use a coin flip to allocate a scarce ventilator to either a twenty-year-old patient or a ninety-year-old patient who have equal survival probabilities. However, dying young is a severe form of disadvantage because the young patient will die having had significantly less opportunity to live through life's stages compared to a patient of very advanced age. Ignoring this form of disadvantage during triage diverges from public preferences about the relevance of age in triage, including the preferences of older adults. K. Huang et al., "Veil-of-Ignorance Reasoning Mitigates Self-Serving Bias in Resource Allocation during the COVID-19 Crisis," *Judgment and Decision Making* 16, no. 1 (2021): 1-19.

Other Voices

Against Exclusive Survivalism: *Preventing Lost Life and Protecting the Disadvantaged in Resource Allocation*

by GOVIND PERSAD

Many values and objectives matter when allocating scarce medical resources. Purely maximizing a single outcome, even survival to hospital discharge or shortly thereafter, is insufficient for fair allocation. Single-outcome approaches, regardless of what outcome they maximize, invariably overlook relevant ethical values.[1]

Maximizing solely short-term survival, as MaryKatherine Gaurke and colleagues and Alex Rajczi and colleagues endorse in their articles in this issue of the *Hastings Center Report*, erroneously regards preventing ten years of lost life as no better than preventing one, and preventing death at forty as no better than preventing death at eighty.[2] This approach, which I call "exclusive survivalism," is not only wasteful but also unjust. Particularly in the Covid-19 pandemic, the populations that have experienced the earliest deaths and lost the most time alive are those who are not merely unfortunate but also subject to injustice.

A preferable, multiprinciple approach would pursue at least two aims. The first is benefiting people and preventing harm. Preventing near-term deaths is one dimension of this objective, but another is preventing lost life—time alive that a scarce treatment can help secure. The second is protecting the disadvantaged. Preventing early deaths serves this value in two ways. First, it is worse to die earlier. Second, those who die earlier are much likelier to have been disadvantaged during their lives.

For most life-threatening conditions, improving the post-treatment life span from two years to six would be a medical breakthrough.[3] A fair allocation policy can realize the same outcome, though in a different way: providing a scarce treatment to one patient rather than another may increase the treated patient's survival by six years rather than two. In this case, lengthened survival involves choosing between patients, but that does not strip it of ethical relevance. Each patient has equal worth, and two years will matter greatly to each. But one can gain those two years three times over. Regarding these additional years of human life as irrelevant to proper decision-making is inconsistent both with the value that medicine typically accords to extending life and with many surveys of public preferences.[4]

Preventing lost life and early death matters even when those outcomes reflect pure misfortune.[5] My adult readers are both fortunate and privileged not to have died before eighteen, which would have denied them every relationship, achievement, and source of meaning they have formed or deepened since. Dying at eighty would be a far lesser loss—in fact, it would exceed many readers' expectations. Similarly, an older grandparent's and a teenage child's deaths both matter. But the latter is far worse, from either a parent's perspective or that of an appropriately reflective grandparent or grandchild. Recognizing that a death's being earlier makes it worse does not require believing that everyone is owed an equal life span.[6] It requires merely recognizing that life is valuable and that having less of it is worse.

Moreover, early death more often reflects injustice than pure misfortune. Both before and during the Covid-19 pandemic, lost life and early death have disproportionately befallen those who face systemic injustice, including destitution, racism, and ableism. Lower income predicts earlier death.[7] In the United States, racial minorities have died nearly a decade earlier than their White counterparts during the pandemic,[8] and minority populations, despite

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being far smaller, have lost tens of thousands more years of life before age sixty-five.[9] Worldwide, residents of poorer countries have died earlier from Covid-19.[10] At the outset of the pandemic, I and others suggested that prioritizing the prevention of these early deaths would "help counteract . . . life-shortening social inequalities,[11] but at that time, we had minimal evidence from the pandemic itself. That evidence is now here. Bioethicists should recognize both that early deaths are worse and that they happen more often to the worst-off, rather than assume that every death is an identically harmful stroke of bad luck.[12]

The link between disadvantage and early death reflects not only background inequalities but also policy choices during the pandemic. Efforts to pursue herd immunity through infection, requirements that people work on-site even when employers did not provide them personal protective equipment, and the spreading of misinformation about vaccine safety and Covid-19 risk exposed poorer and working people to needless infection, hospitalization, and death earlier in life.[13] Many allocation policies for vaccines and therapeutics have excluded or deprioritized younger recipients using the very "blunt age cutoffs" that were previously criticized for crisis standards of care.[14] These one-size-fits-all exclusions of younger people from vaccine access, which are recurring for boosters, both increased death and exacerbated inequality as compared to multiprinciple alternatives.[15]

Alignment and Conflict in Multiprinciple Approaches

A multiprinciple approach must determine how to integrate preventing lost life with values like increasing short-term survival and protecting the disadvantaged.[16] Consider two different scenarios where lost life might be averted: *alignment* and *conflict*.

