000	*
Heard of the fair innings argument before -> Case B.2	0,406	2	0,816	
Already knew what the fair innings argument meant -> Case B.2	2,458	2	0,293	
Thinking an age criterium based on the fair innings argument is fair -> Case B.2	*Does not meet the requirements*			
Education -> Case B.3	*Does not meet the requirements*			
Children -> Case B.3	45,978	2	0,000	*
Heard of the fair innings argument before -> Case B.3	3,916	2	0,141	
Already knew what the fair innings argument meant -> Case B.3	1,655	2	0,437	
Thinking an age criterium based on the fair innings argument is fair -> Case B.3	*Does not meet the requirements*			
Education -> Case B.4	*Does not meet the requirements*			
Children -> Case B.4	18,064	2	0,000	*
Heard of the fair innings argument before -> Case B.4	4,027	2	0,134	
Already knew what the fair innings argument meant -> Case B.4	5,396	2	0,067	
Thinking an age criterium based on the fair innings argument is fair -> Case B.4	*Does not meet the requirements*			

Table 5: Pearson Chi-Square results of background characteristics compared to the various cases. (N = 394).

Chapter 5: Discussion and conclusion

In this chapter, discussion points of this research report are described and recommendations are given. Furthermore, based on the theoretical framework and results, this chapter will give an answer to the research question of this study: *"What are the opinions within Dutch society about the age criterium based on the fair innings argument that will be used to ration ICU beds due to the COVID-19 pandemic?"*.

To answer the research question mentioned above, five sub questions were formulated. The research method consisted of desk research and quantitative empirical research using a questionnaire. The first two subjects were answered with the help of desk research and the other three subjects were answered by empirical research. This was the most appropriate method to answer the research question of this study because the desk research gave background information about the subject and relevant information to form the questionnaire. A questionnaire is the best method to reach a big population (McLeod, 2018). Since the research population consisted of Dutch citizens above 18 years old, a big response was needed. However, this research report has some points of discussion. To increase the validity of the study and the response to the questionnaire, the questionnaire was in Dutch. However, this could have affected the reliability of the study due to translation mistakes, miscommunication and differences between literal translation and what is actually being said. With the questionnaire, only a sample of the Dutch population was looked at. According to the calculations of Taherdoost (2017), a response of 384 Dutch citizens was needed. After the questionnaire was rounded, 451 respondents had started filling in the questionnaire. Only 395 of them also finished it, so 56 people broke off the questionnaire early. Also, 41 respondents left a comment that the subject of the questionnaire and/ or the questions were difficult. Perhaps, the questionnaire was too difficult for the 56 people who broke off early. Another limitation of a questionnaire is that it is always unknown how truthful a respondent is (McLeod, 2018). At the beginning of the questionnaire, it was stated that participation is anonymous, collected data is confidential and only used for this study to increase the response and truthfulness of the respondents. Still, it could be possible that people quickly filled something in to be done sooner or were not truthful which affected the validity and reliability. Furthermore, emotions cannot be measured with a questionnaire. This could have been different with a qualitative research method, for example interviewing. Some of the above described limitations might have been prevented. It would have been possible to explain questions more so that respondents would better understand them. Also, emotions can be better measured and respondents cannot just fill something in to be done which can increase the reliability and validity of the research. However, a qualitative method could not have covered the whole research population.

For this study, collected data was analysed with SPSS (version 25). Even though SPSS does the calculation and statistics, mistakes can still be made because the commands are entered manually by the researcher. Another limitation was that question 19 of the questionnaire did not have an answer option with "retired". Some respondents filled in the text field with "other, namely *retired*", but it might be the case that other respondents that were retired just filled in one of the given answer options. This could have affected the validity and reliability of this question.

Besides limitations, this study also has strengths. For the questionnaire, the structure of the answer options were the same for every question so that respondents would not accidentally answer a

question incorrectly (Verhoeven, 2014). This increased the validity of the study. Furthermore, a pilot version of the questionnaire was tested before the questionnaire was distributed to make sure the questionnaire was free from errors and understandable for respondents, this also increased the reliability of the study. The topic of the study was relevant and 451 Dutch citizens were interested to fill in the questionnaire. Thereby, the necessary response of 384 was achieved (N = 394). Nevertheless, the study is not generalizable to the whole Dutch population because the sample is not representative. The most respondents (48,7%) live in the province Zuid-Holland and more than half of the respondents (57,9%) work in the healthcare and well-being sector. This result is probably due to the fact that the researcher's network has been used. Also, it could be that people working in the healthcare and well-being sector are biased by the study subject. The subject is close to them, because most people working in the healthcare and well-being sector were affected by COVID-19 (Shreffler, Petrey & Huecker, 2020). Additionally, the biggest share of the respondents (80,7%) are female.

