Pandemic Justice

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The history of "triage," deriving largely from war, suggests four possible principles for triaging in times of disaster: medical need, first come first served, doing the greatest good, and expediency. These principles both reflect and threaten two basic Christian and American values: equality and an "option for the poor." Drawing on these values, with attention to the particular circumstances of pandemic, the author rejects some proposed principles for triage and argues for the priority of expediency in order to serve the interests of equality and of the poor. She concludes with some cautioning notes about process.

To answer the question of what justice requires, we have to begin with some generally agreed values. I propose two values: (1) equal value of all people; and (2) option for the poor.

What would justice require in times of pandemic? Surprisingly little has been written on this topic. What I propose here is preliminary and incomplete. My focus is on ethical principles rather than on specific practices or ways to implement principles. This article is intended as a conversational platform from which more immediate and concrete decisions might be made, appropriate to particular settings.

Two Basic Values

To answer the question of what justice requires, we have to begin with some generally agreed values. I propose two that reflect my Christian faith affirmations. However, I believe that these values are sufficiently well entrenched in American narrative, culture, and philosophy to serve as a general grounding from which considerations of justice can be elucidated for social policy. The two values are these:

1. Equal Value of All People

Christians and other Americans share a fundamental commitment to the *equal value* of all people. Equality before the law is a grounding conviction in American culture, even if it is violated in practice.[1] A classic philosophical principle of justice is "treat similar cases similarly." In religious tradition, the equal value of all people is sometimes called "equal dignity." It is grounded in the conviction that all people are "made in the image of God." Whether grounded in secular law and philosophy or in religious tradition, equal treatment is a sufficiently shared value to serve as one of the *constraints* that justice must meet. Justice requires that different treatment be justified on the basis of morally relevant differences between people. I will return below to the question of locating and justifying morally relevant differences.

2. Option for the Poor

The second value is what Christians call the "option for the poor."[2] While this notion has received considerable development in Roman Catholic moral theology, it is also widely acknowledged in current Protestant ethics. It means that those who are oppressed or marginalized are deserving of special attention and that social systems can be judged by how they benefit the least advantaged. The option for the poor implies both an *epistemological privilege* for the oppressed—that is, the perspectives of oppressed people are to be taken most seriously when assessing a situation—and also a *distributive advantage* for those who are disadvantaged, so that any social arrangements benefit "the least of these"[3] For Christians, this option is based on faith convictions—that we are to welcome the widow, the orphan, the alien in the land—those who are outcast or marginalized or powerless. It may be because of the Christian influence on American culture that John Rawls' "difference principle" has also found such resonance and been so influential in

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contemporary Christian and philosophical circles.[4] Rawls' "difference principle" requires that inequalities in distribution of basic goods must redound to the advantage of the disadvantaged.[5] While there has been considerable debate about the precise implications of this principle, Rawls himself clearly thought that it worked toward equality and thus had a leavening effect on society, raising the status of the poor. Thus, in both philosophical and theological circles we get a second basic value—the need to assess situations by how they affect the poor.

Disaster threatens both of these values, particularly the option for the poor. In times of disaster, when many more need medical treatment than can be accommodated, how do we uphold equal value? Is there any way to protect the option for the poor, or must we yield to other principles or procedures in times of disaster? In particular, "triage" in times of disaster has come (as we shall see) to be associated with utilitarian principles of doing the greatest good overall. Can such principles be reconciled with an option for the poor? Does a Christian perspective allow accommodation to principles of utility or expediency?

Facing a Pandemic: Four Reasons Why We Should Worry

1. Recurring Pandemics

Over the last century, we have seen recurrent pandemics of flu. Up to 50 million people died worldwide from the influenza pandemic of 1918; 70,000 died in the U.S. alone in the flu pandemic of 1957; 34,000 died in the U.S. in 1968 from yet another pandemic.[6] Whether it will be this flu or the next strain, experts predict that we cannot avoid a pandemic at some time.[7]

2. The Possible Escalating Current Situation

At present, our eyes are on the H5N1 strain called avian flu. There are fewer than 300 known cases of humans contracting avian flu and until June 2006, it was thought that those who contracted the flu all had direct— and generally prolonged—contact with infected birds. Even so, the rapid spread of the virus (it has been found in Europe most recently) and the potential of all viruses to mutate rapidly engendered a realistic fear that this one may eventually spread from person to person, rather than simply from bird to person. In June 2006, anxiety rose as the first cases were reported in which the flu appeared to have spread from person to person, increasing the likelihood of a pandemic.[8] It therefore seems prudent to consider what justice might require in times of pandemic.