In alignment scenarios, prioritizing the person who will be worse off without treatment also prevents more lost life. For instance, prioritizing an eighteen-year-old for the last intensive care unit bed over an equally ill eighty-year-old both prevents more lost life and avoids the more disadvantaging outcome of dying at eighteen, an outcome strongly correlated with other forms of disadvantage.

In rarer conflict scenarios, the person who stands to be worse off if not treated also is expected to gain less from treatment, as in a situation involving an eighteen-year-old so ill that they are unlikely to survive and a moderately ill eighty-year-old. Exclusive survivalism makes conflict scenarios likelier by regarding the extension of life as an irrelevant benefit. Those who become severely ill earlier in life are likelier to be disadvantaged but also could gain more time alive from treatment than older adults would; providing treatment to the younger person would thus be an instance of both preventing more harm and protecting the disadvantaged.

In alignment situations, a fair policy would—at a minimum—break ties among patients with similar odds of survival in favor of those who will be worse off if not treated but who can be expected to gain more from treatment.[17] Breaking ties in this way is both more beneficent and more just than flipping a coin. In conflict scenarios, a fair policy would not call for flipping a coin. Rather, it would consider, among other things, both how much time alive each person stands to lose if not treated and how disadvantaged each would be if not treated.

Rebutting Defenses of Exclusive Survivalism

Exclusive survivalism has been defended by the claim that "likelihood of survival to hospital discharge" is a uniquely "clinical" decision criterion.[18] Pandemic response, however, is social policy, not a decision for an "exemplary clinician."[19] And even clinical considerations hardly favor ignoring medically relevant outcomes like extending survival. Life expectancy and age are often medically relevant; the result of a coin toss is not.

Other defenses of exclusive survivalism claim that age or expected life-years are discriminatory criteria, akin to race, gender, and religion. But extending life and preventing early deaths are objectives of medical treatment, whereas ascriptive social identities like race, gender, and religion are identities medicine does not aim to alter. The more apposite concern is not that consideration of these factors is fundamentally discriminatory, but that, as I have discussed elsewhere, considering how much life someone can gain may sometimes lead to compounding disadvantage.[20] But considering likelihood of survival could also lead to exacerbating disadvantage.[21] Intentionally offsetting any compounding of disadvantage is preferable to flipping coins.

Framing triage as pitting the "young and able-bodied" against the "sick and disabled,"[22] meanwhile, indicates a misunderstanding about who is likely to need extracorporeal membrane oxygenation, dialysis, or intensive care in a pandemic. Younger people sick enough to need scarce Covid-19 treatments have overwhelmingly not been able bodied or otherwise privileged: they are far likelier to have previously been ill, disabled, or subject to disadvantage and discrimination.

Rajczi and colleagues suggest that administrative guidance documents prohibit considering age or averting lost life.[23] No single administrator or agency determines what's legal. And legal guidance, particularly when issued by an administrator without judicial or legislative scrutiny, does not reliably indicate what is ethical or publicly acceptable. But in any event, agency guidance explicitly permits considering age as one factor among many.[24] Such guidance prohibits only age cutoffs, and even that provision has been inconsistently enforced.[25] Rajczi and colleagues' leap from the plausible premise that triage judgments must be individualized and must avoid categorically excluding

people on the basis of age or disability to the conclusion that "political reasoning" entails considering only episode survival is just that—a leap, and one without grounding in federal statutory or case law.[26]

Rather than leaping, decision-makers should base their judgments on actual public opinion and deliberation, as Rajczi and colleagues did not.[27] And they should recognize that those facing the most early death and lost years of life—severely ill children, poor people, and racial minorities harmed by discrimination—may be ill positioned to influence administrative guidance. Overlooking their interests in favor of administrative edicts or pronouncements from special-interest groups is "political in the wrong way."[28]

Does preventing lost life and early death require politically unsupported or objectionably intuitionistic judgments? I prefer to emphasize these values' coherence with judgments in other contexts, rather than appealing to any one normative theory. But they could be defended foundationally on Kantian,[29] contractualist,[30] consequentialist,[31] or virtue-ethical[32] grounds.