The theoretical framework showed that age has always been a depending factor in rationing lifesaving treatments in the past. While most Dutch citizens (57,6%) agreed that an age criterium based on the fair innings argument is fair to use when there would be a shortage of ICU beds due to the COVID-19 pandemic, the theoretical framework showed very conflicting thoughts about the fair innings argument and the use of an age criterium. For example, Castro-Hamoy and Castro (2020) claim that using the fair innings argument is unjustified discrimination against elderly and that when people are divided in age groups, some people's lives are worth less than other people's lives, while human lives should weigh equal. In contrast to that, Bognar (2015) states that the fair innings argument is a justified argument that does not contain any discrimination. Everybody has the same chance to reach all the different stages in life. Furthermore, Bognar (2015) stated that many people would agree that it is reasonable to let younger generations take precedence over older generations. This statement was tested by using casuistry in the questionnaire. It was seen that for case A, when there was a difference of 20 years between person A and person B the majority of respondents would agree that the younger person should take precedence. When the difference was only ten, five or two years, the majority would disagree that the younger person should take precedence. For case B, it was seen that the smaller the age difference, the less respondents were able to make a decision. However, of the respondents that did decide, the majority would agree that the younger person takes precedence for all case variations. That less respondents could make a decision when the age difference became smaller corresponds to what was stated in the script *"Draaiboek Triage op basis van niet-medische overwegingen voor IC-opname ten tijde van fase 3 in de COVID-19 pandemie"*, namely that an age classification will cause difficulties at the 'edges' of the categories. Furthermore, Archard and Caplan (2020) argued that an age criterium puts a stigma on elderly that they are second class citizens. While Wareham (2015) claims that elderly can feel discriminated because of the age criterium, elderly often wish for young people to get the treatment before they do. It could not be statistically tested if there was an association between age and the given answers, because age did not meet the requirements for the Pearson Chi-Square. Also, *sex*, *marital status*, *work sector* and *province* did not meet the requirements for the Pearson Chi-Square. However, a statistically significant relationship was found for people's level of education and for having (grand)children compared to thinking that an age criterium based on the fair innings argument is fair. Additionally, a statistically significant relationship was found for having (grand)children compared to the answers people gave to the various cases. Also, for the majority of cases there was a statistically significant relationship between thinking that an age criterium based on the fair innings argument is fair and the answers to the various cases.

The research aim of this study was to obtain information about the opinion of Dutch society on using an age criterium based on the fair innings argument to ration ICU beds due to the COVID-19 pandemic. Information about the opinion of Dutch society was collected by asking the respondents closed questions. Almost one third (27,9%) of the respondents left a comment at the end of the questionnaire. Some of these comments consisted of further explained opinions. People felt the need to further express themselves and the questionnaire might have been to limited for this subject. A recommendation that can be done is to perform additional qualitative research, as mentioned before. With qualitative research more extensive information about the opinion of Dutch society can be collected. Also, since the sample size is not representative, this research can be redone with a better sample size so that the results are generalizable to the whole Dutch population. Additionally, the practical aim was for policy makers to learn from the opinion of Dutch society for future policy making. No learning points can be brought forward from this research report. The Netherlands is more prepared for when "code black" presents itself than other countries (Skipr Redactie, 2021). It is important to note that the questionnaire did not have any questions asking about how to improve policy making, which is another limitation of this study. Further research is needed to collect the opinion of Dutch society about policy making.

Finally, an answer to the main question of this research report *"What are the opinions within Dutch society about the age criterium based on the fair innings argument that will be used to ration ICU beds due to the COVID-19 pandemic?"* can be formulated. Taking into account that the sample size is not representative for the whole Dutch population, it can be said that the surveyed respondents think that an age criterium based on the fair innings argument is fair to use to ration a shortage of ICU beds due to the COVID-19 pandemic. Furthermore, it depends on how the question is asked. For case B respondents would say that a younger person should take precedence over an older person. While for case A, respondents only agree that the younger person takes precedence when the age difference is not less than 20 years. Additionally, there might be a relationship between the answers that respondents gave and having (grand)children.

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Appendix 1: Questionnaire

In this appendix, the questionnaire that was used for collecting data, in Dutch, is included.

Het leeftijdscriterium bij COVID-19

Pagina 1

Beste respondent,

Momenteel ben ik bezig met afstuderen aan de Erasmus Universiteit Rotterdam. Voor mijn masterscriptie doe ik onderzoek naar de mening van de Nederlandse samenleving over het mogelijke gebruik van een leeftijdscriterium in fase 3 van de COVID-19 pandemie, ook wel code zwart genoemd. In deze fase is er een tekort aan IC capaciteit ontstaan wegens grote aantallen COVID-19 patiënten en zal er gebruik gemaakt worden van een leeftijdscriterium gebaseerd op het fair innings argument bij de verdeling van IC zorg.

Om het onderzoek zo betrouwbaar mogelijk te maken, heb ik een respons van 384 Nederlanders boven de leeftijd van 18 jaar nodig. De vragenlijst bestaat uit 20 vragen. Het invullen van de vragenlijst duurt ongeveer 5-10 minuten en is geheel anoniem.

Alvast bedankt voor uw tijd!

Femke Manintveld

Toestemming

1. **Gegevens die worden verzameld worden enkel en alleen gebruikt voor dit onderzoek. Gegevens worden opgeslagen en beveiligd bewaard op www.enquetesmaken.com. Alleen de onderzoeker heeft toegang tot de ingevulde antwoorden. Na data analyse zal de verzamelde data vernietigd worden. Het invullen van de vragenlijst is geheel anoniem.**

   In deze vragenlijst wordt gebruik gemaakt van de afkorting IC, dit staat voor Intensive Care. *

   ☐ Ik begrijp bovenstaande en ga akkoord

Achtergrond informatie

Hieronder volgen 5 introducerende vragen.

