

PRIORITIZING PARENTS

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Should parents or other primary caregivers of dependent children receive some priority when health care resources are scarce? This paper argues they should. The COVID-19 pandemic has given new urgency to discussions about resource allocation and yet there has been little to no discussion of the important role parents play in protecting and promoting the health of their dependent children. Historically, priority for parents was justified on questionable grounds of social value and this may have led bioethicists and policy makers to overlook more plausible justifications for prioritizing parents. After discussing and criticizing several such justifications for their violation of principles of pluralism and neutrality, a new justification is offered and defended from objections. The reason we should grant some priority to primary caregivers of dependent children is that research shows that doing so would protect and promote the health and lives of children.


Keywords: rationing, resource allocation, distributive justice, healthcare prioritization, pediatric healthcare.

Introduction

Should parents of dependent children receive some priority when health-care resources are scarce? I suspect many people, and not only parents or other primary caregivers of dependent children,¹ share my intuition that one's role as a caregiver to such children ought to be considered when, due to an insufficient supply, not everyone who might benefit from the provision of a lifesaving resource can receive it. It would not be difficult to confirm or dispute this suspi-

1. For the sake of expediency, and unless otherwise noted, I use 'caregiver' and 'primary caregiver of dependent children' synonymously throughout.

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cion with a study, and perhaps it would be worthwhile to conduct one. Whether or not the intuition is as widely held as I believe it is, there remains the distinct and philosophically more relevant question of whether or not this intuition can be rationally vindicated. The main aim of this paper is to show that it can be, and that, consequently, there is good reason to revise current allocation guidelines, including those developed in response to the COVID-19 pandemic.

A central challenge in deciding how scarce health-care resources ought to be rationed lies in determining which features of the tragic situation are morally relevant and which are not. There is broad agreement about the moral status of some features. The color of a patient's hair or skin is irrelevant from a moral point of view while it is plausible that the extent of their health need is morally relevant.² There also is widespread agreement (if not quite a consensus) that a certain kind of value—sometimes referred to as 'social value' or 'social worth'—ought not to play as strong a role in allocation decisions as the more clinically immediate value of preventing mortality and morbidity. The notion of social value is meant to capture the value that a person has in virtue of the role they play in society or the value that accrues to society in virtue of their membership in it. By way of example, one writer has argued that a forty-five-year-old schoolteacher and parent of dependent children has more social value than a seventy-year-old person with no familial obligations and, therefore, that the former should receive priority over the latter when resources are scarce.³ Presumably the idea here is that someone who cares for and educates children promotes the interest of society in a well-functioning and educated population while a retired person with no dependents plays no such productive social role. Support for such social, value-based guidelines has been generally weak, and considerations of social value play no explicit role in most resource-allocation

2. Skin color can serve as a marker of membership in socially salient categories such as race or ethnicity, which themselves, either as independent variables or in relation to other sociodemographic categories such as class, may be morally relevant to questions of just distribution. But skin color, divorced from its social significance, is as morally irrelevant as hair or eye color. For recent discussions of the role race might play in distributive schemes involving resources that mitigate the harms of COVID-19, see L. E. Egede and R. J. Walker, 'Structural Racism, Social Risk Factors, and Covid-19—A Dangerous Convergence for Black Americans', *New England Journal of Medicine*, 383 (2020), 77; S. A. Berkowitz, C. W. Cené, and A. Chatterjee, 'Covid-19 and Health Equity—Time to Think Big', *New England Journal of Medicine*, 383 (2020), 76;

N. Chomilo, N., N. Heard-Garris, N., M. DeSilva, M. and U. Blackstock, U., 2020. 'The Harm of a Colorblind Allocation of Scarce Resources', *Health Affairs* (blog), H. Schmidt, L. O. Gostin, and M. A. Williams, 'Is It Lawful and Ethical to Prioritize Racial Minorities for COVID-19 Vaccines?' *Jama*, 324 (2020), 2023–24; Harald Schmidt, 'The Way We Ration Ventilators Is Biased', *New York Times*, 15 April 2020 <<https://www.nytimes.com/2020/04/15/opinion/covid-ventilator-rationing-blacks.html>> [accessed 21 June 2021].

3. L. J. Schneiderman, 'Rationing Just Medical Care', *American Journal of Bioethics*, 11 (2011), 7–14.

decisions, such as allocating scarce organs or critical care beds in normal (i.e., nonemergency) times.^{4,5}

Importantly, skepticism about social value does not extend to all instances of instrumental value. During crises such as the COVID-19 pandemic, bioethicists and policy makers have argued that frontline medical workers should receive some priority in the distribution of scarce resources such as ventilators, personal protective equipment (PPE), ICU beds, and so on.⁶ This prioritization is claimed to be justified not because health-care workers are more virtuous than other people or even because they generally provide more value to society than other workers do. Rather, the claim is that during major health crises, where time is very limited, we maximize good health outcomes (such as lives saved, life-years saved, quality-adjusted life-years saved, disability-adjusted life years saved, etc.) by saving the lives of frontline health-care workers.⁷ In order to maximize good health—and this utilitarian aim is the guiding principle in all current triage documents, supplemented with subsidiary principles—it is essential to save the lives of those who have the skills required to save the lives of others.