Last, exclusive survivalism might appeal to epistemic modesty: predicting post-treatment life span is difficult.[33] But individualized assessment that recognizes uncertainty and works to avoid bias is more respectful, beneficent, and publicly acceptable than an arbitrary coin flip.[34] Furthermore, age is not uncertain, and empirical research suggests that incorporating age into scoring systems improves accuracy.[35]

The Covid-19 pandemic has caused inequitable loss of life. But it would have been worse and more inequitable had it disproportionately harmed people early in life, as the Spanish flu did a century ago. A multiprinciple approach that recognizes the relevance of benefiting people and preventing harm, including by preventing lost life, and the relevance of protecting the disadvantaged, including by preventing early deaths, can recognize why the Spanish flu was worse. Exclusive survivalism cannot, which underscores its insufficiency for fair allocation.

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1. Maximizing years of life saved is, of course, also insufficient alone. See G. Persad et al., "Principles for Allocation of Scarce Medical Interventions," *Lancet* 373, no. 9661 (2009): 423-31, which explains that saving more years of life is "undeniably relevant but insufficient alone" (p. 425).

2. M. Gaurke et al., "Life-Years and Rationing in the Covid-19 Pandemic: A Critical Analysis," and A. Rajczi et al., "The University of California Crisis Standards of Care: Public Reasoning for Socially Responsible Medicine," both in *Hastings Center Report* 51, no. 5 (2021): 18-29 and 30-41, respectively. Both Gaurke et al. and Rajczi et al. aim solely to maximize near-term survival, though with slightly different parameters for what constitutes "shortly thereafter." Gaurke et al. consider whether someone will survive for a year, while Rajczi et al. insist that even a year of additional life is irrelevant. Rajczi et al.'s willingness to countenance a "multiplier effect" does not depart from exclusive survivalism, since what they would multiply is the number of individuals who survive to hospital discharge. Strikingly, for instance, their approach would justify prioritizing individuals gestating singletons over single parents, and those gestating twins over both (pp. 37-39, 41).

3. The importance of extending life is why, for instance, policies "match the expected life of the organ to the expected life of the patient" in kidney transplantation (Gaurke et al., "Life-Years and Rationing in the Covid-19 Pandemic," 20). If extending life were irrelevant, policies would not do this.

4. See, for instance, M. Schoch-Spana et al., "Influence of Community and Culture in the Ethical Allocation of Scarce Medical Resources in a Pandemic Situation: Deliberative Democracy Study," *Journal of Participatory Medicine* 12, no. 1 (2020): doi:10.2196/18272 (which states that 50 percent or more of participants in two qualitative research studies thought length of survival should "often or always" be considered, with 30 percent or less believing it should "rarely or never" be), and D. Wilkinson et al., "Which Factors Should Be Included in Triage? An Online Survey of the Attitudes of the UK General Public to Pandemic Triage Dilemmas," *BMJ Open* 10, no. 12 (2020): doi:10.1136/bmjopen-2020-045593 (reporting that 78 to 83 percent of respondents believed that length of survival was relevant). Other studies suggest public support not only for extending lives but also for preventing earlier deaths, particularly when self-serving bias is corrected for. See, for example, M. Li et al., "How Do People Value Life?," *Psychological Science* 21, no. 2 (2010): 163-67; G. Goodwin et al., "Valuing Different Human Lives," *Journal of Experimental Psychology* 143, no. 2 (2014): 778-803; and K. Huang et al., "Veil-of-Ignorance Reasoning Mitigates Self-Serving Bias in Resource Allocation during the COVID-19 Crisis," *Judgment and Decision Making* 16, no. 1 (2021): 1-19. The last of these is particularly relevant to Gaurke et al.'s hypothetical concerning a childless person with elderly parents, which appeals to precisely the self-serving bias that Huang et al. filter out.

5. The public, in most countries, appears to agree, even—unlike in allocation dilemmas—when preventing these losses requires affirmatively inflicting death. See E. Awad et al., "The Moral Machine Experiment," *Nature* 563 (2018): 59-64, which observes that respondents in most countries prioritize children over non-elderly adults, and both over older adults, in "trolley problem" scenarios.