3. Evidence that the Poor Suffer Most in Times of Disaster

Hurricane Katrina and the Asian tsunami of 2004 demonstrate that, in times of disaster, it is often the poor who suffer most.[9] If justice requires an option for the poor, then we must look closely at what might happen in a pandemic.

4. The Failure of the National Disaster Medical System

A study completed in December 2005 for the House of Representatives concluded that the U.S. National Disaster Medical System has been undermined during the Bush administration and is currently inadequate for response to future disaster.[10] Failures at all levels during Hurricane Katrina indicate the urgency for American communities to consider their own disaster response systems.

Some Opening Cautions

Is Justice Applicable to Situations of Dire Scarcity?

Some believe that in times of war or other disasters involving massive casualty and injury, "justice" simply becomes moot. This is for two reasons. First, justice requires *order*. There must be enough remaining authority to keep sufficient order so that decisions about distribution are not simply the result of looting, pillage, and armed citizens run amok. Experience following Hurricane Katrina suggests that in times of disaster, there may not be enough order left for justice to operate at all. Perhaps, then, asking about justice is a futile exercise. Part of the reason that we plan ahead is in hopes of retaining enough order for justice to operate. The need to secure order may itself affect principles of justice, as we shall see below.

Second, justice concerns apply when there is a *shortage* of needed goods—some, but not enough to go around. A pandemic raises the probability of *dire* scarcity of needed resources. For instance, some predict that there will be enough flu vaccine to treat fewer than 500 million people worldwide—scarcely 14% of the population.[11] Does justice disappear under conditions of dire scarcity rather than simple shortage? If there *are* no resources to distribute, then one can hardly be accused of unjust distribution. Under such conditions, failure to treat someone may be tragic, but it may not be unjust or blameworthy.[12] Hence, perhaps considerations of justice do not apply at all in cases of pandemic. Yet I would argue that scarcity, even dire scarcity, renders justice necessary. When not all can be served, the question of who shall be served and who shall be neglected takes on special urgency.

Is War a Good Model?

The question of justice in times of disaster has been best studied with regard to war and treatment of the wounded during war. Principles of "triage" generally derive from that context. Whether war provides a good context for considerations of principles for medicine is certainly debatable. Philosopher Michael Gross has recently argued that war transforms the usual principles of medicine, elevating utility in a way that may run roughshod over

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honored principles of autonomy and doing good for the patient.[13] It is not clear, then, that principles drawn from battlefield experiences should prevail in examining medical disasters or pandemic. Nonetheless, I will begin with some considerations of the triage principles that have emerged from wartime medical interventions, as they help to display some options and principles.

Do Justice Demands Differ for Prevention and for Treatment?

The questions of justice that arise around a flu pandemic should, ideally, be dealt with in two contexts: preventive medicine and treatment of those who become ill. It is possible that principles of distributive justice should differ for each of these contexts—that those who should get priority in access to preventive vaccines, for instance, are not the same as those who should get priority in treatment once ill. In what follows, however, I have not distinguished these two contexts. I do this in part because we have, at present, no effective vaccine for avian flu.[14] If a pandemic hits, the justice questions will be focused on access to treatment and to vaccines such as Tamiflu as part of a combined treatment and prevention plan.[15]

Should We Have Triage at All?

Some may find repugnant the idea that we make any choices about who gets treated. Perhaps it is better to let all die if not all can be saved. One way to ensure equality is to avoid choosing one over another.[16]

But in fact, the everyday context of medicine is rife with "triage" decisions. As medical resources, including time and energy of staff, are often in short supply, decisions are made constantly to determine who gets attention first. Anyone who has sat in an emergency room sees this clearly. Just as clearly, decisions in the emergency room reflect longstanding judgments that those who are in most urgent need get attention first, and those who are less urgent must wait. This is an implicit triage principle.

However, the emergency room is not the only setting where triage occurs in America. As Larry Churchill noted long ago, the very fact of distributing health care on the basis of the ability to pay already involves a "rationing" system[17]—a form of triage in which some are treated first. With more than 40 million Americans uninsured at any given time, there are many hardworking people who have little access to medical care and whose health is demonstrably worse because of it.[18] Access to health care is already "rationed" in the U.S., and we can say with some certainty that our current system of triage does not advantage the poor. By law, emergency rooms may be accessible to all without regard to the ability to pay, but health outcomes will remain very unequal so long as general health care depends on insurance or the ability to pay. This very fact might give additional impetus to adopting principles in times of crisis that are intended to advantage those whose health has already been harmed by rationing schemes. Further, it is very clear that if we have a genuine commitment to the poor, much needs to happen before a pandemic hits. This, too, is a lesson from Hurricane Katrina. Fixing our National Disaster Medical System must be a priority.

