To ethicists 'the trolley problem' does not relate to the number of patients spilling out into hospital corridors, waiting to receive care. It relates to a 1960s thought experiment from a well known ethicist, Philippa Foot.

The trolley in question is the American word for a tram or railway carriage. Imagine an unmanned carriage is hurtling down a track towards five people stuck on the rails, unable to move. You notice that there is a set of points with a lever — if you pull the lever the carriage will be diverted onto a side track where there is one single person stuck on the rails. If you do nothing five people will die, but it will not be your fault. If you pull the lever only one person will die, but you will have killed them. Should you pull the lever?

In case you're wondering, there isn't a 'right' answer. The trolley problem is a way into discussing how much value we put on normal rules and duties, or how far we are prepared to discount them to respond to a greater need. Once the number to be saved starts to climb above three most people say they would pull the lever.

But now, suddenly, the trolley problem has wheels.

DEADLY DELAY

On 2 December 2020 the UK Medicines and Healthcare products Regulatory Agency (MHRA) granted emergency authorisation for use of the Pfizer COVID-19 vaccine. My own local vaccine centre announced that it would start vaccinating patients in mid-December, aiming to protect hundreds of patients daily.

But on 9 December the MHRA introduced the requirement that patients should wait, socially distanced, for 15 minutes following vaccination.¹

If you plan to have a throughput of 120 patients an hour then space will not allow for this in most community healthcare facilities. So our local immunisations never started, along with much of the nation. The reason for the change is that two patients had serious and potentially life-threatening allergic reactions to the vaccine.² Fortunately neither died. However this was predictable. Both had

David Misselbrook

histories of serious allergic reactions and both carried adrenaline auto-injectors. Actually, early experience was reassuring — most severe immediate reactions can be anticipated. Special clinics could be run for those with such histories, leaving the rest of the population to be vaccinated quickly after informed consent.

Locally we are hoping that full scale vaccination will restart in mid-January. But as I write, 2986 people in the UK died from COVID-19 in the last week for which there are official figures.³ It is hard to know how much delay to COVID-19 vaccination there has been across the UK due to the MHRA ruling. But with almost 3000 people dying per week, any delay is bad news. So do we not care if the odd handful of people die from anaphylaxis after COVID-19 vaccination? No, of course we do. However it seems perverse to care so much less about 3000 people dying each week when their protection could have been expedited. Of course, safety risks to COVID-19 vaccination might increase the number of people refusing vaccination, delaying herd immunity. But this is balanced by the risk that delay in the vaccination programme could mean a surge in cases that overwhelms the NHS's ability to give effective care — our worst nightmare, where those who have the potential to be saved die in hospital corridors from lack of available care. The unthinkable trolley problem.

Surely any reasonable balance of risk would mean adding two extra screening questions to the original COVID-19 vaccination arrangements; any history of serious allergy or any history of needing adrenaline auto-injectors? If negative then go ahead with rapid throughput clinics with normal medical backup for those who consent.

Why does the MHRA appear to put less value on the lives of those dying every day from vaccine delay, who may be in their hundreds, than the hypothetical possibility of a very small handful dying from anaphylaxis?

Perhaps the immediate reason is shown in the trolley problem itself. The MHRA will have been following its standard operating procedures. It is easier to restrict one's gaze to the normal duty — the highest level of individual safety. That is the MHRA's job. The thousands who may well die from delay will not be seen as the MHRA's fault. And there are the lawyers circling each of us in our 21st century US-lite society. Who would want to pull the lever?

But when 'standard operating procedures' no longer serve the public good they are not fit for purpose. In this instance, insisting on the highest standard of safety is dangerous to us all.

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