2. **Wat is uw geslacht? ***

   ◯ Man
   ◯ Vrouw
   ◯ Anders/ wil ik niet zeggen

3. Hoe oud bent u? *

Leeftijd: _____ jaar

4. Wat is uw huidige/ hoogst afgeronde opleiding? *

- ☐ Geen opleiding/ onvolledig basisonderwijs
- ☐ Basisonderwijs
- ☐ Middelbare school (VMBO/ HAVO/ VWO)
- ☐ Middelbaar beroepsonderwijs (MBO)
- ☐ Hoger beroepsonderwijs (HBO)
- ☐ Wetenschappelijk onderwijs (Universitair)
- ☐ Universitaire Masters of gespecialiseerd diploma (doctoraal)
- ☐ Anders, namelijk _____

5. Wat is uw burgerlijke staat? *

- ☐ Ongehuwd/ alleenstaand (nooit gehuwd en nooit geregistreerd partner geweest)
- ☐ Gehuwd (wettig gehuwd + geregistreerd partnerschap)
- ☐ Samenwonend
- ☐ Weduwe
- ☐ Gescheiden
- ☐ Anders, namelijk _____

6. Heeft u kinderen en/ of kleinkinderen? *

- ◯ Nee
- ◯ Ja

Het fair innings argument

7. Heeft u ooit eerder van het 'fair innings argument' gehoord of erover gelezen? *

- ◯ Nee
- ◯ Ja

8. Weet u wat het 'fair innings argument' inhoudt? *

- ◯ Nee
- ◯ Ja

Het fair innings argument

Hieronder volgt een uitleg van het fair innings argument:

Het fair innings argument dient als onderbouwing van het leeftijdscriterium dat gebruikt zal worden in fase 3 van de COVID-19 pandemie, ook wel code zwart genoemd. Wanneer code zwart van toepassing is, is er een tekort aan IC capaciteit ontstaan door de grote hoeveelheden COVID-19 patiënten die IC zorg nodig hebben. Bij het leeftijdscriterium worden mensen ingedeeld in leeftijd categorieën van 20 jaar (0-20, 20-40, 40-60, 60-80, 80 en ouder). Het idee is dat jongere generaties voorrang hebben op oudere generaties. Het fair innings argument houdt in dat iedereen in de loop van zijn of haar leven evenveel gelijke mogelijkheden ('fair innings') zou moeten hebben. Oudere generaties hebben meer kansen gehad in het leven, in de zin van tijd, om levenservaring op te doen en levensdoelen te voltooien. Het leeftijdscriterium wordt alleen gebruikt indien onderscheid op basis van medische en andere niet-medische criteria geen uitsluitsel meer geven.

9. Klopt deze definitie met wat u dacht dat het fair innings argument inhield? *

- ◯ Nee
- ◯ Ja
- ◯ Niet van toepassing / Ik wist niet wat het inhield

10. Vindt u het rechtvaardig dat een leeftijdscriterium gebaseerd op het fair innings argument zal worden gebruikt indien er een tekort aan IC capaciteit ontstaat ten gevolge van de COVID-19 pandemie? *

- ◯ Nee
- ◯ Ja
- ◯ Weet ik niet/ geen mening

Pagina 6

Nu volgen 4 fictieve gelijke scenario's waarbij enkel het leeftijdsverschil verandert.

11. **Persoon A en B hebben allebei COVID-19 en een plek nodig op de IC. Ze worden tegelijk binnengebracht en verschillen 20 jaar in leeftijd. Op alle medische en andere niet-medische criteria scoren persoon A en B gelijk en er zal gekeken moeten worden naar het leeftijdscriterium.**

    Zou u het er mee eens zijn als er voor gekozen wordt om de 20 jaar jongere persoon voorrang te geven op een IC plek? *

    - ◯ Nee
    - ◯ Ja
    - ◯ Weet ik niet/ geen mening

12. **Persoon A en B hebben allebei COVID-19 en een plek nodig op de IC. Ze worden tegelijk binnengebracht en verschillen 10 jaar in leeftijd. Op alle medische en andere niet-medische criteria scoren persoon A en B gelijk en er zal gekeken moeten worden naar het leeftijdscriterium.**

    Zou u het er mee eens zijn als er voor gekozen wordt om de 10 jaar jongere persoon voorrang te geven op een IC plek? *

    - ◯ Nee
    - ◯ Ja
    - ◯ Weet ik niet/ geen mening

13. **Persoon A en B hebben allebei COVID-19 en een plek nodig op de IC. Ze worden tegelijk binnengebracht en verschillen 5 jaar in leeftijd. Op alle medische en andere niet-medische criteria scoren persoon A en B gelijk en er zal gekeken moeten worden naar het leeftijdscriterium.**

    Zou u het er mee eens zijn als er voor gekozen wordt om de 5 jaar jongere persoon voorrang te geven op een IC plek? *

    - ◯ Nee
    - ◯ Ja
    - ◯ Weet ik niet/ geen mening

14. **Persoon A en B hebben allebei COVID-19 en een plek nodig op de IC. Ze worden tegelijk binnengebracht en verschillen 2 jaar in leeftijd. Op alle medische en andere niet-medische criteria scoren persoon A en B gelijk en er zal gekeken moeten worden naar het leeftijdscriterium.**

Zou u het er mee eens zijn als er voor gekozen wordt om de 2 jaar jongere persoon voorrang te geven op een IC plek? *

- ◯ Nee
- ◯ Ja
- ◯ Weet ik niet/ geen mening

Pagina 7

Hieronder volgen opnieuw 4 fictieve scenario's waarbij alle twee de personen met COVID-19 tegelijk binnen worden gebracht en op alle medische en andere niet-medische criteria gelijk scoren. Enkel het leeftijdsverschil verandert.

15. **Twee personen hebben IC zorg nodig:**
- Persoon A is 20 jaar oud en leeft nog 10 jaar langer nadat hij/ zij de plek op de IC heeft gekregen.
- Persoon B is 70 jaar oud en leeft nog 10 jaar langer nadat hij/ zij de plek op de IC heeft gekregen.