Competing Triage Principles

As rationing is already a reality, rationing in times of disaster should not come as a surprise. Stuart Rennie and Frieda Behets have recently argued that "in situations of medical scarcity, rationing decisions cannot and should not be avoided."[19] I concur. We must choose some triage principles. Here, a brief history may be instructive.

The term "triage" is defined as the screening of patients to determine their priority for treatment.[20] Casualties in a military or civilian disaster are divided into categories and responses differ accordingly. One of the simplest divisions creates the following response: those who may survive *without* treatment and those who cannot survive even *with* treatment are ignored, while energy focuses on those who need treatment *in order* to survive.

But this simple division is not enough. Those who need treatment in order to survive may be so numerous that not all can be treated at once. Who among them should get priority?

Medical need

A pioneer in military triage was Baron Dominique Jean Larrey, Napolean's chief medical officer. Larrey not only invented

the "ambulance" system of taking treatment into the field, but he systematized and ordered the priority of treatment so that more soldiers could be treated in less time. Larrey sorted casualties on the basis of medical *need*. The dangerously wounded were to be treated first, without regard to rank or distinction. Medical need became his "gold standard." It is interesting that in Larrey's approach to triage on the battlefield, there is no mention of military utility or rank. Generals are not to be given priority over privates! (Note here the nod to equality of all persons.) Medical need, and medical need alone, was the basis for distribution—at least in theory.

This "gold standard" of medical need survives in many discussions of justice in health care today. Certainly, in nondisaster situations it carries many arguments. In what has become a classic essay on Christian views of justice in health care, Gene Outka reviewed several possible approaches—distribution in accord with need, with merit, with contribution, with the demands of the market, and so on—and concluded that health care should be distributed on the basis of "need."[21]

In *Spheres of Justice,* Michael Walzer also argues that money or rank should not be the basis for distribution of basic health care; rather, health care should be distributed on the basis of health need.[22] Thus, we have acceptance in both religious and philosophical circles of *medical need* as a first standard for distribution of resources in health care.

First Come, First Served

From some of Walt Whitman's writings, it appears that the wounded men in the Civil War simply lay in a queue and were dealt with in the order of the queue, not necessarily in order of medical need.[23] Thus, in practice a second standard emerged: not medical need, but *"first come, first served."*

"First come, first served" is also an honored principle in some arenas of medical distribution. In the early days of renal dialysis and artificial organs, for example, there was a great deal of discussion of the ethics of decision-making about who should get scarce organs or access to scarce interventions such as dialysis or organ transplants.[24] Almost all ethicists—certainly Christian ethicists—came down on the side of an egalitarian approach, often thought to be equivalent to "first come, first served." Rather than trying to make qualitative decisions about which patients might "deserve" dialysis, patients were simply to be accepted in the order in which they appeared.

Thus, at least two standards have an honored history: medical need and "first come, first served." These two standards are the ones that are often most comfortable for medical workers; they accord best with the history and values of the medical profession. But they are not the only possible standards.

The Greatest Good for the Greatest Number

World War I changed the triage picture. The motorized ambulance resulted in many seriously wounded soldiers making it back to camp. At the same time, new weapons of destruction rendered more wounded on the battlefield than ever before. Medical personnel were often overwhelmed with the incoming wounded and their own time and energy became the scarcest of resources. Under these conditions, "triage" changed. A single case of "medical need" might absorb hours of time, and during that time numerous others would die. Under these circumstances, a third possible rule emerged: do what saves the most lives—the *greatest good for the greatest number*. Thus did a utilitarian standard surface.[25] "Triage" now involved not simply deciding who needed treatment and who was "beyond hope" or who might recover without treatment, but making decisions designed to bring about the greatest savings of life among those who might be helped with treatment.

Yet a dilemma remained. "The greatest good of the greatest number" is not as clear a standard as it might originally seem. Did "the greatest good" mean *saving as many lives* as possible? Or did it mean *maximizing the fighting strength* of the army?