I will not challenge the strong commitment to utilitarianism, which is ubiquitous if constrained by other principles, in health-care rationing guidelines, nor the arguments set out against allowing considerations of social value to play a role in rationing decisions. Moreover, I will say nothing about whether or not considerations of welfare that extend beyond health benefits ought to play a role in health-care rationing decisions. Rather, I wish to argue that one factor judged morally irrelevant to allocation decisions ought to be reconsidered, despite the fact that it has, historically, been included in the category “socially valuable.” More specifically, I will argue that other things being equal, or close to equal, primary caregivers of dependent children ought to be prioritized over people who are not primary caregivers of dependent children, when potentially

4. There have been explicit calls for giving essential workers (e.g., food-service workers, postal workers, teachers, first responders, etc.) some priority over otherwise similarly situated nonessential workers in receiving the COVID-19 vaccine, but given that inoculating essential workers will slow the spread of the disease, the justification for prioritizing them remains grounded in considerations of reducing mortality and morbidity and, therefore, strictly speaking, is not a social-value-based justification.

5. American Thoracic Society, ‘Fair Allocation of Intensive Care Unit Resources’, *American Journal of Respiratory and Critical Care Medicine*, 156 (1997), 1287; United Network for Organ Sharing, ‘Organ Procurement and Transplantation Network (OPTN) Policies’, <http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Policies.pdf>, <<http://optn.transplant.hrsa.gov/policiesAndBylaws/policies.asp>> [accessed 19 June 2021].

6. Douglas Whiet et al., ‘Allocation of Scarce Critical Care Resources During a Public Health Emergency’ (Pittsburgh, PA: University of Pittsburgh) <https://www.ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy.pdf> [accessed 21 July 2021].

7. Douglas Whiet, E. J. Emanuel, G. Persad, R. Upshur, et al., ‘Fair Allocation of Scarce Medical Resources in the Time of Covid-19,’ *New England Journal of Medicine* (2020), NEJMSb2005114.

lifesaving resources are in short supply, such that either the caregiver or the non-caregiver, but not both, can be provided the resource. After assessing a number of arguments in support of this claim—some bad, one good—as well as objections, I briefly discuss how the acceptance of my conclusion would change some current health-care policies, including those recently developed in response to the COVID-19 pandemic.

How Caregiver Status Came to Be Regarded as Irrelevant

Before elaborating on and defending the main thesis of the paper, it is worth placing it in some historical context by revisiting the story of the Admissions and Policy Committee of the Seattle Artificial Kidney Center, informally known as the ‘Life and Death Committee’ or the ‘God Committee’.^{8,9} This was a group comprised of six laypersons and one nonexpert physician, tasked in 1961 with deciding which patients with end-stage renal disease (ESRD) would get access to the very limited number of early dialysis machines at Swedish Hospital in Seattle, Washington. Those selected by the committee for treatment would live while those not selected would die. After a lengthy piece about the difficult and secretive work of the committee appeared in a 1962 *Life* magazine article, some critics argued the committee’s reliance on judgments about patients’ virtue or social worth was unjustly discriminatory, ‘polluted by prejudices and mindless clichés’.¹⁰ This criticism was based on the committee members’ making life or death decisions partly on the basis of factors such as patients’ marital status, emotional stability, church activity, number of dependents, level of educational attainment, financial status, occupation, future potential, and other similar purported gauges of virtue, personal worth, or social value. In the years following publication of the story, other articles appeared to voice similar objections, and the commitment to guard rationing decisions against the improper influence of judgments on patients’ moral worth or social value remains strong.^{11,12}

The story of the Admissions and Policy Committee is important because it might help explain the continuing failure to include caregiver status as a relevant factor in rationing decisions. The ‘God Committee’ was concerned about how a

8. Shana Alexander, ‘They Decide Who Lives, Who Dies’, *LIFE* 9 November 1962, pp. 102–25.

9. Carol Levine, ‘The Seattle “God Committee”: A Cautionary Tale’, *Health Affairs*, 30 November 2009 <<http://healthaffairs.org/blog/2009/11/30/the-seattle-god-committee-a-cautionary-tale/>> [accessed 19 June 2021].

10. D. Sanders and J. Dukeminier, ‘Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation’, *UCLA Law Review*, 15 (1968), 377.

11. C. Blagg, ‘Development of Ethical Concepts in Dialysis: Seattle in the 1960s’, *Nephrology*, 4 (1988), 235–38.

12. Persad, ‘Principles for allocation’, 423–31.

parent's death could shift the economic costs of child-rearing from the family to taxpayers in the event that the children ended up wards of the state. The committee even considered the relative difficulty of remarriage, concluding it would be easier for a widow with three children to remarry compared to a widow with six children.¹³ More generally, the committee's discussions indicate a propensity to favor patients whose personal characteristics and lifestyles conformed to the parochial norms of white, middle- or upper-class mid-twentieth-century America, patients whose death would represent a greater perceived loss to this segment of society than would the loss of someone less conventionally placed. Seen in this light and judged by current standards, the priority granted to parents was the result, at best, of the overweighting of economic considerations or, at worst, a chauvinistic exercise in promoting the interests of some select social roles, groups, or individuals at the expense of others.

