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OPEN PEER COMMENTARIES

It's Not Easy Bein' Fair

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McGuire et al. (2020) acknowledge that their article "is not an exhaustive list of the ethical challenges arising during the COVID-19 pandemic" (16). Instead, they focus on a cluster of issues concerning the fair allocation of scarce critical care resources, issues they describe as the "most pressing as the US approaches the first peak of this pandemic" (16). Although they effectively address these issues, attending to present problems should not prevent us from grappling with ethical challenges beyond the first peak. This pandemic requires long-term solutions. Science will provide some of them, especially if researchers develop a safe and effective coronavirus vaccine. But scientific breakthroughs will be only part of the story. We will also need ethical breakthroughs to ensure that a coronavirus vaccine is effectively deployed and justly distributed on a global scale.

In this commentary, we offer two criticisms of McGuire et al.'s analyses of justice-related challenges during the pandemic's first peak. Our criticisms are important not only for evaluating what has occurred so far, but also for understanding how justice is at stake in the near future and how it might be achieved. Our first criticism concerns the relevance of comorbidities to resource allocation and the fairness of unequal outcomes. The second concerns reasons for protecting and prioritizing healthcare workers, broadly defined. After offering these criticisms, we forecast justice-related challenges concerning global distribution of a coronavirus vaccine.

In medicine, justice requires the fair allocation of medical resources in accordance with clinically relevant considerations. Allocation schemes are fair when they distribute goods according to the severity and urgency of patients' needs and in the most efficacious way possible. Fair allocation can create unequal distribution: Individual differences in severity, urgency, and efficacy lead to unequal distributions of resources within and across populations. Resulting inequalities do not mean that an allocation scheme is unjust. This holds true for public health emergencies. In the COVID-19 context, physicians and healthcare systems aim to maximize rescue; the goal, long accepted in transplantation using cadaver organs, is and ought to be saving as many lives as possible with scarce resources. Given the maximal-rescue goal and the role of efficacy in fair allocations, comorbidities matter.

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When relevant to efficacy, comorbidities must be factored into an allocation scheme's calculus.

McGuire et al. see this as a serious ethical problem, citing risks of "perpetuating or exacerbating underlying inequities in the health care system" (16). They correctly observe structural inequalities that "put specific economic, racial, ethnic, geographic, and other marginalized groups at a disadvantage in accessing and using healthcare services" (22). And we join them in finding these health disparities unjust. But fair allocation schemes can lead to unequal health outcomes for communities of color, the poor, the elderly, and persons with disabilities, if and when those social categories are associated with conditions rendering allocations non- or significantly less efficacious. Data show that increased age by itself, for instance, correlates with diminishing chance of surviving COVID-19 despite interventions with ventilators and renal dialysis (Grasselli et al. 2020). This justifies considering age-related conditions and relevant comorbidities "to the extent to which data support the risk of failure or the odds of success" (Caplan in Archard and Caplan 2020).

We agree with McGuire et al. that the healthcare system "should not *contribute* to [structural inequalities of the social system]" (23, emphasis added). But it is important to distinguish between contributing to inequalities and having to accept the reality of their consequences. When allocation schemes are sensitive to relevant comorbidities, unfairness in outcomes belongs to pre-pandemic injustices creating pre-allocation health disparities, not to allocation principles. Alternative approaches to distributive justice might consider patients' clinically irrelevant properties, employ broader conceptions of social justice beyond the scope of physicians' competencies and roles, and perhaps even require abandoning the maximal-rescue aim. We doubt that alternatives would be fair even if they were to achieve parity of outcomes across populations, especially if that meant saving fewer lives in total.

Our second criticism concerns protecting and prioritizing healthcare workers. McGuire et al. present a dilemma. Either we prioritize on the basis of health status alone, in which case healthcare-worker status is irrelevant; or, we prioritize healthcare workers on grounds of reciprocity, in which case we struggle to distinguish between essential and nonessential personnel and remain unclear about whether reciprocity-related obligations extend to providing critical care resources.