Expediency

World War II appeared to settle this question.[26] The amazing success of penicillin in overcoming infection coupled with its severe shortage[27] meant that very difficult decisions had to be made about its use. Given the exigencies of the time, sufferers from venereal disease were given priority over those wounded in battle, as the former could return to the battlefield more quickly.[28] Concerns for fighting strength carried the day.[29] NATO subsequently devised a military triage system in which priority is given to those who can be quickly returned to service, then to those who are seriously injured and need immediate surgery, and the "hopelessly wounded" or "dead on arrival" are simply put aside. Expediency defined in terms of a specific goal took precedence over "medical need," "first come, first served," or a general utilitarian principle.[30]

Reconciling Expediency with an Option for the Poor

This (overly) brief review of the history of triage principles suggests a development from treating patients on the basis of medical need to treating them on the basis of expediency in light of a specific cause or purpose. This development may provide a model that could apply to pandemic flu.[31] But is it compatible with a fundamental commitment to equality or with a commitment to the poor and oppressed? While classic defenders of utilitarianism such as John Stuart Mill certainly believed that utilitarian justice upheld the equal value of each person,[32] treating people

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in terms of their utility to a specific purpose seems at first glance a very far cry from giving the advantage to the poor and oppressed.[33] Given the American commitment to equality and the widely shared conviction that justice requires some commitment to the least advantaged, should expediency carry the day or should it be set aside in favor of advantaging the least advantaged? Why not simply adopt a "first come, first served" or other approach that appears egalitarian? Are there good reasons for adopting the kind of expediency that emerged historically in wartime, or should we temper expediency with other principles designed to protect the poor or ensure equal treatment for all? Space does not permit a full exposition of possible principles and arguments, but I will propose the following:

Preserving Equality through Process

By definition, a pandemic implies dire scarcity of resources, risk of huge loss of life, and impossibility of equal achievement of health outcomes. If equal outcome is not possible, then equal treatment must enter the equation in some other fashion. One way to ensure equality is through *process*. Whatever substantive principles are chosen, they must be applied impartially. "Treat similar cases similarly" requires that cases be dealt with on the basis of established criteria, not on the basis of likes and dislikes.[34] In a triage situation, patients should be dealt with impartially, based on the criteria established. Not all will emerge equally healthy, but equality of respect is preserved through impartial procedures. But if equality is preserved through process, what should be the substantive principles?

Principles Proposed for Pandemic Situations

Expediency. Priority should be given to those who could be of most immediate service to the larger group to ensure the saving of others. This principle supports giving priority to nurses, physicians, and others with medical skill. Priority must also be given to those with other sorts of competence necessary to rebuild a community or keep disaster from spreading—firefighters and police, who may be needed to keep order in the community, electricians, engineers, lab technicians, and support staff who may be needed to ensure ongoing medical services. In other words, similar to the triage principles that emerged in wartime, those who have crucial skills are saved first. Moreover, the continued functioning of crucial social institutions, such as transportation systems and food production, must get priority.[35] Here, I admit forthrightly that many of these people will not be among the poor as we typically understand that term; the mere fact that they have jobs and incomes may keep them above the poverty line.[36] In general, however, I believe that those who are genuinely poor will ultimately be best served by saving those with life-saving and order-keeping skills. My proposal here is largely in accordance with the HHS Pandemic Influenza Plan,[37] though it differs in two respects: I have not put vaccine manufacturers into the first category of those to be saved, and I have not divided medical personnel and public safety workers (police, firefighters) into two tiers, but have lumped them into the first category.

Conservation. The next level of priority goes to those who can recover with little medical intervention or with lower doses of medication, saving more for others. Winslow calls this the "principle of conservation."[38] Philosopher Philippa Foot argues that we should save five patients rather than one, if possible.[39] In other words, efficiency is an acceptable value in emergency situations. Because influenza vaccine generally requires a particular dose for everyone, the principle of conservation may not easily apply in pandemic situations. However, it is possible that children or the elderly would need a smaller dose than others. If more can be saved with the same quantity of resources, then save more.

Priority to those who have dependents. Third, I believe that those who have dependents should get some priority. By "dependents," I mean both minor children under the age of 16 and adults who are not able to survive on their own. Nicholas Rescher argues that mothers of minor children should get some priority because of their family role; so does Robert Young.[40] Neither mentions fathers, but their texts were written in more sexist days. Fathers and women used to be given deferment from military service because of their family roles. Winslow suggests that the discussion on this idea is inconclusive, and he does not take a side (even

though—or perhaps precisely because—he was a father with young children at the time of writing). Because I give some priority to the needs of children, I believe that priority to those with dependents can be justified. I would also note that many of the poor would be among those with dependents and therefore might get some priority under such a principle.

These, then, are the principles that I propose for pandemic situations. Principles that I have *rejected* include first come, first served; priority to those with overall social worth; priority to the medically neediest; and priority to the generally neediest.