Wie zou volgens u de plek op de IC moeten krijgen als er nog maar 1 plek beschikbaar is? *

- ◯ Persoon A
- ◯ Persoon B
- ◯ Weet ik niet/ geen mening

16. **Twee personen hebben IC zorg nodig:**
- Persoon A is 30 jaar oud en leeft nog 10 jaar langer nadat hij/ zij de plek op de IC heeft gekregen.
- Persoon B is 40 jaar oud en leeft nog 10 jaar langer nadat hij/ zij de plek op de IC heeft gekregen.

Wie zou volgens u de plek op de IC moeten krijgen als er nog maar 1 plek beschikbaar is? *

- ◯ Persoon A
- ◯ Persoon B
- ◯ Weet ik niet/ geen mening

17. **Twee personen hebben IC zorg nodig:**
- Persoon A is 30 jaar oud en leeft nog 10 jaar langer nadat hij/ zij de plek op de IC heeft gekregen.
- Persoon B is 60 jaar oud en leeft nog 10 jaar langer nadat hij/ zij de plek op de IC heeft gekregen.

Wie zou volgens u de plek op de IC moeten krijgen als er nog maar 1 plek beschikbaar is? *

- ◯ Persoon A
- ◯ Persoon B
- ◯ Weet ik niet/ geen mening

18. **Twee personen hebben IC zorg nodig:**
- Persoon A is 25 jaar oud en leeft nog 10 jaar langer nadat hij/ zij de plek op de IC heeft gekregen.
- Persoon B is 30 jaar oud en leeft nog 10 jaar langer nadat hij/ zij de plek op de IC heeft gekregen.

Wie zou volgens u de plek op de IC moeten krijgen als er nog maar 1 plek beschikbaar is? *

- ◯ Persoon A
- ◯ Persoon B
- ◯ Weet ik niet/ geen mening

Achtergrond informatie

Om af te sluiten nog 2 informatieve vragen.

19. In welke sector bent u werkzaam? *

- ◯ Ik heb geen werk
- ◯ Gezondheidszorg en welzijn
- ◯ Handel en dienstverlening
- ◯ ICT
- ◯ Justitie, veiligheid en openbaar bestuur
- ◯ Landbouw, natuur en visserij
- ◯ Media en communicatie
- ◯ Onderwijs, cultuur en wetenschap
- ◯ Techniek, productie en bouw
- ◯ Toerisme, recreatie en horeca
- ◯ Transport en logistiek
- ◯ Anders, namelijk [ ]

20. In welke provincie woont u? *

Maak een keuze...

Afsluiting

21. Dit is het einde van de vragenlijst.
In het onderstaande tekstveld is ruimte voor eventuele opmerkingen.

Hartelijk dank voor uw tijd en het invullen!

* Vergeet niet om de enquête af te sluiten door op 'gereed' te drukken

* SurveySwap: https://surveyswap.io/sr/Wr86E2LSGl7V7h3f

U bent nu klaar met de enquête. Dank u wel voor uw deelname.

U kunt het venster nu sluiten.

Appendix 2: Comments

In this appendix, the comments that were left by respondents at the end of the questionnaire are included.

- Ik denk dat oudere een groter risico lopen op overlijden aan het covid-19 virus, dus zij de zorg in het ziekenhuis harder nodig hebben dan jongeren, behalve als je gezondheidproblemen hebt op jongeren leeftijd.
- Ik vond dit heel lastig mede omdat er geschreven wordt dat iedereen dezelfde ‘ gezondheid’ zou hebben. Dat weet je nooit van te voren als mensen de de IC op komen.
- Uiteindelijk heeft de jongere persoon inderdaad meer recht om de plek te krijgen, maar toch voelt het wel fout.
- Mijn mening is dat iedereen gered moet worden ongeacht welke maatstaf ook
- Naast leeftijd vind ik dat medische voorgeschiedenis en sociaal vangnet ook meegewogen moeten worden.; ; Een jong persoon met cystic fibrose zou ik misschien niet eerder een plek geven dan iemand van 20 jaar ouder zonder relevante medische vg.
- Het is vrij heftig om in korte tijd God te spelen en te bepalen wie leeft en wie dood gaat.
- Het is onmenselijk om te moeten kijken naar leeftijd . Hopelijk komt code zwart nooit .
- Succes Femke en wat een perfect Nederlands.
- Als een jong iemand alle regels aan z'n laars lapt en covid krijgt versus een oudere die het ook krijgt ondanks zorgvuldig de regels in acht nemen...
- Het ligt voor mij naast de leeftijd ook aan de gezondheidstoestand/leefstijl van de patiënt. ; Rokers en niet-rokers ; Obesitas of een gezonde leefstijl ; Een meervoudige gezondheidsproblematiek of geen voorgeschiedenis.
- Succes met je onderzoek.
- Succes met je enquête
- Duivelse dilemma's waar ik geen afgerond standpunt over heb. Het is aan de artsen naar mijn mening. Bij triagemodellen moet de medische effectiviteit misschien voorop staan: degene wordt behandeld waarbij de kans op genezing het hoogst is. Te beoordelen door een arts.
- Hele moeilijke vragen. Als ik er langer over nadenk, zou het kunnen dat mijn mening over sommige stellingen gaat veranderen.; ; Even 2 spellingstips:; Beiden personen moet zijn beide personen; Leeftijd veranderd moet zijn leeftijd verandert.
- Ik vindt overlevingskans een belangrijker criterium dan leeftijd. Overlevingskans is enig sinds leeftijdsgebonden maar ik vind het lastig leeftijd als maatstaf te gebruiken omdat er veel meer factoren meespelen.
- Ik ben ervan uit gegaan dat alle andere omstandigheden gelijk zijn, dan mag leeftijd een doorslaggevende rol spelen. Ik denk dat andere factoren belangrijker zijn; een alleenstaande moeder van jonge kinderen zou voorrang moeten hebben boven een vrijgezelle student.; ; Ik denk dat realistischer is om snel zorg te geven i.p.v. per persoon een lang onderzoek te doen naar wie voorrang heeft.
- vond de vragen ingewikkeld
- Lastige dilemma's! Waar je zeker niet altijd op basis van leeftijd kunt en mag beslissen. Wat is het toekomstperspectief en kwaliteit van leven. ; Succes met het onderzoek