Viewed as an economic benefit to the state, an indicator of a person's virtue, or evidence of a person's adherence to social norms whose authority may reasonably be contested in a liberal, pluralistic society, caregiver status does indeed plausibly appear to be a morally inappropriate consideration in deliberations about who will receive potentially lifesaving resources and who will not receive them. The reasons for this are easy enough to see. For some people, and for a range of reasons, it is not possible to have children, and thus it may seem unfair to consider caregiver status in rationing decisions. Including caregiver status may appear to penalize people for failing to do something they cannot do, whatever they may wish to do. For others, having children, though possible, would prove unreasonably onerous, for financial or other reasons. Granting this group lower priority may also seem unfair for the same reasons that apply in the case of those who cannot have children. And then there are those people who, though they could have children, choose not to do so, judging that having and raising children would be inconsistent with the life plan they have chosen as the best path to realizing their conception of the good. People in this group might rightly claim that the choice whether to have children, when made autonomously, ought to be protected by any society committed to the protection of fundamental individual liberties—that so long as one's ends and the means taken to achieve these ends are not independently wrongful there is nothing morally objectionable with choosing to pursue a life plan does not include taking on the responsibilities of having or caring for children. Going even further, they might claim, plausibly, that in some cases, such responsibilities may actually *reduce* the contribution a person is able to make to society and, therefore, that it would be morally impermissible for them to take on children given their commitments to improving society with whatever skills and talents make them

13. Alexander, 'They Decide Who Lives', pp. 102–25.

especially effective at increasing social welfare. Caring for children can be very costly in terms of time, money, and energy, and so considerations of social utility may sometimes militate against having children. Thus, even if social value were accepted as a relevant factor in allocation decisions, it would not follow that caregivers ought to receive priority over noncaregivers, for in at least some cases—perhaps many—some noncaregivers might be more socially valuable than some caregivers. Therefore, it is not fair—and perhaps even self-defeating with respect to maximizing social value—to deprioritize or penalize people either for something over which they have no control or for adopting a life plan that best embodies their values and which is both independently morally permissible and consistent with others' ability to live in accordance with their own conception of the good.

Arguments for Prioritizing Caregivers of Dependent Children

The arguments above have force. To the extent that the case for prioritizing caregivers depends on judgments of personal worth or social value, the arguments may be decisive—at least in a pluralistic, liberal society. However, the arguments do not address other considerations that are independent of both the social value of caregiving and the virtuousness of those who have children (or do not). There are morally relevant features of the caregiver role, the family, childhood, and dependency that support prioritizing primary caregivers, features that are not vulnerable to objections arising out of a commitment to state neutrality and a respect for pluralism. If this is right, then rationing guidelines—including the most recent guidelines developed in response to COVID-19-related shortages—should be reassessed and amended to capture and appropriately respond to these relevant moral features. I turn now to several arguments in favor of granting priority to caregivers.

Before presenting and assessing the arguments, it is important to note that none of them are meant to establish that caregivers should receive *absolute* priority or that caregiver status should be weighted more heavily than other factors such as prognosis, frontline health-care-worker status, health-care need, age, length of time on a waiting list, socioeconomic status, membership in historically marginalized groups, etc. Rather, they are meant to support the far more modest claim that caregiver status is a *significant morally relevant factor* and consequently that it should carry *some* weight in resource allocation decisions rather than no weight, which is what it currently receives. For example, at a minimum, caregiver status might serve as a tiebreaker when considerations of other relevant factors do not strongly favor one patient over another, or it might bestow some additional advantage in a system that made use of weighted lotteries. With this

clarification in mind, I turn now to the arguments in favor of granting some priority to caregivers of dependent children. I will begin with two arguments that may initially appear promising but which, I argue, should ultimately be rejected. I then move on to a more promising approach, one that sets out compelling reasons for modifying allocation guidelines.

In order to avoid the sort of objections that were raised against the Admissions and Policy Committee of the Seattle Artificial Kidney Center and to remain consistent with the pluralistic values to which liberal societies are firmly committed, justifications for revising current policies must meet the following conditions:

- No appeals to social value.
- Consistent with a commitment to moral egalitarianism (i.e., no person is of greater moral worth than any other person).
- Consistent with liberal pluralism (i.e., with remaining neutral as between competing conceptions of the good).

Moreover, in order to be theoretically plausible and practically viable, any justification for including caregiver status must also satisfy the following condition:

- Consistent with the presence of other morally relevant considerations (e.g., prognosis, frontline clinician status, age, etc.)

Argument 1: *The Magnitude of the Loss to Caregivers*

To be denied or otherwise unable to access a lifesaving resource is nothing short of devastating for the person who needs and wants it, for without it she will die. Death is bad for the person who will die because it means, among other things, the loss to her of everything she values. It is not trivial—indeed, it is somewhat of a puzzle—to account for what makes death bad.¹⁴ However, it is plausible that the complete and irreversible loss of all valued or valuable relationships, projects, objects, activities, and experiences explains, at least in part, why death is regarded as so terrible. Such deprivation constitutes serious harm.¹⁵ This raises the possibility that some deaths are worse than others. After all, some people have more of value, or value things more, than other people

14. There is fairly extensive literature, going back to the ancients, on the question of what makes death bad for the person whose death it is. A good place to start is with Thomas Nagel's paper. Thomas Nagel, 'Death', *Noûs*, 4 (1970), 73–80