Principles Rejected for Pandemic Situations

First come, first served. This time-honored principle is not adequate for triage in times of disaster. Nor does it serve the interests of the poor. The poor tend *not* to go for treatment as quickly as those who are better off or better insured; therefore, those who are first in line are rarely those who are least advantaged, and the "first come, first served" approach may in fact privilege those who already are better off. If Hurricane Katrina has taught us nothing else, it should have taught us that the poor are often those hardest hit by what we call natural disasters.[41] It is very likely that a flu pandemic would affect poor regions and the poor within other regions more heavily than it will affect those who are better off.[42] "First come, first served" does *not* ensure equality of treatment and is no guarantee of a preference for the poor; indeed, it may work precisely to disadvantage the poor.

Priority to those with overall social worth. While I have defended a principle of giving priority to those with specific skills relevant to the situation, I reject the idea of preferring those who are more important or more worthy overall. Is it possible to determine one's social worth? Winslow argues no.[43] I concur. Childress notes, for instance, that it is difficult to predict social utility. I would note that some who might generally be thought to be of *less* social utility, such as sanitation workers and others who do "dirty jobs" may in fact be the *most* important during a time of disaster. For all these reasons, it seems relevant to choose those whose particular skills may be situationally useful but not to attempt general judgments of worthiness. Certainly, for anyone from a Christian tradition, it is anathema to think that some are worthy of life and others are not.

Priority to the medically neediest. Medical need was the gold standard even on the battlefield for Napoleon's chief medical officer. It is carried over today in proposals such as Robert Veatch's argument that a just health care system tries to equalize everyone's health status and therefore gives more to those who are neediest.[44] It may seem cruel to pass by those who are very needy in order to help those less in need. It violates everyday practice in the emergency room and other medical settings. In discussion, I have found health care workers very reluctant to let go of this gold standard of health care. Yet I believe that the exigencies of disaster may require efficiency in an effort to save more lives, and that the medical gold standard can be overturned in such situations. Further, as Rennie and Behets note: "The criteria for medical rationing are never purely medical." Indeed, what *treatment* requires is never purely medical: adequate transportation, food, water, and community support may all be crucial to treatment outcomes. Hence, a principle of expediency that helps to preserve crucial public institutions does support response to medical need.

Priority to the generally neediest. Of course, as is true of measuring social worth, measuring general neediness is difficult. However, we do have some models. In "normal" (non-pandemic) flu seasons when vaccine is in short supply, those who are relatively healthy are asked not to seek vaccination; supplies are saved for those who are older or more vulnerable. So we are used to the idea that the available care should go to those who are frail, fragile, and particularly needy. Such a principle might be one way to enact an option for the poor and I hesitate to reject it.[45] Under such a rule, those who generally have less would get first treatment. Those least able to fend for themselves would be helped first. Young children, the elderly, and the mentally and physically handicapped might get priority. This fits the classic "women and children first" lifeboat rule. It resonates with the horror many of us felt after Hurricane Katrina when we learned that older people were abandoned to die in flooded nursing homes. Their vulnerability seems to demand that they would not be abandoned. As Hans Jonas once put it: "Utter helplessness demands utter protection."[46] The root question here, however, may be whether general neediness such as poverty is a *morally relevant* criterion in triage decisions. In pandemic situations, it may be more important to save first those who are young enough and strong enough to lift pallets, carry trays of food and other supplies, clean toilets, drive ambulances, and so on.

Conclusions

What makes expediency difficult for those trained to believe that *all* people are created in the image of God is that expediency gives priority to some people over others. It therefore seems to fly in the face of a commitment to equality and, since the priority rarely goes to those who are poor, it also flies in the face of a commitment to the poor and oppressed. Can we reconcile this move away from an option for the poor, which is for many of us deeply grounded in our faith traditions? Does pandemic call for different principles than might apply in other situations? Does a process of "reflective equilibrium" suggest that our convictions must be modified?[47]

The principles that I propose for pandemic situations to preserve equality through process [are] expediency, conservation, and priority to those who have dependents. Principles that I have rejected include first come, first served; priority to those with overall social worth; priority to the medically neediest; and priority to the generally neediest.

I have argued above that expediency, somewhat tempered, must carry the day in cases of pandemic. Yet I remain troubled. The triage criteria proposed above seem to violate the commitment to justice as priority to the poor.[48] If the poor are generally more sick than the rich, then the poor are not likely to be among those who are most easily saved. If the focus is on saving those with crucial skills, then it is likely that more of those who begin better off and are more highly trained and skilled will benefit from such a principle, as those with skills are rarely the poorest of the poor. This bothers me! Nonetheless, I do believe that the poor will be better off from a triage system that saves those whose skills can be used to save others. I also believe that the poor may benefit from a triage system that gives some priority to those with dependents, but I realize that this is not the same as a system that simply prioritizes the poor.