- Hoi! Ik vind het een goede enquête, maar wat wel een beetje blijft hangen is dat ik het moeilijk vind om te kiezen tussen twee mensen die zogezegd “nog 10 jaar leven”. Na 10 jaar gaan ze dan alsnog dood neem ik aan. De kans dat je dat bij ‘t maken van die keuze weet is gewoon nihil toch? Ik zou vaak wel voor de jongere kiesen als z’n tegenpool gepensioneerd is maar dan is ‘t nog een moeilijke vraag.
- Succes
- Er zou niet gekozen moeten worden ieder leven is belangrijk
- Succes met de analyses.
- Ik had vorig jaar een gesprek met een bewoner tijdens de eerste golf die zei ik hoef geen inenting geef ze maar aan jullie wij hebben een mooi leven gehad en als ik het krijg je komt er nooit meer goed vanaf op onze leeftijd mij hoeven ze niet meer in te sturen aan de hand van dat gesprek heb ik mijn antwoorden gegeven ; ; Meissie succes met je opleiding
- Vind het heel.moeilijk oudere zijn /waren een groep die als eerste gevaccineerd moesten worden Wat gebeurt er nu nu krijgen veel jongere mensen covid Naar mijn idee hadden we beter eerst de groep jongere kunnen /moeten vaccineren
- Heel confronterend maar wel waar we misschien mee te makken kunnen krijgen. Ik ben blij dat ik dit niet hoef te beslissen.
- Succes met je scriptie!
- Belachelijke vragenlijst
- Ik vind dit een lastige kwestie. Ik vind dat mensen die zich totaal niet aan de maatregelen hebben gehouden, en van wie dit te bewijzen is, geen plek op de IC verdienen bij overcapaciteit (ongeacht hun leeftijd).
- De vragen zijn op een dusdanige manier ingevuld dat ze de lezer een richting opduwen en dus geen objectief beeld van de scenario geven.
- Lastig onderwerp. Kwaliteit van leven is voor mij vooral belangrijk, maar dit is heel moeilijk te uit te drukken in waardes.
- De casus:; ; Persoon A: Iemand is 30 jaar oud heeft kinderen, en leeft nog tien jaar na opname IC.; Persoon B: iemand is 28 jaar en heeft geen kinderen, en leeft nog 10 jaar na opname IC. ; ; Ik vind nu lastig om te kiezen A of B. Mocht deze criteria horen bij niet-medisch is deze opmerking overbodig.
- Ik begrijp het punt van de enquete niet helemaal aangezien deze o zo gevaarlijke ziekte qua sterftecijfer verwaarloosbaar is, zelfs de WHO geeft toe dat het onder griepniveau ligt. En die angstzaaiverhalen over jongeren in de IC's geloof ik niet in, dat is voor politieke doeleinden :) Wil verder niet onaardig doen, succes met je scriptie.
- Ik beantwoord de vragen met de geschetste situatie met nee of geen mening omdat ik bij de eerste situaties alleen kan lezen dat er 20/10/5/2 jaar verschil is, maar niet over welke leeftijden het gaat. Bij de ander situaties ging het concreet om nog maar een levensverlenging van 10 jaar. Iemand van 20 met nog 10 jaar te leven of 70 jaar met nog 10 jaar te leven vind ik moeilijk te onderscheiden wie er dan meer recht op heeft. Al zouden we kijken naar een volledig herstel en dus (idealiter) de rest van het leven nog heeft gaat iemand van 20 nog veel meer tegemoet dan iemand van 70.
- Veel succes ermee.
- Bij geen mening antwoord is deze keuze gemaakt omdat:; - er verder geen uitleg staat over huidige kwaliteit van leven.; - hoe de patiënt zelf denkt over " voltooid" leven; - bijkomende ,

secundaire ziektes.; - omstandigheden waarin de patiënt verkeerd als hij de I.C verlaat en toekomst beeld.; ; ; ; Wens je heel veel succes met het onderzoek