We dodge the dilemma by adopting an alternative reason for prioritizing healthcare workers. Rather than reciprocity, which brings in extra-medical judgments of merit and relative social worth, we suggest that *sustainability*, indirectly a matter of efficacy and a precondition for providing medical goods, presents an enormously compelling reason for prioritizing healthcare workers in allocation schemes. Sometimes, as the authors note, this is a matter of returning them to front lines as soon as possible; sometimes, it is a matter of preserving morale. But other times—or even simultaneously—it is a matter of securing the long-term stability, capacities, and integrity of institutions and the medical profession. Prioritizing healthcare workers, broadly defined to include those necessary to run a hospital, sustains the institutions that provide care, the very good whose allocation is under discussion.

As mentioned at the start of this commentary, fair allocation of a coronavirus vaccine will require that scientific breakthroughs be joined with ethical breakthroughs. One ethical breakthrough seems to have already occurred. A consensus has emerged regarding the ethical framework for SARS-CoV-2 challenge studies, identifying conditions under which such studies would be justified (Coronavirus Vaccine Challenge Working Group 2020; Eyal et al. 2020; Plotkin and Caplan 2020; Shah et al. 2020; WHO 2020). A key feature of the rationale is the social benefit of challenge studies through time saved or knowledge provided in the course of vaccine development. However, the full social benefit will only be realized if the vaccine is manufactured, deployed, and accessed in an optimal and fair manner.

Many of the issues McGuire et al. address will be newly expressed when allocation problems take global form. The global distribution of a coronavirus vaccine will not be orchestrated by a centralized authority, leaving allocation vulnerable to geopolitical power asymmetries, global market forces, supply-chain contingencies, and geographic luck. Ideally, the distribution would be guided by principles of global justice, according to which the scarce supply would be allocated to populations with the greatest and most urgent needs and in the most efficacious manner. However, the interests and priorities at stake in vaccine allocation may differ from those at stake in critical care resource allocation. The contextual difference, then, may require distinct principles of justice (Rhodes 2018).

Based on our first criticism, vaccine allocations can be fair even if they refract preexisting injustices, but only if the distribution-guiding principles concern population-level needs and efficacy. Based on our second criticism, prioritizing healthcare workers should be justified on grounds of sustainability rather

than reciprocity. This will be important in the earliest stages of a coronavirus vaccine's rollout, when supply will be at its lowest. The strength, resilience, and sustainability of healthcare systems will especially matter during this period.

Once we know what coronavirus-vaccine justice looks like on global scale, two features of McGuire et al.'s analysis might help to realize it: first, community engagement; second, coordination and cooperation.

McGuire et al. are right to note how a concurrent plague of "disinformation and poor planning" has led to a "misinformed, distrustful public, … burdened by deficits in health literacy," which has weakened government responses to the pandemic (21). They identify community engagement as a promising countermeasure. Beyond enhancing public understanding and support for critical care resource allocation schemes and strengthening compliance with social distancing orders, community engagement will be essential to effectively deploying a coronavirus vaccine and countering hesitancy (Schoeppe et al. 2017). Vaccine-related community engagement should endeavor to build public understanding and endorsement of allocation schemes so that unequal access within a community occurs within an ambience of trust and mutually recognized fairness. Community engagement should also promote trust and bolster compliance with mandates or recommendations to ensure uptake is sufficient for community immunity.

Of course, uptake presupposes access. Globally, fair access to a coronavirus vaccine will be a major challenge assuming supply is limited and manufacture is slow. McGuire et al.'s discussion of crisis capacity in rural and remote communities will be helpful here. They recommend that statewide planning include rural and remote communities. We recommend that worldwide planning include low- and middle-income countries (LMICs). As McGuire et al. observe, regional coordination enables collaboration across healthcare facilities and pooling of key resources. Affluent counties should partner with or otherwise empower LMICs so that a coronavirus vaccine reaches their populations.

If the problem is shared, so should the solution be. Since the COVID-19 pandemic is inherently a global phenomenon, the benefits of a coronavirus vaccine should be globally secured. Justice requires this. The question is whether and how we will meet that demand.

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