So, I offer some cautions. First, under the criteria proposed above, I would be at the bottom of the list in times of disaster. I have no medical or engineering skills that would make me immediately useful to the community; I have no dependents to give me priority in terms of family obligations; and while I have spent a lifetime hefting boxes of books, my arthritic hands would be no match for a younger person when it comes to lifting pallets, digging latrines, or any of the myriad of difficult and "dirty" jobs that might accompany disaster. I might be willing to be of service, but I doubt that I could be of as much service as many others. Except insofar as my general health might permit me to be among those who would need less care than others and therefore might be treated before those needing substantial care, the criteria that I propose here do not privilege me. This lack of privileging seems to me important. If the criteria I propose had the effect of privileging me, then I would urge my listener to bring a strong hermeneutic of suspicion to my proposals.[49]

Second, I have spoken here of pandemics. Work needs to be done to sort out some morally relevant differences in different types of disaster, as pandemic is not the only situation that would call for clear principles of justice and priorities in treatment. I have not done that work here, and it is possible that the criteria I proposed above would have to be modified or rearranged depending on the specific disaster contemplated. For instance, the devastating effects of an earthquake or tsunami may be very different from the effects of a flu pandemic, and might require a different response. Further, I have not addressed here one of the most difficult and potentially contentious issues in pandemic: the question of quarantine. When a quarantine would be justified, and what level of isolation of individuals, families, or communities may be consonant with principles of justice, is a matter deserving of separate treatment.

Third, in accord with my principle of epistemological privilege to the oppressed, the proposals offered need to be checked against the considered judgments of those who are poor and oppressed. Would they approve the above suggestions? Or would they have other, more creative and more just solutions to offer? The process of determining just rationing principles is itself potentially as important as the principles chosen.[50] That process requires extensive involvement of those who stand to suffer most.

With these caveats in mind, I offer these proposals as a beginning toward a needed conversation on justice in times of pandemic. ✹

Notes

[1]Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (New York: Basic Books, 1983), 85.

[2]Donal Dorr, *Option for the Poor: A Hundred Years of Vatican Social Teaching* (Maryknoll, NY: Orbis Books, 1983).

[3]In the first of these claims, Western Christians join with and are indebted to liberation theologians around the world.

[4]George Parkin Grant, *English Speaking Justice*, Notre Dame, IN: University of Notre Dame Press, 1974.

[5]John Rawls, *A Theory of Justice,* rev. ed. (Cambridge, MA: The Belknap Press of Harvard University Press), 1999. *A Theory of Justice* has dominated philosophical discussions of justice for more than a quarter of a century. Like many Christians, I have been drawn to Rawls precisely because his "difference principle" requires that social arrangements benefit the least advantaged.

[6]Karen Kaplan, "A Killer Takes Wing," *Los Angeles Times*, January 10, 2006.

[7]The encouraging news is that it may come in milder forms than originally predicted by the WHO. Based on interviews, a Swedish research team reported milder cases of flu; however, their find-

ings require confirmation and other studies have not concurred. Clive Cookson, "Infection Milder But More Widespread, Study Finds," *Financial Times*, January 10, 2006.

[8]Nancy Shute, "A World of Worry," *US News and World Report*, June 5, 2006, p. 52. The CDC does not find evidence that the virus has mutated; nonetheless, it appears that these cases may have been transmitted person to person.

[9]Nicholas Eberstadt, "Why Poverty Doesn't Rate," *Washington Post*, September 3, 2006; E. J. Dionne, "The Poor Still Getting Poorer," *The Buffalo News*, September 5, 2006. A search on Google of "Katrina and poverty" yields numerous essays linking the devastating effects of the hurricane on those who are poor.

[10]"The Decline of the National Disaster Medical System," a report of the United States House of Representatives Committee on Government Reform—Minority Staff Special Investigations Division, prepared for Rep. Henry A. Waxman, Rep. Bennie G. Thompson, and Rep. Charlie Melancon, December 2005. While the study was conducted by Democrats and might therefore reflect political bias against the Republican administration, it quotes extensively from other sources, including an internal HHS study. The report notes, for instance, that HHS found significant gaps in setting up and operating shelters or providing services for special needs patients (pp. 12–3).

[11]John Arras, "Ethical Issues in the Distribution of Influenza Vaccines," *Yale Journal of Biology and Medicine* (forthcoming).