- Ik vind ook dat er naar gekeken mag worden of iemand zich houd aan de covid regels. ; Sommige doen van alles wat niet slim is. Deze groep hoeft voor mij geen voorrang te krijgen. Beetje eigen schuld. ; ; En misschien degene die niet gevaccineerd willen worden ook geen voorrang. Nemen ook zelf het risico.
- Vind het zeer onterechte vragen over leefdtijd kijk eerst naar hie de gezondheid is en hoe iemand leeft
- Kiezen tussen 2 mensenlevens is bijna niet te doen. Blij dat ik die keuze niet hoef te maken
- Om keuze ‘s te maken als je iemand niet kendis heel makkelijk, maar het is anders als het om een persoon uit jou privé situatie gaat. Iedereen wil zijn opa, oma, moeder,vader, broer, zus en vrienden zo lang mogelijk bij zich houden. ; Hopelijk komt het niet zo ver ook al lijkt het er wel op.
- Ik vind leeftijd alleen geen goed criterium,er zijn altijd meer factoren die bepalen
- Vragen kort en bondig.
- Ik vind dat er tussen 0-65 ongeveer niet veel verschil moet uitmaken. Daarboven gaan er ook andere zaken mee spelen. Zoals of iemand zelf nog graag zou willen en of er verder klachten zijn
- Ik vond de vragen over wie je een plek geeft lastig en dat is ook het dillema wat er speelt.; Niemand neemt graag afscheid van iemand ongeacht de leeftijd.; Ook speelt bij de vraag (en ik wil niet discrimeneren/veroirdelen).; Maar stel degene van 20 jaar heeft al van alles op zijn kerfstok en die van 70.heeft altijd geleefd als brave burger ; Waarom zou die van 20 dan voorranf krijfen.; Ik denk hoe je het went of keert dit is een dillema waaron je het nooit goed doet.; Succes mer je opleiding
- Persoonlijk vindt ik dat een ander niet uit kan make of een "ouder persoon" voldoende doelen en leefervaring heeft. Het kan zijn dt hij of zij net nieuwe ervaringen op gaat doen. Of net gaat genieten van rust of kleinkinderen.
- Lastig 9nderwerp maar denk dat het ook belangrijk is om te kijken wat de kwaliteit van leven is na is opname
- Pff lastige zaak! Goed dat je onderzoek doet!; ; Heel veel succes met je afstuderen!
- Indien de leeftijd gaat om het verkrijgen van een IC plaats voor iemand van zeer hoge leeftijd (80-85 +) dan gaat een jonger iemand voor bij mij ; Maakt mij niet uit of iemand 20 of 40 is
- Bij de eerste vraag vind ik daadwerkelijke leeftijd wel meespelen het maakt verschil of het gaat om iemand van 40 tegenover 60 of dat je kiest tussen iemand van 60 tegenover 80.
- Wat een moeilijke keus tussen leeftijden moeten kiezen.; Ethische kwesties.; Persoon van 80 kan net zoveel betekenen voor iemand als een persoon van 20. Ja halve leven zit erop dat klopt maar geef dat masr een plaatsje als t om een dierbare gaat voor de achterblijvers.; Succes
- Ik heb geen mening ingevuld bij verschillende vragen omdat ik te weinig van de personen weet.; Ik ben er mij van bewust dat dit zeer indringende maatregelen zijn op het moment als ze genomen moeten worden.
- Ik vind dit een zeer moeilijk enquête en ben blij niet voor deze keuze te staan. Ik werk zelf in het zh op een covid afdeling en vind dat iedereen evenveel kans moet krijgen om op de ic geholpen te worden. Wel moet ik hierbij aangeven dat de oudere patiënten bij ons op de afdeling vaak een ic- beleid hebben en dit kanbikbgoed begrijpen.

- Mooie enquête. Maar keuzes maken op basis v leeftijd is niet correct,; Succes!!
- Hopelijk hoeft het nooit zover te komen. Het is toch vreselijk als je moet kiezen..
- Zet aan tot denken. Leeftijd is niet alles zeggend. Karakter en fysieke mogelijkheden doen daarin ook iets. Er zij. Nooit 2 identieke casussen. Ik zou niet in de schoenen van artsen willen staan wie voorrang krijgt
- Ik mis een stukje verantwoordelijk leven, dat zou belangrijker moeten zijn bij een bijna onmogelijke keuze dan de leeftijd. Leeft iemand gezond, rookt iemand wel of niet, enz
- Te bedenken dat er leeftijds criterium eventueel zal worden gehandhaafd doet mij denken aan wat 80 jaar gekeden in dit land gebeurde , misschien iets om over na te denken. De geschiedenis lijkt zich op bepaalde vlakken te herhalen .....
- Zie nu hoe moeilijk het is te kiezen. Mijn antwoorden zijn erg tegenstrijdig
- Ik begrijp het principe. Ik werk als verpleegkundige in een ziekenhuis. Het zal gelukkig nooit zo zwart wit verlopen als in de vraagstelling. Stel dat je een 60 en 70 jarige hebt die een ic bed nodig hebben. Je geeft het laatste bed aan de 60 jarige. Na een uur komt er een 20 jarige. Wat dan? De 60 jarige weer van de ic af? . Tijdens de eerste golf lagen er ook mensen op de operatie ruimtes aan de beademing. Er is gelukkig vaak nog een mouw aan te passen.
- Lastige vragen om over na te denken! Ik snap dat jongere mensen meer kans hebben om te herstellen als deze op de ic komen, maar om daarvoor een ouder persoon aan de kant te schuiven vind ik een heftige beslissing. Hopen dat het niet zo ver hoeft te komen
- Deze discussie hebben we in de opleiding 40 jaar geleden ook al gevoerd,in een ander vorm.(0.k alcohol verslaafd roker en iemand die gezond leeft,wie krijgt de o.k.Doktoren maken indien nodig de beslissing hoe iemand te helpen.De politiek moet daar buiten blijven.
- Niemand mag/kan voor God spelen maar,; Mensen die willens en wetens zich niet aan de regels houden en andere in gevaar brengen zouden bij mij wel toorn over zich afgeroepen
- Ontzettend moeilijk deze stellingen. Met name bij het kleine leeftijdsverschil ga ik op mijn gevoel af en merk ik er moeite mee te hebben te selecteren op enkel leeftijd. Erg interessant in ieder geval! Succes!
- Het blijft een erg lastig vraagstuk!
- Succes!
- De laatste vragen heb ik ingevuld met geen mening omdat ik het antwoord geen voorkeur mis!
- Ik vind je onderzoek echt top.; Waar ik een voorstander van ben is dat er per individu gekeken moet worden. Staat iemand nog volop in het leven dan maakt leeftijd niet uit. Ben je erg afhankelijk van andere en veel zorg nodig dan maak ik die keus om zijn/ haar bed te vergeven. ; In verpleeghuizen was ooit een afspraak 3 x ab kuur daarna de natuur zijn werk laten doen. ; En heel eerlijk gezegd, alles draait om geld binnen de zorg. Dus de keuze om een jong persoon een bed te geven en een oudere niet is een economisch belang voor de staat. Jong iemand levert geld op en de oudere kost geld voor de regering. Vooral nu de pensioenen niet toereikend zijn.; ; Heel veel succes verder met je onderzoek.; Verpleegkundige
- Ik vind het kijken naar leeftijd niet alleen bepalend. ; Bijvoorbeeld; 20 jarige alleenstaande of 30 jarige moeder. Zo zwart/ wit ligt de keuze in leeftijdsverschil voor mij niet.; Als een 60 jarige de verantwoordelijkheid over de zorg van een kind heeft, zou die voorrang moeten krijgen op een 50 jarige vrijgezel. Maar hopelijk komen de intensivisten nooit voor deze afschuwelijke keuzes te staan.; Succes met je manuscript.