6. Gaurke et al. unconvincingly suggest that a position advanced by Frances Kamm invites the idea that "justice requires us to try to see to it that people have the opportunity to experience more-or-less-equal sums of life and the goods it affords," which to them seems "peculiar and unrealistic," and they likewise claim, in response to the late Dan Brock, that prioritizing the prevention of early deaths is appropriate "*only* if fairness obligates a society to try to see to it that people have the opportunity to experience more or less equal sums of life and the goods it affords" ("Life-Years and Rationing in the Covid-19 Pandemic," 22, emphasis added). Kamm and Brock do not advocate equality of life span but, rather, priority to those who have had less of a valuable good. See F. M. Kamm, "Moral Reasoning in a Pandemic," *Boston Review*, July 6, 2020, http://bostonreview.net/philosophy-religion/f-m-kamm-moral-reasoning-pandemic (which explains that "the moral idea is to give priority to the worse off"' and that "often a younger death is worse because the person will have had less of the good of life"). Meanwhile, Norman Daniels's *Am I My Parents' Keeper? An Essay on Justice between the Young and the Old*, which Gaurke et al. use (on p. 23 in their article) in critiquing arguments by Kamm and Brock, does not reject the relevance of preventing earlier deaths. All Daniels observes—and I agree—is that other factors may some-

times outweigh the importance of preventing an early death, not that dying earlier is ethically equivalent to dying later.

7. R. Chetty et al., "The Association between Income and Life Expectancy in the United States, 2001-2014," *Journal of the American Medical Association* 315, no. 16 (2016): 1750-66.

8. J. Wortham et al., "Characteristics of Persons Who Died with COVID-19—United States, February 12-May 18, 2020," *Morbidity and Mortality Weekly Report* 69, no. 28 (2020): 923-29.

9. M. T. Bassett, J. T. Chen, and N. Krieger, "Variation in Racial/Ethnic Disparities in COVID-19 Mortality by Age in the United States: A Cross-Sectional Study," *PLOS Medicine* 18, no. 2 (2020): doi:10.1371/journal.pmed.1003402. See also A. Johnson and N. Martin, "How COVID-19 Hollowed Out a Generation of Young Black Men," *ProPublica*, December 22, 2020, https://www.propublica.org/article/how-covid-19-hollowed-out-a-generation-of-young-black-men.

10. G. Demombynes, "COVID-19 Age-Mortality Curves Are Flatter in Developing Countries," *Policy Research Working Paper World Bank* 31, no. 22 (2020): covidwho-887818.

11. G. Persad, J. Phillips, and E. J. Emanuel, "Allocating Medical Resources in the Time of Covid-19—Authors' Reply," response to letters to the editor, *New England Journal of Medicine* 382 (2020): doi:10.1056/NEJMc2009666. See also E. J. Emanuel et al., "Fair Allocation of Scarce Medical Resources in the Time of Covid-19," *New England Journal of Medicine* 382 (2020): 2049-55, which states, "Because young, severely ill patients will often comprise many of those who are sick but could recover with treatment, this operationalization also has the effect of giving priority to those who are worst off in the sense of being at risk of dying young and not having a full life" (p. 2052).

12. It is surprising to see the overwhelming evidence of inequitable disparities in death and lost life overlooked a year and a half later, in favor of analogizing allocation dilemmas to stumbling across two drowning people. See Gaurke et al., "Life-Years and Rationing in the Covid-19 Pandemic," 22-23. Notably, neither Gaurke et al. nor Rajczi et al. recognize poverty or racism as causes of vulnerability or discuss how allocation policies should respond to them. Race—not racism—is described by Gaurke et al. as a "discriminatory criterion" to be ignored (p. 24) and by Rajczi et al. only in quotation (pp. 35, 36); poverty is entirely overlooked.

13. See, for example, M. Kulldorff, S. Gupta, and J. Bhattacharya, "The Great Barrington Declaration," Great Barrington Declaration, October 4, 2020, https://gbdeclaration.org/. Aaron Kheriaty, one of Rajczi's coauthors, has endorsed some of these policy choices. On Twitter, for example, Kheriaty wrote, "I signed the Great Barrington Declaration today. I recommend reading the document. Someday it will be universally acknowledged that this was correct about the right approach to COVID. I hope that day comes sooner than later." Twitter post, November 25, 2020, 3:02 p.m., https://perma.cc/5LEP-7GXH. See also A. Kheriaty and G. V. Bradley, "University Vaccine Mandates Violate Medical Ethics," *Wall Street Journal*, June 14, 2021, which claims that "for those under 30, the risks of serious morbidity and mortality are close to zero" from Covid-19. The latter claim is not correct, particularly in communities subject to racism. See Bassett, Chen, and Krieger, "Variation in Racial/Ethnic Disparities in COVID-19 Mortality by Age in the United States."