[12]Hume, for example, thought that dire scarcity renders justice moot. Winslow notes that "scarcity" itself is a difficult term, depending on desires and needs. There can be false needs and certainly inflated desires. When we say "A needs X," we usually mean that A will suffer harm if A does not get X (Gerald R. Winslow, *Triage and Justice: The Ethics of Rationing Life-Saving Medical Resources* [Berkeley, CA: University of California Press, 1982], 40–1). *Dire* scarcity, suggests Winslow, involves a condition in which there is need and the resource cannot be divided—i.e., The amount of a life-saving resource is insufficient to sustain the lives of all those in need (p. 43). Hume is not the only one to think justice moot in circumstances of dire scarcity. Gregory Vlastos associates justice with meeting legitimate claims or rights; where those rights cannot be met, justice cannot be done. Hence, in dire scarcity there can be no justice (Winslow, 53). But this approach is problematic, in my view. First, it is not clear that there is a "right" to health care. Second, under a Rawlsian approach, justice applies to the basic system, not to specific responses to individual claims. Third, rights can be respected without being fulfilled. Finally, it is circumstances of extreme *abundance* that make "justice" irrelevant. If everyone can get what they need, there is no need for principles of distributive justice. It is precisely *scarcity* that makes distributive justice relevant.

[13]Michael L. Gross, "Bioethics and Armed Conflict: Mapping the Moral Dimensions of Medicine and War," *Hastings Center Report* 34, no. 6 (2004): 22–30.

[14]Part of the difficulty here is that it is not possible to mount a vaccine until the flu spreads from human to human; once it does, a vaccine might be needed quickly, and the question is whether we have the infrastructure to move quickly. Some believe that we do not. Denise Grady reports on a study announced in the *New England Journal of Medicine* that a dose twelve times the standard flu shot gave only "poor to moderate" success in clinical trials. With the needed dose so high, if a pandemic hit soon, "manufacturers could not begin to make enough vaccine for all who would need it." (www.nytimes.com/2006/03/30/health/30vaccine.html.)

[15]For instance, 39 of the 54 people who had contact with the Sumatran woman who died last month were given Tamiflu (Shute, "A World of Worry," 52).

[16]This approach seems to derive from a "lifeboat" scenario and from the presumption that it is better to let all drown than to throw some out of the boat. The lifeboat principle reflects a deeply felt egalitarian thrust that all should have an equal chance at life. To this extent, it is instructive. But lifeboats are not necessarily a good analogy for pandemic or other disaster. Throwing some out involves direct killing and is therefore different from saving only some when not all can be saved.

[17]"[R]ationing is a fact of life for health care in the United States," says Churchill, noting that health care is largely allocated by price and that allocation by price *is* a rationing scheme. See Larry R. Churchill, *Rationing Health Care in America: Perceptions and Principles of Justice* (Notre Dame, IN: University of Notre Dame Press, 1987), 43, see also, p. 14.

[18]See, for example, Emilie M. Townes, *Breaking the Fine Rain of Death: African-American Health Issues and a Womanist Ethic of Care* (New York: Continuum, 1998).

[19]Stuart Rennie and Frieda Behets, "AIDS Care and Treatment in Sub-Saharan Africa; Implementation Ethics," *Hastings Center Report* 36, no. 3 (2006): 23–31.

[20]Winslow, *Triage and Justice*, 1.

[21]Gene Outka, "Social Justice and Equal Access to Health Care," *Journal of Religious Ethics* 2 (Spring 1974): 11–32, reproduced in *On Moral Medicine: Theological Perspectives in Medical Ethics,* ed. Stephen E. Lammers and Allen Verhey (Grand Rapids, MI: William B. Eerdmans, 1987), 632–43. While Outka does not equate the demands of agape with distribution in accord with need, he does find that they are "conjoined in a number of relevant respects" (p. 638). Most important for my purposes, Outka argues that a need-conception of justice applies to health care with greater relevance than some other possible conceptions of justice, such as distribution on the basis of merit or of market value (p. 639).

[22]Michael Walzer, *Spheres of Justice* (New York: Basic Books, 1983), 86–91. Like Outka, Walzer discusses not individual conceptions of need, but social conceptions. Noting that medical care has historically rested in the hands of physicians who "distribute" it in accord with the ability to pay, Walzer argues (89–90) that medical care is a needed good that should not be distributed on the basis of "free exchange" in the market.

[23]Winslow, *Triage and Justice*, 3.

[24]For an excellent overview, see John F. Kilner, *Who Lives? Who Dies? Ethical Criteria in Patient Selection* (New Haven, CT: Yale University Press, 1990).

[25]It was under the utilitarian rule of doing the greatest good for the greatest number that "triage" began to be a popular term and numerous categories of wounded emerged: those who could be immediately evacuated and those who could not; those requiring minor operations and those requiring major surgery; those who could still walk and those requiring motorized transport, and so on.