15. Thomas Nagel and F. Feldman, 'Some Puzzles About the Evil of Death', *Philosophical Review*, 100, 205–27.

do. From this perspective, the deaths of some people may be more harmful, and therefore worse, than the deaths of other people, since some deaths represent greater losses. This also will be true with respect to a single individual at different times. For example, it is worse for a child of fourteen to die than it is for the same individual to die after living to the ripe old age of one hundred. The fourteen-year-old is deprived of many more life-years than the one-hundred-year-old. This thought—that it is generally worse when younger people die than it is when older people die—is captured in some rationing guidelines, which grant additional weight to those who have not yet had a chance to live a complete life.¹⁶

It is a truism that lives can go better or worse. Perhaps it follows from this that the termination of a life that is going well or that has the potential to go well is worse than the termination of a life that is not going as well or that has dim prospects of getting better. That some states of living are worse than death lends support to this thought, for in such cases, where a person of sound mind concludes that the benefits of life do not justify its burdens, a judgment is rendered that the value of life is not absolute or beyond measure.¹⁷

The preceding considerations suggest that if some deaths are worse than others, and if the badness of any given death is at least partly a function of how much a person values the various aspects of her life, or how much objective value is in her life, then the deaths of people who value many things, or who value things intensely, or who have objectively more value in their lives, are worse than the deaths of people who value fewer things, who are mild in their valuations, who are generally apathetic, or who are unfortunate with respect to the amount of value that is objectively realized in their lives. Simply put, the loss to the former will be greater than the loss to the latter. If this is right, then when making life or death decisions under conditions of scarcity, there is reason to prevent some deaths—the worse ones—first. Now, because parents and caregivers tend greatly to value the children for whom they care, tend greatly to value the time they spend with those children, tend to be invested intensely in raising their children, and because the relationships between caregivers and their dependent children may plausibly be thought to be objectively valuable, their deaths will be for them a profound loss. For them, death entails a complete and permanent detachment from their children, an abrupt end to

16. G. Persad, A. Wertheimer, and E. J. Emanuel, 'Principles for Allocation of Scarce Medical Interventions', *Lancet*, 373(2009), 423–31; Douglas White et al., *Allocation of Scarce Critical Care Resources During a Public Health Emergency* (Pittsburgh, PA: University of Pittsburgh, 2020). https://www.ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy.pdf [accessed 21 June 2021].

17. It is this thought that motivates much of the support for euthanasia and physician assisted death.

the central project of raising them, and a total or near-total destruction of their relationship.

On this view, caregivers should receive priority over noncaregivers because caregivers suffer a greater loss in death than do noncaregivers. The argument pertains most directly to parents or other close family members such as grandparents who are primary caregivers of dependent children. Primary caregivers tend to have extremely close and loving relationships with their children, relationships that often provide significant purpose and meaning to the caretakers' lives.

Objections

This argument is vulnerable to at least two objections. First, the inference from the claim partially characterizing the badness of death in terms of the quantity of goods the death will negate to the claim that some deaths are worse than others might be invalid. Even if the badness of death is partly accounted for by the loss it represents, and even if in dying some people lose more than others do, it remains the case that from the perspective of any particular individual, her own death means to her a loss of everything. On this view, there is a sense in which all deaths, or at least all bad deaths,¹⁸ are equally bad, even when there is also another sense, sketched above, in which some deaths represent a greater loss than others. Interpersonal comparisons regarding the badness of death that refer to the amount of goodness or badness in people's lives risk falling afoul of the constraint, set out above, that any acceptable justification for prioritizing caregivers must be consistent with moral egalitarianism.

Second, people value different things, and they value things differently—sometimes more, sometimes less. Many people greatly value their children, but others greatly value art, their partners, their pets, their work, their gardens, or their antique lawn mower collections. How can one be confident that the loss to a caregiver of her children represents a greater loss of value than does the loss of these other things to someone else who has the same clinical need of a life-saving resource? The core of the objection here is that by privileging caregivers, one does not merely capture what people *do* value or how much they value it; rather, a judgment is imposed about what people *should* value or how much they should value it. Allowing this judgment to inform allocation decisions is objectionable, for it runs afoul of the pluralism constraint.

18. Some deaths may not be altogether bad—namely, those in which the life that will end is worse than death.

Argument 2: *The Duty to Ensure That Primary Caregivers Can Discharge Their Duties*

Primary caregivers have a duty to protect and promote the welfare of the dependent children in their care. Parents who abandon their children, or who negligently fail to provide them with necessary support, are fair targets of moral criticism and, in some cases, legal sanction. Obviously, a caregiver cannot discharge any duty to provide care and support when she is dead (though she can, while still alive, make provisions for the child that extend beyond her death). So long as her death was not the product of an action for which she was blameworthy, a caregiver who fails to provide support and care to her dependents cannot reasonably be said to have failed to discharge her duties, at least not insofar as 'fail' carries with it a connotation of moral failing. Nevertheless, a third party in whose control it was to prevent the death of a caregiver might be responsible for the failure. For example, in cases of medical negligence, wrongful-death statutes are designed to compensate the deceased patient's family for (among other things) the loss of the patient's future earnings and (in some cases) the loss of companionship or loss to society suffered by the deceased relative's family.