- Dit zijn onmenselijke beslissingen. Ik ben blij deze niet te hoeven maken en hoop dat deze beslissingen alsnog niet gemaakt hoeven te worden.; Blijf gezond.
- Ik geloof dat de artsen goed bekijken bij een bed tekort op IC naar de levensverwachting van de patiënt,
- Blijft een zeer moeilijke keuze ik hoop dat men hier nooit voor zal komen te staan
- Moeilijk kiezen tussen leeftijden een mens bestaat meer dan alleen uit leeftijd .; Vandaar dat dit ethisch zoveel vraagt
- Ik vind niet dat ik voor iemand kan bepalen of hij wel of geen voorrang heeft op een IC bed. Ik vind dat iedereen, ongeacht de leeftijd kans moet hebben om gelijk behandelt te worden. Iemand van 20 jaar oud kan ook binnen een aantal jaren komen te overlijden, terwijl een persoon van 60 jaar na behandeling misschien nog wel 30 jaar een mooi leven kan hebben.
- Lastig om aan te geven wie voorrang zou moeten krijgen bij code zwart. Dit zou eigenlijk niet eens nodig moeten zijn.
- Pffff wat moeilijk zeg ik hoop echt dat t niet nodig is... hierin kun je toch geen keuzes maken.
- Wat een lastige situaties, ik snap dat deze beslissingen kunnen komen, maar ik zou ze niet kunnen maken…; Succes met je master!
- Ik lees de vragen vrij zwart wit, op basis hiervan kan ik geen goede beslissing nemen. Er zijn onnoemelijk meer factoren welke mijn beslissing zouden ondersteunen.
- Succes verder met alles
- Ik denk dat je ook moet kijken hoe iemand leeft, heeft degene (kleine) kinderen of niet. Gebruikt drugs of niet. Misschien ook, hoe belangrijk is iemand in de maatschappij qau beroep
- Wat een onmogelijke keuzes als leeftijden dichtbij elkaar liggen...
- Ik weet dat er soms vreselijke keuzes gemaakt moeten worden en ben blij dat ik die niet hoef te maken.
- Ik hoop toch echt dat het niet zover komt dat dit ingezet moet worden puur op leeftijd selecteren..; Alsof ouderen geen recht meer op zorg zouden hebben om dat ze ouder zijn!!!!!; ; Succes met je afstuderen
- Het hebben van kinderen is voor mij een belangrijke factor voor mensen van 20-40 jaar
- De vragen 15 -18 zijn wat beperkt in de antwoord mogelijkheden.; Je zult nooit weten hoe lang iemand nog te leven heeft na opname IC.; Of je nu 20 of 70 bent.....de 70 jarige heeft misschien wel heel gezond geleefd, er alles voor over gehad om van de IC weg te blijven, dan vind ik het heel terecht dat deze ook nog kansen krijgt om verder te kunnen in het leven.; in het kader van 70 ist nieuwe 60.; ; Succes met verwerking van de vragenlijst en je studie!
- Het is een zeer moeilijk onderwerp wat je hebt gekozen. Ethisch gezien moeten er vele afwegingen worden gemaakt ondanks dat in de werkelijkheid daar de tijd niet voor is.; Veel succes met het onderzoek.
- Prima onderzoek! Ben benieuwd naar de resultaten? Succes!
- Werk zelf in de zorg in het ziekenhuis en weet dat het eigenlijk nooit voorkomt dat 2 personen hetzelfde scoren, altijd toch verschil in tav leefstijl. Vandaar dat ik steeds geen mening ingevuld heb. Er komt ook een soort onderbuik gevoel bij. En onze missie is iedereen behandelen. Alleen wanneer mensen zelf ervoor kiezen om niet beademd te willen worden vind ik een zwaar wegens argument en ook bij 80 plussers kijk ik naar hun leef kwaliteit. Succes 👍
- Succes met dit onderzoek!
- Ik ben blij, als dit nodig is, dat ik deze keuze niet hoeft te moeten maken.