[26]Of course, World War II also changed forever the face of war and the triage decisions that might have to be made in the midst of it. The use of nuclear weapons created triage quandaries unparalleled in previous wartime. Massive obliteration and the involvement of huge numbers of civilians made previous military strategies about triage seem almost laughable, however well intentioned and useful they had been.

[27]In the spring of 1942, there was only enough of the drug in the United States to treat *one* wounded person.

[28]Winslow, *Triage and Justice*, 8.

[29]Michael Gross argues that the principle used was that of "salvage" ("Bioethics and Armed Conflict," 24). If a combatant could be easily salvaged, he or she not only received priority but indeed had no right to refuse treatment.

[30]John Stuart Mill would likely have considered the maximization of fighting strength to be a principle of *expediency* rather than utility. Expediency is geared to specific interests rather than to the general good. Utilitarianism, for Mill, was not about expediency in the moment but about recognizing the overall tendencies of actions to produce good in the long run. See John Stuart Mill, *Utilitarianism* in *The English Philosophers from Bacon to Mill: The Golden Age of English Philosophy,* ed. Edwin A. Burtt (New York: The Modern Library, 1939), 912.

[31]My focus here is on pandemic, but as I live on the north coast of California where a tsunami warning was recently issued, other forms of disaster must also be considered.

[32]In *Utilitarianism,* Mill argues that each person's happiness is to count exactly as much as any other person's, and he reiterates Jeremy Bentham's dictum, "everybody to count for one, nobody for more than one" (p. 946). This suggests that the founders of utilitarianism held a strong view of equality of persons.
[33]Triaging patients in order to win a war is one thing; treating patients *fairly* may be yet another.
[34]In grading student papers, for example, whether the professor likes a student should not affect the grade. The grades should be given impartially, based on the criteria established for grades on a paper.
[35]See John Arras, "Ethical Issues in the Distribution of Influenza Vaccine" (paper presented to a Yale symposium on pandemic preparedness, January 11, 2006).
[36]Nurses' aides and home health workers might be included, however, and they often are at the bottom of the pay scale, and receive few benefits; hence, they may indeed be among the poor.
[37]www.hhs.gov/pandemicflu/plan/pdf/HHSPandemicInfluenzaPlan.pdf.
[38]Winslow, *Triage and Justice*, 73.
[39]Ibid.
[40]The HHS Pandemic Influenza Plan puts pregnant women into the first tier, because they have historically been shown to be at high risk and because vaccinating them will presumably protect the infant to be. HHS also puts household contacts of children into the first tier. However, it does not specifically discuss the issue of dependency as a rationale for priority in vaccination.
[41]This is not the place to discuss whether Katrina was a "natural" or a "human-made" disaster, though this question is also relevant for thinking about justice issues.
[42]This is in part because of the relatively poor health status of those who are economically marginalized.
[43]Winslow, *Triage and Justice*, 81.
[44]Ibid., 93.
[45]For a general discussion of how such a principle might be applied in medical settings, see James Lindemann Nelson, "Saving the Worst Off (Principle)" in *Rationing Sanity: Ethical Issues in Managed Mental Health Care*, ed. James Lindemann Nelson (Washington, DC: Georgetown University Press, 2003), 147–64; also Dan Brock, "Priority to the Worse Off in Health-Care Prioritization," in *Medicine and Social Justice: Essays on the Distribution of Health Care*, ed. Rosamond Rhodes, et. al. (Oxford: Oxford University Press, 2002), 362–72.
[46]Winslow, *Triage and Justice*, 95.
[47]The term "reflective equilibrium" comes from philosopher John Rawls. It connotes testing our initial convictions against the outcome of a reasoned process, and modifying either the convictions or aspects of the process if the testing reveals an incoherence.
[48]An interesting question here is whether justice is being violated or simply set aside, or whether it is indeed fulfilled by utilitarian considerations under some circumstances. Can we claim that justice requires such utilitarian criteria, or must we claim that justice is superseded by such criteria under conditions of disaster? It would take too long to explore this intriguing theoretical question, so I cannot do it here!
[49]The term "hermeneutic of suspicion" also comes from liberation theologies. It connotes skepticism toward received ways of perceiving the world.
[50]The significance of process is noted by Rennie and Behets. Indeed, since Rawls proposed what he called "pure procedural justice," philosophers such as Norman Daniels have argued that, in a pluralistic society, the best we can hope for is agreement on fair process. While I believe that it is possible to justify substantive principles, I agree with the importance of the process by which those are derived. For a critique of Daniels, see Rennie and Behets, "AIDS Care and Treatment in Sub-Saharan Africa."

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