If decision makers do not take primary-caregiver status into account when allocating potentially lifesaving health-care resources, they make it more likely that caregivers will be unable to discharge their duties to the dependent children in their care. Were they to prioritize caregivers over noncaregivers, decision makers would increase the probability that caregivers' dependent-oriented duties would be discharged. Given the seriousness with which the failure of caregivers to protect their dependents and to promote their welfare is regarded, it might be argued that decision makers have a duty to help caregivers provide this support. Perhaps in some cases, person A's duty with respect to person B generates a duty for person C with respect to person A's carrying out her duty to B. It is plausible that if such duties exist, they could be seen in the context of dependent children, where the state, or society more generally, has a duty to safeguard the well-being of children—a duty that is, in fact, sometimes discharged by the enforcement of parents' duties to their children. If duties can be generated in this way, then decision makers' duties to primary caregivers might be derived from caregivers' duties to their dependent children.

Objections

Although this argument draws plausibility from an abiding commitment to protect, promote, and enforce supportive relationships between caregivers and dependent minors, the claim that those responsible for allocating scarce

resources are duty-bound to ensure that caregivers are able to discharge their duties is too strong. Support for primary caregivers (e.g., tax breaks) and penalties for those who harm, neglect, or abandon their dependent children do not come at the expense of nonprimary caregivers, whereas a decision to provide a primary caregiver with a scarce, lifesaving medical resource comes at the cost of withholding that crucial resource from someone else. More generally, it is hard to see how agent A's decision to have a child and to accept the duties that come with doing so could, just in virtue of those duties, obligate agent C to provide A with a lifesaving resource. Although the state enforces some parental duties, it does not enforce every moral duty a parent has with respect to her child. Finally, caregivers are not the only members of society with duties to others. Attorneys, medical doctors, and some financial advisors have fiduciary duties to their clients or patients, and yet it is not at all plausible that this duty generates some derivative duty for allocators to prioritize fiduciaries over nonfiduciaries just in virtue of the fiduciary duty, *per se*. By prioritizing those who have fiduciary or other duties to protect and promote the interests of others, policy makers would be violating the constraint on social value-based justifications.

Argument 3: *The Tragedy to the Child*

The best argument to the conclusion that caregiver status is morally relevant for resource-allocation decisions begins with the premise that it is a multifaceted tragedy for a dependent child to lose a parent or other primary caregiver. At the earliest stages of childhood, a child's dependence on her caregiver(s) is complete. Even as the child becomes increasingly independent with respect to some of her needs, a great deal of support is required for the child to survive and to thrive. Necessary support comes in many forms (i.e., financial, psychological, educational, psychosocial, nutritional, and moral). Though responsibility for providing this support can, in some cases, be transferred from one caregiver to another, some transfers are either impossible or involve significant and varied costs. For example, financial responsibility is in some cases easy to transfer, but trust, comfort, stability and the deep, intense bonds of love and affection are not. Where these forms of support are nonfungible and irreplaceable, and where their absence causes harms of the sort that are accepted as morally relevant considerations with respect to resource allocation, they ought, where possible, to be preserved.

With respect to the problem of rationing medical resources, the crucial point is this: by granting the lifesaving resource to primary caregivers of dependent children and thereby saving their lives, research suggests that allocators would not only save a life—something they would do if they prioritized noncaregivers

'competing' for the same resource—they also would maximize health benefits for children. Studies show that children who lose a parent are at greater risk of psychological and behavioral health problems—with some leading to and including death by suicide—following their parent's death and that these effects sometimes extend into adulthood.¹⁹ Children also face mental-health challenges when a parent is suffering from a terminal disease, a prognosis that can sometimes be avoided via the provision of a critical health-care resource such as a healthy organ or a vaccine.²⁰ Children who end up in foster care, particularly those lacking stable placement, face additional mental-health hardships.²¹ In short, parental loss, when experienced by dependent children, is a cause of increased morbidity and mortality.

What this means is that by granting some priority to primary caregivers of dependent children, policy makers and clinicians would be promoting the same end as that comprising their central mission—namely, to prevent mortality and morbidity and to protect and promote human health. This end would be achieved with respect to the caregivers, whose lives would be saved via direct receipt of the resource but also—and this is what makes prioritizing primary caregivers health-maximizing—with respect to those whose well-being is intimately tied to