14. W. C. Thomas and H. Grabenstein, "People Over 75 Are First in Line to Be Vaccinated against COVID-19. The Average Black Person Here Doesn't Live That Long," *ProPublica*, February 12, 2021, https://www.propublica.org/article/people-over-75-are-first-in-line-to-be-vaccinated-against-covid-19-the-average-black-person-doesnt-live-that-long; see also G. Persad, E. A. Largent, and E. J. Emanuel, "Age-Based Vaccine Distribution Is Not Only Unethical. It's Also Bad Health Policy," *Washington Post*, March 9, 2021.

15. E. Wrigley-Field et al., "Geographically-Targeted COVID-19 Vaccination Is More Equitable and Averts More Deaths Than Age-Based Thresholds Alone," *Science Advances* (forthcoming).

16. Gaurke et al. profess surprise that no sources cited in support of the multiprinciple framework that Ezekiel Emanuel, our colleagues, and I propose "explicitly prioritize the value of saving more years of life over other relevant values" ("Life-Years and Rationing in the Covid-19 Pandemic," 26). This reflects a misunderstanding of our framework, which does not prioritize saving more years of life over other values and, in fact, regards it as a secondary aim in a pandemic. See E. J. Emanuel et al., "Fair Allocation of Scarce Medical Resources in the Time of Covid-19," *New England Journal of Medicine* 382, no. 21 (2020): 2049-55, which asserts, "Limited time and information in a Covid-19 pandemic make it justifiable to give priority to maximizing the number of patients that survive treatment with a reasonable life expectancy and to regard maximizing improvements in length of life as a subordinate aim" (p. 2052). Unlike Gaurke et al., I believe that preventing lost years of life matters, including when the loss prevented stretches beyond a single year.

17. See M. Z. Solomon, M. K. Wynia, and L. O. Gostin, "Covid-19 Crisis Triage—Optimizing Health Outcomes and Disability Rights," *New England Journal of Medicine* 383, no. 5 (2020): e27; D. Wasserman, G. Persad, and J. Millum, "Setting Priorities Fairly in Response to Covid-19: Identifying Overlapping Consensus and Reasonable Disagreement," *Journal of Law and the Biosciences* 7, no. 1 (2020): doi:10.1093/jlb/lsaa044. Age was also used as a tiebreaker to prioritize pediatric patients over adults in New York's 2015 ventilator allocation guidelines, which Gaurke et al. discuss favorably. See New York State Task Force on Life and the Law, *Ventilator Allocation Guidelines* (New York State Department of Health, November 2015), https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines, p. 84.

18. Gaurke et al, "Life-Years and Rationing in the Covid-19 Pandemic," 24.

19. Ibid., 25.

20. Wasserman, Persad, and Millum, "Setting Priorities Fairly in Response to Covid-19"; see also M. Mello et al., "Respecting Disability Rights—toward Improved Crisis Standards of Care," *New England Journal of Medicine* 383, no. 5 (2020): doi:10.1056/NEJMp2011997.

21. See D. B. White and B. Lo, "Mitigating Inequities and Saving Lives with ICU Triage during the COVID-19 Pandemic," *American Journal of Respiratory and Critical Care Medicine* 203, no. 3 (2021): 287-95, and N. O. Sederstrom and J. Wiggleton-Little, "Acknowledging the Burdens of 'Blackness,'" *HEC Forum* 33, no. 1 (2021): 19-33.

22. Gaurke et al., "Life-Years and Rationing in the Covid-19 Pandemic," 25.

23. Rajczi et al., "The University of California Crisis Standards of Care," 35, 36.

24. "Section 1557: Frequently Asked Questions," U.S. Department of Health & Human Services, May 18, 2017, https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html. The DHHS explains that "it would be permissible for the transplant center to consider age as one factor in assessing the allocation of transplants," although "blanket exclusion of individuals based solely on age is discriminatory."

25. Persad, Largent, and Emanuel, "Age-Based Vaccine Distribution." This commentary describes the use of age-only vaccine distribution policies.