- Leeftijd alleen is niet belangrijk, ook bv of iemand kinderen heeft en hoe diegene leeft, iemand van 35 met kinderen en iemand van 25 die psychische klacht en heeft en het leven niet meer ziet zitten.. dan gaat de 35 jarige voor mij voor.; Succes
- Leeftijd alleen is niet belangrijk, ook bv of iemand kinderen heeft en hoe diegene leeft, iemand van 35 met kinderen en iemand van 25 die psychische klacht en heeft en het leven niet meer ziet zitten.. dan gaat de 35 jarige voor mij voor.; Succes
- Succes
- Ik denk dat niet alleen gekeken moet worden naar leeftijd. Er zijn ook andere criteria zoals een moeder van drie jonge kinderen of iemand die zwaar verslaafd is. Zo zijn er nog wel meer voorbeelden te bedenken waarbij alleen de leeftijd discutabel is.; ; Veel succes met de opleiding
- Het is onmogelijk om te kiezen als je de achterliggende reden niet weet. Je weet niet hoe iemand leeft en wat zijn of haar status is qua gezondheid.
- Bij code zwart vind ik het wel belangrijk te weten of mensen zich zoveel mogelijk gehouden hebben aan de Coronamaatregelen. Voordegenen die er "schijt" aan hebben gehad, met velen bij elkaar komen,feestjes vieren, koningsdag gevierd hebben in veel te drukke omgevingen etc etc...gun ik GEEN behandeling in ziekenhuis of IC, ongeacht hun leeftijd !!
- Bij een keuze maken zou ik ervan uit gaan wie heeft de meeste kans om te overleven...; Maar in pricipe heeft iedereen recht op leven.
- Succes met het onderzoek!
- Ik mis vragen met de vergelijking tussen een jonger persoon met onderliggend lijden die ongezond is tegenover een oudere die geen onderliggend lijden heeft en verder gezond is. In dat geval kies ik voor een gezonde oudere die een IC plek krijgt.
- Heel moeilijk te beslissen vragen, zeker met leeftijden als je moet kiezen tussen 20 of 30 jarige of, tussen 30 en 40 jarige. Allebei zijn ze nog te jong om te sterven en dan is het haast onmogelijk om een voorkeur te geven…..
- Succes!
- Succes met je Master!!
- Ik vind dat bij mensen onder de 65 geen verschil in leeftijd gemaakt moet worden. Wie het eerst komt, e e rest geholpen dan maar, met zelfde klachten en profiel. Een 40-er heeft zeer waarschijnlijk een gezin en en 25 minder waarschijnl8jk, dus bij keuze de 40-er. Maar je wilt je kind ook niet kwijt, maar ik zou ook mn ouders van 61 niet kwijt willen. Dus vindt ik de keuzecop leeftijd niet goed. Boven de 65 of 70 zou ik ook de persoon zelf vragen hoe ze erin staan als dat mogelijk is. Als alleenstaand ouder zou ik toch niet willen dat ik als 38 jarige niet de ic op mag omdat een ander 25 is.
- Mijn antwoorden waren wellicht wat eenzijdig, maar dat komt omdat ik iemand obv leeftijd geen voorkeur zou geven. Ik dacht dat het kabinet dat ook ook had weggestemd?
- Hopelijk kom ik zelf nooit voor dit dilemma te staan want dan zou ik misschien ter plekke toch een andere keus maken. Waarschijnlijk zou het gezin rondom diegene dan ook een rol spelen.
- Ik denk dat leeftijd niet de goede afmeting is, wel kans op overleven en erna ook nog een goed leven te kunnen leiden.
- Als het zou gaan tussen mensen van 80+ en jongeren, vind ik dat de jongeren voorrang hebben. Zij hebben nog een hele toekomst voor zich of zelfs al een gezin. Bij de 80 + is de kans zeer

groot dat ze toch binnen 10 jaar overlijden. Hoe vervelend dat ook is, zij hebben al een leven gehad. Maar voor mij zou de grens dus pas bij 80+ liggen.

- Ik hoop dat de Medici deze maat regelen nooit hoeven toe te passen.
- De situatie worden niet verduidelijkt met privé omstandigheden. Mede daardoor heb ik bij het maken van keuze bij veel vragen geen mening gegeven. ; - is er een gezin om voor te zorgen ; - zijn er kinderen afhankelijk van diegene ; -ect.
- Selectie op leeftijd zie ik als leeftijdsdiscriminatie, ik vind dat iedereen kans moet maken op dat IC bed. Daarom zou naar mijn mening er geld moeten worden geïnvesteerd in het groter maken van de IC-capaciteit, hier is echter sinds de start van de pandemie maar minimaal tot niet in geïnvesteerd door het huidige demissionaire kabinet. ; ; In de vragenlijst heb ik wel gekozen om de persoon die ouder is het IC-bed te geven als de levensverwachtingen na de IC-opname gelijk is. Dit omdat een jong iemand meer kans heeft om beter te worden omdat zijn/haar jonger en vitaler is en hierdoor meer kans heeft om te herstellen zonder IC-bed t.o.v. iemand met een hogere leeftijd.
- Ik vind de vragen iets te kort door de bocht. Het criterium leeftijd is een vaststaand gegeven. Of iemand na covid nog 10 jaar te leven heeft is een aanname. Met dat laatste moet je heel voorzichtig zijn en kun je niet zo zwart/wit stellen als in deze enquete.
- Ik neem aan dat er wel medische zorg wordt verleend aan degene die niet op de ic kan worden opgenomen.