19. L. Berg, M. Rostila, and A. Hjern, 'Parental Death during Childhood and Depression in Young Adults: A National Cohort Study,' *Journal of Child Psychology and Psychiatry*, 57 (2016), 1092–98; J. Li, M. Vestergaard, S. Cnattingius, M. Gissler, B. H. Bech, C. Obel, and J. Olsen, 'Mortality after Parental Death in Childhood: A Nationwide Cohort Study from Three Nordic Countries,' *PLoS Medicine*, 11 (2014), e1001679; J. Cerel, M. A. Fristad, J. Verducci, R. A. Weller, and E. B. Weller, 'Childhood Bereavement: Psychopathology in the 2 Years Postparental Death,' *Journal of the American Academy of Child and Adolescent Psychiatry*, 45 (2006), 681–90; L. Downey, 'Childhood Bereavement Following Parental Death,' *Journal of Child Psychology and Psychiatry*, 41 (2000), 819–30; E. Agerbo, M. Nordentoft, and P. B. Mortensen, 'Familial, Psychiatric, and Socioeconomic Risk Factors for Suicide in Young People: Nested Case-Control Study,' *BMJ*, 325 (2002), 74; D. Brent, N. Melhem, M. B. Donohoe, and M. Walker, 'The Incidence and Course of Depression in Bereaved Youth 21 Months after the Loss of a Parent to Suicide, Accident, or Sudden Natural Death,' *American Journal of Psychiatry*, 166 (2009), 786–94; S. Hamdan, D. Mazariegos, N. M. Melhem, G. Porta, M. W. Payne, and D.A. Brent, 'Effect of Parental Bereavement on Health Risk Behaviors in Youth: A 3-Year Follow-Up,' *Archives of Pediatrics and Adolescent Medicine*, 166 (2012), 216–23; A. Nickerson, R. A. Bryant, I. M. Aderka, D. E. Hinton, and S. G. Hofmann, 'The Impacts of Parental Loss and Adverse Parenting on Mental Health: Findings from the National Comorbidity Survey-Replication,' *Psychological Trauma: Theory, Research, Practice, and Policy*, 5 (2013), 119–27 <<http://dx.doi.org/10.1037/a0025695>>; William Feigelman, Zohn Rosen, Thomas Joiner, Caroline Silva, and Anna S. Mueller, 'Examining Longer-Term Effects of Parental Death in Adolescents and Young Adults: Evidence from the National Longitudinal Survey of Adolescent to Adult Health,' *Death Studies* <<http://dx.doi.org/10.1080/07481187.2016.122699>>.

20. K. Siegel, D. Karus, and V. Raveis, 'Adjustment of Children Facing the Death of a Parent Due to Cancer,' *Journal of the American Academy of Child and Adolescent Psychiatry*, 35 (1996).

21. David M. Rubin, Evaline A. Alessandrini, Chris Feudtner, David S. Mandell, A. Russell Localio, and Trevor Hadley, 'Placement Stability and Mental Health Costs for Children in Foster Care,' *Pediatrics*, 113 (2004), 1336–41 <<http://dx.doi.org/10.1542/peds.113.5.1336>>.

that of their caregivers.²² Saving the life of a primary caregiver will, *ceteris paribus*, maximize health benefits when the alternative is saving the life of a noncaregiver. It is crucial that this argument, unlike social value-based arguments that draw on judgments of value that often extend far beyond the domain of human health, draws on features of the situation that fall well within the purview of health-care providers, administrators, and policy makers who are obligated to take into consideration any factors that directly impact human health.

Moreover, it is inconsistent of policy makers to ignore caregiver status during rationing decisions while prioritizing other groups for the same reasons that speak in favor of prioritizing caregivers. For example, triage guidelines such as those developed in response to COVID-19 prioritize frontline health-care workers because of the instrumental value they have with respect to promoting the good health of everyone else who depends on their expert care. This is a way of maximizing the number of lives and life-years saved. Again, research shows children who lose their parents are at significantly higher risk of suicide.²³ Thus, saving the lives of primary caregivers maximizes the number of lives saved. Primary caregivers have the same sort of instrumental value as critical-care clinicians do: both provide health benefits to others.

Not only is maximizing the number of lives or life-years saved the justification given for prioritizing frontline health-care workers, it is also the overarching and explicit aim of rationing policies adopted for crisis situations, such as the COVID-19 pandemic. Even where utilitarianism is tempered by considerations

22. Although considerations of social value are excluded from the main argument of this paper, it can be noted that saving the lives of caregivers provides benefits to their children over and above those that have been captured in purely clinical terms. Research shows that the loss of a parent at a young age can damage the child's long-term economic and educational prospects. Moreover, parents provide their children with less tangible goods, such as general information about the world, family stories and history that help situate the child within a larger social context, and a system of values through which the child will interpret and engage the world. The especially sharp sadness with which people react to stories of bereaved children is one way of recognizing the value of primary caregivers to their children. If policy makers should decide to recognize social value, they should recognize the social value of parenting. One way to do so is by prioritizing primary caregivers when potentially lifesaving health-care resources must be rationed. See Mary Shenk and Brooke Scelza, 'Paternal Investment and Status-Related Child Outcomes: Timing of Father's Death Affects Offspring Success', *Journal of Biosocial Science*, 44, 549–69; John Kane, Lawrence Spizman, James Rogers, and Rick Gaskins, 'The Effect of the Loss of a Parent on the Future Earnings of a Minor Child', *Eastern Economic Journal*, 36 (2010), 370–90 <<http://dx.doi.org/10.1057/ej.2010.25>>; P. Gertler, S. Martinez, D. Levine, and S. Bertozzi, 'Lost Presence and Presents: How Parental Death Affects Children' (Berkeley: University of California, Haas School of Business, 2004).

23. I. Jakobsen, and E. Christiansen, 'Young People's Risk of Suicide Attempts in Relation to Parental Death: A Population-Based Register Study', *Journal of Child Psychology and Psychiatry*, 52 (2011); M. Guldin, J. Li, H. S. Pedersen, et al., 'Incidence of Suicide Among Persons Who Had a Parent Who Died During Their Childhood: A Population-Based Cohort Study', *JAMA Psychiatry*, 72 (2015). 1227–34 <<http://dx.doi.org/10.1001/jamapsychiatry.2015.2094>>.

of justice that are inconsistent with utilitarianism—and there is plenty of debate here about if and how such considerations might be incorporated into allocation decisions—it is not controversial that maximizing good health outcomes is, at a minimum, a central aim of health-care-resource allocation, even if it is not the *only* aim. Moreover, where justice is explicitly invoked in order to prioritize one group over another, it is not always clear that utilitarianism is being rejected. For example, some arguments for prioritizing Black people in the United States for COVID-19 vaccination invoke empirical claims about racial inequalities with respect to things like disease burden, ability to socially distance given population density, and access to health care—all variables that are or should be relevant to any forward-looking theory of distributive justice such as utilitarianism.