26. See Mello, Persad, and White, "Respecting Disability Rights," and Solomon, Wynia, and Gostin, "Covid-19 Crisis Triage." Rajczi et al. misread prohibitions on categorical exclusions outside scarcity as precluding policies for multifactor prioritization of access to a scarce treatment, like the age-aware policies

used for Covid-19 vaccine allocation. Bowen v. American Hospital Association, 476 U.S. 610 (1986), concerns regulations prohibiting the categorical denial of all medical care to anencephalic infants; Western Air Lines v. Criswell, 472 U.S. 400 (1985), concerns employer policies categorically excluding pilots over sixty and was decided under the Age Discrimination in Employment Act, not the Age Discrimination Act of 1975; and Lovell v. Chandler, 303 F.3d 1039 (9th Cir. 2002), concerns the categorical exclusion of individuals from a state insurance program "on the basis of age, blindness, or disability." The legal treatment of age and disability discrimination are also different in more comprehensive ways that are beyond the scope of this paper.

27. Rajczi et al., "The University of California Crisis Standards of Care." The authors claim that their approach grounds "its decisions on the public's preferences for triage protocols" (p. 30), but nowhere do they show that public deliberation or the results of public surveys support their approach. Instead, they seem to assume that selected administrative guidance captures public preferences.

28. J. Rawls, *Justice as Fairness: A Restatement* (Cambridge, MA: Belknap Press, 2001), 188. Rawls explains that "a political conception is political in the wrong way when it is framed as a workable compromise between known and existing political interests, or when it looks to particular comprehensive doctrines presently existing in society and tailors itself to win their allegiance" (p. 188).

29. S. Kerstein, "Dignity, Disability, and Lifespan," *Journal of Applied Philosophy* 34, no. 5 (2017): 635-50.

30. J. Bidadanure, "In Defense of the PLA," *American Journal of Bioethics* 13, no. 8 (2013): 25-27.

31. R. Y. Chappell, "Against 'Saving Lives': Equal Concern and Differential Impact," *Bioethics* 30, no. 3 (2016): 159-64.

32. R. M. Antiel et al., "Should Pediatric Patients Be Prioritized When Rationing Life-Saving Treatments during the COVID-19 Pandemic?," *Pediatrics* 146, no. 3 (2020): doi:10.1542/peds.2020-012542.

33. Gaurke et al., "Life-Years and Rationing in the Covid-19 Pandemic"; Rajczi et al., "The University of California Crisis Standards of Care." Rajczi et al. criticize "estimates of length of survival that involve a great deal of uncertainty" (p. 36).

34. In "Influence of Community and Culture," Schoch-Spana et al. report a respondent's disapproval of random selection as akin to playing "bingo with my life," and they note that "[t]he most unpopular principles in the survey and in the discussions [that were part of the public engagement study conducted by Schoch-Spana's research team] were first come, first served and a lottery," with 80 percent or more of respondents believing that lottery allocation should rarely or never be used.

35. R. Raschke et al., "Discriminant Accuracy of the SOFA Score for Determining the Probable Mortality of Patients with COVID-19 Pneumonia Requiring Mechanical Ventilation," *Journal of the American Medical Association* 325, no. 14 (2021): 1469-70. This article explains that age was more predictive of mortality than the Sequential Organ Failure Assessment score in "patients requiring mechanical ventilation for COVID-19 pneumonia" (p. 1469).

Other Voices

Centering Social Justice for Covid-19 Resources and Research

by VIRGINIA A. BROWN

Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death.

—Martin Luther King Jr.[1]

In offering insight into developing guidelines for the creation and implementation of crisis standards of care (CSC) in this issue of the *Hastings Center Report*, neither MaryKatherine Gaurke and colleagues nor Alex Rajczi and colleagues confront the impact of lifetimes of structural racism and the resulting inequitable distribution of health and health care between and among communities. Moreover, they do not offer a collaborative process for remediating such inequities.

While Gaurke et al. implore readers to remember that "[w]hen the circumstances are dire, we need our fundamental ethical principles more than ever,"[2] Rajczi et al. turn to the "will of the majority"[3] to settle matters of justice without addressing how society ought to respond when the will of the majority violates the fundamental rights of those in the minority. Neither article offers a comprehensive analysis of a just allocation of scarce resources—one "rooted in a collective agreement about what constitutes health in/justice."[4] These articles reflect a larger problem in bioethics: the field's praxis continues to fail to recognize and respond to the obligation to address the fair distribution of burdens and benefits that comes with the principle of justice. More specifically, bioethics

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