In the absence of a compelling argument showing why the health benefits conferred by the work of primary caregivers of dependent children should be discounted as compared to health benefits conferred by the work of clinicians, the discrepancy in how rationing guidelines treat the two cases is unjustified and arbitrary. Further, some rationing guidelines already emphasize the indirect health benefits of prioritizing those whose health is directly tied to the health of children. A 2005 document from the Department of Health and Human Services (HHS) outlined a response plan for an influenza pandemic.²⁴ The plan included a prioritization scheme for the distribution of scarce vaccines. HHS granted pregnant women and persons in regular contact with infants under six months of age the highest level of priority. This was because fetuses and infants under six months of age would be too young to receive the vaccine, and thus the only way to confer benefit would be to provide them with what amounts to a form of highly localized herd immunity. HHS must have reasoned that they would be maximizing lives saved by inoculating pregnant women and others who might otherwise infect a young infant. This is fundamentally the same justification offered in this paper for prioritizing parents: doing so prevents illness and death for their children.

Objections

Objection 1: Unjust Discrimination

The first objection is that prioritizing caregivers is unjustly discriminatory and thus falls afoul of the requirement that justifications for allocation priority be

24. Since 2005, HHS has since amended their policy at least twice. The current guidelines are much less specific on rationing guidelines. HHS, *Pandemic Influenza Plan: 2017 Update* (Washington, DC: Department of Health and Human Services, 2017) <<https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>> [accessed 21 June 2021].

consistent with liberal pluralism. It goes like this: There is no general moral obligation to have children and some people choose not to do so. Competent adults should be free to lead their lives as they see fit, so long as doing so is compatible with others' liberty to do the same. Some life plans do not include raising or caring for children. There is nothing inherently inferior about such plans, at least insofar as those committed to liberal pluralism are concerned. Moreover, some people are, for various reasons, unable to have or to care for children. Thus, prioritizing caregivers when lifesaving resources are scarce substantially disadvantages a class of people, either for making a choice they are morally entitled to make or for failing to do something they were unable to do and for which they are not morally responsible. Such disadvantaging amounts to unjust discrimination, and because the disadvantage is very significant—the death of the noncaregiving patient—the injustice is serious indeed.

Rejoinder

Prioritizing caregivers places noncaregivers at a disadvantage relative to caregivers at the time the rationing decision is made. However, the advantage enjoyed by caregivers is not based on a judgment that raising children is morally better than not raising them or that being a caregiver makes one a more virtuous person. Rather, the best argument in support of prioritizing caregivers is based on the nature and magnitude of the harm to the child that attends a caregiver's death. Very roughly, discrimination is unjust when a benefit or burden is allocated on the basis of features of a person or group that are irrelevant with respect to a person's or group's moral entitlement to receive the benefit or to avoid the burden. I have argued that the substantial harm visited upon the child by the death of a primary caregiver makes caregiver status a morally relevant factor for allocation decisions and that because the harm is directly health related, it is permissible²⁵ for health-care professionals to minimize harm. Discrimination on the basis of morally relevant features is not unjustly discriminatory. Prioritizing parents does not fall afoul of the commitment to moral egalitarianism: primary caregivers are not morally better people than noncaregivers. It just happens to be the case that the welfare of dependent children is closely intertwined with the welfare of their parents, such that the parents' death can be a cause of morbidity and mortality for children. In the absence of a convincing argument for why such harm should not count for purposes of rationing scarce medical resources while other health-related benefits and burdens do count, it is hard to

25. I think it is probably obligatory, though I will not explore that possibility here.

see why the prioritization of caregivers should be thought unjustly discriminatory. If it is not unjust to grant some priority to frontline health-care workers, it is not unjustly discriminatory to grant some priority to parents or other primary caregivers.

Another reason granting priority to caregivers is not unjustly discriminatory is that noncaregivers are not, in fact, excluded from receiving all the benefits that would be gained by granting priority to caregivers. This is because although not everyone is a caregiver to dependent children, it is a basic fact of life that every person, caregiver or not, who has reached the age at which caregiver status may play a role in advantaging or disadvantaging them in allocation decisions was at one time themselves a dependent child. One may, for a variety of reasons, not be a parent, but it is not possible to avoid having been a dependent child. The justification for prioritizing caregivers is grounded in the health benefits that accrue to their children, irrespective of whether those children grow up to have children of their own. The proposed policy will be a benefit to anyone who goes through a period of dependency on their caregivers because the policy decreases the likelihood that anyone will, as a dependent child, lose a parent and suffer the associated negative health effects. All of us—caregivers or not—were once dependent children.²⁶

Objection 2: What about Other Kinds of Caregivers?

The second objections asks: Why focus only on children? What about adult children who care for their ailing parents? What about those who care for their seriously disabled siblings or friends? Plenty of other people are dependent and would suffer from the loss of their caregiver. Prioritizing those who care for dependent children falls afoul of the commitment to pluralism because it unfairly distinguishes between parents or other primary caregivers of dependent children and other sorts of caretakers. If the justification for prioritizing parents is that doing so brings health benefits to those in their care, then we should prioritize anyone who falls into this category.

26. The argument here is in certain respects similar to those developed by Norm Daniels in defense of his 'prudential life span account', as well as to the 'complete lives system' sketched by Persad, Emanuel, and Wertheimer. I do not have the space here to explore the extent to which the central claim of this paper might find broader support in the work of these writers. See N. Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008) and Govind Persad, Ezekiel Emanuel, and Alan Wertheimer, 'Principles for Allocation of Scarce Medical Resources', *Lancet*, 373 (2009), 423–31.

Rejoinder

In principle, this response is correct. I interpret it as a call to expand the class of people who should receive some priority to include any group of caregivers whose deaths will lead to increased mortality or morbidity among those for whom they provide care. That being said, there are two considerations against making this move in practice.

First, the evidence for increased morbidity and mortality among bereaved children is quite strong, whereas less is known about adult dependents who lose a caregiver. It is known, for example, that widowhood correlates with higher mortality rates, and thus it might be tempting to grant some priority to married or otherwise coupled individuals in an effort to reduce mortality among their partners.²⁷ However, research on the ‘widowhood effect’ compares mortality rates among individuals who are married, on the one hand, and individuals who recently lost a spouse, on the other. In order to justify prioritizing married individuals, married individuals would need to be compared to individuals who never had a spouse (or at least to those who did not have a spouse who recently died) rather than to individuals who lost a spouse and learn that the latter suffer worse health outcomes than the former. Such evidence is currently lacking. The same goes for other caregiver relations—the empirical research on the health effects of caregiver death on those who received the care is not nearly as robust as research on parental loss and bereaved children.

Second, granting, for the sake of argument, that plenty of adults suffer health effects on par with those suffered by bereaved children, as a matter of policy it simply will be too complicated a task to distinguish those who should receive priority and who should not. Determining parental status is easy to do, and thus incorporating that status into allocation guidelines and putting it into practice is relatively straightforward. It may not be as simple as determining a patient’s age, but given medical and other records, it should not be too difficult to determine who is and who is not a parent. Of course, sometimes mistakes will be made, but this is true with respect to the application of *any* criterion. On the other hand, establishing the relevant kind of health-related caregiver status when it comes to adult dependents would be a far more onerous task, especially if it is common knowledge that claiming adult dependents—in the applicable, health-related sense—might confer a lifesaving benefit to the caregiver. Many people, in order to get the resource, may be tempted to claim, with varying degrees of sincerity,

27. J. Espinosa and W. N. Evans, ‘Heightened Mortality after the Death of a Spouse: Marriage Protection or Marriage Selection?’ *Journal of Health Economics*, 27 (2008), 1326–42; F. Elwert and N. A. Christakis, ‘The Effect of Widowhood on Mortality by the Causes of Death of Both Spouses’, *American Journal of Public Health*, 98 (2008), 2092–98.

that their death will adversely affect someone for whom they provide some care. Investigating such claims would be impractical, costly, and invasive.

Conclusion

Current allocation guidelines for scarce, potentially lifesaving medical resources do not incorporate patients' caregiver status. In the United States, published and emerging guidelines that respond to the COVID-19 pandemic consider frontline health-care-worker status, clinical need (using proxies such as age and comorbidities), and essential worker status. Organs are allocated by the United Network for Organ Sharing (UNOS) on the basis of clinical criteria and, in some cases, on a patient's place on the waiting list coupled with her age (i.e., the criteria vary in some cases between patients under the age of eighteen and those over eighteen).²⁸ Similarly, in articulating guidelines for allocating influenza vaccine in the event of a severe shortage brought about by a pandemic, the Centers for Disease Control and Prevention (CDC) has considered a person's age, pregnancy status, degree of contact with infants under six months of age, job as an emergency or health-care worker, and increased susceptibility to complications from influenza.²⁹ A systematic review of studies on the rationing of ICU resources revealed that doctors considered patients' clinical characteristics and age but not their caregiver status.³⁰

Such policies should be revised to include status as a primary caregiver of dependent children. It is a tragedy for a child to lose a primary caregiver. Recognizing the importance of this incredibly impactful role by giving it weight within rationing guidelines does not entail the judgment that those who raise children are of greater moral worth than those who do not, nor the judgment that raising children is more socially valuable than pursuing ends that are inconsistent with the raising of children. Rather, it merely expresses the same noble inclination that is central to the field of medicine generally and the domain of resource allocation specifically, which is the urge to protect and promote human health and well-being.

28. United Network for Organ Sharing, 'Organ Procurement and Transplantation Network (OPTN) Policies' <http://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Policies.pdf>, <http://optn.transplant.hrsa.gov/policiesAndBylaws/policies.asp> [accessed 21 June 2021].

29. Centers for Disease Control and Prevention, 'Use of Influenza A (H1N1) 2009 Monovalent Vaccine Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2009', *MMWR*, 58(2009), 1–8.

30. T. Sinuff et al., 'Rationing Critical Care Beds: A Systematic Review', *Critical Care Medicine*, 32, (2004), 1588–97.